NINETEENTH SESSION OF THE
WHO REGIONAL COMMITTEE FOR SOUTH-EAST ASIA
HELD IN NEW DELHI, INDIA
FROM 27 SEPTEMBER TO 3 OCTOBER 1966

FINAL REPORT AND MINUTES
OF THE MEETINGS

OCTOBER 1966
NEW DELHI, INDIA
WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR SOUTH-EAST ASIA

REPORT AND MINUTES OF THE
NINETEENTH SESSION
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October 1966
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PREFACE

Section I of this volume consists of the Report on the Nineteenth Session of the WHO Regional Committee for South-East Asia, and Section II, the Minutes of this session. Also included as Annexes to Section I are the Final List of Participants, the Agenda of the session, the Report of the Sub-Committee on Programme and Budget, the Recommendations arising from the Technical Discussions on "Health Laboratory Services", and the Final List of Documents.
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REPORT OF THE REGIONAL COMMITTEE*

INTRODUCTION

The nineteenth session of the Regional Committee for South-East Asia was held from 27 September to 3 October 1966 at World Health House, New Delhi, India. Representatives from eight of the nine Member Countries in the Region** were present. The Maldives Islands, which had become a Member of WHO after the last session of the Regional Committee, was not represented. For final list of participants, see Annex 1.

The session was declared open by the retiring Chairman, Dr Mohd. Osman Anwary (Afghanistan). The Prime Minister of India, Mrs Indira Gandhi, delivered the inaugural address, and an address was also given by the Minister for Health and Family Planning, Dr Sushila Nayar. A statement was made by the representative of the Director-General of WHO, Dr John Karefa-Smart, Assistant Director-General. Messages of good wishes for the success of the meeting were also conveyed by the representative of the United Nations and United Nations Development Programme, the representative of UNICEF, the representative of the Food and Agriculture Organization of the United Nations, the representative of UNESCO and representatives of several non-governmental organizations in official relation with WHO.

At the first meeting a Sub-committee on Credentials was appointed, consisting of representatives from Afghanistan, India and Thailand. Dr Hakimi (Afghanistan) was elected Chairman of the Sub-committee. The Sub-committee made a report (document SEA/RC19/19), recognizing the validity of the credentials presented by all the delegations.

The Regional Committee elected the following office bearers:

Chairman : Dr Marsaid Soesilo Sastrodihardjo (Indonesia)
Vice-Chairman : Dr Lun Wai (Burma)

The provisional agenda was adopted (see Annex 2).

The Committee established a Sub-committee on Programme and Budget consisting of representatives of Afghanistan, Burma, India, Mongolia and Thailand, and adopted terms of reference for this Sub-committee (see Appendix to Annex 3). The Sub-committee elected Dr Hakimi (Afghanistan) as Chairman; it held four meetings and submitted a detailed report (Annex 3), which was subsequently endorsed by the Regional Committee.

*Issued as document SEA/RC19/22, on 2 October 1966, and incorporating a few corrections made at the final meeting of the Regional Committee (see Section II).

**Afghanistan, Burma, Ceylon, India, Indonesia, Mongolia, Nepal and Thailand.
On 28, 29 and 30 September, technical discussions were held on the subject of "Health Laboratory Services", under the chairmanship of Dr D.B. Gunasekera (Ceylon). The conclusions and recommendations arising from these discussions are given in Annex 4.

"Maternal and child health, with particular reference to integration into the general health services" was chosen as the subject of the technical discussions to be held during the Regional Committee's session in 1967.

In the course of seven plenary meetings the Committee considered a number of subjects and adopted ten resolutions, which make up Part I of this report. Parts II, III and IV are devoted to summaries of important matters brought out in the discussions. A complete list of documents is given in Annex 5.
PART I

RESOLUTIONS

The following ten resolutions (circulated in a special resolution series) were adopted in the course of the session. For further comments on the subject of some of these, see other sections of this report.

SEA/RC19/R1     EIGHTEENTH ANNUAL REPORT OF THE REGIONAL DIRECTOR

The Regional Committee,

Having made a careful study of the Eighteenth Annual Report of the Regional Director on the activities of WHO in South-East Asia during the period from August 1965 to August 1966 (documents SEA/RC19/2 and Corr.1),

1. CONSIDERS that the report presents a most useful record of the cooperation of WHO in the development of health work in the Region during the period under review;

2. EXPRESSES its satisfaction at the efforts made by the governments in the Region to surmount the numerous difficulties which continue to hamper the further improvement of health activities in their respective countries, and

3. THANKS the Regional Director and his staff for the work done during the year.

Handbook III, 3.1 (18)     Sixth Meeting, 1 October 1966
Page 7     SEA/RC19/Mn.6

SEA/RC19/R2     SOCIO-ECONOMIC VALUE OF THE CONTROL OF COMMUNICABLE DISEASES

The Regional Committee,

Having considered the large financial investments made in national disease eradication and control programmes,

1. RECOGNIZES the need for maintenance of these programmes through basic health services;

2. STRESSES the importance of accelerating the further development of basic health services;
3. APPRECIATES the importance of providing adequate justification for the expenditure necessary to enable basic health services to undertake the maintenance of communicable-disease control programmes, and.

4. REQUESTS the Regional Director to examine the feasibility of advising on a methodology for measuring the socio-economic benefits derived from the control of communicable diseases.

Handbook II, 2.1 (3)       Sixth meeting, 1 October 1966
Page 1                     SEA/RC19/Min.6

SEA/RC19/R3     PROVISION OF TEXTBOOKS

   The Regional Committee,

   Having discussed the difficulties of providing an adequate supply of cheap and standard medical textbooks,

   REQUESTS the Regional Director to investigate ways and means by which standard textbooks may be made available at moderate cost to institutions and students.

Handbook II, 2.4 (7)       Sixth meeting, 1 October 1966
Page 47                    SEA/RC19/Min.6

SEA/RC19/R4       SEMINAR ON REQUIREMENTS IN MANPOWER

   The Regional Committee,

   Having discussed the manpower position in the field of health, and

   Realizing that there is a shortage of manpower in the countries of the Region,

   REQUESTS the Regional Director to organize a seminar with broad participation from countries of the Region, to discuss the organizational and manpower requirements for health services and the measures to be taken to meet the needs for various categories of manpower in the Region, with special emphasis on conservation of medically qualified personnel.

Handbook X, 10.6         Sixth meeting, 1 October 1966
Page 6                    SEA/RC19/Min.6

SEA/RC19/R5     INCREASING THE SIZE OF THE EXECUTIVE BOARD

   The Regional Committee,

   Noting the resolution approved by the Executive Board at its thirty-eighth session on this subject (EB38.R20),
Agreeing with the Board in its belief that an increase in its membership would be desirable, and

Considering that the limitations of having in the Executive Board two Members only from the South-East Asia Region results in the selection of a new Member from the Region in only two out of every three years,

RECOMMENDS to governments of the Region that they propose to the World Health Assembly:

(1) that the Executive Board of WHO should consist of twenty-eight persons designated by as many Member States, and

(2) that each region should be represented by at least three Members so as to provide for the election every year of at least one fresh Member from each region.

Handbook VI, 6.1 (2)  Sixth meeting, 1 October 1965
Page 1  SEA/RCl9/Min.6

SEA/RCl9/36  PROCEDURE FOR THE NOMINATION OF REGIONAL DIRECTORS

The Regional Committee,

Considering that Rule 49 of the Rules of Procedure of the Regional Committee require amendment, and

Having regard to Articles 49 and 52 of the Constitution and the proposal contained in document SEA/RCl8/16 on this subject,

RESOLVES that Rule 49 of its Rules of Procedure shall be amended to read as follows:

Rule 49  Nomination of Regional Director

(a) Not less than six months before the date fixed for the opening of a session of the Committee at which a person is due to be nominated as Regional Director, the Director-General shall inform each Member of the Region that he will receive proposals of names of candidates for nomination by the Committee as Regional Director.

(b) Any Member of the Region may propose the name of one person from within the Region who has indicated willingness to act as Regional Director, submitting with the proposal particulars of the person's qualifications and experience. Such proposals shall be sent to the Director-General so as to reach him not less than twelve weeks before the date fixed for the opening of the session.
(c) A person holding office as Regional Director for the Region shall, if he is eligible and has so requested the Director-General, be a candidate for nomination without being proposed under the preceding paragraph.

(d) The Director-General shall, not less than ten weeks before the date fixed for the opening of the session, cause copies of all proposals for nomination as Regional Director (with particulars of qualifications and experience) received by him within the period specified to be sent to each Member of the Region. The Director-General shall also indicate to each Member whether or not the person holding the office is a candidate for nomination.

(e) If no proposals have been received by the Director-General in time for transmission to Members in accordance with this Rule, Members shall be informed accordingly not less than ten weeks before the opening of the session of the Committee. The Committee shall itself establish a list of candidates composed of the names proposed in secret by the representatives present and entitled to vote.

(f) The procedure laid down in the second sentence of paragraph (e) above shall also apply in cases where the post of Regional Director falls vacant within the period of six months laid down in paragraph (a) of this Rule.

(g) The nomination of the Regional Director shall take place at a private meeting of the Committee. The Committee shall make a selection by secret ballot from among the persons who are candidates under this Rule.

(h) For this purpose each representative entitled to vote shall write on his ballot paper the name of a single candidate chosen from the above-mentioned list. If no candidate obtains the majority required, the candidate who obtains the least number of votes shall be eliminated at each ballot. If the number of candidates is reduced to two, there shall be as many ballots as are necessary in order to secure a majority for either candidate. In the event of a tie between the remaining candidates after three such ballots, the whole procedure established by this Rule shall be recommenced.

(i) The name of the person so nominated shall be submitted to the Executive Board.

Handbook VIII, 8.3 (5) Fifth meeting, 30 September 1966
Page 7 SEA/R19/Min.5

SEA/R19/77 HEALTH ASPECTS OF WORLD POPULATION PROBLEMS

The Regional Committee,

In pursuance of resolution WHA19.43 of the Nineteenth World Health Assembly, dated 20 May 1966, on the programme activities in the health aspects of world population which might be developed by WHO,
Realizing the importance of family planning in ensuring maternal and child health and welfare, subject to the national policies of Member Governments, and

Bearing in mind the need for basic health services to ensure the health of mothers and children as a prerequisite for limiting the size of the family in the interests of the health and happiness of the family,

REQUESTS the Regional Director to explore the possibilities of providing and obtaining maximum assistance for expanding basic health services and strengthening maternal and child health services with supplies and equipment, including vehicles, and to promote training facilities as appropriate, as well as to encourage research programmes in neglected areas.

Handbook X, 10.1 (2) Sixth meeting, 1 October 1966
Page 1 SEA/RC19/Min.6

The Regional Committee,

Having examined the proposed Programme and Budget Estimates for 1968, as shown in document SEA/RC19/3,

1. EXPRESSES its satisfaction with the report of the Sub-Committee on Programme and Budget (document SEA/RC19/20);

2. APPROVES the Regular Programme and Budget Estimates (document SEA/RC19/3), and

3. RECOMMENDS to the Director-General their incorporation in his annual budget estimates for 1968;

4. EXPRESSES itself satisfied with the proposed programme under the United Nations Development Programme;

5. RECOMMENDS to the Director-General its incorporation in his annual budget estimates for 1968, and

6. RECOMMENDS specifically, the implementation of the inter-country projects included under the Regular Budget and under the United Nations Development Programme.

Handbook IV, 4.1 (18) Sixth meeting, 1 October 1966
Page 9 SEA/RC19/Min.6
The Regional Committee,

1. DECIDES to hold technical discussions at its twentieth session in 1967 on the subject of "Maternal and child health, with particular reference to integration into the general health services";

2. REQUESTS the Regional Director to take appropriate steps to arrange for these discussions and to place this item on the agenda of the twentieth session, and

3. URGES governments of the Region to include adequate technical representation in their delegations for the twentieth session.

Handbook V, 5.3 (13)  Sixth meeting, 1 October 1966
Page 12        SEA/RC19/Min.6

The Regional Committee,

1. CONFIRMS its previous decision to hold its twentieth session in Ulan Bator in August 1967, and,

Bearing in mind the principle of holding alternate sessions of the Regional Committee at the regional headquarters,

2. DECIDES to hold its twenty-first session at the seat of the Regional Office in New Delhi in September 1968.

Handbook V, 5.1 (18)  Sixth and seventh meetings, 1 and 3 October 1966
Page 6            SEA/RC19/Min.6 and Min.7
In the discussion on the Regional Director's report (SEA/RC19/2), there was general agreement that serious financial difficulties had hampered any major advances in health.

Notwithstanding these economic difficulties and shortage of health personnel, the Committee appreciated that all countries of the Region were engaged in developing long-term plans for health services, particularly to provide integrated basic health services giving comprehensive coverage, both curative and preventive. The urgency in building up these services arose from the necessity to avoid the loss of considerable investments in malaria and smallpox eradication and to absorb other specialized communicable-disease control programmes.

However, there remained a severe shortage of all categories of health personnel, which demanded further strenuous efforts to surmount. The Committee stressed that the adverse effect of these circumstances on the vulnerable groups, mothers and children - and in particular the pre-school child - would lead to an increase in the ill-nourished and under-developed, which in turn would contribute to a reduced manpower potential for economic development whilst simultaneously increasing the numbers of the relatively dependent and disabled. There was a need to standardize the various categories of health personnel and to appraise critically, through operational studies, the functions and work output of health personnel, in particular the auxiliary health workers at peripheral and intermediate levels. Efforts to induce health personnel to work in increasing numbers in rural areas were also discussed.

The Committee agreed that there should be greater appreciation that health plans should form an integral part of the overall national plans for social and economic development. WHO's assistance was increasingly required in the field of complementary training in planning and administration. The requirements in manpower for health services and measures to be taken to meet the needs for various categories of manpower within the Region needed to be assessed, and WHO should also continue to assist in operational research studies in connection with the performance and attitudes of different categories of health personnel.

Also, the considerable increase in national efforts for family planning in some countries demanded that health departments should cautiously develop them as a part of general health and maternal and child health services without disturbing the normal preventive and curative functions of those services.
The Committee considered that it was important to assess the economic gains from communicable-disease control, and requested that WHO should examine the feasibility of advising on a methodology for measuring the socio-economic benefits derived from control programmes (see resolution SEA/RC19/R2). This was important to secure continued financial support for the maintenance of this service.

In the Region WHO and governments continued to spend about 50 per cent of financial resources available for health on the control of communicable diseases. It had become clear that without proper epidemiological, laboratory and statistical services this effort was not fully economical or effective. Further efforts in this direction were therefore essential. There was appreciation of the nine-month international course in epidemiology organized by WHO, for studies partly in Europe and partly in India, and it was agreed that WHO should examine the practicability of awarding a certificate for this course. Ultimately, recognition of the course might lead to an agreement between the universities concerned to award a diploma or degree.

Problems of increasing significance were the persistence of smallpox transmission, notwithstanding the smallpox eradication or control programmes that had been in operation, and the changing epidemiological pattern and spread of cholera El Tor, of haemorrhagic fever, of chikungunya and dengue fevers, and of viral hepatitis. The Committee appreciated the assistance given by WHO in cholera research, in epidemiological studies, in the production of rehydration fluid, and in providing the services of a regional cholera team.

Concern was expressed over the shortage of medical teachers, due partly to the increase in the numbers of medical colleges established to meet the demands of expanding health services. The Committee endorsed the need to establish post-graduate schools for the training of teachers in various medical disciplines, especially in the basic medical sciences. International assistance in holding workshops for medical teachers and in simultaneously assigning groups of experienced teachers in a number of disciplines for short periods, as recently developed by the Regional Office, promised to be particularly useful. Another direction in which WHO assistance would be valuable would be in providing textbooks, which were in short supply, and the Committee requested that the Regional Director investigate ways and means of making standard textbooks available at moderate cost (resolution SEA/RC19/R5).

It was urged that, wherever possible, countries should achieve self-sufficiency in the production of materials necessary for control programmes, e.g., DDT in malaria eradication and chemotherapeutic substances for the control of tuberculosis. The need for WHO's assistance in developing national laboratories for the quality control of drugs, including the procurement of necessary equipment, was emphasized.

The Committee expressed its satisfaction with the report and with the efforts made by governments in the Region to surmount the numerous difficulties which they continued to face in efforts to improve their health services (resolution SEA/RC19/R1).
PART III

EXAMINATION OF THE PROPOSED PROGRAMME AND BUDGET ESTIMATES FOR 1968

The Sub-Committee on Programme and Budget appointed by the Regional Committee met on 28 and 29 September 1966 to review the Proposed Programme and Budget Estimates for 1968 (document SEA/RC19/7) in accordance with the terms of reference laid down by the Regional Committee (Appendix to Annex 3). The Sub-Committee submitted its report (see Annex 3), which was reviewed by the Regional Committee at the time when it made its detailed study of the Proposed Programme and Budget Estimates.

It was noted that the Sub-Committee had undertaken a broad examination of all new elements in the programme, as well as a detailed examination of selected current projects. The Sub-Committee had fully scrutinized the nursing programme and had expressed its general agreement with the pattern of development of WHO nursing assistance in all countries of the Region.

The Regional Committee agreed with the proposal submitted by the Sub-Committee that "Epidemiology" should be the field of activity for specific examination by the sub-committee to be appointed in 1967.

Finally, the Regional Committee expressed itself as satisfied with the Report of the Sub-Committee and approved the Proposed Programme and Budget Estimates for 1968, including the inter-country projects, recommending that the Director-General incorporate these proposals in his annual budget estimates for 1968 (see resolution SEA/RC19/R8).
1. Planning of Health Services

In considering document SEA/RC19/10, submitted by the Government of Thailand, a short discussion took place on the planning and implementation of national plans in countries of the Region. A statement was made on WHO's work in the field of health planning; the observations and recommendations of the 1966 Expert Committee on Health Planning were awaited with interest.

The Committee requested that WHO should continue its assistance in the training of public health administrators in planning techniques, and that a seminar on the requirements in manpower and its utilization be organized, with broad participation from the countries of the Region (resolution SEA/RC19/R4).

2. Reporting and Recording of Health Activities

The Committee considered a paper on this subject presented by the Government of Thailand (document SEA/RC19/11) and agreed that there were at present so many reports of varying complexity that their utilization was difficult. It was necessary to streamline and simplify forms so that they would be intelligible to the persons completing them and would yield information useful to the health administrations. In this connection, the Regional Director presented two charts on the flow of information between peripheral health units and the central health services. The Committee appreciated the fact that WHO had planned a seminar on this subject.

3. Appointment of a Regional Appraisal Panel to Evaluate the Progress of Malaria Eradication Programmes

During the discussion of a paper on this subject submitted by the Government of Ceylon (document SEA/RC19/16), the Committee agreed that the problems of approach to the maintenance phase emphasized the need for periodic independent assessment with the help of WHO. In view of the fact that the WHO programme provided for a regional assessment team on malaria eradication (SEARO 7) every year, the appointment of a regional panel for that purpose, as originally proposed by the Government of Ceylon, was considered unnecessary, and the suggestion was withdrawn.

It was emphasized that success in malaria eradication programmes depended upon observance of the criteria defined by WHO. The importance of active case-finding was also stressed.
4. The Training of Sub-Professional Personnel for Health Education

The representative of the Government of Ceylon, who introduced the paper on this subject (document SEA/RC19/17), posed the question as to the best kind of persons to recruit as health educators. In this connection, the practices prevailing in countries of the Region and the role to be played by public health inspectors and similar grades, after short periods of training in health education, were discussed. It was agreed that if the task of health educators was to produce behavioural changes in the people and to exercise leadership, graduates with a post-graduate degree in health education would be essential. Sub-professional groups were useful at lower levels, where their duties would be concerned with carrying out well-defined functions. For this group short periods of training in health education would be sufficient.

5. Resolutions of Regional Interest Adopted by the World Health Assembly and the Executive Board

In document SEA/RC19/15, the attention of the Committee was drawn to the following resolutions adopted during the past year by the World Health Assembly and the Executive Board, which were thought to be of special interest to the Region:

(a) Consolidation of the Special Fund and the Expanded Programme of Technical Assistance in a United Nations Development Programme (EB37.R41)

(b) Establishment of a Revolving Fund for Teaching and Laboratory Equipment for Medical Education and Training (WHA19.7)

(c) Malaria Eradication Programme (WHA19.13)

(d) Smallpox Eradication Programme (WHA19.16)

(e) Programme Activities in the Health Aspects of World Population Which Might Be Developed by WHO (WHA19.43)

(f) Study of the Nature and Extent of Health Problems of Seafarers and the Health Services Available to Them (WHA19.48)

These resolutions were noted.

In the discussion on (b), the Committee greatly appreciated the establishment of this fund, by which governments could acquire teaching and laboratory equipment for medical education against reimbursement in local currency. It was explained by the Regional Director that the limitation of
$10,000 was placed only on individual requests; there was no limit to the number of requests which could be made, provided WHO was able to use the local currency received. It was agreed that this assistance could help to meet a very great need in the Region.

The support that WHO was in a position to give to smallpox eradication was discussed in the context of the resolution on this subject (d) above. It was explained that WHO could now meet the costs of certain supplies and equipment, as well as of training, and delegates were asked to inform the Regional Director of their requirements in these programmes to enable him to plan such assistance.

The resolution concerning the health aspects of world population (e) gave further guidelines to WHO for considering technical assistance to maternal and child health services and basic health services which included family planning. It was thought to be of much importance to a number of countries in the Region. The Committee felt that in view of the need for the basic health services to maintain the health of mothers and children as a prerequisite for family planning in some countries, the Regional Director should be asked to explore the possibilities of expanding and strengthening maternal and child health and basic health services with supplies and equipment, including vehicles, as well as promote training facilities as appropriate and encourage research programmes in neglected areas (see resolution SEA/RC19/H7).

6. Procedure for the Nomination of Regional Directors

At the eighteenth session of the Regional Committee, held in Kabul, the Committee had agreed that it would be advantageous to amend its Rules of Procedure so as to provide for advance notification to Member Governments of the names of candidates for the post of Regional Director. A sub-committee of the whole had been set up to consider the necessary changes and had proposed a draft resolution incorporating these changes. However, the question had been deferred, and the Regional Director was asked to collect some additional information and to place this item on the agenda for the next session.

At the present session, the Committee, after studying the documentation submitted by the Regional Director (document SEA/RC19/12) and considering an amendment proposed by the Government of India, decided to adopt the original draft resolution which had been presented in Kabul (see resolution SEA/RC19/H6).

When discussing this resolution, the delegates, in agreeing on the usefulness of advance negotiation, to give the governments time to ascertain the suitability of the proposed candidates, laid particular stress on the personal qualities required in a regional director. His knowledge of and adaptability to the needs of the Region were thought to be even more important than his technical qualifications.
7. Increasing the Size of the Executive Board

In the discussion on this subject, which had been proposed by the Government of India, it was evident that the representatives of the governments comprising the South-East Asia Region felt rather strongly that the Region's representation on the Executive Board (two members) was inadequate. It was pointed out that the Director-General had forwarded to governments the Executive Board resolution (EB3R, R20) in which the Board stated its belief that an increase in the membership of the Board would be desirable, asking the Member Governments to submit their proposals to him. At the same time it was realized that this might not lead to any increase for South-East Asia Region. It was decided that it would be useful to express a collective opinion on this subject, particularly in view of the fact that the Members comprising the South-East Asia Region were able to provide fresh representation on the Board only twice in three years. The Committee therefore recommended to governments in the Region that they propose to the Assembly that the Board should consist of 28 persons and that each Region should be represented by at least three Members (SEA/RC19/R5).

8. Technical Discussions on Health Laboratory Services

The conclusions and recommendations arising from the technical discussions were presented to the Committee. These discussions were based on working papers which had been circulated earlier (SEA/RC19/TD 1, 2, 3, 4; SEA/HLM/13).

The group had agreed that a unified organization was necessary for national health laboratory services as an integral part of the general health services.

The health laboratory service should ensure a balanced and co-ordinated development between the clinical and public health aspects of the service. The service should progressively extend from the central through the intermediate to the peripheral levels, keeping pace with the development of general health services.

The group recognized the need for making a "work study" of the workload of the peripheral-level laboratory worker, keeping in mind the fact that the examination of specimens from priority national programmes, such as malaria eradication, should have the highest consideration.

The educational and specific qualifications for the different categories of both professional and technical laboratory staff and the opportunities for further training were considered in detail, and the need for standardizing the period of training and the curriculum content of courses was stressed.

The conclusions and recommendations (Annex 4) were noted by the Committee.
9. Selection of Subject for the Technical Discussions at the Twentieth Session

The Regional Committee agreed that maternal and child health should be the topic for the technical discussions to be held in connection with its twentieth session, and that particular attention should be given to integration of these services into the general health services (see resolution SEA/RC19/R9).

In this connection, the delegation from India requested that when the time was appropriate for the selection of a subject for technical discussion in 1968, attention might be given to two topics which his delegation thought most important, i.e. (1) Staff training for senior health administrators, and (2) Planning of health services, including manpower studies, as a part of general planning.

10. Time and Place of the Twentieth and Twenty-first Sessions

The representative from Mongolia renewed his Government's invitation to the Regional Committee to hold its twentieth session in Ulan Bator, and the Committee confirmed its decision to meet there in August 1967. It was decided that the twenty-first session would be held in the Regional Office in September 1968 (see resolution SEA/RC19/R10).
FINAL LIST OF PARTICIPANTS*

1. Representatives, Alternates and Advisers

AFGHANISTAN

Representative: Dr Mohdi Osman Anwary, Minister of Education, Kabul
Alternates: Dr A.R. Hakimi, Deputy Minister of Public Health, Kabul
: Dr Satar Nazar, Public Health Institute, Kabul

BURMA

Representative: Dr Lun Wai, Divisional Assistant Director of Health, Ministry of Health, Rangoon
Alternate: Dr Saw Ba Hein, Assistant Director, National Health Laboratory, Rangoon

CEYLON

Representative: Dr V.T.H. Gunaratne, Director of Health Services, Colombo
Alternate: Dr D.B. Gunasekera, Deputy Director of Laboratory Services, Colombo

INDIA

Representative: Mr B.S. Murthy, Union Deputy Minister for Health and Family Planning, New Delhi
Alternates: Dr K.N. Rao, Director-General of Health Services, New Delhi
: Dr J.B. Shrivastav, Director, National Institute of Communicable Diseases, New Delhi
: Dr A.K. Thomas, Director, Central Research Institute, Kasauli
: Dr B.L. Taneja, Director-General, Indian Council of Medical Research, New Delhi

*Issued as document SEA/RC19/18 Rev.2, on 27 September 1966.
INDIA (cont’d)

Alternates

- Dr A.P. Ray, Director, National Malaria Eradication Programme, New Delhi
- Mr S.N. Varma, Deputy Secretary to the Government of India, Ministry of Health and Family Planning, New Delhi
- Dr P.K. Tosa, Deputy Director of Medical and Health Services, in charge of State Vaccine Institute, Patiala
- Dr D. Choudhury, Assistant Director-General of Health Services, New Delhi

Advisers

- Dr P.R. Dutt, Assistant Director-General of Health Services, New Delhi
- Dr S.L. Unr, Director, Planning Bureau, New Delhi
- Dr Y.K. Subrahmanyan, Assistant Director-General of Health Services, New Delhi
- Dr K.M. Lal, Adviser (Health), Planning Commission, New Delhi
- Dr K.C. Patnaik, Director, Central Bureau of Health Intelligence, New Delhi
- Dr V. Ramakrishna, Director, Central Health Education Bureau, New Delhi

INDONESIA

Representative

- Dr Marsaid Soesilo Sastrodihardjo, Director-General, Eradication of Epidemic and Communicable Diseases Operational Command (KOPPEM), Djakarta

MONGOLIA

Representative

- Dr P. Dolgor, Head, Department of Foreign Relations, Ministry of Public Health, Ulan Bator

Alternate

- Dr U Gotov, Head of the Department of Health Service, Ministry of Public Health, Ulan Bator

NEPAL

Representative

- Dr Y.R. Joshi, Director of Health Services, Kathmandu
THAILAND

Representative: Dr Chitt Homachudha, Inspector General, Ministry of Public Health, Bangkok

Alternates: Dr Somboon Vachrotai, Director, Division of Venereal Diseases and Yaws Control, Department of Health, Bangkok

: Dr Chalerm Mekasuta, Chief, Division of Diagnostic Laboratories, Department of Medical Sciences, Bangkok

2. Representatives of the United Nations and Specialized Agencies

UNITED NATIONS, DEVELOPMENT PROGRAMME

: Mr Nessim Shallon, Acting Resident Representative of the United Nations Development Programme in India, New Delhi

UNICEF

: Dr Charles A. Egger, Regional Director, UNICEF, New Delhi

Mr H.F Gordon Carter )
Dr S. Cuapllici )
Dr K.G. Simonyan ) UNICEF, New Delhi
Dr W.D. Ernert )
Dr H.S. Nayak )

FAO

: Dr I.A. Simpson, Regional Nutrition Officer, FAO, New Delhi

UNESCO

: Mr A.G.W. Dunningham, Deputy Chief of Mission, UNESCO, New Delhi

3. Representatives of Non-Governmental Organizations

International Committee of Catholic Nurses

: Miss Simone Liégeois, President, Catholic Nurses' Guild of India, New Delhi

International Council of Nurses

: Miss E.H. Paull, Vice-President, Trained Nurses Association of India; Staff Officer (Nursing), Indian Red Cross Society, New Delhi

International Dental Federation

: Dr P.P. Sahni, New Delhi
International Federation of Obstetrics and Gynaecology and Obstetrics: Dr Vera Hingorani, Associate Professor of Obstetrics and Gynaecology, All-India Institute of Medical Sciences, New Delhi

International: Mr T.N. Kuppuswami, Vice-President of the Indian Hospital Association and Administrative Officer at Safdarjung Hospital, New Delhi

International: Mr M. Jai Rattan Bhalla, President, Indian Institute of Architects, New Delhi

League of Red Cross Societies: Dr (Mrs) L. Menon, Indian Red Cross Society, New Delhi

World Confederation: Mr M.J. Alexander, Indian Association of Physiotherapists, New Delhi

World Veterans' Federation: Major S.K. Lal, New Delhi

5. Observers

Ford Foundation: Dr Edward M. McGavran, Adviser to the Intensive Rural Health and Family Planning Programme, Government of India, New Delhi

Rockefeller Foundation: Dr Le Roy R. Allen, Representative for Medical and Natural Sciences, New Delhi
AGENDA*

1. Opening of the session

2. Sub-Committee on Credentials
   2.1 Appointment of Sub-Committee
   2.2 Approval of the report of the Sub-Committee SEA/RC19/19

3. Election of Chairman and Vice-Chairman

4. Adoption of provisional agenda SEA/RC19/1

5. Appointment and terms of reference of the Sub-Committee on Programme and Budget SEA/RC19/4

6. Adoption of agenda, and appointment of Chairman, for the technical discussions SEA/RC19/5

   SEA/RC19/8
   SEA/RC19/9

8. Technical discussions: Health laboratory services SEA/RC19/TD/1-4

9. Resolutions of regional interest adopted by the World Health Assembly and the Executive Board SEA/RC19/15

10. Procedure for the nomination of regional directors SEA/RC19/12

11. Planning, in general, of health services (item proposed by the Government of Thailand) SEA/RC19/10

12. Reporting and recording system of health activities (item proposed by the Government of Thailand) SEA/RC19/11

13. Improving the existing training facilities for junior technical staff of laboratories in developing countries (item proposed by the Government of India) SEA/RC19/13

*Issued as document SEA/RC19/1 Rev.1, on 1 October 1966.
14. Allotment of foreign exchange for the specific purpose of importing reference reagents, chemicals, replacements and spare parts (item proposed by the Government of India) SEA/RC19/14

15. Increasing the size of the WHO Executive Board (item proposed by the Government of India)

16. Appointment of a regional appraisal panel to evaluate the progress of malaria eradication programmes (item proposed by the Government of Ceylon) SEA/RC19/16

17. The training of sub-professional personnel for (i) health education and (ii) implementation of the Food and Drugs Act (item proposed by the Government of Ceylon) SEA/RC19/17

18. Proposed regional programme and budget estimates for 1968 SEA/RC19/3

18.1 Consideration of the report of the Subcommittee on Programme and Budget SEA/RC19/20

19. Consideration of the recommendations arising out of the technical discussions SEA/RC19/21

20. Selection of subject for the technical discussions at the twentieth session of the Regional Committee SEA/RC19/7

21. Time and place of the twenty-first session of the Regional Committee SEA/RC19/6

22. Any other business

23. Adoption of the final report of the nineteenth session SEA/RC19/22

24. Adjournment
The Sub-Committee on Programme and Budget met on 28 and 29 September 1966 and reviewed the Proposed Programme and Budget Estimates for 1968 (document SEA/RC19/3), in accordance with its terms of reference (see appendix to this report) as approved by the Regional Committee.

The Sub-Committee consisted of Dr Hakimi (Afghanistan), who was elected Chairman, Dr Lun Wai (Burma), Dr Choudhury (India), Dr Dolgor (Mongolia) and Dr Chitt (Thailand).

The Sub-Committee examined its terms of reference and asked that the five working papers prepared by the Secretariat and the Proposed Programme and Budget Estimates for 1968 be explained. An explanation of the document and working papers was provided, with specific reference to the programme cycle. The Regular budget covered the fiscal year 1968, and the budget under United Nations Development Technical Assistance Category I was for the biennium 1967/1968.

Annex 1, "The Voluntary Fund for Health Promotion", consisted of four sub-accounts, the projects under which were dependent for their implementation on sufficient voluntary contributions being available.

The supplementary projects under the Regular Programme and projects under the United Nations Development Programme Category II were shown in Annex 2 (green pages) in the budget document. No provision had been made for these projects, but they represented sound requests which could be implemented should savings accrue, although they were of lesser priority than those included in the Regular budget and UNDP (TA) Category I proposals.

In reply to a query, it was confirmed that all projects, Regular and TA I and projects included in Annex 2, were projects which had been discussed with governments through the WHO Representatives and Regional Office staff and had been requested by the governments. It was confirmed that the appointment of a WHO Representative to Mongolia was under consideration and that in the meantime a suitable project team member would undertake the functions of WHO Representative.

1. General Review of the Proposed Programmes

The Sub-Committee then proceeded with an examination of the proposed programme, following the sequence listed in its terms of reference.

*Issued as document SEA/RC19/20, on 30 September 1966.
1.1 New activities in 1968, including new projects
1.2 and new components of current projects

The Sub-Committee examined in detail the new projects and new components which had been set out in Working Paper P&B/WP/2. It noted that the total of new projects and new components represented about 21% of the total field programme. It expressed the view that the new projects and new components were satisfactory in the light of government needs and WHO resources.

After some discussion, the Sub-Committee decided that it preferred to undertake a broad examination of all the new elements in the programme rather than to examine selected new projects in detail.

In reply to a question, it was explained that ad hoc requests from governments were considered by WHO for implementation from savings, if the requests were regarded as technically sound. However, emphasis was laid on the desirability of implementing the programme as planned, with the corollary that this demanded maximum foresight on the part of governments in making their requests.

The Sub-Committee noted that the WHO budget contained no reserve element and, further, that ad hoc requests could be met only from savings; however, the possibility of meeting urgent requests from the Contingency Fund of UNDP was explained and exemplified. A full justification for contingency requests was necessary.

In reply to a question, the Sub-Committee was advised that the increase in the proposed provision for 1968 was just under 10% of the provision for 1967.

1.3 Field staffing pattern

The Sub-Committee next turned its attention to the field staffing pattern (Working Paper P&B/WP/3). It felt that the over-all distribution of field staff was satisfactory, was in accordance with the needs of the various countries and was realistic in the context of recruitment resources available to WHO.

The Sub-Committee was advised that all the engineers shown in the programme would be sanitary or public health engineers engaged in assistance to the development of environmental sanitation.

2. Detailed Examination and Analysis of Selected Projects

The Sub-Committee selected the following current projects for examination:

Inter-country projects

SEARO 102, Asian Institute for Economic Development and Planning
Country Projects

(In making its selection of country projects, the Sub-Committee decided to choose projects from countries which had not been included in the examination undertaken by the Sub-Committee in 1965, except for a project in Mongolia, which had been included in the 1965 examination.)

Afghanistan 13  Medical Education
Ceylon 64  Community Water Supply
Mongolia 1  Strengthening of Health Services (Epidemiology)
Nepal 8  Maternal and Child Health Services and Training
Thailand 2  Strengthening of Health Services (Integration of Specialized Programmes)

2.1 Selected inter-country projects

The Sub-Committee requested an explanation of the method in which inter-country projects had been included in the programme and budget proposals. It was stated that inter-country projects reflected, for example, resolutions of the Regional Committee and the World Health Assembly, discussions with governments and the known needs of governments. The Director-General also made suggestions for inter-country projects.

In reply to a question, it was also recalled that all Member countries of the Region were requested to express their interest in the list of proposed inter-country projects submitted to them.

It was also explained that inter-regional projects covering two or more regions were included in the programme proposals. Generally, inter-regional projects were financed from headquarters funds, but sometimes the Regional Office would make additional provision for regional participation in these activities.

The question was raised as to whether an adequate number of fellows had been recommended by countries to utilize fully the provision for fellowships made in inter-country and inter-regional projects. It was confirmed that there was no shortage of recommendations.

It was added that the number of fellowships which could be given under inter-regional projects financed from headquarters funds was limited to the numbers allocated to the Region by headquarters. It was possible to exercise more flexibility in fellowships financed from the regional budget.

Before embarking on its detailed examination, the Sub-Committee requested and was given an explanation of other "Statutory Staff" costs and "Duty Travel" costs.
to assist the Government in developing epidemiological services. Initially the project had studied the problem of the zoonoses, especially brucellosis, and the Government had developed a central anti-brucellosis unit. The project was now also assisting with epidemiological investigations of diphtheria, whooping cough and tetanus. The project had been very successful; local problems had been defined and clarified and methods of prevention indicated. It was stated that the Government was now receiving considerable bilateral assistance in veterinary public health; hence this project was concentrating more on other health aspects. Appreciation was expressed for the WHO provision of DPT vaccine for the immunization of the existing susceptible population. It was confirmed that the provision of vaccine for maintenance of this immunization programme was a government responsibility. It was appreciated that WHO assistance to this project fitted in with the over-all national health plan. In reply to a question, it was confirmed that the proposal in Annex 2 (green pages) reflected a request from the Government and could be further discussed with the Government in the light of over-all developments.

2.2.4 Nepal 8 - Maternal and Child Health Services and Training

The development of basic health services in Nepal was outlined. WHO was providing a maternal and child health officer and a public health nurse. The aim of the current project was to develop maternal and child health services integrated into the general health services and to train maternal and child health staff. A satisfactory beginning had been made in Kathmandu Valley, and extension to other areas was being undertaken. Three schools for training auxiliary nurse midwives were being formed. UNICEF was supporting the project with supplies and equipment. The Committee appreciated the importance of assistance to maternal and child health and particularly to the integration of maternal and child health into the general health services.

2.2.5 Thailand 2 - Strengthening of Health Services (Integration of Specialized Programmes)

It was explained that this project had developed from a successful yaws control programme, with the initial aim of integrating specialized control programmes into general health services. WHO had provided a public health officer and a public health nurse, and the services of a WHO laboratory technician from another project were available. The project had worked out a staffing and operational pattern to give adequate coverage of rural health services in one district. A practicable workload and the training necessary for rural health personnel had been defined. The project was being extended to three other districts and was being used to train the staff of the malaria eradication programme in preparation for its integration into the general health services. The Sub-Committee appreciated the operational research importance of the project and of its training activities.
2.3 One specific field of activity - nursing

The Sub-Committee studied Working Paper P&I/EWP/4 and noted the pattern of development of WHO assistance to the nursing services, from assistance to basic training, with present concentration on the strengthening of nursing administration and particularly on post-basic training, to provide nursing administrators and nurse educators. The Sub-Committee expressed its agreement with this pattern of development and stressed the importance of assistance to nursing services in all countries. It was noted that the total expenditure on assistance to nursing programmes from 1960 to 1965 had been about 1.6 million dollars and that the estimated expenditure from 1966 to 1968 would be about 1.2 million dollars. In view of the importance of the subject, the Sub-Committee considered that this expenditure was reasonable.

2.4 Selection of subject for examination in 1967

The Sub-Committee decided to recommend to the Regional Committee that the subject of "epidemiology" would be suitable for specific detailed examination by the Sub-Committee in 1967.

3. Examination of Staffing and Budget of the Regional Office

The attention of the Sub-Committee was drawn to the estimates for the Regional Office. It was noted that there was no increase in the staffing for 1967 and 1968, and also that the common services estimates showed no increase in 1968 over 1967.

In reply to a question, the Sub-Committee was informed that the supplies and materials under "Public Information" showed an increase in 1967 of $5,000 to cover the publication in 1967 of a document reviewing the work of the Organization in the various countries of the Region since the inception of the Regional Office in 1948. The estimates were approved.

4. Formulation of Questions to be Considered, and General Conclusions and Recommendations

Following this detailed examination, the Sub-Committee considered that the Proposed Programme and Budget Estimates for 1968 followed the general programme of work approved by the Regional Committee and the World Health Assembly.

The Sub-Committee expressed its appreciation of the note submitted indicating the action taken in the follow-up of requests and recommendations made by the Regional Committee at its eighteenth session. It thought that the actions taken had been suitable.

The Sub-Committee did not wish to refer any questions or remarks for discussion by the Regional Committee in plenary session.
The Sub-Committee recommended that its terms of reference should be continued on the lines of those in document SEA/RC19/4 (see Appendix).

In conclusion, the Sub-Committee expressed its appreciation of the preparations made by the Secretariat for the examination of the programme and budget proposals.
SUGGESTED TERMS OF REFERENCE FOR THE SUB-COMMITTEE ON PROGRAMME AND BUDGET

The following terms of reference are suggested for the Sub-Committee on Programme and Budget:

1. General Review of the Proposed Programme and Budget Estimates for 1968 (SEA/RC19/3)

   The general review should include, inter alia:
   
   (1) New activities in 1968, including new projects and new components of current projects
   
   (2) Comparison of the cost of new activities in relation to the total cost of field activities
   
   (3) Field staffing pattern.

2. Detailed Examination and Analysis of Selected Projects

   The detailed examination should include:
   
   (1) Selected inter-country projects
   
   (2) Random sampling of selected country projects
   
   (3) One specific field of activity (At its eighteenth session, the Regional Committee decided that in 1966 the subject should be "Nursing").

3. Examination of Regional Office Staffing and Budget as Required

4. Formulation of Questions To Be Considered and General Conclusions and Recommendations

   In drawing its conclusions, the Sub-Committee may wish to keep the following questions in mind:
   
   (1) Does the programme follow the general programme of work approved by the Regional Committee and the World Health Assembly?
   
   (2) How are the requests and recommendations made by the Regional Committee at its eighteenth session reflected in the proposed programme and budget?
   
   (3) Does the Sub-Committee wish to refer to the Regional Committee any questions or remarks which it feels might require discussion in plenary session?
CONCLUSIONS AND RECOMMENDATIONS ARISING OUT OF THE
TECHNICAL DISCUSSIONS ON HEALTH LABORATORY SERVICES*

At the nineteenth session of the Regional Committee for South-East Asia, held in New Delhi from 27 September to 3 October 1966, four sessions were devoted to the technical discussions on the subject of "Health Laboratory Services".

The following five documents had been prepared and distributed to the participants**:

1. HEALTH LABORATORY RECORDS AND REPORTS - (SEA/RC19/TD/1)
2. GENERAL PRINCIPLES FOR THE DEVELOPMENT OF A NATIONAL HEALTH LABORATORY SERVICE - (SEA/RC19/TD/2)
3. ROLE, QUALIFICATIONS, NEEDS AND TRAINING OF STAFF FOR THE HEALTH LABORATORY SERVICES, WITH SPECIFIC REGARD TO THE MEDICAL STAFF - (SEA/RC19/TD/3)
4. HEALTH LABORATORY SERVICES: REVIEW OF THE SITUATION IN THE COUNTRIES OF THE REGION - (SEA/RC19/TD/4)
5. TENTATIVE PROPOSALS FOR FIELD TRIALS OF A SYSTEM FOR RECORDING AND REPORTING LABORATORY ACTIVITIES - (SEA/RC19/TD/5)

Number (4) above was prepared from information provided by the participating countries.

The discussions were chaired by Dr Gunasekera (Ceylon), and were attended by representatives of the following countries: Afghanistan, Burma, Ceylon, India, Indonesia, Mongolia, Nepal and Thailand. Dr Shrivastav (India) was rapporteur. The tentative agenda** was approved and formed the basis for the discussions which followed.

All the documents were extensively referred to during the course of the discussions. Keen interest was shown by delegates from all the countries. Observers on behalf of the Ford Foundation and the Indian Red Cross Society participated in the discussions. Representatives from UNICEF, the World Veterans' Foundation and International Hospital Federation also attended the meetings.

*Issued as document SEA/RC19/21, on 30 September 1966.
**Will be included in annexes to this report when it is prepared for wider circulation.
The following conclusions and recommendations were adopted:

1. The Need for a National Health Laboratory Service

All the countries in the South-East Asia Region were engaged in the building up of a national health laboratory service. However, it was noted that the stage of development varied from country to country and even within a country, from area to area. In some countries the service operated at national level only. In most countries peripheral activities were relatively few and still in a rudimentary stage of development. In the majority of the countries of the Region the service was not yet fully organized in a uniform pattern to operate at all levels, that is, central, intermediate and peripheral. It was therefore concluded that it was desirable to aim at a centralized* organization for the laboratory services. This should be under the responsibility of a suitably qualified medical official with adequate training and experience in the whole field of laboratory work.

The national health laboratory service should cover all aspects of laboratory activity (clinical, public health, control of food, drugs, toxicology including pesticides, production of such biologicals as deemed necessary by government, diagnostic reagents and special investigations (as and when indicated)). It should form an integral part of the general health services. The general principles, as given in document SEA/RCl9/ID/2, with regard to organization, functions, staffing, equipment of the laboratories at the central, intermediate and peripheral levels were discussed, and there was general agreement on this subject amongst the participants. Some points of detail are further delineated below.

2. Functions at the Central Level*

It was noted that in several countries there was a tendency to develop specialized chains of laboratories for diagnosis, public health, etc., independent of one another. This resulted in duplication of effort and excessive expenditure of manpower and funds. To prevent this, it was agreed that the central headquarters of the laboratory services should ensure:

(1) A balanced and co-ordinated development of all functions of the laboratory service, e.g.

   (a) a balanced development of the clinical and public health aspects;

   (b) the full utilization of the laboratory facilities, and

   (c) the establishment of efficient reference and referral systems.

*Different countries had different systems of government, as, for instance, India and Indonesia, with a federal system, and other countries with other types. Therefore, the word "centralized" would have different connotations for these countries and would need suitable modifications.
(2) Extension of the laboratory services from the centre, through intermediate to peripheral levels, in parallel with the development of general health services;

(3) Utilization of the data collected in the routine work for the assessment of health problems;

(4) The promotion of epidemiological surveys;

(5) The study of laboratory methods, techniques and training of personnel suitable for each country with a view to standardization;

(6) Standardization of methods of recording, reporting and filing, with a view to simplifying procedures and leading, in turn, to better supervision and improved health intelligence.

3. Functions at Intermediate and Peripheral Levels

The functions of laboratories at intermediate and peripheral levels should ensure the rendering of certain minimum services (as shown in section 3.1.1 and in section 3.2.1 of document SEA/RC19/TD/2). To provide for these services, the minimum requirements in the way of physical facilities, equipment and staff were also generally agreed (sections 3.1.2; 3.1.3; 3.1.4 and sections 3.2.2; 3.2.3; 3.2.4 of document SEA/RC19/TD/2).

There was considerable discussion on the work-load suggested for the single laboratory worker at the peripheral level (SEA/RC19/TD/2, section 3.1.1). Participants felt the need for defining this specific work-load more precisely. This could best be done by an operational study of the worker under different circumstances. It was, however, agreed that the examination of specimens dealing with priority national programmes - malaria, for example - should have the first consideration.

The importance of being able to mobilize a service unit at short notice for emergency and investigative work in the field was emphasized. Such a unit should be drawn from the intermediate and, if necessary, central laboratories, should include an epidemiologist and should have adequate transport. The role of this unit would primarily be the collection of suitable material for expeditious despatch to a laboratory where it could adequately be handled, and local investigation to the extent possible.

4. Laboratory Records and Reports

It was noted that methods of recording, reporting, filing and presentation of performance reports differed greatly from one laboratory to another. At present, performance reports were being mainly designed for administrative rather than technical purposes, resulting in inadequate supervision.
The meeting agreed that the adoption of a uniform system by the national health laboratory service to meet the need would prove useful and would be worthy of trial in some selected laboratories, on the lines indicated in document SEA/HLM/13 (section 6).

5. **Laboratory Staff**

5.1 **Medical staff**

The group realized that the success of a laboratory service depended primarily on the quality and numbers of the staff manning the service. It also realized that in the service a variety of professional and sub-professional members was required. It was felt that in developing countries the primary responsibility of the service would devolve on medical staff and that the head of the laboratory, especially at the intermediate level, should have, as far as was feasible, the same status and position as other professional heads at that level. In view of the comprehensive role played by the laboratory service, the group considered that in addition to suitable training and experience in the technique of laboratory work, the medical staff should have basic orientation in the field of epidemiology and public health. Furthermore, the chief of a laboratory should be well conversant in organization and management.

In view of the existing paucity of medical men and the fact that laboratory work did not attract them, it was thought that countries might, of necessity, have to employ suitably trained non-medical personnel (microbiologists, biochemists, etc.) to man some of the laboratories.

5.2 **Non-medical scientific staff**

The group fully realized the role of non-medical scientific staff in health laboratory services. The relatively new disciplines of microbiology and biochemistry, taught in some universities, could go a long way toward fulfilling the requirements of the laboratory services. However, it was essential that such staff should have practical training and orientation in medical laboratory work before being entrusted with a responsible role in health laboratory services.

It was agreed that efforts should be made by selected laboratories to afford opportunities for post-graduate training of the non-medical scientific staff (M.Sc. and Ph.D. in microbiology, pathology, biochemistry, etc.).

5.3 **Technical staff**

It was recognized that there was at present no uniformity in the designation of the technical staff in the different countries. Technical staff, the backbone of the service, generally tended to fall into three categories, namely, technicians, laboratory assistants and laboratory
attendants (aides). In the context of each country, it was considered desirable that a precise definition of the basic qualifications, of the specific nature of the duties and of the training and designation of technical staff should be formulated.

(a) Laboratory technician

The minimum qualifications for this category should be high-school certificate or higher secondary-school certificate of equivalent, with science subjects, and a minimum of two years' polyvalent theoretical training in the various phases of laboratory work.

(b) Laboratory assistant

The basic educational requirement should be as close to the high-school or higher secondary-school level as possible, with science subjects, and polyvalent training in laboratory work for a minimum period of one year. In addition, it was recognized that most countries of the Region already had a special category of laboratory assistants with training in a single field, as, for instance, microscopists in the fields of leprosy, tuberculosis, malaria, filariasis, etc. Such laboratory assistants would require further training in polyvalent activities to make them suitable to man the laboratories at the peripheral level. A further period of training could later be envisaged to make them suitable as multi-purpose polyvalent laboratory assistants. It was recognized that suitable short courses or in-service training would have to be planned for this purpose. The candidate should be given credit for this cumulative training and experience when considering his chances for promotion.

(c) Laboratory attendants (aides)

This category includes unskilled staff of the laboratory.

5.4 Training

For the training of technical staff, the need for uniformity in the length of courses as well as the curriculum content was stressed. The group appreciated the importance of laboratory equipment and laboratory animals (at appropriate levels) in developing the technical competence of the laboratory service. In addition to training the laboratory staff in the routine laboratory work, as indicated above, suitable steps should be taken in selected laboratories for imparting specialized training in the care and maintenance of equipment and in the breeding and care of laboratory animals.

It was noted that there were a number of training centres in countries of the Region for medical graduates, medical scientists and technical staff. For the benefit of all countries in the Region it was recommended that data
concerning all the existing centres in countries of the Region and their training programmes for the various categories should be prepared and circulated, as curricula for trainees were found to vary from place to place.

5.5 Career prospects

The group discussed at length the career prospects of all categories of laboratory staff - ways of making the service sufficiently attractive and of offering possibilities of promotion. In a well-developed national laboratory service, with laboratories of greater complexity and competence at various levels, there should be adequate promotion prospects for the medical staff.

The promotion prospects for non-medical scientific staff received the special attention of the meeting, and it was felt that in intermediate and central-level laboratories, there were several senior posts which could be adequately filled by suitably qualified staff belonging to this category. In the service adequate provision should be made for them to reach positions of responsibility and seniority, keeping in view their competence, experience and training.

Career prospects for the technical staff must also be considered. For instance, a laboratory assistant, on acquiring high-school qualification or the equivalent, with sufficient training and experience, should be able to look forward to promotion as laboratory technician.
Recommendations

It is recommended:

(1) That there be a unified organization for national health laboratory services as an integral part of the general health services, operating at central, intermediate and peripheral levels;

(2) That the chief of this service should be a suitably qualified medical officer with experience in laboratory work, public health administration and management;

(3) That the service should cover all aspects of laboratory activity;

(4) That the organization, functions, staff, etc., should follow the guidelines laid down in document SEA/HCl9/TD/2;

(5) That minimum requirements with reference to physical facilities, equipment and staff, animal houses (where relevant), etc., should also follow the lines indicated in document SEA/HCl9/TD/2;

(6) That the central headquarters of the health laboratory service should ensure:

   (i) a balanced and co-ordinated development between the clinical and public health aspects of the service;

   (ii) extension through the intermediate to the peripheral levels, keeping pace with the development of the general health services;

   (iii) that the data obtained from laboratories at different levels are utilized for the determination of health problems and for epidemiological service;

   (iv) that methods, techniques and training are studied with the aim of standardizing them, and

   (v) that periodic seminars, discussions and workshops are conducted for the officers in charge of intermediate-level laboratories for the proper and successful implementation of the objectives of the service;

(7) That the work-load of the worker at the peripheral level should be defined precisely and should form the subject of a work study, keeping in mind that the examination of specimens from priority national programmes (e.g. malaria eradication) should have the first consideration;
(8) That it should be possible to mobilize at short notice a service unit, including an epidemiologist and adequate transport, for emergency investigation in the field;

(9) That the adoption of a uniform recording and reporting system (document SEA/HFM/13, section 6) should receive trial in selected laboratories;

(10) That heads of laboratories should have the same status as other professional officers at the same level;

(11) That the medical staff should have basic orientation in public health;

(12) That adequately trained science graduates, in microbiology and biochemistry, for example, might be employed to be in charge of laboratories at certain levels; such staff should be fully oriented in the medical aspects of laboratory work, and this non-medical scientific staff should have opportunities for post-graduate training;

(13) That, with reference to the technical staff, precise definitions of designations, basic qualifications, duties and training should be formulated for each country of the Region;

(14) That importance be given to providing adequate prospects of promotion for all categories of laboratory staff. (This, in a reasonably well-developed national health laboratory service, should not offer any difficulties);

(15) That provision be made for the specialized training of laboratory personnel in the care and maintenance of equipment as well as in the breeding and care of laboratory animals, in selected laboratories at suitable levels;

(16) That WHO be requested to collect and circulate information on training programmes for the various categories of laboratory staff as available in different countries of the Region;

(17) That a conference of technical and administrative experts dealing with laboratory services from the countries of the Region should be organized by WHO at some suitable time in 1967. The purpose of the conference would be to discuss in detail how best the laboratory services, as mentioned above, could be established in each country, in the context of the prevailing administrative and technical conditions in countries of the Region.
**FINAL LIST OF OFFICIAL DOCUMENTS OF THE NINETEENTH SESSION***

- **SEA/RC19/1 Rev.1** Agenda
- **SEA/RC19/2 and Corr.1 and 2** Eighteenth Annual Report of the Regional Director to the Regional Committee for South-East Asia
- **SEA/RC19/3** Proposed Programme and Budget Estimates for 1968, South-East Asia
- **SEA/RC19/4** Suggested terms of reference for the Sub-Committee on Programme and Budget
- **SEA/RC19/5** Proposed agenda for the technical discussions on health laboratory services
- **SEA/RC19/6** Time and place of sessions of the Regional Committee
- **SEA/RC19/7** Selection of subject for the technical discussions in 1967
- **SEA/RC19/8** A note on some operational research activities in the South-East Asia Region
- **SEA/RC19/9** A note on fluoridation of water supplies
- **SEA/RC19/10** Planning of health services
- **SEA/RC19/11** Reporting and recording system of health activities
- **SEA/RC19/12** Procedure for nomination of Regional Directors
- **SEA/RC19/13** Improving the existing training facilities for junior technical staff of laboratories in developing countries
- **SEA/RC19/14** Allotment of foreign exchange for the specific purpose of importing reference reagents, chemicals, replacement and spare parts, etc.
- **SEA/RC19/15** Resolutions of regional interest adopted by the World Health Assembly and the Executive Board

*Issued as document SEA/RC19/23, on 3 October 1966.
SEA/RC19/16  Appointment of a regional appraisal panel to evaluate the progress of malaria eradication programmes

SEA/RC19/17  The training of sub-professional personnel (i) for health education, and (ii) for implementation of the Food and Drugs Act

SEA/RC19/18 Rev.2  List of participants

SEA/RC19/19  Report of the Sub-Committee on Credentials

SEA/RC19/20  Report of the Sub-Committee on Programme and Budget

SEA/RC19/21  Conclusions and recommendations arising out of the technical discussions on health laboratory services

SEA/RC19/22  Report of the nineteenth session of the WHO Regional Committee for South-East Asia

SEA/RC19/23  Final list of official documents of the nineteenth session

**MINUTES**

SEA/RC19/Min.1 and Corr.1  Summary minutes - first meeting, 27 September 1966, 10 a.m.

SEA/RC19/Min.2 and Corr.1  Summary minutes - second meeting, 27 September 1966, 2.30 p.m.

SEA/RC19/Min.3 and Corr.1  Summary minutes - third meeting, 28 September 1966, 9 a.m.

SEA/RC19/Min.4 and Corr.1  Summary minutes - fourth meeting, 28 September 1966, 2.30 p.m.

SEA/RC19/Min.5  Summary minutes - fifth meeting, 30 September 1966, 9 a.m.

SEA/RC19/Min.6  Summary minutes - sixth meeting, 1 October 1966, 10.30 a.m.

SEA/RC19/Min.7  Summary minutes - seventh meeting, 3 October 1966, 11 a.m.
SECTION II

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SUMMARY MINUTES

First Meeting, 27 September 1966, 10 a.m.*

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*Originally issued as SEA/RC19/Min.1, on 27 September 1966, and incorporating subsequent corrections.
1. Opening of the Session (item 1 of the Provisional Agenda)

The nineteenth session of the WHO Regional Committee for South-East Asia was opened by the CHAIRMAN, DR MOHD OSMAN ANWARY (Afghanistan). Welcoming the Prime Minister of India and others, he said that the contribution of WHO and UNICEF towards the promotion and establishment of better health for the peoples of the Region had been of great importance. Within the limitations of their own technical and financial possibilities and with the help of WHO, UNICEF and FAO, governments of the Region had now found the right path towards the eventual goal, which was the attainment of a complete state of health. They still had a long way to go, and organizations such as WHO and UNICEF should increase their assistance to the countries of the Region to enable them to learn to help themselves. He then invited the Prime Minister of India to give her inaugural address.

2. Inaugural Address by the Prime Minister of India

The Prime Minister, Mrs INDIRA GANDHI, welcoming those present at the session, said that WHO was a symbol of the growing co-operation among nations in the field of public health and medical research.

Although the world was often referred to as one world, the implications of this idea were not fully appreciated. It should not be half poor and half rich, half healthy and half diseased. Most diseases were the product of poverty, and it was only through economic development that science could be harnessed for the conquest of disease. Malnutrition was the mother of much illness, and the food shortage in India was not merely one of quantity but one of quality as well. Planning for development should not lose sight of investment in health, because this paid dividends both in the greater well-being of man, and also in greater vitality and efficiency. It had been estimated that during the span of one generation some countries in Asia lost no less than 32 per cent of their potential total productive capacity as a result of premature death.

Although every child had a right to health, education and congenial recreation, his share was limited by the economic level of his parents, and it was the duty of the State to correct this imbalance and to afford every child an opportunity to develop his potentialities. She then referred to the WHO Constitution, which stated that "the healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development", and said it was necessary to induce the young person to think in terms of the community as a whole, and to inculcate in him a regard for life and a sense of true values. The preamble to the Constitution stated that an informed public opinion was essential to the success of efforts at improving public health, and this point, she recalled, had been stressed by her father when he inaugurated the new building of the Regional Office. With the spread of industrialization,
the individual could no longer confine himself to matters relating to personal hygiene but should be taught to think in terms of the common good.

Not all countries had the means to carry out basic research, from which came life-saving discoveries, and all were indebted to the discoverers. However, the benefits of such discoveries must be made available to mankind as a whole at the lowest possible cost, and in this connection there was a need to arouse the conscience of the world in the matter of reducing the prices of essential drugs.

The aim of public health programmes was fewer deaths and longer lives, and this in turn led to a conflict between the rate at which the population was growing and the rate at which food supplies and job opportunities grew. That was the reason why most countries in Asia and Africa had undertaken programmes of family planning. This also formed part of India's Fourth Five-Year Plan, a most important feature of which was their determination to provide 3 oz. more of food per head of the population. It was hoped that the family planning programme would bring down the birth rate from 40 per 1,000 to 25 per 1,000 in the next ten years. This programme was a large undertaking, requiring large armies of qualified medical personnel, vast resources and also the involvement and co-operation of millions of married couples in India's 560,000 villages.

In addition to expansion in medical education, a large-scale programme in public education had been planned, and it was hoped to have nearly 100 million children at school by 1971. However, there still remained the problem of creating a consciousness of environmental hygiene among the large masses of illiterate adults.

The Government of India attached the greatest importance to programmes for giving protective foods to the poorer section of the population, and she hoped that some of the programmes which had been launched during the recent food shortage in many States of India would be continued, especially those related to school-going children.

In conclusion, she thanked WHO for having given her an opportunity to meet the representatives of the countries of South-East Asia to this session of the Regional Committee, and welcomed them to India (for full text of speech, see Annex 1).

The CHAIRMAN thanking the Prime Minister, said that he was sure her suggestions would be very useful and inspiring to all the delegates.

3. Address by the Minister of Health and Family Planning, Government of India

DR SUSHILA NAYAR, Minister of Health and Family Planning, India, welcomed the representatives of the Member Governments of the South-East Asia Region and expressed pleasure that the Maldives Islands had joined WHO. She hoped that country would soon take part in the deliberations of the Regional Committee.
She recalled that it was just over twenty years ago that the International Health Conference had met in New York to draft the Constitution of WHO. The objective of the Organization, namely, "the attainment by all peoples of the highest possible level of health", was an exalted one. Some striking advances in health had been made in the world, but there were still many health hazards and problems. The burden of preventible communicable diseases still consumed a large portion of national and international resources devoted to health. Most parts of the world still had no safe water supply nor even minimum standards of sanitation, housing and nutrition.

It was true that the campaign for the eradication of malaria had made good progress. This progress represented an extraordinary effort on the part of governments, which had resulted in an enormous saving of lives and reduction in morbidity, leading to the release of increased manpower for economic development. Some reverses had been encountered in some parts of the world, due to administrative and operational difficulties. Organization of basic health services throughout the country was essential to take over surveillance in the maintenance phase of malaria eradication.

She referred to the spread of cholera and to the cholera outbreaks last year affecting 23 countries, which had imposed a heavy burden on social and economic development. India, with other countries in this Region, was trying to find better methods of controlling cholera.

Smallpox was another great world challenge. Although in India there had recently been a 50 per cent decrease in the number of cases, the case-fatality rate remained high, and an independent assessment of the situation had revealed incomplete coverage. Health education would greatly help in making the people more vaccination-conscious. In India, 80 per cent of the population had already been vaccinated. She hoped that countries in this Region would soon undertake an accelerated smallpox eradication programme on a ten-year co-operative plan, as urged by the Nineteenth World Health Assembly.

The Minister emphasized that the shortage of trained personnel was a major hindrance to the establishment of the required number of health centres. It was also necessary to train medical and para-medical personnel to staff not only the basic health services but also the family planning programme. She recalled that it had been decided at the last World Health Assembly that the Organization might advise governments, when requested, on the development of family planning activities as a part of the local health services, especially of integrated maternal and child health services; she felt that previously WHO’s approach to this subject had been rather negative.

As regards the Revolving Fund for supplying equipment for teaching institutions, which had been created by the last Assembly, India had already submitted requests for such equipment. It was hoped that advantage would be taken of this fund by other countries.
To raise the standard of living of the people in the countries of the Region, better utilization of manpower was important. Drugs and other medical requisites were essential commodities, and Member States should give high priority to their production and testing. Equally important was assistance from the Regional Office on drug standards, the quality control of drugs and development of analytical facilities. She suggested that a regional drug testing laboratory should be established.

In conclusion, Dr. Sushila Nayar thanked WHO for its assistance in raising the level of health services in India (for full text of speech, see Annex 2).

4. Statement by the Regional Director

The Regional Director thanked the Prime Minister on behalf of WHO for graciously consenting to be present at the Regional Committee to inaugurate the session. He observed that India had a long and close association with WHO and had contributed abundantly to the success of the Organization in numerous ways. Prime Minister Jawaharlal Nehru had been responsible for bringing the Regional Office to India, and the magnificent building in which the present meeting was being held had been the result of his personal endeavour to provide a suitable place for WHO's work, in keeping with India's dignity and that of the countries of the Region. Mrs. Gandhi's own active association with child welfare work was already well known, and he hoped that the little WHO had been able to achieve so far and expected to do after her inspiring address would give her some satisfaction. WHO was indeed very happy and honoured to have the Prime Minister with them, and he was sure that her inspiring address would give all participants much food for thought and act as a beacon for WHO's programmes for many years to come.

5. Statement by Representative of the Director-General

Dr. Karefa-Smart, Assistant Director-General, WHO, conveyed the best wishes of the Director-General for the success of the deliberations of the session.

He had been associated with the work of the Organization during the past fifteen years in different capacities and was aware of the important role which the regional offices played in responding to the health needs of the regions. He expressed satisfaction at the opportunity of being present during the deliberations of the nineteenth session of the Regional Committee for South-East Asia.

Referring to the agenda item on increasing the size of the Executive Board, he said that the World Health Assembly had already considered tentatively the question of increasing the size of the WHO Executive Board in order to ensure fair and proportionate geographical representation. He was sure that the Assembly would reach a satisfactory decision.

He referred to smallpox eradication and to the development and training of health manpower. The success of the smallpox eradication programmes would depend to a great extent on the availability of adequate numbers of trained health staff, both medical and auxiliary. The realization that any successful
implementation of a programme was dependent on adequate manpower had led
WHO to give priority to the education and training of all categories of
health staff (for full text of speech, see Annex 3).

6. Messages from the United Nations and Specialized Agencies

6.1 United Nations and the United Nations Development Programme

MR SHALLON (acting Resident Representative of the United Nations
Development Programme) said that he had a double honour - that of greeting
the nineteenth session of the Regional Committee not only on behalf of the
Secretary-General of the United Nations but also on behalf of the Adminis-
trator of the United Nations Development Programme. WHO was in the fortunate
position of being one of the least controversial of the specialized agencies
and was one of the most successful. The results of the work of WHO were well
known. He referred to the increased life expectancy in India in recent years.
It was gratifying that the United Nations Development Programme had been able
to support the work of WHO in such fields as tuberculosis, medical education,
water supply and sanitation. He looked forward to the continued expansion of
these joint activities.

6.2 UNICEF

DR EIGER (Director, UNICEF South Central Asia Regional Office) conveyed,
on behalf of both the UNICEF South Central Region and the UNICEF Region for
East Asia and Pakistan, sincere good wishes for the success of the meeting.
UNICEF was closely associated with many WHO-sponsored activities, and he
hardly needed to emphasize the close co-operation that existed between the two
agencies in the Region. UNICEF concentrated its activities on children and
youth and wished to be closely associated with the governments' plans for this
section of the population. He appreciated the challenging message of the
Prime Minister as well as the instructive report of the Regional Director.

6.3 FAO

DR SIMPSON (Regional Nutrition Officer, FAO, New Delhi) conveyed greet-
ings and good wishes on behalf of the Director-General and the Deputy Regional
Representative of FAO. FAO, together with WHO, had been assisting governments
throughout the world in joint programmes. The two organizations had jointly
participated in providing experts to many countries in a search for additional
and alternative sources of protein, which could be produced economically and
made available for human consumption. This was an important effort in over-
coming the world shortage of protein. FAO was also associated with WHO in
increasing the production, consumption and utilization of protective foods, in
improving the nutritional standards and in nutrition education in South-East Asia.

6.4 UNESCO

MR DUNNINGHAM (Deputy Chief of Mission UNESCO) conveyed the greetings
of the Director-General of UNESCO. The work of UNESCO had been complemen-
tary to that of other specialized agencies, and there had been continuing co-opera-
tion between UNESCO and WHO, as recorded in the current report of the Regional
Director. He was confident that the deliberations of this session would be of
benefit to the Member States of the Region.
7. Messages from Other Organizations

7.1 International Dental Federation

DR SAHNI (International Dental Federation) brought greetings from the International Dental Federation and wished the delegates success in their deliberations in terms of betterment of public health in the countries of the Region. The Federation was keenly interested in raising the level of dental health throughout the world, and he had been asked again to request WHO to appoint a dental health adviser in the Regional Office, at least on a part-time basis. The Federation was always prepared to give necessary help and assistance in suggesting programmes for the prevention and treatment of dental diseases.

7.2 International Union of Architects

MR BHALLA (President, Indian Institute of Architects, New Delhi) conveyed the greetings of the International Union of Architects to the Regional Committee and said that the Union would extend the fullest cooperation to the World Health Organization in the spheres of town planning and architecture.

7.3 World Confederation for Physical Therapy

MR ALEXANDER (Indian Association of Physiotherapists, New Delhi) extended greetings and good wishes, on behalf of the World Confederation for Physical Therapy and the Indian Association of Physiotherapists, for the success of the deliberations of the Committee. The different categories of workers in the field of medical rehabilitation, such as occupational therapists, physiotherapists, medical social workers, rehabilitation nurses, etc., were in short supply, and this problem deserved the full consideration of the Regional Committee.

7.4 International Council of Nurses

MISS PAULL (Vice-President, Trained Nurses' Association of India, New Delhi) said that the International Council of Nurses and the World Health Organization had been working in close co-operation for many years, and, with the headquarters of the Council now in Geneva, even close co-operation could be expected. On behalf of the Council, she expressed good wishes for a successful session.

8. Appointment of Sub-Committee on Credentials
   (item 2.1 of the Provisional Agenda)

The CHAIRMAN proposed that the delegates from Afghanistan, India and Thailand should constitute the Sub-Committee on Credentials. This proposal was adopted, and the meeting was adjourned temporarily to permit the Sub-Committee to meet.
9. Approval of the Report of the Sub-Committee on Credentials
(item 2.2 of the Provisional Agenda)

After the meeting was resumed, DR A.R. HAKIMI (Afghanistan), Chairman of the Sub-Committee on Credentials, was asked to present the Sub-Committee's report (SEA/RC19/19). The Committee had found the credentials of the representatives from all the countries represented - i.e., Afghanistan, Burma, Ceylon, India, Indonesia, Mongolia, Nepal and Thailand - in order, and therefore recommended that the validity of these credentials be recognized.

The report of the Sub-Committee on Credentials was adopted.

10. Election of Chairman and Vice-Chairman
(item 3 of the Provisional Agenda)

On a proposal by DR DOLGOR (Mongolia), seconded by DR CHITT (Thailand) and by DR HAKIMI (Afghanistan), Dr Marsaid Soesilo Sastrodihardji, the representative from Indonesia, was elected Chairman of the Regional Committee. Welcoming the newly-elected Chairman, the retiring Chairman, DR ANWARY, said that during the previous session of the Regional Committee held in Kabul, Dr Marsaid, who had been Vice-Chairman at that time, had very competently carried out the functions of the Chairman on the different occasions when he had to occupy the Chair, and no doubt had the confidence of all.

On the nomination of DR DOLGOR, seconded by DR HAKIMI, Dr Lun Wai, representative from Burma, was elected Vice-Chairman.

11. Adoption of Provisional Agenda
(item 4 of the Provisional Agenda)

The Provisional Agenda (document SEA/RC19/1) was adopted.

12. Appointment of and Terms of Reference for the Sub-Committee on Programme and Budget
(item 5 of the Agenda)

On a proposal by the CHAIRMAN, a Sub-Committee on Programme and Budget, composed of representatives of Afghanistan, Burma, India, Mongolia and Thailand, was established.

The terms of reference for the Sub-Committee, as outlined in document SEA/RC19/4, were approved.
13. **Adoption of Agenda, and Appointment of Chairman, for the Technical Discussions**
   (item 6 of the Agenda)

On the nomination of MR MURTHY (India), seconded by DR JOSHI (Nepal), Dr Gunasekera (Alternate on the Ceylonese delegation) was elected as Chairman of the technical discussions.

The proposed agenda for the technical discussions (document SEA/RC19/5) was adopted.

14. **Adjournment**

The meeting was then adjourned.
Text of the Address Given by Mrs Indira Gandhi, 
Prime Minister of India

It is indeed both an honour and a pleasure to welcome public health administrators and delegates from nine countries of this part of the world.

The aim of WHO is a healthy world. WHO is a symbol of the growing co-operation among nations in matters of public health and medical research.

We speak of the world being one, but the implications of this idea are not fully appreciated. The unity of the world means that this globe cannot be half poor and half rich, half healthy and half diseased. An epidemic or an endemic disease in any part of the world should rightly be regarded as a potential danger to all mankind and a challenge to the skill of science.

Most diseases are the product of poverty. It is only economic development which can create a social administration which is capable of harnessing science to the task of conquering disease. Malnutrition is the mother of much illness. The food battle of India is not only one of quantity but one of quality as well. Our Government attaches the greatest importance to programmes which give protective foods to the needy - in particular to children and to mothers. All who are engaged in development planning cannot, therefore, afford to lose sight of investment in health, for it pays dividends both in the greater well-being of man, which is the ultimate aim of all development, and in greater vitality and efficiency, which are indispensable qualities of human resources in creating a reasonable standard of living for all. Both high dependence rates and short life expectancy militate against economic progress. It has been estimated that during the span of one generation some Asian countries lose no less than 32 per cent of their potential total productive capacity as a result of premature death.

Every child has a right to health, to education, to congenial recreation. But his share of the sun and air, of water and sustaining food, is limited by the economic status of its parents. We feel that it is the duty of the State to correct this injustice. All children do not come with the same natural endowments, but every government should be able to give to every child the best opportunity to develop its potentialities to the fullest. Among the principles of WHO's Constitution, one seems particularly valuable to me. It says: "Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development." How can this ability be inculcated in the young? A very important task is precisely to induce every young person to go outside the narrow framework of his own personality, to go beyond the present, and to think in terms of the community and of those who will come after him. It is necessary to inculcate a regard for every life -
which implies respecting everything which maintains health and life, respect-
ing the vital elements of air, water and earth. The more rapidly the world
population increases, the more widespread industrialization becomes; the
more towns grow, the more essential it becomes, in this rapidly changing
total environment, to do every thing possible to promote the harmonious
development of the child, in trying to teach a sense of true value.

The Constitution of the World Health Organization states clearly in
its Preamble that success does not depend solely on the work of specialists
but, to a very great extent, on informed public opinion. As my father said
when he inaugurated this building, people must be convinced of the cause to
be furthered. Informed opinion and active co-operation on the part of the
public are of the utmost importance in the improvement of their health. This
informed public opinion can no longer confine itself to matters concerned
merely with individual hygiene. The individual must be taught above all to
respect and set true value upon the common good, for which we are accountable
not only to ourselves but to the world of tomorrow. International co-operation
has a great role to play in enabling developing countries to improve
their public health and medical aid programmes. Not all our countries have
the means to carry out the basic research from which come life-saving
discoveries. Therefore we all owe a lot to the discoverers. But the benefit
of those discoveries must be available for all mankind at the lowest possible
cost. Modern research needs large investments, but it is well known that,
in the name of research, some firms charge exorbitant prices for drugs.
There is urgent need for arousing the conscience of the world in the matter
of reducing the prices of the basic tools of birth control and death control.

An essential precondition is the provision of health facilities and
medical aid today. Even amongst advanced countries, not all can provide
prompt and adequate medical aid to their people.

The public health programme is a programme of saving lives and
conquering disease. It means fewer deaths, longer lives. Thus we are con-
fronted with a dilemma: the conflict between the rate at which the population
is growing and the rate at which food supplies and job opportunities grow.
This is why most nations of Asia and Africa have undertaken programmes of
family planning. It forms part of our Indian Fourth Five-Year Plan - the
most important feature of which is our determination to provide 3 oz. more
of food per head and to be relatively independent of foreign imports of
food. The family planning programme, we hope, will bring down the birth
rate from 40 to 25 per 1,000 in the next ten years.

This is no small undertaking. It requires a large army of qualified
medical people who can provide advice and guidance; it demands efficient
organization of supplies of contraceptive materials, and it depends on the
involvement and co-operation of millions of married couples in India's 560,000 villages - calling for individual approach and persuasion. I have every confidence that we shall achieve the goal we have set out for ourselves.

Besides the big expansion in medical education, we have also planned for a big expansion of public education in matters of health. Expansion of general education brings about increasing health awareness, and by 1971 we shall have nearly 100 million children at school. But we have the large mass of grown-up people, three-fourths of them illiterate, in whom we must create a consciousness of environmental hygiene.

I said earlier that malnutrition is the mother of many illnesses. The food battle of India is one of changing diet habits and persuading people to eat not only what they like but what is good for them and for their growing children. Our Government attaches the greatest importance to programmes which give protective foods to our poorer people. We had to undertake many such large-scale programmes during the recent food shortage in many States of India. I hope that it will be possible to continue some of these programmes, especially those which relate to school-going children.

I am grateful for the opportunity which WHO has given me to meet so many distinguished representatives of the countries of South-East Asia. I have great pleasure in welcoming you all to India and in inaugurating your conference.
I am very happy to have the privilege of addressing once again the WHO Regional Committee for South-East Asia, and take great pleasure in welcoming all representatives from our sister countries. Since our meeting in Kabul last year, the Maldives has joined our region as a full Member, and I am happy to take this opportunity of welcoming them, and express the hope that they will soon be participating in our Regional Committee. I am happy to see the representatives here this morning.

I was recently reminded that WHO - and the Regional Organization for South-East Asia, the first to come into being - will soon be twenty years old. In fact, it is just over twenty years ago that the International Health Conference was convened in New York to draft WHO's Constitution. The aim assigned to the Organization by this Constitution is an exalted one and is defined in such a way that it will always remain an ideal - an ideal that indicates the objective towards which we are trying to move together - namely, the attainment by all people of this planet, Earth, of the highest possible level of health. How far have we come since these words were drafted into WHO's Constitution twenty years ago? Some striking advances have been made, but, as we shall no doubt learn from the Regional Director's report, our international community still faces many health hazards and problems. The burden of preventable communicable diseases is still with us and continues to consume a large portion of our national as well as our international resources. A major part of the world is still without protected water supply and minimum standards of sanitation, housing and nutrition.

It is true that the campaign for the eradication of malaria has made very great progress. This progress represents an extraordinary effort on the part of our governments and the international community, and has resulted in an enormous saving of lives, a reduction in illness, and consequent increase in manpower, as well as the opening up of new areas for economic development. There have been some reverses in several parts of the world, including South-East Asia, due not so much to technical problems as to certain administrative and operational factors, and great efforts are still required in our final phases of this programme. Not only have we to complete the job, but we must also ensure constant vigilance to prevent the enemy from coming back. For that, the organization of basic health services all over is most essential.

The situation of cholera is disturbing. Last year it spread to 23 countries and, as expected, maintained its westward spread. Last year's cholera outbreaks are a sad reminder that usually the greatest burden of such social and economic problems of the world falls on us: 51,000 cases were reported globally, and of these, 44,000 were from our Region. A great deal of work is going on in South-East Asia to find better means of controlling cholera, as will no doubt be reported to you during the course of this meeting. But is it enough? Have we done enough to provide pure drinking water for the people? This is the first requisite in the fight against cholera.
Smallpox is another great challenge facing us. Although in India, for example, there has been a 50 per cent decrease in the number of cases, the case fatality rate remains high, and independent assessments of the eradication programmes in India and Nepal have shown that biological protection was not conferred on all the population of the areas covered by vaccination. The assessments also indicated that it has not been possible to achieve primary vaccination in a considerable proportion of infants and young children, who are the most susceptible to smallpox. Health education of the mass of the people so as to make them aware of the need for vaccination of all newborns and revaccination from time to time has still not been achieved and is the most essential task.

In my own country we have for some years pursued a programme of smallpox eradication and have already vaccinated 80 per cent of our vast population. We were therefore fully in favour of the decision taken by the last World Health Assembly to undertake an accelerated global smallpox eradication programme based on a ten-year co-operative plan. Let us hope that our region will soon be free from the scourge of smallpox as a result of this concerted drive.

In this connection it is interesting to recall here the lessons we have learnt from the malaria eradication programme. An eradication programme is much more than an episode, for it requires the establishment of a network of public health services as a fundamental prerequisite for the success of the campaign. And this applies equally to all campaigns, such as those against smallpox, etc. When the objective is obtained, the infrastructure of a basic health service must be there to maintain the beneficial results. In India we are busy setting up this basic health service, utilizing the trained malaria personnel after full orientation training to fit them for the job.

However, it is clear that no one can hope to establish national networks of public health services until the trained manpower is available in requisite numbers. In the final analysis, the shortage of trained manpower may very well be the greatest problem facing us in this region, and to solve it we must continue to expand our educational and other training facilities.

When I speak of the importance of basic health services - and in speaking of training I mean not only physicians but also middle-level and paramedical personnel to staff these basic health services - I must also mention family planning. I am happy that in so far as advisory services to its Member Governments are concerned, the last World Health Assembly decided that WHO might advise governments, upon request, in the development of family planning activities as an integral part of the over-all function of the local health services, particularly of their maternal and child health services. We are glad of this advance of WHO over its earlier rather negative (if I may say so) approach.
Any programme of family planning is of necessity a long-term one and, owing to its very nature, calls for mutual confidence between the population concerned and the health staff. This confidence cannot be obtained unless permanent health services are available and health education forms a part of them, so that parents can feel reassured that if they have fewer children, they can expect them to become full, adult citizens.

In conclusion I would like to say that we have taken advantage of WHO assistance in many health programmes, and I take this opportunity to thank the Organization, and especially the Regional Director, for making available to us their services through field staff members, fellowships and other training facilities, which have done much to raise the level of our health services. At the request of my delegation, a proposal for setting up a revolving fund for supplying equipment for training institutions was recently approved by the World Health Assembly. My Ministry has already submitted two or three requests for such equipment, and I hope that other countries in our Region also will take full advantage of this facility. Our needs for equipment are, of course, much larger, but still this small step in the right direction is most welcome.

The South-East Asia Region is a developing region. There is a keen desire on the part of Member States to raise their standard of living, which can be accomplished only by better utilization of manpower, and that means industrialization. Industrialization is, therefore, inevitable, and many Member States have taken steps towards the realization of this goal. Drugs and other medical requisites being essential commodities for the maintenance of health, it is to be expected that Member States would give a high priority to the production of such commodities. In the present state of development, therefore, it is essential that the Regional Office of WHO should have at their disposal technical personnel who would be able to guide the developing States in a co-ordinated development of the drug industry, particularly in the field of developing drug standards, control machinery and analytical facilities. I hope that this question will be discussed in the current session and that concrete steps will be taken towards this end. I would also suggest the setting up of a regional drug testing laboratory for the help of those developing countries who may not have adequate machinery at their disposal in their own countries. This is very necessary, and I commend to our Regional Director that this project be given very high priority.

I hope your discussions will be fruitful. I shall look forward to their outcome, and assure you that any recommendations that you make will receive the fullest consideration of our Government.

With these words I would like once again to thank the Prime Minister and extend a very warm and cordial welcome to you all.
Text of Statement by Dr J. Karefa-Smart,
Assistant Director-General, WHO Headquarters,
and Representative of the Director-General

I have the privilege of having been nominated as the representative of the Director-General of WHO, and I bring to all of you distinguished representatives of the Member States in this Region, to our colleagues representing our sister-agencies in the United Nations family and the several non-governmental organizations in official relations with WHO, to the official observers, and, last but not least, to the Regional Director, the official greetings of Dr Candau, our Director-General, and his warm personal regards and best wishes for a successful meeting of this Regional Committee.

I count it a very great privilege that the first Regional Committee which I am attending as a representative of the Director-General since I joined his staff at Headquarters is this meeting of the South-East Asia Regional Committee. My pleasure derives not only from the fact that during the fifteen years of my association with our Organization in different capacities, I have been aware of the pioneering role of this Regional Office and of the satisfactory way in which it responds to the health needs of the Region, but also because in my home country, Sierra Leone, and throughout the African Region, we have always acknowledged with gratitude that we owe the inspiration which guided us in the path towards national independence to the example set by two of India's greatest gifts to the world, Mahatma Gandhi and Jawaharlal Nehru.

Among the important matters which will be discussed by you is the question of increasing the size of the WHO Executive Board, a subject which has already had preliminary consideration in the World Health Assembly. I know that with the help of whatever resolution you may pass here, after discussion, the Assembly will find a reasonable solution to this problem, which will reflect the principles of fair and proportionate geographical representation as enshrined in the WHO Constitution.

Among the programmes which are submitted for your consideration and approval in the Proposed Programme and Budget Estimates for 1968, I would like to make a short comment on two in which your concern is shared by every Member country in every region of WHO. These are smallpox eradication, and development and training of health manpower.

The various country and inter-country smallpox programmes which you will be considering will greatly benefit from the trials and errors as well as from the successes which you already have encountered in the malaria eradication programme. But such success as we all hope will be achieved
is almost entirely dependent on the quality of the basic health services and the extent to which these services are available to all communities. We know, of course, that this, in turn, depends on the availability of sufficient numbers of adequately trained members of what I would call the "health services team", which includes physicians, nurses, sanitarians, health educators and other workers in the medical, para-medical and allied professions. It is this inter-dependence between successful programmes and adequate manpower which has led our Director-General to express on several occasions the need to give the highest priority to the education and training of all members of this health service. The limited resources of the Organization can be put to no better use than to help our Member countries to increase the quantity and the quality of workers in the field of health.

It is on this note of the importance of men and women with trained minds and willing hands in our work that I add my own personal best wishes to those which I have already conveyed from the Director-General for a successful meeting of the Regional Committee for South-East Asia.
SUMMARY MINUTES

Second Meeting, 27 September 1966, 2.30 p.m.*

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*Originally issued as SEA/RC19/Min.2, on 28 September 1966, and incorporating subsequent corrections.
1. **Address by the Chairman**

DR MARSAD (Indonesia) thanked the delegates for electing him Chairman. He thought that the countries of this Region had benefitted from WHO assistance in promoting the health of the people, although, as pointed out by the Regional Director, progress in this regard had been hampered by economic difficulties.

With assistance from WHO, Indonesia had been able to protect two thirds of its population from malaria, extend maternal and child health centres throughout the country, effect considerable control of leprosy and tuberculosis, and increase the skill of its technical staff through fellowships.

His country had been faced with the difficulty of providing counter-part costs for international assistance. In trying to tackle so many problems, the Government had to set priorities. The main problem was to combat communicable diseases, which were both endemic and epidemic and had a serious impact on the economic life of the people. In view of this, the Ministry of Health had revised its structure to provide territorial services and operational services.

Another major problem in the country was the overcrowding of the so-called central islands: Java, Madura and Bali, which contained two thirds of the total population of the country. In these islands there were about 500 persons per square kilometre in an area which was one thirteenth of the total area of the country, and there was a population increase of two million people a year. Efforts to solve this uneven distribution had not succeeded.

He hoped that, with assistance from WHO and other international agencies, the health of the people in the Region would improve.

2. **Eighteenth Annual Report of the Regional Director**

*(item 7 of the Agenda)*

The REGIONAL DIRECTOR said that he had pleasure in presenting his annual report. As usual, it comprised an Introduction, three main parts and some annexes. Part I was most important, as it gave subject-wise information on the year's work. He hoped there would be full discussion on this section, to serve as future guidance in developing programmes in the Region. Part II dealt with administrative matters, and Part III gave descriptions of the individual projects in each country.

Some minor corrections to the report had been made in document SEA/RC19/2 Corr.1, which had been issued.

He suggested that delegates might like to comment on the report as a whole and then to take it up section by section.
DR HAKIMI (Afghanistan) congratulated Drs Marsaid and Lun Wai on their elections as Chairman and Vice-Chairman, and also the Regional Director for his report.

He was glad to note the emphasis placed on malaria eradication, and the integration of special programmes into the general services (he thought malaria and smallpox might be integrated), on the training of personnel, medical education and medical research. These problems were given high priority by many countries, including Afghanistan. By its new Constitution, his Government was committed to making planned health facilities available for the whole nation. The Third Five-Year Plan required the construction and operation of new health centres in areas where health facilities were not yet in existence, and the provision of safe water supply. He hoped considerable assistance for meeting the water supply problem would be provided by WHO and UNICEF. The Afghan Government was fully aware that these health problems could not be separated from economic progress.

His Government was grateful to the Government of the USSR for the supply of three million doses of freeze-dried vaccine for smallpox eradication, to the Government of India for a 100-bed hospital for children, and to the National Ophthalmic Rehabilitation Organization (NOOR) for constructing training centres and eye banks for the prevention of blindness. Finally, he thanked WHO and UNICEF for their assistance.

DR CHITT (Thailand) expressed his gratitude for the warm welcome received from the Prime Minister of India and congratulated the Chairman and Vice-Chairman on their election. He also congratulated the Regional Director on his excellent annual report, which, he thought, gave a clear picture of health in the Region.

Thailand faced the problems of insufficiency of funds, uneven distribution of doctors and early specialization, as well as over-specialization, in certain disciplines. He would welcome assistance from WHO in the strengthening of epidemiological services for the purpose of controlling communicable diseases.

MR MURTHY (India) also congratulated Drs Marsaid and Lun Wai on their election. He thanked the Regional Director for his report - an excellent exposition of the health problems and needs of the Region - and also for the assistance given in solving these problems. The difficulties mentioned by the Regional Director - the unprecedented drought, the shortage of foreign exchange and the universal rise in the cost of living - had retarded the progress of different health programmes not only in India but also in other countries of the Region. While this was so, the main problem in India was the tremendous growth of population, which had been calculated at about 10-12 million per year. In its Fourth Five-Year Plan (1966 to 1971), India had started a mass crash programme in family planning costing Rs.2 000 million. India was also conscious of the importance of basic health
services essential for the maintenance of malaria and smallpox eradication. By the end of 1965 nearly 50% of the population (approximately 500 million) had entered the maintenance phase of malaria eradication.

India was also facing the major problems of tuberculosis, filariasis and leprosy, and had made adequate provision in the Fourth Five-Year Plan for their control.

Other important problems were the supply of safe drinking water and, related to this, the control of cholera and of other water-borne diseases. The Government of India, in its Fourth Five-Year Plan, had allocated one third of its total health outlay for this purpose.

Attention had also been given to the training of health personnel, both professional and auxiliary staff. In the past three five-year plan periods, the number of medical colleges in the country had increased from 25 in 1950 to 89 in 1965. However, due to population rise, the doctor/population ratio had not notably increased. It was proposed to establish 25 more medical colleges in the Fourth Five-Year Plan period and also to provide increased facilities for training teachers for these colleges by establishing post-graduate medical education and research institutes in different parts of the country.

He thanked the Regional Director and his staff for the achievements in the Region in the field of health, and also thanked other international agencies for their assistance.

DR GUNARATNE (Ceylon) congratulated the Chairman and Vice-Chairman on their election.

On behalf of his country and delegation he expressed appreciation for the Regional Director's comprehensive report. It was notable, he thought, that in this region WHO was spending, and continued to need to spend, about 50 per cent of its budget on the control of communicable diseases. It was becoming abundantly clear that without proper epidemiological services no economical or effective control was possible. This called for further efforts in this direction.

In Ceylon, malaria eradication had been nearly achieved but had lately seen resurgent foci. A WHO consultant had visited Ceylon in February of this year to assess the present status of the programme. His recommendations were being implemented.

He agreed with the Regional Director's statement in the Introduction about the importance of planning, based on operational research.
He also referred to the Asian Development Bank and agreed that it was an excellent example of inter-regional co-operation. It was to be hoped that every country would make use of its provisions, especially for long-term loans for eradication and prevention of diseases in the Region.

Referring to the comments of the Health Minister of India with respect to family planning, he stated that this was a serious problem in Ceylon as well. The population increase was 2.4 to 2.5 per cent per year. Ceylon had embarked on a four-year family planning programme with assistance from the Swedish Government, and it was hoped to bring the birth rate down from 30 to 20 per thousand in a period of ten years.

He thanked WHO and especially the Regional Director for all the assistance given, especially in providing fellowships. He also thanked UNICEF and other agencies for their co-operation.

DR MARSÄID (Indonesia) expressed appreciation of the Regional Director’s report, which he thought was comprehensive and gave a good picture of health conditions in the Region.

Indonesia had been facing economic difficulties, which had, of course, affected its health services. There had been an increase in the number of professional health workers, but their distribution had so far been very uneven.

Although there had been no progress in malaria eradication in recent years there had also been no serious resurgence of malaria in the areas already sprayed. A start had been made in training malaria workers for general health work in integrated services.

The incidence of smallpox had been on the increase, causing many deaths: 3,975 in 1965 (almost double the figure for 1964) and 7,545 in 1966 (up to August). He hoped that UNICEF might be able to help. It was encouraging to note that the new government had given high priorities to smallpox and malaria eradication.

Floods followed by epidemics had caused serious difficulties in the country.

He referred to the day’s news item about typhoons in Japan, and suggested that the Regional Committee might send a message of sympathy.

DR DOLGÖR (Mongolia) congratulated Drs Marsaid and Lin Wai on their election and welcomed the accession of the Maldives Islands as the ninth Member of the Region. He thanked the Regional Director for presenting a very interesting report.
It was noted that economic difficulties had adversely affected the improvement of public health in some countries. The basic activities of the Region were still mainly directed at controlling communicable diseases like smallpox, cholera, etc., and this trend was likely to be continued for a long time. In his country, degenerative diseases and malignant tumours were problems. He agreed with the Regional Director’s emphasis on the training of medical personnel, both doctors and nursing staff, which was one of the key problems in the development of national health services, and was glad to note the progress made in countries of the Region in this regard.

He enquired why the number of WHO fellowships, especially in health administration, had been reduced in 1965 as compared to 1964, and wondered whether the Regional Director might explore the possibility of increasing the number awarded in future years.

He agreed with the Regional Director’s remarks in his report that assigning long-term teachers to medical institutes had not been found practical. The problem of shortage of health staff could be solved in two ways: firstly, by inviting professors with necessary experience to visit the institutions, and secondly by sending national doctors to other countries for two to three years for advanced training. So far as laboratory equipment for medical institutes and hospitals was concerned, it was felt that the countries of this Region were insufficiently equipped, and it was gratifying to note that the Nineteenth World Health Assembly had established a Revolving Fund for assisting countries in this regard.

Ulan Bator had also suffered from severe floods, but outbreaks of communicable diseases had been prevented. He thanked WHO for assistance in this emergency.

DR JOSHI (Nepal) congratulated the Regional Director on dealing with different health problems at length in his annual report. He expressed the view that the various problems would have to be considered in the light of available resources and personnel. In Nepal, multi-purpose health centres had been started, to cover all services, including tuberculosis, leprosy, maternal and child health and nursing, and these were functioning well. Malaria control alone was consuming almost half the budget for the health services. He hoped that WHO assistance might be provided to train malaria workers for multi-purpose duties at health centres.

Tuberculosis was a major health problem in Nepal, and the withdrawal of the WHO expert was regrettable. Up to the present, 26,000 persons had been given BCG vaccination. The smallpox vaccination programme was proceeding well, but lack of adequate transport caused some difficulties.
Training of basic personnel was an urgent need of the country, and a programme for training health assistants had been going on for some years. The training of nurse midwives had been delayed through lack of adequate accommodation in some of the hospitals.

On the question of family planning, he felt that the subject deserved greater attention than given to it in the past. In Nepal it was proposed to train volunteers for family planning work to visit different parts of the country.

He thanked UNICEF for providing supplies and equipment for the maternal and child health programme.

The REGIONAL DIRECTOR, replying to the question raised by the Mongolian delegate about the reduction in the number of fellowships, quoted figures showing that the fellowships awarded to Mongolia had actually increased.

DR DOLGOR (Mongolia) stated that his question referred to the Region as a whole and not to Mongolia.

The REGIONAL DIRECTOR said that the award of fellowships was generally planned two years in advance and that they were mostly related to projects. For various reasons some projects were delayed in implementation, and this resulted in savings toward the end of the year which could be used for awarding further fellowships. He estimated that the number of fellowships awarded in 1966 would be much higher than in past years and that the general trend was definitely upwards, in spite of the slight difference between 1964-65.

He agreed with Dr Joshi (Nepal) that the retraining of malaria workers for general work was most important; efforts were being made in India and Thailand to attempt to give some form of multi-purpose training to these workers. The Regional Office was now acquiring some experience in this regard, and it would certainly do everything possible to assist governments with such training.

As regards family planning, there had been a positive approach in the last World Health Assembly, which had directed that WHO could give advisory assistance if it were a part of maternal and child health services, which in turn were an integral part of general health services.

Drug manufacture and quality were also problems. The Regional Office was trying to get into this field and had recruited a short-term consultant initially to visit Ceylon to advise on quality control.

Should minimum skills and resources for such work be available in different countries, WHO would be willing to help in making a start and in trying to see that some progress was made.
The Committee then considered the report section by section.

**Smallpox (pp.9-12)**

The REGIONAL DIRECTOR reminded delegates that the last World Health Assembly had approved a considerable budget for the smallpox eradication programme; he invited suggestions as to what type of assistance WHO could usefully give to governments.

DR LUN WAI (Burma) said that in his country smallpox eradication activities had been spread over 37 districts. The First Three-Year Programme had ended in 1965, and during the Second Three-Year Programme, it was proposed to cover 67-69 districts. The target of six million vaccinations had been achieved in 1964-65, and during the next few years of a yearly supply of seven million doses would be needed. His Government was grateful to the USSR for supplying freeze-dried smallpox vaccine for this programme.

DR JOSHI (Nepal) said that in his country 2,400 panchayat leaders had been trained to give smallpox vaccinations in their areas. He felt that this group needed close supervision and hoped that WHO would grant fellowships to supervisors so that they could, on return, give training on the spot.

MR MURTHY (India) said that in India there were large numbers of cases of smallpox every year, in spite of the great efforts which had been made to eradicate this disease. Epidemiological investigations had shown that in India its persistence could be mainly attributed to residual pockets, due to (1) unprotected newborns, (2) children who had not yet had primary protection, and (3) unprotected migrant labour population in towns. Special efforts were being made to conduct a house-to-house check and to see that all those missed were vaccinated. The USSR had kindly donated 450 million doses of freeze-dried smallpox vaccine, and 46 million more would be supplied by February 1967. Production of freeze-dried vaccine had started at Patwadangar, Madras, Belgaum and Hyderabad, with assistance from WHO and UNICEF, and a new production centre at Calcutta was being set up. The four existing centres now had the capacity to produce 60 million doses per year, as against the yearly requirement of 160 million, and the USSR has been requested to provide 100 million doses by the middle of 1968, by which time it was hoped that necessary additional equipment would be installed so that the country could itself produce enough vaccine.

DR MARSAID (Indonesia) stated that Indonesia was also producing freeze-dried smallpox vaccine but required equipment and transport. He expressed hope that perhaps UNICEF could help in this regard.
The REGIONAL DIRECTOR observed that, although a very serious effort towards smallpox eradication was being made in a number of countries of the Region, at considerable cost, much of it was nullified because of inability to give proper coverage to the newborn. It was essential that no newborn should escape vaccination.

Cholera (pp.12-13)

DR SUBRAHMANYAN (India) stated that, as given in the Annual Report, the majority of cholera cases were reported from India, and he enumerated the various measures taken by the Government. In the Fourth Five-Year Plan, it was proposed to allocate Rs.30 million for cholera control. It was further proposed to establish an epidemiological unit in each State and to train basic health workers in cholera intelligence work, mass inoculation, disinfection and treatment. These basic health workers would ultimately be integrated into the permanent health services. In 25 cholera endemic districts in India, this integration scheme would be introduced along with a programme for safe water supply. Environmental sanitation would also receive high priority. The Indian Council of Medical Research, with the assistance of a WHO consultant, was engaged in a study of cholera carriers in Calcutta. He hoped that WHO and UNICEF would assist in the manufacture of saline infusion plastic containers, which had proved to be life-savers in rural areas.

DR ANWARY (Afghanistan) endorsed the statement of the Indian delegate on the need to intensify control measures in cholera. In 1965, Afghanistan had faced an epidemic of cholera El Tor. Owing to lack of proper arrangements and means of transport, the measures instituted to control the disease were not so satisfactory as they should have been. Plastic containers with rehydration solution, for example, had to be imported by air.

The REGIONAL DIRECTOR, in reply, stated that for the manufacture of plastic containers and rehydration fluid, WHO had engaged a consultant; he thought that UNICEF might be interested in this programme if a satisfactory scheme could be worked out. WHO had a cholera team in Afghanistan, which will help prepare for, and deal with, possible cholera epidemics.

DR EGGER (UNICEF) said that he doubted whether this work fell within the scope of the Joint Committee on Health Policy, but he would enquire. UNICEF had, however, assisted in rural water supply schemes in cholera-affected areas. In Afghanistan especially, UNICEF was collaborating with the Rural Development Department in improving rural water supply.

DR SHIVASTAV (India) stated that as in India, at least, children were the most vulnerable group affected by diarrhoeal and enteric diseases, including cholera, and as UNICEF was primarily concerned with the health of children, it was hoped that UNICEF might give assistance in the manufacture of the life-saving plastic infusion sets.
DR GUNARATNE (Ceylon) enquired as to the most recent findings of WHO on the period of quarantine recommended for cholera contacts. Was it correct that in respect of cholera El Tor the incubation period (2-6 days in classical cholera) had been extended up to 10-14 days? He enquired whether the length of period of quarantine for cholera contacts had also accordingly been extended in El Tor infections.

DR RAMAKRISHNAN (WHO Secretariat) pointed out that the incubation period of cholera El Tor was not different from that of classical cholera. A longer period of surveillance for contacts but not of quarantine was, in his opinion, desirable. There had been no change in the provisions of the International Sanitary Regulations.

**Plague (pp.14-15)**

DR SUBRAHMANYAN (India) stated that during the current year, no cases of plague had been reported from the three endemic states of Madras, Mysore and Andhra Pradesh. In the plague control programme in India, the emphasis was placed on anti-rat measures.

**Leprosy (pp.15-16)**

DR SUBRAHMANYAN (India) said that India had made a budgetary provision of 150 million rupees for leprosy work in the Fourth Plan. Special emphasis would be placed on the control of leprosy in the States of Madras, Andhra Pradesh and Orissa, which had almost 60% of the total cases. An International Seminar on Leprosy was being organized and would be held in India towards the end of January 1967, to synchronize with Anti-Leprosy Day.

The REGIONAL DIRECTOR referred to two important documents issued by WHO on this subject (LEP/TNT/1/66 and LEP/TNT/2/66), which had been circulated. These documents contained the latest information on drug trials in the countries co-operating in leprosy research and on BCG vaccination in relation to leprosy control. Information on chemoprophylaxis work done at the Central Leprosy Research Institute, Chingleput, was included in these reports.

DR BOSIER (UNICEF) stated that the UNICEF Executive Board was in full agreement with the recommendations of the WHO Expert Committee on Leprosy, which included, inter alia, priority for lepromatous cases, initiation of case-finding, and the need to register and treat 75 per cent of the infectious cases within a target period.

DR RAO (India) pointed out that feasibility studies were being carried out in the use of BCG and administration of INH for the prevention of tuberculosis. He wondered whether the studies in Bangalore could not include a feasibility study of the prevention of leprosy by BCG.
DR TANEJA (India) stated that in another study, half the population in Pondicherry had been given BCG vaccination. Among leprosy contacts in the population vaccinated, the incidence of leprosy was lower than among those in the unvaccinated population. The results would soon be published.

Venereal Diseases and Yaws (pp. 17-18)

DR SHRVASTAV (India) observed that in certain tribal populations in Central India, nearly 10% of the population had yaws. A careful assessment had been made in this area following a control programme, and the disease had been completely eradicated in several areas and almost eradicated in others.

Diarrhoeal and Enteric Diseases (p.18)

DR SHRVASTAV (India) drew attention to his earlier statement that the brunt of such diseases was borne mostly by children, and that UNICEF could therefore be expected to take an interest in prevention and control.

Diphtheria, Whooping Cough and Tetanus (p.18)

DR RAO (India) endorsed the stress placed on routine immunization of children against diphtheria, whooping cough and tetanus. In India the use of tetanus vaccine among pregnant women was being advocated so that both mother and the baby might be protected. He felt that this required follow-up by the basic health services.

DR LUN WAI (Burma) said that from statistics obtained from a paediatric hospital in Rangoon, 125–180 children had been admitted for tetanus in one year, and tetanus toxoid injections were being given to pregnant mothers for the control of this disease. The toxoid was being obtained through CARE.

DR CHITT (Thailand) said that Thailand had been producing tetanus toxoid since 1963 but that the need for immunization was not fully recognized. The production of DPT vaccine had started in January 1966.

Trachoma (pp.19-20)

DR HAKIMI (Afghanistan) said that WHO was assisting a project in Herat to train doctors and health auxiliaries in trachoma control. The activities were to be extended to Kandahar, where the disease had a prevalence rate of 79 per cent.

DR SUBRAHMANYAN (India) stated that for the control of trachoma, a sum of Rs.80 million was to be allocated in the Fourth Five-Year Plan, and it was proposed to cover 1,400 community development blocks located in endemic areas. The methodology of control work had changed from a uni-purpose programme to integration into the rural health services, using the services of the basic health workers trained in trachoma control.
DR LUN WAI (Burma) said that the incidence of trachoma was specially high (prevalence rate 9.95 per cent) among the rural population inhabiting dry areas in Central Burma. A start had been made in April 1964 with four districts, and the area would gradually be extended. Preparations were being made to integrate this work into the general health services. It was hoped that UNICEF would assist with transport.

Viral Hepatitis (p.22)

DR SHRIVASTAV (India) observed that the disease was increasing in many countries including India. Investigations were being carried out in three States, and it was found that the supply of safe water in adequate quantity could meet the problem; this, of course, involved heavy expense. A trial had been made of hyper-chlorinating the water supply and maintaining the high concentration of chlorine for six to eight hours, followed by dechlorination. This trial, conducted in Delhi, had yielded promising results.

DR GUNARATNE (Ceylon) pointed to an error in the statement on page 22 of the report. Ceylon had made viral hepatitis a notifiable disease.

DR MARSAID (Indonesia) said that it was also notifiable in Indonesia.

The REGIONAL DIRECTOR said that this error would be corrected. A WHO short-term consultant was going to the Central Public Health Engineering Research Institute, Nagpur, to carry out studies on water supply in connection with viral hepatitis. The work mentioned by Dr Shrivastav would be kept in mind.

Filariasis (pp.22-23)

DR RAY (India) invited attention to the filaria control programme in India, with particular reference to the proposal of integration with the national malaria eradication programme. In recent years malaria in urban areas was posing an increasing problem in some parts of the country. However, a malaria eradication programme was not equipped to undertake anti-larval work in urban areas, and application of residual insecticide was not feasible in most cases. Consequently a proposal had been submitted to the Government recommending the integration of the activities of the two programmes in some urban areas (32 townships) where malaria transmission potentialities were high, with the primary objective of undertaking intensive mosquito control operations; this would automatically accelerate the progress of the malaria eradication programme and at the same time help in the control of filariasis. Provision had been made in the Fourth Five-Year Plan for a gradual expansion of activities, and some of the old filaria units would be converted to follow the revised pattern. Two additional filariasis research and training centres as well as night clinics for the training of medical officers and health assistants in control work had been established.
DR RAO (India) expressed the view that filariasis was a challenging problem to the public health services, in view of the rapid urbanization which was taking place. He felt that biological control and the introduction of sterile male techniques might give satisfactory results.

At the request of the REGIONAL DIRECTOR, DR RAMAKRISHNAN (WHO Secretariat) explained that the WHO Filariasis Research Unit in Rangoon was at present conducting research in the use of genetically incompatible males to control the vector population.

The earlier interest in the use of ionizing radiation and chemicals to sterilize the male to control the mosquito population had not led to the expected results. The approach was now to determine mutations or biotypes genetically incompatible with the local mosquitoes, to mass produce them and to release the males in large numbers, to obtain a reduction in the local mosquito population, as a supplement to other measures.

3. Adjournment

The meeting was then adjourned.
SUMMARY MINUTES

Third Meeting, 28 September 1966, 9 a.m.*

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*Originally issued as SEA/RC19/Min.3, on 29 September 1966, and incorporating subsequent corrections.
1. Eighteenth Annual Report of the Regional Director
   (item 7 of the Agenda) (Continued)

   The Chairman called the meeting to order.

   Communicable Diseases (pp3-24): Conclusion of Discussion

   DR RAO (India), speaking generally on the eradication and control
   programmes of the prevailing communicable diseases and the difficulties
   experienced by the public health administrators of such programmes, said
   that it was becoming more and more difficult to convince the economists
   about the economic benefits to be derived from the continuation of malaria
   eradication and other similar countrywide programmes, and that it was still
   necessary to spend money to retain what had been achieved. Experience in
   India had shown that it was necessary for the administrator of the programme
   to show repeatedly how particular economic benefits were to be calculated,
   if the government was to be convinced of continued support.

   There were other administrative difficulties to be faced: for instance,
in the field of malaria eradication, there had been a serious shortage
of DDT during the national emergency, and its supply would have been a
problem had it not been for the strong support given by WHO. It was
necessary, first, that, wherever possible, countries should achieve self-
sufficiency in the production of materials necessary for control programmes;
secondly, basic health services must be ready to take over the maintenance
phase.

   The same applied to tuberculosis control, which from the very start
had been integrated into the general health services. The latter were
not yet strong enough to make proper use of modern means of control, e.g.,
domiciliary chemotherapy.

   In smallpox eradication, the difficulties experienced were in
part due to the general lack of cooperation from the people, sometimes
to insufficient supply of vaccines but mostly to the inability of the
basic health services to take over the maintenance phase of the programme.

   In the field of cholera, knowledge with regard to modern treatment
methods was available but had not reached the general practitioners and
hospital services. In order to create the necessary awareness in the
profession, there was need for more refresher and orientation courses.
In the Indian Fourth Five-Year Plan, there was a scheme for regionalization
of cholera control and for improving water supplies in endemic areas. He
emphasized the need for long-range planning and the importance of health
education of the public in this regard.

   Plague was still a problem: not only were the fleas that caused the
disease developing resistance to insecticides in certain areas, but sylvatic
plague had not been tackled. Rodent control required attention from the
point of view of both conservation of food grains and control of the disease.
In this connection, advice from WHO would be welcome.
Referring to virus diseases, especially the spread of haemorrhagic fever, he said that he had already drawn attention to the need for the control of Aedes aegypti and the importance of biological control of the mosquitoes.

He also described the rapid urbanization which was taking place and the consequent problem of mosquito control, which stressed the importance of efforts to control parasitic diseases in general and filariasis in particular.

Finally, he said, partly as the result of the public health work and communicable diseases control, the population was increasing to the extent that population control was now also urgently required, and had become a public health problem. In India, it had been found that public health planning had to be associated with socio-economic planning and also with family planning.

He asked the Regional Director to give further thought to the points he had raised, and would be grateful for suggestions as to how to tackle long-range planning of the control of communicable diseases so as to elicit more government support.

The REGIONAL DIRECTOR said that he thought Dr Rao's summing-up of the situation on the control of communicable diseases was an excellent one; he agreed that there was a need to take stock of the efforts made so far and to give new direction to them. It might be useful if some of these suggestions could be embodied in a suitable resolution. For instance, there was a real need to attempt some kind of an economic evaluation of the malaria and smallpox eradication programmes and of other communicable-disease control programmes. Such an evaluation would not be easy. Difficulties included paucity of accurate statistical data and the effect of other socio-economic factors which were also partly responsible for any results achieved. However, it was time that serious thought was given to carrying out such an evaluation, and he would explore the possibility of recruiting an economist and a public health administrator for this purpose.

WHO had often stressed the importance of developing adequate basic health services and the need to integrate communicable-disease control programmes from the start; yet at the same time new specialized control programmes were still being started. A good deal had been attempted towards integration in the past five years in almost all the countries of the Region; however, much remained to be done to accelerate this development, and WHO was the agency to promote this.

The CHAIRMAN agreed that a resolution containing the main points of Dr Rao's recommendations would be useful, and he asked that such a resolution be prepared for the consideration of the Regional Committee at a later meeting.
Epidemiology (pp.25-26)

DR SHRIVASTAV (India) highlighted the role in epidemiology played by the National Institute of Communicable Diseases, Delhi, in the establishment, strengthening and development of a division of epidemiology, and in the organization of training courses. He referred to their three-month training courses and also to the nine-month course organized by WHO, which had earlier been held partly in Europe and partly in Delhi.

The REGIONAL DIRECTOR added that the international course mentioned by Dr Shrivastav was referred to at the bottom of page 25 and at the top of page 26 of his Annual Report. Two thirds of the course was being given in Europe and the final third at the National Institute of Communicable Diseases, Delhi. WHO was willing to offer as many fellowships for this course as were needed.

DR GUNARATNE (Ceylon) felt that this particular course was very important. Ceylon had been sending some post-graduates to Czechoslovakia and other countries on WHO fellowships. He had also thought that the three-month course which had been offered earlier was quite satisfactory. Now that the course was being expanded and was of nine months' duration, he wondered whether the award of a diploma or a certificate at the end of the course could be considered.

The REGIONAL DIRECTOR said that not only for the nine-month course but also for the three-month course, WHO would consider award of fellowships.

For the nine-month course, no diploma was being awarded, and there would be certain difficulties in trying to arrange this. On the other hand, it might be quite possible to issue a certificate.

DR SHRIVASTAV referred to the enthusiasm for the course in the participating institutes, which themselves were seeking WHO's approval of the idea of a diploma to be awarded conjointly by the Universities of Prague and Delhi.

DR GUNARATNE (Ceylon) hoped that WHO would find some way to award a diploma for this course. This would particularly help participants from Ceylon, as such a post-graduate qualification was likely to entitle the candidate to better pay.

DR ANWARY (Afghanistan) said that if a diploma were to be issued, universities would need to evaluate the curriculum of the post-graduate course. In this connection, he suggested that UNESCO might be of help.
The REGIONAL DIRECTOR said that, of course, the recognition of any such diploma, if given, would be for individual universities. He pointed out that universities were independent bodies, and that it might take a long time for such negotiations, even if the University of Prague and the University of Delhi agreed to the joint award of such a diploma. He would take up the possibility of issuing a certificate in the first instance.

DR DOLGOR (Mongolia) said that the Ministry of Public Health in Mongolia attached great importance to the field of epidemiology. WHO was assisting by providing a team to strengthen the epidemiological services, as well as consultants, who were helping in the training programmes. In this way, and by means of WHO fellowships, the technical personnel in Mongolia were gaining much-needed knowledge and experience.

The suggested award of a diploma for the international course would, he felt, be useful for the Region.

DR JOSHI (Nepal) said that if a diploma were awarded, this could only after success in an examination, and there might be difficulty in getting professional personnel to attend a course requiring examinations. He also drew attention to the fact that in Nepal, a person attending a diploma course was entitled to draw only half pay during the period of deputation.

MR MURTHY (India) agreed that the award of a diploma or degree might be difficult. Inter-university collaboration and recognition first by governments and national service commissions were all involved. He suggested that the Regional Director's proposal was the correct approach - first to try to arrange for the award of a certificate at the end of the course, and simultaneously to start negotiations between the universities for the ultimate award of a diploma or degree, if possible.

DR PATNAIK (India) expressing his gratitude to WHO for its assistance in the field of epidemiology, stated that while a great deal of attention had been paid to the training of epidemiologists, another important aspect which needed to be looked into was the gap between training and utilization.

The REGIONAL DIRECTOR replied that with regard to utilization, WHO had been emphasizing the need for governments to provide epidemiological units at national, provincial and state levels, and would be glad to offer fellowships to promote this development.

Health Laboratory Services (pp.26-28)

DR SHRIVASTAV (India) stated that India had been much interested in the subject of health laboratory services ever since 1961, when it had been associated with the technical committee of WHO which formulated ideas for
the organization of such services in developing countries. The committee had recommended the utilization of the limited resources available for evolving the laboratory as a multi-purpose unit instead of developing it vertically, as had been done in more advanced countries. With assistance from WHO, India had therefore drawn up a fairly detailed list of requirements for initiating laboratory services at the rural, peripheral level; it was hoped to extend these services to the district, regional and state levels gradually.

Emphasis was also being placed on the need for a well-balanced approach to the public health laboratory vis-à-vis the diagnostic and curative laboratory. The Government had therefore taken steps towards providing for a balanced development of both these aspects, with the help of WHO and with help from UNICEF in basic equipment for the peripheral units as part of its assistance to the community health services.

DR JOSHI (Nepal) referring to the statement on page 26 of the Report, regarding the delay in the construction of the laboratory building in Kathmandu, remarked that his Government had now given top priority to the establishment of this public health laboratory. The building had been almost completed, and they were now asking WHO for advisory assistance in the setting up and functioning of the laboratory. A sum of Rs.150 000 for staff had been allocated in the current year's budget, and he expressed his Government's appreciation to UNICEF for having supplied equipment worth $4 000. Regarding the development of laboratory services, they were concentrating on the central level, to provide a nucleus for training laboratory technicians, who, in turn, would eventually go into the rural laboratories.

The REGIONAL DIRECTOR assured the delegate from Nepal that an adviser would be provided to assist in setting up and starting the laboratory in Kathmandu.

DR RAY (India) referring to the development of laboratories at the peripheral level, said that the malaria eradication programme needed a chain of such laboratories. Provision had accordingly been made for about 14 to 15 laboratories per district (with a population of one million people). These laboratories, which had already been functioning in most areas, had been attached to the primary health centres to examine blood smears for malaria. They had now also started taking over other functions, such as sputum examination for tuberculosis. Laboratory personnel should be given reorientation training in order to enable them to play their part in programmes such as those for malaria eradication and tuberculosis control.

DR HAKMI (Afghanistan) said that he agreed with the views expressed by Dr Shrivastav regarding the development of peripheral laboratories. He drew attention to the fact that the WHO personnel attached to the Public Health Institute, Kabul, all seemed to be leaving at the same time, and wondered whether the services of some of them could be continued.
The REGIONAL DIRECTOR replied that staff members reaching the end of their assignments would be replaced.

Vaccine Production (pp. 28-29)

DR SHRIVASTAV (India) reviewed with satisfaction the recent advances that had been made in India in the field of vaccine production. India had become more than self-sufficient in certain vaccines, such as cholera vaccine, which, on several occasions, the Government had been able to supply to help with epidemics in other countries. With regard to the quality of the vaccine, the agar-grown cholera vaccine produced in India had given the best results in the cholera vaccine field trials conducted in Calcutta. Efforts were being continued to evolve a more potent vaccine for the prevention of cholera. India had also started manufacturing yellow-fever vaccine in quantity, also with assistance from WHO. Triple vaccine of a high potency was also being produced, although on a limited scale, and it was hoped to augment the production with assistance from WHO and UNICEF. Manufacture of oral polio vaccine had been started at Coonoor; large-scale production was expected from 1967, and a polio vaccine testing laboratory would be set up at the National Institute of Communicable Diseases, Delhi. The one vaccine in which India was not yet self-sufficient was freeze-dried smallpox vaccine, although, as mentioned earlier, they were taking energetic steps to produce it in increasing quantities, with assistance from WHO and UNICEF. He suggested that the Committee might wish to hear the Director of the Vaccine Institute at Patwadangar elaborate on this point.

DR TOPA (India) after describing the work at his Institute, said that, as mentioned earlier, although the total production capacity of the four institutes producing smallpox vaccine in India was about 60 million doses, it was impossible, with the equipment at present available, to meet the annual requirement (about 200 million doses). He requested assistance from WHO and UNICEF in order to bring the production up to the level of the country's requirements. The shelf-driers at these institutes were producing much smaller quantities of vaccine than had been expected.

The REGIONAL DIRECTOR stated that he was happy to note the progress made by India with regard to the production of different vaccines. The production of triple DPT vaccine, however, had been disappointing despite all the efforts of the last five years. The question of equipment provided for the production of freeze-dried smallpox vaccine would be thoroughly explored, and in this connection he mentioned that Dr Topa would soon be visiting several countries in Europe to study production there. He assured the Indian delegation that WHO would do everything it could in this important matter.

DR CHITT (Thailand) referring to the difficulties in the production of anti-rabies vaccine due to the rising cost of sheep in his country, stated that Thailand had not been very successful in their efforts to control rabies,
as the vaccine had been their only weapon against the disease. With regard to the production of freeze-dried smallpox vaccine, an additional shelf-drier would be required to enable them to use only freeze-dried vaccine and to discontinue the production of lymph vaccine. The production of DPT vaccine had been successfully started early in 1966.

Health Statistics (pp. 29-31)

DR PATNAIK (India) giving a description of the organization and development of vital and health statistics in India, stated that appreciable progress had been made in the field in recent years, with the assistance of WHO. With regard to training, a nine-month diploma course had been introduced this year at the All-India Institute of Hygiene and Public Health, Calcutta, for senior personnel who could take over responsibility at the central and state levels. For the training of intermediary personnel, a centre had been established at Nagpur, with WHO assistance; another such centre was being started at Chandigargh, again with assistance from WHO. In addition, orientation courses in health statistics were being held for district health officers in order to train them in programme operation and evaluation. He also drew attention to a course which was being run for medical records officers and medical records technicians at the Christian Medical College at Vellore, with assistance from the Rockefeller Foundation. In order to meet the increasing requirement of personnel, regional training institutions were being multiplied.

Another field of activity being pursued concerned the introduction of certification of causes of death in line with the International Classification of Diseases and Causes of Death. With assistance from WHO, this had been undertaken on an experimental basis in Delhi, where all the hospitals were being covered by this scheme. With regard to organization, the Central Bureau of Health Intelligence had combined in itself three components, namely, collection, compilation and dissemination of statistical data, in addition to carrying out small field surveys and evaluation work. At the state level, cells had been established within the health directorates. As a result of the importance of health statistics to the family planning programme, the statistical organization was being strengthened at district and peripheral levels by appointing certain categories of statistical personnel. The services at these levels, however, had continued to remain the weak links in the statistical set up. He added that, with respect to national and vital statistics, a committee had been set up to standardize the numerous forms currently being used in different parts of the country. Also, with the shifting of emphasis from mortality to morbidity, the Government had agreed to the establishment of a morbidity survey unit, and had been paying attention to the question of medical economics.

DR GUNARATNE (Ceylon) stated that his country had been placing particular emphasis on the improvement of the quality of morbidity statistics and thereby on the strengthening of statistical departments of
hospitals. While the mortality rate had been brought down, morbidity continued to be a problem. Improvement of the study of morbidity was being effected, with WHO assistance. The Government had now agreed to the appointment of a medical records officer to act as counterpart to the consultant provided by WHO, and it was hoped to open the medical records section of the Colombo South Hospital before the end of the year. This section would serve as a training ground for medical records officers for provincial hospitals. The statistical unit in the hospital would be started later.

The REGIONAL DIRECTOR referred to the second paragraph on page 30 concerning the publication by WHO of a new 1966 edition of the "Summary of Vital and Health Statistics in the South-East Asia Region" (SEA/VHS/69), which had been circulated, and requested the permission of the Chairman to allow the Regional Adviser in Health Statistics to comment on this document.

DR HELWEG-LARSEN (WHO Secretariat) explained to the meeting that the aim of compiling a summary of vital and health statistics for the South-East Asia Region had been to present all available data in an easily accessible form for the use of national and international health workers. The summary now brought out was the third in the series, the first two having been published in 1956 and 1962 respectively; it was planned to continue to issue new editions every four years.

After giving a section-by-section outline of the contents of the summary, he added that the limitations of the data presented should be borne in mind. The urgent needs of public health planning and administration in Asia required the use of information of widely varying degrees of reliability, even "well-informed guesses". Such statistics, though inaccurate, could be useful indicators of changing trends in the health situation of a country, although they were not normally valid for comparisons between countries. The data presented in the summary had been largely based on information which had been made available in international publications such as the United Nations Demographic Yearbooks, the World Health Statistics Annual, the WHO Annual Epidemiological and Vital Statistics, the WHO Epidemiological and Vital Statistics Reports, the Reports on the World Health Situation, etc., supplemented by the latest figures, made available, on request, by the authorities of the countries concerned.

The Regional Office hoped to receive from the governments of the Region any necessary amendments and supplementary information as well as suggestions as to the form and contents of future editions.

He expressed gratitude for the excellent co-operation of the national health services in the Region in assisting the Regional Office to bring out this summary.
Community Health Services (pp. 31-35)

DR DUTT (India) said that his Government had appointed a special committee in 1962 to recommend the necessary preparations for an assessment (carried out in 1963) of the distribution of existing peripheral health units, including dispensaries, the area to be covered and the degree of their utilization. The Committee laid down the framework of comprehensive health services in rural areas by gradual integration. A small unit (with a population of about 10,000) was to be staffed by three basic health workers - two men and one woman. The men workers were to carry out vigilance activities, a fever census, basic health education, recording of births and deaths and health intelligence, and the women workers, family planning and maternal and child health activities. Functions at the sub-centre level were integrated, and every two sub-centres were to be supervised by a health assistant. The staff to be allotted to a primary health centre were: two medical officers, one health inspector, one extension educator-computer, one public health nurse, a lady health visitor and one clerk, in addition to a small nucleus of staff to undertake the examination of blood smears. The committee also recommended that the intermediate, i.e., district-level, organizations should continue as they were until States entered into the maintenance phase of the malaria eradication programme. To assist in this, the district health organization would be strengthened to provide a health supervisor for two districts and a separate officer at the district health level. On this pattern, there were about 1,700 primary health centres in India in operation, and another 800 were to start functioning within the course of next two months.

With a change in priorities in favour of family planning and smallpox, another committee had recently been appointed and had made certain suggestions: i.e., that the basic health services should be planned and oriented towards the tasks directly related to the most urgent problems; that the staffing pattern should depend entirely on the work-load, taking care that the workers were not over-worked and the functions of the workers periodically reviewed. Emphasis was placed on adequate supervision, guidance and job definition. The committee also recommended that there should be a basic health worker for every 10,000 people. Their recommendations included the strengthening of the district health organization with integration of the services. Another important recommendation made by the Committee was the appointment of adequately trained administrative officers to relieve the technical officers of non-technical routine work. These recommendations relating to basic health services appeared to be as defined by the WHO-UNICEF Joint Committee on Health Policy.

In addition to the studies mentioned in document SEA/RC19/C, the Government of India, he stated, was now carrying out another study in Maharashtra.
The National Institute of Health Education and Administration, established in 1964 by the Government of India, had so far conducted three staff courses and a number of short courses and seminars on topics such as the basic concepts of general administration, health administration and hospital administration. It was hoped that other governments in the Region would make use of these courses.

With the entry of large numbers of malaria eradication units into the maintenance phase and the primary health centres, in consequence, being manned by more workers, a review had been made in order to standardize the various categories of personnel. The proposed categories were: basic health workers, health assistants or health inspectors, senior inspectors or senior health inspectors, and, at the district level, a health and sanitary supervisor. There was also a proposal to recruit and train non-medical personnel as graduates of sanitary science, to fill the posts of medical officers in municipalities faced with lack of resources.

DT. JOSHI (Nepal) mentioned that in Nepal health assistants were being trained to serve as multi-purpose workers. He suggested that integration not only should be at the peripheral level, but should extend to higher levels as well. This would considerably reduce administrative costs.

DR RAO (India) said that the vertical approach to programmes, though initially successful, did not result in bringing people together closely enough to affect the improvement of health conditions in the country as a whole. Integration was therefore a natural corollary. To this end, efforts were being made to train health administrators at both the top and the district level. He felt that the document on operational research activities in the South-East Asia Region (SEA/RC19/8) was a very useful one. It contained guidelines for the carrying out of operational research studies which would help immensely in understanding the deficiencies in and defects of running the various health services, and would also help in the study of primary health centres that was at present being carried out.

He suggested that a uniform training programme for the intermediate-level auxiliary health worker (e.g. the health assistant, who was usually in charge of general health administration, sanitation, control of communicable diseases, etc.) should be drawn up. The present level of his training was not sufficient to enable him to take over greater responsibility in these spheres.

In India most of the public health work at lower levels was not adequately supervised - partly because of shortage of qualified personnel and partly because opportunities in this field were not sufficient to attract qualified doctors. To remedy the situation, a graduate (B.Sc.) course in public health was being established. Graduates of such a course could be of use, particularly for work in the smaller municipalities.
He also recommended, for the consideration of the Regional Committee, the holding of short courses or seminars for health planners.

To answer a question from DR KAREFA-SMART (Representative of the Director-General of WHO), he said that a candidate for B.Sc., in public health was taught, in the first year, physiology, anatomy, biology, nutrition and other allied subjects at basic level. Later, training was given in public health aspects, but essentially in the duties that the candidates would be likely to perform as municipal health officers. At the block level, they would be expected to have responsibilities in the fields of communicable diseases, vital statistics, maternal and child health, family planning, food and drug control and water analysis.

With respect to the suggestion for preparing a uniform syllabus for the training of intermediate-level auxiliary health workers, the REGIONAL DIRECTOR stated that the pattern of training differed in each country; the syllabus was modelled to suit the needs of the individual country. These workers were known by different terms in each country. In Burma, there were about four to five hundred health assistants in health centres under the supervision of local township medical officers. The training of these health assistants was considered satisfactory. In Ceylon, the intermediate-level workers were called public health inspectors. In Nepal, the training programme was for health assistants. With regard to India, it was doubtless desirable to have a uniform syllabus throughout the country. WHO had suggested a few modifications in the syllabus drawn up by the Central Council of Health.

On the subject of operational research, DR GRIFFITH (WHO Secretariat) mentioned that such research had been developed over the course of a few years and had started with some studies on health centres in the working of health centre staff. In India, investigations had been carried out on how district health services operated and in what ways they might be improved or changed in order to provide the best possible kind of service to the community. From the studies carried out in Jamnagar District, it was found possible, with good co-operation, to use local authorities and local leaders to improve the health programmes, through support of the health services. It was also found possible to involve other organizations, such as medical colleges, in developing the peripheral health services by using consultants and advisers on epidemiology and by involving them in training programmes. It had also been noted that laboratory services could be improved both at the periphery and at district level by involving specialists from the colleges. One other aspect that had come up in the operational research was how the most effective use could be made of the malaria surveillance worker (now called "basic health worker"). A study was being carried out in India on the activities of the surveillance worker, his workload and his capabilities. This study had started late in 1965.
Most of the information about the basic health worker came from work started about two years ago in Thailand. When an attempt had been made to upgrade the services in one particular province, it was felt that possibly the cheapest and most effective way to do this was initially to increase population coverage by relatively low-grade health workers; the programme was developed in one small district with five "tambol" health workers. This pilot project led to a very considerable interest not only at provincial but at governmental level. Many divisions of the Health Department had co-operated in improving the over-all activities of the provinces to the extent that the programme had now been extended this year to three more districts in the same province. This should enable a more complete study of the operation of health services in a province.

DR EGGER (UNICEF) said that though his organization was not directly involved in studies of this sort, they could, subject to the priorities fixed by WHO, assist governments by giving support in logistics or in helping to improve the basic health services as a result of these studies. He suggested that these studies should also be extended to non-technical aspects. The relationship with local authorities should be made more use of, to obtain a greater degree of interest, of participation and of support, particularly financial involvement of local authorities, in order to enhance the possibilities otherwise available only through state or central government funds.

DR ANWARY (Afghanistan) said that, to induce basic health workers to work in rural areas, the Government of Afghanistan had recently passed a resolution exempting from military service those doctors who opted for work in rural areas. In addition, housing facilities and additional allowances were offered for those who undertook this work.

MR MURTHY (India) mentioned that in India both Central and State Governments were trying to encourage doctors to work in rural areas. Some State governments had made it compulsory for doctors in government service to serve in rural areas for two to three years; they were provided with residential accommodation and were given extra allowances. There was a proposal to locate future medical colleges in rural areas. Some of the existing colleges sent their students for training to primary health centres, where they worked under the supervision of medical officers.

Maternal and Child Health (pp. 35-37)

DR RAO (India) appreciated the activities of WHO directed to arousing interest in this subject, and also the large amount of assistance in this field given by UNICEF.

Roughly 40 per cent of the population was under the age of 14 years; if one added to this the 20-25 per cent population of women in the reproductive
ages, the total population to be covered by maternal and child health activities worked out to about 65 per cent.

Maternal and child health work in India had initially been developed as a separate entity and later, with the establishment of primary health centres, was integrated into the general health services. There was a shortage of health staff; a midwife at the peripheral level covered about 10,000 persons.

The pre-school child had been neglected. This had been emphasized by WHO, and all concerned agreed that pre-school children needed greater attention as regard nutrition and general health.

Another aspect of the maternal and child services which required attention was irresponsible motherhood. The expenditure incurred during pregnancy up to the birth of a child in India was estimated as Rs. 1600. By the time the child was one year old the amount had risen to Rs. 3600. When he was of 18 years of age, the expenditure incurred in his upkeep amounted to Rs. 28,000, of which the Government contributed about Rs. 14,000.

He drew attention to this enormous waste of resources which had led the Government to give priority to family planning.

It was encouraging to note that finally in 1965 and 1966 resolutions had been adopted by the World Health Assembly enabling WHO to take some responsibility for the health aspects of population control. He hoped that, as the problem was so urgent in this Region, the Regional Committee would take the importance of family planning into consideration.

He was glad that UNICEF had discussed this subject at its Executive Board meeting in Addis Ababa, where, however, it had been decided to await the advice of the WHO/UNICEF Joint Committee on Health Policy.

DR GUNARATNE (Ceylon) stated that Ceylon had also recognized the importance of maternal and child health work. Some years ago, on the recommendation of an expert who visited Ceylon, his Government had eliminated the services of the medical officers of health who were doing maternal and child health work, and had transferred their duties to the specialists. As a result, the maternal and child health work had suffered; the ante-natal clinics, which were responsible for these services, could not regularly provide them because the medical officer in charge had to look after curative and other activities. Orders had recently been issued for the immediate appointment of medical officers of health in the country's 89 health units, 76 of whom were already now in position, with a full staff. The maternal and child health services had since improved, as the medical officer could concentrate on these services. He also attended to school health.
It had been decided to appoint an Assistant Director of Health (Maternal and Child Health Services) in the Directorate of Health Services, who would also be responsible for carrying out work related to family planning, which in Ceylon would be part and parcel of maternal and child health services.

He expressed his gratitude to WHO and UNICEF for their support in this field and hoped that further assistance would be forthcoming to help improve these services.

DR DOLGOR (Mongolia) said that maternal and child health was indeed an important subject. In this work governments were working in close collaboration with WHO and other United Nations organizations. He hoped that the problem would be given thorough consideration and that even more work would be done to improve the health of children.

DR ANWARY (Afghanistan) endorsed the views expressed by Dr Dolgor and said that Afghanistan was in need of a well organized plan to tackle this problem in complete detail. The villages and rural areas required assistance in providing services for pregnant mothers and the newborns.

MRS MENON (League of Red Cross Societies) enquired as to the policy followed by WHO and other international organizations regarding the development of maternal and child health services through the use of the voluntary organizations.

In India maternal and child health services had started in 1921, and since then the voluntary organizations had carried out activities in this field in collaboration with the Government, especially in rural areas. Voluntary organizations were in direct contact with the village women and children, from the ante-natal stage in maternal and child health centres to the fruitful stage in nursery schools. This provided a good opportunity to improve the health of both mother and child.

DR EGER (UNICEF) stated that the subject of maternal and child health was the essence of the work of UNICEF, and he promised that UNICEF would look forward to the appraisal of these programmes which WHO and UNICEF had embarked upon and which would be presented to the 1967 UNICEF Executive Board.

At the last meeting of the Board, concern had been expressed about maternal and child health services, towards which it was felt that UNICEF's contribution had not been sufficient.

In one of its meetings last year, attention had also been given to the pre-school child and the steps being taken to devote more attention to the development of activities for reaching this particular vulnerable group.
It was encouraging to note that in some of the schemes in the Region, attempts were being made to utilize personnel at the local level to reach the pre-school child. UNICEF had also taken interest in the school child, and in programmes for family and child welfare, and discussions would be held with sister organizations on how UNICEF assistance in these fields could be further developed.

The Executive Director had also recommended that UNICEF accept for consideration requests for assistance for family planning programmes; however, also that UNICEF should not offer advice on techniques or supply contraceptive tools. The advice of WHO would be sought in respect of each request, and assistance directed to the strengthening of maternal and child health services and over-all rural health services.

The UNICEF Board, however, had deferred formulation of a policy on family planning by one year and had decided to review the question at its next meeting in 1967. The Board had requested the advice of the WHO/UNICEF Joint Committee on Health Policy, which would meet early in 1967.

In the meantime, the UNICEF Board had established the following guidelines for such assistance:

(a) UNICEF assistance would be given in response to government requests as part of the country's requirements for its general health services and not as a separate category of assistance,

(b) It would be limited to taking the form of training of personnel and provision of vehicles and other equipment,

(c) UNICEF would not take any responsibility for the organization and administration of national programmes relating to family planning, and

(d) UNICEF would request the technical advice of WHO and the Bureau of Social Affairs of the United Nations in connection with any such assistance.

The Board, in addition, had asked the Secretariat to review the recommendations put forward by India and Pakistan in order to enable UNICEF to provide assistance on accepted lines. It was expected that these revised recommendations would be approved.

2. Adjournment

The meeting was then adjourned.
**SUMMARY MINUTES**

*Fourth Meeting, 28 September 1966, 2.30 p.m.*

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*Originally issued as SEA/RC19/Min.4, on 29 September 1966, and incorporating subsequent corrections.*
1. **Eighteenth Annual Report of the Regional Director**  
(Item 7 of the Agenda) (continued)

**Nursing (pp.37-39)**

The REGIONAL DIRECTOR announced that a curriculum guide for the training of nurses, which had been prepared with the assistance of WHO to accompany the syllabus published by the Indian Nursing Council, was under print. It was hoped that copies could be made available to the delegates before the end of the session. This should be a most useful guide for nursing schools in the Region.

DR JOHSHI (Nepal) recalled that a school of nursing had been started in Kathmandu in 1954 with assistance from WHO. The Government was now proposing to establish two more schools - one for the Eastern and the other for the Western Zone, to meet the requirement for increasing numbers of nurses. WHO's assistance in this would be welcome.

The REGIONAL DIRECTOR said that this would be discussed with the delegate from Nepal.

DR GUNARATNE (Ceylon) observed that Ceylon had experienced some difficulties because of the numerous categories of nursing personnel, including staff nurses (who underwent three years' training), emergency nurses (with only three to six months), assistant nurses, assistant tuberculosis nurses, nursing aides and ward attendants. The Government was now proposing to have two categories of personnel only - those of staff nurse (a fully qualified nurse), and of ward labourer, who would have nothing to do with patient care. The nurse aides, emergency nurses, etc., were being given the opportunity to undergo further training to qualify as nurses. The intention of the Government was to have 10 000 trained staff nurses in seven or eight years.

**Environmental Health (pp.39-41)**

DR SUBRAHMANYAN (India) stressed the importance of environmental health and said that in spite of all the efforts during the Second and Third Five-Year Plan periods, about 75 per cent of the urban population was still without adequate sewerage facilities and 40 per cent without water supplies. Of the 360 million population in rural areas, 75 per cent had yet to be provided with adequate potable water supply. In all, 399 urban water supply schemes and 104 sewerage schemes had been implemented under the first two Plans. In the Third Plan, 435 urban water supply schemes, including sewerage at a cost of about Rs.209 million, were put into effect. The Fourth Plan now provided 730 million rupees for water supply and sanitation schemes, of which 450 million would be set apart for sinking wells under the community development programmes.
Two difficulties faced by the country in implementing its water supply schemes were shortage of technical personnel and lack of materials, especially pipes. To meet the personnel problem, India had post-graduate training facilities at the All-India Institute of Hygiene and Public Health, Calcutta, and at the Victoria Jubilee Technical Institute, Bombay, and was training other grades at Madras and Roorkee. It was difficult to obtain cast-iron or galvanized pipes. His Government wondered whether WHO might help with details of the experience of countries which had used plastic pipes.

MR MURTHY (India) referred to the Gandhi Centenary Celebrations, to be held in 1969, as a part of which it was proposed to provide water supplies to 100,000 villages, at an estimated cost of $35 million.

**Health Education** (pp. 41-43)

DR RAMAKRISHNA (India) said that health education was fundamental for the successful implementation of all health programmes; India had placed great emphasis on this subject. In the Third Five-Year Plan, there had been an allocation of 5.2 million rupees, and in the Fourth Plan 10.2 million rupees.

Health education was being included in the training of doctors, nurses, midwives, auxiliary nurse-midwives and other categories of health personnel. The Central Health Education Bureau had developed a two-and-a-half month training course for health educators, and health education units had been set up at district and state levels. Both WHO and UNICEF had assisted in this work. With the family planning programmes coming to the fore, the importance of health education had also increased.

He drew attention to two demonstration projects for developing the methodology of integrating health education into different types of public health work, which had proved successful in enlisting the cooperation of the public. The lead given by WHO in the development of health education on scientific lines had been of great help both to India and to other countries. India had set up a National Committee on Planning and Evaluation to consider the development of health education in the country, according to the suggested guide circulated by WHO, and was making proposals for problems to be discussed at the forthcoming regional workshop.

DR EGGER (UNICEF), referring to WHO/UNESCO/UNICEF co-operation mentioned on page 42 of the report, stated that he thought it was important for Health Ministries to be aware of the programmes being undertaken in the science education field so that health education could become an integral part of such teaching. Although WHO was advising on these programmes, and also basic teacher training programmes were already in operation in Afghanistan, Burma, Ceylon and India, he thought that it was important that health ministries should be more involved in the health aspects of these programmes.
DR RAMAKRISHNA (India) stated that a WHO/UNICEF jointly assisted project to integrate health education into science teaching in schools was already in operation in India. He also drew attention to the course in health education for graduates which had recently been started at the All-India Institute of Hygiene and Public Health, Calcutta, with 30 students. The successful candidates would receive a diploma in health education from Calcutta University.

Nutrition (pp. 43-45)

DR TANEJA (India) expressed his gratitude to UNICEF and WHO for their support to the Nutrition Research Laboratories at Hyderabad. The training courses which had been introduced in these laboratories had proved very successful and had been attended by trainees from other countries of the Region. The introduction of a diploma course was being contemplated, as there was a real need for such a course. These laboratories, apart from carrying out research programmes in other fields, were engaged in studying concentrated vitamins which would help fortify children against common diseases arising from vitamin deficiencies and in the fortifying of cereals with amino-acids. Continued support from WHO and UNICEF to these laboratories was needed.

The Nutrition Research Laboratories at Hyderabad were also collaborating with WHO in the collection of pituitaries.

Support for research in family planning was also required.

DR SUBRAHMANYAN (India) referred to the scarcity conditions prevailing in 1965, which had affected 125 districts containing 47 million people, of which 29 million were in the vulnerable group. International agencies, such as UNICEF, FAO and WHO, and bilateral sources, as well as many governments, had given magnificent support. UNICEF had also assisted with nutrition programmes in drought-affected areas. The Government had strengthened nutrition cells both at the centre and at the State level, and a nutrition adviser had been appointed at the Centre. The assistance of WHO in providing a consultant to visit the different States where applied nutrition programmes were in operation and to advise on the shortcomings of the health aspects of such programmes was much appreciated.

DR SIMPSON (FAO) said that one of the main problems facing the countries was malnutrition. Health education could greatly help the people in raising their nutritional standards.

When special health programmes, such as malaria eradication programmes, were drawing to an end, a certain number of personnel working in these programmes would be released, and thought should be given to utilizing them in rural health programmes. Health education carried out through such personnel could lead to a change in the traditional food habits of the people and thus raise the nutritional standards. FAO attached much importance to this subject.
MINUTES OF THE FOURTH MEETING

FAO was also paying considerable attention to the introduction of nutrition education into the curriculum of agricultural colleges.

DR EGGER (UNICEF) was impressed by the work being done in the States of India which were faced with food shortage, drought and other problems. UNICEF would give full support to the continued implementation of applied nutrition programmes. UNICEF was also assisting in specific studies on nutritional problems in Afghanistan and Nepal, in collaboration with FAO. In Ceylon the programme could be developed to cover a wide network of schools. UNICEF would support training facilities. The question of supporting a diploma course, referred to by Dr Taneja, would need further discussion between agencies before the final shape of assistance to be given could be formulated.

Social and Occupational Health (pp.46-47)

MR ALEXANDER (World Confederation for Physical Therapy) said that there was an acute shortage of different categories of medical rehabilitation personnel, both in India and in other countries of the Region. In order to ensure proper rehabilitation of the physically handicapped, it was estimated that there should be one physiotherapist per 10,000 population. WHO had assisted in setting up the School of Physiotherapy and Rehabilitation Centre in Bombay. There was a great need for more centres in the Region for training personnel in this specialty.

The REGIONAL DIRECTOR observed that in addition to the assistance given to the School of Physiotherapy in Bombay, WHO had assisted in establishing such schools in Solo (Indonesia), Colombo (Ceylon) and Bangkok (Thailand).

Education and Training (pp.48-51)

DR RAO (India) stated that there was an over-all shortage of teachers in medical colleges in most of the countries. This had resulted in some countries trying to produce non-medical scientists as teachers. The question of establishing institutes of basic medical sciences had been taken up by the University Grants Commission in India. The question of replacement of doctors by non-medical scientists in public health had been dealt with in the Health Survey Planning Committee Report, which had outlined a three-year B.Sc. course in public health. It was hoped that the graduates would be able to work at the district and peripheral level, and that some of them could, after post-graduate education or a Ph.D. constitute a cadre of teachers in medical institutions. He suggested that WHO might take up the question of formulating a syllabus for training auxiliary health workers (health assistants and sanitarians). Such workers could be utilized in sanitation and public health programmes.

The curricula of medical institutions were mainly based on the curriculum followed in developed countries and should be modified to meet local needs.
There was also need for introducing vocational adaptation. A seminar to go into the problem of adapting the educational pattern to the different needs of developing countries, so as to emphasize maternal and child health, communicable diseases, mass campaigns and social paediatrics, for example, in the training of doctors, would be very useful.

The Revolving Fund set up by the Nineteenth World Health Assembly would help to provide teaching equipment to medical institutions. India had already submitted a request for assistance under this scheme, and other countries should also avail themselves of this facility.

With the increase in the number of medical colleges and students, there was a growing need for making cheap text-books available. Any assistance which WHO could give in this direction would be very valuable. He also suggested that WHO might set up a study group on medical manpower to see how the shortage of doctors could be offset by the use of more non-medical staff. Finally, he thought that the fellowships programme should be directed towards providing advanced training in different specialties for a relatively short period. This would obviate the loss of medical manpower arising when trainees sent abroad elected not to return to their country.

The REGIONAL DIRECTOR said that Dr Rao had covered many important points; he would mention only a few. WHO would now be able to purchase text-books for governments against reimbursement in local currency. Dr Rao had asked for his comments on their proposal for a B.Sc. in Public Health. It was necessary to have more details before giving a mature opinion. However, his first reaction was not favourable. Everywhere the trend had been towards integration of all fields of public health, and it would appear that the creation of a separate cadre of non-medical graduates to carry out national medical and public health work would be a violation of this principle. With reference to the proposal for sponsoring a Seminar on Medical Manpower, there should be no objection, if clear-cut proposals were made as to its scope and aim. He would need to study further the proposal that WHO assist in providing cheap text-books. He realized its importance, and possibilities would be investigated.

2. Endorsement of the Report

There were no comments on further sections of the report, and its examination having been completed, the REGIONAL DIRECTOR said that the Committee would no doubt like to adopt a resolution endorsing the Annual Report, as usual. A draft would be presented at the next plenary session.

3. Adjournment

The meeting was then adjourned.
# SUMMARY MINUTES

Fifth Meeting, 30 September, 9.00 a.m.*

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*Originally issued as WHO/RC19/Mln.5, on 30 September 1966, and incorporating subsequent corrections.
1. Procedure for the Nomination of Regional Directors
   (item 10 of the Agenda)

   The CHAIRMAN drew the attention of the Committee to the document on
   this subject (SEA/RC19/12).

   The REGIONAL DIRECTOR recalled that this subject had been discussed
   by the Regional Committee at its last session in Kabul. A sub-committee
   had been appointed at that time to consider the question of revising the
   procedure for the nomination of candidates in order to bring about a system
   of advance notification. The sub-committee had presented a report
   (SEA/RC18/16), and its findings had been embodied in the form of a draft
   resolution which had been attached as Annex 2 to that report. In addition,
   the Regional Committee had asked the Regional Director to try to provide some
   additional information with regard to some of the points raised in the
   discussion of the sub-committee's report. He had sent this information to
governments in the form of a circular letter (No.SEA-CL-66-2) dated 21 March
1966, which was attached as an annex to the present document. In this letter
he had endeavoured to provide, as a result of his consultations with the
Director-General and the Legal Section at Headquarters, as much information
as he could, over and above what had already been presented.

   DR RAO (India) stated that his Government supported the revised
process, subject to certain amendments. Firstly, they thought that proposals
should be sent to the Director-General not less than six weeks before the
opening of the session of the Regional Committee. Secondly, the Director-
General should send copies of all proposals for nominations to each Member
of the Region not less than four weeks before the opening of the session.
Thirdly, a government should have the right to withdraw, substitute or add
to any proposal under notification to the Director-General. Fourthly, any
government should have the right to propose more than one name, and, finally,
one name only should be submitted by the Regional Committee to the Executive
Board.

   The REGIONAL DIRECTOR suggested that the Chairman might wish to have
these amendments circulated to enable delegates to study them.

   This was agreed, and copies were circulated during the discussion.

   DR GUNARATNE (Ceylon) stated that when the subject had been discussed
at the last session, one of the reasons for postponing final consideration
of the resolution until the present session was with regard to last-minute
nominations in case a candidate already nominated withdrew, died or was
otherwise incapacitated. They had, however, agreed that advance notification
was useful, and his Government felt that if advance notification were
considered useful and accepted as such, the question of last-minute nomina-
tion did not arise. The proposal now put forward by India was to reduce
the period from twelve to six weeks. As had been stated clearly in the Regional Director's circular letter, the main objective of the revised rules had been to provide for advance notification, and he felt that objective would be nullified if one allowed last-minute nomination of additional candidates on the expiry of the time-limit of twelve-weeks. His Government would therefore support the Kabul draft resolution which was now before the Committee and not the proposed amendments by India. He wondered if the delegate from India would throw more light on why his Government had suggested that the period be reduced to six weeks.

DR RAO (India) replied that the later the proposals were sent in, the more time government would have to make a suitable selection.

The CHAIRMAN recalled that the draft resolution had been prepared by all the members at the last session, as the sub-committee was a sub-committee of the whole, and the Committee had postponed the adoption of the resolution at a suggestion put forward by India. The feeling then had been that an amendment was not necessary, and that it might nullify their objective in revising the rules. He wondered whether it would not be simpler to consider the original amendment by India rather than the new one.

DR JOSHI (Nepal) felt that the subject was of vital importance to all and that a decision must be taken. The success of health programmes launched with WHO assistance depended to a large extent on the ability to select the right person for the post of regional director. Even more than technical qualifications, the candidate's personal qualities, his integrity, his understanding of, and adaptability to, the needs of the Region were of primary importance. His Government felt that advance notification was not only a distinct advantage but a necessity in order to find the right type of candidate, and that there was no scope for further discussion on this point. He would support the draft resolution put forward last year.

DR DOLGOR (Mongolia), agreeing with the views expressed by the delegates from Ceylon and Nepal, also stressed the importance of personal qualities in a candidate. His Government felt that it was necessary to have sufficient time to study the information on candidates to be distributed to governments by the Director-General. He thought one should not be pessimistic, but should assume that not all the candidates proposed would withdraw or would be otherwise unavailable. He also favoured the Kabul draft resolution.

The VICE-CHAIRMAN, speaking as the representative from Burma, also felt that due weight should be given to the qualities of the candidate and that governments would need time to consider them. He also supported the original draft resolution.

DR HAKIMI (Afghanistan) wished to associate himself with the delegates from Ceylon and Mongolia.
DR CHITT (Thailand) stated that his Government was also in favour of advance notification and against submission of additional candidates after the time-limit.

The CHAIRMAN said that the original draft resolution was now before the Committee, as was the amendment proposed by India. He would put the amendment to the vote first, according to the Rules of Procedure.

The voting was one in favour and six against; the amendment was therefore rejected.

DR RAO (India) observed that there were many positive aspects to the amendment. It had been only the period which was under discussion, and he wondered how the whole amendment had been rejected.

The CHAIRMAN said that as the amendment had already been voted on, the matter was no longer open for discussion. The Committee now needed to take a decision on the original draft resolution, which he would put to the vote.

After the voting had begun, DR RAO (India) asked the Chairman for a little time to study the draft resolution again, and this was granted. After some time, he requested that further discussion of the item be postponed temporarily, under Rule 31 of the Rules of Procedure. He thought that the Committee needed more time to study the original draft resolution, which could be adopted with perhaps little modification.

The CHAIRMAN replied that under Rule 43 of the Rules of Procedure, he could not accede to the request of the delegate from India, as the voting had already started.

The original draft resolution (attached to document SEA/RC19/12, as Annex 2 of Appendix 4 to SEA/RC18/7) was then adopted by a majority of six for the resolution, none against and no abstention (see SEA/RC19/R6).

2. Resolutions of Regional Interest Adopted by the World Health Assembly and the Executive Board
   (item 9 of the Agenda)

The REGIONAL DIRECTOR, referring to the document on this subject (SEA/RC19/15), said that, following the usual practice, certain resolutions of special interest to the Region which had been adopted by the World Health Assembly and the Executive Board had been placed before the Regional Committee. The following resolutions were considered:

2.1 Consolidation of the Special Fund and the Expanded Programme of Technical Assistance in a United Nations Development Programme (EB37.R41)

The Committee noted this resolution.
2.2 Establishment of a Revolving Fund for Teaching and Laboratory Equipment for Medical Education and Training (WHA19.7)

The REGIONAL DIRECTOR explained the purpose behind this important resolution, which had been sponsored by the Government of India, and requested delegates to encourage their governments to send in requests for teaching and laboratory equipment for medical education and training purposes; the Organization would accept local currency and make the necessary foreign exchange available for this purpose. So far the Regional Office had received requests only from India; these were being processed. He recalled that the limit of $10 000 was placed only on individual requests and that there was no limit to the number of requests that could be made by governments, provided WHO was able to use the local currency. This should present no problem at this early stage of the programme.

DR RAO (India) asked about the status of the requests that had been made by India for assistance under this fund.

The REGIONAL DIRECTOR replied that out of three lists of equipment requested, two were being processed; the third did not entirely meet the criteria set forth by the Assembly. The Regional Office would be quite willing to entertain further requests.

2.3 Malaria Eradication Programme (WHA19.13)

The REGIONAL DIRECTOR drew attention to the importance of this resolution, which, he said, had already been discussed in Kabul in 1965. The Regional Committee took note of it.

2.4 Smallpox Eradication Programme (WHA19.16)

The REGIONAL DIRECTOR stated that, in terms of this resolution, WHO was in a position to meet the costs of certain supplies and equipment to assist in the further development of the programme, and asked the delegates to let the Regional Office know about the phasing of their programmes and their requirements. He added that the requests should be properly documented to enable WHO to arrive at a decision.

DR JOSHI (Nepal) enquired whether the request for assistance should be limited to supplies and equipment or could also include vehicles to assist in the training of supervisors of smallpox eradication programmes.

The REGIONAL DIRECTOR replied that there was no reason why vehicles should not be provided by WHO in support of training programmes.

DR JOSHI (Nepal) said that he really meant to ask whether WHO would be able to provide assistance in conducting training programmes in Nepal for the training of supervisors in the field.
The REGIONAL DIRECTOR confirmed that WHO would be prepared to provide assistance for training programmes for supervisors.

2.5 **Programme Activities in the Health Aspects of World Population which Might be Developed by WHO (WHA19.43)**

In inviting attention to this subject, the REGIONAL DIRECTOR explained that many delegates had felt that the resolution passed by the Eighteenth World Health Assembly had not gone far enough. The present Assembly resolution gave further guidelines to WHO for considering technical assistance to maternal and child health services and basic health services which included family planning.

DR RAO (India) said that he thought that resolution WHA19.43 was of paramount importance to India and also to all countries which were attempting to improve the health of mothers and children by methods of family planning and other such activities. In this connection the need for basic health services and also the necessity to reinforce all these centres should be borne in mind. He hoped it would be possible for the Regional Director to explore the possibility of providing maximum assistance for expanding basic health services and also for strengthening maternal and child health services with supplies and equipment, including vehicles, as well as to develop training facilities for all maternal and child health and family planning workers and to initiate research programmes, as envisaged under this resolution.

DR JOSHI (Nepal) enquired whether WHO could assist family planning programmes by providing loops and other contraceptives.

DR GUNARATNE (Ceylon) stated that Ceylon had also started a programme in family planning in collaboration with the Swedish Family Planning Agency. He thought that the present Assembly resolution, although it confirmed WHO's role as that of giving Members technical advice upon request, did not go very far; he hoped that future Assemblies would adopt a more positive attitude. He wanted to know whether WHO would be able to provide an adviser on family planning.

Replying to Dr Joshi and Dr Gunaratne, the REGIONAL DIRECTOR said that the programme approved by the Assembly did not include the provision of contraceptives, nor would the Regional Office be able to provide an adviser in family planning. The Assembly resolution, he explained, supported basic health services and maternal and child health services, which might include an element of family planning. WHO field personnel engaged in maternal and child health work could now also render technical advice on family planning, if requested, as long as this formed part of the basic health services.
2.6 **Study of the Nature and Extent of Health Problems of Seafarers and the Health Services Available To Them (WHA19.48)**

Referring to this resolution, the **REGIONAL DIRECTOR** said that some countries at the World Health Assembly had expressed special interest in the welfare of seafarers, and that the intention of the resolution was to start a pilot project in two of the large ports. He asked if any delegate were interested in having the pilot project established in his country.

**DR GUNARATNE** (Ceylon) stated that Ceylon had already given some thought to this proposal, but was faced with a temporary administrative difficulty in that the Port of Colombo was going to be declared a separate Authority. As soon as the matter had been discussed with different departments concerned, his Government would send a reply to the Regional Director.

The document in which these resolutions were included (SEA/RC19/15) was noted.

3. **Planning of Health Services**  
*(item 11 of the Agenda)*

The **CHAIRMAN** asked **Dr Somboon** to introduce the paper submitted by the Government of Thailand (SEA/RC19/10).

**DR SOMBOON** (Thailand) observed that the planning of health services had recently assumed great importance. It had been the subject for discussion at a number of meetings held under the auspices of WHO. Thailand had formulated its Second Five-Year Plan, which was going to be implemented from next month. The Government was also thinking of enacting some legislation to ensure the smooth running of the Plan during the implementation period. They were very desirous of obtaining advice from WHO and of learning about the experience gained by other countries of the Region.

**DR DHIR** (India) gave a short account of the planning and implementation of the five-year plans in India. By March 1966, India had completed three such plans. He described the composition and work of the Planning Commission, which had been established in March 1950 by a resolution of the Government of India, to meet the need for comprehensive planning based on a careful appraisal of resources and an objective analysis of all the relevant economic factors. In framing its recommendations, the Planning Commission acted in close consultation with ministries of the Central Government and various States.

In the Planning Commission there was a Division of Health Planning headed by an Adviser, and the Ministry of Health was responsible for coordinating health planning in different States. The Centre dealt with coordination and provided broad guidelines, leaving it to the States to prepare
their own detailed plans. The planning of the five-year programme was started three years before its implementation was due to begin; the Centre indicated to States the funds that would be made available. There was much flexibility, and the States enjoyed a great deal of freedom in giving the final shape to their programmes. The States also had organized units for planning, and he described the set-up for health planning in States.

Replying to a question from DR SOMBOON as to the characteristics of a realistic plan, he stated that it should be simple, comprehensive, costed, well phased and of reasonable duration, and should take into account the absorbing capacity of the receiving end. Most of all, it was thought, it should be flexible. It should also include machinery for evaluation.

DR RAO (India) mentioned the notable part played by the Organization in assisting India in the development of its national health plans, for which his Government was most grateful, and suggested that WHO arrange a seminar on health planning for the benefit of countries of the Region.

The REGIONAL DIRECTOR said that he would be glad to do this, and that he would consult Member Governments to find a suitable time for such a seminar.

At the request of the REGIONAL DIRECTOR, DR GRIFFITH (WHO Secretariat) made a short statement on WHO's work in the field of health planning. He said that the first report of the Expert Committee on Public Health Administration (WHO Technical Report Series No. 55) issued in 1952, although somewhat general in scope, noted defects in the organization of health services likely to interfere with planning and its implementation. A short section was also devoted to planning and assessment. The second and third reports of the Expert Committee (TRS 83, issued in 1954, and TRS 194, in 1960) were particularly concerned with the organization of health services at the local level. The fourth report (TRS 215, issued in 1961) specified long-term plans at the national or federal level and described the general principles of planning and development of health programmes. It also included recommendations regarding both short-term and prospective planning, the stages for drafting a plan and operational research.

In 1962, annual training courses for senior health personnel, run jointly by the Pan American Sanitary Bureau/WHO and the Latin American Institute for Economic and Social Affairs, were introduced. There had also been courses at Johns Hopkins in the USA.

In 1964, a seminar on national health planning was held in Manila, and in 1965, on Inter-Regional Seminar on National Health Planning in Addis Ababa was held.

In 1965, health planning had formed the subject for the technical discussions at the Eighteenth World Health Assembly, and the report on these discussions emphasized the problems of adequacy of personnel, their training and their distribution, stressing the necessity for continuous review of the implementation of plans.
In Africa the Organization had assisted with the health plans in four countries.

In South-East Asia, WHO was assisting Afghanistan and Nepal in the development of national health services under their economic development plans, and India and Thailand with the development of operational research projects, which should be of use in the operation and evaluation of rural health services.

He mentioned also the Asian Institute of Economic Development and Planning, Bangkok, to which WHO had provided a public health administrator as a faculty member.

4. Reporting and Recording System of Health Activities (item 12 of the Agenda)

The CHAIRMAN invited the delegate from Thailand to introduce the paper on this subject (SEA/R19/11) which had been submitted by the Government of Thailand.

DR SOMBOON (Thailand) said that the problem in Thailand was that there were too many different kinds of reports and records in the health services. There seemed to be a need to screen them and to evaluate their usefulness. The object of proposing this subject for discussion was to learn about (1) the organization of systems in the other countries, and (2) the assistance WHO could provide in terms of advisory services and training.

The CHAIRMAN, speaking as representative of his Government, said that Indonesia also had similar complaints. WHO had issued a manual for preparing annual health reports which, in his view, could provide the guidelines for such reports. He felt, however, that there was need for a review of the reports from the periphery so that they could be designed as simply as possible and utilized more fully.

DR RAO (India) said that he thought this was a most important subject. He agreed that there were too many reports and that they required an evaluation with regard to their usefulness. In this connection, he drew attention to WHO document A18/Technical Discussions/1, of 18 March 1965, a background document based on summary reports received from countries and other material, by Sir John Charles, prepared for reference and use at the technical discussions on health planning which had been mentioned by Dr Griffith. This document set out pre-conditions for planning - administrative, legal, technical and psychological.

The approach, of course, must vary with the country, but the above guidelines might be useful.
DR LUN WAI (Burma) said that Burma too had problems in recording and reporting. There were forms and charts, and the system was working well, but the persons responsible for recording and sending in returns required proper supervision at all levels. In this connection advice from WHO would be welcome.

The REGIONAL DIRECTOR said that the first step was to simplify and streamline the forms so that they were intelligible to the person completing them, and secondly, to arrange for the appropriate training of the individual so that he understood the format, the need for it and its usefulness to the health administration. WHO was already helping to solve both these problems by helping governments to simplify and standardize formats and by giving fellowships for training. With the permission of the Chairman, he requested Dr Helweg-Larsen to give some details.

DR HELWEG-LARSEN (WHO Secretariat) presented two charts on the flow of information between peripheral health units and the central health services, reflecting the experience gained so far from project activities in Afghanistan, India and Nepal. He laid stress on the practical utility of the individual record cards, the patient register and the individual notification card for communicable disease. It was suggested that the periodic report should be quarterly and not monthly, as was often the case at present. The graph illustrated an important principle used when designing a recording and reporting system, namely that the peripheral health unit should send in the quarterly reports to the central health department to enable it to prepare health statistics to be fed back to the periphery.

In conclusion, he referred to individual diagnostic reports, which should be sent from peripheral health centres to the central health department for preparation of detailed out-patient morbidity statistics. Statistics should be produced by the central health department, which had trained staff and equipment for the purpose, and not on the peripheral or intermediate level.

DR RAO (India) suggested that in view of the importance of the subject with regard to simplification of the recording system, and also because of the obligation to help in the preparation of international statistics, a study group might be formed with representatives of different countries, to examine the ways and means of achieving the objective.

The REGIONAL DIRECTOR said that there was provision for a seminar on this type of activity next year and that this would be implemented.

5. Improving the Existing Training Facilities for Junior Technical Staff of Laboratories in Developing Countries (item 13 of the Agenda)

The CHAIRMAN invited the delegate from India to introduce the paper which his Government had presented on this subject (SEA/RC19/13).
DR SHRIVASTAV (India) said that the group now holding the technical discussions, which this year were on the subject of "Health laboratory services", had been deliberating on this subject and would be formulating certain specific recommendations concerning the training of all categories of laboratory staff. It would therefore be unnecessary to discuss this subject at the present meeting.

This was agreed.

6. Allotment of Foreign Exchange for the Specific Purpose of Importing Reference Reagents, Chemicals, Replacements and Spare Parts (item 14 of the Agenda)

The CHAIRMAN invited the delegate from India to introduce the paper submitted by the Government of India on this subject (SEA/RC19/14).

DR SHRIVASTAV (India) said that there were two organizations in India which were deeply interested in this subject: the Ministry of Health and the Indian Council of Medical Research on the one side, and the Council of Scientific and Industrial Research on the other. Several meetings had taken place, and a list of the equipment, chemicals, etc., required for the scientific, research and training activities carried out by these organizations had been compiled. In the meantime, however, he had understood from the Director-General of Health Services, Government of India, that there was now a WHO Revolving Fund and that a certain amount of foreign exchange might also be available through UNICEF. By taking advantage of these two facilities, his Government was hoping to obtain the spare parts, etc., required.

This statement was noted.

7. Increasing the Size of the WHO Executive Board (item 15 of the Agenda)

The Indian delegation had circulated a proposal that Article 24 of the Constitution of the World Health Organization should be amended to provide that the membership of the Board be increased to twenty-eight and that, in electing the Members to designate persons to serve on the Board, the Health Assembly should take into account the need for an equitable geographical distribution and also ensure that each region was represented by at least three Members, so as to provide election of a fresh representative from the Region every year.

Speaking on this subject, DR RAO (India) said that it had recently been suggested in the Executive Board that an increase in the numbers would
be desirable (resolution EB38.R20). The present membership of the Board, according to region, was:

<table>
<thead>
<tr>
<th>Region</th>
<th>Seats</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Region</td>
<td>4</td>
</tr>
<tr>
<td>American Region</td>
<td>5</td>
</tr>
<tr>
<td>Eastern Mediterranean Region</td>
<td>4</td>
</tr>
<tr>
<td>European Region</td>
<td>7</td>
</tr>
<tr>
<td>South-East Asia Region</td>
<td>2</td>
</tr>
<tr>
<td>Western Pacific Region</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
</tr>
</tbody>
</table>

This was in proportion to the number of countries in each Region. Such representation, based on the number of countries rather than on population, was thought to be out of balance. The suggestion of the Indian delegation was therefore to increase the membership to twenty-eight, and to have at least three members from the South-East Asia Region. The proposed distribution of the twenty-eight members would increase the membership from the African Region by two and the members from South-East Asia and the Western Pacific by one each.

He welcomed comments on this proposal.

The REGIONAL DIRECTOR stated that the Director-General had forwarded the Executive Board's resolution, EB38.R20 (which was circulated), to all Member Governments with his circular letter No.21 of 1966 of 4 August 1966. In this letter he had said that in order to enable consideration of an amendment to the Constitution within the time limit referred to in Article 7 of the Constitution, and in accordance with the provisions of Rule 117 of the Rules of Procedure of the World Health Assembly, it was necessary that Member Governments submit their proposals in time to reach him not later than 25 October 1966.

The CHAIRMAN suggested that in the light of the Regional Director's observations, the procedure was for the governments to send their proposals in to the Director-General and that perhaps discussion by the Regional Committee was not warranted.

DR KAREPA-SMART (the Director-General's representative) agreed that, as pointed out by the Regional Director, the individual Member Governments had been asked to send their proposals to the Director-General. However, he felt there was nothing to prevent the Regional Committee from discussing the subject, so as to be able to report back to their respective governments on the views expressed; they could even adopt a collective resolution. This might provide a useful opportunity for ascertaining the views of the other governments of the Region.

DR GUNARATNE (Ceylon) felt that this was an important subject, and agreed that all the Member Governments in South-East Asia would like to have
more representation from this region in the Board. Two representatives from this Region appeared to be an inadequate number. Unfortunately, the Constitution did not provide for geographical distribution but for independent sovereign countries. Representation on a population basis might provide for four instead of two seats in the Board. In his opinion, it was necessary to do everything possible to get more representation, and he thought it would be useful for delegates to take back to their respective governments a resolution passed in the Regional Committee on this subject.

The REGIONAL DIRECTOR said that it might be helpful if he explained the present system of representation in the Executive Board. Since the membership of the Organization had increased, the need for a larger Executive Board had been felt, and the guiding principle had been the allotment of seats according to the number of countries in a region. Accordingly, at present, Africa had 4 seats (1 seat for 7 countries), America, 5 seats (1 for 4.8), Europe, 7 (1 for 4.4), the Eastern Mediterranean 4 (1 for 4.5), the Western Pacific 2 (1 for 5.5) and South-East Asia, 2 (1 for 4.5). If it were agreed to increase the membership of the Board to 28, there still would be no change in the representation of South-East Asia, based on the present system of representation; to achieve that result, the membership would have to be raised to 42.

DR JOSHI (Nepal) said that Nepal had not yet decided on the question of whether Articles 24 and 25 of the Constitution of the World Health Organization should be amended, but he was of the opinion that the representation for South-East Asia was inadequate.

The REGIONAL DIRECTOR recalled that the WHO Constitution could be amended only by the World Health Assembly; the Regional Committee could only make recommendations.

MR MURTHY (India) said that the proposal made by India was to ensure that there was no gap at any time in the representation of South-East Asia in the Executive Board.

The REGIONAL DIRECTOR explained that there were always two seats for South-East Asia: the point raised was that in only two out of three years were any new Members from the Region eligible to select a person to serve on the Board.

DR JOSHI (Nepal) supported the suggestion that the proposal made by India should be drafted as a recommendation to the governments of the Region.

The REGIONAL DIRECTOR observed that the Regional Committee could certainly express a collective opinion, and said he would submit a draft for consideration.
8. Appointment of a Regional Appraisal Panel to Evaluate the Progress of Malaria Eradication Programmes (item 16 of the Agenda)

DR GUNARATNE (Ceylon) introducing the Ceylonese paper on this subject (SEA/RC19/16), enumerated the various reasons for proposing this item. The malaria eradication programme had been working satisfactorily in Ceylon, but there had been recent setbacks and some focal outbreaks, which had caused anxiety. His Government wanted to ensure that this major programme remained on a sound basis. It was thought that other countries might have similar problems, and therefore that it might be useful to have a Regional Appraisal Panel to study them.

As a result of recent discussions of this problem in the Regional Office, however, he now thought that the usual independent assessment being carried out with the assistance of WHO might be more objective and more useful than the proposed panel.

DR RAY (India) said that he would like to comment on some of the points made in the document presented by the Government of Ceylon. Certain disappointments in malaria programmes had been caused by failure to apply the criteria laid down by WHO.

A recent review of malaria eradication programmes had shown that the countries which had followed the criteria had made good progress throughout. India had undertaken periodical annual appraisals from 1962 with the help of WHO, and the importance of such annual assessments had been stressed at the Fifth Asian Malaria Conference. He thought that a regional appraisal panel such as proposed by Ceylon would not be the proper body to undertake appraisals, which preferably should be undertaken by independent teams composed of nationals and internationals, who could determine the progress and point out weaknesses. He expressed the gratitude of his country to WHO for its continued assistance in the annual independent assessment carried out in the Indian programme.

The REGIONAL DIRECTOR observed that in the Programme and Budget there was provision every year for a Regional Assessment Team on Malaria Eradication (SEARO 7). The composition of this team could be modified as necessary to meet the needs of different countries.

It was agreed that the WHO team could meet the needs indicated by Dr Gunaratne.

9. Training of Sub-Professional Personnel for: (i) Health Education and (ii) Implementation of the Food and Drugs Act (item 17 of the Agenda)

DR GUNARATNE (Ceylon) said that in Ceylon the health education officer was a graduate and under him there were assistant health education officers,
recruited from the ranks of experienced public health inspectors, who had received a six-month training course in health education. The position he sought to clarify was whether future recruits should be graduate health educators or whether the existing practice should be continued. He had also wondered whether possibly too much was being expected from the present assistant health education officers. He would be grateful for guidance. In this connection he was glad that WHO would be providing a short-term consultant to assess the health education work in Ceylon.

DR RAMAKRISHNA (India) emphasized that health education was the foundation for the successful implementation of all public health programmes. The training needed for health educators depended on their jobs. If they were to bring about behavioural changes in the people they served and exercise leadership, persons with an understanding of psychology and social anthropology, graduates and experienced persons were necessary. The Government of India was training many sub-professional staff in courses of varying length. However, at block level, where health educators were being posted, those selected were graduates with experience and special training; the one-year course at the All-India Institute of Hygiene and Public Health, Calcutta, had already been mentioned. At state-level, health educators with a master’s degree and considerable experience were desirable. Evaluation was important and was carried out at central and state levels. Public health administrators were not always clear about the functions of the health educator. The proposed assessment of health education was therefore important.

DR SAW BA HEIN (Burma) felt that the development of general education was essential in order to push through health education activities. Health education should be introduced at primary, secondary and high-school level.

DR SAMBOON (Thailand) said that in Thailand the health educator not only imparted health education to the people, but was also required to study the felt needs of the area.

DR GUNARATNE (Ceylon) expressed his appreciation of the excellent analysis given by Dr Ramakrishna and the important points he had raised.

MISS PAULL (International Council of Nurses) stressed that in India the public health nurses were doing a great deal of health education. The Red Cross Society had home nursing programmes, and this enabled the nurses to give guidelines in health education, among other things.

10. **Adjournment**

The meeting was then adjourned.
### SUMMARY MINUTES

Sixth Meeting, 1 October, 10.30 a.m.*

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*Originally issued as SEA/RC19/Min.6, on 1 October 1966, and incorporating subsequent corrections.*
In the absence of the Chairman, the Vice-Chairman presided.

1. **Consideration of Draft Resolutions**

Draft resolutions on the following subjects were considered and adopted without modification:

1. Eighteenth Annual Report of the Regional Director (see resolution SEA/RC19/R1)
2. Socio-economic Value of the Control of Communicable Diseases (resolution SEA/RC19/R2)
3. Provision of Textbooks (resolution SEA/RC19/R3)

The draft resolution on "Seminar on Requirements in Manpower" was adopted with a short amendment, providing that in the Seminar, in considering measures to meet the needs for various categories for the health services, special attention would be given to the conservation of medically qualified personnel (see resolution SEA/RC19/R4).

In the discussion of a further draft resolution, on "Increasing the Size of the Executive Board", DR DOLGOR (Mongolia) said that in view of the prevailing practice of allocating seats on the basis of the number of countries in a region, it was doubtful whether a recommendation for three seats for South-East Asia was realistic. He would accept the resolution but feared that the Committee could not hope for good results.

The resolution was adopted (see SEA/RC19/R5).

2. **Proposed Regional Programme and Budget Estimates for 1968 and Consideration of the Report of the Sub-Committee on Programme and Budget** (items 18 and 18.1 of the Agenda)

The REGIONAL DIRECTOR introduced the Proposed Programme and Budget Estimates for 1968 and said that the Regional Committee had referred this to the Sub-Committee on Programme and Budget for examination. The report of the Sub-Committee (SEA/RC19/20) should be read along with the main document (SEA/RC19/23).

He outlined the contents of the budget document. The presentation followed the broad policies established by the World Health Assembly, the Executive Board and the Regional Committee.

DR HAKIMI (Afghanistan), Chairman of the Sub-Committee on Programme and Budget, presented the report and said that the Sub-Committee had made
a detailed examination of the main document, in accordance with its terms of reference. It was of the view that the programme followed the general programme of work approved by the World Health Assembly, that it had been based on requests from Member Governments and that it was suitable for the health needs of the Region. The Sub-Committee did not wish to raise any particular points for discussion in plenary session.

The CHAIRMAN suggested that the Proposed Programme and Budget Estimates be taken up for consideration section by section.

Under the country and inter-country activities, the following amendments were suggested for consideration by the Regional Director subject to budgetary and other limitations:

2.1 **Afghanistan**

Afghanistan 60, Dental Health (UNDP/TA II), in the green pages:
deletion of the provision for a short-term consultant and an increase in the number of fellowships.

The REGIONAL DIRECTOR made a note of this and stated that the Regional Office would advise the Government about the method of presenting such a request for substitution of components to the UNDP, as this was a UNDP/TA project.

2.2 **India**

An increase in the number of fellowships in malaria (India 153) to six; inclusion of one six-month fellowship for the production of standard viral diagnostic antigen and anti-serum for Kasauli; one six-month fellowship for the development of animal breeding at the Central Research Institute, Kasauli; a short-term consultant for three months for the establishment of research and training units of the Central Research Unit, Kasauli and Chandigarh, and the services of the regional cholera team, consisting of one epidemiologist and one bacteriologist, together with the necessary supplies.

2.3 **Mongolia**

Mongolia 5, Environmental Health: the provision of the sanitary engineer under this project in 1968, shown for three months in the white pages and for nine months in the green pages, to be accommodated for the full twelve months in the white pages.

Mongolia 3, Tuberculosis Control (green pages): the provision for the consultant in tuberculosis to be deleted.

The REGIONAL DIRECTOR stated that the Regional Office would advise the Government on how they should request such alterations to be made by the UNDP, as these were UNDP/TA projects.
2.4 Nepal

Nepal 16, Tuberculosis and Leprosy Control: continuation of the provision for a medical officer in tuberculosis.

Nepal 20, Smallpox Eradication: as the Government was training panchayat workers in vaccination, fellowships for the training of supervisors in 1967-68 to be made available.

Nepal 10, Health Laboratory Services: an adviser to enable the Government to start the laboratory.

Nepal 8, Maternal and Child Health: to increase the number of stipends for auxiliary nurse-midwives, as the Government had started two schools in the country; also, more fellowships in maternal and child health for lady doctors.

2.5 Thailand

Thailand 80, Health Laboratory Services: the laboratory technician and the supplies and equipment to be shifted from the green to the white pages if possible.

2.6 Inter-country Projects

SEARO 147, Seminar on Dental Health: to be transferred from the green to the white pages.

SEARO 200, Fellowships (National Health Planning): the provision for fellowships to be utilized for holding the seminar on health planning which had been proposed earlier in the discussions.

The REGIONAL DIRECTOR said that he would do his best to accommodate all these proposed changes, subject to budgetary limitations and priorities.

In the consideration of these inter-country projects, DR RAO (India) drew attention to the discussions at the Eighteenth and Nineteenth World Health Assemblies on the question of quality control of drugs. He enquired as to the possibility of establishing a laboratory for this purpose in order to help those countries which did not have such laboratories. He proposed that the Regional Office should provide equipment as well as technical personnel for the development of a regional laboratory for the Region.

The REGIONAL DIRECTOR stated that he was ready to provide fellowships for training national staff in these activities. The main problem was the provision of equipment for such laboratories. WHO had brought this to the attention of the United Nations Development Programme/Special Fund. Where a
country would be willing to put up a priority request to the Special Fund, WHO would be happy to support it strongly and would provide short-term consultants to assist in formulating the request. Otherwise, recourse would have to be made to bilateral sources in order to equip such laboratories. A consultant in quality control of drugs was now visiting Ceylon and, it was hoped, would be able to visit India in February of next year.

DR RAO (India) suggested a survey of the situation in the whole Region. He amplified his suggestion of the establishment of one regional laboratory supported by existing laboratories in the Region.

The REGIONAL DIRECTOR pointed out the difficulty of making such a regional survey, as the situation was so different in the individual countries. With regard to a regional laboratory, if a testing laboratory were meant, he doubted that countries would be willing to send drugs for testing to another country in the Region.

DR SAW BA HEIN (Burma) stated that a diagnostic laboratory in virus diseases had been established in Burma, but that only professional staff were being sent out for training. It would be useful if some of the lower-level technicians and assistants could also be offered training within the Region.

The REGIONAL DIRECTOR said that WHO’s policy was to award most of its fellowships to professional staff. Some departures from this policy had been made for training sub-professional staff in the Region. He wondered, though, whether the technicians should not be trained in their own laboratories.

DR SHRIVASTAV (India) said that a virologist could train his technicians in his own national laboratory only if the laboratory was fully equipped. In the absence of such equipment, it would be better to send technicians to some neighbouring, well equipped virology laboratories for training. He mentioned that in India, for instance, there were several well equipped laboratories that would be glad to offer such training to WHO fellows.

The REGIONAL DIRECTOR said that he would note this possibility.

2.7 Special Accounts, Annex XI

The REGIONAL DIRECTOR stated that provision was available for a few of the projects listed in this annex. The Voluntary Fund for Health Promotion consisted of voluntary contributions from Member Governments and had been insufficiently supported.
2.8 **Approval of the Programme and Budget**

The CHAIRMAN announced that, as there seemed to be no more comments, the Proposed Programme and Budget Estimates for 1968 (document SEA/RC19/3) and the Report of the Sub-Committee on Programme and Budget (document SEA/RC19/20), together with its recommendations on pages 6 and 7, would be considered as approved.

A draft resolution on the subject was then adopted (see resolution SEA/RC19/8).

3. **Selection of Subject for the Technical Discussions in 1967**

(item 20 of the Agenda)

DR RICHARDS, speaking for the Regional Director, referred to the document on the above subject (SEA/RC19/7) and invited suggestions.

DR DOLGOR (Mongolia) proposed the subject of "Maternal and child health" for the 1967 discussions. He said that heretofore most of the subjects of technical discussions had been concerned with communicable diseases, whilst maternal and child health, though so important, had not been discussed.

DR RAO (India) supported this proposal. He requested that when the time came to select the topic for the discussions to be held in 1968, the Committee might consider either "Staff training for senior health administrators" or "Planning of health services, including a manpower study, as part of general planning."

DR HINGORANI (International Federation of Gynaecology and Obstetrics) said there was a great need for increasing the training of midwives. She thought that the selection of maternal and child health as subject of the technical discussions might serve to focus the attention of the governments on the subject.

DR RICHARDS suggested that maternal and child health was a very wide subject to be exhaustively discussed during the course of the time allotted for the technical discussions. Perhaps the committee might consider a more limited aspect of it, such as "Integration of maternal and child health into the general health services."

DR JOSHI (Nepal) favoured the more general topic of "Maternal and child health", as otherwise the discussions might tend to be concentrated more on the administrative aspects.

DR RAO (India) suggested "Integrated maternal and child health services."
DR JOSHI (Nepal) suggested a compromise: "Maternal and child health with particular reference to integration into the general health services"; this proposal was accepted, and a resolution to this effect adopted (SEA/RC19/R9).

4. **Time and Place of the Twenty-First Session of the Regional Committee** (Item 21 of the Agenda)

DR DOLGOR (Mongolia) confirmed his Government's invitation to the Regional Committee to hold its twentieth session in Ulan Bator in 1967 and said that it would be preferable to meet there in August because of climatic conditions. Necessary instructions were being issued to the Mongolian Embassies both in New Delhi and Moscow regarding issue of visas to the participants. His Government was planning field trips for the delegates, and he hoped all of them could plan for an extra two days' stay in Ulan Bator, over and above the time taken by the session.

The REGIONAL DIRECTOR, introducing the document on this subject (SEA/RC19/6), said that necessary arrangements for facilitating the travel of participants to the twentieth session of the Regional Committee would be made by the Regional Office. In accordance with the principle of holding alternate sessions of the Regional Committee at its headquarters, the twenty-first session should be held in New Delhi in September 1968.

This was agreed, and a draft resolution concerning the time and place of the twentieth and twenty-first sessions was adopted (see SEA/RC19/R10).

The REGIONAL DIRECTOR added that an indication as to the venue of the twenty-second session, to be held in 1969, would be welcome, as the budgetary preparations for that year would have to be started early in 1967.

DR JOSHI (Nepal) said that in the absence of any instruction from his Government, it was not yet possible to extend an invitation to the Committee to hold its twenty-second session in Kathmandu, but that a communication would be sent to the Regional Director early in 1967.

5. **Consideration and Adoption of the Recommendations Arising out of the Technical Discussions** (Item 19 of the Agenda)

DR GUNASEKERA (Ceylon), Chairman of the technical discussions, in introducing document SEA/RC19/21, said there had been a useful and exhaustive discussion, greatly facilitated by the working papers prepared and listed on page 1 of the document. He drew special attention to the conclusion mentioned in paragraph 2 on page 2, that the national health laboratory should form an integral part of the general health services, and also to the final recommendation (page 8) for convening, in 1967, a conference of technical and administrative experts dealing with laboratory services in the countries of the Region.
DR RAO (India) congratulated the Chairman of the technical discussions on the excellent report. He wondered whether it was feasible for a national health laboratory to cover all the aspects of laboratory activity enunciated on page 2, viz., clinical, public health, control of food, drugs, toxicology, etc.

DR GUNASEKERA (Ceylon) said these activities referred to the national laboratory service as a whole, and it was thought desirable and possible for such a service to include these aspects. It was not intended that any one laboratory should perform all the activities listed.

DR RAO (India) suggested that as the equipment and staff required by a laboratory service to carry out the necessary activities were in such short supply, consideration might be given to his earlier suggestion for a regional laboratory, or, if this were not possible, to the designation of some special laboratories as referral laboratories for the Region, assistance to be given to them by way of equipment and staff training facilities.

DR GUNASEKERA (Ceylon) said that the feasibility of setting up a regional referral laboratory had not been considered by the technical discussions group.

In the absence of any further observations, the conclusions and recommendations arising from the technical discussions were noted.

6. Health Aspects of World Population Problems

Under the item "Any Other Business" (item 22 of the agenda), MR MURTHY (India) introduced a draft resolution by the Indian delegation on the above subject.

DR CHITT (Thailand) said that he could not commit his Government to the draft resolution as it stood.

DR JOSHI (Nepal) supported the proposed resolution.

DR DOLGOR (Mongolia) recalled that this subject had been discussed during the Nineteenth World Health Assembly. In his country there was no problem of family limitation. However, he would support the resolution because some other countries in the Region were experiencing population pressure. He noted that the resolution merely requested the Regional Director to explore the possibilities of providing assistance in the matter of supplies. He wondered whether it was possible for WHO to provide supplies and equipment, including vehicles, or whether they might not more appropriately come from UNICEF.
DR EGGER (UNICEF), who was invited to reply, said that as far as UNICEF was concerned, one of its main interests was the strengthening of basic health services and maternal and child health services at the request of the governments concerned, subject, of course, to technical advice from WHO. He referred to the discussions at the previous UNICEF Executive Board meeting on the subject, and to the requests of the Governments of India and Pakistan for assistance to basic health services, which he had mentioned earlier; they had now been approved by the UNICEF Executive Board. UNICEF was trying to increase the funds available for the development of such services in its two Asian Regions. With this increase, it should be possible in 1967 and later years to meet even more generously requests for this type of activity. It was entirely for governments to decide on priorities in their requests.

The REGIONAL DIRECTOR explained that in the matter of such supplies, governments should make a direct approach to UNICEF. WHO came into the picture when these requests were referred to it for technical approval.

DR DOLGOR (Mongolia) observed that his country would be grateful to receive some medical teaching equipment.

DR HAKIMI (Afghanistan) said that for the time being Afghanistan did not need to limit the size of its population.

DR CHITTI (Thailand) wondered whether the draft resolution might be somewhat revised. He suggested the addition of the words "subject to the national policies of Member Governments" to the end of the second paragraph.

This addition was accepted, and the resolution was then adopted (see SEA/RC19/R7).

7. Adjournment

It was announced that the final plenary meeting of the Committee would be held at 11 a.m. on Monday, 3 October 1966.

The meeting was then adjourned.
**SUMMARY MINUTES**

Seventh Meeting, 3 October 1966, 11.15 a.m.*

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*Originally issued as SEA/RC19/Min.7, on 5 October 1966, and incorporating subsequent corrections.*
1. Adoption of the Final Report of the Nineteenth Session
   (item 23 of the Agenda)

   The CHAIRMAN referred to the draft final report (SEA/RC19/22), which
   had been circulated, and asked members for their comments.

   The REGIONAL DIRECTOR said that the following amendments should be
   made:

   (1) Page 5, paragraph 3, the last two words, "was appreciated",
       to be omitted.

   (2) Page 8, in the paragraph under item 4, in the last two lines,
       the words "up to a maximum of twelve months" to be deleted,
       the final sentence to read: "For this group, short periods of
       training in health education would be sufficient."

   (3) Page 11, paragraph 1 under item 9, the last word in line 3
       to read "to" instead of "its".

   He also asked delegates to correct Resolution SEA/RC19/R10, on the
   time and place of the twentieth and twenty-first sessions of the Regional
   Committee, in which the introductory phrase "Bearing in mind .." etc.,
   should come down between operative clauses 1 and 2, so that the resolution
   would read:

   "The Regional Committee,

   "1. CONFIRMS its previous decision to hold its twentieth session in
      Ulan Bator in August 1967, and,

      Bearing in mind the principle of holding alternate sessions of the
      Regional Committee at the regional headquarters,

   "2. DECIDES to hold its twenty-first session at the seat of the Regional
       Office in New Delhi in September 1968."

   The Committee accepted these corrections, and the report, after
   being examined page by page, was adopted without further changes.

2. Adjournment of the Session
   (item 24 of the Agenda)

   MAJOR LAL (World Veterans' Federation) conveyed the greetings of
   the Federation to WHO. He said that the World Veterans' Federation believed
   in peace and the betterment of mankind - a task in which WHO had played a
   commendable role.
MR KUPPUSWAMI (International Hospital Federation) also greeted the Regional Committee on behalf of his Organization. He expressed his appreciation for the business-like conduct of the session, and thanked the Regional Director for the courtesies extended. He expressed the hope that WHO would gather more and more strength as the years passed and would become an effective voice in all matters of health in all parts of the world.

DR MINGORANI (International Federation of Gynaecology and Obstetrics) thanked the Regional Committee for the opportunity to be present. The International Federation which she was representing would continue to support matters related to maternal and child health and family planning.

MR MURTHY (India) thanked the Chairman, the Vice-Chairman, representatives from international, inter-governmental and non-governmental organizations, observers, and the Regional Director and his staff for their valuable contribution to the success of the nineteenth session of the Regional Committee. The smooth and efficient way in which the Chairman had conducted the business had won the highest admiration of all. He underlined the contribution of WHO, UNICEF and FAO towards the promotion and establishment of better health for the people of South-East Asia, in which almost one-third of the world’s population lived. He recalled the words of the Prime Minister of India in her inaugural address, when she had said that most of the diseases were the product of poverty and malnutrition, and remarked that the high birth rate and short life expectancy almost nullified economic progress, thus creating a vicious circle. International co-operation could play a vital role in breaking this vicious circle, but if the benefits of science were not made available to those who needed them most and if exorbitant prices were charged for life-saving drugs and biologicals, the smaller countries would derive little benefit from them. There were many problems, and funds were, of course, limited. He hoped that a sense of urgency would prevail among the more affluent nations, that, in combating sickness in this part of the world, international organizations would give priority to family planning, sanitation, maternal and child health and the control of communicable diseases, and that WHO would help the nations to fulfil the needs of their people. He wished all the delegates a happy return to their homes.

MISS PAULL (International Council of Nurses) expressed appreciation for the opportunity given to her to attend the session. Nurses, as she had said earlier, were also health educators, and, with doctors, played an important part in building up the health of the nations. She would report back to the Council and to other nurses and thought that the experience gained by her attendance at the meetings would be of great help to them.

DR GUNASEKERA (Ceylon) said that due to some urgent work, the chief delegate of Ceylon, Dr Gunaratne, regretfully had to leave Delhi earlier. He thanked the Government of India for the numerous courtesies extended, and
expressed his appreciation to the Regional Director and his staff for making the session such a success. He extended special thanks to Dr Shrivastav (India), and to Dr Ramakrishnan and Dr Modica (WHO Secretariat) for the success achieved in the technical discussions, and extended the best wishes of his Government for the continued success of WHO.

DR JOGHI (Nepal) agreeing with the sentiments expressed by the previous speakers, said that he was full of admiration for the efficient way in which the Regional Office was functioning and the spirit of co-operation among its staff. The whole credit for it, he said, went to Dr Mani. He paid glowing tributes to the personal qualities of the Regional Director and repeated his earlier recommendations that, in selecting the future Regional Director, the utmost importance should be given to the personal qualities of the incumbent. He also praised the Director of Health Services in the Regional Office for his real contribution to the organization of health programmes in the Region. He referred with appreciation to all the delegates and other representatives present and mentioned the close ties between India and Nepal, which had many common problems in the field of health. He thanked UNICEF for providing supplies and equipment for various projects in Nepal. Finally, he suggested that some sort of inter-country organization should be formed which would enable different countries in the Region to exchange information on common problems. This organization should offer an opportunity to officials of health directorates to visit the other countries in the Region and see how things were progressing there. He said that he would take this matter up with his Government on his return to Kathmandu.

DR CHITI (Thailand) said that the session had been most successful and had taken place in a spirit of great friendliness and collaboration. He expressed his appreciation to the Chairman and the Vice-Chairman for their conduct of the meetings. He paid tribute to the Regional Director and his staff for their efforts in making the conference a success and said how grateful he was to the Government of India and to people of Delhi for their warm hospitality.

DR DOLGOR (Mongolia) also thanked the Chairman for successfully conducting the meetings, which, he thought, had led to wise guidance and important discussions. He appreciated all the arrangements made during the session, referring particularly to the excellent transport facilities. He was grateful to the Government of India and especially the Prime Minister for inaugurating the session. The twentieth session of the Regional Committee would be held in Ulan Bator in 1967, and he would be looking forward to meeting the delegates again at that time. He wished the delegates bon voyage.

DR LHN WAI (Burma) also expressed appreciation to the Chairman for conducting the meetings so successfully and to the Regional Director and his staff for the arrangements made.
DR. EGGER (UNICEF) expressed his appreciation for the opportunity given to him to take part and to listen to the discussions on the Annual Report and for the keen interest evinced in the important problem of maternal and child health, as shown by the choice of the topic for the technical discussions at the next session. There should be a deeper understanding of maternal and child health and the role it could play within the basic health services. UNICEF, he said was prepared to redouble its efforts, and looked to WHO for leadership and guidance. Addressing Dr. Marsaid, Dr. Egger said that the Executive Director of UNICEF had confirmed UNICEF's willingness to resume its work in Indonesia, and he expressed the hope that this could be arranged in the very near future.

DR. McGAVRAN (Ford Foundation) thanked the meeting for the privilege of attending and of listening to the deliberations. He congratulated the Regional Director for his excellent report and the way in which the session had been organized, and said that he was greatly impressed by the scope of health activities in South-East Asia, the development and progress of health in the Region, and the leadership in health activities shown by the representatives of the different countries.

In his concluding remarks, the CHAIRMAN thanked the delegates for having elected him to preside over their deliberations and also for their contributions, which had made the discussions so fruitful. He thanked the Vice-Chairman, the Chairman of the technical discussions and the Chairmen of the various sub-committees for their leadership. He was pleased that Dr. Karefa-Smart (representative of the Director-General) had been present, and also was grateful for the participation of the representatives of other agencies and of the observers. He paid tribute to the Regional Director for his assistance in running the meetings and to the Regional Director's staff for their efficient contribution to the work of the session.

Delegates had all been most appreciative of the opportunity given to meet the President of India and were also grateful to the Prime Minister for having kindly inaugurated the session, and to the Minister of Health and Family Planning for her address during the inaugural session and for the reception held at the beginning of the session. He wished all a safe journey home.

He then declared the nineteenth session closed.