

8  
DIV.  
ENDING

JOINT STAFF CONFERENCE

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION

U. S. PUBLIC HEALTH SERVICE

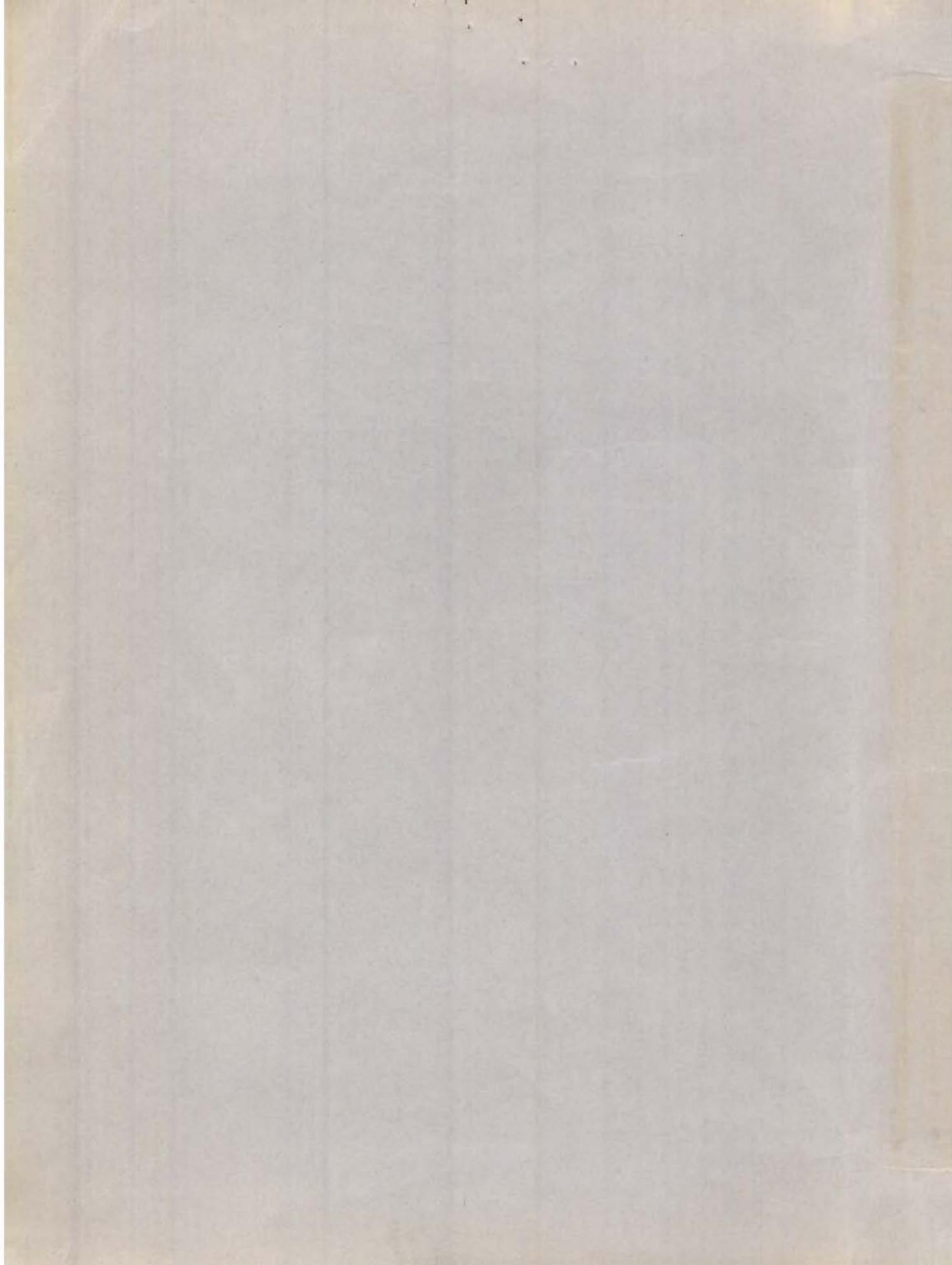
*gambind*

CAT FOR  
PUBLIC HEALTH

February 12 through 19, 1953

Geneva, Switzerland

Issued by  
U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
Public Health Service



PROCEEDINGS

OF

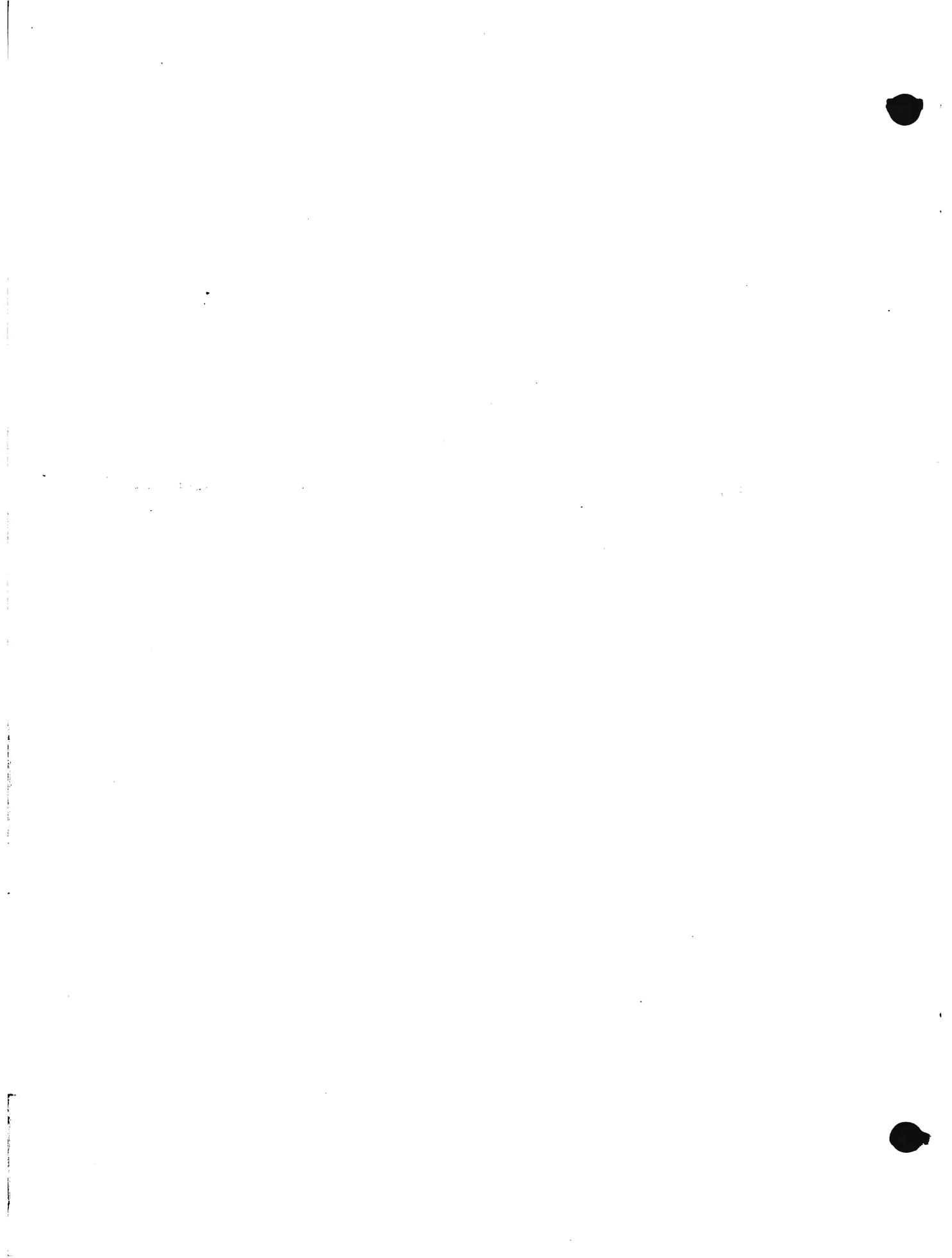
JOINT STAFF CONFERENCE

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION

U. S. PUBLIC HEALTH SERVICE

FEBRUARY 12 through 19, 1953

GENEVA, SWITZERLAND



## TABLE OF CONTENTS

	Page
Introduction	1
List of Participants	2
Composition of Working Groups	7
Agenda of Joint Sessions	9
Statements	
Statement by Mr. Stanley Andrews	12
Statement by Dr. Frederick J. Brady	19
Statement by Dr. George K. Strode	23
Summaries	
First Plenary Session	44
Second Plenary Session	51
Third Plenary Session	56
Fourth Plenary Session	66
Fifth Plenary Session	74
Conference Summary and Conclusions	77
Annexes	
Resolutions Quoted in Conference Summary and Conclusions (Annex A)	91
Report Working Group I - Training (Annex B)	92
Report Working Group II - Planning and Relationships (Annex C)	96
Report Working Group III - Programme Content (Annex D)	101
Report Working Group IV - Operating Methods (Annex E)	105



## INTRODUCTION

At the invitation of the Director-General of the World Health Organization a Joint Staff Health Conference including representatives of WHO, public health personnel of the Technical Cooperation Administration missions to various countries abroad and Washington representatives of the TCA and the Public Health Service was held in Geneva, Switzerland, February 12 through 19, 1953. Concurrently, there were held a series of meetings and individual conferences among the TCA and PHS personnel present.

The reports that follow are those of the Joint Staff Conference including a statement of the summary and conclusions of the Conference.

All who participated seemed to be of the opinion that the conference was highly successful and worthwhile. We hope this will be demonstrated conclusively by more effective operation of the field programs and closer and more effective coordination between the WHO and U. S. technical assistance programs in the years to come.

H. van Zile Hyde  
Medical Director, PHS  
Director, Health and Sanitation Staff, TCA

Washington, D. C.  
February 24, 1953

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
JOINT STAFF CONFERENCE  
February 12 through 19, 1953  
Geneva, Switzerland

PARTICIPANTS

World Health Organization

Dr. Brock Chisholm	Director-General
Dr. P. Dorolle	Deputy Director-General
Dr. H. S. Gear	Assistant Director-General Department of Central Technical Services
Dr. V. A. Sutter	Assistant Director-General Department of Advisory Services
Mr. M. P. Siegel	Assistant Director-General Department of Administration and Finance
Dr. Fred L. Soper	Regional Director for the Americas
Dr. C. Mani	Regional Director for South-East Asia
Dr. I. C. Fang	Regional Director for Western Pacific
Dr. A. T. Shousha	Regional Director for Eastern Mediterranean
Dr. N. D. Begg	Regional Director for Europe
Mr. J. Perlstein	Chief of Field Operations, United Nations International Children's Emergency Fund, Paris Office
Dr. E. Grzegorzewski	Director, Division of Education and Training

Dr. James Troupin	Assistance to Educational Institutions Section
Miss Olive Baggallay	Nursing Section
Mr. J. Wright	Division of Environmental Sanitation
Dr. T. S. Sze	Social and Occupational Health Section
Dr. S. Swaroop	Statistical Studies Section
Dr. L. Han	Assistance to Educational Institutions Section
Dr. P. Kaul	Director, Office of Technical Assistance
Dr. N. Sinai	Director, Office of Reports and Analysis
Dr. W. P. Forrest	Director, Office of External Relations
Prof. H. Baity	Director, Division of Environmental Sanitation
Dr. M. Pascua	Director Consultant Health Statistics
Dr. Y. Biraud	Director, Division of Epidemiological and Health Statistical Services
Dr. E. Pampana	Malaria Section
Mr. T. H. Butterworth	Health Education of the Public Section
Miss H. Martikainen	Health Education of the Public Section
Dr. W. Bonne	Director, Division of Communicable Disease Services
Mr. R. N. Clark	Division of Environmental Sanitation
Dr. W. Timmerman	Director, Division of Therapeutic Substances

Dr. N. Howard-Jones	Director, Division of Editorial and Reference Services
Dr. J. Holm	Tuberculosis Section
Dr. F. W. Reynolds	Venereal Diseases and Treponematoses Section
Dr. R. C. Burgess	Nutrition Section
Mr. H. C. Grant	Director, Division of Administrative Management and Personnel
Dr. J. S. Peterson	Director, Division of Organization of Public Health Services
Dr. J. Vesely	Fellowships Section
Dr. C. K. Chu	Public Health Administration Section
Dr. M. Kaplan	Endo-Epidemic Diseases Section
Mr. T. Hughes	Administrative Management Section
Mr. E. Renlund	Director, Division of Budget and Finance
Dr. S. Gilder	Department of Advisory Services
Mr. J. Handler	Director, Division of Public Information
Mr. D. Messinezy	Fellowships Section
Dr. W. Crichton	Public Health Administrator Eastern Mediterranean Regional Office

Technical Cooperation Administration - Public Health Service

Technical Cooperation Administration Washington

Mr. Stanley Andrews	Administrator, TCA
Dr. H. van Zile Hyde	Director, Health and Sanitation Staff, TCA

Dr. John J. Hanlon	Associate Director, Health and Sanitation Staff, TCA
Mr. Wyman R. Stone	Director, Division of Health, Sanitation and Housing, Institute of Inter-American Affairs, TCA
Dr. Lewis C. Robbins	Public Health Service, Asian Development Service Staff, TCA
Mr. Claude T. Coffman	Legal Counsel, Asian Development Service, TCA

Technical Cooperation Administration Field

Egypt -

Mr. F. A. Flohrschutz, Jr.	Chief, Health Division, TCA Mission
Miss Lucille Perozzi	Public Health Nurse Consultant United States Children's Bureau

Ethiopia -

Mr. John R. Thoman	Chief, Health Division, TCA Mission
--------------------	-------------------------------------

Iran -

Dr. Emil E. Palmquist	Chief, Health Division, TCA Mission
Mr. Frederick J. Aldridge	Chief Sanitary Engineer
Mrs. Ruth McArthur	Chief Nurse

Iraq -

Dr. Glenn S. Usher	Chief, Health Division, TCA Mission
--------------------	-------------------------------------

Israel -

Mr. Abraham W. Fuchs	Chief, Health Division, TCA Mission
----------------------	-------------------------------------

Jordan -

Mr. Edward L. Borjesson	Chief, Health Division, TCA Mission
Miss Elizabeth C. Hilborn	Division Nurse Training

Lebanon -

Dr. Eugene A. Gillis	Chief, Health Division, TCA Mission
Miss Margaret E. Willhoit	Division Nurse Training, American University of Beirut
Mr. Leonard N. Phelps	Statistical Consultant, United States Office of Vital Statistics

Liberia -

Dr. John S. Moorhead	Chief, Health Division, TCA Mission
----------------------	-------------------------------------

Libya - Dr. Paul A. Lindquist	Chief, Health Division, TCA Mission
Burma - Dr. LeRoy R. Allen Dr. Raymond L. Laird	Chief, Health Division, TCA Mission Chief Malariaologist
India - Dr. Estella F. Warner Miss Lillian M. Bischoff	Chief, Health Division, TCA Mission Chief Nurse, Health Division TCA Mission
Indonesia - Miss Lorena J. Murray	Chief Nurse, Health Division TCA Mission
Nepal - Dr. George Moore	Chief, Health Division, TCA Mission
Brazil - Dr. Eugene Campbell	Chief, Field Party, Institute of Inter-American Affairs, TCA
Chile - Dr. Ted Gandy	Chief, Field Party, Institute of Inter-American Affairs, TCA

Public Health Service Washington

Dr. Frederick J. Brady	International Health Representative, PHS
Mr. Harry G. Hanson	Assistant Chief, Sanitary Engineer Officer, PHS
Miss Virginia Arnold	Chief Nurse, Division of International Health, PHS
Dr. Howard M. Kline	Chief, Education and Training Branch, Division of International Health, PHS
Mr. Robert C. Coulter	Executive Officer, Division of International Health, PHS
Dr. George K. Strode	Consultant to PHS

Mutual Security Agency

Mr. Kaarlo W. Nasi	Acting Public Health Advisor, Office of the Assistant Director for the Far East, MSA
--------------------	--

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
 JOINT STAFF CONFERENCE  
 February 12 through 19, 1953  
 Geneva, Switzerland

Organization of the Conference

Co-Chairmen: Dr. Hyde (TCA)  
 Dr. Chisholm (WHO)

Rapporteurs: Dr. Brady (PHS)  
 Dr. Gilder (WHO)

Working Groups

Group 1

TRAINING

Convenors: Dr. Palmquist (TCA)  
 Dr. Grzegorzewski (WHO)

Rapporteurs: Dr. Kline (PHS)  
 Dr. Troupin (WHO)

Group 2

PLANNING & RELATIONSHIPS

Dr. Warner (TCA)  
 Dr. Dorolle (WHO)

Dr. Robbins (TCA)  
 Dr. Kaul (WHO)

WHO

(Miss Baggallay  
 (Mr. Wright  
 (Dr. Sze  
 (Dr. Swaroop  
 (Dr. Han

(Dr. Sinai  
 (Dr. Forrest  
 (Dr. Baity  
 (Dr. Pascua  
 (Dr. Biraud  
 (Dr. Pampana

TCA/PHS

(Dr. Lindquist  
 (Miss Hilborn  
 (Miss Bischoff  
 (Mr. Fuchs  
 (Miss Willhoit  
 (Miss Arnold

(Mr. Aldridge  
 (Dr. Allen  
 (Mr. Thoman  
 (Miss Perozzi  
 (Mr. Phelps  
 (Dr. Strode

Group 3

PROGRAMME CONTENT

Group 4

OPERATING METHODS

Convenors: Dr. Campbell (TCA)  
Dr. Sutter (WHO)

Mr. Borjesson (TCA)  
Mr. Grant (WHO)

Rapporteurs: Mr. Hanson (PHS)  
Mr. Butterworth (WHO)

Mr. Coulter (PHS)  
Dr. Peterson (WHO)

WHO

---

(Dr. Bonne  
Mr. Clark  
Dr. Timmerman  
Dr. Howard-Jones  
Dr. Holm  
Dr. Reynolds  
Dr. Burgess

---

(Dr. Vesely  
Dr. Chu  
Dr. Kaplan  
Mr. Hughes  
Mr. Renlund  
Mr. Handler

TCA/PHS

(Mrs. McArthur  
Dr. Laird  
Mr. Flohrschutz  
Dr. Moore  
Mr. Nasi (MSA)

(Dr. Moorhead  
Dr. Usher  
Miss Murray  
Dr. Gillis  
Mr. Coffman

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
JOINT STAFF CONFERENCE  
February 12 through 19, 1953  
Geneva, Switzerland

A G E N D A

( 1st day) February 12 (Thursday)

Morning  
(Plenary)  
9:30

-  
12:30

Introduction and identification of  
participants

Adoption of agenda and announcements

Statement by representative of WHO

" " " " PHS

" " " " TCA

Statement by Dr. Sinai on relation  
of health to economic development

Statement by Regional Director  
WHO Eastern Mediterranean Regional  
Office

Statement by Regional Director  
WHO Regional Office for the Americas

Statement by Regional Director  
WHO Regional Office for South East Asia

Statement by Regional Director  
WHO Regional Office for Western Pacific

Afternoon  
(Plenary)  
2:30  
on

Statement by Regional Director  
WHO Regional Office for Europe

Statement by UNICEF Liaison Officer

(2nd day) February 13 (Friday)

Morning  
(Plenary)

9:30

-

12:30

Summary of IIAA evaluation study -  
Dr. G. Strobe

Selected country programmes

Chile . . . . . Dr. Ted Gandy

Iran . . . . . Dr. Emil Palmquist

India . . . . . Dr. Estella Warner

Discussion of the three country programmes

Afternoon  
(Plenary)

2:30

Statements by Deputy Director-General and  
Assistant Directors-General on WHO  
Headquarters organization and methods of  
operation

Statements of Conveners of Working Groups

- 1) Training
- 2) Planning and Relationships
- 3) Programme Content
- 4) Operating Methods

Statement by Dr. Hanlon

Personal Assignments to Working Groups

---

(3rd day) February 16 (Monday)

Morning

No sessions

Afternoon

Working Groups

2:30

---

(4th day) February 17 (Tuesday)

Morning

Working Groups

9:30

Afternoon

No sessions

(5th day) February 18 (Wednesday)

Morning  
9:30

Working Groups

Afternoon  
2:30

Working Groups

---

(6th day) February 19 (Thursday)

Morning  
(Plenary)  
9:30

Reports of the Working Groups and  
discussion

-  
12:30

Afternoon  
(Plenary)  
2:30  
on

Reports of the Working Groups and  
discussion concluded.

---

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
JOINT STAFF CONFERENCE  
February 12 through 19, 1953  
Geneva, Switzerland

Detailed Summary of address given by Stanley Andrews, Administrator, TCA,  
on February 12, 1953

Your agenda suggests that I am to talk here this morning on some of the objectives of TCA. I shall touch briefly on some of our overall objectives but I would, speaking as a layman and an Administrator, rather indicate two or three things which I hope will come out of this technical conference of the heads of our various missions in the general area of the Middle East and Far East and the regional heads of the World Health Organization.

Brushing aside the legal and philosophical definitions of the Technical Assistance programme of the United States, we have a very simple formula as I see it - that is to help countries who desire us to help them "increase production of the things which human beings need and desire for a little better standard of living". The things which go then into making men, women and nations better producers of goods are the elements of what we are driving at. It is the fundamental belief of those of our country who gave action to the idea and those who are carrying it out that with improved standards of living in most of the so-called under-developed countries of the world, there will be improved political and social stability. That means a better chance for peace in the free world. Health, education, improving technical skills, making better use of the human, material and natural resources of a country are all component parts of and all are essential to increased production. That is one of the many reasons why co-operative action in the field of health is a large component of the American technical assistance programme.

Now as a group of Americans, leaders of health teams in the various countries in which we are working and as colleagues in an even broader effort of the World Health Organization, as workers in the ranks and in the various fields of activity connected with health - what may we reasonably hope to get out of a conference like this?

Here is what I hope will come out of it among many other things. First, I hope we get a genuine interplay of experience here on the problems, the successes and failures of each of you in your respective areas of activity. I hope you will be more than frank and tell us where we are falling down in Washington, where we fail to assist you and where, sometimes I'm sure, we make your job more difficult.

Secondly, I would like to see come out of this conference a sounder basis for cooperation between TCA groups, world health groups and any other agencies or groups to the end that the total objective - that of improving the health of the nations in which we are working is accomplished.

Thirdly, I'd like to see this group, working with our colleagues and associates of WHO, come up with a few basic and sound general fields of activity in the various areas of our work to the end that we can, with our host countries, tackle some basic job so that in matters of months or years, we can say, "This we have done. This was here when we came. Together, we and our hosts have met the problem."

By that I do not mean the dashing in and typing up the whole health problem in an area in a neat package and then going home with the job done. The health job is never done as I see it. If we stamp out malaria, for instance, something else comes along. As areas urbanize or as movements of people between areas increase, new diseases and problems arise. We, I think, have the right to hope that in the attack now on some basic common problem, the means, the organization, the sophistication and the growth of a country will develop to the point where the people in the countries will be able to handle their problems in the years ahead without our help. I would, therefore, urge, especially those in TCA, to pull some of our schemes out of the clouds and get down to a concerted attack on the fundamental problems of family and community well-being.

Fourth and last, I hope we can design a plan of action and a system of attack on health problems which our host countries can afford to carry forward after a few years without a subsidy from the United States or some other national or international agency.

I have just gone over some reports on bilateral technical assistance in health in some of the countries of our Latin American neighbours. I understand that later in this programme there will be an evaluation of that work by a member of this conference. To me, the considerable data on this work is rather revealing as to how these public health programmes grow and how countries grow and develop their own programmes over the years. May I then briefly review some of the work with which I am most familiar in our Latin American countries? The Institute of Inter-American Affairs operates as the Regional Arm of TCA in Latin America.

During the past ten years, great achievements have taken place in the eighteen Latin American countries in which health and sanitation programmes have been in operation. Action programmes are now operating in Bolivia, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, and Venezuela.

Each health and sanitation programme is planned to meet, insofar as is possible, the specific needs of the area in which it is to operate. It may dig a well so that the people of a single village can have pure drinking water. Or it may tackle the job of ridding a large jungle area of malaria, typhoid, and other water-borne diseases.

Generally the programmes in the other Americas have endeavoured to alleviate the following prevailing conditions:

It has been estimated that perhaps 80 per cent of all the people suffer from intestinal diseases caused by parasites. In many areas one in every 10 persons has malaria; in some communities the rate is near 100 per cent. Tuberculosis death rates reach more than 200 per 100,000 persons, but in some regions this disease appears in epidemic proportions. There are thousands of deaths each year from smallpox, diphtheria and whooping cough that could easily be prevented by vaccination. Life expectancy is estimated at less than 45 years; in many areas death claims one of every five babies born alive.

In 1952, active projects in the 18 Latin American countries numbered 609. These included construction of 72 water supply systems and 8 sewage systems; construction of 26 hospitals and operation of 27; construction of 21 health centres and operation of 69; construction of one nursing school; operation of 26 mobile health units, 69 local training courses, 24 health education projects and 12 malaria control projects.

A significant phase of the health and sanitation programme has been the emphasis on training Latin Americans to assume complete responsibility for each project as soon as possible. Recent figures for 1952 showed 119 United States technicians working with 2,535 Latin American doctors, nurses, sanitary engineers, and other professional personnel; 1,183 clerical personnel; and 3,416 unskilled workmen.

An outstanding example of what has been accomplished in the health and sanitation programmes is to be found in Brazil. In the Amazon River Valley, 56 health centres and their subposts minister to two million people scattered over an immense area. Efforts have been concentrated on reducing malaria and intestinal diseases that affected almost 100 per cent of the entire population. As a result of the co-operative programme, these diseases have been virtually eliminated, not only from the great Amazon Valley but also from the Rio Doce Valley. When the work first began in 1942, there were 40 United States technicians co-operating with 500 Brazilians. Today not a single U. S. technician is in the Amazon Valley. The work is being carried forward by 1,000 Brazilians, most of whom were trained as a part of the co-operative programme.

Another interesting example is the industrial hygiene programme being carried on in the mines of Peru - the first such programme in the world at such high altitudes. The mines in the Andes mountains of Peru are from 14,000 to 16,000 feet above sea level, and only the Indians who are native to these altitudes can work in them. This labour force is a diminishing one, however, since occupational diseases, including silicosis, draw off men and there are none to replace them.

These high-altitude Peruvian mines contain copper, zinc, lead, vanadium, antimony, bismuth, and other strategic products that are important in world markets. In 1947, the Peruvian government passed a law making an industrial hygiene programme mandatory, to start in the high mining areas, and laid a tax on industry to support it. The Peruvian government then asked the co-operative health staff to accept responsibility for this programme.

The Institute borrowed the best available United States industrial engineer and an industrial chemist and sent them to Peru. A Peruvian physician had already been sent to this country to study industrial hygiene and safety. These three and local nationals whom they trained, went to work on what is considered one of the unique endeavours in the history of industrial hygiene as it applies to mining.

Since silicosis results from inhaling dust, a comprehensive study was made of dust conditions in the Peruvian mines. Legislation was passed requiring the use of masks and other preventive measures. Periodic counts of dust are made as well as regular checks on the health of the miners, and remarkable progress is being made in controlling the progress of the disease.

Estimates vary and are difficult to obtain, but observers believe that more than 25 million people, or one of every six Latin Americans, have benefited from the co-operative health and sanitation programme during the past ten years. Under it diseases have been checked by extending controls over the environment, thus providing the stimulus to improved human resources. These in turn are opening new vistas to the development of the great natural resources of Latin America. Thus Point 4 helps to build strength in the Americas.

The kind of health activities that were started in Latin America in 1942, when there was a hemisphere emergency, are just as essential in peace as in war. They are helping to raise a permanent defense against disease in the entire hemisphere. The people who benefit range from the natives of a tiny village in the high Andes to the tourist and businessman who visit the large cities or the small hamlets of Central and South America and find there safe food and water supplies, which in many cases have resulted from the co-operative efforts of Good Neighbours working together in the Point 4 programme. Thus we are building a better hemisphere.

I frankly am not too familiar with how our health programmes in Latin America tie into the work of the Pan American Sanitary Bureau, which is the regional arm of the World Health Organization in America. I would hope that if there is not already the fullest co-operation we might begin now working together to the end that a national programme of health is established and carried forward by each country in Latin America and that our forces be combined to that end.

I am receiving from time to time some rather heartening reports from our Near East and Far Eastern areas of the kind of co-operation I think is essential if we do the health job in these countries. For instance I have before me a recent health project for Iran where six WHO experts are working hand in hand with TCA experts in the Iranian Ministry of Health. This amazingly successful close co-operation resulted in a country-wide anti-malaria campaign for Iran last year under the supervision of a World Health Organization director assisted by two American sanitary experts. The record of reduction in the incidence of malaria in the Caspian sea region and other parts of Iran where this programme operated is simply unbelievable.

I am told that tri-partite programmes in trachoma, venereal disease and nursing are under way. While perhaps the organization of the Iranian Ministry of Health is not all that could be desired I would like to emphasize that this programme is being carried out within the framework of what the country has now. There was no waiting for ideal and optimum conditions in Iran before they started to work. They started with what they had and with what Iran had.

Just before leaving my office for this meeting I received a cable from our country director in Ethiopia outlining a programme along the same lines. I was glad to see that in the take-over of the MSA programmes in Indonesia there had been in that country some fine teamwork between the American and World Health and even the Colombo plan technicians.

The one thing I hope will be standard procedure in all of these countries, certainly on the American side, is that the health technicians working with the Ministry of Health in the host country should call the shots on what is to be done in health - that it should not be what some politician or even extra-official administrator wants. Of course it goes without saying that such planning must be within the framework and with due regard to the funds and facilities available for such a programme. As a layman, of course, I can only talk on public health and its results on what I see in terms of vital statistics and charts on the incidence of various types of diseases and better yet, results in terms of production. I can truthfully say, in terms of agricultural production, that health programmes pay off in big numbers. In

some of our areas we must lick the health hazards before we can talk about agricultural development. I know also that the producer of industrial goods cannot hope successfully to meet present day competition or have the efficiency in production which will permit his products to sell within the range of his market without an efficient, healthy, well-trained and well-nourished labour force.

I will not dwell on these facts because they are perhaps "old hat" to most of you though they are continually startling and amazing to a layman like myself.

In conclusion, then, summarizing the overall TCA programme and relating those principles to health, may we suggest:

1. We must take people where they are and as they are and start with what they want and to the best of our ability with what they need... whether it be a mere sump hole for the refuse of the village or a health centre.
2. We must be ever conscious of the culture, the heritage, the religion and the lores of the people with whom we deal... we must give those individuals the same rights we demand for ourselves. That is the right to be proud of our heritage and our way of life. We can only change those ideas and culture patterns by showing and proving to the person... not yourself, that our way might be better.
3. Our programmes must be geared to reaching the greatest possible number and to meet the greatest pressing needs of a particular country.
4. There should be no such thing as an "American Programme" or a "WHO Programme" in a country; we should be a part of a national programme of a country hammered out if necessary by our groups in co-operation with the country. But it will mean only trouble in the future if it is not an accepted country programme. We cannot impose a programme and make it stick upon even the poorest and most backward of areas.
5. Whatever leadership and influence and even money we can provide, must be used toward the sort of a programme which the country can afford and, if need be, carried on by the country after we have been able to prove its worth. In other words these programmes, if they are going to be anything more than irritants and sources of future trouble, must be based on the economics of the country.

6. Last on this subject of TCA-WHO co-operation, in the past we have stressed the necessity of no overlapping and duplication, in other words, staying out of each other's way. As I see it, if we are to do the job which these, our friends in the under-developed countries need and require, we are going to have to go farther. There must be positive combined efforts with the best resources of each plus the host country, if we are even to start on the job that is ahead.

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
JOINT STAFF CONFERENCE  
February 12 through 19, 1953  
Geneva, Switzerland

Address given by Dr. Frederick J. Brady,  
International Health Representative,  
Division of International Health,  
U. S. Public Health Service  
on February 12, 1953

In the thousands of years of recorded history it is quite likely that future historians may look upon this half century as the most significant to mankind. It immediately comes to mind that man has made tremendous technical progress in recent years. New weapons have been developed capable of wiping the human race off the face of the earth. We have made new discoveries of the total resources of the world, such as the recognition of the vast potential of the oceans for minerals and fertilizers. In medicine discoveries of antibiotics and new specific synthetic drugs have revolutionized the practice of medicine.

Great as these technical discoveries have been, the tremendous social forces presently at work may transcend them in importance. Today men are engaged in a struggle for freedom, peace and prosperity, a struggle which will have profound effects for millenia to come. Accompanying this is the drive towards independence, the drive for individuality and autonomy of vast populations. Nations in their drive for a better life strive for accomplishments in a few years - accomplishments which have taken other nations centuries to achieve.

Thus all of us find ourselves facing problems which the world never before faced, problems requiring the highest type of judgment to evaluate, and the highest type of statesmanship to solve. Errors may not be only costly but may be catastrophic. The United States has arrived at a decision of tremendous importance, namely to share our technical knowledge abroad and contribute towards the economic health of less fortunate nations.

It has been accepted that the improvement of human health is not only essential for economic development in underdeveloped areas, but also a major tool for preserving world peace and security. My Government feels that health assistance given abroad is playing a tremendous role, and could perhaps play a greater one, in building a peaceful world.

In spite of our conviction of the importance of health, it is necessary for us to maintain perspective. Other types of activity, particularly improvement in agriculture and assistance in education, are necessary components if we are to achieve our objectives. Improvement in these fields develops man as a resource or provides the means to make this resource more effective. Little improvement in agriculture and education can be expected, however, unless a minimum level of healthfulness has been attained.

The World Health Organization Constitution, which was signed by all Member Governments, states that the World Health Organization shall be the co-ordinating international authority in health. While the money available and the size of the programme of bilateral agencies exceed those of the World Health Organization, it does not mean that they overshadow the World Health Organization. The United States Government for example, considers the World Health Organization as a permanent agency responsible for directing all international health resources into the most efficient channels. The TCA and MSA as well as the Columbo Plan and private agencies can do more by assisting the World Health Organization in this difficult task than by competing with it.

The World Health Organization is now in its fifth year. Its organizational pattern has been set and its technical assistance programme is developed. Both TCA and MSA are in the field with programmes of considerable magnitude. Thus during the last few years we have all been engaged in active campaigns the world over to such an extent that we have almost lost sight of the central fact that this is a completely new venture. Never before has the world seen international action of such magnitude. Hundreds of persons are working side by side with their colleagues in sovereign countries other than their own. All other forms of international relations and collaboration have been evolved only after many years, often centuries, of trial, appraisal and readjustment. The exigencies of our times have not given us centuries but only a few years to achieve results. Nevertheless, there is no substitute for the cycle of trial, appraisal, and adjustment - even though it be shortened. It is for that purpose - a joint appraisal of our experience - that we are here gathered, and we will find ways to improve our work.

When personnel of several organizations, both national and international, are set to work on the same general problem in a country with which they have only scant, if any, previous experience, the highest attainable efficiency obviously cannot be reached at once, nor can problems of adjustment be avoided. However, there can be no real conflict because the aims are the same for all participating organizations and their existence depends on policies set by the governments in international agreements.

As we review the work initiated and the experience accumulated, we shall first consider the opinions of those who have been in the field as leaders of the various operations. They know best the difficulties encountered as well as the procedures found profitable. Their experience will weigh most when we come to determine the suggestions for future improvements. But the headquarters people, both from Geneva and from Washington, have also struggled with problems and will have something to contribute.

Before giving the floor to our colleagues who have come from distant lands I should like to remind you of certain principles which must be kept in mind because they stem from policies determined on levels higher than those on which we are accustomed to walk. These principles will be no obstacle to anyone - only helpful in promoting agreement and in clarifying the relationships of our programmes.

I would list them without any claim as to their relative importance or as being all-inclusive.

1. There is no WHO or TCA health programme in a given country. Rather, it is the health programme of that country. Outside national or international organizations are in that country only to assist the national health service. Co-ordination of such programmes and their adjustment to the life of the nation is therefore in the first instance the responsibility of the national government.

2. This being so, it is desirable that planning be done with help both from multilateral and bilateral sources. In fact, a co-ordinating committee should be established by the national government.

3. In appropriation of funds for technical assistance, through our own agencies or through the United Nations, the Congress of the United States has stipulated that such assistance should contribute to the economic development of the beneficiary countries. Programmes which may not have such effect within a foreseeable future are therefore not acceptable under our appropriations.

4. Since the goal is economic development, it follows that close co-ordination must exist between the health, agricultural, industrial, educational, and other programmes. There must also be joint appraisals from time to time to ascertain that the required results are being attained. It is not enough to show that a hospital has been built or that the infant death rate has been reduced some points.

5. Lasting results must be obtained. It is essential therefore that there be long-range planning. The national health administration, for example, must be developed to a point where it can itself assure the permanency of a well rounded programme. It is also essential that the cost of the

programmes does not exceed what the country may be expected to provide once outside aid has come to an end.

We are sure that these meetings which have been long overdue will be of very material assistance to the cause of world health. Our job in Washington is to get American personnel - either for TCA or for WHO - into the field and to give them all the assistance we are able to provide - assistance which will increase the efficiency of those who are on the firing line.

The Public Health Service has played a large role in the development of international health programmes. We point with considerable pride to the influence that Dr. Williams and Dr. Hyde had in the early organization and subsequent development of the World Health Organization. Similarly, in the case of our bilateral programmes, the Public Health Service has been the agency that has encouraged, developed, and even crusaded for health activities. Today we are seeing our responsibilities continuing and increasing. Some 160 Public Health Service officers are now detailed abroad in connection with bilateral health work. In the Division of International Health, we have had the good fortune to be able to draw upon the resources of not only the whole Public Health Service, but through the Service even to utilize resources of our state and local health agencies.

Let me say particularly to the TCA staff here, you may be sure that the Public Health Service is indeed proud of your accomplishments. We hope that during this meeting you will point out to us our deficiencies and suggest ways in which we may overcome them. We expect these meetings to give us a clearer concept of the programmes and the difficulties with which you have to cope and how they may be met. These meetings should also bring a closer co-ordination and fuller co-operation between the World Health Organization and the bilateral field programmes. We will determine how the deficiencies in one programme may best be supplemented by the other. We expect to part from here with a feeling of mutual confidence and complete solidarity, ready for achievement of the goals that we set out together to reach.

Dr. Scheele has asked me to give you his regrets that he is not able to participate in these important meetings. He wishes you success in your deliberations and expresses his hope that many of the problems which have beset you in the past may be solved to the future benefit of world health.

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
JOINT STAFF CONFERENCE  
February 12 through 19, 1953  
Geneva, Switzerland

Certain Aspects of the U. S. Public Health Service Evaluation of the  
Institute of Inter-American Affairs Health Programme

by

Dr. George K. Strobe  
(Consultant, U. S. Public Health Service)

An address given on February 13, 1953

The actual launching of the co-operative health program of the IIAA occurred with the activation of the first bilateral agreement with Ecuador in February 1942. The inauguration of this programme was a projection of one of the decisions of the third meeting of Ministers of Foreign Affairs of the 21 American Republics held in Rio in January of that same year.

In a resolution unanimously approved, the Foreign Ministers had recommended the use of a binational health device as an instrument for furthering the security and prosperity of the nations of the Western Hemisphere.

The Rio Conference had been convened against the backdrop of World War II. It stands out chiefly as an achievement for a solid hemispheric front in face of the Axis threat. But it was more than that - it was part of a movement of international co-operation among the nations of the Western World in the health field that stretched back to the first half of the 19th century and that witnessed in 1902 the establishment of the PASB.

Planning of the bilateral co-operative programmes had been from the premise that the administrative mechanism of existing multilateral, national or private philanthropic organizations could not be adjusted to take care of the new foreign-political-technical work seen as necessary for the solution of critical economic, food and health problems that were identified as obstacles in the way of the attainment of either the immediate or long-range goals. Although the activities of the Inter-American system, both governmental and private, had prepared the way for the new programmes, it became apparent that a new governmental device would be necessary.

The mechanism devised had two major parts:

1. A corporation in Washington to be known as the IIAA.

2. A unit in one of the Ministries of the host government, generally called the Servicio, to plan and carry out projects which would constitute the programme in the host country.

The advantages of a subsidiary corporation like IIAA were:

1. Funds received by the Corporation are good until expended and do not need to revert to the Treasury if not spent or unobligated at the end of the fiscal year.

2. The corporation device makes it possible to conduct operations in foreign areas in accordance with local laws, customs and procedures instead of those of the USA.

3. The autonomy of the members and board of directors of the corporation assists in efficiency of operation.

The object and purpose of the IIAA was stated in its certificate of incorporation to be "to aid and improve the health and general welfare of the people of the Western Hemisphere in collaboration with their governments".

From the beginning the Institute's programmes were activated by agreements entered into with governments of the neighbour nations. These were established through an exchange of diplomatic notes. This was generally followed by a so-called "Basic Agreement" made between the representative of the Institute and the Minister of Health.

Under this agreement both parties provided contributions and agreed to the establishment of a unit in the host government, the Servicio, as already mentioned.

Furthermore the agreement provided that the Institute would send to the host country a small Field Party of professional and technical personnel including usually a physician, engineer and nurse. Incidentally, the entire cost of the Field Party was carried by the Institute.

It was provided that the Chief of the Field Party would also be Director of the Servicio in the host government, subordinate to the Minister or other designated officer in the co-operating Ministry.

Under the agreement, all work undertaken was to be broken down into projects and before these were started "project agreements" were signed by both the Chief of Party as representative of the Institute and by the designated officer of the local co-operating Ministry. This was to encourage joint planning as well as joint financing and execution of all work undertaken.

Usually the first project agreement was the Administrative Project which provided funds for the establishment and maintenance of the Servicio's office and staff. All other project agreements had to do with specific undertakings. It should therefore have been possible to appraise the cost of administration as compared with total programme funds expended but because of the pronounced tendency to charge many activities against administration which should have been set up under separate projects, this could not be done. To illustrate - in one country the engineering section of Servicio was requested to design and prepare plans for a hospital to be built by another agency; this was done and charged to Administration instead of setting up a separate project.

Finally there were "Completion Agreements" which, incidentally, were initiated some years after the several programs started. This agreement is a written document signed by the Minister and Chief of Party in which both parties agree that work outlined in the project has been completed to the point of logical transfer. It is also a complete record of programme accomplishment whereas the project agreement sets forth quite properly goals and plans. Completion Agreements can be of great value in self evaluation of performance and in planning future undertakings. In actual practice the Completion Agreements left much to be desired. Made long after completion of the project and often by individuals who had replaced those responsible for the work, it was inevitable that many would be faulty.

In addition to the Administrative and programme projects there were "Special Projects", which in every case were financed entirely by the Institute, not the Servicios. The considerable Fellowship programme, the Field Parties, the special conferences and translations of texts are examples of activities carried as Special Projects.

It will be of interest at this point to total the several contributions that were made to the co-operative programmes and to special activities during the 10 years under review. These of course now appear as expenditures.

125 Special Projects	3, 382, 965. 00
1540 Co-operative "	<u>99, 632, 950. 56</u>

Thus the total was 1665 projects \$103, 015, 915. 56 expenditures

The financial contribution ratio in support of the co-operative projects varied from year to year and from country to country. In the earlier years

contribution from the USA preponderated, but in the later years that of the host countries did so. For example in 1951 Venezuela contributed 92%, Haiti 59%, Chile 75% and Brazil 95% of the co-operative funds.

There were technical contributions from both sides as well. Technicians from the USA have always been small in numbers compared with those from the co-operating country. Some idea of the relationship is given by the following:

In 1951, in all the co-operating countries there were 110 Institute employees and approximately 7100 nationals in the field - 1:65.

In addition to the previously mentioned, there were Third Party Contributions. For the most part these funds were put up by local governments and local citizen groups as a further inducement to secure Servicio assistance in some local project such as a water supply, hospital or Health Centre. The Third Party Contributions totalled approximately \$10 million. In addition to money, contributions were also made in kind to an estimated total of \$6 1/2 million.

Thus summing up all contributions, the total value may be given as \$120,000,000.

---

For a number of reasons it seems desirable to discuss in more detail the Servicio. It is defined as "the administrative framework within which two countries party to a bilateral agreement pool a portion of their economic and technical resources in order, in the case of health, to raise the health level of the host nation and promote, develop and perpetuate a sound health programme".

The full title of this administrative device is usually - Servicio Co-operative International de Salud Publica. In Brazil it is Servicio Especial de Saude Publica. The name Servicio is probably Brazilian in origin and was chosen by Dr. Dunham on one of his trips to Rio. He was following a precedent he had found there.

It should be stressed that since the Chief of Party is also the Director of Servicio, as is the rule, he is responsible to two masters. There is an inherent administrative weakness in this but it cannot be said to be too serious as it has worked well over the years.

The favourable features include the following:

1. It provides an organizational framework for technical assistance. Being an actual administrative unit of the host government, it forms an established base of operations with firm lines of communication and contact with other officials of the host government.

2. The basic agreements give to Servicio the privilege of operating in a preferential setting. The Chief of Party does not need prior clearance with Washington to approve projects and to put them into operation. Servicio can procure directly and cheaply. It can adopt personnel practices, account and record keeping and other administrative procedures which it prefers and thus demonstrate the advantages of good practice.

3. The fact that Servicio operations are continuous and not short term, that they are concerned with performance of service and not "study and report", has great value. It has brought to Servicio popularity with people and their governments alike.

4. It provides a base for training nationals:

- (a) through in-service training;
- (b) through a fellowship programme. Though the Institute provides the fellowships it is Servicio that selects the candidates. The latter can therefore be scrutinized over an extended period and errors in selection minimized.

5. It provides a stable base. Experience shows that political changes have little effect upon operations. All political parties appear to endorse Servicio.

6. The most successful development of a health programme cannot be accomplished by the application of skills in the field of health and cannot be accomplished by the application of skills in the field of health and sanitation alone. Basic principles of general administration if developed in a country along with the highly technical skills in such fields as health, education or agriculture, will give greater assurance of optimal achievement. The Servicios offer excellent conditions to test and demonstrate the best in general administration.

The unfavourable features are few:

1. Divided responsibility of the Chief of Party could result in playing one party against the other. Though we found no evidence of this it is listed as a potential danger.

2. The danger of Institutionalization and Self-Perpetuation.

The mere fact that Servicio works in a preferential setting makes possible the development and maintenance of high level efficiency. It is understandable that there develops a sense of pride in a good piece of work and a desire to protect it from losing ground. Reluctance to transfer it to the normal authorities at the appropriate time, because of fear of regression, has been observed.

A contributing factor in the situation is the length of time a Chief of Party remains in one country. As the period lengthens, the more the Chief of Party and the Servicio come to be regarded as permanent institutions.

In the chapter on General Administration a number of other subjects are discussed including:

- (a) Recruitment of Field Party Staff;
- (b) Relationships of the Field Party and Servicio to the IIAA headquarters in Washington;
- (c) The need for full time consultants to serve both the Washington office and the field;
- (d) Records and Reports.

These and much more I shall pass over except to say that Records and Reports form an area which needs further study and can be improved.

#### PROGRAMME PLANNING

Good planning in any field is one of the most important functions of management and the benefits from operations vary with quality of planning.

Before programme planning can be undertaken there must be a decision in regard to objectives. If these are clearly and specifically defined, the programme can be precise and complete.

The chapter discusses the objections that pertained during the first half of services operations and those of the second half. In the latter period they were more general in character. As a consequence, evaluation of the second period was more difficult.

The purpose of the Institute as defined by Act of Congress of August 5, 1947, was "to further the general welfare of, and to strengthen friendship and understanding among, the peoples of the American Republics through collaboration with other governments and governmental agencies of the American Republics in planning, initiating, assisting, financing, administering and executing technical programmes and projects, especially in the fields of public health, sanitation, agriculture and education.

The Institute, in line with this objective, declared that the broad aim of its postwar programme would be to raise the level of living of the people of the several American Republics.

The evaluators agreed among themselves that it would be extremely difficult to determine the degree to which the co-operative health programmes were successful in raising the level of living of the people in question. They recognized that many other influences were at work besides health programmes to improve the standard of living and it would take almost super-human powers to disentangle them. For this reason they established the following criteria for their guidance in evaluation.

1. The extent to which indigenous health organizations were being developed and established.
2. The rate at which programmes and methods were being incorporated into the permanent public health structure.
3. The extent to which health habits and practices of the people were being influenced.

The Servicios, however, did have the official objectives before them in planning their programmes.

The programmes varied from those of a limited scope like that visited in Venezuela (cite) to those of a broad range of interests covering many public health subjects as was true in Brazil.

Planning, it must be realized, was a joint undertaking of the Chief of Party and the Minister of Health. This made it easier or harder depending on those two personalities and their motivations.

Once a programme had been agreed upon, one or more projects were undertaken to carry it to a conclusion.

Our chief criticism of programme planning was that it was undertaken with insufficient knowledge of the facts pertaining to the country and its people. This was not universally true but frequent enough to justify the recommendation that before attempting to develop a programme, an array of facts should be assembled, which would cover quite thoroughly the following areas of knowledge.

#### 1. Characteristics of the population

(a) Its racial composition should be determined since it is well known that susceptibility or resistance to certain diseases are in some way related to race.

To cite an example, reference may be made to the State of Tennessee where it has been well established that the incidence of tuberculosis was two or three times as high in the coloured as in the white population. Another well recognized example is the resistance of the negro to hook-worm disease.

(b) Its literacy must be known since this will have value in deciding upon the most effective means of communication that may be employed. The techniques of health education will have to be adjusted accordingly.

(c) Its distribution geographically is likely to have direct bearing on the type of its disease burden and the ease with which it can be reached in a programme of health betterment. If the population is predominantly rural the problem of establishing contact between it and the health service will tax the administrators inventiveness; this will be all the truer if the rural population lives in scattered farms rather than in villages.

(d) The age of the population should be established since programme planning will vary in accordance therewith. If the population is a young one with a large proportion in the lower age brackets and a relatively short life expectancy, planning will be concerned with the health hazards of infancy, youth and early adult life rather than the diseases that characterize old age such as cancer and the degenerative disorders.

(e) The occupations of a population should also be known and their relative frequencies established since it is well recognized that certain of them carry intrinsic health hazards. For example the lumberjack in the endemic areas of jungle yellow fever is in special danger of contracting the disease.

Among certain types of miners silicosis may be a hazard. The factory worker from the rural areas appears to be especially susceptible to tuberculosis. As a result of failure to have built up any resistance because of the infrequency of the disease in the areas of his birth he succumbs more readily to it. This factor combined with poor housing, improper diet and overcrowding places such a worker in a serious hazard. Occupation then must be given due weight in planning health services.

## 2. Vital statistics of the population

(a) An accurate census is essential in every field of social endeavour. It not only provides the information required to establish the characteristics of the population, some of which have already been mentioned, it also permits one to calculate rates and establish base lines which are so necessary in measuring the effectiveness of health programs.

(b) The number of births, deaths, marriages and divorces should be known with appropriate breakdowns as to political sub-division in which the event occurred, the sex and the age. An effort must be made to determine the nature of the mechanism established for the collection of vital statistics and the precision with which it functions, otherwise it will be impossible to form a judgement as to the reliability of the statistics or to determine how best they may be improved. .

(c) Knowledge of the causes of death and if obtainable the causes of illness, will identify the principal disease burdens of a population and be of the utmost value in programme planning. Frequently the incidence of a disease in an area, or in an entire country, is unknown and just as frequently no mechanism for ascertaining the facts exists. In such circumstances a field study to elucidate the subject by sampling the population may have to be undertaken. The prevalence of hookworm infestation was not appreciated in many Latin American countries thirty years ago any more than it had been in the southern United States, until spot surveys were undertaken when it was discovered that infestation of the population ranged up to 100% and actual disease varied from 10% to 50% or more.

(d) The average family income is important information to the programme planner and should be an ever present warning to avoid activities that call for contributions from householders beyond their financial competence.

3. The number, location and capacity of institutions devoted to medical and health problems serving a population

The majority of these institutions are concerned with the prevention, diagnosis and treatment of disease. They include the local and state health departments with their health centres, specialized clinics and other preventive services; the laboratories for the control of water, milk and other food products and the diagnosis of morbid conditions; and the hospitals of all types, specialized as well as general. In addition there is another, smaller group of institutions whose importance cannot be overestimated. They are the research institutes which, in large measure, determine the rapidity with which advances are achieved in medical care, both preventive and curative. It should be added that often times the institutions primarily concerned with the application of medical knowledge, such as hospitals, diagnostic laboratories and health departments, also engage in research. Their investigations are as likely to be focussed on administrative practices and organizations as on medical knowledge per se.

It is needful to secure a complete list of these several institutions, to know if their geographical locations assure to the population ready access to their facilities and to what extent they are capable of meeting the needs of the country.

4. The number, distribution and character of medical and health personnel serving a population and the nature and capacity of institutions which prepare such personnel.

Until facts are at hand as to the numbers of doctors, engineers, dentists, dental hygienists, hospital administrators, nurses, nurse-aids, visitadoras, social workers, sanitarians, dieticians and other specialized workers, there will be difficulty in determining where expansion of training institutions is most needed. It must also be known the extent to which such personnel is concentrated in urban areas especially in situations where the principle disease burden of the population is carried by those living in rural communities. Some estimate as to the quality as well as the quantity of workers in the health and medical fields is highly desirable though obviously more difficult to determine.

5. The nature of governmental structure with special reference to direct and collateral responsibilities in the health field.

Though the Ministry of Health usually carries the major obligation for health services, this may be shared by the Ministry of Social Welfare and the Ministry of Social Security, where these exist, since they frequently administer a part of, if not all, the hospitals and custodial institutions of a country. The Ministry of Education frequently has the obligation to maintain school health services and to this extent shares in the administration of the nation's health services but its major responsibility has to do, usually, with the preparation of medical and health personnel required by those services. The Ministry of Public Works is likewise tied-in closely to the health field in view of its role in the construction, and often design of hospitals, health centres, water supplies, sewage treatment plants and so forth.

The organization and the functions of each part of government that carries a responsibility in the health field should be recorded.

6. The nature and importance of voluntary agencies in the health field.

These vary greatly from country to country. The Red Cross usually conducts a health programme wherever organized on a national basis.

In a number of countries a large part of the tuberculosis campaign and the venereal diseases control work are conducted by voluntary organizations. Wherever this situation is to be found a careful analysis should be made of their programmes, qualitatively and quantitatively, so that due weight may be given to them in the total national health programme.

7. The social institutions, the customs and cultural traits of a people should be known when planning a health programme. These are matters that are less easily identified and understood than the infectious diseases for example, but they are equally important if not more so. The health planner needs to be familiar with the current beliefs of folk-medicine and the attitudes of people towards modern scientific medicine. He must have an understanding of the habits of the people, the motivations of individuals and their goals in life. Caste and class structure must be known. Land tenure laws, social legislation and housing are additional subjects in this field important to planning.

8. The economic and financial potentialities, as well as present position of a country, must be understood as a basis for realistic planning and a means of protection against undertakings beyond the national resources. The level of productivity, the nature of the labour market, the trend towards industrialization, the national income and the tax system are additional matters requiring investigation and understanding.

9. Education, agriculture and industry, along with health form an aggregate of inter-relationships and inter-dependency that determine in no small measure the advances in all four directions. If the level of living of a people is to be raised no one of them may be ignored. The planner in the health field must, in consequence, understand the problems of education, agriculture and industry and whenever possible, should seek ways and means whereby the health programme will aid and reinforce that of the others.

10. The geographic and climatologic characteristics of a country have a direct relationship to many of its health problems. This stems not only from the physical factors such as altitude, latitude, soil, insolation, temperature range and rainfall but many biological factors as well. The fauna and flora are most important and determine in no small measure the health hazards of an area. Knowledge of the nature of the sanitary environment of a population is essential. These characteristics cannot be neglected if programme planning is to be of a high order.

The availability of such basic data is a first step in good programme planning. Then comes the task of determining what the outstanding problems are which are susceptible of solution within the economic and financial capacity of the nation and establishing priorities re their relative urgency.

The individual projects generally were well prepared though they fell short in failing:

1. To include terminal dates, without which there tends to be less incentive to push the projects to a conclusion;
2. To provide for an orderly transfer to the appropriate Government agency.

The reasons for this might be:

- (a) Fearing less efficient administration;
- (b) Retaining for training purposes when other facilities exist;
- (c) Certain inherent difficulties that were not foreseen. Brazil Amazon Valley.

Two further considerations in Programme Planning are worth mentioning.

1. Since in some Latin American countries private agencies play important roles in Public Health, it is clear that joint planning with them would be of considerable value. Furthermore since success of all health programmes depends to a considerable extent upon an alert and informed public, it is desirable that it should be brought into relationship with the official planners. A National Health Council, advisory in character, would be a mechanism to secure co-ordination and broad public support. Such a Council could wield a powerful moral force and bridge gaps when government changes. Such a recommendation is made.

2. Since there are International and Private Foundations operating in Latin America a Clearing House Conference is proposed at both the national and international levels. Benefits should accrue from joint planning and where feasible, joint action.

## CULTURAL ASPECTS

Development of successful public health programmes depends not only on technical excellence of medical knowledge and practice but also on the socio-economic potential of a country and readiness of a people to accept new ideas and develop new habits. The economic handicaps of Latin America are a function of relatively low productivity. Improvement of its economic situation will come only by a rising standard of living.

Other problems with which public health programmes must cope may be termed cultural problems. These stem from the great differences which exist between the ways of life and thought patterns of the people towards whom such programmes are directed and those who create such programmes, and in part from lack of understanding of the factors which make for the most effective human relations in any given situation.

In the evaluation survey this meant that the evaluators must understand the ways of life, the value standards and particularly the beliefs and customs of the Latin American people with respect to health and illness, and must know also the motivations of both public health personnel and the people towards whom the programmes are directed, as well as their attitudes towards each other.

Cultural problems must be studied and analyzed with appropriate scientific methods. In this survey cultural anthropologists were employed but in any long-range programme sociologists and social psychologists should also be called upon.

The chapter emphasizes the dual role in which the social scientists were found to be of use:

- (a) In participation in original planning.
- (b) At the operational level.

In planning it must be known what are the practical limits to any programme. What the people are willing and able to accept. What they will reject. What the social and economic conditions are which must exist before certain innovations can be introduced into a culture.

At the operational level, the role of the social scientist is that of the educator. After determining the most practical programme, how can the people be convinced that it is really best for them, that it is in their interest to adapt the new and abandon the old?

In terms of a public health programme, it seems to mean that health and sanitation are not isolated parts of the life of a people. They are related to education, to social security, to economic productivity, to distribution of income and many other things. Changes in the level of health

may result from improvements in one or several of the aspects of culture just mentioned.

The anthropologist believes it is possible to bring about only limited changes in any aspect of culture without accompanying changes in the other aspects of culture. He believes it impossible to take a very backward area and introduce into it a modern first-class public health programme.

Fundamentally the problem is one of persuading people to drop old habits and ideas and to substitute for them new ones which heretofore have formed no part of their conceptual world. The public health specialist is not operating in a vacuum. His subjects do not feel he is necessarily bringing light on a problem about which they know nothing. The subjects already have definite and hard-to-shake beliefs which they are as convinced are correct as he is certain they are mistaken. They are not at all sure the doctor's ideas are better than those of the curandeiro; in many cases they are convinced that they are inferior.

The Health Centre was the focal point of certain studies that the anthropologist carried on. Interviews took place with the doctors, nurses, and sanitarians of the Health Centre. Door-to-door opinion surveys were made of the populations served. Health education programmes were studied. A rather full account of folk medicine was secured as well as information on the types of illness for which patients will consult doctors and those which they prefer to take to the curandeiro.

Several categories of data emerged from the studies:

1. Those related to "Interpersonal Relation"

Genuinely sympathetic relationships between Health Centre personnel and patients are essential for smoothly functioning programmes. Rigid concepts of class and caste, innate fear and suspicion of the masses towards other groups, hinder greatly good interpersonal relationships.

2. Those relative to Emphasis on Curative and Preventive Medicine

Whatever the merits of a public health programme based on Preventive Medicine, the fact remains that the average Latin American is interested in doctors and nurses because they can cure his ills. In most cases he avails himself of services not primarily to keep well, but to get well.

The reluctance to seek or accept medical advice when apparently well is deep rooted. Health, it is thought, consists in feeling well; it is not

possible to be ill if one feels well and has no evident symptoms of disease. Since sickness is due to sins of omission or commission, or to fate or luck, there is little a well person can or ought to do to keep himself well, at least as far as a doctor's attentions are concerned. It was noted, however, that good care when illness is present is an effective way to raise the prestige of Western medicine. Gradually it is borne in on the people that medicine is good for certain conditions and in time this will create a favourable atmosphere for a preventive programme.

### 3. Regarding the Nature of Folk Medicine

It is desirable that Health Centre personnel should be better acquainted with Folk Medicine. A rather lengthy description is given of this subject, which I shall not try to trace. However, the point is made that if patients come to believe that doctors and nurses are familiar with the native's own ideas of health and sickness, approve of some of the curandeiro's treatments (e. g. isolation, bathing, specialized diet, herbal teas) and demonstrate that for many things they, the doctors, have even better methods, it is very likely that greater tolerance for modern medicine would be evinced.

The chapter ends on this note.

"One of the best uses of the social scientist in the Institute's bilateral health programmes is the direct assignment to field parties of individuals well versed in the most recent developments in their fields, both to do generalized cultural research and simultaneously to gather specialized information to facilitate specific projects. Such a plan would make it possible for administrators and programme planners to have a continually growing body of precise factual information which, judiciously utilized, would eliminate much of the guess work which otherwise could not be avoided."

## TRAINING EDUCATION

The evaluation of Training and Education in the American Republics proceeded from two broad principles.

1. Well prepared personnel is indispensable in the foundation upon which strong and effective organizations are built. Those who established the Servicios were fully aware of this and from the beginning, training was accorded a high place among programme priorities.

2. Training is not something separate and distinct from the whole fabric of health services. It is a part of their warp and roof. The one cannot be modified or altered without at the same time changing the other.

Personnel when prepared must have a place for employment. Otherwise training loses its primary purpose which is to assure good services. This means that training of personnel on the one hand and facilities for its utilization on the other, are in reality a single problem. Under ideal conditions the two are in balance; but in the world of actuality balance is rarely encountered.

Throughout Latin America there was observed a lack of trained personnel. This lack was especially obvious in hospitals where fully trained nurses were inadequate in numbers and many hospitals were operating without a single graduate nurse.

A similar situation was encountered in respect to sanitary engineers. Even physicians were insufficient in numbers if entire populations were to benefit from health services. Except in the urban centres, there was for one reason or another, little effort to provide services for everybody. In Bolivia the entire medical corps was serving one-third of the population; the other two-thirds were with services. In Brazil 75% of physicians serve 24% of the population living in towns of more than 10,000. The reasons for this situation are largely economic just as in other parts of the world.

With large unsatisfied requirements for trained personnel in the urban centres, and even larger ones in the rural areas, it appears that facilities for the preparation of all types are inadequate. It is claimed that there is not enough money to permit the employment of a larger number of well trained personnel and the imbalance between resources and needs cannot therefore be corrected by establishing more educational institutions. This raises a problem that calls for diligent study. It may be that by instituting better methods the existing funds could be made to cover the needs more widely. The hospital situation may be used to illustrate what we have in mind. The average hospital stay and therefore the average cost per patient can be lowered by improvements in the administrative, medical, nursing and therapeutic techniques. A well trained hospital administrator in a large teaching hospital in Santiago, Chile, lowered the average hospital stay from 26 to 16 days within a few years. The saving thus effected could be used to employ additional trained personnel without entailing an enlarged budget. The major question therefore may not be whether a hospital can afford wider use of well qualified personnel but whether it can afford operations without such.

The staffing of health institutions, which include the hospitals, involves quantitative as well as qualitative considerations. Probably there never will be sufficient trained nurses to perform all the traditional functions of nursing and it has become necessary to analyze nursing functions and decide which must be performed by the highly trained nurse and which may be safely performed by a person of less training. Nursing functions may be broken down into parts, each functionally distinguishable. Each part is capable of creditable performance by persons of widely different backgrounds and training and the resultant quality of the service may be improved, provided the parts are integrated into a functional system that operates as a team. The professionally trained, in such a system, must be the administrator responsible for training, supervision and co-ordination. The evaluators observed a number of situations in which sub-professionals were used as a means of solving the quantitative aspects of staffing. (Amazon Valley - Uruguay are examples). In none had the problem been adequately met and too often quality of the work left much to be desired. It was recommended therefore that the Servicios give greater attention and support to experimentation aimed at the elucidation and solution of the problem.

I shall now discuss training as it relates particularly to the co-operative programmes. The subject may be divided into two parts:

1. Training of Professionals
2. Training of Sub-professionals

Typically, these are physicians, dentists, nurses, sanitary engineers but also include others with academic preparation such as hospital administrators, statisticians, public health laboratory workers, health educators, etc.

Professional training may be of two types - in-service and academic. The former was used extensively in the early years of the Servicios. Typically the sanitary engineer of the Field Party would associate himself with an unspecialized national engineer and in time, by on-the-job training, the latter would become proficient. This was a slow process but served an urgent need. In-service training however is important also in maintaining quality service among the specialized. It should be a constant preoccupation of administrators who are concerned with continuous improvements in performance.

The academic type of training has to do with specialization in public health such as is offered by the schools of public health. In the early

years of Servicio operations it was usually necessary to send nationals abroad for such specialization and hundreds of Latin Americans were sent. This eased the situation but did not solve it. Not until several of the host countries had established and matured special schools or courses was the outlook substantially brightened. Today the Latin American may choose among several institutions which teach in his native language and in a cultural environment that is his own.

The men and women who have benefited or will do so as a result of academic and in-service training are for the most part the product of the professional schools of their own countries. The medical and health services of each country are conditioned in a very real sense by the nature and quality of the medical, dental, engineering, and nursing education offered in each.

Logically, any effort to advance a broad health programme, one that neglects neither preventive nor curative medicine and that is concerned with environmental as well as personal health, must take into account all such educational institutions. Because of the major role of the physician in medical and health services it is appropriate to make special mention of Medical Education.

It appeared to the evaluators that in much of Latin America, medical education was not at a level consonant with the best health and medical interests of the countries. Improvements are underway, but in many places much remains to be done including such things as:

1. Limitation of students so as to maintain a proper balance between a proper balance between them and the facilities of the school. This is far from easy in the face of a serious shortage.
2. Selection of faculty on the basis of teaching skill and scientific productiveness.
3. A school plant with adequate space and equipment; control of hospital wards for clinical training and good working relationships with the health services to assure an adequate experience in them.
4. A good modern library.
5. An adequate budget.

These changes will be difficult to realize and in many places will have to be undertaken gradually. It is important however that a master plan be developed to ensure that each change fits into it.

Medical education is not a subject that can be carried on in a vacuum without concern for any but its own interests. I shall discuss some of the problems that seem particularly important.

Schools exist to train physicians but shall they devote their efforts to meeting the quantitative needs of the countries or shall quality of their product have priority?

Since only part of the population enjoys medical services, some advocate more physicians even at a sacrifice of quality. The evaluators agree that this extreme position is not tenable if the best interests of the people are to be safeguarded. Nor is the opposite position, in and of itself, more tenable. The solution must lie between the two.

An important reason for these divergent views stems from the fact that institutions charged with responsibility for education rarely carry responsibility for providing medical services to the people. The Ministry of Health, which carries the latter responsibility, supervises or actually operates the hospitals and medical care institutions as well as the health services of the country. It is concerned with the procurement of doctors in sufficient numbers and would choose, if that were possible, men who had been prepared to operate its services efficiently, economically and with understanding. But this Ministry usually has no voice in medical education, nor do those who are responsible for it seem to give much thought to the question of preparing its product to carry the load of curative and preventive medicine with enlightened social understanding. This situation needs for its solution comprehension and good will, rather than money.

Medical education is costly in both time and money. Some have suggested that amelioration might result if there were instituted a shorter period in an academic institution, with an extended intensive vocational period in the clinical fields. This suggestion, I believe, has already had a trial in India where two types of practitioners were trained. Recently it has been abandoned. Another experiment of somewhat analagous nature has been carried on for years in Fiji (South Pacific Islands).

The evaluators felt that medical education should receive a larger share of attention by the Servicios than in the past. The mere fact that no sure course of action can be suggested, other than continuous study and experiment, should but add gist in accepting the challenge. Correlative to the subject, medical education is another that I shall mention at this time.

I should like to suggest that a careful study or job analysis of the physicians' work - an analysis not dissimilar to that suggested earlier in regard to nurses - might prove most useful. It is reasonable to believe that there are quite a number of functions performed by physicians which could be performed by others. Indeed in many parts of the world this has been going on for years. Examples are: Immunization campaigns, mass treatment campaigns for hookworm disease and so on. The important consideration is that the physician should never neglect nor lose responsibility for training, supervision and administration of those who perform a part of his functions.

This leads my discussion quite naturally to the subject - The Sub-professional.

Two important questions are raised regarding the sub-professional:

1. How shall training be provided?
2. How shall recruitment be conducted?

As in the case of the professional, training may be in-service or institutional in character. In either case it must be such as to ensure competence to perform the limited tasks called for. As already noted, the professional must carry responsibility for such training and it should be continuous.

In regard to recruitment the evaluators found little in the way of experience. Many people question the value of the sub-professional on the grounds that their educational background and understanding are such as to unduly limit their effectiveness and that, in the long run, it is more economical to abandon them in favour of the well trained professional. Experience has already taught that reliance cannot be placed in the professional alone. The sub-professional must be used. Poor recruitment techniques may account for a good deal of the failure that has so often accompanied their use. All too frequently it is felt that anyone can be trained to be a sub-professional. No account is taken of the fact that the sub-professional is called upon to perform a limited number of functions and that these call for a limited range of qualities. Too often it is forgotten that the qualities may be found as frequently in one class of society as another. It is certainly true that the qualities of kindness, dexterity, self-confidence, devotedness, reliability as well as intelligence and wisdom are not restricted to the educated classes but are to be found in all strata of society. Given these qualities it should not be difficult to add through training the technical knowledge that is required. The problem is how to identify and, if possible, measure, such qualities so that recruits may be selected accordingly. We must look to psychologists, social

and cultural anthropologists and perhaps other social scientists for help. The task will be slow but not hopeless.

In looking back over the discussion in this chapter, it seems that quantity is associated with the sub-professional and quality with the professional. First and foremost reliance must be placed on the shoulders of the highly trained, well qualified professional for leadership in planning, in training, in supervision and in general administration of the lower category. But there is one other point to be emphasized over and over - it is necessary to develop team consciousness among both the professionals and sub-professionals. Unless the team functions smoothly and coordinately, maximum benefit will not be achieved.

In conclusion let me emphasize that many lacunae continue to exist in our knowledge re training and education - the Servicios are in a position to sponsor, subsidize or conduct the study and experimentation necessary to secure the knowledge that is lacking. It was therefore recommended that they devote a larger proportion of their resources to the subject.

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
JOINT STAFF CONFERENCE  
February 12 through 19, 1953  
Geneva, Switzerland

Summary Report on First Meeting  
Thursday, February 12, 1953 at 9:30 a. m.

Co-Chairmen ( Dr. Hyde ( Director, Health and Sanitation Staff,  
( Technical Cooperation Administration  
( Dr. Chisholm ( Director-General,  
( World Health Organization

The meeting was opened by Dr. CHISHOLM. Dr. HYDE introduced the participants from TCA, the United States Public Health Service and MSA; and Dr. CHISHOLM presented the WHO participants.

The agenda was adopted.

Dr. CHISHOLM stated that he thought that this conference would be of the greatest importance for the health of the world and that he hoped that it would help to make the services of both TCA and WHO more effective to the people with whom both were working. He sketched the situation in which WHO did its work, emphasizing the autonomy of the specialized agencies of the United Nations and the fact that WHO, with 83 Member States (of which 73 are active) was one of the specialized agencies having a very large membership. WHO had been in existence for four and a half years, following a two-year interval in which an Interim Commission operated. The Organization inherited a variety of traditions, integrating the health work of the League of Nations, the Office Internationale d'Hygiene Publique, UNRRA, the Pan-American Sanitary Bureau and the Arab League. There had been a shift in attitude, however, since the Organization began. From first establishing priorities in a number of fields - malaria, venereal diseases, tuberculosis, maternal and child health, environmental sanitation, nutrition and mental health - and working chiefly in those fields, the Organization now had a more general policy of assisting all governments at their request to take the "next appropriate steps" in developing their own health services, the aim was not to superimpose foreign ways but to try to produce an effect by taking advantage of the customs and traditions of the country. WHO had one advantage

over some of the other specialized agencies in that it was more homogeneous; its Assembly and, even more, its Executive Board were composed of persons working in the field of health. Because the members of the Executive Board acted as individuals and not as delegates of governments, they were able to give the Assembly direct technical advice relatively free from political considerations which were the responsibility of the United Nations.

Dr. BRADY (United States Public Health Service) stressed the great significance of the first fifty years of the present century, the magnitude of the problems existing and the grave consequences of error in their solution. In an age in which important discoveries, such as antibiotics, had been made, social forces were now being unleashed leading to efforts to bring about in some countries within a few years the progress which others had taken centuries to achieve. A high sense of values and judgment must accompany any such attempt. The United States Government was keenly aware of the value of direct assistance in international health for both social and political progress in the world, and recognized WHO as the co-ordinating authority on health and the permanent agency for channelling the assistance which such agencies as MSA and TCA were giving in the health field. This was a new venture; never before had such large numbers of technicians been actively at work in so many countries in collaboration with their nationals. This had come about within a very short time; the process of trial and error which always occurred was still operating, and a joint appraisal of the work being done was now needed. The United States Public Health Service hoped to make proposals for improving the work later; in the meantime, he would remind them of the following principles which, it was thought, should be applied to joint work to be done by TCA and WHO:

- (1) The health programmes carried out in a country with assistance from TCA and WHO should be the health programmes of that country and the responsibility of the national government concerned; there should be no "WHO" or "TCA" programme.
- (2) A co-ordinating agency within the country was therefore essential to integrate the activities carried out by the government and external agencies.
- (3) The assistance given should contribute to the economic development of the country.
- (4) There should be close co-operation between those working in health, agriculture, education and industry, and joint appraisals of the various programmes from time to time.

(5) Long-range planning was essential so that eventually the governments would be in a position to take over the programmes in which assistance was given; this would mean that national health departments would have to be strengthened to the point where they could take over the services provided, and that the cost of the projects should not exceed what the government could assume after foreign aid was removed.

Mr. ANDREWS (Administrator, TCA) pointed out that he had come not to impart knowledge on health but to obtain it. There were a number of things which he would like to see come out of this conference. The objectives of TCA, in establishing a "bold new approach", had been almost over-advertised. In reality the programme was neither bold nor altogether new, although it was a new idea for a government of one state to accept some responsibilities for less fortunate countries, and to furnish technical knowledge, money and leadership for this purpose. The TCA programme was a production programme - one of helping human beings to produce the things they needed and might use. Only through increased production could standards of living be raised, and it was recognized that public health was an essential element of production. He gave as an example the rise in production in Germany parallel to progressive increase in calorie intake.

He pointed out that TCA was now working in 35 countries with a population of over a billion, whose average annual income was the equivalent of \$41 per capita. These people had 0.17 of a doctor per 1,000; their average span of life was 30 years, as compared to 63 in the developed countries; other similar comparisons could be made. There was an endless job to be done and on the part of TCA the demand for co-operation in doing it would be almost aggressive.

The need for avoiding the pitfall of imposing the standards of the United States of America on the peoples of the countries in which TCA was working was paramount. The West, in dominating some areas of the East, had destroyed without providing adequate substitutions; it had introduced some but not all of the aspects of Western culture, and in some countries the bad rather than the good elements had been absorbed.

Details would later be given by other speakers about the programmes which the United States had helped to carry on in 18 Latin American countries for the past ten years; over 600 active health programmes were now in operation. An excellent example of a programme successfully taken over by a government was the one carried out in the Amazon area of Brazil, where there were now 56 health centres serving some two million people. A few years ago there had been 40 North Americans and 500 Brazilians directing this programme; there were now no North Americans but 1,000 Brazilians.

The following basic concepts were perhaps of importance:

- (1) The people to whom assistance was to be given had to be taken as they were found. It had been found advisable to start by giving them what they wanted and what they themselves thought they needed.
- (2) It was imperative to pay attention to the culture and the mores of the people concerned and not to impose foreign standards on them.
- (3) An attempt should be made to reach the greatest number of people possible and to attack the most pressing problems first; it was essential to find out the greatest basic needs and deal with those instead of trying to solve all problems at once; this Conference would undoubtedly be valuable in ascertaining such needs.
- (4) As stated before, the programmes of assistance should be programmes of the country, not those of TCA or WHO.
- (5) Any programme started must be graded to the economic capacity of the country to carry it on and conditioned by the government's willingness to pay for it.
- (6) Lastly, the time had come when it was not enough for TCA and WHO just to stay out of each other's way; they had to work together as a team.

Dr. SINAI (Director of the Office of Reports and Analyses, WHO) considered that this conference was a very rare and unusual one: It would be the occasion not only for constructive criticism of health work but for a discussion of the relationship of health to economic and social development. In the conference itself, economics, sociology and the biological sciences were all represented, as were many different geographical localities of the world. He was impressed not only by the work which had been accomplished by those present but also by the philosophies of those who had done it.

There were many examples of progress in the developed countries from which one might derive principles on which to base assistance given to other countries. In recent years a new field linking medicine with the social sciences had developed; it was not very appropriately called "medical economics." Studies of the incidence of sickness and its cost had called for economic support, and this development had led to studies involving actuaries and new types of administrators, who when they came to examine the problems of economic values in health, encountered grave difficulties: The

actuary's predictions and the administrator's work were upset by the entry of human relations into the picture. For example, there arose such questions as the reason for increase in medical consultation when economic barriers were lifted, and the social psychologist had to be brought in. Overcrowding of hospitals had been found to be caused in some cases by total absence of home care; this had involved other social problems.

Dr. Sinai stated that, in making the distinction between motivation and financial gain, at least some industrialists had realized that values could not always be measured in financial terms and that leadership must be created in order to solve social problems.

He pointed out that in countries in which economic development had occurred in the past, there had always been medical problems, but there had also existed a fair level of education and a fair to good level of economic support. On the other hand, in underdeveloped countries in which economic development was taking place, the medical problems existed without the educational levels and facilities or the necessary economic support to deal with them.

There were two principles to be derived from studies of economic development. One was that social development, economic progress and the improvement of health form an inseparable triad; no one of the three could move forward rapidly without the others. Health improvements could not be planted in a sterile economic and social soil, and, conversely, economic and social developments were greatly retarded by low levels of health.

The second principle was that the phenomenon of uneven growth in health development was to be found all over the world. Even in a large, developed country a very small area with excellent health conditions often existed alongside one in which standards of health were very low.

If these two precepts were accepted it would put an end to such arguments as those about the relative importance of health and education or health and agriculture. Schemes for making under-developed areas productive would no longer be launched without their health aspects being taken into consideration.

Dr. SHOUSA (Regional Director for the Eastern Mediterranean, WHO) mentioned the visit of Dr. Hyde of TCA to the WHO Regional Office in Alexandria, at which it was agreed that co-operation between the two agencies was needed at all levels, particularly in regions and countries. The lack of a regional TCA official was deplored, and it was hoped that this gap might soon be filled. National co-ordinating committees had been established in two countries, Egypt and Iran, and an appeal for the creation of others had already been made to the other countries of the Eastern Mediterranean region.

On the technical side, there had been differences in the approach to countries by the two organizations, and more uniformity in this sense would be highly desirable. Joint project procedures were being prepared, and there was no reason why TCA/WHO co-operation should not go ahead, once uniformity had been achieved.

Dr. Shousha made reference to a nursing project in Jordan in which WHO and TCA were both participating, and noted a number of examples selected from the WHO programme for 1953 in which TCA might co-operate to the benefit of countries whose requests might otherwise remain unfulfilled as a result of financial stringency. Such projects were: The one for rural sanitation in the health demonstration area in Egypt, the bilharzia projects in Egypt and Jordan, malaria work in Iran, the malaria demonstration centre in the Hezirah area in Syria, and the award of fellowships.

Dr. SOPER (Regional Director for the Americas, WHO) reiterated the importance of the present conference. He recalled his experiences in 1920 in Brazil, when the health work of the Rockefeller Foundation was successively ascribed by the local population to religious, commercial and imperialistic motives. He also gave illustrations to show that the question of development or under-development depended on the point of view, and that it was not enough to tell nationals of one country how things were done in another.

He mentioned some of the problems of co-ordination of health work which had been encountered in the Americas, between the Rockefeller Foundation and the Pan American Sanitary Bureau, and went on to describe the progress towards co-operation between TCA and WHO which had been furthered by holding joint meetings monthly in Washington and by giving identical instructions to field chiefs and zone representatives of the two organizations. Co-operation among a number of organizations interested in medical education in the Americas had been furthered by a series of meetings begun by Dr. Hyde in 1951. He used the case of Aedes aegypti eradication in his region to illustrate the difficulty of obtaining at first the necessary interest of governments which could not see the need for such a programme.

Dr. Soper stated that although TCA/WHO co-operation was good in the Americas, the work of the two organizations was not co-ordinated adequately at the planning stage of projects or in their fellowship programmes.

Dr. MANI (Regional Director for South East Asia, WHO) stated that in 1952 agreement had been reached between himself and Dr. Hyde on:

- (1) The prior need in the South East Asia Region for malaria control and for the supply of pure drinking water in rural areas;

(2) The need for joint consultation before TCA and WHO decided on the fulfillment of requests from governments.

Of these first steps, only the question of water supplies was still unsettled.

TCA was now operating in five out of the six countries in his region, and was doing a substantial amount of health work in four of them. Mutual agreement on co-operation and a certain amount of planning had already been obtained; the problem now was how to work together.

Like Dr. Shousha he felt the need of an opposite number in TCA, appointed on a regional basis, with whom daily conferences could be held, in addition to direct contact at the country level. National co-ordinating committees had been established in almost all the countries in his region, and WHO had appointed or was appointing area representatives to work directly with them. TCA should also work directly with these committees.

WHO had assisted particularly with the control of communicable diseases and with education and training in the region. The large programmes of communicable disease control were now beyond the financial resources of WHO and could with much benefit receive assistance from TCA. How to co-ordinate the work in education and training remained a problem which could perhaps be tackled at this conference.

Neither WHO nor TCA had yet done very much about environmental sanitation, health education or nutrition in the region. Efforts were being made to introduce sanitation into the fifty community development projects in which the United States was assisting. Drainage and sewerage were important problems, but the supply of safe drinking water mentioned above was perhaps even more urgent, and it was more feasible to work on this problem than on the others at the present time. In health education different methods had to be used; the high-grade propaganda popular with Western people was utterly lost on the people of Asian villages. Widespread malnutrition was an enormous problem, being a normal accompaniment of life in many areas; there was a need to increase calorie intake and to produce more milk in the region, and it was hoped that the present conference would throw some light on these urgent problems.

Dr. Mani stated that the stimulation of schemes for building hospitals in his region might not be wise, since some governments had inadequate resources even for running the existing hospitals.

Lastly he mentioned the universal shortage of urgently needed medical supplies.

The meeting rose at 12:30 p. m.

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
JOINT STAFF CONFERENCE  
February 12 through 19, 1953  
Geneva, Switzerland

Summary Report on Second Meeting  
Thursday, February 12, 1953 at 2:30 p. m.

Co-Chairmen ( Dr. Hyde (Director, Health and Sanitation Staff,  
( (Technical Cooperation Administration  
( Dr. Chisholm (Director-General,  
( (World Health Organization

Dr. FANG (Regional Director for the Western Pacific, WHO) said his experience of bilateral agencies had been principally with MSA. Apart from the Americas, the Western Pacific was the first WHO regional office to come into contact with American bilateral organizations. He recalled particularly the "Griffin Memorandum" issued by ECA (predecessor of MSA) in November 1950 which gave directives making co-operation not only possible but effective. There was a Chinese saying that "a good time never lasts" and unfortunately, following a change in personnel, full comprehension of the spirit so clearly outlined in that Memorandum had been less evident. Nevertheless, the collaboration established had been close, cordial and friendly. This did not exclude the desirability and the possibility of further improvement. All parties were harmed by misconceptions such as that MSA assistance to governments was a supplementary contribution to WHO.

Although the statements of Dr. Brady and Mr. Andrews covered most of the points he had intended to raise, he felt that it would not be superfluous to emphasize some of them. Firstly, co-ordination committees now established in many countries should not be centres for exchange of information only, but should be developed into centres for joint planning. Secondly, it should be generally accepted that all efforts should be directed to one object - effective assistance to governments in the attainment of higher standards of health for their peoples. Thirdly, he hoped that the statements of Dr. Brady and Mr. Andrews would be included in the briefing supplies to all staff going into the field.

Finally, Dr. Fang felt that it was important that TCA should provide for consultation on a regional basis.

Dr. Begg (Regional Director for Europe, WHO) thought that, although what he had to say was not particularly related to the present conference, it would be of interest to outline the WHO approach to health problems in Europe, an approach which must be different to that for other regions, and to describe what had happened to Europe in the post-war period. Some of the mistakes made by countries and international organizations were mistakes which tended to be repeated from country to country and region to region.

The end of the war had seen some European countries severely devastated and all of them economically damaged. Institutions had been wrecked and personnel lost, and after a long period of technical blackout they had been faced by major problems in controlling some communicable diseases, such as venereal disease and tuberculosis. During the post-war period 1945-48 many agencies had poured relatively large amounts of supplies into European countries and although some were put to good use, others had been completely lost in terms of recovery of the country, because of the lack of adequate supervision. There had been, nevertheless, an outstandingly successful training problem in the course of which hundreds of medical personnel emerging from the blackout period had learned of the technical advances which had occurred in that time.

On the other hand it had been found that, in general, the long-term assignment of technical advisers was unsuited to needs of European countries. As a result of that lesson, WHO had turned to the use of an entirely different type of advisory personnel, employing for relatively short periods high calibre personnel normally occupying teaching positions in their own countries. Dr. Begg wondered whether even the use of that type of technical advice was likely to continue in Europe. WHO had learned that such personnel could build up a relationship with the personnel of the country by repeated visits and could arrange for the reception of such personnel in institutions in their own countries, and so on. Apart from these benefits, however, WHO was beginning to doubt whether the use of consultants was properly applicable to the European region.

From 1948 onwards, therefore, WHO had been dealing with some of the problems on a regional or inter-country level. A series of activities had been developed which could be grouped under three headings: (1) Studies of health problems and health services; (2) exchanges of experience where experience had been sufficiently stabilized; and (3) broad development of education and training.

The need for the first type of activity, studies of health problems and health services, which should be preliminary to other activities, was frequently overlooked. Such studies brought to light many mistakes which had been made in setting up services and much experience of value to European countries and perhaps also to others.

In the second type of activity, WHO had brought together responsible technical personnel to exchange their experience on a wide variety of health topics. Europe was less interested at the present in communicable disease but was facing such problems as industrial medicine, environmental sanitation and mental health. WHO had found that a conference or seminar called for no other purpose than the exchange of information achieved results which had been unattainable through the development of projects of direct assistance to countries. As an example, Dr. Begg recalled that during the post-war period WHO and UNICEF had been ready to use penicillin on a large scale to combat venereal diseases. There had been no shortage of penicillin or of personnel but a factor peculiar to Europe had been encountered - that success in the treatment of syphilis depended not so much on using new weapons, but on discarding old ones. Consultant after consultant failed in European countries to persuade leading dermatologists and venereologists that penicillin was the weapon which would conquer the disease. The difficulty was solved after three years by bringing together the older and the younger men in a conference - at a cost of \$8,000. From that time on, syphilis eradication campaigns had succeeded in many countries.

With regard to the third type of activity Dr. Begg said that training methods accepted all over Europe before the war no longer suited the needs of the health services, and there was a desire to readapt training and to set up new institutions. It was felt that this could be dealt with on the international plane. The European office had a fellowship programme which tended more and more to emphasize group training, which was not easy to organize on a national level. In undertaking this activity the Regional Office had met another problem and stumbled on its solution. In the most highly developed countries of Europe there could be found a whole series of isolations of medical personnel and health personnel generally - people restricted to their own little areas and ignorant of related fields in their own countries. That undesirable state of affairs was not being solved on a national basis, but the regional programmes of WHO tended to remove isolationism and restore perspective.

Dr. CHISHOLM (Director-General, WHO) regretted the absence of Dr. Daubenton, Regional Director of WHO Office for Africa. Hitherto there had generally been no Technical Assistance activities in Africa except in Liberia. However, a quite considerable programme of Technical Assistance in Africa had been planned by WHO beginning in 1953, but this programme was threatened by the limitation of funds for United Nations Technical Assistance; as all these projects were "new" none could now be implemented.

He called on Mr. Perlstein, the Chief of Field Operations of the Paris Office of UNICEF. That office serviced a very wide area comprising the African and a large part of the Eastern Mediterranean Regions as well as Europe.

Mr. PERLSTEIN (UNICEF) outlined briefly the major principles governing UNICEF aid:

1. It was to be given without discrimination as to race, creed or politics.
2. It was to be given to country programmes run by the government or by voluntary or other agencies endorsed by the government, the government or agency was to provide funds or local services to match whatever aid UNICEF was giving.
3. Finally, although emergency help was still being rendered, it should be given preferably to permanent programmes having an influence on the wellbeing of large numbers of children.

The Executive Board of UNICEF was composed of representatives of 26 countries who voted its funds. The Board had a permanent committee which examined closely all requests for help. Their Asia office was in Bangkok and there were sub-area offices in Brazzaville for Africa South of the Sahara, Lima for South America, and Guatemala City for the Caribbean region. He felt that the specialized agencies were technically competent to give advice, to teach and to set up demonstrations and model programmes; they provided supplies only as an adjunct. Under Technical Assistance supplies were provided in connection with those projects which could be demonstrated as influencing the economic development of a country. UNICEF could give both forms of aid.

Mr. Perlstein concluded by mentioning some types of programmes developed with the assistance of UNICEF supplies and with the complete and cordial co-operation of WHO. In malaria control UNICEF had helped in all continents with the exception of North America and Australia. In yaws, bejel and syphilis it had assisted in South America, the Caribbean region, Europe, Asia and Africa (Liberia); such aid would probably be extended to more countries in the future. UNICEF had given assistance to trachoma-control programmes in North Africa and in Europe; its BCG campaigns were well-known, and it had also helped to establish DDT plants in Egypt, India, Pakistan and Ceylon, penicillin production in India and in Chile and sera and vaccine production particularly in Asia but also in Europe and South America.

Finally, he said that co-operation with TCA, in the particular area with which he was directly concerned, was only beginning. It was more advanced in Asia. In the Eastern Mediterranean Region (Jordan) it had been very close and in Africa there had been some co-operation in Liberia. He hoped that future co-operation would be positive and not confined simply to preventing duplication.

Dr. CHISHOLM said that relations between WHO and UNICEF all over the world were now excellent. Consultation took place before commitments were made; that was the proper time for it. The two agencies had become to a great extent mutually dependent on each other's resources.

The meeting rose at 4 p. m.

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
JOINT STAFF CONFERENCE  
February 12 through 19, 1953  
Geneva, Switzerland

Summary Report on Third Plenary Meeting  
Friday, February 13, 1953 at 9:30 a. m.

Co-Chairmen ( (Dr. Hyde, (Director, Health and Sanitation Staff  
( Technical Cooperation Administration  
(Dr. Chisholm, (Director-General  
( World Health Organization

In opening the meeting Dr. Hyde, replying to the wish expressed by the Regional Directors of WHO that there should be an opportunity for consultation on a regional basis, said that TCA was moving in that direction as fast as it could. Already Dr. Robbins was consulting with Dr. Mani on work in South East Asia; TCA was actively recruiting for a similar post in the Near East; he hoped to be able to announce during the Conference the appointment of a sanitary engineer to the same area.

When recruited, this type of personnel would be stationed in Washington because TCA had no regional offices; moreover, frequent contact of personnel with Washington was considered desirable.

Dr. STRODE (Institute of Inter-American Affairs) in introducing his summary of the United States Public Health Service evaluation of work of the IIAA, outlined the developments leading to the setting up of the Institute and its work in Latin America on which the evaluation had been based.

A survey team of eight persons first spent four months in the field observing work in Chile, Ecuador and El Salvador; spot surveys by smaller groups were made in the other 15 countries. The team first examined every active project in the three countries and reviewed a number of partially active projects. After the data were compiled the Chiefs of Field Operations went to Washington to analyze them.

The study was divided into three sections: (1) The background of the projects on which the original plan had been based; (2) the approach which had been made by the field staff in its efforts to improve the background, and (3) the actual accomplishments in solving the problems.

The report was sub-divided into ten chapters, on a few of which he would give some comments: 1. Background; 2. Cultural Aspects; 3. General Administration; 4. Programme Planning; 5. Sanitation; 6. Specific Diseases and Nutrition; 7. Training and Education; 8. Nursing; 9. Health Education; 10. Hospitals and Health Centres.

There was a final chapter giving a summary of the evaluation. The summary would shortly be available.

The co-operative programme of the Institute had been launched in execution of the first bilateral agreement with Ecuador in February 1942 arising from a decision of the third meeting of the Ministers for Foreign Affairs of the 21 American Republics in Rio de Janeiro in January 1942. The administrative mechanism consisted of: (1) The Corporation in Washington; (2) a unit in a ministry of the Host Government, generally called the "Servicio", to plan and carry out the projects.

The advantages of a subsidiary corporation such as the IIAA were that: (1) Funds received were available until expended and did not automatically return to the treasury if unspent at the end of the fiscal year; (2) operations could be carried out in foreign areas in accordance with local laws, customs and procedures; and (3) the autonomy of the members and Board of Directors of the Corporation promoted efficient operation.

By an exchange of diplomatic notes, bilateral agreements were made between the Institute and the governments, followed by further agreements between the representative of the Institute and the Ministers of Health, under which both parties provided contributions establishing the "Servicios". The agreements stipulated that the Institute would send to the host country a field party of which the entire cost was borne by the Institute and which usually included a physician, engineer and nurse. They provided that the Chief of Field Party should also be Director of the Servicio in the host government, subordinate to the Minister or other designated officer.

The work undertaken was catalogued by projects, given status by project agreements. Usually the first project agreement was the Administrative Project providing funds for the establishment and maintenance of the office and staff of the "Servicio". Other project agreements dealt with specific undertakings.

The fellowship programme, the field parties, special conferences and translations of texts were "special projects" financed entirely by the Institute.

The cost of the 1,665 projects carried out during the ten years under review was approximately 120 million dollars.

Dr. Strode said that, although there seemed to be an inherent administrative weakness in the fact that the Director of the "Servicio" as Chief of Party, was responsible to two masters, in actual practice the device had worked well. Its favourable features were:

1. As an administrative unit of the host government it provided firm lines of communication and contact with other officials of the government;
2. The Chief of Party had considerable autonomy with regard to approving projects, purchasing goods and services, and adopting personnel practices;
3. Its operations were such that it achieved popularity with people and government alike;
4. It provided a basis for training nationals working with the "Servicio" and by fellowships provided by the Institute.
5. The "Servicio" possessed stability even in countries with political instability.
6. The "Servicio" provided a mechanism to improve general administration as well as technical skills. The unfavourable features were the divided responsibility of the Chief of Party already mentioned, and the danger of self-perpetuation.

The preferential setting in which the "Servicio" worked made a high level of efficiency possible, and it was understandable that pride in a good piece of work and the desire to prevent its losing ground were the cause of some reluctance to transfer the project to the normal authorities at the appropriate time.

Too often programme planning was undertaken with insufficient knowledge of the facts. Before developing a programme the following information should be assembled:

1. The characteristics of the population - its racial composition, geographical distribution; occupations;
2. Vital statistics;

3. the number, location and capacity of medical institutions;
4. the number, distribution and character of medical and health personnel;
5. the nature of governmental structure, with special reference to its direct and collateral responsibilities in the health field;
6. the nature and importance of voluntary agencies in the health field;
7. the social institutions, the customs and cultural traits of the people;
8. economic status and potential;
9. problems concerning education, agriculture and industry; and
10. the geographical and climatological characteristics of the country.

The individual projects were generally well prepared, though agreements often failed to include terminal dates thereby decreasing incentive, and to provide for an orderly transfer to the appropriate government agency.

The survey team also recommended the establishment of national health councils for securing broader public support and bridging gaps due to changes in governments. Clearing-house conferences on both national and international levels would also be of value.

The chapter on cultural aspects had been written by an anthropologist, who emphasized the fact that developing a successful public health programme depended not only on technical excellence but on the readiness of the people to accept new ideas and new habits. In any long-range programme sociologists and social psychologists should be called upon to participate both in the early planning and in operations. Several categories of data emerged from the studies, relating to inter-personal relations, to emphasis on curative and preventive medicine and to the nature of folk medicine.

Training was accorded a high place among programme priorities because of the lack of trained personnel throughout Latin America. Probably there never would be sufficient trained nurses to perform all the traditional functions of nurses; it was necessary to analyze nursing functions in order to discover which could be satisfactorily performed by sub-professionals.

It appeared to the evaluators that much remained to be done to improve medical education and that this should receive a larger share of attention from the "Servicios" than in the past. One important problem was the relative importance of quality versus quantity in medical education. The team felt that there had to be some sacrifice of quality for quantity.

Although the effectiveness and economy of using sub-professionals had been questioned, experience had taught that their use was a necessity. Poor recruiting techniques might account for some of the post difficulties. The problem was how to identify and, if possible, measure certain character attributes in recruiting personnel.

In conclusion, the team felt that there was still much to be learned regarding training and education. "Servicios" were, they thought, in a position to sponsor the experiments necessary to obtain the required information and it was suggested that they should devote a larger proportion of their resources to the subject.

## SELECTED COUNTRY PROGRAMMES

Dr. HYDE introduced three TCA field workers, Dr. Gandy, Dr. Palmquist and Dr. Warner, to give brief summaries of the work accomplished in the countries in which they were working:

Dr. GANDY (Director of TCA, Chile) stated that a common understanding, mutual respect and the ability to readjust the basic concepts of public health to local conditions were fundamental in achieving the goal toward which both WHO and TCA were working.

The co-operative programme of health and sanitation in Chile began in May 1943, when an agreement was signed and the most effective manner of operating joint programmes was formulated. The agreement represented a departure from the routine methods of procedure. It placed the co-operative programme on the operating level, provided for an Inter-American co-operative "Departamento" of health to be placed within the Chilean Public Health Service on an equal technical basis with the other departments of that Service; an official of the Institute of Inter-American Affairs was named honorary chief of the Departamento; other American technicians were given official governmental titles, and United States technical personnel were thus placed on a legal working basis with their Chilean counterparts. The chief was responsible for policy and programme development. This arrangement greatly strengthened the public health service and avoided the existence of competitive health programmes.

In 1942 Chile had been considered more in advance in its public health services than other Latin American countries because of early legislation in social security and preventive and curative medicine, but the Public Health Service had become little more than an administrative organization with considerable legal power but without health programmes, and required strengthening.

The most serious health problems in Chile at that time were infant mortality and tuberculosis. In 1943 the infant mortality rate was 172.9 per 1,000 live births, and the tuberculosis mortality rate 234.6 per 100,000. The picture had been greatly complicated by the division of responsibility for medical care and preventive services among the various social security and health agencies, resulting in duplication of services and emphasis on care rather than prevention.

To help solve this problem the co-operative health programme was divided into (1) impact programmes to help with the immediate problems, and (2) long-range programmes to ensure the development of a strong health department. Both were important.

Four different urban areas were chosen for health demonstration programmes. In these areas health centres were constructed with house to house groups working in maternal and child health, tuberculosis, venereal diseases and environmental sanitation. The family was treated for the first time as a unit. The health activities were co-ordinated under the direction of the Public Health Service. The best personnel available from the United States Public Health Service was used in the development of the sanitation programme.

The inadequate compensation of health workers had been a deterrent to the success of public health programmes in Latin America, and the co-operative service had provided a mechanism to remedy this situation in Chile. Technical standards were raised, and the training of personnel had been given particular attention, by the provision of local training and, with the help of a number of outside agencies and the University of Chile, by the strengthening of the University's School of Public Health. Assistance was also given to the School of Medicine and the Nursing School. With the long-range programme put into effect, the health projects became a part of the Chilean Public Health Service.

Dr. Gandy listed as the outstanding accomplishments during the past ten years:

- (1) a law passed in August 1952 creating a National Service of Health combining the medical services, both curative and preventive, of four of the former services;
- (2) the training of 717 technicians by the School of Public Health at the end of 1952;

- (3) the fall in infant mortality rate from 172.9 in 1943 to 128.6 in 1951, and in tuberculosis mortality rate from 234.6 to 127.7 during the same period;
- (4) the establishment of 18 health centres by the health authorities themselves in addition to those established by the co-operative health programme, as an important part of community health facilities;
- (5) the increase in the annual budget from around 30 million pesos in 1943 to over 550 million in 1953, and
- (6) the financial support now being given to the co-operative health projects by the Government of Chile.

It would be difficult to say how much would have been accomplished without the aid of the Institute and other organizations. Dr. Gandy pointed out that errors in judgment as to the time when financial aid should be withdrawn from a given project might cause serious difficulties; also the need for gearing technical aid to the state of development of the people and country concerned could not be over-emphasized. There would be no question of "turning over" the projects which he was describing to the Government of Chile, since they had always been a part of the governmental agencies concerned and directed by them with the technical assistance of the Institute.

He then went on to speak of some of the disappointments of the programme; it had been shown that for success in combating tuberculosis, for example, more attention must be given to sanitation and nutrition in rural areas.

Dr. Gandy mentioned some of the plans for the rural demonstration programmes which were being carried out, in which much attention was to be given to environmental sanitation, the improvement of housing and agriculture, and the development of community organization, in addition to work in communicable disease control, maternal and child health, and health education.

Finally, he described the successful co-operative work which the Institute had carried out in Chile with such agencies as WHO, the Pan American Sanitary Bureau, UNICEF, and the Rockefeller and Kellogg Foundations.

Dr. PALMQUIST (Chief of the Health Division, TCA, Iran) after describing the geographical and political features of that country, said that though malaria had been the most serious health problem in Iran, it had now yielded pride of place to those diseases resulting from poor environmental sanitation - the enteric disorders, helminthiases, and trachoma. Although

the statistics available were notoriously unreliable, the infant mortality rate could be said to be about 500 per thousand. There were empty hospital and dispensary buildings which were being built faster than personnel could be trained to run them. The country's own seven-year plan had been in operation for at least three years. It was financed by the oil revenues, and a Health Section devoted to preventive medicine had been set up apart from the Ministry of Health, which had had only a hospital programme. In the fall of 1950 the Health Section was moved to the Ministry of Health to form its new Division of Preventive Medicine.

Dr. PALMQUIST said that the objectives of TCA's co-operative programme of public health were: (i) to facilitate the development of public health, especially the prevention of disease; (ii) to stimulate and increase the interchange between Iran and the USA of knowledge and techniques in public health; (iii) to promote and strengthen understanding and goodwill between the peoples of Iran and the United States of America and to foster the growth of democratic ways of life.

At the present time TCA had 29 American public health personnel in Iran. About nine of them were in Teheran, the others were in the provinces.

During the fiscal year 1952 (July 1951-July 1952) it had spent about seven million dollars on the health programme and would spend about six million dollars in the fiscal year 1953.

TCA's funds gave it an advantage in enabling it to make an impact and immediate start in Iran at that particular time. On the arrival of TCA personnel in the country in April 1951 they had found the malaria programme on the point of collapse, and in 1952 the economic situation of the country was such that there could have been no progress without TCA aid. It was a source of gratification that the malaria programme had thus been enabled to carry on. During the past year two and a half times as much had been done, 12,659 villages being sprayed with DDT and the work affecting four million villagers. The work of the Malaria Institute, aided by the WHO advisory unit, had achieved excellent results, and it was believed that in another two or three years control in that country would be achieved.

TCA was placing emphasis on its demonstration and training programs, in which overlapping with WHO was being resolved.

The most significant development recently in Iran was the setting-up of the co-operative "Bureau of Local Health Services" as part of the Ministry of Health. In principle this was much the same thing as the "Servicios" of Latin America. In Iran there had been encountered much the same difficulty

as had been encountered in Latin America. Low salaries of the civil service, for instance, gave rise to difficulties, and the Bureau was an administrative device which, among other advantages, gave an assurance that whatever progress was made in the improvement of public health would have some chance of being maintained.

Dr. WARNER (Chief of Health Division, TCA, India) said that the agreement for TCA participation in programmes in India had been signed a year ago on 5 January. It should be recognized that India in some ways was a new country; it had gained its independence only five years before but had inherited all of the economic and social problems of centuries past. In its first year of independence it had faced a tragic situation, with flood and famine and six million refugees. This had cut deeply into the resources of the country.

It had started on a five-year plan which was carefully thought out and in which medical care played an important part. Because of financial and economic problems and the autonomy given to the 26 States co-ordination had been difficult.

India was two thirds of the size of the United States, with 356 million people, about 85% of whom lived in villages and 80% were illiterate or almost so. Most of the jurisdiction for health had been given to the States; the centre had very limited powers of co-ordination and leadership, although both had a joint responsibility for the control of epidemics, etc. Administrative channels were not always clear, and the relationship of the central government with the States was ill defined. Some progress was now being made, however, in smoothing out these difficulties.

The health problems within the country were great: There were approximately 200 million cases of malaria, with a million deaths annually attributed directly to malaria and another million to which malaria contributed. The life span was from 28 - 30 years, and half the deaths were among children of under twelve years of age. The enteric diseases, malnutrition, smallpox and tuberculosis were among other important health problems.

When TCA began its work in India it found that there had been much work done before by outside agencies, first by missionaries and later by the Rockefeller Foundation, WHO and UNICEF, but there was little co-ordination between the Agencies working within the country. Dr. Warner had been assigned as both consultant to the Ministry of Health and Chief of Health Services in the TCA Mission.

The first effort had been to support the five-year plan and then to try to correlate the services - those of health, agriculture, education, rural development, etc. TCA's work in India had been concerned mainly with five different problems:

- (1) It had tried to strengthen the health administrations by bringing about closer co-ordination of the work of the Ministry of Health with that of the agencies working in India. A Co-ordination Committee had been established for this purpose.
- (2) It had concentrated on the problem of malaria control. Up to a year ago only about 30 million people were given some sort of protection against malaria, and 200 million people needed it. TCA therefore had planned a three-year programme jointly with WHO, UNICEF, the Rockefeller Foundation and the Government of India. It had been planned to operate 75 units for malaria control in 1953; according to a report just received from the Indian Council of State Health Ministries more money had been raised and the total would be set up and co-ordinated centrally, and the supplies and equipment would be channelled through the central government to the States.
- (3) TCA was also helping with the community project programme, which included work on agriculture, education, campaigns against communicable diseases, and health. The centre had taken some of the initiative for this project, but the responsibility was gradually being given more to the States.
- (4) Assistance had also been given in the training programme, and 27 Fellows had been selected for study in public health overseas. TCA had also participated with WHO and UNICEF in helping to train public health nurses and other staff, particularly those who would help with the community development programme.
- (5) Finally, TCA was beginning to help with environmental sanitation. 500,000 villages had poor or no water supplies. Manuals on sanitation, designs for latrines, etc., were being prepared, but this project needed to be developed, and this work would be continued.

Dr. HYDE announced that at the end of the afternoon meeting, assignments would be made to working groups, which would meet during the first three days of the following week.

The meeting rose at 12:45 p. m.

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
JOINT STAFF CONFERENCE  
February 12 through 19, 1953  
Geneva, Switzerland

Summary Report on Fourth Plenary Meeting  
Friday, February 13, 1953 at 2:30 p. m.

Co-Chairmen ( Dr. Hyde (Director, Health and Sanitation Staff  
( Technical Cooperation Administration  
( Dr. Chisholm (Director-General  
World Health Organization

Dr. DOROLLE (Deputy Director-General, World Health Organization) said that he would deal with the general structure of WHO and the functions of the Office of the Director-General. The World Health Organization was one of the intergovernmental specialized agencies of the United Nations. The supreme body which met annually was the World Health Assembly, composed of delegations representing Member States; Associate Members also attended but did not vote. The Assembly established the broad policies of the Organization, its programme and its budget and had the power to adopt international regulations in the field of health.

The executive organ of the Health Assembly was the Executive Board, composed of 18 persons (not representative of their governments) designated by the 18 Member States which were selected by the Assembly.

Headed by the Director-General, the Secretariat carried out the work of the Organization. To keep the Organization up-to-date in the technical details of its programmes and to recommend action on the basis of the latest research, Expert Advisory Panels of carefully chosen specialists covered practically every technical aspect of the Organization's work. From those panels the Director-General selected the members of the Expert Committees, whose reports constituted an essential documentation of the greatest use for national health administrations. The World Health Organization differed from the other specialized agencies in the fact that it had been established on a regional basis by its Constitution and had set up regional offices in Africa, the Americas, South-East Asia, Europe, the Eastern Mediterranean and the Western Pacific. Each regional organization consisted of a Regional Committee composed of the representatives of the Member States and Associate

Members in the region and a Regional Office headed by a regional director. Regional Committees planned local programmes and reviewed the work of the Regional Office. In the Americas there was a special case - the Pan American Sanitary Organization serving as the Regional Committee.

It was not necessary to elaborate on the functions of the Director-General, but his general authority extended to both Headquarters and Regional Offices. He appointed the staff and prepared and submitted to the Health Assembly the budget of the Organization together with the comments of the Executive Board.

The Director-General and his Deputy had no executive office, and no one came between the Director-General and the heads of the Departments. A few units remained under the direct supervision of the Director-General and his Deputy - the Office of External Relations, the Office of Technical Assistance, the Office of Reports and Analysis and the Division of Public Information.

The function of the Office of External Relations was liaison and co-ordination with the United Nations and the specialized agencies. The Office of Technical Assistance coped with the responsibilities of WHO participation in the United Nations Expanded Programme of Technical Assistance for Economic Development. The Office of Reports and Analysis was concerned with programme planning and evaluation and prepared the Annual Report of the Director-General to the Health Assembly and ECOSOC. The title of Division of Public Information was self-explanatory.

Dr. GEAR (Assistant Director-General, Department of Central Technical Services, WHO) stated that the Department of Central Technical Services was organized in three divisions, some of whose activities he described.

The Division of Editorial and Reference Services was mainly occupied with WHO publications, of which he would mention two probably of major interest to TCA. The first was the Technical Report Series, the collection of Expert Committee reports containing much information of value to health administrations and organizations conducting health work, and which was not to be found in textbooks or other sources. The second publication was the International Digest of Health Legislation, a somewhat forbidding title, but a publication which contained much material of interest to his hearers in connection with their negotiations with governments. Recently in the Digest emphasis had been laid on comparative studies of health legislation. It furnished different models for formulating health legislation suitable to the varying conditions throughout the world. Other publications were the Official Records, the Bulletin, the Chronicle, and the Monograph Series. Common to all was the principle that they should not compete with national publications but be complementary to the latter and provide otherwise unavailable information required by governments and health administrations.

In the Division of Epidemiology and Health Statistics were grouped the so-called traditional services which went back a hundred years or more and had their beginning in the quarantine services. The international quarantine service was today operated under WHO Regulations No. 2. The application of the truly medical features of this control must be known to all present, but perhaps it was not realized what an important influence the Regulations had on international traffic and trade. The fact that today goods and persons moved over the face of the globe subjected to the minimum of irksome restrictions and without unnecessary delay was due to the acceptance of those Regulations by governments. Without them there would be arbitrary and chaotic interference with traffic and trade. This division had the further function of collecting epidemiological material which it circulated by radio bulletins from Headquarters and by the publication of weekly and monthly bulletins. A repository of medical intelligence and world epidemiological data was being developed in WHO to which governments and institutions could increasingly turn for global information which they would otherwise have great difficulty in collecting for themselves.

The purpose of WHO Regulations No. 1, International Statistical Classification of Diseases, Injuries and Causes of Death, adopted by the World Health Assembly, was to secure throughout the world complete and comparable statistics on morbidity and mortality.

The Division of Therapeutic Substances, among other things, continued the work of the League of Nations. An International Pharmacopoeia had been prepared by a committee of pharmaceutical experts called together by WHO; it was of great value to those countries which were beginning to manufacture their own drugs, antibiotics and insecticides.

The work in biological standardization had been developed over the last 30 years, and it was anticipated that the number of standards would rise to about 80. There again the work was carried out by a group of international experts.

In addition to the three divisions, there was attached to the department a special senior consultant on health statistics entrusted with the task of stimulating the collection of better and more complete health statistics so badly needed in many countries of the world.

Dr. Gear concluded by saying that the work of Central Technical Services was not spectacular or dramatic, but without it much industrial and economic development would be more difficult and cumbersome. This was especially true with regard to the application of the International Sanitary Regulations.

Dr. SUTTER (Assistant Director-General, Department of Advisory Services, WHO) said that the Department of Advisory Services was set up to give technical advice to governments at their request. Its structure had undergone a number of changes as the years had passed, with shifting emphasis from one part of the programme to others. The latest example of this was the setting-up of a Division of Environmental Sanitation. At present this department consisted of four divisions.

The Division of Communicable Disease Services had a historical background and rendered direct services to governments. It also played a direct role in the co-ordination of research on such diseases as influenza, brucellosis and malaria. It dealt with the treponematoses as well as venereal diseases, and was in close association with the Tuberculosis Research Office in Copenhagen in connection with the preparation and use of BCG vaccine. A growing tendency was to be observed to develop field campaigns attacking more than one disease at a time.

The Division of Education and Training Services dealt with fellowships, the exchange of scientific information and assistance to educational institutions. One of the features of its work was organizing seminars, symposia and training groups as well as the special device (sometimes in cooperation with the Unitarian Service Committee) of sending visiting teams of scientists for short periods to a country in order that they might demonstrate techniques as yet not practiced there. One such team had just set out for India.

The Division of Organization of Public Health Services covered a wide field and was divided into seven sections. Time did not permit enumeration of all its activities, but he would select a few examples, such as the malnutrition of children and the geographically widespread disease known by some 80 different names but perhaps best as 'kwashiokor'. The discovery that this disease was due to protein deficiency had led to a search for alternative local sources of animal or vegetable protein, because the distribution of imported dried milk was not a long-term solution of the problem.

In mental health the division tried to improve the teaching of psychiatry and to emphasize the mental health aspects of public health. Health education of the public was another important activity whose value had been stressed by other speakers. In the field of social and occupational health WHO limited its work to fields such as rehabilitation, hospital planning and, with the International Labour Organization, the relation of occupational health to a general public health programme.

The Division of Environmental Sanitation supplied advisory services in such subjects as rural sanitation, insect control, housing, milk and food sanitation. The recent publication of the Fourth Report of the Expert Committee on Insecticides should be of great service to national and international health workers.

The small technical staff at WHO Headquarters could not and was not expected to give an expert opinion on any and every aspect of public health. The mechanism chosen for dealing with this problem was the use of short-term consultants and of advisory panels composed of experts selected from all parts of the world.

Mr. SIEGEL (Assistant Director-General, Administration and Finance, WHO) described the difficulties encountered by WHO in living up to its administrative and financial responsibilities, and the role of administration and finance in furthering the planning, execution and evaluation of WHO's programme. At the end of 1952 there was a total staff of 1,249, working in 50 different countries. In an international organization there was no permanent treasury and no rules and procedures had been laid down, such as the Civil Service codes, etc., common in national governments. This was advantageous in that WHO could profit from the administrative experiences of all nations. The difficulty was that all the different staff members, as well as the members of the Executive Board, and delegates at the World Health Assembly had their preconceived ideas about administration and finance, and the problem was one of finding a system which would be effective and yet acceptable to all.

Administrative changes and financial practices had to be approved by both the Executive Board and the Assembly by a majority vote, and thus a sort of trial by error system had evolved. It was felt that it was too early to define exactly what administration and finance were or should be in WHO. All procedures had to be reviewed frequently and remain flexible because of the ever changing requirements of the Organization.

WHO had maintained close relations with the other international organizations in the United Nations system and had entered into agreements with them so as to co-ordinate administrative and financial practices. The practices of the United Nations had been followed in general, and an international civil service was slowly being built up so that the staffs of all international organizations were being treated similarly.

The Department of Administration and Finance was composed of two divisions, the Division of Administrative Management and Personnel, which comprised sections on Administrative Management, Personnel, and Conference and Office Services, and the Division of Budget and Finance, with sections on Budget and on Finance and Accounts. There were, in addition, three offices directly responsible to the Assistant Director-General - the Legal Office, the Office of Internal Audit and the Office of Supplies. With the decentralization of WHO's operations to the Regional Offices, many administrative and financial responsibilities had also been decentralized. In establishing the annual programme and budget estimates the Director-General

laid down the general policy and provisionally allocated funds to the regions and to headquarters; the regional budgets were prepared by the Regional Directors, reviewed by the Regional Committees and then finally compiled and adjusted by the Director-General before being submitted to the Executive Board, which presented the entire budget with its comments to the Health Assembly. The programme and budget were adopted by a majority vote in the Health Assembly, which also appropriated the funds. The regular budget was financed by assessments on Member States in accordance with the scale voted by the Assembly. It was interesting, perhaps, to note that the contribution of the United States, originally 38.9%, had been reduced in the last two years to 33 1/3%.

The United Nations Technical Assistance Programme was a joint programme of the United Nations and specialized agencies, with a special fund, which was made up of voluntary contributions from governments, and of which specialized agencies were given their share: WHO's share had been approximately 22%. In 1951 WHO's Regular Budget had amounted to about \$6,300,000 and its funds under Technical Assistance were \$1,300,000, giving a total of \$7,600,000. For 1952 the Regular Budget had been \$7,300,000, the Technical Assistance Budget \$5,000,000, with a total of \$12,300,000. This had been a fairly large increase, and the volume of work had increased by 70% in 1952. There were areas of joint action with UNICEF, the United States Bilateral Agencies, the Colombo Plan and some multi-lateral sources. On the Programme and Budget Estimates prepared each year attempts were being made to give information on the programmes and to show the amounts which came from each source. Information on the funds furnished through United States Bilateral aid was not available but it was hoped to incorporate them in future budget estimates so as to show all the work to be done with the help of WHO regardless of the source of funds. It was perhaps interesting to note that for programmes assisted by WHO the governments concerned were now providing four times as much as that contributed by the Organization.

Mr. SIEGEL pointed out that one would be able to use WHO's budget as a tool for the planning of programmes; it was conceived primarily as a device to express these programmes in monetary terms. Also WHO's financial system, its accounting records on projects, etc., were now providing information which could be used with value in programme planning and evaluation.

As for the present financial crisis he explained that WHO found itself in the position of being unable to start the new programmes planned for 1953 and threatened even with having to discontinue some of those already in existence. It was hoped that WHO might transfer certain parts of its programme to other agencies which would be able to finance it. He hoped that one of the developments of this conference would make it possible for WHO and TCA field workers to devise better means of using some of their resources in joint endeavours.

Dr. HYDE stated that WHO had not been able to prevent the financial crisis which had arisen because of the sudden shortage of Technical Assistance funds. He hoped that the possibility of TCA's giving assistance at this critical period could be explored. It was, however, an involved matter with legal considerations that went beyond good will.

### Statements of the Convenors of Working Groups

Dr. HYDE then called on the convenors of the four working groups to state briefly the subjects which they intended to cover in the groups.

Dr. PALMQUIST (Training Group) said that in his group it was planned to cover three subjects in particular; professional training, sub-professional training and public-health education.

Dr. WARNER (Planning and Relationships Group) observed that her group would pay special attention to the strengthening of the health programme of the host country, the whole subject of programme planning, the responsibilities of the host government, the role and use of the advisers, the mechanisms involved, and the relations of both multilateral and bilateral agencies with WHO and with the central government, particularly in the planning of programmes.

Dr. CAMPBELL (Programme Group) felt that the content of programmes could not be compartmentalized, but he mentioned several aspects which might be discussed: The definition of what was meant by programme, the various activities involved, the relationship of the content of the programme of one agency with that of another, the durability of results, conditions, factors and guide lines, the "impact project", projects of public health and medical care, and programme control in relation to strengthening public health services.

Mr. BORJESSON (Operating Methods Group) announced that his working group would consider such problems as organization, consultative services and other techniques, agreements, and the questions of when personnel should be recruited, what kind of personnel was desirable and the kind of facilities which should be given them within a country.

Dr. HYDE remarked that the documents which would emerge from the group discussions would be judged not by their length but by their wisdom. A better definition of what TCA and WHO were doing and how they were doing it was needed. The economic factor had to be kept in mind, but he was sure that the recommendations that came out of this conference would carry great weight with TCA.

Dr. HANLON (TCA) gave some suggestions as to the methods of procedure within the groups. He felt that:

- (1) in the working groups the field workers should have the most to say and the people from headquarters the least;
- (2) the chairmanship of the working groups should be rotated among the people from the field;
- (3) the agenda should not be rigidly adhered to;
- (4) the working groups should break up into sub-groups so as to ensure that each question should be thoroughly covered and no one person should speak too much;
- (5) the working groups should discuss questions, not argue about them; they should plan for the future, not bemoan the past; and should give constructive not destructive criticism;
- (6) they should be entirely informal;
- (7) they should be particularly preoccupied by the need for co-operation in solving all problems and in deciding on the next steps to be taken.

He felt that a major purpose of the conference was for TCA and WHO officials to get better acquainted, and he hoped to leave the conference feeling dissatisfied because of what had still not been accomplished and the necessity for holding another conference in the future.

In taking leave of the meeting Mr. ANDREWS (Administrator, TCA) said it had been a vital experience for him to hear of the wonderful human side of the work on which all were engaged, in comparison with his own strictly "dollars and cents" approach. Although TCA could not solve the financial problems of WHO - he did not at that time know whether they could help at all - he hoped that all the staffs in the countries themselves could get together to see that the programmes did go on. He did not think the United States should spend a single dollar or send a single individual anywhere where somebody else was willing and able to spend that dollar or send that individual.

The meeting rose at 5 p. m.

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
JOINT STAFF CONFERENCE  
February 12 through 19, 1953  
Geneva, Switzerland

Summary Report on Fifth Plenary Meeting  
Thursday, February 19, 1953 at 2:30 p. m.

Co-Chairmen: (Dr. Hyde (Director, Health and Sanitation Staff  
( Technical Cooperation Administration  
(Dr. Chisholm (Director-General  
World Health Organization

The Conference at its final meeting considered the "Draft Summary and Conclusions", drawn up by the two general rapporteurs on the basis of the reports of the four Working Groups.

This summary was divided into five sections: (1) Planning Health Programmes, (2) Co-ordination and Relations, (3) Programme Content, (4) Training and Education, and (5) Operating Methods.

It was introduced by Dr. Brady and Dr. Gilder (rapporteurs), who stated that because of the short time at their disposal for compiling the report, they had not been able to organize it properly, to guard against duplication in the various sections, or to check for omissions; in the interests of brevity, the meaning of the Working Groups had in some cases possibly been altered.

The Conference then reviewed the report, section by section, making a number of drafting changes and occasionally changes of substance. In sections (4) and (5) in particular, it was decided in some cases to go back to the original wording of the Working Groups. The final drafting was left to the rapporteurs. In the discussion on the report, the following principles were brought out:

(1) The separate functions of planning the national health programme in a country (for which, it was felt, the formation of a national health planning board should be stimulated by TCA and WHO, with the participation of international agencies assisting with the health programmes in the country,

if possible), and the co-ordination of the programmes assisted by the different agencies (for which national co-ordinating committees were often formed); these two functions might very well be carried on by the same body in some countries but should be recognized as being separate;

(2) the distinction between the evaluation of a national health programme, for which the government concerned would be responsible and with which outside agencies might assist, and the evaluation of the effectiveness of the assistance given by a particular agency, for which that agency was, of course, responsible;

(3) the desirability, however, of having joint TCA/WHO evaluation of programmes with which both agencies were assisting;

(4) the need for further study of the basic health service, the concept of the health demonstration area and the distinction between them;

(5) the desirability of adhering to standards for supplies, etc., and the specifications for such substances as insecticides, as set out by WHO expert committees in their reports; and, finally,

(6) the advantages to be derived from holding future joint conferences similar to the one being held.

It was decided that this summary as revised by the rapporteurs on the basis of the discussions and the modifications proposed would constitute the main report of the Conference. The reports of the Working Parties, minutes of the plenary meetings, list of participants, and copies of the addresses given by Mr. Andrews, Dr. Brady and Dr. Strode would be annexed as supporting documents.

Dr. HYDE and other speakers emphasized that this report was not a manual or a comprehensive study of co-operative health programmes; it had necessarily been limited to the aspects which there had been time to discuss.

The importance of issuing the report immediately and ensuring full distribution was stressed. Dr. CHISHOLM pointed out that, as this meeting was on the staff level only, the report could not be published officially as a WHO document; copies would be ready within a few days, however, and could be widely distributed throughout the staffs of WHO and TCA. On the other hand, there was nothing confidential about the report, and if it were recognized that it was not an official document, there would be no difficulty about issuing it to anyone outside the agencies who requested it.

In closing the Conference, Dr. HYDE thanked the Director-General of WHO and his staff for making the arrangements for and participating in the meetings in the Palais des Nations. He thought that a major step had been taken in developing friendships and closer relationships which would undoubtedly lead to more effective joint action. Dr. CHISHOLM appreciated the initiative which had been taken by Dr. Hyde in suggesting the Conference and also in having, long before, notified all TCA officials that WHO was the organization responsible for co-ordinating international health work, thus paving the way for close co-operation in field projects. He also was much encouraged by the results of the Conference.

The meeting rose at 6 p. m.

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
JOINT STAFF CONFERENCE \*  
February 12 through 19, 1953  
Geneva, Switzerland

Summary and Conclusions

The objective of the World Health Organization is stated in the Constitution as the "attainment by all peoples of the highest possible level of health". This objective could equally well be applied to the health activities of TCA.

All health work, whatever its nature, contributes to a greater or a lesser degree to social and economic development. The effect may be promptly apparent and readily measurable in terms of economic development, or it may not be apparent except after the passage of a considerable length of time and even then difficult to relate directly to social and economic progress. Nevertheless a favourable effect always is produced by any well planned and successfully implemented project in the field of public health.

As a general principle in international health work the fundamental objective is to assist countries to develop, strengthen and improve the effectiveness of their own health services.

In considering what should be the "most appropriate next steps" to be taken by host governments, international organizations should take into account the cultural characteristics of the country and the felt needs of its people.

1. PLANNING HEALTH PROGRAMS

1. General Observations

A. Principles

1. Long range planning is not an operation which can be performed quickly.

---

\* This document is not an official WHO or TCA document, but is a summary record of informal technical discussions between staff members of the two organizations.

2. No plan can be assumed to be applicable in any other country than that for which it was prepared.

3. In international health assistance, emphasis should be placed on the carry-over value of each project, so that a permanent effect will have been produced that will survive the withdrawal of international assistance.

4. Projects should be so planned that they can be taken over completely by the national health agency at the earliest possible time consistent with practical considerations.

5. Health planning is that process of projection by which the goals to be attained are clearly defined and the actions intended to achieve these goals are clearly described.

6. The goals to be achieved may vary for specified groups of a national population.

7. The goals to be achieved should be set out as those attainable within a specified number of years (i. e. the targets should be reasonable.)

8. Planning for health is a continuing process and any plans made for a specified period should then be succeeded by plans for comparable subsequent periods and based upon experience gained during previous years.

9. The various actions set out in order to achieve the goals defined in such a plan for health should be described according to the times and places in which and at which specific programmes will be carried out, and should as clearly as possible describe the resources which will be used in their implementation. (By resources is meant all the available resources in manpower, materials and cash which can be mobilized by the government and through voluntary and international assistance upon which the government can call.)

10. No plan for health must ever be regarded as inviolable. The variable pace at which development of services for health can be achieved, the rate of and extent of growth of scientific knowledge, and in many cases political and other unforeseeable variables make necessary regular review and probably revision of the plan.

✓ 11. Social development, economic progress and improvements in health are inseparable component parts of the national well being.

12. Any national health plan has to give full weight to existing and proposed economic and social developments; it should recommend objectives and should describe the actions in the field of health that are complementary to such developments.

13. A national health plan including short term projects, which are component parts of it, should exhibit social, economic, administrative and medical soundness.

14. In planning for long term objectives, there is a place for short term unipurpose programmes. However, these should be designed to assist the long term objective.

15. In the planning, control and evaluation of programmes the fullest possible use should be made of the statistics available and of modern statistical methods.

## B. Implementation

1. The responsibility for the planning of health programmes, including the short term component parts of these, lies with the agencies of the government of the country which are directly responsible for the activities to improve health.

2. The role of extra-governmental health agencies is to assist the government upon request in the development of its own plans. These agencies may be the following: Governmental or non-governmental, multilateral or bilateral, international or national.

3. The government is responsible for the control and the continuous evaluation of the work done, assisted by the outside agencies as it may request. This does not preclude self-evaluation by agencies.

4. Provision for such control and continuous evaluation should be a part of the planned programme and not an afterthought.

5. Unless there is satisfactory reporting on, and periodic assessment of, the work done, with continuous collection of experience, planning of future programmes is unlikely to be effective.

6. Multipartite agreements between a government, WHO and TCA present certain difficulties and may lead to delays in negotiation. But the purpose of such agreements would be equally well served by attachment to each of the bipartite agreements (government - WHO, government - TCA) of quite detailed plans of operations indicating the role of the other agency or agencies. This method would be useful where three or more parties are involved in a programme: e. g., United Nations, FAO, Colombo Plan.

7. In many countries suitable statistics are not readily available. The absence or inadequacy of these statistics should not prevent necessary action being undertaken in these countries where prima facie considerations indicate that such action is necessary. In this connection the World Health Assembly resolution WHA2.40 may be noted.

8. In planning programmes it is desirable that provision be made for (a) adoption of uniform standard techniques for assessment of results, wherever standards are available (e. g., recommendations of the WHO Expert Committee on Malaria); (b) use of equipment and supplies complying with international standards or with established specifications (for example, the specifications set out in the reports of the Expert Committee on Insecticides, WHO).

## II. Some Observations on the Role of International Health Staff in Planning and Relationships

1. The international health staff assigned to work in a country has widely differing terms of reference, programming, budgetary cycles and backgrounds. All such officers should be inculcated thoroughly with the necessity of obtaining the fullest possible discussion of a programme before any commitments are made. Consultation between all parties concerned, before any commitment, is a golden rule of planning. Haste is usually the enemy of success.

2. The meeting ground for planning a health programme is in the country concerned. A national co-ordinating committee, or national planning board for health work where such exists, might form the focal point for such planning. The relationship between such a committee or board and any existing interdepartmental committee for economic and social development should always be kept in mind.

3. International staff should avoid becoming hypnotized with co-ordination as an end in itself, as well as becoming preoccupied with the mechanism rather than the objectives toward which they are working. One of the foremost objectives is so to assist the government that it can carry on without the imported personnel.

4. Where the programme of international assistance merits it, each organization should have a full time public health man in the country. Day to day contacts are valuable in ensuring the continuity and the development of the programme.

5. At the present time WHO has not many such officers assigned to countries. TCA has appointed some and, where environmental sanitation appeared to be a major problem, has provided sanitary engineers to fill these positions. Governments sometimes request WHO to assist them in recruiting an adviser to work as a part of the governmental health administration.

6. The work of the adviser on public health to a country is handicapped if he has to carry much administrative work of a personnel or fiscal nature.

7. Should a government insist on presenting requests which are not sound public health work with long range objectives, the international health staff should attempt to steer the requests towards such objectives.

8. In order that internationally recruited staff may be fully oriented in the complex pattern of obligations and relationships, it is a good investment to provide ample time and resources so that they may familiarize themselves with the background, national and international, within which they are going to work. Such an investment would be insurance against the continued repetition of mistakes too often made in the past.

9. Where non-governmental, voluntary or private agencies, national or international, are active in a particular field of health work, the opportunity of consulting them, or working with them, should not be neglected.

## 2. CO-ORDINATION AND RELATIONS

Co-ordination and collaboration between WHO and TCA is desirable and necessary to assure the best utilization of the resources available from each agency and within the country in which operations are being conducted. Collaboration is urged on all matters at all stages from the pre-planning stage through the operational stage.

The following methods of collaboration should be used:

- (a) The prompt and full exchange of ideas, plans, requests received, and reports on programmes and projects, between the two agencies;
- (b) The close and regular contact between WHO area or country representatives and the TCA Public Health Chief within a country;
- (c) Where WHO does not have an area or country representative but does have a Public Health Adviser to a Government this latter will maintain such contact;

- (d) It is suggested, where practical and convenient, that any WHO field staff going into a given country should establish contact with the TCA Health Team, and similarly TCA personnel should establish contact with the WHO personnel within and outside the country;
- (e) If there are no WHO personnel in a country, TCA should maintain liaison with WHO offices elsewhere;
- (f) Periodic meetings of staff or co-operating organizations such as the current one in Geneva, are urged for the future;
- (g) Periodic meetings in a country of all WHO and TCA field staff in that country are recommended, at least on an annual basis. It is urged that the timing of these meetings be considered, so that they may be of value in the WHO schedule of programme and budget making;
- (h) The possibility of mutual exchange of WHO and TCA personnel in appropriate circumstances might be explored;
- (i) Consideration might be given to the possibility of WHO and TCA each stationing a liaison officer at the other organization's central headquarters;
- (j) The reciprocal briefing of personnel en route to and from assignments is recommended.

At the national level, the resolution of the Fourth World Health Assembly (WHA4.27; of Annex A) should be kept in mind. The Conference believes that TCA and WHO should encourage governments in short-range and long-range planning to establish a national health planning board with representatives of international agencies sitting without a vote.

It may in some circumstances be desirable to develop projects with, and give aid and advice to, voluntary societies within the framework of policies of international organizations, provided that the government concerned concurs.

Governments should be stimulated to require that the effects of private capital developments on various aspects of public health be studied before the development is undertaken and to require that the developers provide such health facilities as are necessary. All possible assistance in the form of technical advice should be rendered by WHO and TCA technicians to private capital developments when the activities of such developments have public health implications.

### 3. PROGRAMME CONTENT

#### I. Basic Considerations

- A. Each programme should be planned to provide for the training of national personnel qualified to operate eventually all phases thereof.
- B. In promoting trained national health leadership, consideration should be given to training of public health administrators.
- C. A sound and appropriate national public health administrative organization adequately staffed is essential to the implementation of an effective health programme. If such organization does not exist, an early step in international aid to a country should be to assist in the development of such essential organization.
- D. In the development of health programmes the social and economic value of both sexes of the population should be considered.
- E. In developing public health services there is need to maintain close co-ordination with other public administrations such as agriculture, housing, public education, and public works.
- F. In the co-ordination of basic individual health activities consideration should be given to co-operation with general community development schemes.

#### II. Specific Considerations

- A. Capital Outlay - In the light of the importance of capital outlay as a means of assistance in international health work, in relation to public works such as water works, sewage systems and health centres, and in order to increase the effectiveness of such outlay, co-operation between multilateral and bilateral agencies in planning the use of such capital outlay is desirable.
- B. Equipment - Free exchange of information between multilateral and bilateral agencies on conditions of use of, and specifications of, equipment for various countries will result in more effective international assistance (cf. Section 5 para. III).
- C. Surveys - Greater exchange of information between multilateral and bilateral agencies on the establishment of priorities in determining programme content is desirable, with a view to reducing the number of initial appraisal surveys and generally increasing the effectiveness of programmes.

D. Impact Programmes - Impact programmes may be used in developing long-term co-ordinated health programmes and should be directed toward this end wherever possible. Impact programmes should therefore have the following characteristics; (1) Be readily acceptable; (2) have immediate and obvious value; (3) carry the possibility of early conclusion; (4) be designed to develop long-term programmes.

E. Seminars and Symposia - Seminars and symposia are useful in facilitating:

- (1) exchange of ideas and information between professional persons with common interests;
- (2) exchange of new ideas and methods between health agencies and professional leaders;
- (3) the development of support for international health work.

Co-ordination between multilateral and bilateral agencies on the sponsoring, planning and conduct of national and regional seminars and symposia is desirable. The use of visiting teams of medical scientists sponsored by international health organizations also facilitates the exchanges of ideas, information and techniques mentioned above.

F. Basic Health Services - In the development of a broad national health programme some basic unit of local health service is desirable, no matter how primitive. In the development of such units the principle of participation and assumption of responsibility by the people concerned is fundamental.

G. Mobile Units - Mobile units may have a significant place in a health programme, their usefulness perhaps falling into three categories:

- (1) in emergencies such as epidemics or disasters,
- (2) for survey and appraisal purposes in limited situations, and
- (3) for the reinforcement of local services.

In any case they serve principally as an adjunct to a regularly established service.

H. Specific Health Projects - Regardless of the nature of specific health activity initially used in the development of national health services, its maximum value will derive from its use in furthering the development of an integrated and co-ordinated total health programme.

I. Demonstration Areas - Demonstration areas are useful if considered as a step in a planned programme of teaching public health administration and techniques.

J. Co-ordination of Programme Content - This is discussed in Section 1. II, paras. 1, 2 and 7.

Attention is also drawn to the ten methods of collaboration enumerated in Section 2.

In addition it is recommended that WHO assume responsibility for developing with the agencies concerned a reference mechanism to assure knowledge of and availability of reports and other information useful in the development of country programmes.

### III. Guiding Principles in Establishing Programme Content Priorities

The following guiding principles, not arranged in order of importance, were identified: Felt need, acceptability and availability of resources; specificity of control methods; effect of the programme on production potential; timing, lasting benefits; economy of results; and potential for stimulating broader health developments.

### IV. Criteria for Appraisal of Programmes

Programme appraisal is a continuous process. Depending upon circumstances it may extend from the determination of the baseline stage to the attainment of goals.

Programme appraisal should be (1) objective, (2) qualitative and so far as possible quantitative, (3) related to objectives, (4) appropriately timed, and (5) designed to include subsidiary benefits.

## 4. TRAINING AND EDUCATION

### I. Planning for Education and Training

Education and training programmes must be regarded as important means of accomplishing long-range objectives of health programmes, namely the development of health services. They require to be adjusted to the needs and plan of a country.

If a national health planning body exists, one of its tasks should be determination of needs for education and training and of methods of meeting these needs. Such a body should include representatives of: The national health administration, ministry of education, training institutes and health personnel groups.

Factors affecting training programmes are: (1) Number and quality of personnel available. (2) Number and quality of personnel needed in the future. (3) Social, economic, cultural and administrative background. (4) General level of education and technical ability available. (4) Priority of needs.

The most desirable first step is training of general rather than specialized health workers.

Selection of trainees as regards personality and ability is of great importance.

## II. Professional Training

1. The importation of qualified people from abroad cannot be considered as permanent or completely satisfactory. At the same time, varying in different countries, the appropriate next steps must be taken to establish, maintain and develop indigenous professional training and education.

2. Professional training is a long-term process and needs development of a long-range plan.

3. The following factors affect professional training: (1) Economic, social and cultural development of the country, with special reference to economic status (expense of professional training is relatively great). (2) Needs of the country for professional workers. (3) Needs of a country for prestige and psychological well-being might lead to such establishment before the country is ready.

4. Content of training. This is adequately discussed in various publications of WHO, USPHS and IIAA.

5. The need for teachers is an important aspect of training. A time limit must always be put on use of imported personnel and other foreign aid.

6. Improvement of existing services involved: (a) Improvement of preliminary education and training in basic sciences. (b) Improvement in practical work. (c) Improvement in relations between training school and health agencies.

## III. Training of Auxiliary (sub-professional) Personnel

1. A primary need of a country with limited health services is auxiliary (sub-professional) personnel. This does not mean, however, that professional training should be excluded. The latter is needed: (a) for teaching; (b) as a basis for future development; (c) for supervision of sub-professional personnel.

The primary need in auxiliary training is for general health workers.

2. Long-term and short-term objectives should be defined. The short-term objective is the more important here, but auxiliary and professional training must always be integrated.

3. Factors affecting auxiliary training include: (a) Needs. (b) Economic status of the country. (c) Government administrative structure. (d) Social and cultural patterns.

4. Establishment of clear categories both as to level and function is necessary, with possibility for advance of individuals from class to class.

5. Teachers must be trained concurrently with auxiliary personnel; the country must develop its own resources as soon as possible in this respect. The need for adequate supervisors must not be forgotten.

6. Provision must be made for giving adequate status in the community to auxiliaries, and for recognition of the importance of their role.

#### IV. In-Service Training

New and transferred health workers should receive a carefully planned introduction to the organization, the job to be done and the necessary skills required. Continuing programmes of staff education, in which the team concept is employed, are essential to economy, effective service and continued employment.

#### V. Fellowships

These are not a panacea but an aid in training. Education and training facilities within the region should be utilized to the maximum and existing institutions should be encouraged to accept students from nearby countries. Fellowships must be integrated into the long-range plan for public health services and professional education.

#### VI. Seminars and Symposia

These, as well as visiting teams of medical scientists (cf. Section 3.II.E), are useful for aiding exchange of ideas between professional health workers and their agencies and for developing support for international health work.

#### VII. Health Education of the Public

1. Health education implies education of the public and of the professional and auxiliary health workers in relation to their contact with the public.

2. Health education of the public, in its real essence, is a two-way educational process in which the interests and felt needs of the public should serve as the basis for programme development.

3. Experiments and observation of new educational techniques are very necessary. There is a need also for determining more economical means of local production and use of visual materials related to needs at the village level.

4. Health authorities should establish training programmes in health education of the public for a wide variety of professional and auxiliary health workers. This training should provide an understanding of the social and cultural factors, of education, and of psychology.

## 5. OPERATING METHODS

### I. Agreements

In the framing of agreements by WHO or TCA, consideration should be given to inclusions and omissions in respect of certain requirements imposed upon governments which cause problems to the other technical organization.

The problem of differences in WHO and TCA agreements should be referred to appropriate authorities in the two organizations, so that these authorities might explore the possibility of eliminating such differences as those in salaries of counterpart personnel, privileges and immunities for technical personnel, and conditions of service which TCA and WHO require governments to provide.

Sample tripartite agreements might be drawn up by lawyers and TCA and WHO staff members.

### II. Personnel

Recruiting and procurement of supplies and equipment should be so timed that as nearly as possible project personnel and the supplies and equipment needed for the project arrive at the same time.

### III. Supplies, Equipment and Transportation

The two organizations should collaborate to the fullest extent on exchange of information on supplies and equipment, sources for procurement and costs. Such information may be obtained from TCA, Washington, and from WHO offices in Geneva, Washington, New Delhi and Alexandria (see also Section I. I. B. para. 8).

#### IV. Technical Aspects of Projects

(a) There should be full interchange of technical methods and techniques with a view to standardizing practices and technical approaches wherever possible.

Reports of the WHO Expert Committees and the other technical publications of WHO should be made standard technical literature for TCA and WHO personnel and teams working in the field of health, should be included in the briefing of such personnel, and should provide the basis for their field operations so far as possible.

TCA personnel in the field might suggest places where this WHO literature might usefully be sent.

Communication on technical matters between TCA and WHO personnel should be encouraged.

(b) The following principles should be observed in the carrying out of a technical operation within a country:

(i) Appropriate division of work between international and national members of a team, so as to obtain maximum participation from nationals.

(ii) Encouragement by international field staff of co-operation between Ministries.

(iii) Exploitation to the full of training possibilities in the field.

(iv) The possibility of linking up with other projects to establish an inter-country programme.

#### V. Reports and Evaluation of Projects

It is time to consider the evaluation of the results of work so far accomplished by WHO and by TCA. (Cf. "Self-evaluation", Section I. I. B. para. 3). The USPHS evaluation study of IIAA activities and recent studies by WHO on general principles and methods may provide an adequate basis for evaluating at least one country or major area project. If one organization (WHO or TCA) were to consider making an evaluation of its results, such an evaluation should be planned in close consultative collaboration with the other organization. The country or countries concerned should participate in any such study.

#### VI. Inter-Country Operations

It is highly desirable that technical work involving communicable disease control, training programmes and other appropriate activities be de-

developed on an inter-country basis. Where either organization holds specialized technical training sessions or seminars, the other organization should be informed and every effort be made to include appropriate participants from the non-sponsoring group.

VII. Public Information Aspects of Programme Promotion

- (a) Informing the public before starting a project is extremely important in order to ensure their co-operation.
- (b) Progress in collaboration between TCA and WHO should be emphasized in public relations and public information activities carried out by the two organizations.
- (c) There should be the fullest possible exchange of information material between TCA and WHO.
- (d) Local groups and local organizations should preferably be used for disseminating information to the public and for enlisting support of the public in projects.
- (e) Different public information techniques should in general be applied to urban and rural areas; for the latter, simple graphics, posters and wallcharts are particularly useful.

Resolutions of the World Health Assembly mentioned in the preceding text:

WHA2.40

The Second World Health Assembly

RESOLVES

- (1) that in the field and laboratory investigations and action carried out by WHO or with its assistance, the fullest possible use of available statistics and modern statistical methods should be made in the planning and execution of such investigations and action and in the evaluation of their results;
- (2) that it is desirable that, wherever suitable health statistics exist or can be made available within a reasonable time, they should be examined in order to make a preliminary assessment of the need for the investigation or action contemplated;
- (3) that although it is recognized that, in many countries, such suitable statistics may not be readily available, the absence or insufficiency of these statistics should not prevent investigations and necessary action being undertaken in those countries where prima facie considerations necessitate such investigations or action;
- (4) that it is essential in any event that continuous statistical control and analysis of the investigations and action should in every case be provided for and carried out to the fullest extent practicable; and
- (5) that the Director-General be requested to submit to an early meeting of the Executive Board a report on the present administrative arrangement in the sphere of statistics (health, epidemiological, medical and vital) and to indicate any changes he thinks necessary or has carried out.

WHA4.27

The Fourth World Health Assembly

REQUESTS that in the future special attention should be given by the Executive Board and the Director-General to the importance of assisting Member States, particularly under-developed States, to draw up short- and long-term health programmes for their respective territories, in order to promote the orderly development of public-health measures and to utilize to the best advantage, along with the national resources, the help that may become available from time to time from WHO and other sources.

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
JOINT STAFF CONFERENCEWORKING GROUP No. 2:REPORT ON PLANNING AND RELATIONSHIPS

This report does not concern itself exclusively with planning and relationships as they concern TCA and WHO, but it does concern itself with an attempt to enunciate principles involved in planning, control and assessment of programmes. It also deals with the relationships which can and should exist between the various agencies, international, governmental and non-governmental, national and private, which operate in the field of health and are available to assist governments in developing programmes for the health of their people.

I. Some general observations on the planning of health programmesA. Principles

1. Long-range planning is not an operation which can be performed quickly.
2. No such plan can be assumed to be applicable in any other country than that for which it was prepared.
3. Health planning is that process of projection by which the goals to be attained are clearly defined and the actions intended to achieve these goals are clearly described.
4. The goals to be achieved may vary for specialized groups of a national population.
5. The goals to be achieved should be set out as those attainable within a specified number of years (i. e. the targets should be reasonable).
6. Planning for health is a continuing process and any plans made for a specified period should then be succeeded by plans for comparable subsequent periods and based upon experience gained during previous years.

7. The various actions set out in order to achieve the goals defined in such a plan for health should be described according to the times and places in which and at which specific programmes will be carried out, and should as clearly as possible describe the resources which will be used in their implementation. (By resources is meant all the available resources in manpower, materials and cash which can be mobilized by the government and through voluntary and international assistance upon which the government can call.)

8. No plan for health must ever be regarded as inviolable. The variable pace at which development of services for health can be achieved, the rate of and extent of growth of scientific knowledge, and in many cases political and other unforeseeable variables make necessary regular review and probably revision of the plan.

9. Social development, economic progress and improvements in health are inseparable component parts of the national wellbeing.

10. Any national health plan has to give full weight to existing and proposed economic and social developments; it should recommend objectives and should describe the actions in the field of health that are complementary to such developments.

11. In planning for long-term objectives, there is a place for short-term unipurpose programmes. However, these should be designed to assist the long-term objective.

12. A national health plan including short-term projects, which are component parts of it, should be socially, economically, administratively and medically sound.

13. In the planning, control and evaluation of programmes the fullest possible use should be made of the statistics available and of modern statistical methods.

14. In planning programmes it is desirable that provisions be made for (a) the adoption of uniform standards techniques for assessment of results, wherever they are available (for example, recommendations of the WHO expert committee on malaria); (b) the use of equipment and supplies complying with international standards or with established specifications (for example, the specifications set out in the reports of the Expert Committee on Insecticides, WHO).

## B. Implementation

1. The responsibility for the planning of health programmes, including the short-term component parts of these, lies with the agencies of the

government of the country which are directly responsible for the activities to improve health.

2. The role of extra-governmental health agencies is to assist the government at its request in the development of its own plans. These agencies may be one or more of the following: International, governmental, bilateral, international or national non-governmental, or private.

3. The government is responsible for the control and the continuous evaluation of the work done, assisted by the outside agencies as it may request.

4. Provision for such control and continuous evaluation should be a part of the planned programme and not an afterthought.

5. Unless there is satisfactory reporting on, and periodic assessment of, the work done, with continuous collection of experience, planning of future programmes is unlikely to be effective.

6. No remarks here exclude the duty of the international agencies to evaluate the quality of their operations.

7. In many countries suitable statistics will not readily be available. The absence or inadequacy of these statistics should not prevent necessary action being undertaken in these countries where prima facie considerations indicate such action is necessary. In this connection, resolution WHA2.40 should be noted.

## II. Some observations on the role of international health staff in planning and relationships

1. The international health staff assigned to work in a country has widely differing terms of reference, programming, budgetary cycles and backgrounds. All such officers should be inculcated thoroughly with the necessity of obtaining the fullest possible discussion of a programme before any commitments are made. Consultation between all parties concerned, before any commitment, is a golden rule of planning. Haste is usually the enemy of success.

2. The meeting ground for planning a health programme is in the country concerned. The national body for planning health work where such exists should form the focal point for such planning. WHO and TCA should encourage the establishment and efficient working of such a body. The relationship between such a national body for planning health work and any interdepartmental committee for economic and social development should always be kept in mind.

3. International staff should avoid becoming hypnotized with coordination as an end in itself, as well as becoming preoccupied with the mechanism rather than the objectives toward which they are working. One of the foremost objectives is so to assist the government that it can carry on without the imported personnel.

4. Where the size of the programme of international assistance merits it, each organization should have a full-time public health man in the country. Day to day contacts are valuable in insuring the continuity and the development of the programme.

5. At the present time WHO has not many such officers assigned to countries. TCA has appointed some and, where environmental sanitation appeared to be a major problem, has provided sanitary engineers to fill these positions. Governments sometimes request WHO to assist them in recruiting an adviser to work as a part of the governmental health administration.

6. The work of the adviser on public health to a country is handicapped if he has to carry much administrative work of a personnel or fiscal nature.

7. Should a government insist on presenting requests which are not sound public health work with long-range objectives, the international health staff should by further discussion attempt to steer the requests towards such objectives.

8. In order that internationally recruited staff may be fully oriented in the complex pattern of obligations and relationships, it is a good investment to provide ample time and resources so that they may familiarize themselves with the background, national and international, within which they are going to work. Such an investment would be insurance against the continued repetition of mistakes too often made in the past.

9. Where non-governmental, voluntary or private agencies, national or international, are active in a particular field of health work, the opportunity of consulting them, or working with them, should not be neglected.

### III. Miscellaneous Points

Multipartite agreements between the government, TCA and WHO present certain difficulties and may lead to delays in negotiation. But the purpose of such agreements would be equally well served by attachment to each of the bipartite agreements (government-WHO, government-TCA) of quite detailed plans of operations indicating the role of the other agency or agencies. This method would be useful where there are three or more parties involved in a programme; the various parts of the United Nations, FAO, the Colombo Plan, etc.

WORKING GROUP No. 1:

REPORT ON TRAINING

I. Long-range planning for education and training programmes

Education and training programmes are not ends in themselves, but important means or methods of attaining the long-range objective of all health programmes, namely, the development of health services.

Training of health personnel should fit into the needs and plans of the country. Outside aid should be designed to accelerate the progressive development of health programmes. Where a national health planning body exists, a special responsibility of that body, or of one of its committees, should be the determination of the long-range needs for health personnel and the methods for meeting such needs. Such a committee should be composed of representatives of the national health administration, the Ministry of Education, leading training institutions, and representatives of the major health personnel groups, preferably those engaged in training services.

Training programmes for health workers should be planned in relation to: (1) number and quality of health workers now available; (2) number and quality of health workers needed in the future; (3) social, economic, cultural, and administrative framework of the country; (4) general level of education and technical ability available; and (5) priority of needs.

All training plans and programmes should be evaluated in terms of the financial and technical ability of the country to continue those programmes unassisted by outside agencies.

In training programmes, the emphasis should be on the acquisition of knowledge and skills, not on the obtaining of degrees and certificates.

Auxiliary workers are no substitute for fully qualified personnel but depend upon qualified personnel for their training, guidance, and supervision. The training of such fully qualified personnel provides not only the immediate needs for teachers and supervisors, but also a firm basis for future development. The training of such personnel should not be neglected in responding to the urgent immediate needs for the production of auxiliary workers.

In so far as possible, fundamental health training programmes should be designed to provide basic training for generalized, rather than specialized, health workers. If specialized training is found necessary, it should be considered a temporary expedient and an intermediate step toward generalized training.

Successful results of training programmes require the proper selection of trainees as to their personality, vocation, and technical ability, and recognition of the role of the health worker in the community through adequate pay and opportunity for advancement.

New and transferred health workers should receive a carefully planned introduction to the organization, the job to be done, and the necessary skills required. Continuing planned staff education programmes, employing the team concept, are essential to economy, effective service, and continued employment of the staff.

## II. How to assist professional education and training

In line with a previous discussion (on sub-professional personnel) the group agreed that the development of professional education and training is a long-term process, and as such requires the formulation of long-range plans. Many countries, in order to meet immediate needs with respect to professional health workers, have been able to provide certain medical, nursing, sanitation, and other services by the importation of qualified people from abroad but this manner of solving the problem cannot be considered as permanent nor completely satisfactory. At some time, varying in different countries, the "appropriate next steps" must be taken to establish, maintain, and develop indigenous professional education and training.

In addition to the consideration of whether a particular society is ready for its own professional education and training, the question of expense was brought up. Too often, countries have embarked upon the establishment of what were intended as high grade institutions, but without an adequate understanding of the financial (and other) obligations they would have to face during the life of the institution. Assistance from outside sources is to be encouraged, but it must have logical time limitations and in no way be construed as a permanent transfer of authority and responsibility to the assisting agency.

The material side of the problem deserves considerable study and attention, but other factors are likewise important. The presence of institutions of higher learning adds considerably to the prestige and "psychological well-being" of a country and sometimes stimulates the creation of such establishments before the country is ready for them. The other side of the

picture also exists, as for instance the demonstration of a need which can be met with professional education and training activities. An intimate part of all of these considerations is, of course, "politics". The group recognized this fact, but could not treat this subject in general terms because of extreme variability from place to place and from time to time.

The group decided that it would not discuss the substance of professional education and training, as this was already well covered in many places, among which were the Expert Committee Reports of WHO in a number of subjects: Nursing (2nd Report); Environmental Sanitation (2nd Report); Professional and Technical Education of Medical and Auxiliary Personnel (2nd Report). Publications of other agencies, such as USPH Service, Institute of Inter-American Affairs, etc. were also suggested as valuable reference. However, three general requirements for the improvement of professional education and training were emphasized: (a) there must be improvement in the teaching of basic sciences, as well as in the level of preliminary education; (b) there must be improvement in the facilities for practical work; (c) there must be improvement in the collaboration and co-operation between the professional school and the agencies responsible for health services to the community. (Note: The last statement does not imply that there should be a coalescence of these two functions - only better working relationships between them.)

While it was recognized that the establishment of professional educational institutions is a basic method for the production of qualified health workers, the use of fellowships was also thought to be important, though it was stressed that the prescription - fellowships - did not constitute a panacea for the many ills which characterize the problem. The use of fellowships for study abroad was considered to be a means towards an objective. In order to make the best use of funds and facilities, fellowships should be awarded in accordance with a long-range plan for development of both health services and professional education. Thus, the subject for study will be outlined in advance, a candidate could be selected in terms of the anticipated goals, and a place where the returning fellow could perform in accordance with his newly-acquired knowledge would be ready. It was felt that this method of operating - that is, formulating long-range plans - would help assisting agencies in allotting funds for fellowship purposes by anticipating each year's needs.

### III. How to Assist Sub-Professional Education and Training

An "under-developed" country with rudimentary health services and with limited resources must contemplate how best it can utilize these resources (both human and material) in order to develop its health services.

This means that a plan should be formulated wherein both long- and short-range objectives are stated, as well as the successive steps necessary to approach them. The training of sub-professional (or auxiliary) personnel was considered to be an immediate kind of action designed to meet (at least partially) present needs. In the discussion, however, the problem of integrating auxiliary workers' functions with those of later-developed professional workers came up several times.

Inherent in any plan must be careful attention to (and as accurate an evaluation as possible of) the country's: health needs, present and potential; economy; governmental administrative structure; and its social and cultural patterns. In most "under-developed" countries this leads to the concept that, concurrent with the training of professional personnel, emphasis be placed on the training of sub-professional personnel as the best utilization of limited resources.

Since a training programme requires the presence of teaching staffs, the country must take steps to prepare health workers who can fulfill this function. In the beginning, outside help may be available in meeting a shortage of teachers, but the country should prepare to develop its own faculties for institutions training auxiliary workers. These may be drawn from among professional personnel, the preparation of which is discussed under Item II.

Sub-professional workers, it was agreed, cannot be entrusted to any great extent with the vital tasks involving human health and disease without adequate leadership. This leadership must operate within the administrative structure of the country and in recognition of its culture and traditions. The problem of finding persons capable of giving supervision and inspiration to auxiliary workers in the several fields of health is one which must be solved if the programme is to succeed. Obviously, many countries cannot provide such high-level workers themselves and must seek help from other sources, at least temporarily. However, an integral part of the comprehensive plan must take into account the development of this kind of supervisory personnel.

Sub-professional workers must be delineated into categories of different levels, with the training and limitations of each clearly defined. Provisions should be made for in-service training after the basic qualifying training so that an ambitious individual may advance himself to the limits of his own capabilities. Morale and effectiveness in work are consequent upon careful attention to these factors. Even when standards are raised so that there is a fully-fledged professional category, the incumbents of positions within the one or more sub-professional levels will have honoured and respected status in that society.

#### IV. How to Assist Health Education of the Public

Education, in its real essence, is a reciprocal or two-way process. Health workers need to arrive at a situation wherein the public and the health workers are each learning from the other - specifically, where the public are expressing their interests and felt needs which can become the basis for further discussions and programme development. Conversely, health workers should strive to avoid a working relationship wherein one is doing all the telling and the individuals or groups are passive recipients.

Health education implies education of individuals and groups of the public, e. g. teachers, school age children, family and village groups, as well as education of professional and auxiliary workers in relation to their contact with the public. Opportunities for health education of the public come to a variety of health workers and related personnel. In those instances where the services of full-time professional health educators may be made available, one of their primary roles is to help extend and strengthen the health education activities of all health workers and of other co-operating groups and individuals.

Although a number of effective methods for working in small groups and for fostering village participation are being tried and established, further experimentation and observation of new techniques are needed. There is a need also for determining more effective and economical means for local planning, production and use of visual materials closely related to the needs and requirements at the village level.

Careful long-term planning will be essential to reach so many villages with so few village workers trained in health education skills. It is suggested that health authorities encourage the establishment of various training programmes in health education for a wide variety of professional and auxiliary health workers, teachers, adult educators, village leaders, etc. All such workers should be afforded an understanding and appreciation of the contribution of social and cultural aspects, of education, and of psychology in explaining human behaviour. This emphasis on training would serve to extend leadership for health education work with individuals, families, school and village groups. The establishment of leadership training courses for these workers would appear possible in some countries through re-allocation of some monies for this purpose from large sums being currently spent in the production of propaganda materials.

WORLD HEALTH ORGANIZATION - TECHNICAL COOPERATION ADMINISTRATION  
JOINT STAFF CONFERENCE

WORKING GROUP No. 3:

REPORT ON PROGRAMME CONTENT

I. Definition of Area for Discussion

The following definition was agreed upon: A health programme is the sum total of all the planned activities that can be encompassed within any of the well recognized fields of public health. It may include, among other things, a number of specific projects, each of which is designed to meet a limited, agreed-upon objective. This definition applies to country, regional or headquarters programmes.

II. Programme Objectives

A. WHO Programmes - The objective of the World Health Organization shall be the attainment by all peoples of the highest possible level of health\*

B. TAED Programmes - The purpose of TCA programmes and the purpose of WHO programmes financed by TAED funds is the same - the improvement of health for the purpose of furthering economic development of economically under-developed areas of the world.

III. General Principles

A. All health work, whatever its nature, contributes to a greater or a lesser degree to social and economic development. The effect may be promptly apparent and readily measurable in terms of economic development, or it may not be apparent except after the passage of a considerable length of time and even then difficult to relate directly to social and economic progress. Nevertheless, a favourable socio-economic effect always is produced by any well planned and successfully implemented project in the field of public health.

---

\* Constitution of the World Health Organization

B. As a general principle in international health work the fundamental objective is to assist countries to develop, strengthen and improve the effectiveness of their own health services.

C. In considering what should be the "most appropriate next steps" to be taken by host governments, international organizations should take into account the cultural and ethnological characteristics of the country and the felt needs of its people.

#### IV. Basic Considerations

A. In international assistance in health work, emphasis should be placed on the carry-over value of each project, so that a permanent effect will have been produced that will survive the withdrawal of international assistance.

B. Projects should be so planned that they can be completely taken over by the national health agency at the earliest possible time consistent with practical considerations.

C. Each programme should be planned to provide for the training of national personnel qualified to operate eventually all phases thereof.

D. In promoting trained national health leadership consideration should be given to training administrators of public health programmes who are public-health minded and conversant with modern public-health methods.

E. A sound minimum administrative organization is essential to the implementation of an effective health programme. If such organization does not exist an early step in international aid to a country should be to assist in the development of such essential organization.

F. In the development of health programmes the social and economic role of both sexes of the population should be considered.

G. In developing public health services there is need to maintain close co-ordination with other public administrations such as agriculture, housing, public education, public works, etc.

H. In the co-ordination of basic individual health activities consideration should be given to co-operation with general community development schemes.

I. Capital Outlay - In the light of the importance of capital outlay as a means of assistance in international health work, and in order to increase its effectiveness, co-operation between multilateral and bilateral agencies in planning the use of such capital outlay is desirable.

J. Equipment - Free exchange of information between multilateral and bilateral agencies on conditions of use of, and specifications of, equipment for various countries will result in more effective international assistance.

K. Surveys - Greater exchange of information between multilateral and bilateral agencies on the establishment of priorities in determining programme content is desirable. This should reduce the number of initial appraisal surveys needed and generally increase the effectiveness of programmes.

L. Impact Programmes - Impact programmes may be used in developing long-term co-ordinated health programmes and should, therefore, be directed toward this end wherever possible. Impact programmes should have the following characteristics: (1) Readily acceptable, (2) immediate and obvious value, and (3) possibility of early successful conclusion.

M. Seminars and Symposia - Seminars and symposia are useful in facilitating:

- (1) exchange of ideas and information between professional persons with common interests who usually do not have opportunity to meet,
- (2) exchange of new ideas and methods between health agencies and professional leaders, and
- (3) the development of support for international health work.

Co-ordination between multilateral and bilateral agencies on the sponsoring, planning and conduct of national and regional seminars and symposia is desirable.

N. Basic Health Services - In the development of a broad national health programme some basic unit of local health service is desirable no matter how primitive. In the development of such units the principle of participation and assumption of responsibility by the people concerned is fundamental.

O. Mobile Units - Mobile Units may be of value in a health programme, their usefulness falling into perhaps three categories:

- (1) For emergency use as in case of epidemics or disasters,
- (2) For survey and appraisal purposes in limited situations, and
- (3) For the reinforcement of local services.

In any case they serve principally as an adjunct to a regularly established service.

P. Specific Health Projects - Regardless of whatever specific health activity may be initially started in the development of national health services, its maximum value will derive from its use in furthering the development of an integrated and co-ordinated total health programme.

Q. Demonstration Areas - Demonstration areas are useful if considered as a step in a planned programme of teaching public health administration practices.

R. Co-ordination of Programme Content - Group 3 endorses the principles contained in paragraphs II.1 and 7 of the Report of Working Group No. 2 (q. v.) as they apply to development of programme content.

S. Group 3 endorses the eight methods of attaining collaboration set forth in paragraph I. (1) of the Report of Group 4 (q. v.).

In addition it is recommended that WHO assume responsibility for developing with the agencies concerned a reference mechanism to assure knowledge of and availability of reports and other information useful in the development of country programmes.

T. It is recommended that consideration be given by WHO and TCA to the stationing of a liaison officer, each in the Central Headquarters of the other.

U. The reciprocal briefing of personnel en route to and from assignments is recommended.

#### V. Guiding Principles in Establishing Programme Content Priorities

The following guiding principles, not arranged in order of importance, were identified: Felt need, acceptability and availability of resources; specificity of control methods; effect of the programme on production potential; timing; lasting benefits; economy of results; and catalytic potential for contributing to broader health developments.

#### VI. Criteria for Appraisal of Programmes

Programme appraisal is a continuous process. Depending upon circumstances it may extend from the determination of baseline stage through attainment of goals.

Programme appraisal should be (1) objective, (2) quantitative where possible, (3) related to objectives, (4) appropriately timed, and (5) designed to include subsidiary benefits.

WORKING GROUP No. 4:

REPORT ON OPERATING METHODS

I. Co-ordination of Programmes and Projects

This subject is to be considered under two headings: (1) Collaboration between TCA and WHO which would involve discussions, interchange of ideas, plans, information etc., at all levels, and (2) co-ordination at the national level.

(1) Collaboration

Collaboration between TCA and WHO is desirable and necessary to assure the best utilization of resources available from each agency and within the country in which operations are being conducted, to avoid duplication in effort and to avoid any element of competition between the two agencies.

Collaboration is urged on all matters at all stages from the pre-planning stage through and including the operational stage.

It is suggested that collaboration can be attained through the following methods;

- (a) The prompt and full exchange of ideas, plans, requests received, and reports on programmes and projects, between the two agencies;
- (b) The close and regular contact between WHO area or country representatives and the TCA Public-Health Chief within a country;
- (c) Where WHO does not have an area or country representative but does have a Public-Health Adviser to a Government this latter will maintain such contact;

(d) It is suggested, where practical and convenient, that any WHO field staff going into a given country should establish contact with the TCA Health Team, and similarly TCA personnel should establish contact with the WHO personnel;

(e) If there are no WHO personnel in a country, the WHO Regional Office should consider sending a representative to the country for discussions with the TCA Public-Health Chief. It is also recommended that the TCA Public-Health Chief should go periodically to the Regional Office for liaison;

(f) Periodic meetings of WHO and TCA staff, such as the current one in Geneva, are urged for the future;

(g) Periodic meetings in a country of all WHO and TCA field staff in that country are recommended, at least on an annual basis. It is urged that the timing of these meetings be considered, so that they may be of value in the WHO schedule of programme and budget making;

(h) It is urged that the TCA Public-Health Chief and the WHO country representative or Public-Health Adviser visit the WHO Regional Office at least once a year for discussion and consultation;

(i) Appointment of TCA health personnel at the regional level corresponding to the WHO Regional Directors is advised; the Group has not defined their duties, responsibility and authority, but recommends that, so far as possible, TCA and WHO Regions be conterminous.

## (2) Co-ordination at the National Level

The group called attention to the following two WHO Resolutions and urged the implementation of them:

### "Co-ordination and Implementation of International Health Activities"

Sixth Session of the Executive Board,

Resolution No. 10 -

Whereas Article 2 (a) of the Constitution of the World Health Organization states that one of the functions of the Organization shall be "to act as the directing and co-ordinating authority on international health work";

Whereas the needs for intensive work in public health at the national and international level in the interest of many or all countries surpass the financial and organizational resources of WHO;

Whereas it should be recognized that various activities in public health, including some research and training activities carried out by national institutions, international bodies and private organizations, would yield more valuable results for the health of the world if they were put in an international co-ordinated programme; and

Whereas there are individuals, institutes, groups and organizations willing to give support to worthy projects in the field of public health,

#### The Executive Board

1. RESOLVES THAT, in pursuance of Article 2 (a) of the Constitution, it is desirable that steps be taken to facilitate international co-ordinated and co-operative programmes of health work, and
2. REQUESTS the Director-General to study methods and work out programmes for the implementation of this resolution, and to submit a report on the question.

#### Fourth World Health Assembly, Resolution No. 27

#### The Fourth World Health Assembly

REQUESTS that in the future special attention should be given by the Executive Board and the Director-General to the importance of assisting Member States, particularly under-developed States, to draw up short- and long-term health programmes for their respective territories, in order to promote the orderly development of public-health measures and to utilize to the best advantage, along with the national resources, the help that may become available from time to time from WHO and other sources.

The Working Group was of the opinion that TCA and WHO should join in assisting governments in short-range or long-range planning. In attaining the collaboration described on pages 1 and 2, it must be borne in mind that all projects should be a part of the plan for national health developed by the government. The Working Group believes that this can be attained by the

government establishing a non-operational national health planning board, in order to obtain a single national health programme. This board would be a governmental board with representatives of international agencies or groups sitting in as advisers without a vote.

## II. Types of Agreement

Under the agenda item "Types of Agreements", the Working Group discussed the inclusion in or omission from Agreements of certain requirements imposed upon host governments which caused problems to the other technical organization.

It was concluded that the problem of areas of conflict in Agreements should be referred to appropriate authorities in WHO and TCA, with a recommendation that these authorities explore the possibility of eliminating such conflict. Examples given of conflicts included:

1. TCA augments the salaries of counterpart personnel, while WHO does not.
2. A number of differences of privileges and immunities for technical personnel exist.
3. There are a number of differences in conditions of service which TCA and WHO require the host government to provide.

The Group recommended that the lawyers and other appropriate staff members of the two organizations develop sample tripartite Agreements.

## III. Personnel

Three recommendations were developed during the discussion of the agenda item on "personnel":

1. An Administrative Officer should be assigned to the public-health division of each TCA mission.
2. When possible, recruiting should be so timed that the entire TCA basic public-health team, including the administrative officer, arrives in the country together.
3. Recruiting and procurement of supplies and equipment should be so timed that as nearly as possible project personnel and the supplies and equipment needed for the project arrive at the same time.

#### IV. Supplies, Equipment and Transportation

It was urged that the two organizations should collaborate to the fullest extent on exchange of information on the following: Types of supplies and equipment, sources for procurement and costs.

The WHO Procurement Service for medical supplies was referred to with a suggestion that TCA might wish to get information about this service from the offices where it can be obtained; namely, Geneva, Washington, New Delhi and Alexandria.

The TCA field representatives recommended that the TCA Chiefs of Health Divisions in countries be given more latitude in making direct purchases.

#### V. Execution of Technical Aspects of Projects

Under this heading, two main topics were discussed.

(a) The technical basis on which health work is to be carried out by the two organizations. It was the opinion of the group that there should be full interchange of technical methods and techniques with a view to reaching standard practices and common technical approaches wherever possible.

It was recommended that the reports of the WHO Expert Committees (which are international in character) and the other technical publications of WHO should be made standard technical literature for TCA and WHO personnel and teams working in the field of health. This material should be included in the briefing of such personnel and should provide the basis for their field operations so far as possible.

It was also suggested that TCA personnel in the field might suggest places where this WHO literature could be sent so that it would be of value.

The Group urged that direct lines of communication on technical matters between TCA and WHO personnel be encouraged.

(b) Certain principles to be observed in the carrying out of a technical operation within a country.

(i) It was urged that the international specialist avoid trying to do

all the work in a given programme himself, but should get as much of the work done by nationals as possible. As a general principle, it was felt that the long-term objective should be to have such nationals working on a TCA, WHO or other international agency assisted programme, in the employ of the government. However, it was recognized that exceptions to this might be necessary, but the long-term objective of having such nationals ultimately taken on by their own governments should always be borne in mind.

- (ii) The international specialist in the field should always be looking for opportunities to develop inter-ministerial co-operation wherever possible. The outsider often has some influence in this sphere and can be successful in getting together groups within a country that have not been collaborating much.
- (iii) It was urged that the specialist should try to make every assignment an on-the-job training opportunity, and seize every chance he can within the country to further training programmes for nationals. The possibility of inter-country programmes should also be borne in mind.

#### VI. Reports and Evaluation of Projects

The group believed that it was timely to consider the evaluation of the results of work so far accomplished by WHO and by TCA. The study reported on by Dr. Strode and a recent study by WHO on general principles and methods should provide an adequate basis for evaluating at least one country or major area project. If TCA were to consider making an evaluation of TCA results, the planning of such an evaluation project should proceed in close consultative collaboration with WHO so that all aspects of TCA evaluation would be useful to WHO. It is understood, of course, that the host country or countries should be fully consulted and should participate in any actual evaluation study of programmes or projects undertaken.

#### VII. Inter-Country Operations

It is highly desirable that technical work involving communicable disease control, training programmes and other appropriate activities be developed on an inter-country basis wherever possible, in the interests of pooling resources and encouraging co-operation between contiguous territories.

Where either organization holds specialized technical training sessions or seminars the other organization should be informed and every effort be made to include appropriate personnel from the non-sponsoring group.

## VIII. Relations with Voluntary Agencies

It is recognized that in some circumstances it may be desirable to develop projects with, and give assistance and advice to, voluntary societies within the framework of the policies of the respective organizations. This, of course, must be done with the concurrence of the host government.

## IX. Carrying out of Projects by Contract or by Force Account

Where justified by expediency and/or economy and/or efficiency, consideration should be given to carrying out projects or parts thereof by contract. Where possible, preference should be given to non-profit organizations.

## X. Public Information Aspects of Programme Promotion

1. It was thought that informing the public before starting a project is extremely important, and that therefore TCA and WHO representatives should bear this in mind when projects are commenced.

2. The Group recommended that whatever progress is achieved in collaboration between TCA and WHO should be emphasized in public relations and public information activities carried out by the two organizations.

3. In order to take maximum advantage of public information facilities available to either organization, there should be the fullest possible exchange of information material between TCA and WHO.

4. It was felt that in disseminating information to the public and in enlisting support of the public in the project, it would be more effective to use local groups and local organizations for such purpose.

5. The general feeling was that different public information techniques should be applied to urban and rural areas, emphasis in the rural areas being put on simple, easily understandable visual methods.

6. In order to promote health education of the public programmes, every effort should be made jointly by TCA and WHO to ensure to underdeveloped countries the services of experts in production and use of simple audio-visual aids.

## XI. Relations with Private Capital Developments

The host government should be stimulated to require that the effects of private capital developments on various aspects of public health be studied before the development is undertaken, and to require that the developers provide such health facilities as are necessary. All possible assistance in the form of technical advice should be rendered by WHO and TCA technicians to private capital developments when the activities of such developments have public health implications.

