WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN

الهيئة الصحية العالمية

المكتب الاقليمي لشرق البحر الأبيض

ORGANISATION MONDIALE DE LA SANTÉ

BUREAU RÉGIONAL DE LA MÉDITERRANÉE ORIENTALE

REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN

Eleventh Session

SUB-COMMITTEE A

SUB-DIVISION ON PROGRAMME

EM/RC11A/Prog.Min.3
31 August 1961

ORIGINAL: ENGLISH

MINUTES OF THE THIRD MEETING

Held at the Park Hotel, Chtaura
Thursday, 31 August 1961, at 8.30 a.m.

CHAIRMAN: Dr. M.H. EL BITASH (UNITED ARAB REPUBLIC)

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Representatives

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CYPRUS	Dr. Z.G. Panos
ETHIOPIA	Mr. E. Borrou
FRANCE	Médecin-Colonel P. Faure
IRAN	Dr. A.T. Diba
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JORDAN	Dr. A. Nabilsi
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TECHNICAL ASSISTANCE BOARD	Mr. T.O.P. Lilliefelt
UNITED NATIONS CHILDREN'S FUND (UNICEF)	Mr. M. Sandberg Mr. Arthur Robinson

Representatives and Observers of International, Non-Governmental, Inter-Governmental and National Organizations

American University of Beirut	Dr. Bernard Brandstater
International Association for the Prevention of Blindness	Dr. R. Kammermann
International Committee of Catholic Nurses	Mrs. M. Ejeil-Cree Miss A. Kazan
International Council of Nurses	Mrs. Aida Sultan
League of Red Cross Societies	Mrs. G. Hochar
Lebanese Red Cross School of Nursing	Miss Lucie Majdalany
United States Naval Medical Research Unit No.3, Cairo, UAR	Dr. James H. Boyers
World Federation for Mental Health	Dr. A.S. Manugian
World Medical Association	Dr. J.L. Wilson

1. TECHNICAL MATTERS: Agenda Item 12 (continued)

(e) Rural Health (EM/RC11/8 and Add. 1-4)

Dr. EL HALAWANI, Deputy Regional Director, introducing the report on the item (EM/RC11/8), drew attention to the account of the historical background of social and economic conditions in the Middle East that was given in addendum 1 to the report. A knowledge of the background, in all its aspects, was essential for community planning and the report stressed that the overall responsibility for such work should preferably be entrusted to a body of experts, constituted as a board. Action of the kind had recently been taken in some countries of the Region, to deal with such matters as education, health, water supply, public utilities, sewerage, food control, nutrition, housing, distribution of population, and so on.

The report also drew attention to the role that might be played by democratic unions and institutions in the work of community development and stressed the importance of basic general education for promoting positive health. Medical supervision of schoolchildren and health education in school were the very foundation of child health protection.

Rural health in the Region was dealt with in a general commentary. It was well known that certain indices were important for reflecting health conditions, such as the rate of infant and maternal mortality. The keeping of health and vital statistics was still at an early stage in the Region. WHO was giving help to Member countries for the purpose of instituting suitable recording systems.

The prevalence rate of tuberculosis was another significant pointer to the health situation and addendum 4 gave data on the prevalence of that disease and of trachoma in the Region. Surveys carried out by WHO teams had shown that there was no significant difference between urban and rural areas as regards the incidence of tuberculosis in the Region.

The state of development of health services varied widely from country to country in the Region and the report therefore devoted a special chapter to rural health and community development over the years. The patterns of rural health services in a number of countries of the Region were described; the main types were: (1) a central unit, with a hospital of fourteen to twenty beds attached, and four to six sub-centres, to serve a population of 30,000 to 50,000; and (2) a rural health centre designed to serve 15,000

of the population and provided with fourteen beds for maternity cases and general medicine and surgery. Interesting examples that were described included the pilot project in Ceylon, instituted with WHO assistance, where health and education were combined; the project in El Salvador, again carried out with WHO assistance, where activities were confined to health; and the Qalyub project in the United Arab Republic. The last-named was a rural health centre covering all services, including planning and coordinating of preventive and curative work, re-organizing of the local administration in a way adapted to the socio-economic conditions of the area, and studying of ways of integrating health and other services with the object of raising the general social and economic level.

The community development programme was the most recent approach to the problem of rural health. The immediate objectives of that programme were very comprehensive and covered all aspects of life in a rural community (cf. EM/RC11/8, page 12). The Qalyub project he had already mentioned exemplified that approach; it was accompanied by a land reclamation programme which was also described in the report (Addendum 2A & B). A similar community development project in the Northern Province of the United Arab Republic was also covered (Addendum 2C).

Addendum 3 covered in detail the development of rural health and environmental sanitation in Iran. The matter of rural health had been given special attention in Pakistan recently. The scheme there consisted of establishing a main centre, together with three sub-centres, to serve 50,000 of the population. The technical aspects had been approved by WHO and assistance was being provided by UNICEF.

WHO was also giving an impetus to rural health work in the Lebanon. Two projects, one in the North and the other in the South, had already been instituted. The Sudan also had plans for setting up a rural health demonstration area, as part of a pilot scheme in community development which was to be assisted by WHO and UNICEF.

In Ethiopia, the Gondar College, which enjoyed technical assistance from WHO and US ICA, had been training auxiliary staff for rural health services. Provision was made in the 1961 budget for WHO to provide a supervisory team to Ethiopia to advise on rural health work.

Following a survey carried out in 1951 by a WHO consultant, a demonstration and training centre had been established in Iraq, with WHO assistance. Help was being given to various other countries of the Region as well, in the form of advisory services (Jordan and Tunisia among others) and assistance in the training of sanitarians, nurses and community nurses (Yemen and Libya). Plans were already in being to set up a second centre and a mobile unit in Yemen, where recent road construction would facilitate the working of the health services. Saudi Arabia was actively preparing for the establishment of rural health services; a training centre had been set up, with WHO assistance, to train the requisite para-medical personnel and a community development project was to be undertaken with United Nations and WHO assistance.

Undoubtedly, the development of rural health services in the Region was faced with many difficulties, the chief of which were lack of funds, shortage of trained personnel, and lack of suitable living quarters in the villages for the health staff. The endemo-epidemic diseases were one of the greatest problems in rural areas and effective efforts to reduce them to manageable proportions were called for. Then, too, an efficient rural health service would plan from the outset for absorbing the malaria eradication campaign.

The report pointed out in conclusion that control of communicable infections, education in personal hygiene, organization of medical and nursing services for the early diagnosis and prevention of disease were but one part of a complex undertaking to develop the machinery needed to ensure an adequate standard of living to the rural community. All services essential to the health and well-being of the community must be integrated. The rural centre would be the simplest unit in the chain of services linking the villages and the towns into the rural-urban health district, which must be assured by a certain measure of economy in regard to financing and supplies, so that the necessary central district hospital and central health laboratory might be set up.

Lastly, the report dealt also with the training of staff, evaluation and financing of the work and social research.

Dr. BORAI (Kuwait) stated that the public health authorities of his country subscribed to the generally accepted concept of the integrated rural health unit as the nucleus of the rural health service in any area, and had begun in 1959 to plan for the establishment of a network of such units to cover the entire territory.

The staff assigned to each unit would consist of a senior medical officer, 2 - 6 physicians, a dentist, an oculist, a sanitary inspector (responsible for statistics as well), a public health nurse, 2 - 3 midwives, 3 - 4 nurses, together with auxiliary and administrative staff. Four such units, serving about 30,000 of the population, had been established up to date. The units had not yet reached the required standards in their work but it was hoped that by the middle of 1962 the desired level would have been attained. The plan was to establish sufficient such units by the end of 1963 to cover the entire rural population (approximately 100,000). Each unit would serve one to three villages situated in close proximity; hence, Kuwait had no need of rural health centres.

The units would eventually use all modern techniques of public health care, with the object of ensuring to the rural population the highest possible standard of health and well-being.

Dr. FAURE (France) maintained that the rural health problem could be separated into two widely differing aspects, both of which needed suitable emphasis. First, there was the need for the infra-structure of curative and preventive health services to care for the population; and secondly, complementary support was required by way of health education to inculcate in the individual habits of personal hygiene and knowledge of simple health principles. That work of health education could be done through instruction in the schools and by mass education campaigns. The help of religious institutions and voluntary agencies was invaluable, and indeed almost essential, in efforts of the kind.

For areas where the rural population was widely dispersed, he advocated that consideration be given to the use of mobile units to supplement the work of the centres.

Dr. PANOS (Cyprus) congratulated the Secretariat on the excellent and comprehensive report that had been submitted.

As long ago as 1945, Cyprus had established fixed rural health units, combining both curative and preventive services, and enjoying a fair measure of autonomy. Those units had given most satisfactory service. However, around 1950, it had been decided that mobile health units would serve the purpose better. The change-over had been made and had proved a failure, due

largely to the fact that all the staff of the mobile unit, irrespective of function, had to travel at the same time. That had been found to be an inconvenient procedure, since very frequently the services of the midwife were required in one area and the services of the dentist in another. Moreover, communications in Cyprus made it difficult for a motorised unit to reach the most outlying parts. Accordingly, Cyprus had reverted to the use of fixed rural health units from which the staff could, if necessary, go out to patients by donkey.

Mr. AZOUZ (Tunisia) confirmed that special attention was being given to rural health in Tunisia. In addition to the regular activities, an interesting experiment designed to improve social conditions in rural areas had been tried, with results far exceeding all expectations.

In July 1959, a number of young women volunteers had been sent out on mission, following a short period of training, to the most under-privileged of the rural communities. Their function had been to give elementary health education. In view of the very satisfactory results obtained, it had been decided to expand the experiment and further volunteers had been given general training over a period of several weeks in general hygiene, maternal and child welfare, communicable diseases, environmental sanitation, diet and utilization of the family income to the best effect.

The results obtained from that further effort had been equally encouraging and it had been decided to convert the activity into a national programme on a more comprehensive and permanent basis, and steps to that end had already been taken. He went on to give details of the corps of social workers that had thus been formed and to describe how they worked. UNICEF was contributing equipment, supplies and vehicles for the work, which was done in close collaboration with the medical and para-medical staff and the maternal and child welfare centres.

Dr. KHAN (Pakistan) said that Pakistan had a vast rural health problem since 80 per cent of the total population lived in rural areas. Under the current five-year plan, 320 rural health centres were to be established, 80 of which had already been built and were in operation. During the remainder of the period covered by the plan, it was expected that 60 such centres, fully equipped and staffed, would be built and put into commission each year.

The medical and para-medical staff required were already being trained and would become available as the centres were established. Earlier plans to utilize existing buildings, whether or not of the right size, had been abandoned and the Government had now agreed to construct new buildings of full scale for all the centres. The initial outlay would be greater but the facilities eventually provided would meet all the requirements. Preventive and curative medicine and public health education and maternal and child welfare were to be integrated in the centres.

Dr. EL HALAWANI, Deputy Regional Director, thanked the speakers for the interesting comments they had made. It was noteworthy that the ideas expressed closely accorded with the view put forward in the report.

The question of health education was dealt with in the report in detail, as part of the integrated services of the rural health units. Likewise, the problem presented by a widely scattered population was also covered (EM/RC11/8, page 26).

The CHAIRMAN, noting that there were no further speakers, submitted a draft resolution on the item for the Committee's consideration.

Decision: The draft resolution was adopted unanimously, on the understanding that the Arabic text would be brought into line with the English. (EM/RC11A/R.13)

(f) The Management of Medical Stores and Pharmacy as part of Public Health Administration

Mr. BISHARAH (Secretariat), presenting the report prepared by the Regional Office on the Management of Medical Stores and Pharmacy as part of Public Health Administration (Document EM/RC11/9- item 12(f) of the agenda), said that it was the first of its kind. The Regional Director had on several occasions met the recognized needs of Member Governments in the Region, extending limited assistance in that field in answer to requests.

Considering the complexities involved in the administration and management of pharmacy and medical stores, the paper was intended to explore further the needs of Governments and to present a few basic facts which might stimulate countries to consider ways and means of organizing such services, the importance of which was increasingly recognized.

A medical stores department, as an integral part of a Ministry of Health, was vital to all services whether curative or preventive, integrated or not. It was expected to furnish the necessary medicaments, dressings, sera, vaccines, insecticides, surgical instruments, hospital furniture, X-ray equipment, and numerous other types of medical supplies promptly, when and where they were needed, and to the best economic advantage of the Government. If such a service was not well organized, however, it would drain the budget of the Ministry in the same way as inefficient hospital administration.

The paper, brief as it was, merely touched on the various aspects of storekeeping and medical supply administration, including the location and design of the premises, the sectioning of the stores, the care and refrigeration of perishables, fire prevention, transport, etc. It also dealt with the organizational pattern of staffing; the accounting of medical supplies; the establishment of a standard list of items most commonly used in the Ministry's health units in the form of a stores catalogue; a formulary of compounds and mixtures for the purpose of reducing the use of the numerous specialities and marketed by the growing number of pharmaceutical firms, and restricting such medicaments as far as possible to their generic origin.

The paper also introduced the pharmacist who, in his capacity as a professional man and a university graduate, able to assume professional responsibilities in collaboration with the medical professions as well as the administration, was most useful in that field. It was believed that a pharmacist might very well, with special training, form the best possible liaison between the medical and the administrative staff. No college or university in the world prepared medical supply officers as such. However, practical experience gained the hard way in the various aspects of medical storekeeping could produce supervisors, assistants and storemen capable of assuming the diverse responsibilities, technical or otherwise. Three types of training were accordingly suggested:

1. For senior staff, pharmacists, etc.
2. For all medical personnel with custody of medical supplies - hospital superintendents and administrators, laboratory technicians, sanitarians, public health administrators, etc.
3. For training assistant-pharmacists, dispensers, and lower grades of staff in the medical services

Member Governments should therefore consider the possibility of financing potential fellows for such work, to spend three to six months in well organized medical stores. Cyprus presented a field for training for those who knew English, and the Sudan, perhaps, for Arabic-speaking personnel. Further exploration of such facilities was to be undertaken for the preparation of comprehensive courses as well as practical experience. A curriculum was to be prepared for each level of training.

Finally, WHO had helped to provide supply services in Member States in accordance with the resolution adopted by the Executive Board at its Twenty-third Session (EB23.R48), copies of which had been despatched to each Member State of the Region at the time of its adoption: further copies were available from the Documents Officer at the present Session. Eight Member States of the Region had availed themselves of the opportunity offered, and supplies and equipment had been procured on their behalf on a reimbursable basis.

The Regional Director had extended limited assistance in the organization of medical supply services to Jordan, Lebanon and Saudi Arabia. Consideration was being given to requests made recently by the United Arab Republic and Somalia.

Dr. ABU SHAMMA (Sudan) commended the Regional Director for his foresightedness in bringing up the question of medical stores management. The document submitted had been well prepared and covered the essentials of the matter.

Decentralization of medical supplies in a large country such as the Sudan, with its transport and communication difficulties, would entail the establishment of sub-depots in addition to the provincial central store. Secondly, from the standpoint of management, it was very important to include a repair workshop in the service, staffed by a technician capable of repairing medical equipment and surgical instruments. That would be less costly than replacements.

Thirdly, although probably not practicable everywhere, it would be desirable to have a small laboratory within the service for testing vaccines and drugs for potency after the expiry date. In many cases, such supplies would be found to be still usable and thus further savings would be effected.

In addition to the recommended formulary of compounds and mixtures, he would suggest that a standard list of equipment and instruments for the various types of hospital, dispensary and so on, should be drawn up, which could be used as a guide for the setting up of new establishments.

Lastly, he would advocate that suitable financial provision be made to enable the local officials of the service to procure locally such items of equipment as tables and chairs. That again would result in economies.

Dr. NABILSI (Jordan) had little to add to the points raised by the previous speaker. The management of medical stores was a subject of considerable importance, particularly at a time when the variety and complexity of medicaments was increasing and the number of trade names had multiplied. The proper organization of medicalstores, and the creation of a special section for the purpose in Ministries of Health, would certainly result in enormous savings. An expert sent by the Regional Office had visited Jordan during the past year and the Government had begun to apply his advice, with considerable benefit. WHO had also granted two fellowships, and he was sure that in the future coordination would be better.

Dr. PANOS (Cyprus) said that any country which wished to make use of the facilities in his country would be most welcome to do so.

He agreed with the Representative of Sudan that there was great advantage in obtaining supplies and getting repairs done locally whenever possible.

Dr. WAKIL (Lebanon), referring to the request he had made at the previous meeting for an expert to be sent in 1962 rather than 1963, said that there was an urgent need for the re-organization of medical supply services in his country. The Regional Office had already sent an expert to advise on the organization of medical supply services and his recommendations were being studied. In 1962, L.L. 165 000 had been allocated in the budget of the Ministry of Health for the purpose of implementing those recommendations.

Dr. ABDULGHANI ARAFEH (United Arab Republic) thanked Mr. Bisharah for his introduction of the subject. Although the suggestion that there should be a special course in pharmacy and medical stores management was interesting, it would involve considerable expense for governments. He would propose, therefore, that such training should form part of the curriculum in the existing courses for different categories of medical and health staff.

Médecin-Colonel FAURE (France), associating himself with the previous speaker in thanking the Regional Office for its report on the subject, pointed out that the aim was to provide the patients with the best available medicaments while limiting the expense to the authorities as far as possible. The cost of transport and packaging was considerable when supplies had to be sent to distant destinations and all too often, expensive containers and packaging were wasted, especially in rural centres where there was no supervision. If care was taken to ensure that packages could be re-used whenever possible, about ten per cent of the cost of the medicaments could be saved.

Dr. TABBAA (Saudi Arabia) said that the Ministry of Health in his country was coordinating its medical stores services along the lines suggested by the expert sent by the Regional Office in response to its request for assistance.

Mr. AZOUZ (Tunisia) paid tribute to the effort which had led to the inclusion of the subject on the agenda, and commended the Regional Office on its report. The importance of coordination in the management of medical stores and pharmacy was generally recognized. In Tunisia, most of the problems involved had been solved, and the solution adopted was along the lines suggested in Document EM/RC11/9.

In 1956 there had been only one special pharmaceutical establishment in the country. In 1958 a central pharmaceutical service had been established by law, under the management of a pharmacist, and with fifty subsidiary establishments under its direction which supplied rural areas. The staff was recruited by competitive examination. The establishments served as pilot projects in which methods of production and distribution were studied. A pharmaceutical industry was about to be established in the country, which, it was hoped, would contribute to the development of the economy and to the improvement of health. Attention had also been given to the control of imports, and the restriction of profits on pharmaceuticals. WHO had given assistance in regard to the production, grading and classification of pharmaceuticals. It was hoped that the remaining problems would soon be solved and that further progress could be reported.

Dr. SHAHEEN (Iraq) said that the question of the management of medical stores and pharmacy was of particular importance to the countries of the Region. The population of Iraq, for example, was scattered in remote areas and it was becoming increasingly difficult to supply modern anti-biotics and other

medicaments which had to be transported long distances in difficult climatic conditions. His Government would ask the Regional Director to send an expert to advise them on the organization of pharmacy and medical supply services.

Dr. ABU SHAMMA (Sudan) said that his country would always be ready to offer facilities for study in the field of pharmacy and medical supply services.

The CHAIRMAN thanked the Representative of Sudan and his Government for that offer.

Mr. BISHARAH (Secretariat), thanked the representatives for the interest they had shown and said that all their comments would be noted.

The REGIONAL DIRECTOR explained, in reply to the request by Lebanon for an expert to be sent in 1962 rather than 1963, that the 1962 Budget had been approved last year and some amendments had already been made to it. As things stood, it seemed unlikely that it would be possible to appoint an expert before 1963: if it was found, however, that there were some savings in the Budget towards the end of the year, an effort might be made to appoint an expert by the end of 1962. Meanwhile and in case of urgent need, the Regional Office would try to see that governments will have, as far as possible, assistance of the Medical Supply Officer who had been helping countries in the Region in a way which, he was glad to note, had been considered satisfactory.

The CHAIRMAN read the draft resolution on the management of medical stores and pharmacies as part of public health administration.

Dr. ABDULGHANI ARAFEH (United Arab Republic) suggested that a fourth paragraph might be added to the draft resolution recommending that a study should be made of the possibility of training the various categories of medical and health personnel in the organization of medical supply services.

Dr. ABU SHAMMA (Sudan) felt that the medical student's course was already very heavy. Before any recommendation to add a subject to the curriculum was made, it might be advisable to consult medical schools on the matter. The management of medical stores was in any case the responsibility of the pharmacist and the person in charge of supplies, and not of the doctor.

Mr. AL ATEEQI (Kuwait) supported the Representative of Sudan. The management of medical stores was a distinct duty which could not be confused

with other subjects. In addition, it would be impossible for any country in the Region to spare any qualified personnel, already trained for a particular job, for further training in the management of medical stores.

The CHAIRMAN felt that the draft resolution was satisfactory as it stood and that paragraph 3 adequately covered the question of training.

Decision: the resolution on the management of medical stores and pharmacy as part of public health administration was adopted unanimously, on the understanding that the Arabic text would be brought into line with the English text (EM/RC11A/R.14).

(g) Khat: A Preliminary Study

Dr. TIGANI (Secretariat), introduced the preliminary study of Khat prepared by the Regional Office (Document EM/RC11/10 - item 12 (g) of the agenda).

He wished to mention some points in relation to the study which might be of interest and importance in pharmacological research on animals or human beings. Firstly, the ephemeral nature of the green leaves and the possibility that the process of drying might reduce the potency of the active biochemical principles of the plant, or at least inactivate some of them, made it necessary that research should be organized and carried out on the spot where fresh leaves were readily available.

Consideration might be given to the possiblity of using other animals for research, for example, the goat. According to legendary tradition, its action became known as a result of observing striking changes in the behaviour of goats and camels feeding on the plant. The use of normally hyperactive animals or disturbed laboratory animals might react to a greater extent under Khat. Trained baboons might, in fact, be very suitable for laboratory work.

In whatever form Khat was used, it should be given regularly once a day for some weeks until the threshold period had been passed or until the test had lasted for about eight weeks. The daily doses should be given punctually after a period of regular activity. There existed some rythm and some periodicity in relation to its optimum effect which could not yet be clearly defined. In animals of nocturnal habits, Khat should be given in association with the physiological pattern if giving it by day produced no response.

Fresh green leaves bruised and given by mouth in a dose of specified weight should be used at the beginning. Glucose or carbohydrate diet should

be given before the leaves were taken or together with them, and a blood sugar estimation should be made before and after Khat. The possibility of an anti-diabetic effect was a point of some importance.

It should also be given together with large quantities of fluids, and possibly with coffee or tea, as potentiators.

The influence of Khat on appetite was also important: it appeared to stimulate appetite immediately after its ingestion but that effect disappeared rapidly and was replaced by loss of appetite. Khat also appeared to stimulate sexual activity for a short period which was followed by complete loss of libido. It was better to keep animals together to see whether the gregarious tendency was increased by the use of Khat, as well as for the purpose of observing the changes in sexual behaviour.

In view of the fact that Khat seemed to be effective as a socializing agent, it might perhaps be used experimentally in the treatment of certain hospitalized psychiatric cases, such as restless, anti-social psychopaths, depressives and in paranoic conditions. Its use might also be tried for certain types of habitual criminal, to see whether it could break the pattern of repeated crime, and in certain other conditions such as catalepsy and epilepsy. He felt that it would be of great importance to estimate the effect of Khat as an anti-diabetic and in the anti-social cases which he had just mentioned.

Dr. MORSHED (Iran) said that his country had a vast anti-narcotics programme, the cost of which to the Government, including damages resulting from the prohibition of cultivation, amounted to US$ 9,000,000 each year. It had not yet suffered from Khat, but it was possible that as the world came closer, that problem might be introduced. He had therefore read the outstanding paper with great interest, and congratulated the Regional Director and his staff on its preparation.

Médecin-Colonel FAURE (France) also congratulated Dr. Tigani on his important, well-written and comprehensive report and the way in which he had presented it. In his own experience in French Somaliland, he had found that the workers who consumed Khat (and who were often labourers doing heavy manual work) deprived their families of adequate nutrition in order to buy supplies

of Khat. The resultant malnutrition opened the way to diseases such as tuberculosis. He felt that the report had perhaps not given sufficient emphasis to the pathological effects on habitual consumers of Khat: he had observed in the Djibouti hospitals many instances of digestive disturbances, including complete occlusion, as a result of its consumption.

The CHAIRMAN read the draft resolution on Khat.

Decision: the resolution was adopted unanimously (EM/RC11A/R.15).

The CHAIRMAN announced that discussion of item 12 - Technical Matters - was completed.

The meeting rose at 10.45 a.m.