

A Call for Wiser Spending

Health in South East Asia

W.H.O. Regional Director's Report

(12th Session of the WHO Regional Committee for South East Asia, held in Kandy, Ceylon, from 23 to 29 Sept., 1959.)

"Governments of South East Asia have limited resources in men and money to spend on health—therefore what little they have must be spent in a stricter order of public health priorities", says Dr. C. Mani, WHO Regional Director, in his annual review of health progress.

Dr. Mani lists seven examples where a stricter priority rating is needed. He says:

1. Because we are very short of qualified doctors, we have multiplied medical schools and doubled the admissions to existing schools *but without providing adequate teaching staff*. The result may well be a vast number of inadequately trained doctors. Medical education is so costly that this is not a good investment.

2. Although we all deplore the acute shortage of doctors and nurses, it is a common enough sight to see them spending their valuable time and skill on work which can be done more efficiently and economically by clerks, or, in some cases, by domestic workers.

3. We use thousands of auxiliary medical personnel in support of the doctors and should, therefore, streamline their training to the fewest possible categories of a multi-purpose type so as to deploy them in different programmes as required. *Instead, we find ourselves training a bewildering variety of little specialists*, and all these categories will be difficult to assimilate into the general public health service.

4. Nature, fortunately, provides that

most babies shall be born normally. Poor countries would be expected to exploit this natural provision. And yet we see too little encouragement of domiciliary midwifery. On the contrary, there seems to be a growing ambition that even normal deliveries should take place in some health centre or hospital. *This is unnecessary and most uneconomical.*

5. To provide health services to our vast rural population, we are putting up hundreds of so-called health centres at a very considerable cost. And yet we do not succeed in obtaining from many of these centres more than a slight amount of curative medical relief. Although they will no doubt be called upon to continue to give such curative services, more strenuous efforts should be made to see that they also fulfil their preventive functions. *Far too little has been done so far at these centres to improve sanitation or to give proper health education, especially in nutrition; yet these are the foundations on which public health in this region must be built.*

6. *There is very little real enthusiasm about improving sanitation*, and this in spite of the fact that bulk of our child population is riddled with intestinal worms and gastro-intestinal infections! The adult population is not much better off. If a reminder were needed of the bad state of sanitation in this region, the recent fresh epidemics of cholera in Nepal and Thailand, and the occurrence in 1958 of almost 5,000 cases of this disease in the city of Calcutta alone, should surely suffice. It is inconceivable that with the existing resources we cannot make a better showing against the gross insanitation which prevails almost

everywhere. These very same resources are readily available for public health activities of a much lower priority.

7. Costly medical equipment, especially X-ray units and other electromagnetic apparatus, is frequently out of order for lack of proper maintenance. Public health institutions possess millions of dollars worth of such costly equipment, and yet hardly any one of them has properly trained technicians on its staff.

All this is not to disparage the heroic efforts which S.E. Asian countries are making against tremendous odds to improve the health of their people. These efforts have resulted in some expansion of public health programme despite the economic difficulties.

WHO Assistance

During the period under review WHO has helped governments in South East Asia with about 130 field projects, employing some 240 field workers—mainly in control of communicable diseases, promotion of rural health services and the training of many categories of health workers. The Regional Office in 1959 is handling a programme which amounts to nearly eight million dollars, inclusive of extra-budgetary funds.

Every country in the Region now has a malaria eradication programme and if adequate resources and facilities continue to be provided tangible benefits

should be possible within the next seven years.

India

The malaria eradication programme, which aims at protecting 390 million people and is the largest single undertaking of the kind ever undertaken, continues to make headway. The programme is being carried out through six regional anti-malaria organizations. Against a target of 230 "malaria units" (each to cover one million people) 225 have been established. Another 160 units were being added during 1959.

A National Tuberculosis Institute was set up in Bangalore as a first step in the national tuberculosis programme. This is the largest and most ambitious of the T.B. control programmes with which WHO has been associated.

The Government is studying the possibilities of smallpox eradication and, at the same time, of conducting a mass campaign against cholera. The yaws treatment programmes in the States of Andhra Pradesh, Orissa and Madhya Pradesh are expected to be completed by the end of 1961.

Eight States now have public health programmes connected with community development. In respect of rural health 572 primary health centres had qualified for WHO-UNICEF assistance by the end of March 1959. Five rural training areas began work during the year.

How People become ill and How they are cured — (Continued from page 367)

in mental disease. Prolonged application, combined with psychotherapy and sociotherapy, even without resorting to artificial sleep, sometimes brings about a veritable resurrection. At all events, these drugs relieve the most painful symptoms of mental disorder such as agitation, anxiety, aggressiveness, in nearly all cases.

Results: These vary according to the gravity and length of the disorder.

On the whole, however, one can say that properly co-ordinated treatment under satisfactory technical conditions makes it possible to restore 70 to 80 per cent of mental patients to normal social life. The average stay in hospital, for patients who are cured, is about four months. If we recall that a few years ago only about 30 per cent recovered, and that these patients required on the average more than a year to get well, the progress that has been made is evident.