WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTE

EB80/SR/2

18 May 1987

EXECUTIVE BOARD

Eighteenth Session

PROVISIONAL SUMMARY RECORD OF THE SECOND MEETING

WHO Headquarters, Geneva
Monday, 18 May 1987, at 14h30

CHAIRMAN: Dr A. GRECH



CONTENTS

SECOND MEETING

Monday, 18 May 1987, at 14h30

Chairman: Dr A. GRECH

1. REPORT ON MEETINGS OF EXPERT COMMITTEES AND STUDY GROUPS: Item 5 of the Agenda (Document EB80/2) (continued)

WHO Expert Committee on Specifications for Pharmaceutical Preparations: Thirtieth Report (WHO Technical Report Series No. 748) (continued)

Dr DUNNE (Pharmaceuticals) said that the trade in counterfeit drugs mentioned by several speakers was a concern to which the Organization had repeatedly drawn attention. It had also been aired in many forums, such as the Commonwealth Pharmaceutical Conference held in Nairobi, and raised in all pharmaceutical journals. WHO had asked the officially designated information officers in each Member State to provide the Organization with details of counterfeit products, but partly perhaps because no country wished to draw attention to weaknesses in its own control apparatus and partly because many such matters were sub judice, very few such incidences had been notified to the Organization, which was thus unable to disseminate much specific information to governments on the issue despite its importance.

In reply to Professor Westerholm and Dr Young, who had queried the need for an International Pharmacopoeia, and to Dr Hye, who had questioned its legal status, he said that the wish of the First World Health Assembly that WHO should produce a pharmacopoeia for worldwide use had never been a realistic objective. The endeavour in recent years had been to develop a pharmacopoeia that addressed the needs of developing countries, concentrating on essential drug substances and producing monographs reliant upon technology appropriate for use in developing countries. While it was true that the International Pharmacopoeia was not the sole pharmacopoeia in use in any country, it was one of several published pharmacopoeias that were very widely accepted and officially recognized in a large number of Member States. Among future plans for the International Pharmacopoeia was the inclusion of monographs on dosage forms as well as drug substances. In that connection it was unique in that the monographs would be developed from information on the preparations currently marketed in developing as well as developed countries. National pharmacopoeias, in contrast, dealt only with the products registered in the country concerned.

Dr de Souza had asked whether issues were not being confused by bringing in new concepts and revising methods described in some national pharmacopoeias. In that context, Board members were referred to the list of members of the Expert Committee, who represented many of the major national pharmacopoeias. The biennial meetings of the Expert Committee had, in fact, provided a unique forum for considering the need and feasibility of departing from established practice where that was felt to be desirable. In the particular case of the use of plastic discs in the tablet disintegration test mentioned by Dr de Souza, the members of the Expert Committee had assured the Organization that their own national pharmacopoeias would be urged to follow the lead given by the International Pharmacopoeia. Furthermore, all draft texts for the International Pharmacopoeia were circulated to all national pharmacopoeia committees around the world before they were endorsed. The consultative procedure was very arduous, long and very complete.

With regard to the stress laid by Dr Maruping on the necessity of simplicity and directness of approach in drug quality control methods of developing information that was structured for the countries with the greatest need in that regard, the International Pharmacopoeia was only one element in the broader strategy of drug quality assurance; a whole spectrum of interrelated activities was involved. For example, in its previous report, the Expert Committee had described the requirements for a small quality control laboratory; that was closely related to the International Pharmacopoeia in that it presented the array of apparatus needed to undertake the analyses the International Pharmacopoeia required. That report had also provided the basis for a new publication on basic texts for verification of the identity of pharmaceutical substances. The Organization realized that relevant information was at present widely scattered throughout the literature. An attempt had been made to collate it for the Conference of Experts on the Rational Use of Drugs held in Nairobi in 1985. A further effort would be made to have a definitive compilation prepared in time for the planned consultation on guiding principles for national drug control authorities to be held in late 1987.

Professor MENCHACA drew the Board's attention to the problem of the use in other countries, especially developing ones, of drugs banned in their countries of origin. Many developed countries had very stringent rules and long procedures for approval of the use of new pharmaceuticals for human administration. Such drugs were, however, often put on the market elsewhere before their use in the domestic market had been approved. He deplored such practices, which amounted to using the populations of developing countries as guinea-pigs, and considered that the Organization should make every effort to prevent them.

Dr DE SOUZA, expressing his appreciation for Dr Dunne's explanation, said he fully acknowledged the points made by the members of the Expert Committee. His particular concern was that there should be harmonization between the International Pharmacopoeia and the United States Pharmacopoeia and the British Pharmacopoeia, since although the last two were national pharmacopoeias they were in very wide international use.

Dr DUNNE (Pharmaceuticals), replying to Professor Menchaca, said that WHO fully understood concerns about the use in other countries of drugs restricted or banned in their domestic markets. In recent years a network of national information officers located in every drug regulatory authority had been established. Information on withdrawals of or restrictions on drugs currently on their markets received from those officers was mailed monthly by the Organization to all drug regulatory authorities.

Hospitals and health for all: Report of a WHO Expert Committee on the Role of Hospitals at the First Referral Level (WHO Technical Report Series No. 744)

Dr MARKIDES, commending the report, said that although hospitals in Cyprus were based on the district system, they still had most of the problems mentioned in the report. The district system was thus clearly not a magic solution in itself; success also required the presence of other components such as good referral systems, changes of attitude, good statistics and a balanced distribution of resources. He therefore fully agreed with the recommendations of the Expert Committee, especially those addressed to the Organization - in particular those regarding the establishment of a collaborative network of institutions, possibly organized on a regional basis, and the widespread distribution of the report to hospitals and other interested parties.

Some effort should be made to encourage rather than to sever connections between general practitioners and the hospitals, perhaps by allocating them some beds, as that would help to overcome some of the problems of integrating hospitals into health for all. There should also be greater encouragement of hospital specialists to become part of the primary health care team, visiting rural health centres and gaining an awareness of local problems.

Professor SCEPIN said the report was a very important one. The issue had been maturing for a long time; the last consideration of the role of hospitals had taken place in 1959. Many changes had, of course, occurred since that time including the reorientation of health care towards primary health care. It had to be recognized that in most countries hospitals continued to have the bulk of the resources, the most highly skilled staff and the most expensive apparatus, but by no means all those resources were being actively used in support of primary health care. The Expert Committee was therefore right to point out that fact and it should be supported in its view that given the lack of resources in practically all primary health care systems, the activities of hospitals at the first and higher referral levels must be closely linked with all health care facilities at local level and especially with primary health care. That was the basis of the district health care delivery system. The Expert Committee had done useful and necessary work in identifying a number of the problems preventing the integration of hospitals within the district health care delivery system based on primary health care.

The report's recommendations to WHO, governments, nongovernmental organizations and hospitals themselves, which took into account the variations in primary health care systems both between countries and between different health care systems, were both useful and feasible. It should be noted, however, that at the present time different forms of integration of hospitals and other health services, including primary health care, could be found. In the Soviet Union, for example, most polyclinics and outpatient services were part of the hospital proper. In rural areas such medical establishments provided advisory and technical services to all preventive and curative services within the district concerned and

assisted in improving the qualifications of their staff. Complete integration had thus been achieved as part of long-term programmes based on intersectoral cooperation. Further information on the subject could be provided on request.

Professor GIRARD said that he fully supported the Secretariat in its work on the establishment, renewal and updating of panels of experts, noting that the faster techniques developed the greater the need for renewal and adaptation. In particular, the excellent report on hospitals and health for all provided much useful food for thought. It was perhaps a pity that the report had confined itself to expressing opinions. Hospitals were, for reasons not always within their control, becoming increasingly technically sophisticated. First-level referral hospitals were also being caught up in that trend and the gap between hospitals and primary health care was growing. That was a problem that would have to be tackled. In addition, the evaluation referred to in the report's conclusions, if it was not to be a half-measure, should comprehend both costs and quality of care.

Dr HAPSARA commended the report. According to the last paragraph in section 7.3, referral systems were easy to design but extremely difficult to put into practice; he therefore wondered to what extent that situation was likely to continue into the future. With regard to recommendation 4 to governments (section 8.1), he asked what the likelihood was of changing the attitudes of the various clinical specialists and persuading them to give real support to more appropriate referral systems in support of health for all.

Dr BA welcomed the report; the recommendations were very relevant. Although the concept of primary health care had made progress and was being implemented in several countries, there was still misunderstanding about the role of hospitals, which were considered by some to run counter to primary health care. A number of nongovernmental organizations refused to become concerned with the primary health care role of hospitals. The report contained useful recommendations for such organizations to encourage funding for integration and to improve financial management and control. He proposed that efforts should be made not only to circulate the report but also to establish effective communication between WHO, governments, nongovernmental organizations and hospitals. The WHO representatives could, at national level, play a decisive part in such efforts.

Dr MARUPING said that Lesotho had recognized that hospitals formed an integral part of primary health care since its health care delivery system was thus reoriented. Each of its 18 general hospitals covered a total population of 1.5 million in a "health service area", within which patients were referred from the clinics. Each hospital provided supervisory and support services to clinic staff, and each clinic in the area was visited monthly by a physician from the hospital. The management team for the hospital was responsible for its own budgeting and that of the clinics in its area as well as for training, community-based activities, and drug procurement, storage and distribution to the clinics. That approach had, through extended training, taught hospital staff to appreciate their responsibilities with regard to community care outside the hospital. In some health service areas the hospital provided additional services for which there was a demand. Training for traditional birth attendants and other community workers was provided through the area hospital extension services. Encouraging progress had been made after initial difficulties. Much effort was currently directed to bringing public health teams closer to the hospital service area management teams for joint planning and implementation of programmes. The experience had been positive.

The Expert Committee report, especially the list of questions in Annex I, would prove very useful as Lesotho moved forward with its integrated approach to primary health care.

Dr QUIJANO supported Professor Girard's general remarks of commendation. However, the report under consideration, as borne out by its recommendations 4 and 5 to WHO and recommendation 7 to governments, appeared to be reversing a rather less favourable opinion of hospital services held a few years previously. Such swings of opinion were only human, however, and the time had clearly come to look on the development of hospitals more kindly in order to integrate them with primary health care and the district health care delivery system.

Professor MENCHACA said that all countries recognized that the solution to their health problems depended basically on primary health care but that the hospital concept was still viable. However, the hospital as a bastion for the gentlemen of curative care far above the

lowly beings delivering primary health care remained and should be recognized as a fundamental problem. All hospitals, even those with the most sophisticated degree of technology, should be made part of the referral system for primary health care. Countries should make rational and equitable use of those highly developed resources. Such an approach was nevertheless difficult, if not impossible, in countries that did not have a unified health system. There was also a danger in the concept of the university hospital if the students were not familiarized with the reality of primary health care and their opportunities for acting within that framework. The integrated hospital system described in the report already existed in Cuba; that experience should be used by WHO's experts and made available to other countries.

Dr AASHI said that countries which had had experience of integrating hospitals into primary health care had found such hospitals indispensable and their operating costs much reduced. The changeover proposed was an evolutionary process that would take time. Governments were, however, ultimately in control of a country's hospitals and were thus in a position to develop legislation to compel hospitals to implement the report's recommendations. There was therefore no reason for apprehension that hospitals would not be capable of playing a role in primary health care. The report had laid a foundation that could be drawn on by each country in establishing a system in accordance with its needs and circumstances.

Dr DIETERICH, referring to section 6.1.2 of the report, on "lack of functional coordination between the hospital and other agencies", said he would have liked the report to provide more information and recommendations for action to be taken within hospitals. The latter could be of great help to other agencies in areas such as education and nutrition, the first two elements of primary health care, and could in turn be supported by other sectors, particularly in relation to health systems research and similar activities supported by WHO.

Professor RAKOTOMANGA commended the report. Concerning the integration of hospitals into the primary health care system, he drew attention to two measures which should be encouraged at national level. First, hospital budgets should be integrated into the sector in which hospitals were situated; the direct dependence of hospitals on the ministry of health meant that they tended to concentrate on curative efforts and paradoxically to neglect the broader health policies of the ministry. Secondly, efforts should be made at university level by providing systematic training of hospital personnel in primary health care for the community.

The CHAIRMAN, speaking in his personal capacity, said that the report was timely and important. It was the first time since 1959 that there had been a review of the role of hospitals in broader health system context. The report correctly laid emphasis on the kind of changes necessary to effect close integration of hospitals and other, primary health care services: particularly, organizational and functional interaction focused on the district health system, restructuring of educational programmes with a view to reshaping attitudes and capabilities of health personnel, and development of new career options. The Expert Committee was the first to admit that given the entrenched traditions and the rigidity of the health sector, any movement towards integration would require strong commitment and intense effort. Nonetheless an attempt had to be made, if only to maximize the hospital resources. As stated in the report, part of the answer to overburdened hospitals lay in primary health care. The recommendations contained in the report merited consideration by WHO, governments, nongovernmental organizations and hospitals.

Dr MONEKOSSO (Regional Director for Africa) said that in the African Region two main scenarios presented themselves at district level; either the hospital or the district health office was at the top of the health service pyramid - separately or in parallel. However, neither one had so far proved successful, particularly where contact with other sectors had become important for development. Hospital personnel were so busy that they had little time for dialogue with other sectors. The underlying issue was one of defining hospital services and their objectives, of the work in health offices and their objectives, and of the tasks and objectives of other sectors. An attempt had been made to define the purpose of the hospital as being to prevent death of cells, tissues and organ systems in individuals. Health office personnel on the other hand were generally trained to promote health in the meaning generally adopted in WHO - the promotion of physical, mental and social well-being. Other sectors had the aim of promoting social, cultural and economic wealth to pay for health services. In practice, health administrators had to determine which - of hospitals, health offices or other sectors - took the lead.

Management of hospitals must also be considered, as the major share of health resources tended to be invested in hospitals, and only by careful management of those resources would enough remain to be allocated to primary health care. In the African Region there was a fairly uniform pattern of management, with a business manager to deal with material and financial matters and who could also consider cost-recovery aspects, a health manpower manager (usually the matron), and the medical officers and physicians who dealt with the technological aspects and the quality of care for hospital patients. Horizontal relationships among personnel with corresponding responsibilities were required; for example, paediatricians in hospitals, child health workers in health centres, and child protection officers in other sectors would collaborate "horizontally". Such an approach seemed to be more effective where personnel were at the same technical level than where efforts were made to integrate them administratively from the top.

The report would be most useful to the countries of the African Region in the immediate future by application of the recommendations to specific situations.

Dr SIEM TJAM (District Health Systems) thanked members of the Board for their comments. Referring to questions concerning involvement of general practitioners in hospitals and of specialists in the community, and concerning ways of putting hospital technology to better use, he said that a study group on technology in hospitals at the district level was to analyse the major technological issues and draw up information for use by Member States in developing their own priorities.

In reply to Dr Hapsara's question on implementation of a referral system, he referred to a recent visit to a country where the Government had called a meeting to try to develop a referral network of general and specialist hospitals, the main issue proving to be control of resources. In general, the allocation of resources tended to determine the overall referral pattern. The financing system of the health sector and specifically of hospitals was therefore being considered by the study group and it was hoped to give some indication of how better distribution of resources could be found to promote better balance and referral relationships, as well as of possibilities for changing often ingrained attitudes by building up a network of institutions which might study constraints at the local level and support governing bodies of hospitals in implementing change. The regional offices of Europe, the Western Pacific and the Eastern Mediterranean were already taking such steps.

In response to Professor Menchaca's comments, he said that the International Hospital Federation would be conducting a study tour in Cuba later in 1987 to look at the role of the district hospital in the health system. On the question of training of professionals and the long-term influence on the health system, an initiative was under way to look into what teaching hospitals were doing both in relation to teaching and as role models. It was ironic that the physician who had to take a lead in primary health care was usually trained at a tertiary level institution, exposed to high technology and therefore not always well equipped to function in the periphery. There were several initiatives in different countries to rectify that situation and it was hoped to provide further information on them in the future.

Prevention and control of intestinal parasitic infections: Report of a WHO Expert Committee (WHO Technical Report Series No. 749)

Dr DE SOUZA commended the report, which was non-technical and non-controversial and provided a valuable review of the global situation, factors underlying the development of prevention and control strategies, strategy content and the need for field, epidemiological, operational and laboratory research. While the report was generally optimistic about measures against intestinal parasitism, it must be borne in mind that implementation of the recommendations would take place not in an ideal world but one where control of intestinal parasitism had to compete for limited resources with more apparent health problems, such as malaria, AIDS, schistosomiasis and maternal and child mortality, so that it risked neglect as a highly tolerated infection in the very populations most afflicted by it. The promotion of field studies associated with economic research was therefore of the highest priority: if they confirmed the partially hypothetical morbidity from intestinal parasitism and established that it imposed a heavy economic burden, with a clear cost-benefit for prevention and control and a persuasive argument for communities for their long-term involvement in such prevention and control, the political or economic obstacles to the identification of resources for implementation of the other recommendations would not be insurmountable.

WHO Expert Committee on Drug Dependence: Twenty-Third Report (WHO Technical Report Series No. 741)

Mr BOYER commended the Secretariat for its recent efforts to modify procedures for reviewing psychoactive substances, and observed that the report under discussion was the second to follow the new guidelines. The report stated that WHO had recommended scheduling of five barbiturates on the basis of a review of 31 substances; the fact that the recommendations had been adopted in February 1987 by the United Nations Commission on Narcotic Drugs without opposition was testimony to the usefulness of the WHO recommendations. The recommendations contained in the report were very useful and he particularly agreed with recommendation 4 that the practice of preselection of drugs for review should continue to be coordinated through the Programme Planning Working Group. He also agreed that, as stated in recommendation 5, the control of drug abuse could be better handled at national than international level. In addition, he endorsed the concern expressed at the end of the recommendations that the availability of certain useful drugs in developing countries might be restricted following the placing of those drugs under international control; he referred in particular to the status of phenobarbital. Such problems might well arise from the otherwise well-intentioned scheduling of drugs, and it might be in the interest of the Expert Committee to review the impact of their scheduling recommendations.

Dr DE SOUZA, referring to the problem of the use of phenobarbital mentioned by the previous speaker, in the treatment of epilepsy, asked whether the Secretariat could give advice on the extent of the problem. National health authorities should be able to make it clear that inclusion of the substance in Schedule IV of the 1971 Convention on Psychotropic Substances did not mean that it could not be prescribed in the treatment of epilepsy. The problem was the result of a misunderstanding that could be cleared up easily at national level and was not an argument against scheduling.

The CHAIRMAN, speaking in his personal capacity, said that the Expert Committee had a difficult task in deciding whether a particular drug should be included in a schedule; there were probably "grey areas" where it had been agreed that there should be no control at the current stage. However, he wondered why the Expert Committee had recommended not scheduling metharbital (paragraph 3.15.7), when it had been confirmed (in paragraph 3.15.2) that the drug was metabolized to barbital, which was a scheduled drug of which there had been isolated reports of abuse and illicit trafficking. Although the drug was of considerable therapeutic use and thus far no public health or social problems had been reported, there should perhaps be a recommendation that continued surveillance was warranted, as in the case of febarbamate (paragraph 3.10.7). A similar recommendation for continued surveillance should also be applicable to those preparations where abuse, however sporadic, had been reported, as in the cases of aprobarbital, hexobarbital and vinbarbital. The recommendations contained in chapter 4 of the report were very valid; the second recommendation might be considered to imply what he had just stated although it was not absolutely clear. He noted with satisfaction recommendation 5 on help for national authorities in their efforts to implement and interpret the Conventions, which was particularly useful for those countries which did not have the expertise or the facilities necessary. He agreed with the final paragraph of the report that the problem of phenobarbital was best solved by WHO in collaboration with the developing countries affected by the problem. Finally, the importance of Schedule IV drugs, where drugs with a high abuse potential were listed, should not be minimized.

Dr NAKAJIMA (Regional Director for the Western Pacific), in response to Dr De Souza's comment concerning phenobarbital, said that in the Western Pacific in recent years no question of abuse of the substance had been raised. It was still fairly widely used in the developing countries of the Region for treatment of epilepsy. Inclusion of the drug in Schedule IV might not therefore be appropriate. Reports of abuse varied considerably, not only from one region to another but also from one country to another, so that national rather than international control was required. Only six countries in the Region - Australia, China, Papua New Guinea, Philippines, Republic of Korea and Tonga - were party to the 1971 Convention on Psychotropic Substances.

Dr KHAN (Division of Mental Health) said that phenobarbitone had been controlled under the 1971 Convention on Psychotropic Substances, Schedule IV. Since then, within the Division of Mental Health, information had been received from the regional offices that its availability was restricted. The Expert Committee on Drug Dependence had been informed and

had decided not to change the status of the drug. The Expert Committee stressed that it was important to ensure a better understanding at the national level of the implication of putting a drug in Schedule IV, which was that it required the prescription of a doctor or - where so permitted by the ministry of health - by a nurse or pharmacist. The other possibility was to remove the substance from the Schedule, a matter that was currently being considered.

He agreed with the Chairman's comments concerning metharbital; the Expert Committee had to consider drugs in the light of their ability to produce dependence and other problems before it made any recommendation. Metharbital and some other substances needed to be monitored and reviewed in collaboration with the International Federation of Pharmaceutical Manufacturers.

Evaluation of certain food additives and contaminants: Thirtieth Report of the Joint FAO/WHO Expert Committee on Food Additives (WHO Technical Report Series No. 751)

Mr BOYER commended the Expert Committee on its work and noted that the operation had been carefully regulated so that it was shielded from outside pressures. The Expert Committee had never been accused of operating under any bias from industry or government, and its scientific conclusions carried very significant international weight; in developed countries the Expert Committee's evaluations had set international standards, acting as a template by which national evaluations could be measured; in developing countries it provided an unbiased source of expert advice and information, and for the Codex Alimentarius Commission it provided expert advice on the safety of food additives and safe levels of contaminants in food. The recommendations contained in the report under consideration showed that the Expert Committee was providing an outstanding service.

Dr DE SOUZA welcomed recommendations 6 and 7, which concerned routine checks for lead in foods for infants and young children; the setting of a tolerable weekly intake for infants and children had been long awaited. The mean daily intake and the provisional tolerable weekly intake, given in section 3.7.1, would be of use in assessing health implications of lead intake in that target group.

Professor WESTERHOLM said that the Expert Committee reports in general were of very high quality and it was therefore important to ensure that they were widely disseminated and used. It would be useful if, at a future session, the Secretariat informed the Board how it followed up the matter.

Community-based education of health personnel: Report of a WHO Study Group (WHO Technical Report Series No. 746)

Professor SCEPIN commended the report for showing the need for improved training of students in health institutions and for providing them with knowledge and practical training which would be of use to them within the framework of primary health care. The report emphasized that community-based education must impart an awareness of the real problems both of the community and of the individual. The integration of health manpower training was indeed one of the most important aspects of any health training programme in meeting the real, practical needs of the population, particularly in countries where medical education was not carried out in accordance with an overall plan or where the link between the needs of the population and existing practice in planning for health manpower development was weak.

Despite the theoretical value of the report, implementation of the recommendations would no doubt be impeded by the traditions and conditions prevailing in different countries in relation to health manpower of different categories. The practical value of community-based training of health personnel for community involvement would differ from one country to another. It would not be possible in all cases to introduce the recommendations of the Study Group immediately. The report was nonetheless useful and would be of interest to specialists involved in health personnel planning and training and the evaluation of relevant training programmes.

Dr HAPSARA, welcoming the report, said that, in the primary health care approach, emphasis was placed on the importance of human resources development and community development, in which the creativity and commitment of the people to health for all were highly significant and should be strengthened in order to give full support to the health-for-all strategy.

Referring to section 5.6, concerning the establishment of a teacher training programme, which he said was an extremely difficult process, he asked what significant constraints had been met with in pilot activities carried out in a number of countries. They would serve as a basis for realistic forecasts to facilitate improvements.

The definition of primary health care on page 7 of the report should be compared with other definitions, such as the principles of primary health care mentioned in the "health leadership" document, the "Health-for-All" series and other related documents, in the interests of clarity and ease of implementation.

Professor MENCHACA agreed with Dr Scepin's comments. From the time of the Alma-Ata Conference, recognition had been given to the need for reforming health personnel training programmes, yet nearly ten years later there were few countries in which that was being done. Such a move would constitute a genuine revolution in medical education. No revolution was easy and the field of medicine was no exception. The aspects of health systems reorientation, the equitable distribution of resources, intersectoral coordination and active community participation should all be stressed in that respect.

He, too, recognized the difficulties of establishing a programme of continuing education. The main requirement was to secure the necessary political will. Without political commitment in the country concerned, it was impossible to carry out such a programme. Socioeconomic conditions sometimes conspired against it. Although science was universal, its application was limited by those conditions and by the degree of political will that was forthcoming. If that were not so, poliomyelitis, for example, would no longer exist in any country. The considerable experience that was available should be thoroughly analysed.

A social definition should be added to the definitions of "community" at the beginning of chapter 2 of the report. The needs of all the population should be met so that no sector was neglected and all social groups had an equal opportunity to participate in decision-making.

Dr CAMANOR, welcoming the timely report and its clear and useful recommendations on how to start a community-based educational programme, said that it would be extremely valuable in the training of primary health care workers. It should be distributed particularly to countries and their training institutions for health workers, and WHO should follow up the implementation of the Expert Committee's recommendations and guidelines.

He realized that introducing a community-based training programme might be difficult and protracted, but he believed that it could lead the way in efforts to develop primary health care, particularly as other community-based programmes developed.

Professor GIRARD said that the observations he had made concerning the Expert Committee report on "hospitals and health for all" applied, mutatis mutandis, to the report under consideration, which was remarkable in revealing WHO as a "think-tank" demonstrating what must be done. It was essential to be clear, to recognize the difficulties ahead and to realize that community-based education was far from fulfilment, especially where hospitals where concerned. Such efforts as the establishment of university networks, which had begun in certain regions, were a step in the right direction, but much remained to be done. There was a greater need for clarity than for vision.

Dr NAKAJIMA (Regional Director for the Western Pacific) said that the matter had been widely discussed at the time he had put forward the question of the Tokyo Declaration on health manpower for the twenty-first century. The Study Group's recommendations were highly relevant to educational policy for the Western Pacific Region, particularly in the light of developments following the Declaration. He nevertheless agreed with Professor Girard and others that a number of years would elapse before the conflict between the primary-health-care-minded educator, administrator or politician and those who were oriented towards the traditional and curative fields was resolved. The work of the Study Group would help to pave the way to health for all. One of its members who had since joined the Secretariat of the Regional Office for the Western Pacific had recognized the seriousness of the problem, but everything possible would be done to cope with it as one of the endeavours for health for all by the year 2000.

Dr MONEKOSSO (Regional Director for Africa) said that he was somewhat astonished at the utopian view which the Board appeared to be taking on the subject. Many medical schools, particularly in the Third World, had endeavoured to implement such an approach, which in itself was a comparatively simple matter in small developing countries where there were no particular traditions of medical excellence or strong professional associations. The problem was, however, that the larger countries had few similar models, and the Third World Governments, which looked up to those countries, finally came to believe that such an approach was inferior. Professional groups within a particular country, who had been trained in well-established schools of medicine in the most advanced countries, not unnaturally opposed the system because it did not conform to their ways. Even when the exercise had commanded the necessary political will and had been successfully carried out, difficulties remained unless the health system as a whole had adapted itself to the primary health care approach. Community-based teaching should form an integral part of the primary health care implementation effort in which everyone was involved.

Some institutions had regarded community-based education in too small a community context; the better models, as described in the report, were those in which the educational institutions were incorporated in a fairly large area. Further, in endeavours to adopt a community-based approach for a wide variety of health personnel it was often forgotten that, although they shared the need for community experience, the community-based approach should not be overdone to the extent that physicians were prevented from working in hospitals and acquiring the proper clinical skills expected of them by society.

The current initiative of the World Federation for Medical Education, which was to lead to an international conference in 1988, was timely. If the same kind of results came out of that conference on medical education as had come out of the Alma-Ata Conference, it would be easier to follow the approach under consideration in many countries, developing and developed alike. If the approach was respected in the developed countries, developing countries would be more likely not merely to implement it but to continue to apply it; in his experience, after the initial "success" society had gradually lapsed into its former habits.

Professor GIRARD said that he was not being utopian. The goal was an ambitious one and what was needed was to determine the means of reaching it. He endorsed the action of the World Federation for Medical Education. The difficulty was how to reach the objective as quickly as possible within the given structures, in countries, States, schools and universities that were not typically open to the community.

Dr GUILBERT (Educational Planning, Methodology and Evaluation) thanked Board members for their comments. The constraints and difficulties met with in implementing the teacher training programmes, to which Dr Hapsara had referred and which were linked to problems of resistance to change and of academic attitudes, had been overcome in the teacher training programme established by Member States in cooperation with WHO over the past 20 years. Even though the vast majority of health training centres, throughout the world, were not implementing the principles described in the report, those principles had, in fact been shown to be implementable and a number of institutions were now endeavouring to apply them. Dr Monekosso, who had worked in the field concerned and had been able to overcome some of the difficulties, had partly replied to the questions that had been asked, relating also to the follow-up of the report, which was of no value unless it was put to use.

WHO had helped to establish a network of community-oriented educational institutions in a nongovernmental organization now in official relations with WHO.[1] That network at present comprised some 22 institutions and some 60 associate member bodies in which people could learn how to apply the principles in question, and which could also be used by those who were not members of the network. A task force within the network was preparing a handbook for the practical implementation of the principles set forth in the report, whose global nature might make it somewhat theoretical. The task force was collecting information on all the techniques used in the innovative training centres to facilitate the task of those wishing to implement such principles.

---

[1] The Network of Community-oriented Educational Institutions for Health Sciences, admitted to official relations by the Board at its seventy-ninth session in resolution EB79.R23.

Among the existing mechanisms that had been applied was that known as the "separate track", which consisted of taking a sample of students from a school who, with the help of a corresponding group of teachers, could carry out an experimental programme parallel with the existing one. The schools that had established such separate programmes had attended a meeting in New Mexico (USA) organized by the network to which he had referred, with the co-sponsorship of WHO. The host to the meeting had been the Faculty of New Mexico - one of the faculties which had implemented the "separate track" programme. It had been possible to compare the various elements of the approach in eight institutions. A WHO report on innovative tracks at established institutions for the education of health personnel was to be issued in September 1987 for discussion by the general assembly of the network to which he had referred.

Technology for water supply and sanitation in developing countries: Report of a WHO Study Group (WHO Technical Report Series No. 742)

Dr HYE said that little had been heard recently about the International Drinking Water Supply and Sanitation Decade, and governments in some developing countries appeared to be devoting insufficient attention to it. It might be desirable for WHO to reactivate the Decade approach in view of its importance for some countries.

He asked why population density had not been taken into account in the design criteria for sanitation in urban and rural areas.

Mr SULEIMAN (Community Water Supply and Sanitation), replying to Dr Hye, said that the Study Group had endeavoured to distinguish between the requirements for sanitation projects in rural and urban areas, and the special features of the former were outlined in Annex 1 to the report. The issue of population density was implicitly covered in the same annex.

Decision: The Executive Board considered and took note of the Director-General's report on the meetings of the following expert committees and study groups: the WHO Expert Committee on Biological Standardization, thirty-sixth report; the WHO Expert Committee on Alternative Systems of Oral Care Delivery; the WHO Expert Committee on Specifications for Pharmaceutical Preparations, thirtieth report; the WHO Expert Committee on the Role of Hospitals at the First Referral Level (Hospitals and health for all); the WHO Expert Committee on Prevention and Control of Intestinal Parasitic Infections; the WHO Expert Committee on Drug Dependence, twenty-third report; the Joint FAO/WHO Expert Committee on Food Additives, thirtieth report (Evaluation of certain food additives and contaminants); the WHO Study Group on Community-based Education of Health Personnel; and the WHO Study Group on Technology for Water Supply and Sanitation in Developing Countries. It thanked those experts who had taken part in the meetings, and requested the Director-General to follow up the experts' recommendations, as appropriate, in the implementation of the Organization's programme, bearing in mind the discussion in the Board.

2. REPORT OF THE UNICEF/WHO JOINT COMMITTEE ON HEALTH POLICY ON ITS TWENTY-SIXTH SESSION: Item 6 of the Agenda (Document EB80/3)

The CHAIRMAN said it would be noted, as stated in the introduction to the report, that the UNICEF/WHO Joint Committee on Health Policy had shifted its focus from detailed review of the implementation of technical health policies in all UNICEF country programmes to a general review of the manner in which new health policies were being integrated into the work in areas of joint interest for the two organizations. He drew particular attention to the conclusions and recommendations in paragraphs 28 to 34 of the report.

Dr MARUPING (Rapporteur, UNICEF/WHO Joint Committee on Health Policy) said that the Committee had met in Geneva on 27, 28 and 29 January 1987 for its twenty-sixth session, with Dr R. Hapsara as its Chairman. The Joint Committee was a unique body in the United Nations system, consisting of six members each of the Executive Boards of WHO and UNICEF.

The twenty-sixth session had been conducted in a productive spirit of cooperation and of understanding of the complementary roles of the two organizations. The Committee had appreciated the fact that the proceedings had started with a review of health policies as expressed in certain recent World Health Assembly resolutions and related UNICEF Executive Board recommendations.

The discussion of the health policies had shown that the two organizations had important common goals and that there was a need for a common understanding of international health policies in order to implement them fully in support of national health strategies. The Joint Committee had also discussed the current world economic crisis and had expressed concern about its impact on people and on the work of WHO and UNICEF. Specific recommendations concerning the resolutions discussed by the Committee were included in the report.

A further crucial subject of discussion had been the complementarity of UNICEF and WHO in support of primary health care at the country level. Specific examples from two countries had shown how health policies could be put into practice constructively when there was good coordination and collaboration between the government and its international partners, and an open dialogue. The background document prepared by the two Secretariats had provided a description of the mandates, structures and operating procedures of the two agencies and an analysis of the complementary functions at country level and of factors that could facilitate such collaboration. It highlighted the importance of the leading role of governments, and of national development programmes as the framework for WHO and UNICEF country support activities.

The Committee had felt that the background document should be brought to the attention of both Executive Boards, and it was therefore annexed to document EB80/3.

The third main item for policy discussion had been the joint strategy for information, education and communication for health. An increasing amount of experience had been gathered in recent years in the area of social mobilization for health in both organizations, and UNICEF's special role at the grassroots level and WHO's strength in technical information made them highly complementary partners with governments in that matter. The collaboration process in that area had been extremely beneficial, and the Committee's recommendation that the two Secretariats should establish a working group and a joint plan of action was being implemented.

The Joint Committee's report had also been discussed at the UNICEF Executive Board's session in April 1987, in which she had participated. The report had created much constructive interest, and the review of international health policies had frequently been referred to as a valuable contribution and a useful framework. The mechanism of the Joint Committee on Health Policy had been mentioned as a useful tool for interagency collaboration, and it had been suggested that such a mechanism could also be useful in other parts of the United Nations system to bring about complementary action and effective collaboration.

Dr HAPSARA (Chairman, UNICEF/WHO Joint Committee on Health Policy) said that he wished to emphasize three salient points for the Board's consideration, with a view to accelerating implementation still further.

The first concerned the guidance given to the Joint Committee by the Directors-General of UNICEF and WHO for the improvement of the work of the two organizations, as outlined in paragraphs 7 to 17 of the report. Efforts had been made to reflect the policy issues concerned.

His second point concerned the complementarity of WHO and UNICEF in support of primary health care, the subject of part III of the report (paragraphs 35 to 41). The Joint Committee had discussed the main factors that were considered to be of particular importance for facilitating fruitful cooperation between governments and officers of the two organizations working in the field, as listed in paragraph 39. The one in subparagraph 39.1 (firm government leadership in coordination and in establishing and promoting an effective health planning process) was particularly important.

Particular attention should be paid to information, education and communication for health (part IV of the report), which still faced many challenges (subparagraph 45.1), with a view to achieving improvements and accelerated development.

Professor MENCHACA recalled that, at the twenty-sixth session of the UNICEF/WHO Joint Committee on Health Policy, Dr Mahler, Director-General of WHO, and Mr Grant,

Director-General of UNICEF, had both recognized the crisis confronting the United Nations system, and that the former had stressed the importance of taking action to redress the situation. The relationship between UNICEF and WHO could set an example in that respect. Such relationships, which also existed between other agencies were very important. Indeed, the "United Nations family" must be maintained because it had an increasingly important role to play in the solution of the problems of mankind. The Joint Committee had examined the complementarity of WHO and UNICEF in support of primary health care. Despite certain problems in interaction between the two organizations, resolute steps were being taken to make full use of their complementarity.

Regarding the problem of tobacco and health, Mr Grant had drawn attention to the special situation of women during gestation and motherhood, which called for careful consideration. AIDS had also been discussed, and participants from UNICEF had acquainted themselves with the information available to WHO on that subject. It had been gratifying to note that UNICEF had decided to work on acute respiratory infections, in addition to the other areas which it covered, such as nutrition, oral rehydration and essential drugs.

Professor SCEPIN said that the report reflected the complementarity of the two organizations, which characterized cooperation between them. It was gratifying to note the interest shown by UNICEF in the WHO AIDS programme, which had been highlighted during the recent World Health Assembly. Special attention should be given to the parts of the report devoted to information, communication and education for health, and social mobilization, which must be an integral component of all health programmes and of social development programmes in general. The Joint Committee had recommended that anniversaries and special events should be commemorated to promote health work. The fortieth anniversary of WHO and the tenth anniversary of the Alma-Ata Conference would provide good opportunities.

The report was satisfactory, and cooperation between WHO and UNICEF was bound to continue to develop on the basis of the genuine complementarity of the humanitarian goals of the two organizations.

Dr DIETERICH thanked the authors of the report and all the members of the Executive Boards of both organizations for their work. However, certain problems had been overlooked in the report, Annex III to which did not provide a very clear picture of complementarity in a number of important fields such as maternal and child health, diarrhoeal diseases control and information, education and communication for health. It would be interesting to know why complementarity appeared to be lacking in such important areas, despite the programmes undertaken separately by the two organizations in the framework of primary health care.

It was expedient to develop joint policies and strategies in view of the programmes already embarked upon by the two organizations. Rapid progress could perhaps be achieved in that area by directly undertaking joint planning at the country level, without waiting for plans of action to be elaborated. With regard to the approach to discussions in the Joint Committee, it was felt that the consideration of individual country projects was not very useful, and that efforts should be made at future sessions to strike a better balance, with a view to considering managerial issues without altogether leaving aside overall policy and strategy. Indeed, such issues were essential if cooperation between the two organizations was to be effective.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean), referring to the problems mentioned by Dr Dieterich, said that there were significant structural differences between WHO and UNICEF, which lacked strong regional offices. Therefore, cooperation largely depended on personal relations at the country level. In that connection, there had been changes in recent years in UNICEF's approach. However, the role of the governments was very important, and success depended on their ability to make good use of the assistance provided by WHO and UNICEF. That fact was amply illustrated by the situation with regard to the Joint Nutritional Support Programme, which was proceeding very smoothly in countries where the government had clearly defined the requirements to be satisfied by each Organization. In some vaccination campaigns, however, social mobilization had gone too far, neglecting proper target groups and outstripping the country's ability to cope with the situation. In one country for example, all the vaccines to be used in an immunization campaign were used to administer the first dose, and it had been very difficult to procure more vaccines for the second and third doses. Problems had also arisen in connection with remuneration, when local

staff had refused to resume work at normal levels of remuneration after receiving high salaries, increments or pay supplements. There had also been difficulties in recruitment because candidates had claimed that they received higher salaries elsewhere. However, all such problems were gradually being overcome through good personal relationships at the regional and country levels, between the staff of WHO and UNICEF.

Dr FERNANDO shared the views expressed by Dr Gezairy, and reiterated the view that collaboration at the country level was absolutely essential for the achievement of concrete results. Governments therefore had a crucial role to play in ensuring complementarity between the two organizations, and WHO was urged to make governments aware of that fact.

Dr AASHI said that duplication sometimes persisted where the two Organizations worked in the same field because the tasks to be carried out by each of them were not clearly defined. Such had been the case with immunization, diarrhoeal diseases control and information and education. The report under consideration was not sufficiently precise. Although it set out priorities in cooperation between the two organizations, it failed to define their respective roles. The two organizations must coordinate their activities when they worked in the same country, and do so at the outset of their programmes, at the stage of formulation. Indeed, their programmes must not be elaborated separately. Cooperation must therefore be strengthened at the national and regional levels at that stage.

Dr MONEKOSSO (Regional Director for Africa) said that, in view of the willingness of the two organizations to collaborate on a global scale, special attention should be devoted to the role of governments in such collaboration. Each organization should benefit from the other's contacts with a government. For example, WHO usually had contacts with the ministry of health, whereas UNICEF had sometimes established close contact with the ministry of finance, economic planning or development. Efforts had been made to that end with a view to making good the other organization's weaknesses, and much progress had already been achieved in the area of primary health care in recent years.

Mrs BRUGGEMANN (Director, Programme for External Cooperation), replying to the questions raised earlier by Dr Dieterich, said that the report could not possibly cover all the areas and programmes that UNICEF and WHO were involved in. In that connection, it was pointed out that the two Organizations also held inter-secretariat meetings, more frequently than the Joint Committee sessions, to discuss cooperation in greater detail. With regard to the discussion of managerial issues, it had been felt that priority must first be given to reaching a common understanding on health policies, which would serve as a basis for a better organization of managerial issues. It was suggested that Dr Edström, in her capacity as liaison officer with UNICEF and Secretary of the Joint Committee, should reply to the specific question raised in connection with maternal and child care.

Dr EDSTROM (Secretary, UNICEF/WHO Joint Committee on Health Policy), said that the study on complementarity in the annex to the report was based on two case studies, which did not necessarily reflect the situation prevailing in all countries. Admittedly, the areas in question were more affected by overlapping than certain other areas, and it was perhaps more difficult to distinguish between the different tasks undertaken by each Organization in those areas at the country level. The two secretariats had therefore jointly worked out statements on the programme areas, not only maternal and child health, but also EPI, diarrhoeal diseases control, malaria and acute respiratory infections. Those statements analysed the problem and described the implementation of the relevant health policies as well as the respective roles of the two organizations. However, at the country level, much depended on coordination by the government, in terms of sharing or dividing responsibility for various tasks.

The DIRECTOR-GENERAL said that UNICEF's cosponsorship of the Alma-Ata Conference had been crucial because it had thereby subscribed to the primary health care policy and, indirectly, to the health-for-all policy. As a result, the debate had become much more coherent because it involved all the issues related to primary health care and health-for-all policies; great progress had thereby been accomplished. The Expanded Programme on Immunization, the Action Programme on Essential Drugs, the Diarrhoeal Diseases Control Programme and others did pose problems for collaboration between the organizations, but the way in which they were overcoming their differences was remarkable and the prospects for the development of their complementarity and cooperation were excellent.

The Board noted the report on the twenty-sixth session of the UNICEF/WHO Joint Committee on Health Policy.

3. APPOINTMENT OF REPRESENTATIVES OF THE EXECUTIVE BOARD AT THE FORTY-FIRST WORLD HEALTH ASSEMBLY: Item 7 of the Agenda

The CHAIRMAN, recalling resolutions EB59.R7 and EB59.R8, suggested that Dr Hapsara, Dr Maruping, and Professor Menchaca should be appointed as representatives of the Board.

Decision: The Executive Board, in accordance with paragraph 1 of resolution EB59.R7, appointed its Chairman, Dr A. Grech, ex officio, and Dr R. Hapsara, Dr Arabang P. Maruping and Professor J. R. Menchaca, to represent the Board at the Forty-first World Health Assembly.

4. FILLING OF VACANCIES ON COMMITTEES: Item 8 of the Agenda (Document EB80/4)

The CHAIRMAN, recalling resolution EB61.R8, paragraph 4, and drawing attention to document EB80/4, submitted by the Director-General, proposed that the vacancies should be filled following the order in which the committees were listed in that document.

It was so agreed.

Membership of the Programme Committee of the Executive Board

The CHAIRMAN proposed that the number of additional members should be increased to eleven in view of the greater responsibilities assigned to the Programme Committee by the Executive Board at its seventy-ninth session.

Decision: The Executive Board decided, in view of the additional responsibilities assigned to its Programme Committee at the Board's seventy-ninth session, to increase to eleven the number of members of the Programme Committee in addition to the Chairman, member ex officio.

Decision: The Executive Board appointed Dr J. M. Aashi, Dr I. F. Camanor, Dr S. D. M. Fernando, Professor S. Rakotomanga and Dr R. Figueira Santos as members of its Programme Committee, established under resolution EB58.R11, for the duration of their terms of office on the Executive Board, in addition to the Chairman of the Board, member ex officio, and Professor J.-F. Girard, Dr M. M. Law, Mr B. V. McKay, Professor O. P. Scepin, Mr Song Yunfu and Dr F. E. Young, already members of the Committee. It was understood that if any member of the Committee was unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.

The CHAIRMAN announced that the Programme Committee would be holding a short, preliminary meeting immediately after the eightieth session of the Executive Board.

Membership of the Executive Board's Standing Committee on Nongovernmental Organizations

Decision: The Executive Board appointed Mr H. Hadjipanayiotou, Dr H. K. M. A. Hye, Dr J. C. Mohith and Dr T. Shimao as members of the Standing Committee on Nongovernmental Organizations for the duration of their terms of office on the Executive Board, in addition to Dr M. Quijano Narezo, already member. It was understood that if any member of the Committee was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.

Membership of the UNICEF/WHO Joint Committee on Health Policy

Decision: The Executive Board appointed Dr H. Oweis and Dr H. O. Tall as members of the UNICEF/WHO Joint Committee on Health Policy for the duration of their terms of office on the Executive Board, in addition to Professor J.-F. Girard, Dr R. Hapsara,

Professor J. R. Menchaca and Professor M. Steinbach, already members. The Board also appointed Dr Blackman, Dr H. M. Ntaba and Dr T. Shimao as alternate members of the Committee, in addition to Dr J. M. Aashi, Dr Arabang P. Maruping and Professor W. J. Rudowski, already alternate members of the Committee.

Members of the Léon Bernard Foundation Committee

Decision: The Executive Board, in accordance with the Statutes of the Léon Bernard Foundation, appointed Professor F. Pocchiari as member of the Léon Bernard Foundation Committee for the duration of his term of office on the Executive Board, in addition to the Chairman and Vice-Chairmen of the Executive Board, members ex officio. It was understood that if Professor Pocchiari was unable to attend, his successor or the alternate member of the Board designated by his Government, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.

Membership of the Jacques Parisot Foundation Committee

Decision: The Executive Board, in accordance with the implementing regulations of the Jacques Parisot Foundation, appointed Professor J. R. Menchaca as member of the Jacques Parisot Foundation Committee for the duration of his term of office on the Executive Board, in addition to the Chairman and Vice-Chairmen of the Executive Board, members ex officio. It was understood that if Professor Menchaca was unable to attend, his successor or the alternate member of the Board designated by his Government, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.

Membership of the Ad Hoc Committee on Drug Policies

Decision: The Executive Board appointed Dr Arabang P. Maruping and Professor Barbro Westerholm as members of the Ad Hoc Committee on Drug Policies, in addition to Dr R. Hapsara, Mr B. V. McKay, Dr A. A. A Nasher, Dr M. Quijano Narezo, Professor M. Steinbach and Dr F. E. Young, already members of the Ad Hoc Committee. It was understood that if any member of the Ad Hoc Committee was unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Ad Hoc Committee.

The meeting rose at 17h30.

= = =