COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE NINTH MEETING

Palais des Nations, Geneva
Saturday, 18 May 1974, at 9.30 a.m.

CHAIRMAN: Professor J. TIGYI (Hungary)

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1. Detailed review of the programme and budget estimates for 1975 (continued):

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Note: Corrections to this provisional record should reach the Chief, Editorial Services, World Health Organization, 1211 Geneva 27, Switzerland, before 5 July 1974.

Family health (section 3.2) (continued)

Draft resolution on health education (A27/A/Conf.Doc. No.9 and Adds.1-4)

The CHAIRMAN asked if the Committee was prepared to approve the draft resolution on health education introduced at the eighth meeting with the amendment proposed by the delegations of New Zealand and the USSR adding a third preambular paragraph to read:

Recalling that health education of the population and the involvement of people in all health programmes is a collective responsibility of all elements of society.

Dr JAROCKIJ (Union of Soviet Socialist Republics) recalled that at the previous meeting he had requested that his delegation's name be added to the list of sponsors.

Decision: The draft resolution, as amended by the delegations of New Zealand and the USSR, was approved.

Draft resolution on health education of children and young people (A27/A/Conf.Doc. No.10 and Adds.1-3)

The CHAIRMAN asked if the Committee was prepared to approve the draft resolution introduced at the eighth meeting with the amendments proposed by the delegation of Iran, adding in the first preambular paragraph, after the word "healthy", the words "growth and", and in subparagraph (2) of the operative paragraph, after the words "health education of" the word "mothers,"

Decision: The draft resolution, as amended by the delegation of Iran, was approved.

Draft resolution on the role of WHO in bilateral or multilateral health aid programmes

Professor HALTER (Belgium) introduced the following draft resolution:

The Twenty-seventh World Health Assembly,

Considering the urgency of the needs of developing countries in regard to health promotion from the point of view of both the infrastructure and the staff required;

Noting that many countries provide bilateral or multilateral aid through special programmes in the field of health;

Believing that the wide experience acquired by WHO and the information at its disposal are such as to facilitate the establishment of useful and effective programmes, and that countries with large bilateral aid programmes could effectively use WHO in the planning and implementation of their assistance activities in health and sanitation;

Stressing that assistance in the field of health may have important repercussions over vast areas and that coordination of effort and concerted action between assisting and assisted countries could materially improve the results;

1. RECOMMENDS that Member States make use of WHO in its advisory and coordinatory capacity with regard to bilateral or multilateral aid programmes in the field of health; and

2. INVITES the Director-General to study ways in which WHO could strengthen its role in the establishment of bilateral or multilateral aid programmes and priorities and to report on the matter to the Executive Board in relation to its forthcoming organizational study on "The planning for an impact of extra-budgetary resources on WHO's programmes and policy".
He recalled that he had alluded to the matter during the discussion in plenary on the Annual Report of the Director-General, and again when the Director-General had made his positive and interesting statement on the establishment of the WHO budget level, appealing to Members to supplement the regular budget with voluntary contributions.

Many countries had bilateral or multilateral assistance programmes, and it would be interesting to try to assess their total value; in his country alone it was nearly as much as the WHO budget. Those programmes often ran into political or other difficulties which obliged governments to take steps that were not always the most reasonable or the most effective in the field of aid and collaboration. He adduced the case of a modern hospital building he had seen in a developing country; it would have been the object of envy in his own country, but all the doctors in the country in question would not have sufficed to operate it. In such cases there was an evident lack of precision in the establishment of priorities and perhaps in the direction of their financial efforts by the donor country.

He had been emboldened by such considerations and by discussions with the Director-General to suggest the measures forming the subject of the draft resolution, giving WHO the role of adviser in the elaboration of bilateral and multilateral programmes and recommending that Member States should seek such advice on programmes of assistance affecting health. The Director-General was invited to propose methods of applying such a procedure to the Executive Board and the next Health Assembly.

If the present Assembly agreed to the proposal, the Director-General, after the Executive Board had considered the matter in relation to its "Organizational study on the planning for and impact of extrabudgetary resources on WHO's programmes and policy", would submit a document as the basis on which countries could adapt their assistance policy to make the best use of the Organization's advisory role. WHO might also play an executive role in those programmes for which donor countries had not the necessary equipment for implementation of their assistance. That would ensure that the assistance was consistent in areas such as the Sahel region of Africa where health problems knew no frontiers.

Dr TOTTIE (Sweden) supported the draft resolution, but felt that countries with large bilateral aid programmes should not be the only ones to benefit. He therefore proposed the deletion of the word "large" in the third preambular paragraph.

He further proposed the insertion of the words "of the globe" after "vast areas" in the last preambular paragraph.

Dr CHITIMBA (Malawi) said that the important subject of the draft resolution touched on problems of developing countries. His delegation had no objection to WHO's acting as a leading consultative body in bilateral and multilateral assistance programmes; that was indeed the purpose for which a specialized agency was established. But it should be recognized that certain countries had eminent health consultants of their own who knew the local conditions and needs best, so that the advisory role of WHO should not be absolute; donor countries should take the advice of experts in the recipient countries as well as that of WHO experts. WHO was not, and would never be a supranational body, and must not therefore be given powers that might enable it to thwart national interests; nor was it a party to all national programmes for health, but only to those in which its assistance was requested.

The DIRECTOR-GENERAL said that the last note sounded by the delegate of Malawi, suggesting competition in expertise between WHO and its Members, made him very sad; the one message he himself had been trying to communicate during the present session was that WHO existed to serve developing and developed countries in whichever capacity they wished, and the whole purpose of his remarks in reference to a critical dialogue and the humility WHO was to show in its role had been to prevent such misunderstandings. In the past WHO had perhaps played a too aggressive advisory role.

The proposal presented by Professor Haile was in accordance with the spirit of the constitutional coordinating role of WHO. It was understood that it was not possible to replace national expertise. That was rare enough for WHO to wish, on the contrary, to facilitate its mobilization for the achievement of maximum inputs to improve health in a given country.
Member States must be confident that WHO was not trying to usurp national prerogatives; only then could progress be made in that difficult area of coordination.

Dr GUILLÉN OVALLE (Peru) said that, as his delegation understood it, the advisory role proposed for WHO was for governments to use or not as they wished, and the text of the draft resolution reflected that clearly. It was a positive initiative and his delegation wished to be associated with it as a co-sponsor.

He proposed that the advisory and coordinatory capacity of WHO should be exercised through its regional organizations, and that operative paragraph 1 of the draft resolution should be amended accordingly.

Professor ALIHONOU (Dahomey) said that it was not clear from the text of the draft resolution that countries receiving assistance could benefit from the advisory role of WHO, and expressed anxiety lest donor countries should impose the conditions of their assistance, reminding the Committee that developing countries were most in need of judicious and objective advice. With that reservation, his delegation wished to be included among the sponsors.

Dr LEKIE (Zaire) said that the draft resolution was limited to the enunciation of a principle, leaving it to the Director-General to propose specific measures for its practical application. A decision could be made at a later stage on those measures. Meanwhile, his delegation fully supported the proposal and wished to be included among the sponsors.

Dr SAMBA (Gambia) said that for a long time developing countries had been urging WHO to be aggressive in its approach to the solution of their problems, and it was only logical that countries like his own that had always wished such a role for WHO should support the draft resolution.

Dr GERRITSEN (Netherlands) supported the draft resolution and said his delegation wished to be included among the sponsors.

Dr DOLGOR (Mongolia) said that the Russian text of operative paragraph 1 should be brought into line with the English.

Dr HASSAN (Somalia) said that developing countries had been urged to treat UNDP as the coordinating authority for all external assistance. He knew that WHO representatives in countries had an advisory and coordinating capacity, and he wondered how, with country programming, the two procedures could be reconciled.

The DIRECTOR-GENERAL replied that there should be no difficulty, as WHO was moving forward together with national bodies, and was training WHO representatives to act with nationals in the ministries of health on activities in the health sector and with all other social and economic sectors within the context of country health programming.

WHO was recognized as an agency that had moved forward in the most imaginative way to accomplish such co-ordinative measures, and was prepared to play the coordinating role not only with ministries of health but also with the resident representatives of UNDP and with the ministries responsible for planning, finance and other related questions.

The Organization was engaged in studies on methods of solving various difficulties in overall co-ordination and, although it had been accused in the past of a high degree of isolationism, it had recently moved forward to the point where it was possible to consider its regular budget in its entirety in relation to any country's total development effort. Certain difficulties had to be faced, but WHO had the will and the imagination to avoid major problems.

Professor HALTER (Belgium) agreed to the deletion of the word "large" in the third preambular paragraph of the draft resolution, and with the other proposal of the delegate of Sweden.

He assured the delegate of Dahomey that the advisory and coordinatory capacity of WHO was intended as much for countries receiving as for those giving assistance in the terms of the proposal. It was intended, indeed, to give bilateral or multilateral assistance an essentially objective humanitarian character.
He welcomed the association of other delegations as co-sponsors of the draft resolution.

Dr SHRIVASTAV (India) said that the word "large" had been used deliberately in the third preambular paragraph by the authors of the draft resolution, which included his delegation; it had been felt that if WHO became involved in large numbers of small programmes it might have to expand its services, with a consequent increase in staff and costs. He was sure WHO would not deny assistance to smaller programmes, but might find it difficult to execute them. Countries should perhaps try to participate in major programmes aimed at a lasting impact on the health situation. However, in deference to the delegate of Belgium, he would not oppose the amendment.

The SECRETARY said that the proposal of the delegate of Peru could be accommodated by adding, after "capacity" in operative paragraph 1 of the draft resolution, the words "through its regional organizations".

Professor HALTER (Belgium) asked the delegate of Peru not to press that amendment, as it could be taken for granted that WHO would act through its existing machinery, which included its regional offices as well as WHO representatives and others. He thought that the Health Assembly could have confidence in the Director-General to use those channels.

Dr GUILLEN OVALLE (Peru) assured him that his Government had confidence in the Director-General, and he had proposed the amendment only because of the concern expressed at the possibility of WHO's role becoming supranational. However, he was willing to withdraw it.

Decision: The draft resolution was approved, with the amendment proposed by the delegate of Sweden to delete the word "large" in the third preambular paragraph.

Draft resolution on World Population Year and Conference, 1974 (A27/A/Conf.Doc. No.15)

The CHAIRMAN called for comments on the following draft resolution:

The Twenty-seventh World Health Assembly,
Recognizing the importance of 1974 as World Population Year and the interest expressed at this Health Assembly by many Member governments; and
Noting that during August of this year, under the auspices of the United Nations, the World Population Conference will be held in Bucharest,

1. WELCOMES the emphasis given to health and the enhancement of the quality of life in the draft World Population Plan of Action, to be considered at the World Population Conference;

2. CALLS ATTENTION to the importance of including health officials in national delegations to the World Population Conference; and

3. REQUESTS the Director-General to report to the fifty-fifth session of the Executive Board and the Twenty-eighth World Health Assembly on implications of the results of the World Population Conference and the action taken thereon by the Economic and Social Council and General Assembly of the United Nations for the work of the World Health Organization.

Dr BAHRAWI (Indonesia) said that population growth was an acute major public health problem in his country, where the inhabitants had totalled 119.2 million at the last census in 1971, compared with 97 million in 1961, 60.7 million in 1930 and 52.3 million in 1920. The rate of growth was complicated by the uneven distribution of the population, more than 60% living in Java, Madura and Bali, which totalled only 20% of the land area of Indonesia. The population density in Java was 1400 per square mile, and the population was growing at the rate of 2.5% per annum, which would make any economic development aimed at improving the people's welfare very difficult. The population pressure in Java, Madura and Bali was creating a bad socioeconomic and psychosocial environment.

The Government had since 1970 been implementing a family planning programme attached to the maternal and child health services. Experience had shown that the integrated approach yielded better results than a separate campaign in terms of the rate of acceptance among the population.
His delegation wished to be included among the sponsors of the draft resolution.

Dr PARNELL (United States of America) stressed the importance of the Declaration on Food and Population reproduced in document A27/WP/11, which emphasized that food shortage was the greatest manifestation of world poverty and that some solution to the present world food crisis must be found within the next few years. The problems of food shortage and population growth were closely related and must be discussed by the international community.

Dr HOSSAIN (Bangladesh) wished his delegation to be included among the sponsors of the draft resolution.

Dr TOTTIE (Sweden), agreeing with the delegate of the United States of America, proposed the addition of the following preambular paragraph to the draft resolution in order to amplify the connexion between food and population:

Noting the Declaration on Food and Population delivered to the Secretary-General of the United Nations on 25 April 1974.

Dr CHOWDHRY (Pakistan) welcomed the draft resolution, and particularly operative paragraph 2, because the population planning programmes in some countries were adminis-

tered by non-medical people and he felt that one reason for failure of the programmes was that they did not have the necessary medical supervision. In some countries the population had avoided the specialized clinics and had been reserved in their attitude to workers in family planning. Coordination between health personnel and other competent services would improve the chances of success of measures to control population.

He wished his delegation to be included among the sponsors.

Dr ACUÑA (Mexico) said that his delegation, a co-sponsor of the draft resolution, considered that the technical aspects of the Declaration on Food and Population were not entirely acceptable. For instance, in relation to food supplies, it was not a question of shortage of supply but of poor distribution of food. Approval of the draft resolution before the Committee would enable representatives of ministries of health to stress the relevant aspects of the problem at the World Population Conference.

With reference to the second operative paragraph of the draft resolution, he proposed the replacement of the words "health officials" by "representatives of health services".

Dr HOSSAIN (Bangladesh) agreed with the delegate of Pakistan about the effects of staffing the population programmes with non-medical personnel. Bangladesh had suffered from the same situation.

Dr HEMACHUDHA (Thailand), as one of the co-sponsors of the draft resolution emphasized the importance of the World Population Conference not excluding health from the population problem. Thus, he would support the proposal suggesting that the words "health officials" should be changed to "representatives of the health services".

Dr VALLADARES (Venezuela) proposed instead the term "public health administrators" in operative paragraph 2 of the draft resolution.

Dr ACUÑA (Mexico) and Dr HEMACHUDHA (Thailand) withdrew their amendments in favour of that proposed by the delegate of Venezuela.

The amendments proposed by the delegates of Sweden and Venezuela were accepted by the co-sponsors.

Decision: The draft resolution was approved, as amended.

Sir William REFSHAUGE (World Medical Association) drew attention to document A27/WP/15, which gave details of the forthcoming international conference on the physician and population change. The role of the physician in this connexion was of particular concern to the World Medical Association in the present period of unprecedented demographic change, with world population; at current rates of growth, doubling every 35 years. There were many factors contributing to population growth and they included the increased effectiveness of health measures. Since population growth had become one of the greatest forces in
social change, it could not be studied in isolation: action programmes must be developed in the context of the totality of activities that contributed to reinforcing the quality of life for peoples everywhere. The World Medical Association believed that the physician could have a very significant influence on those activities, in particular because of his primary role in reducing morbidity and mortality. There was a particular challenge to broaden the traditional orientation of the physician towards individual patient care and to inculcate a new awareness of, and involvement in, community health problems. That approach would require also the assistance of auxiliary health personnel as important members of the health care team. For that reason, the World Medical Association, in association with the World Federation for Medical Education, the International Planned Parenthood Federation and WHO, was sponsoring such a conference in Stockholm, immediately after the United Nations World Population Conference.

Health manpower development (section 4.1)

Dr HENRY, representative of the Executive Board, read out the text of the resolution recommended to the Twenty-seventh World Health Assembly in resolution EB53.R24. The Executive Board believed that the adoption of that resolution and the implementation of its operative paragraphs 1 and 2 would be of considerable assistance in furthering the work of WHO.

Dr PHOUTHASAK (Laos) noted with interest that there would be a consultation in Geneva on the role of medical assistants in the improvement of health services delivery; and that the Eastern Mediterranean Region would be undertaking a comparative study on the cost of training and the utilization of physicians and medical assistants. His Government would be pleased to be informed about the results of those discussions, since Laos was a country in which medical assistants were widely used. Although the training of doctors had begun, medical assistants continued to be trained for work in rural areas.

Sir John BROTHERSTON (United Kingdom of Great Britain and Northern Ireland) said that a recent innovation in the United Kingdom had been the evolution of the specialty of community medicine and its introduction into the newly integrated National Health Service. The first initiative had been the establishment of a Faculty, or College, of Community Medicine that brought together the public health specialists, academics, and medical administrators who had become increasingly separated from each other. The reorganization of the National Health Service involved the disappearance of separate public health authorities and medical officers of health under city and county government. Under each of the new health authorities there would be teams of specialists in community medicine, with a chief medical officer as leader, which would function as the main health service planners and epidemiologists for their areas and would work closely with their clinical colleagues to assist in the integration of clinical services. The community medicine specialists would be appointed and paid on the same basis as clinical specialists in the National Health Service. This would lead to more stringent standards of training and appointment but would also improve the financial and career opportunities as compared with other medical careers. The responsibilities of the new specialty were most important for the new integrated service, but recent experience in recruitment had shown that candidates did not always match the challenge of the new responsibilities. The Faculty of Community Medicine and the National Health Service were currently busy with plans and programmes for training, recruitment and examinations for the new specialty.

Dr BRAGA (Brazil) expressed his satisfaction at the increasing importance being given both by headquarters and the regional offices to the fundamental issue of providing assistance to Member countries in developing the manpower required for the improvement and expansion of their health services. Nearly all the projects in the programme and budget for 1975 included an element of education and training, and the concept of health manpower development was present throughout the long-term programmes of WHO. Although in many countries the training of health workers was still carried out in isolation from the country's health system, he was confident that the efforts of the Organization towards interrelating training schemes with health systems would be completely successful in the not too distant future. In his view, there should be established in every country a
permanent mechanism for coordinating this interrelationship through continuing surveillance of the health manpower situation. The success of any health plan entirely depended on how well everything connected with the manpower component—demand, projections, preparation and proper utilization of the health labour force—was not only worked out but also implemented. WHO had an essential role to play in this connexion.

Professor PACCAGNELLA (Italy) said that in the last few decades the field of public health had changed very rapidly, and it was well known that there were difficulties in retraining medical personnel to meet the new needs of the health services. In that respect mention had been made of psychological barriers: he thought there were also cultural barriers.

His delegation considered that the projects in medical education and training, and medical pedagogy proposed in the programme for 1974 under the programme for health manpower development were in fact fundamental to that other aspect of the programme—the strengthening and the planning of health services. By such projects, WHO could stimulate university medical schools, in countries where the universities were the responsibility of the ministry of education, to adapt their curricula. There was already evidence that WHO's activities in that connexion were producing their effect, even in his own country.

Dr KUPFERSCHMIDT (German Democratic Republic) gave three examples of ways in which his country had tried to overcome gaps in health manpower. First, it had introduced a five-year period of compulsory specialization after graduation from medical school for all medical graduates, including the specialty of general practice; the period ended with an examination. Second, a central academy of postgraduate training for physicians had been established in Berlin, and had delegated some of its functions to teaching hospitals. Third, his Government had passed new legislation improving the social status of nurses, midwives, and medical assistants by giving them special training in medical colleges.

Dr HOSSAIN (Bangladesh) said that members of the medical professions in countries that had been members of the British Commonwealth were grateful to the late Aneurin Bevan, who introduced the National Health Service in the United Kingdom, which they were thus able to study. In his experience it had hitherto been a curative-oriented health service and he was pleased to note that, with the new integration of the health services, the preventive aspect was being emphasized.

In developing countries such as Bangladesh, the health manpower development was the most challenging task encountered: no amount of planning would be effective unless proper leadership was available throughout the service. Leaders at the political level and professors and specialists should be able to talk to the basic health workers in the same language. There were two types of parasite in the medical profession—the top specialist or professor who did not share their knowledge with the basic health worker, and the busy practitioner who was interested only in earning more money. He thought that members of the medical profession, if they were to become a real asset to society, should have a broader education that should include sociology, psychology, and philosophy.

Dr SHRIVASTAV (India) said that a medical education commission was being established in India, following a strike by junior doctors. Increasing importance was being given to medical education in the developing countries, and to the question of what the students were actually being trained for. In India, the majority of medical colleges seemed to be training doctors who did not know enough about the rural areas or the problems of the primary health centres, and who were more suited for work in countries other than their own. There was of course, a "brain drain", and a large number of doctors were going to the United Kingdom, to the Americas, and to certain countries in Africa. A number of changes had been proposed by medical educationists, but their implementation was still awaited.

Regarding multipurpose health workers, there was no doubt that auxiliary personnel could be used effectively in certain health programmes in areas where the incidence of communicable diseases had declined. A programme of in-service training was being established at six or seven centres in India to provide, for example, three-month orientation courses for malaria workers, so as to enable them to deal with other communicable
diseases, with family planning, and with nutrition. The aim was to train enough auxiliary personnel to achieve the ratio of one to every 5000 of the population. At a conference recently held on the subject in India, it had been repeatedly stressed that it was very difficult to change people's attitudes, and that training must be provided by those who themselves were adequately trained in the philosophy of integration and multipurpose work.

Closer study was required of the whole subject of adapting the training of auxiliary health workers in the developing countries to meet actual needs. He suggested that regional conferences and meetings might be held - for example, in the African, South-East Asia, and Western Pacific Regions - to bring together people with experience in this field, in order to draw up suitable curricula and a plan of operation.

Professor LEOWSKI (Poland) said it had become apparent during past years that, to meet health needs satisfactorily, an integrated approach to training was required that would cover psychological and social problems and not merely physical health and well-being. During the Technical Discussions at the present Health Assembly, an attempt had been made to list the main relevant factors, and it had been the general opinion that the physician alone was - or very soon would be - unable to solve the numerous problems. The need for a team approach to health manpower development had been stressed in many countries and also during the Technical Discussions at the last Health Assembly. He asked what steps WHO was taking in that direction.

Dr CHOWDHRY (Pakistan) referred to the vicious circle in developing countries: on the one hand the problems of disease, population increase, malnutrition and limited resources and, on the other, the lack of manpower to deal with the situation. Despite the emphasis on training, manpower remained insufficient. In Pakistan, for instance, the doctor/population ratio was about 1:9000. Quite apart from the "brain drain", there was the problem that most trained workers tended to stay in the urban areas. In Pakistan, where more than 80% of the population lived in rural areas, incentives were being provided to induce health workers to stay in rural areas. However, the problem remained serious, and efforts were now being made to provide short-term training for auxiliary personnel to work in those areas.

The training of doctors should include more emphasis on the preventive aspects of medicine, so as to better suit them for work in rural areas.

Dr CHITIMBA (Malawi) said that countries like Malawi, suffering from an acute shortage of health personnel, could not afford to ignore the large number of workers practising traditional medicine and midwifery. He therefore welcomed the call for action to improve their methods and restrain them from harmful activities. However, he did not believe that a poor health worker was necessarily better than no health worker at all. While endorsing the philosophy behind the encouragement to countries to improve the activities of traditional health workers, he therefore wished to sound a note of caution. The emphasis should be on the improvement of those practices, and there should be no room for WHO pronouncements on the matter to be interpreted as a licence for wholesale acceptance of traditional medicine and midwifery. Perhaps the whole issue might be studied by the regional committees.

Dr UPADHYA (Nepal) was pleased to note WHO's emphasis on the training of multipurpose health workers as a means of enabling governments to develop a basic health infrastructure.

Even where medical education was said to be community-oriented, experience in most developing countries had shown that medical graduates were reluctant to go and work in the community. Perhaps WHO could study the problem and make suggestions to the governments of developing countries in that respect. It might be that real incentives were still lacking.

With the cooperation of WHO, Nepal was concentrating on training various categories of auxiliary personnel in order to be in a position to provide basic health care to the whole population.

The "brain drain" was a problem that was not confined to the developing countries: it also affected some of the developed countries. If the present trend continued, governments would have to rely entirely on auxiliary workers and would be unable to develop their hospital services effectively. WHO should study the various causes of the whole problem.
Dr SHAHRIARI (Iran) said that there had been considerable changes in recent years in the health programme in his country, in line with the various rapid changes that were taking place there: a population growth of 3.2% per year, rapid industrialization, and the modernization and reorganization of rural areas. With the assistance of the Health and Literacy Corps, educational programmes had been carried out in the rural areas, where a large proportion of the total population lived. As a result, there was a new awareness among the rural population of the importance of public health services and medical care - and the demand for health care was correspondingly increasing. However, the shortage of medical manpower constituted a serious obstacle to the development of effective health services in the rural areas. About half of the 600 physicians who graduated each year left Iran. The present educational system in the medical schools and other health institutions was not suitable for training community-orientated health workers. The problem would soon become universal, and a new approach would be required on the part of governments and of WHO as regards (1) the training of middle-level and auxiliary personnel to compensate for the shortage of physicians and other university-level personnel, and (2) the revision of the curricula for all health professions so that the training was truly adapted to the needs of the countries concerned.

Dr BAHRAWI (Indonesia) said that the health manpower problem in Indonesia was one of quality as well as quantity. There was a lack of health workers who understood the needs and demands of the community in which they were working. At the moment, medical and paramedical workers trained in a hospital environment waited for the sick to ask for help. He supported the proposal of the delegate of India that the problem should be approached at regional level, so that a more aggressive plan for health manpower development could be drawn up, coordinated and implemented.

Dr TOUA (Papua New Guinea) said that political developments in Papua New Guinea had created a particularly acute health manpower problem, in that experienced workers were leaving the country. Attempts were being made to overcome the problem by training auxiliaries and by fostering the team approach, to which the delegate of Poland had referred. With regard to that approach, however, certain difficulties had arisen, and he stressed the need for closer cooperation between the universities and the various sections of the health services, as well as between the different categories of health workers.

Dr VIOLAKI (Greece) said that the particular difficulty in Greece - where the number of physicians was high and the doctor/population ratio was 1:550 - was to attract medical people to take training in public health. She asked how WHO was dealing with that problem.

Dr LARREA (Ecuador) said that, despite the fact that the universities of Ecuador were training large numbers of professional health workers, the latter were still far from sufficient to meet the country's health needs. At the moment some 2300 doctors served a population of six-and-a-half million. Moreover, the distribution of health workers throughout the country was very uneven: most of them were concentrated in the urban areas, whereas 60% of the population lived in rural areas. The universities were trying to adapt training programmes to bring them more into line with the country's needs; in particular, in the past insufficient attention had been given to the preventive aspects of medicine.

There was also a lack of auxiliary personnel, and in that connexion the Ministry of Health was drawing up a programme, in cooperation with the universities, that would provide six-month courses for the training of auxiliaries.

Ecuador, like other countries in the Americas, had started to train a new type of auxiliary health personnel, who carried out simple health tasks in population groups of less than 1500. Professional health workers leaving the universities were required to work for one year in rural areas; before going there they received a basic orientation in health problems, but it was not sufficient to equip them fully for work in rural areas. More emphasis needed to be laid on the training of auxiliary personnel in Ecuador if it was ever to have valid health teams.
Dr SUAREZ (Bolivia) expressed appreciation to WHO for the assistance provided to Bolivia in the training of health personnel, in particular with regard to national courses and in-service training for hospital administrators, environmental health staff and auxiliary nurses for rural areas. He hoped that the Organization would continue to provide such assistance.

He would also thank Belgium, France and other countries that had provided bilateral assistance for training programmes.

Dr FÜLÖP, Director, Health Manpower Development, thanked the Committee for the encouraging comments that had been made during the discussion.

The delegate of India had stressed the need to adapt training to local needs and demands. In accordance with the Director-General's slogan in his introductory statement regarding the need to adapt and not adopt, WHO was carrying out a programme aimed at assisting Member States to train teachers who could teach their students to serve the community more competently, taking account of local needs. In that connexion, the Organization fully shared the view of the delegate of Italy - namely, that the ultimate aim of health manpower development was the strengthening of health services.

Many delegates had asked that WHO should intensify its programme for the training of auxiliary personnel; that was very much in line with the Organization's own thinking, and an interdivisional programme team had recently been established. The aim was to produce feasible proposals that would assist Member States that were finding difficulty with coverage of their rural population to train first-line health workers (who would be able to cope with the basic needs in rural areas), and also supervisors (who, in addition to their supervisory function, would provide continuing education and consultation). Those proposals would be finalized before the end of 1974.

The "team approach", mentioned by the delegate of Poland, was constantly kept in mind by the Organization. At its fifty-third session the Executive Board had considered the report of the Expert Committee on Continuing Education for Physicians¹ and had adopted a resolution on the subject. He drew attention to section 5 of that report (Interprofessional education programmes) and, in particular, to the following introductory sentences:

"This section is concerned with educational activities provided for mixed teams of health care workers as distinct from those directed toward particular professions on their own. Interprofessional education should not replace programmes for individual health professions, but should offer a new opportunity for members of health care teams to learn together how to solve problems in which all have a common interest."

In the mid-1960's, when the Government of Cameroon had asked for assistance in developing a medical school, it had been suggested that a university centre for health sciences should be developed, where the different health workers would be trained together as a team. That proposal had been accepted, and the centre was now functioning. The same suggestion had been made on a number of occasions subsequently. However, it was true that much remained to be done in this field, both to convince governments and teachers to accept the idea and, in the theoretical field, to work out in detail how the approach could best be implemented.

The delegate of Greece had referred to training in public health. He would draw his attention to the recently published report of the Expert Committee on Postgraduate Education and Training in Public Health.² It attempted to summarize the situation on the basis of the various experiences, including the particular aspect described by the delegate of the United Kingdom.

Regarding the problem of the "brain drain", a comprehensive study on migration was planned by WHO and was due to start during the next few weeks. The aim was to provide

alternative intervention strategies for use by governments wishing to tackle the problem more aggressively.

The delegate of Brazil had stressed the need for a permanent mechanism in every country to coordinate health manpower development. WHO was about to draw up a proposal regarding the establishment in Member States of manpower development centres that would deal with the whole process of health manpower development from the planning to the final "production" stage, carry out a monitoring of the "product", and feed back the results into the system.

He assured the delegate of Laos, who had requested the dissemination of reports of two consultations to be held in 1975 (on the role of medical assistants, and on a comparative study on the cost of training), that WHO would do everything possible to meet that request.

Dr SUMPAICO (Philippines) said that the Philippines, like many other countries, was faced with the problem of lack of health manpower, particularly in rural areas. The Government had accordingly decided to require new graduates to serve in rural areas for a certain period (six months for doctors and four months for nurses), working either in the public health services or in hospitals.

Dr TARIMO (United Republic of Tanzania) said that consideration should be given to the possibility of reducing the period of training of both auxiliary and professional health workers. Steps had already been taken in that connexion in Tanzania with regard to auxiliary personnel.

Decision: The draft resolution proposed by the Executive Board in resolution EB53.R24 was approved.

The meeting rose at 12.30 p.m.