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THIRTY-FIRST WORLD HEALTH ASSEMBLY

COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE NINTH MEETING

Palais des Nations, Geneva
Thursday, 18 May 1978, at 14h30

CHAIRMAN: Dr N. N. MASHALABA (Botswana)

CONTENTS

		Page
1.	Medium-term programme for health manpower development (continued)	2
2.	Procedures for introducing changes into the Sixth General Programme of Work Covering a Specific Period (1978-1983 inclusive)	12

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NINTH MEETING

Thursday, 18 May 1978, at 14h30

Chairman: Dr N. N. MASHALABA (Botswana)

1. MEDIUM-TERM PROGRAMME FOR HEALTH MANPOWER DEVELOPMENT: Item 2.6.7 of the Agenda (Resolutions WHA29.72 and EB61.R27; Official Records No. 246; Document A31/18) (continued)

Mrs BRUGGEMANN, Secretary, drew the attention of the Committee to the draft resolution proposed by the delegations of Australia, Belgium, Italy, Jamaica and Spain, which read:

> The Thirty-first World Health Assembly,
> Having noted the Director-General's report on the medium-term programme for health manpower development and resolution EB61.R27,
>
> 1. CONGRATULATES the Director-General on the preparation of the first medium-term programme in one of the major programme areas of the Organization;
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> 2. URGES that this programme be carried out as rapidly as possible;
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> 3. INVITES Member States to consider close cooperation with WHO with a view to making as rational a use as possible of already existing health manpower;
>
> 4. REQUESTS the Director-General to report periodically to the Executive Board and the World Health Assembly on the progress made in WHO and the Member States.

In the process of translating that draft resolution, a number of minor editorial changes had been made, notably the addition of the words "of the Organization" to the first operative paragraph. If any of the changes were not acceptable to the originators of the draft resolution, they could be re-examined when the text was considered by the Committee.

Dr MICHELSEN (Colombia) said that the Director-General's report was excellent in both practical and theoretical terms. His country had a programme similar to that described in the report, and it had yielded very good results so far. Colombia had a good infrastructure for health manpower planning, thanks to continuous programming supported by administrative processes and in accordance with the national health programme. At the end of 1977, his Government had set up a national council for human resources for health, composed of members of the ministries of education and health, and of others entrusted with coordinating and recasting educational strategies in the health field. Statutes for health personnel, covering such important components as stability and incentives, were in full operation. Various institutions provided training in health administration at all levels. The curricula of medical faculties were being redesigned, and efforts were being made to train more nurses, since the greatest gap in health personnel was in nursing. Thus Colombia was on the right road as far as health personnel was concerned. He supported the WHO medium-term programme for health manpower development described in the report and hoped for the full cooperation of WHO in providing his country with full health coverage. He also supported the draft resolution before the Committee.

Dr ČAMOV (Bulgaria) noted that changes had been made in WHO's health manpower development programme in accordance with resolution WHA29.72 and in line with the Organization's new policy, with its emphasis on technical cooperation. His delegation fully supported the programme, which was well thought out and realistic, and also approved the Board's resolution EB61.R27 on the subject.

New medical schools had been established in a number of countries, with a view to overcoming the shortage of trained national medical personnel. WHO had an important role to play in that connexion, by helping to establish training programmes based on the real medical needs of the people. It was a sphere in which the Organization had acquired considerable experience and provided most valuable assistance.

WHO had also achieved striking success with regard to the training of teachers of medical and health personnel. The fact that eight regional teacher training centres were now operating

in five regions indicated that WHO was working along the right lines; the activities of those centres certainly greatly helped national efforts in that field.

Several previous speakers had referred to the longstanding problem of the international migration of health personnel from developing countries; it was a difficult problem, which might possibly be solved at the international level, with the help of WHO. The Organization had now completed the first stage of the study on the causes and extent of the problem, and the various factors involved. The results should be published as soon as possible, so that WHO might proceed to the second stage: to find ways of stopping the "brain drain". It was true that considerable national efforts were required, but WHO, as an intergovernmental organization, could play a vital role.

Dr SAMBA (Gambia) noted with satisfaction that WHO considered health manpower development to be sufficiently important to include it among the major programme areas of the Organization. The Director-General's report was stimulating and comprehensive. In most cases, health manpower management lay in the hands of politicians and lay administrators. There was an unfortunate tendency towards an antiprofessional phenomenon in newly independent countries, and the medical profession had been singled out for special treatment in that respect. In many developing countries, health was accorded a low status in national socioeconomic plans. The results were a low budgetary allocation to health; erosion of the status of health workers at all levels; unattractive working conditions for health personnel, especially in rural areas; poor career prospects; and lack of job satisfaction. Unless that trend were halted or indeed reversed, no amount of planning and programming would achieve the desired result, and the brain drain would continue. He therefore requested the Director-General to intensify his efforts to improve the status of workers in the national health service. He supported the draft resolution.

Professor ORHA (Romania) said that many of the activities foreseen in the WHO programme were already taking place in his country, though some of the subjects and priorities mentioned in the document were not directly relevant to the situation in Romania. In his country, there were national socioeconomic development programmes and health development was a part of national planning, as proposed in the document. Health service activities and manpower were intrinsically linked with the objectives of health policy, according to the country's needs and resources. Efforts aimed at improving training programmes and continuing education had followed the creation, in 1971, of a national system of advanced professional training, covering all sectors including health.

WHO should adopt a systematic approach towards the improvement of training programmes, and give direct or indirect assistance to interested countries. The activities foreseen by WHO in educational planning and processes needed to be further developed by the creation of education centres for health personnel, the organization of meetings of specialists, and the dissemination of documents on educational studies. WHO should play a more active role in overcoming the difficulties in effecting changes from traditional educational methods in the European Region. In addition to training, modern methods of educational planning should be formulated and applied, involving students so as to achieve a change in attitudes towards health training establishments.

He expressed satisfaction that the WHO medium-term programme paid due attention to better coordination between the development of health services and the various categories of health personnel; health management training; methods of organizing and administering research in health manpower development; training of specialists in public health; a study of factors resulting in more economical use of qualified personnel; fellowships; and the development of learning materials. Romania trained many students and physicians from developing countries, and the teaching process required specific activities in which WHO would cooperate. Those activities aimed at better adaptation of training programmes to the needs of the countries concerned, the preparation of teachers to meet the new needs of the programmes, and the provision of audiovisual equipment for teaching tropical medicine.

In view of the complexity and diversity of health manpower development in different countries, emphasis should be laid on the development of a WHO network to provide scientific and technological information and to share experience and documentation. It was to be hoped that the suggestions made by Member States would enable the medium-term programme of WHO to become even better adapted to ever-changing health needs, so as to ensure its success.

He supported resolution EB61.R27 and wished his delegation to be included among the cosponsors of the draft resolution before the Committee.

Professor WOJTCZAK (Poland) said that the Director-General's report rightly laid stress on the training of health professionals, who were needed for the successful implementation of other WHO programmes. The education of health personnel should be closely interrelated with the organization of health services and should be an integral part of the health care delivery system in order to meet the changing health needs and demands of the community. The programming of medical education could therefore not be left to medical schools alone. Although it was difficult to break the centuries-old tradition of autonomy of the medical schools and universities, it was crucial to do so for the successful implementation of the WHO programme for health manpower development. Experience in Poland had shown that it was more easily accomplished by placing the full responsibility for health manpower development, at both undergraduate and postgraduate levels, in the hands of the Ministry of Health. That also allowed the professional profiles of health personnel to be better adapted to health needs and the organization of health services. A further advantage of the approach was that it made the training of health personnel more effective and less expensive. He therefore urged that particular stress be laid on manpower planning and management (Programme Area A, of the Annex to the report), which should be continuously improved and evaluated. Special attention should also be paid to the education and training of health personnel for primary health care - an area that required multinational action with WHO playing a leading part. He stressed the importance of continuous postgraduate education of medical personnel as a centrally planned and managed process fully integrated with the health services.

The undesirable tendency towards overspecialization was due to the increasing body of medical knowledge and technology, and did not correspond to the real health needs of the population. It was gratifying that a trend towards a more comprehensive approach in medical specialization, taking into account not only professional ambitions but also the need to meet the health needs of society, was growing in various countries including his own. That approach was based on the principles that health personnel were trained for the complex task of promoting physical, mental, and social health, and that such training should be coordinated according to health needs, with particular attention to primary health care.

The problems that he had mentioned deserved an important place in the WHO medium-term programme, since they were relevant to developed and developing countries alike. He emphasized the significance of research into the amount of manpower with a view to obtaining a proper "mix" of the various categories, and the importance of conditions of employment, including educational and training levels, specialization, management, and the team approach to health care delivery. Such research programmes were beyond the scientific potential of any individual country, and required international cooperation and coordination by WHO.

He asked what the Secretariat considered to be the most important practical steps in the complete reorientation of the health manpower development programme. His delegation supported the proposed programme and pledged the active help of Poland in its implementation. It also wished to be included among the cosponsors of the draft resolution.

Dr TABA (Regional Director for the Eastern Mediterranean) was gratified to see the high priority allotted to the programme by delegations and countries. WHO, in collaboration with governments, was playing an active role as regards the training of all categories of health manpower and the sensitization of governments to the need for reorientation. Governments, in that context, did not mean only the health authorities, but also the educational authorities. WHO could play a role in making the latter realize the need for reorientation of the whole question of training, whether at medical schools or at other institutions concerned with education of health personnel. Coordination between the health services and educational authorities in that matter was very important. WHO had recently sponsored a ministerial consultation in Teheran, in collaboration with the Government of Iran, which had been attended by the ministers of health and of education, and by the deans of medical faculties. Interesting exchanges of views had taken place, especially as the group had been able to discuss the problems of production and consumption quite freely.

The Eastern Mediterranean Region had been one of the first to sponsor the medium-term programme for health manpower development and to put it into operation, because of its importance to the Region. In the programme up to 1983, an effort had been made to state objectives as clearly as possible so that the programme could be monitored, evaluated, and adjusted as required. In the Eastern Mediterranean Region, and probably in other regions, the whole approach and curricula of medical schools needed to be reoriented with special emphasis on public health teaching and community health. Four regions of WHO (Africa,

Eastern Mediterranean, South-East Asia, and Western Pacific) had for years been holding biennial interregional meetings in which all those teaching public health participated under WHO sponsorship and exchanged views on the introduction of more community health in the curricula of medical schools.

The migration of doctors, or brain drain, which had been mentioned many times, was a complex problem that could not be solved by any one approach. However, if postgraduate education in countries and regions could be strengthened, there would be less need for doctors to go abroad for specialization. Nursing services and training had not been advancing at the same rate as medical education and related areas, and that whole question, including the role of the nurse in the health team, required much more attention. Teacher training was another important field, since most teachers, while they may be eminent in their fields, were not necessarily good teachers. The teacher training centres that existed in all the regions were extremely active, and in his region more than one thousand teachers at all levels of the health professions had been trained exposed to medical pedagogy. He drew attention to the regional directories of training institutions - not only WHO collaborating centres of WHO and centres of excellence - that were potentially suitable for training people from neighbouring countries. There was also a World Directory of Medical Schools in which all such regional institutions were to be included. The development of information services on health manpower was extremely important and useful.

Dr ACUÑA (Regional Director for the Americas) said that the problem of the development of human resources had long existed in the Americas and had been approached in various ways. Within the past 10 years two Latin American Centres of Educational Technology (CLATE) had been set up, one in Rio de Janeiro and the other one in Mexico, by groups of countries that, individually, could not have afforded such a luxury. The former had concentrated its activities on the production of teaching materials for the instructors of auxiliary and medium-level personnel, and the latter had focused particularly on the training of teachers in the health sciences. Attempts to associate the educational and health sectors had often failed in the past because the health sector had immediate needs, and, by the time the curricula of educational institutions had reached a certain stage, health plans and programmes had changed radically. Such had been the case with primary health care and the extension of coverage, which demanded rapid and energetic action to train staff at all levels. The Latin American educational technology centres, in turn, were supported by a series of national centres established in most countries of the Americas, which dealt both with teaching materials and the training of teachers in modern educational techniques. The national centres, with the support of the Latin American centres, had set up in certain countries a network of centres in each university or institute of higher education. The system had made it possible to meet the ever increasing needs of the countries of the Region. Compared with some other regions, the Americas had a high doctor : population ratio, but there was an immense need for medium-level and auxiliary health personnel and at least twelve countries had embarked on national programmes of increased coverage with primary health care. The medium-term programme under discussion had been referred to the governments of the Americas, and the Regional Committee had approved, by means of a resolution, the part relating to the region. It was to be hoped that that would be only the beginning in a continuous process of consultations between governments and the Organization, so that the medium-term programme for health manpower development might be an example of an active programme adapted to the constant variations and increasing needs of countries.

Dr FERNANDO (Sri Lanka) said that his country, with the active help of the Regional Office for South-East Asia, had carried out a health manpower study five years earlier. As a result, projections had been made and a medium-term programme had been drawn up, with three alternative routes of development of manpower. Unfortunately, especially as far as doctors were concerned, even the lowest target had not been fulfilled. In the public sector, Sri Lanka had a cadre of 2368 medical officers, which had not been increased for 10 years because it had not been possible to fill all the posts. The manpower study and its projections had made no difference to the doctor shortage in Sri Lanka because certain factors had not been taken into account, notably the large numbers of doctors leaving the service for various reasons. A similar shortage existed in the private sector. The situation was paradoxical, since there had been no shortage of doctors in 1969 - indeed there had been a surplus. As a part of medical manpower development, it had been decided at that stage to stop the training of assistant medical practitioners, since there were enough doctors to provide health care for the population. The

programme of training of assistant practitioners and doctors had since been resumed. Two more medical schools were planned, and it was hoped that a number of new doctors would have qualified in five years. However, at that stage, if there was no longer a shortage of doctors, the manpower plan would again go wrong, possibly resulting in another excess of doctors. The delegate from New Zealand had also mentioned the problems caused by overtraining. Thus no manpower planning could be undertaken without taking that important factor into account. He asked for guidance from the Secretariat on how the factor could be incorporated into the mechanism of manpower development.

The Sri Lankan delegation supported the draft resolution before the Committee.

Dr MUZIRA (Uganda) welcomed the emphasis placed in the medium-term programme on the health needs of the entire population rather than the satisfaction of a few professionals whose training had been mainly hospital- and disease-oriented and who were for the most part resistant to change.

Health teams should be trained under the conditions of the area where the members of the team would eventually work. The training of field personnel had started in 1967 at Makerere and targets and funds for health manpower development were provided under Uganda's third development plan (1971-1976), in which the emphasis was on serving the rural population. Because their resistance to change could make for difficulties in the programme, it was necessary to train the conventional types of health personnel first before primary health care workers. That phenomenon had been seen in Uganda where paediatricians had not approved the training of the nutrition scouts who had successfully shown that monovalent primary health care workers could play a very useful part in the prevention of malnutrition, at a fraction of the cost.

He paid tribute to the very useful role that the WHO regional teacher training centre was playing in the training of tutors for nurses, midwives and other paramedical personnel, which had begun in 1972 in Uganda. Those categories of personnel, as well as physicians, should be trained in management and administration; and care had been taken to see to that. His Government was aware of the importance of ensuring optimum utilization of health personnel and orienting them to meeting the needs of the majority, and had formed a special committee to review all training programmes from that point of view.

His delegation deplored the absence from the medium-term programme of any mention of ways of reducing the undesirable migration of health manpower.

He had noted with great appreciation the efforts made to develop the medium-term programme and could fully endorse the draft resolution.

Dr KLIVAROVÁ (Czechoslovakia) considered that the programme under review constituted a successful response to resolutions WHA24.59 and WHA29.72 on the training of health personnel and a step towards the implementation of the Sixth General Programme of Work, while being fully consonant with the requirements of resolution WHA29.48 on the reorientation of the programme budget. Noting that it constituted the first attempt to elaborate a concrete and comprehensive programme of activities to be undertaken by WHO at both headquarters and regional office levels, and in cooperation with Member States, she welcomed the emphasis laid on the need to train workers within the health systems they were to staff.

The purpose of the programme was twofold: to support the development of the health manpower required to meet the needs of the whole population, trained to work in teams, on the basis of a coherent, unified plan for the training and national utilization of all health personnel; and to support the rational development and use of all effective methods and available resources in the basic training and further education of health personnel.

Commenting on the 11 interrelated global targets and the tables indicating the tasks of headquarters and the regional offices, in cooperation with Member States, she expressed approval of the main objectives of the programme, which corresponded to those of her own country's training activities. She offered the cooperation of institutions in her country in the global and European aspects of the programme. That cooperation was offered particularly for the development of mechanisms for integrating health service and manpower development (programme area A), for the promotion of national training of all types of personnel, particularly primary health care workers (programme area B), and for the development of effective methods of teacher training (programme area C). She endorsed Dr Tatočenko's suggestion that the Organization compile a data bank of curricula.

Her country had so far participated actively in the Organization's health manpower development programme and hoped to continue doing so.

Mr IMO (Samoa) expressed his satisfaction with the format of the medium-term programme, which covered the health manpower requirement in any one country; the development and application of relevant processes for basic and continuing education; the targets, activities and advantages of medium-term health manpower development planning, and the role of WHO in cooperation with Member States. The translation of the plan into action would be welcome and timely for every country reviewing its health manpower development situation.

While expressing his support for resolution EB61.R27, he pointed out that countries, like his own, following the guidelines would need to show flexibility in tailoring them to their own special needs.

Concluding, he wished to ask whether the medium-term programme was not a part of the Sixth General Programme of Work and to associate himself with the other delegations in supporting the draft resolution.

Professor DOĞRAMACI (Turkey) said that judging from his experience of a comprehensive and elaborate plan for bringing health care to all the people, which had started some 15 years previously and was expected to achieve its aims in another seven or eight years, the main problem was number and kind of manpower.

Whenever manpower development was discussed, the need for reform in teaching methods and training programmes, and for the modernization of curricula was emphasized. It was recognized that the teaching systems in use in developed countries, which often did not meet even their needs, should not be applied elsewhere, and that new systems were needed to meet the needs of different societies. But so far little had been achieved, owing to three main obstacles.

The first was the lack of cooperation between training institutions, particularly those in the universities, with the health administration and its services. The second was the attitude of the teachers who had to be taught to modify their teaching systems and widen their interests to include the more general tasks of primary health care. Certain WHO activities were to be warmly commended from that point of view. He had in mind the activities mentioned by the delegate of the United Kingdom and the Regional Director for the Eastern Mediterranean: the regional ministerial consultation in Teheran, which had been attended by leading personnel from the ministries of health and of education and from the universities, and similar meetings organized in the European Region, as well as the conference to be held in October 1978 in Budapest. The third obstacle to progress was the lack of practical models of methods, systems, programmes and syllabuses to be used in schools of medicine, nursing and health care in place of the time-honoured but now inappropriate models. He suggested that WHO should prepare a large spectrum of such models for use in institutions training health workers of all levels.

His delegation supported the draft resolution and wished to be included among the cosponsors.

Dr JOSHI (Nepal) said that his country was in many respects, including health manpower development among the least developed among the developing countries.

With its 400 or so physicians, oriented to work in towns and hospitals, Nepal had experienced the difficulties of providing coverage for rural areas, especially as it produced no physicians of its own, all of them being trained in China, Bangladesh, India, Pakistan or USSR. Even when the physicians were posted to outlying areas they would find pretexts to return, particularly to the Kathmandu valley where half the total number of physicians served less than 5% of the population.

In future, Nepal would therefore be relying largely on village health volunteers and village health workers who collected information about communicable diseases, vital statistics, tracing defaulters and distributing drugs in the village panchayats. In addition there were health posts, staffed by auxiliary health workers and assistant nurse/midwives under the supervision of a health assistant who had undergone two-and-a-half years' medical training after high school.

A seminar on the community physician that had been held in Nepal and another, on the regional medium-term programme, in New Delhi had provided opportunities for several meetings between the personnel from ministries of education and health and from university institutes of medicine, as a result of which a course for community health physicians was to start in Nepal in July 1978. The four-year course, with its specially designed curriculum, would produce physicians specifically to meet local needs. Only health assistants who had already graduated and served in the community for at least one year would be admitted to the course which would not lead to a degree.

His delegation considered that resolution EB61.R27 pointed out the right direction to take and endorsed the draft resolution which it would like to cosponsor.

Dr MARKIDES (Cyprus) considered that the main objective of countries such as his own should be to train a new public health minded type of worker to staff the primary health care system.

In the case of Cyprus, there were a number of constraints. Cyprus was a small newly independent developing country and it had many of the same political, social and economic problems as others in that situation. As yet there were no health training institutions, except a school for nurses and public health inspectors. All the country's medical practitioners were trained abroad in almost all countries of Europe - though places for medical students were becoming more and more difficult to find - and it was impossible to control their total number, the number trained in each specialty, or their educational achievements. Consequently there were, for example, too many practitioners in the lucrative and prestige subjects of internal medicine and surgery and too few general practitioners, public health physicians, public health nurses, and so on.

Another drawback of training abroad was that studies were directed to work in the host country, and were often disease and hospital oriented rather than adapted to work in the country of origin. In addition, there was no uniformity in the academic attainment owing to the curriculum differences between foreign schools, sometimes even when the degree was the same. Lack of textbooks and educational materials could also be a problem, where schools existed.

In that situation, his delegation strongly supported the draft resolution in the hope that, in bilateral and multilateral cooperation with the developed countries, the country's problems could be solved.

Dr HOULD (Canada) said that, in his country's experience, it was preferable to substitute new categories of personnel for old, rather than attempt to add a new category to those in existence, thus promoting a proliferation of professional staff that would not contribute in lowering the costs of medical care.

Another Canadian experience was that the efforts to help other countries through technical and financial cooperation in health manpower development could, paradoxically, harm them by drawing off their potential health professionals, who often failed to return to their countries after training. Again, although his country practised a policy of zero-growth for physicians, 2000 applications were received annually from foreign doctors. To diminish the migration of qualified health personnel, who were more useful in their countries of origin than in his own, Canada would wish to have close cooperation with those countries, for that specific purpose. Resolution WHA29.72 requested the Director-General "to collaborate with Member States... in the development of measures to control undesirable migration of health manpower". It was up to WHO to find ways and means of doing more in that line. Such possibilities should be explored as contracts with individuals requiring them to return, or the award of qualifications not carrying with them or opening up the right to practise in the host country.

In conclusion he expressed his support for resoltuion EB61.R27 and his wish to join in cosponsoring the draft resolution.

Professor DE CARVALHO SAMPAIO (Portugal) said that health manpower development was the key to success in the achievement of the Organization's objective of health for all by the year 2000, and as such was perhaps the most important subject before the current Health Assembly.

He fully agreed with all the proposals in the medium-term programme; the problem would be to implement it. He had little to add to the points raised by previous speakers, except to say that health manpower development should be given absolute priority because if that programme failed, all other programmes might fail. Within that programme, the prime need was for a change of attitude, among teachers and health workers, because without such a change all its other aspects would come to nothing.

His delegation would like to be included among the cosponsors of the draft resolution.

Dr FÜLÖP (Director, Division of Health Manpower Development) expressed his appreciation of Committee members' comments, assuring them that they would all be considered during the continuing review of the medium-term programme. The dialogue with Member States during the preparation of the programme had continued in the Health Assembly and the adjustment process was also continuing drawing on the wealth of experience manifested during the discussion.

Three main questions had been raised. The first, from the delegate of the Philippines, concerned the process by which the medium-term programme had been prepared. It had been prepared by strict application of the provisional working guidelines for WHO's medium-term programming, which were annexed to the Director-General's report on the subject.

The planning had been conducted along the classical lines of first defining the problems, to be dealt with by WHO and Member States; a list was included in the programme. Priorities were then defined by selecting, among the most serious problems, those for which acceptable solutions or approaches to solutions could be found during the programme period. Then observable and measurable targets - a new departure this - were defined; as stated in section 2.1 of the Director-General's report, that had proved to be possible at country and regional level, but not at global level. Annexes to the programme, giving details of regional programmes, were available for consultation, in the meeting room, and examples of quantified regional targets were cited - in the case of Africa, for instance - in Programme Area C - targets C.1 and C.2. All targets expressed, not what WHO would do, but what Member States would achieve towards solving their highly relevant social problems and what the impact of that would be; that too was something new. All efforts would be directed towards national self-reliance in health manpower development, so that the targets became a basis for technical cooperation aiming at socially relevant national health goals.

On the basis of the targets, activities had been worked out for cooperation with Member States towards the achievement of their socially relevant goals, in which the WHO contribution would be just one among those of other agencies, bilateral and multilateral, but the basic responsibility for achieving those targets remained entirely a national one. In the report submitted to the Twenty-ninth World Health Assembly, which contained the philosophy behind the medium-term programme and which was endorsed by resolution WHA29.72, lists of activities that the countries themselves might wish to undertake were accompanied by corresponding lists of activities for WHO, in order to show recognition of the fact that countries' problems would be and should be solved by the countries themselves.

The process of building up the programme had been characterized by continuous consultation with constant review, the programme annexed to the Director-General's report being the fourth and not the last version. It was the outcome of teamwork in the Secretariat and close and constant collaboration with Member States, the regional seminar mentioned by the delegate of Nepal being one step in the dialogue with Member States. Discussions had been held in five of the regional committees, three of which had adopted resolutions on the subject. There was also a continuous exchange of ideas and review of the programme with the 100 members of the Expert Advisory Panel on Health Manpower.

As the Director, Programme Policy Development, had explained, there was an inherent relationship between the various elements of the programme's development management process, of which medium-term programming was one element and which had been discussed under item 2.5 of the Committee's Agenda. As the delegate of Australia had indicated, the entire medium-term programming process should be based on country health programming, which could be expected to supply more and more material as it went ahead, in each of the Organization's major programme areas. References to the training of national personnel in planning and management for country health programming were frequent in the medium-term programme for health manpower development.

The next element in the planning process was evaluation which, as could be seen from any of the targets, was built in to the programme, to permit continuous monitoring of implementation. Reading across any of the tables of the global breakdown of activities by region 1978-1983 in the Annex to the report would show that the activities were not isolated but were all chains of activities, directed to the achievement of the target at the top of the page. Most of these activities also had built-in evaluation elements. Output indicators were also given for national and regional programmes.

On the question raised by the delegate of Romania, he agreed that the monitoring required by EB61.R27 could not be carried out without information systems. There were many references to those systems in the programme, often in the titles of the proposed activities; that was the case with Activities A 2.2, B 1.1 and C 3.2. A health manpower information service had already been set up in the Secretariat to help Member States with the generalization and dissemination of information at the national level.

In reply to the delegate of Poland, who had asked what was new in the reoriented health manpower development programme and consequently in the medium-term programme, Dr Fülöp explained that, over and above the new elements to which he had already referred, the most

significant new development would be obvious from a comparison of the summary records of the current meeting with those of meetings only a few years ago. Then the programme had been a WHO output-oriented series of unrelated activities, with no clear objectives, geared to high, but uncertain academic standards, mainly for physicians and nurses. That programme had been superseded by a holistic, integrated programme drawn up in response to resolution WHA29.72, which itself followed on resolution WHA24.59. The new programme is based on a clear philosophy of integrated development of health services and health manpower (called the health services manpower development - HSMD - concept) for the development of all types of personnel, in the quantity needed by Member States, with social relevance instead of uncertain academic standards as a measure of quality. This programme now dealt with all the three main components of the health manpower development process (planning, production and management of health personnel) and not only with the education and training elements as previously. The new programme had clear targets and objectives for technical cooperation between WHO and its Member States, and among Member States themselves, with self-reliance as the aim.

In reply to the Australian delegate's question as to what came next, he said that, briefly, the answer was implementation, which meant a continued dialogue with Member States, stimulation of and cooperation in country health planning and implementation efforts, organization of coordination meetings between the Secretariat and representatives of Member States (the first of which would take place from 11-15 December 1978 in Brazzaville), development of mechanisms for monitoring, evaluation and continuous adjustment to changing needs and demands and raising of extrabudgetary funds, because, without such funds, the programme would hardly be feasible.

In conclusion he said that because of lack of time he could not reply fully to some questions but he would be happy to provide any further information that delegates desired.

Dr CASSELMAN (representative of the Executive Board) said that the discussion on agenda item 2.6.7 had been most worthwhile. The fact that over 40 persons had spoken on it showed the interest of and importance attached to the matter. The Committee had heard views on the medium-term programme itself and on the application of the medium-term process to one of the major programme areas in the Sixth General Programme of Work. It had also heard of Member States' and WHO's experiences, concerns and priorities in respect of health manpower development and how they related to the delivery of health services in general, all of which had been clearly summarized by the Director, Division of Health Manpower Development in his reply to the questions: how was it done, what was new about it and what were the next steps.

The SECRETARY said that, since several amendments had been proposed to the draft resolution, it seemed worthwhile setting up a drafting group to deal with them rather than spending time on them in the Committee.

Professor HALTER (Belgium) said that, since he was partly responsible for the draft resolution, which read:

> "The Thirty-first World Health Assembly,
>
> Having noted the Director-General's report on the medium-term programme for health manpower development and resolution EB61.R27,
>
> 1. CONGRATULATES the Director-General on the preparation of the first medium-term programme in one of the major programme areas of the Organization;
>
> 2. URGES that this programme be carried out as rapidly as possible;
>
> 3. INVITES Member States to consider close cooperation with WHO with a view to making as rational a use as possible of already existing health manpower;
>
> 4. REQUESTS the Director-General to report periodically to the Executive Board and the World Health Assembly on the progress made in WHO and the Member States."

he wished to explain it.

The Committee had been presented with an excellent report by the Director-General, as well as with resolution EB61.R27 prepared by the Executive Board. Although the Executive Board had not suggested that the World Health Assembly should adopt a resolution on the matter, in the light of what the Committee had done the day before with regard to mental health programmes, it had seemed expedient that the Health Assembly should adopt a resolution showing

its satisfaction with the development of the medium-term programme for health manpower development. The text he had read that morning had been very simple and he had perhaps been mistaken in allowing the Secretariat to modify some of his proposals when it was being typed. His aim was not that the Health Assembly should comment on either the resolution or the problem, but merely that it should express its satisfaction with what was being done. A paragraph asking Member States to take an interest in the matter, with a view to giving more impact to the Director-General's work, had then been added.

It therefore seemed inappropriate to accept a series of amendments necessitating an extensive resolution dealing with all the important points of the programme. The preamble to the draft resolution was roughly that which he had proposed, except that he had said "Having noted the documents, the report and the resolution proposed by the Executive Board", which the Secretariat had altered. He had also proposed that paragraph 1 read merely: "Congratulates the Director-General on the work already done". He had not asked that the "first medium-term programme", etc. should be mentioned, for that was irrelevant. He had requested the Director-General to proceed as rapidly as possible (paragraph 2) and invited Member States to consider close cooperation, which still seemed necessary. Other delegates had asked for "monitoring", but that appeared in the resolution proposed by the Executive Board, which he had not wished to modify. He had merely requested the Director-General to report to the Executive Board and the Health Assembly on the progress made. His resolution had been very simple but very important, because it had reflected the Committee's enthusiastic consensus on the Executive Board's resolution. If other delegates were of a different opinion, the Committee would have to accept the Secretary's proposal, but he hoped that could be avoided and that the Committee would merely express its satisfaction, ask that rapid progress be made and invite Member States to help to achieve the aims.

Dr CUMMING (Australia) agreed with the Belgian delegate's comments, because the whole purpose of the Australian delegation's original proposal to have a resolution was to have the Committee express its satisfaction with the rate of development of the programme of health manpower development. However, a number of delegates had expressed the desire to add points, perhaps with a view to making the resolution clearer. He had been satisfied with the first text presented that morning and supported the Belgian delegate's plea for avoidance of a drafting group, but was willing to join such a group if the authors of the amendments felt they should be maintained.

The SECRETARY asked the authors of the amendments whether they would accept the Belgian delegate's suggestion that the Committee merely endorse that which was stated in the previous resolution, as it had done in respect of the mental health programme.

Professor DOĞRAMACI (Turkey) said that his was one of the delegations which had proposed an amendment, with a view to encouraging Member States to develop models of curricula and systems, such as existed in Edinburgh, Paris and Boston. The purpose of that amendment had been to avoid giving the impression that such models might have been imposed by the Secretariat. However, if the other authors of the amendments were willing to withdraw them, the Turkish delegation would do likewise, provided its views were recorded.

Professor PACCAGNELLA (Italy) said that his delegation had endorsed the resolution proposed by the Executive Board. However, it had subsequently agreed to both the draft resolution proposed by the Belgian delegate and the amendments proposed thereto. He therefore suggested that the amended text of the draft resolution be distributed and discussed at the next meeting.

Dr HERMIDA (Ecuador) said that, in view of the fact that the draft resolution, if it were to be adopted, must contain some of the points brought up by the Committee, his delegation was in favour of setting up a drafting group.

Dr GUZMAN (Chile) said that he had wanted to suggest that the draft resolution be amended, but did not now wish to provoke a debate by so doing. Paragraph 3 seemed to disregard all that had been said, since it invited Member States to make use of already existing health manpower, but not to participate actively in medium-term programming. At least that was the impression he got from the draft before him. However, he would not make an issue of the matter.

The SECRETARY remarked that the situation was not easy to sum up. The Italian delegate had proposed that a new text be distributed, but no new text had as yet been made available to the Secretariat and that was why it had suggested setting up a drafting group. Thus the alternatives were either to return to the Belgian delegate's original text or to convene a short meeting of a drafting group very early the following morning to settle the matter.

Professor SENAULT (France) said that, since it was clear from the Belgian delegate's explanations that he had proposed a resolution expressing general appreciation, but that the text prepared by the Secretariat was not exactly what he had intended, the only way to settle the matter was to distribute a copy of the Belgian delegate's original text.

The SECRETARY said that, if the Committee so desired, she could read out the Belgian delegate's original text in French.

Professor PACCAGNELLA (Italy) pointed out that, since the Committee appeared to agree to the new text, it could be distributed if the Belgian delegate agreed to it too.

Professor HALTER (Belgium) said that the sole purpose of his previous statement had been to try to avoid further discussion in a drafting group. However, if that were the Committee's desire, he would not oppose it out of author's vanity.

The DEPUTY DIRECTOR-GENERAL said that it was up to the Committee to decide on the sort of resolution it wished to adopt and that the compromise proposed by the Turkish delegate seemed reasonable. Resolutions could be modified ad infinitum. The important thing was that all statements, views, preoccupations and issues were recorded and would be taken into consideration in the implementation of the programme, so that nothing would be lost. The Turkish delegate had mentioned the need to look into the whole area of curricula designing for medical schools, universities and institutions, but that was already being done by the Division of Health Manpower Development. Nevertheless, that was an innovative approach that would be recorded. The Secretariat felt that a short, precise resolution would suffice, since any concern expressed would be noted in the Summary Records.

Professor DOĞRAMACI (Turkey) said that he had had certain reservations about the draft resolution, which had been shared by other speakers. He had, for instance, been concerned about the reference to already existing health manpower and about new curricula. However, since he was assured that those reservations would be recorded, he was prepared to withdraw his amendment if the other authors of amendments would do likewise. If not, he would be happy to have a drafting group meet the following morning.

The CHAIRMAN asked if all the authors of amendments would be prepared to withdraw them so as to leave the draft resolution as it stood. The Belgian delegate's text of the draft resolution would be reissued and all the comments made would be recorded. The discussion of item 2.6.7 of the agenda was thus kept open.

2. PROCEDURES FOR INTRODUCING CHANGES INTO THE SIXTH GENERAL PROGRAMME OF WORK COVERING A SPECIFIC PERIOD (1978-1983 INCLUSIVE): Item 2.4 of the Agenda (Official Records No. 244, page 15, resolution EB61.R23; Document A31/7)

The CHAIRMAN after recalling that it had been decided to postpone consideration of that item until matters such as programme development and the two medium-term programmes on mental health and health manpower, which were related to the policies expressed in the Sixth General Programme of Work, had been discussed, she called on Dr Violaki-Paraskeva to introduce the the subject.

Dr VIOLAKI-PARASKEVA (representative of the Executive Board) said that the Sixth General Programme of Work covering the period from 1978-1983 inclusive, referred to the Organization's Work Plan for six years. Delegates might recall that resolution EB59.R27 had requested the Programme Committee of the Executive Board "to study procedures for introducing changes

into the Sixth General Programme of Work in order to reflect new programme policies, and to present its recommendation to the Executive Board".

The Director-General's report on these procedures for introducing changes into the Programme of Work had the report of the Programme Committee annexed to it. At its meeting in 1977, the Programme Committee had recalled that it was the function of the Executive Board to submit a general programme of work covering a specific period to the Health Assembly for its consideration and approval. In fulfilment of its constitutional function, the Executive Board had submitted the Sixth General Programme of Work to the Twenty-ninth World Health Assembly in 1976. The Board also had the responsibility of observing whether any changes had become necessary in the Sixth General Programme of Work as a result of new policy or strategy decisions of the Health Assembly and, if so, of presenting them to the Assembly. However, in order to be able to do that, the Executive Board needed a mechanism and a formal procedure for introducing changes into the Sixth General Programme of Work. In that respect, the Committee should note that there was no question of any programme changes as such at the present time, since the Sixth General Programme of Work was only just starting to be implemented. However, the Board did require the mechanism through which it could propose any changes that became necessary in the future. Therefore, following the Programme Committee's recommendations, the Executive Board had approved the procedures set out in the Annex to the Director-General's report, which would make the introduction of changes into the Sixth General Programme of Work possible in the future.

The Executive Board had proposed a draft resolution for the World Health Assembly in resolution EB61.R23, setting out the procedures for future changes which the Committee might wish to consider. The draft resolution proposed for the Committee's consideration would provide the Executive Board with adequate procedures for recommending necessary changes in the General Programme of Work to the World Health Assembly whenever new programme policies and strategies called for such modifications.

Dr CUMMING (Australia) said that his delegation regarded that as an eminently logical way of handling the possible need to introduce changes into the Sixth General Programme of Work. The procedure recommended in the draft resolution proposed in resolution EB61.R23 seemed to be entirely in accordance with the constitutional roles of the various bodies of WHO and the Australian delegation would therefore vote in favour of it.

Dr BEAUSOLEIL (Ghana) said that no plan, programme or even activity could be considered complete unless it had a built-in mechanism for effective periodical and terminal evaluation. In other words, a plan, programme or activity should not be rigid but sufficiently flexible to allow for appropriate modification or changes in the light of foreseeable or unforeseeable developments, and there was no reason why the Sixth General Programme of Work should be exempted from that rule. The Ghanaian delegation therefore supported the draft resolution proposed in EB61.R23 and proposed that the Committee immediately take a decision on the matter, since a long debate was not necessary.

Dr MAFIAMBA (United Republic of Cameroon) said that, since his delegation had always considered the procedure for preparing the six-year programme and other programmes very complicated, and since it felt that a mechanism for reviewing the changing situation in Member States was a good idea, it would vote in favour of the draft resolution.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) said that his delegation supported the draft resolution. In view of the late hour, and since there seemed to be general support for that resolution, he proposed that a vote be taken on it immediately.

Decision: The draft resolution recommended by the Executive Board in resolution EB61.R23 was approved.

The meeting rose at 17h30.

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