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1975 session

UNICEF-WHO JOINT COMMITTEE ON HEALTH POLICY

Report of the twentieth session held at
the headquarters of the World Health Organization
Geneva, 4-6 February 1975

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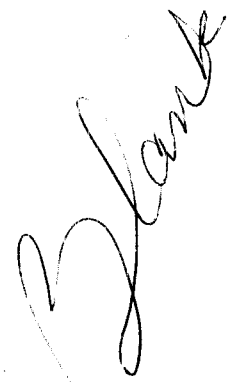
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UNICEF-WHO JOINT COMMITTEE ON HEALTH POLICY

JC20/UNICEF-WHO/75.6

Twentieth Session

ORIGINAL: ENGLISH

Geneva, 4-6 February 1975

REPORT OF THE TWENTIETH SESSION HELD AT THE HEADQUARTERS OF THE WORLD HEALTH ORGANIZATION

CONTENTS

1. ATTENDANCE

The twentieth session was held at the headquarters of WHO on 4-6 February 1975. Attendance at the session was as follows:

UNICEF Executive Board	WHO Executive Board
Representatives:	
Dr H. Conzett	Professor J. Sulianti Saroso (Chairman)
Mr P. N. Luthra	Dr N. M. Chitimba
Dr R. Mande (Rapporteur)	Dr S. P. Ehrlich, jr
Dr (Mrs) M. A. Silva	Professor J. Kostrzewski
Mr Nils Thedin	Professor J. J. A. Reid
	Dr G. Restrepo Chavarriaga
	Dr A. Sauter (Rapporteur)

Joint-Secretaries of the Committee: Dr A. Mochi and Dr P. L. Fazzi

UNICEF Secretariat	WHO Secretariat
Mr Charles A. Egger	Dr T. A. Lambo (Deputy Director-General)
Mr Newton R. Bowles	Dr W. C. Cockburn, Director CDS
Mr G. Carter	Dr S. Flache, Director COR
Mr S. Bacic	Dr T. Fülöp, Director HMD
Miss M. Hodgson	Dr K. Newell, Director SHS
	Dr A. Zahra, Director FHE
	Dr V. Djukanovic, Chief DVH
	Dr D. Flahault, Chief HTD
	Dr E. Mach, DVH
	Dr A. Noguer, MAL
	Dr A. Petros-Barvazian, Chief MCH

On the second day of the session, Dr H. Mahler, Director-General of WHO, and Mr H. R. Labouisse, Executive Director of UNICEF, addressed the meeting and emphasized the importance attached by them to the close collaboration between the two organizations and the role of the Joint Committee on Health Policy in shaping this cooperation.

2. OPENING OF THE SESSION

In welcoming the members of the Committee on behalf of Dr H. Mahler, Director-General of WHO, Dr Lambo stated that great importance is attached by the two Organizations to the provision of health care to the total population of developing countries, and furthermore, he emphasized the importance of immunization and patterns of education and training for nurses and midwives.

3. ELECTION OF CHAIRMAN AND RAPPORTEURS

Professor J. Sulianti Saroso was unanimously elected Chairman and Dr R. Mande (UNICEF) and Dr A. Sauter (WHO) were elected as Rapporteurs.

4. ADOPTION OF THE AGENDA

The Committee adopted the following agenda:

(1) Election of Chairman

(2) Election of Rapporteurs

(3) Adoption of agenda

(4) WHO/UNICEF Joint Study on Alternative Approaches to Meeting Basic Health Needs of Populations in Developing Countries

(5) Subjects for the information of the JCHP:

5.1 Review of patterns of Education and Training Programmes for Nursing and Midwifery Personnel

5.2 The WHO Expanded Programme on Childhood Immunization

(6) Other matters

(7) Adoption of the Report of the Twentieth Session

5. TERMS OF REFERENCE OF THE COMMITTEE

The Secretary recalled the terms of reference of the JCHP as approved by the Executive Board of WHO at its January/February 1960 Session, and the Executive Board of UNICEF at its March 1960 Session.

6. ASSESSMENT OF UNICEF/WHO JOINT STUDY ON ALTERNATIVE APPROACHES TO MEETING BASIC HEALTH NEEDS OF POPULATIONS IN DEVELOPING COUNTRIES

6.1 Presentation of the study

The Committee had before it a report with 11 annexes and copy of nine full length studies prepared jointly by WHO and UNICEF on the basis of consultations between the two secretariats, following the Nineteenth Session of the JCHP. The report is based on a large scale study of alternative approaches to meeting basic health needs of populations in developing countries.

The two Organizations have decided to carry out this study in view of the magnitude of health needs throughout the world and the fact that these basic needs are not yet met in a satisfactory way in many developing countries. Despite the efforts made over the years by many governments and by WHO and UNICEF to elaborate policies and strengthen the health services, it is estimated that in a number of developing countries less than 15% of the rural population and of other underprivileged groups, such as slum dwellers, nomads and people in remote areas, have access to health services. A hostile environment, poverty, ignorance of the causes of disease and of protective measures, lack of health services, or inability to utilize them are some of the factors that may combine to produce this situation.

The strategy so far adopted by many developing countries of modelling their health services on those of developed countries has not been conducive to serving adequately the needs of underprivileged populations. It has tended to create relatively sophisticated health services staffed with well-qualified personnel, which it was hoped to expand progressively as resources increased until the entire population was covered. This has not occurred. Instead, the services have become predominantly urban-oriented, mostly curative in nature, and accessible mainly to a small and privileged part of the population.

WHO and UNICEF believe that in spite of the widespread poverty and gravity of the problems,much can be done to improve the health of the people in the developing world and arrangements were made to study successful or potential successful primary health care programmes existing in a number of countries.

The objectives of the study were to examine promising systems of delivery of primary health care, with a view to outlining the factors that appear to be the key to success; and to observe the effect of some of those key factors in the development of primary health care within various political, economic and administrative frameworks.

Special attention has been paid to those features of particular systems which appear to contribute to:

(a) better coverage to meet basic health needs;

(b) better mobilization of potential resources;

(c) better utilization of services;

(d) better understanding of health services by both consumers and providers;

(e) better quality of health care.

It was agreed that a promising approach to meeting basic health needs provides:

(a) adequate immunization;

(b) assistance to mothers during pregnancy and at delivery, postnatal and child care and appropriate support to countries that accept and implement family planning programmes;

(c) safe, sufficient and accessible water supply, adequate sanitation and vector control;

(d) diagnosis of and treatment for simple diseases, first-aid and emergency treatment and facilities for the referral of serious conditions;

(e) other services that may be considered in the light of local conditions to meet basic health needs.

The report consists essentially of an introduction followed by four sections:

Part 1: Introduction and background information

Part 2: Statement of the problem

Part 3: Main features of the case studies

Part 4: Conclusions

Part 5: Recommendations

Abbreviated reports of the teams visiting various countries and programmes are attached as annexes to the study.

All sources of information confirmed the widely known fact that for lack of even the simplest measures of health care, throughout the world vast numbers of people are dying of preventable and curable diseases. However, there is a striking difference in this respect between the underprivileged world and the developed world.

While the principal causes of morbidity are different in various developing countries, it appears that malnutrition, parasitic and communicable disease (including vector-borne, gastroenteric and respiratory diseases) - themselves the results of poverty and ignorance - are the main factors influencing the health of the population.

The major problems of health services were analysed from the point of view of broad choices and approaches (a) resources; (b) general structure of health services, and (c) main weaknesses of a technical nature. Within these broader areas, a considerable list of problems emerged as requiring attention, such as lack of clear national health policies and poor linkage of health services systems with other components of national development; lack of clear health priorities; opposition to changes in social aspects of health policy; inadequate community involvement in providing health care; inappropriate training of health personnel.

Lack, inadequacy and maldistribution, as well as non-utilization of actual and potential resources for health services were considered, together with restricted use of primary health workers, as important obstacles to developing primary care.

Weak development of the "total system" concept, i.e. to consider all health care delivery systems - public and private, national and international, curative and preventive, peripheral, intermediate and central - as a whole and the lack of effective machinery for health planning were also regarded as causes of inefficiency of some health services.

Among the many weaknesses of a technical nature, deficiencies of communication and transportation, lack of basic sanitation, inadequate use of health education, and lack of adequate health information were recognized as major problems.

Successful national programmes were characterized by a strong political will that has transformed a practicable methodology into a national endeavour. In most cases there has been a fundamental decision to accept substantial changes. Although it is a difficult aspect for international organizations to influence, every effort should be made to identify potential driving forces behind promising programmes and to help harness them to national plans.

Simplifying the technology, so that many tasks can be carried out by primary health workers with limited, task-oriented training, seems to be an important feature of innovative health care systems. Primary health workers locally recruited and supported by their communities should form the front-line of and the entry point into the health service system.

Different types of indigenous healers may be trained and integrated into the general health system. The possibility of having some form of integration of these into the existing health systems should be investigated further.

Health services are only one factor contributing to the health of the population. It is generally recognized that certain actions initiated for the sake of economic or social development often have an influence on the health status of a community. Sanitation, housing, nutrition, education and communications, among others, must be considered as important factors contributing to good health by improving the quality of life.

In many cases, adequate utilization of preventive and curative health services and the extension of health care to the total population at the village level have been achieved by the population taking major responsibility for primary health care. Local contributions play an important role in providing the necessary manpower and facilities and in bringing the health services closely into line with the needs and priorities of the population they serve. Community involvement also means participation of the population in decision-making about their health services, and usually ensures and increases the motivation of the community towards accepting and utlilizing the health services.

The Joint Committee on Health Policy fully discussed the recommendations presented in the study, adopting a number of them in reading its conclusions as set out below.

6.2 Summary of discussions

The Committee accepted both the study and the report with enthusiasm and approval. It considered that the proposal for vigorous action-orientated expanded programme in health service development, starting with a major effort in primary health care, was a most suitable subject for a simultaneous priority effort by both WHO and UNICEF.

The Committee was aware that the WHO Executive Board at its Fifty-fifth Session had requested the Director-General to develop a programme of activities in the field of primary health care including the identification of the primary health care activities best suited to populations in developing countries; the evolution of methods of promoting such activities

in the community; the planning and implementation of the training of primary health care workers; the coordination and participation in technical and financial matters for the establishment and improvement of primary health care at the country level; and evaluation and reporting upon major efforts to develop primary health care systems. The Director-General had also been requested to consult Member countries and relevant agencies in order to obtain assistance in the development of an expanded long-term programme for primary health care, including the technical as well as financial aspects, with the aim of having a plan, action on which should be launched as soon as possible.

The Committee discussed relevant experiences in a number of countries, considering both successes, difficulties and constraints encountered. While it was accepted that a firm national will is a prerequisite, this included many additional aspects, which must follow a political decision. Some ministries of health are often not in a strong enough position to put forward sufficiently forceful arguments to effect the necessary changes. Such proposals may require the support of other national decision makers. Although it is essential that there should be a strong national will it is also essential that local initiatives should be encouraged. This is desirable because local initiatives can lead to nationwide endeavours.

The Committee stated that the suggested approaches to meeting basic health needs could be considered a pragmatic starting point, even though such a programme would take many years to realize. It was emphasized that the two-way connexion between health and rural development was important. Economic development did not automatically bring about an improvement in health status, but sometimes it did so, even without the improvement of health services. While it was desirable for a community to define its own needs it was perhaps utopian to expect that this would always be the case. Many people became adapted to the type of life they led and it would therefore be the task of someone like a "health promoter" to alert people to their needs.

The next important consideration was how to link up a primary health care service, when it existed, with the national health services and how to provide for the supervision and continuing training of the primary health worker and some kind of career opportunities. Sometimes the population had insufficient confidence in the ability of the primary health worker and it was therefore necessary to find ways of enhancing his status. The Committee emphasized that while the community should be involved and should assume a major share of responsibility for its own health, the government should also accept its responsibility and should cooperate with the community.

The Committee agreed that the report gave practical examples from a number of countries ranging from national programmes to projects in limited areas. There were lessons to be learned from all the examples from different social systems without subscribing to any particular political philosophy. One of the important conclusions of the report was the shift in the centre of gravity from capital cities to the periphery. That shift gave rise to a problem of communications. The Committee emphasized the need for primary health care rather than specialized and costly hospital care. The right balance must be found between hospital and community care, and between prevention and cure, which are in fact part of the same process. This national balance should be understood both by the country and by potential donors of funds or assistance.

The Committee pointed out that in many countries primary health care was frequently provided by practitioners of traditional medicine, for example, the traditional midwife. WHO and UNICEF should be prepared to play an active role in that respect, and put forward to governments ideas as to how traditional workers, as for example, those concerned with Ayurvedic medicine, could be used safely and effectively as a channel for health care delivery.

A WHO working document on the training and utilization of village health workers was presented to the Committee which noted with interest the attempt made to achieve a practical approach in this field.

The discussion brought out two seemingly conflicting points: that it was necessary to think in holistic and systems terms, viewing the health system as a whole; and that when segments of the health service - such as primary health care service - were missing or deficient, they should be developed and fitted in the whole. Most of the failures in programmes came in those imposed from the top without consultation, when primary health care never really started. It was important, first, to make a start with the development of primary health workers as that would be a rapid way of getting people to serve the community. Subsequently, ways of incorporating these primary health workers into the overall structure of the health services should be devised.

The Committee pointed out that it was important to define the responsibilities of primary health care workers, for example, in relation to the distribution of drugs and the giving of injections. Each country has its own laws and its own restrictions and these must be considered in any proposal for the development of the health services. For example, the draft Village Health Worker Manual described the primary health worker giving injections. In some countries it would be against the law.

6.3 Recommendations

The health care delivery systems that were taken as examples for this study show characteristics that appear to have been instrumental in leading to wider and more evenly distributed primary health care, greater satisfaction for the consumers, and more effective and more economical delivery of services. Duly adapted, these systems appear to be applicable in many political, social, economic and environmental situations.

The following recommendations were made:

(1) WHO and UNICEF should adopt an action programme aiming at extending primary health care to populations in developing countries, particularly to those which are now inadequately provided with such care, such as rural and remote populations, slum dwellers and nomads. Since the development of primary health care services is a national undertaking that requires action at all levels and since it is hardly feasible for all countries to introduce radical reforms, the proposed action programme should initially be selective. The criteria for selection should include one or more of the following:

(a) the existence of a national decision to proceed along this path; or

(b) a potential for change; or

(c) local health endeavours which could lead at a later step to national change.

(2) The following principles in the reorientation and development of health services to achieve extensive primary care should be adopted subject to local conditions:

(a) primary health care services should be recognized as forming part of overall development (urban, rural and other underserved groups), taking into account the interaction between development and health programmes;

(b) firm policies, priorities and plans should be established for the proposed primary health services;

(c) all other levels of the health system should be reoriented to provide support (referral, training, advisory, supervisory and logistic) to the primary health care level. Such an orientation of the health system would require active participation and training in the basic principles for all members of the health services;

(d) communities should be involved in the design, staffing, functioning, and in other forms of support for their local primary health care centres;

(e) primary health care workers who have undergone simple training should be utilized;

(f) the primary health care workers should be selected, when possible, by the community itself, or at least in consultation with the community - acceptability of such workers is in fact a crucial factor of success;

(g) there should be special emphasis on (i) preventive measures; (ii) health and nutrition education; (iii) health care needs of mothers and children; (iv) utilization of simplified forms of medical and health technology; (v) association with some traditional forms of health care and use of traditional practitioners; and (vi) respect for the cultural patterns and felt needs in health and community development of the consumers.

(3) A programme proposal such as that recommended requires a detailed awareness and understanding by all members of WHO and UNICEF staff and an organizational adaptation to respond to the new challenges. Therefore it is recommended that positive planned steps should be taken by WHO and UNICEF to inform, educate, and orientate their staffs to these policies.

(4) WHO and UNICEF should study in detail not only the innovations described in this study but also those that are occurring continuously in different parts of the world under different sponsorship; they should record and monitor them; learn from them; evaluate them; make their results widely available; assist them when necessary; adapt them; build upon them; and encourage similar endeavours, even though some may present some risk in the sense that their favourable outcome is not clearly predictable. Some of these risks can be minimized by adequate preparation and the building of a meaningful partnership with government.

(5) WHO and UNICEF should pursue research on the effects of rural and community development on the health of people and on the role that other sectors can play in the delivery of primary health care, develop methodology for application of the findings, and assist in its implementation.

(6) WHO and UNICEF should encourage and support:

(a) the adaptation of manpower planning and educational methods and techniques to situations in developing countries;

(b) the introduction of changes in the curricula and training of doctors, nurses and midwives to enable them to discharge their duties as envisaged in a health service system oriented towards primary health care;

(c) the introduction of changes in the training programmes of other health personnel to provide community orientation and inculcate the health team concept, so that such personnel become integral members of the community capable of putting the local resources available to the best use.

(7) Within the context of national resources and plans, WHO and UNICEF should seek the definition and adaptation of medical and health technology so that primary health workers can use as much of it as possible.

(8) WHO and UNICEF should study promising existing or potential approaches in health education with a view to disseminating knowledge about them and sponsoring their application, so as to create health awareness in the people and encourage them to become partners in the delivery of primary health care.

(9) WHO and UNICEF should study possible solutions of transport and communications in the delivery of primary health services and encourage the implementation of promising solutions, particularly in rural areas.

(10) The comments of national health administrations should be solicited for use in the development of plans of operations.

(11) This report should be widely circulated among international organizations and in developing countries, particularly among those responsible for the formulation of national policies, plans and programmes affecting the health of populations in rural and other underprivileged areas. An edited version might subsequently be published.

7. SUBJECTS FOR THE INFORMATION OF THE COMMITTEE

7.1 Review of patterns of education and training for nursing and midwifery personnel

The Committee had document HMD/NUR/75.1 before them for their information. The study was based on the decisions from the 1971 session of the JCHP relating to the need for such a review. It reports on the action that had been implemented in the intervening years. In particular a study had been conducted on the role of the traditional birth attendant in MCH and family planning, guidelines prepared, and a series of interregional meetings held; an extensive review and evaluation of teaching materials including much new material had been continued. Extensive studies of education and training programmes for all levels and categories of nursing/midwifery personnel including teacher training had been undertaken with the collaboration of non-governmental organizations. An Expert Committee on Community Health Nursing was convened in 1974.

Discussions

The discussions that followed showed the great interest of the members in the subject and the importance they attached to the contribution of nursing and midwifery personnel in the development of primary health care and community oriented health services. In fact, most participants saw the report as intimately related to and supportive of Item 4 of the agenda, "Alternative approaches to meeting basic health needs of populations in developing countries", (JC20/UNICEF-WHO/75.2).

It was recognized that the nursing/midwifery inputs required for the training and supervision of large numbers of primary health workers imposed fundamental changes in the educational process and in the role and functions of nursing/midwifery personnel at all levels. Such changes would need to take into account the necessity of ensuring a proper link up of the new types of health workers with the traditional care system and their functional interrelations with existing categories of health personnel. Special attention would need to be given to the necessity of ensuring an active involvement of the community in any system aimed at strengthening and developing primary care services.

Stress was laid on certain points and recommendations made in the paper.

The primary health care worker was seen as an integral part of the health care system and as such the training of this type of worker should be clearly oriented to the job to be performed. In addition to the introduction of new categories of primary health workers great importance was placed on the need to recognize, collaborate with and train members of the traditional health care system, such as traditional birth attendants, and to integrate them into primary health care. In view of the support, guidance and assistance the above workers will require, fundamental changes in the training and orientation of other levels of health workers will have to be undertaken. In order to implement these changes a systematic approach to the development of personnel and to the educational programmes was required. It was stressed that nursing/midwifery personnel had a vital role to play in this educational process.

Priorities in the training programmes were identified as

(i) basic revision of curricula for the different levels and categories of nursing and midwifery personnel oriented to community health practice in the community;

(ii) reorientation of teaching practices and teacher training programmes based on the principles and methods of vocational education for new cadres of teachers for auxiliaries, primary health workers, aides and traditional birth attendants;

(iii) refresher and continuing education to maintain and improve the quality of care and to expand the range of competencies of the personnel.

The concept of the open curriculum to permit opportunities for career mobility for health workers was advocated.

The new approach to the delivery of primary health care entails a reassessment of the potential role of nursing midwifery personnel in various health care settings to make full use of their professional and non-professional skills without prejudice to the primary role of the nurse as a provider of direct care. It also entails a change in the locus of the teaching/learning experiences of students from the exclusively curative setting in hospitals to real life experiences in the community with their teachers and supervisors.

The importance of team training and team work was emphasized. The interdependent and congruent role of the health team members rather than the hierarchial concept was mentioned, together with the necessity of flexibility of the attribution of responsibilities.

In conclusion all interventions were clearly directed to the need for the development of an action programme particularly at country level for which the active participation and contribution of nursing and midwifery personnel was of vital importance.

7.2 The WHO Expanded Programme on Childhood Immunization

The Committee had before it a report (JC20/UNICEF-WHO/75.4) which summarized the development of the WHO Expanded Programme on Childhood Immunization.

The report emphasized that infectious diseases are still among the major public health problems in the developing countries which are Member States of WHO.

Diphtheria, pertussis, tetanus, measles, childhood tuberculosis and poliomyelitis have almost ceased to be important public health problems in the developed world because efficient immunization programmes have been established. In contrast, in the developing world, diphtheria, pertussis, tetanus, tuberculosis and measles are important contributors to childhood mortality, and poliomyelitis is fast reaching the epidemic scale that was common in many temperate-climate countries in the pre-vaccination era.

To assist developing countries to extend to their children in the susceptible age-groups the benefits of effective routine vaccination which has been so eminently successful in the affluent world, WHO initiated in 1973 the Expanded Programme on Childhood Immunization.

The obstacles to vaccination in the developing areas are numerous. On the operational side these are: inadequate coverage and weak organization of health services; absence of trained personnel and efficient supervision; lack of equipment; lack of transport and cold-chains; high cost of imported vaccines and currency exchange difficulties; reliance on complex too-many-dose schedules; failure to obtain public understanding and cooperation. There are also a number of technical problems, e.g. sensitivity of vaccines to temperature and light; insufficient research on simple methods of administration.

The report also stressed that, jointly, WHO and UNICEF have a long history in this field of health activity.

During the presentation the size of the problem in the developing world was mentioned: 70 million infants every year would reach one year of age. If the objective was 80% coverage this would mean vaccinating 56 million infants annually.

If the Programme was designed to deal with the following seven diseases:[1] diphtheria, tetanus, pertussis, poliomyelitis, measles, smallpox, tuberculosis, the cost for vaccine alone would be between US$ 15 and 18 million. Even if this figure is multiplied by two or three times, to take into account the other expenses (excluding salaries of personnel) it would still be a very cheap and rapid method of control.

During the discussion, emphasis was put on practical problems that have so far led to many failures in immunization programmes and that should have the highest priority: lack of manpower training, effective cold-chains, lack of functioning transport and ineffective management.

It was mentioned that use should be made of existing health structures and facilities in order to maintain and extend the vaccination programme but that in certain areas of the programme mobile teams must continue to provide the needed coverage. It was emphasized that in Africa measles is a killing disease and priority should be given to measles vaccination. A special case should be made of vaccination against yellow fever where the disease is endemic.

Combinations and associations of a number of vaccines have proved successful and should be used to cut down costs and the numbers of visits. But it was stressed that new vaccine combinations should not be applied before they had been carefully studied experimentally. Care should also be taken in giving certain bacterial vaccines simultaneously with live virus vaccines because some reduction in immunological response to the live vaccines may be observed.

There was furthermore a need for simplifying the vaccination procedure by cutting down on the number of visits the child has to make. Whenever possible this should be made known to the health and medical authorities.

WHO/UNICEF assistance to countries to produce their own vaccines should be considered for each vaccine individually.

Production should be encouraged on a geographically regional basis. Together with assistance in production, WHO and UNICEF would assist in developing control laboratories in the countries.

The need for continuous evaluation was stressed.

It was recognized that it is of paramount importance that the major effort in the Programme must come from the individual countries concerned. This is for many reasons, one of the most important being that, once established, the national programmes will have to continue into the indefinite future on a regular basis.

It is, however, recognized that in some countries outside assistance would have to be maintained for a very long time.

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[1] Where neonatal tetanus is a problem a programme for vaccinating mothers should be instituted. Vaccination may also be extended against other diseases according to local needs (yellow fever in Africa, Japanese encephalitis in south-east Asia and the Western Pacific).

In conclusion the consensus was that it was high time that both WHO and UNICEF renewed their interest and doubled their efforts in assisting countries to extend immunization to their children. It was recognized that immunization is an effective tool that can give immediate results and has a very low cost/benefit ratio.

Ways and means to overcome the organizational problems such as cold-chains, newly developed vaccine-administration equipment and transport should be worked out jointly by WHO and UNICEF.

8. OTHER MATTERS

8.1 Antimalaria programme

The meeting was informed by the WHO Secretariat of the serious deterioration of the malaria epidemiological situation and of the action initiated at the Fifty-fifth Session of the WHO Executive Board to reverse the actual trend which affects the health status of millions of individuals.

In reply the UNICEF Secretariat recalled that the UNICEF policy regarding malaria control had been established by the Executive Board of UNICEF in 1970 on the basis of the recommendations of the Joint Committee on Health Policy. This policy was still in effect. In the framework of this policy, UNICEF was prepared to consider the provision of some assistance to countries seriously affected by the resurgence of malaria in consultation with WHO.

8.2 Subject for discussion at next JCHP meeting

The meeting was informed that, on the basis of consultations having taken place between WHO and UNICEF secretariats and with the agreement of the two Directors, the subject of health education was being recommended for study and reporting to JCHP twenty-first session. Health education would be approached as a subject closely related to and supportive of the new approach in development of primary care-oriented health services.

The Committee reacted favourably to this proposal. The need of health consciousness in a community-based health approach was stressed. It was mentioned that the study should take into account the discussions of the UNICEF Executive Board on the subject of primary health care development. It should seek the answers to basic questions in the process of public education in health and formulate innovative approaches to the delivery of health education.

9. APPROVAL OF THE REPORT

The Committee unanimously approved the report for its twentieth session subject to such editorial amendments as the Joint-Secretaries would introduce.

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