WHO’s Fortieth Anniversary

Glen Williams

WHO—the days of the mass campaigns

The World Health Organization was created and shaped by thousands of men and women of all nationalities. To mark its fortieth anniversary year, World Health Forum asked Glen Williams to give us his impressions of some of the main events. In passing, he mentions just a few names from among the many people who are part of the history of the Organization. The Forum presents, in two parts, snatches from WHO’s life story, including episodes from its foundation in the aftermath of a world war, through the high hopes of the mass campaigns and the brilliant victory over smallpox, to the present great endeavour to achieve health for all.

It was in the Palais des Nations overlooking Lake Geneva, European headquarters of the United Nations and former headquarters of the League of Nations, that the First World Health Assembly met on 24 June 1948. At that time, WHO’s Constitution had been in existence for less than three months and the Organization itself had yet to be formally established.

Between the two World Wars, international health work had been carried out by three separate organizations. The oldest, the Pan American Sanitary Bureau (later changed to Pan American Health Organization, then to Pan American Health Organization), had been founded in 1902 and included all the independent nations of the Americas. The Paris-based Office International d’Hygiène Publique (OIHP), founded in 1907, was concerned mainly with the administration of international conventions such as those on cholera, smallpox, and typhus. After the First World War the newly formed League of Nations established its own Health Organisation, based in Geneva, which was intended to absorb those already in existence. The USA, however, which was a member of the OIHP but not of the League of Nations, objected to the proposed fusion. As a result, during the inter-war period, three separate organizations attempted to deal with international health problems.
With the outbreak of the Second World War, international health work came virtually to a halt. Immediately after the war, the Health Division of the United Nations Relief and Rehabilitation Administration (UNRRA) assumed responsibility, on a temporary basis, for international sanitary conventions as well as for epidemiological reporting, previously carried out by the Paris-based OIHP. Urgently needed, however, was a new, truly global health organization to replace the three separate bodies that had existed between the two wars, and this was what the delegations from Brazil and China proposed to a conference of the newly formed United Nations in San Francisco in 1945. The proposal was readily accepted, and in July 1946, after preparatory work in Paris, an International Health Conference of 51 governments met in New York and approved the 82 articles of WHO’s Constitution. But before the Constitution could come into force and WHO take its place on the world stage, it still had to be ratified by at least 26 governments.

According to the Constitution, the new World Health Organization was to consist of a supreme governing body — the World Health Assembly — comprising three delegates from each Member State meeting annually; an Executive Board of 18 members (since increased to 31), all “technically qualified in the field of health”, nominated by Member States on a rotating basis but acting as individuals; and a professional Secretariat working at headquarters and in regional and country offices.

The International Health Conference established an Interim Commission to pick up the threads of the work carried out by the OIHP and the Health Organisation of the League of Nations and to lay the organizational foundations for WHO once the Constitution came into force. The Commission consisted of eminent public health experts representing 18 nations from a wide political spectrum. One particularly sensitive issue was the appointment of its Executive Secretary, who would be well placed to become the first Director-General of WHO. After intense behind-the-scenes lobbying, a Canadian psychiatrist, Brock Chisholm, was appointed. Formerly Director-General of Medical Services in the Canadian Army, Brock Chisholm had been Deputy Minister of Health since 1944 and had played a prominent role in drafting WHO’s Constitution.

A difficult birth

Looking at WHO today — a global organization of 166 Member States and a staff of over 6000 — it is difficult to imagine the uncertainty and anxiety that marked its birth 40 years ago. There was nothing inevitable about the way WHO came into being. Whether it would be born at all depended on a sufficient number of countries ratifying their representatives’ signatures to the Constitution. China and the United Kingdom were the first to ratify, and several other countries followed, but obtaining all 26 ratifications proved to be a surprisingly long-drawn-out process. Even after 18 months only 20 countries had ratified, and what was particularly worrying was that the USA, which was expected to contribute, at that time, nearly 40% of the
Setting WHO’s course

The Chairman of the Committee on Programme, Dr K. Evang (Norway), said that there was no short cut to good health. For thousands of years mankind had worked on those problems, and no one supposed that WHO, in a year or two, could solve them. There seemed general agreement that WHO must concentrate on a few selected tasks, giving them priority aid, and, in regard to the other activities, take more modest steps until further experience had been gained.


Organization’s budget, had still not ratified. At long last, however, on 7 April 1948, the Soviet Socialist Republic of Byelorussia became the twenty-sixth country to ratify, thus bringing the Constitution into force.

The First World Health Assembly, which opened soon after on 24 June 1948, was enlivened with elements of drama, suspense, and even farce. One observer remembered it as “necessarily something of a circus. The Secretariat had no previous experience of a meeting on such a scale, and everything had to be done by ear”(1).

The Assembly was attended by 53 of WHO’s 55 Member States. The majority were from the industrial world; only 22 were from the developing world, and only one of these, Liberia, was from Africa. Today 130 of WHO’s 166 Member States are developing or least-developed countries—a change that has brought about a fundamental reorientation of the Organization’s priorities in the past two decades.

Coming so soon after the horrors of the Second World War, the formation of the World Health Organization gave rise to exalted hopes—not just for a healthier world but for one that would also be more peaceful, prosperous, and tolerant. One of the “founding mothers” of the Organization, the Indian Minister of Health Rajkumari Amrit Kaur, expressed the aspirations of many delegates (2):

I should like to stress... the immense potentialities for good that the World Health Organization has, if we can harness our energies, in the many spheres...open to us. I am of the opinion that if the nations of the world were to unite in such humanitarian activities as do not, or should not, come within the sphere of power politics, we would help enormously towards breaking down the barriers of race...mutual suspicion and mistrust which today block the way of peace and progress throughout the world.

The Assembly was charged with idealism and emotion, as one delegate after another forecast a glittering future for the newest addition to the United Nations family of specialized agencies. The Assistant Secretary-General of the United Nations predicted that WHO would become: “the most all-embracing international organization which ever existed in the history of the world. It may legitimately entertain the most soaring ambition”.

Some of the speeches evoked themes that emerged three decades later as the main

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strands of the primary health care approach. Andrija Stampar, the remarkable Yugoslav
paediatrician who had been elected President of the Assembly, reminded delegates that health had wide social and economic dimensions: "Disease is not brought about only by physical and biological factors. Economic and social factors play an increasingly important part in sanitary matters, which must be tackled not only from the technical, but also from the sociological point of view."

The Philippine delegate urged the Assembly not to overlook the role of the community: "Let us not forget that no less than 70 per cent of the success of public health measures... depends upon the cooperation of the people." The Canadian delegate emphasized the importance of countries developing and improving the capacities of their own health systems: "It is the belief of the Canadian delegation that the fundamental task of WHO is for the moment to stimulate and facilitate in every appropriate way the development of national health organizations in each country."

This latter point was crucial. WHO was never intended to be a global health service, or even an aid donor agency, but rather an international "health cooperative" to help its Member States develop and improve their own systems of health care. This basic purpose, however, became somewhat blurred as soon as WHO began to operate.

**The period of campaigns**

Those who founded the World Health Organization were motivated not only by a passionate wish to build a more decent, humane, and peaceful world out of the rubble and ashes of the Second World War but by the conviction that medical science was their chief tool for doing so. Their optimism was perhaps understandable. Three of the most outstanding of the wartime medical discoveries—penicillin, streptomycin, and DDT—seemed to bring the control, and even the eradication, of major communicable diseases within human reach.

The First World Health Assembly had approved a work programme that listed its top priorities in the following order:
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malaria, tuberculosis, maternal and child health, venereal diseases, nutrition, and environmental sanitation.

Andrija Štampar and other eminent speakers at the Assembly had stressed that health was not merely a technical matter but had socioeconomic, cultural, and political dimensions. Yet, from the start, the emphasis in WHO was on the control of disease rather than the promotion of health. The first two decades of WHO’s life came to be dominated by mass campaigns against single diseases. In country after country, WHO initiated campaigns against tuberculosis, malaria, yaws, syphilis, smallpox, leprosy, typhoid, schistosomiasis, onchocerciasis, and trachoma.

It is easy now, with the benefit of hindsight, to criticize this highly medicalized, single-disease-campaign approach to health. At the time, however, it seemed to be what the developing world was ready for. The campaigns were popular with governments and some were highly successful, none more so than the campaign against yaws.

**Yaws: an early success story**

In the early 1950s there were believed to be around 20 million yaws cases worldwide, but as the decade progressed the figure was revised upwards. The great majority of yaws victims contracted the disease in early childhood. It was the availability of penicillin that completely transformed the prospects for yaws sufferers. One injection of procaine penicillin in oil (known as PAM) would usually clear up the painful sores within a week. In some cases, two or three shots would even cure the disease for good.

The first yaws campaign was in Haiti, where a programme assisted by the Pan American Sanitary Organization and UNICEF started in 1950. Within three years, teams going from house to house had visited 2.7 million people and treated 1.6 million yaws sufferers and contacts. Follow-up surveys found virtually no recurrence of the disease, raising...
hopes for its eradication—not just in Haiti but globally. The year 1950 also saw the start of the largest anti-yaws campaign in the world—in the archipelago state of Indonesia. The campaign, assisted by WHO and UNICEF, was a triumphant success: by 1957 over 23 million Indonesians had been examined and over 3 million patients successfully treated. On the island of Java, where two-thirds of the population lived, the disease was virtually eradicated well before the end of the decade.

During the late 1950s, WHO was assisting yaws campaigns in 28 countries with a combined population of over 150 million. In Haiti, Nigeria, and Samoa, the prevalence rate had fallen from 20–30% to 0.1–0.5%. By 1965, a total of 46 million yaws patients had been successfully treated in 49 countries. The disease had not been eradicated, but throughout most of the developing world it was no longer a significant public health problem.

Success with yaws fuelled hopes of victory over other, more intractable health problems. However, more than any other disease, yaws was susceptible to the “magic bullet” approach: a mobile team could arrive in a village, examine the population, give “shots” to yaws patients and likely contacts, and then move on to the next village. It was a strategy that required no permanent health infrastructure and little follow-up. Nor did it require any active participation—or even any understanding of how the disease was caused—on the part of the community.

The yaws campaigns gave an important clue to the direction health care in the developing world would take four decades later. Their success was due largely to the involvement of lay medical workers who were recruited and trained specifically for the campaign. In Haiti they were called “lay inspectors”, in Indonesia jurupateks, in Nigeria “yaws scouts”. These lay medical workers were the forerunners of today’s community health workers.

**TB campaigns—and a change of direction**

During the first half of the 1950s, by far the largest international health campaign was the crusade against tuberculosis. In 1948 UNICEF had made a grant of US$ 4 million to assist a tuberculosis control campaign carried out in the war-ravaged countries of Europe by the Danish Red Cross and voluntary agencies from Norway and Sweden. Within three years the number of tuberculosis patients in Europe declined dramatically, but a WHO study found that there were still tens of millions of cases in the developing world. In 1951 WHO took on the responsibility of coordinating a worldwide tuberculosis campaign, with UNICEF providing most of the funds for vehicles, medical supplies, fluid for tuberculin testing, vaccines, laboratory and X-ray equipment, and the salaries of WHO staff. A typical WHO team consisted of a medical officer, a statistician, a laboratory technician, an X-ray technician, and a public health nurse who remained in the country for two to four years. Among their many tasks was the training of national counterparts to take over their responsibilities when they left the country. The programme was backed by research carried out by the Tuberculosis Research
Office in Copenhagen, set up by WHO in 1949.

Until the late 1950s, the tuberculosis programme concentrated on vaccinating children and adolescents with BCG. The campaign approach was extremely popular with the governments of developing countries. By 1960, campaigns were being carried out or had been completed in 64 countries or territories, 265 million children and adolescents had been tested with tuberculin, and 106 million vaccinated with BCG. Over four-fifths of the children vaccinated were in Asia, and of these, more than two-thirds were in India, where an estimated 4 million cases occurred every year.

But by now serious doubts about the campaign approach had already begun to surface. In 1957, a WHO Expert Committee had reviewed the many campaigns assisted by WHO and UNICEF and had concluded that, despite the real public health gains that had been made, the programme was still falling far short of its objectives. Even the best of the campaigns had not reached more than half the children under the age of seven—the most vulnerable age group. Moreover, campaigns were operating in an indiscriminate manner, achieving high coverage in regions where prevalence of the disease was low and failing to reach populations whose chances of contracting the disease were high.

Voices were raised in favour of integrating BCG vaccination with other health services. Although the campaigners carried the day on this occasion, the days of the mass tuberculosis campaigns were numbered. In 1964 WHO was able to announce a new approach. The first of its two main weapons was direct BCG vaccination. Painstaking research had shown that BCG vaccination could be given safely to all young children; a tuberculin test was not necessary. The second main weapon was an improved version of the drug isoniazid, first developed in 1951, which could be administered at home. Most importantly, in spite of an initial reluctance on the part of some of them, WHO’s experts now agreed that the only viable strategy for the long-term control of tuberculosis was to incorporate means for its prevention, diagnosis, and treatment within the normal health system rather than outside it. Mass campaigns, mobile teams, special clinics, and sanatoria became obsolete.

The mighty mosquito

As early as 1947, even before WHO had been formally established, the Interim Commission had set up an Expert Committee on Malaria, a disease regarded by international health experts as the world’s gravest threat to public health. It was estimated to affect at least 300 million people and to claim 3 million lives every year. The Committee recommended controlled experiments in the use of two new antimalarials—chloroquine and proguanil. Synthetic antimalarial drugs had been used before and during the Second World War, but their possibilities were largely unexplored.

For the main instrument of malaria control, however, the Committee placed its faith in
the insecticide DDT, which had been developed in Switzerland in 1940. The technique of residual spraying with DDT, devised by Fred Soper and Paul Russell of the Rockefeller Foundation and used successfully in Brazil, Ceylon (Sri Lanka), and Italy held out the promise of conquering malaria by preventing the transmission of the malaria parasite. It was a dazzling prospect, and one that was to fire the imagination and energies of governments, international agencies, and public health workers for the next two decades.

In 1947, Fred Soper became Director of the Washington-based Pan American Sanitary Bureau (which in 1949 became WHO’s Regional Office for the Americas) and began pressing for the eradication of malaria from the American continent. WHO, meanwhile, had begun sending out demonstration teams to visit any country requesting assistance with malaria control. A typical team consisted of a malarialogist, an entomologist, a sanitarian, and a sanitary engineer. By 1951, WHO teams were involved in 22 malaria control projects, mainly in Asia. While WHO provided the professional staff, UNICEF supplied transport, equipment, insecticides, and drugs—a pattern that was rapidly becoming the norm for the mass-campaign approach to international public health in the 1950s and 60s.
The initial results were extremely encouraging. By 1955, the number of malaria cases worldwide had dropped by at least a third. Over half the world’s population then estimated to live in malarious areas was protected from the disease by DDT spraying. It did not seem unreasonable to believe that an all-out effort over the next five or six years could eradicate malaria from the face of the earth. But it was the anopheles mosquito itself that finally pushed WHO into deciding to go for eradication rather than control. From Greece, Indonesia, and parts of Africa and South America came disturbing reports of resistance to DDT by the malaria-carrying anopheles. It was reckoned that, on average, mosquito populations needed about six years to become resistant to DDT. What now developed, in country after country, was a race against time to stop transmission of the malaria parasite before the mosquito developed immunity to DDT.

In a momentous decision, the World Health Assembly, meeting in Mexico City in 1955, urged Member States to abandon malaria control and make malaria eradication a priority of the highest order and urgency. The health community of the entire world, it seemed, was now committed to an unremitting crusade against the world’s most ancient recorded disease. The decade that followed was, in the words of a veteran malarialogist, “the most glorious in the annals of public health in general and of malaria eradication in particular” (3). USAID and UNICEF advised their staff throughout the world of the new priority, and governments were encouraged to apply for assistance. Mexico, where an estimated 19 million people lived in malarious areas, was the first to mount a comprehensive national campaign. The herculean task of spraying, on a regular basis, over three million houses scattered over a wide area of mostly inhospitable terrain was tackled with a sense of idealism and euphoria that was typical of the time. Journalist Murray Morgan watched a malaria spray team at work (4):

A sprayman was working on the far wall of the Lopez shack. He slowly waved the wand of his pump over the dusty surface of palm canes—a modern magician exorcising discomfort and disease and death. It was beautiful; beautiful not only in the slow, graceful movements of the sprayman as he moved the brass-tipped wand down and up, down and up, depositing two grams of DDT on each square meter of wall, but beautiful too as a symbol of something men the world over can agree upon. The young Mexican with the pump was a representative of all the scientists and technicians who are fighting to end the menace of mosquitoes that breed in the lime sinks of Georgia, the swamps of Panama, the treetops of Trinidad, the gullies of the Sahara, the water jars of Enugu-Ezike, the rice paddies of Formosa, the river potholes of Ecuador.

Meanwhile, at WHO headquarters in Geneva, Brock Chisholm had decided to stand down as Director-General in 1953. His successor was Marcolino Candau, who had worked with Fred Soper on malaria control in his native Brazil. An indication of the concern about malaria is the fact that during the late 1950s, five of WHO’s six regional directors were, like Candau, ex-malarialogists. Curiously, perhaps, the heyday of the malaria eradication campaign, with its mobile teams working independently of the normal health services,
coincided with the painful reappraisal of the mass-campaign approach to tuberculosis control, which resulted in the integration of BCG vaccination and curative care with the normal health services.

By the late 1960s, however, it was malaria's turn to feel the pinch, as pressure built up for the integration of antimalaria activities within the general health services of each country. The previous decade had seen unprecedented achievements. WHO's Expert Committee on Malaria, meeting in September 1966, noted with satisfaction that nearly 1000 million people, or 60% of the population of the originally malarious areas of the world, were living in areas where malaria had been eradicated or was no longer a major health problem. But despite the undoubted gains, the problems were also legion. In Africa, which had more malaria cases and deaths than any other continent, no progress had been made at all. And even in Mexico, where a massive, military-style campaign had been waged with great tenacity, over 4 million people lived in areas where the anopheles mosquito still held out against DDT and other insecticides.

The programme received a further blow in 1968–69, when over a million people in Ceylon (Sri Lanka) contracted malaria. Between 1946 and 1963 the number of malaria cases had fallen from 2.7 million to a mere 17, owing to a remarkably effective house-spraying campaign. In 1967, convinced that the battle had been won, the government stopped spraying. One year later, the anopheles mosquito took its grim retribution.

Malaria eradication had now ceased to be glamorous. Experienced people began leaving the service and were not replaced. By the end of the decade the writing was on the wall for the spraying teams, with their own jeeps, their special allowances, and their complete independence of the general health services. The World Health Assembly of 1970, bowing to harsh reality, decided to emphasize the need “to initiate malaria control schemes within the general health services where eradication is at present impracticable”. The wheel had turned full circle: from control to eradication and back again to control in only 15 years.

The return to control might well have been an effective strategy, had it been fully implemented. But national governments...
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interpreted it as a signal to relax their efforts against malaria. The anopheles mosquito and its malaria parasites exploited their chance, and in the early 1970s malaria made a stunning come-back in many regions of the developing world where it had been almost eradicated by the late 1960s.

In the heated discussions between the “campaigners” and the “integrationists” in WHO over who should bear the blame for the resurgence of malaria, the real achievements of the global programme have often been overlooked. Within 12 years of its launch, it had brought protection against the scourge of malaria to almost one billion people — more than a quarter of the world’s population. In India, eight years of the campaign had cut the number of malaria cases from 100 million to 80 000 a year, preventing an estimated 259 000 deaths in the years 1967–68 alone. When the campaign was integrated into India’s normal health services, tens of thousands of malaria workers were retrained as multipurpose health workers.

Today, malaria still affects an estimated 100 million people a year — an appallingly high figure but only a third of the estimated number of sufferers four decades ago. WHO still gives high priority to combating malaria through its Malaria Action Programme, but there is a sense of realism about what can be achieved, especially in Africa, without a prior improvement in socioeconomic conditions and development of primary health care.

The mass campaigns of the 1950s and 60s pointed to three crucial lessons. The first was that no sustained improvement in public health could be achieved without a network of basic health services, to which the great majority of the population had reasonable access. The second was that people needed to take greater responsibility for their own health — and in order to do so they had to understand more about the causes of ill health and disease. And the third was that national governments had to take responsibility for developing their own health strategies and programmes, bearing in mind local conditions and the human and material resources available.

Success with smallpox

WHO has sometimes been accused of setting its sights too high and trying to achieve the

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impossible. In 1966 the Organization took one of its greatest-ever leaps of faith. At that time, smallpox victims worldwide were estimated at 10–15 million each year, of whom 1.5–2 million died. The disease was endemic in 30 countries, with 75–80% of cases occurring in Asia, mainly on the Indian subcontinent. Against a background of widespread disenchantment with mass campaigns against a single disease, the World Health Assembly voted unanimously to make an all-out effort to eradicate smallpox within the next 10 years.

A worldwide smallpox eradication programme had already been launched in 1958. Teams of WHO experts had been dispatched to several countries and pilot projects launched; the production of freeze-dried vaccine, the result of research initiated by WHO in 1952, was well under way. Technically, the eradication of smallpox seemed feasible — far more so than
the eradication of malaria. But governments and international donors had failed to respond adequately to the call for action, and progress had been very slow. What was needed was a properly funded, carefully designed, and coordinated effort on a global scale. Only WHO could provide the leadership for such an undertaking.

There was no lack of sceptics, disillusioned by the experience of malaria and other mass campaigns, who poured scorn on the notion that smallpox could be totally eradicated in the world’s least developed countries. But within less than a decade the goal had been achieved and the sceptics forced to eat their words. It was the most spectacularly successful disease eradication programme of all time.

Today, a decade after the last natural outbreak of smallpox on earth, the programme’s massive achievements tend to be taken for granted. At the time, however, the outcome was far from certain.

Unlike the malaria eradication teams, the smallpox workers functioned within existing health service systems, however fragile, and had to coordinate their work with that of other high-priority health programmes. The basic health services network constituted the foundation for the disease-reporting structure, and in all countries this had to be greatly improved through training and supervision. As part of the normal health system, smallpox teams also provided other vaccinations, including BCG, measles, polio, and DPT.

Smallpox: the protected and the vulnerable. The little girl on the left, in Côte d'Ivoire, is the proud possessor of a vaccination certificate; but the little boy in Zaire was one of millions to be afflicted with smallpox in the days before it was eradicated worldwide.

Photos WHO/Government of Côte d'Ivoire and WHO/UN.

The smallpox eradication programme, the only global effort ever to succeed in eradicating a disease, was also WHO’s last great mass campaign. No other disease would lend itself to eradication in the same way. It had demonstrated, however, that the global health community was indeed capable of learning from the mistakes and disappointments of the past and applying at least some of the lessons in a systematic manner. The learning process might be slow, cumbersome, and tinged with bitterness, but it did function.

Immunization

The place of the mass campaigns against single diseases was effectively taken by an expanded programme on immunization. This has the aim of immunizing all children against a spectrum of diseases—measles, diphtheria, pertussis, tetanus, polio, and tuberculosis—by the year 1990 at a cost per child of about $5.
After a slow start in the mid-1970s, the programme has made extraordinary progress during the 1980s. Part of this progress can be credited to technical breakthroughs that led to marked improvements in the systems used to store and transport vaccines (the "cold chain"). Part can be credited to the availability of vaccines and equipment, much of which has been provided by UNICEF. But the main factors relate to human issues: WHO developed training materials which, with the collaboration of UNICEF, were quickly put into the field, reaching over 15,000 workers in internationally sponsored courses and over 100,000 workers in nationally sponsored courses. A major boost to national immunization efforts has come from the mobilization of political commitment and community involvement, activities in which UNICEF has been playing a central role.

Today, half the infants born each year in the developing world are receiving the full three doses of DPT and oral polio vaccine, and 43% are being vaccinated against measles. An estimated 1.3 million child deaths a year are being prevented annually through immunization.

**Mother and child**

In the late 1940s over 20 million children worldwide were dying every year before reaching the age of five. In the developing countries of Asia, Africa, Latin America, and the Caribbean child mortality rates ranged between 200 and 350 per 1,000 live births and two-thirds of all deaths were among infants and young children. For mothers in the developing world, the experience of pregnancy and childbirth was itself a major risk. Maternal mortality was in fact the leading cause of death among women of childbearing age. Clearly, the field of maternal and child health (MCH) warranted high priority from WHO.

But despite their declared intentions, neither governments nor WHO (nor even UNICEF) accorded MCH the same priority as they gave to the campaigns against the major
communicable diseases. The problem was that MCH was not a disease. Rather, it was the basis of human life itself, with nutritional, educational, and socioeconomic aspects alongside the purely medical. As such, it was far more complex than a mass treatment or vaccination campaign.

Each pregnant mother and each young child had to be seen individually, their problems identified and discussed, and advice or treatment given when needed. It was widely thought that only trained health professionals—midwives, nurses, and doctors—were qualified for these tasks, and of these there were very few, working almost exclusively in the cities. In the rural areas of the developing countries, 80% or more of the rural population had no contact at all with modern health services, except for the occasional visits of mobile teams from the mass disease campaigns or the services provided by a small number of missionary hospitals.

WHO attempted to fill this vacuum by helping to train more health personnel in the many fields related to MCH. It provided specialist staff to strengthen the teaching of paediatrics and other MCH-related subjects at medical colleges, schools of midwifery and nursing, and institutions such as the All-India Institute of Hygiene and Public Health in Calcutta. In addition, the WHO fellowship programme enabled hundreds of doctors and nurses from developing countries to upgrade their knowledge and skills in the MCH field at institutions such as the International Children’s Centre in Paris and the London School of Hygiene and Tropical Medicine.

UNICEF helped to equip these facilities, while WHO provided staff for the first few years. In Africa and Asia, WHO staff were usually expatriates from Europe or North America with little or no experience in developing countries. The MCH centres provided a midwifery service to pregnant mothers and also trained MCH auxiliaries—known variously as “home visitors”, “health visitors” or “lady health visitors”.

With the benefit of hindsight, it is not difficult to find fault with the MCH centres and the types of training they provided. The expatriate doctors, nurses, and midwives, usually unable to speak the local language and with little or no experience of the conditions in which ordinary families lived, were far from ideal teachers of the young women who came to be trained as MCH auxiliaries. The MCH centres themselves were generally cut off from the mainstream health services and preoccupied with preventive care. This artificial division greatly diminished their potential usefulness and also resulted in overburdening the curative section of the health system.

Despite these limitations, the MCH centres were gradually reaching more and more women and children in developing countries who previously would never have received modern health care. But it was obvious that despite the best efforts of governments and international agencies it would be many decades before the formal health system would be able to make MCH care available to all mothers and children. Something very different was needed. That “something” was a person whom doctors had traditionally regarded as one of the greatest threats to the health of mothers and children.

Throughout the developing world, 80% or more of births were taking place at home, assisted only by a traditional birth attendant,
they still enjoyed the respect of their own communities and of mothers in particular.

Recognizing this fact, and in spite of fierce resistance from many doctors, WHO began encouraging health ministries to train traditional birth attendants in basic hygiene and methods of safe delivery and to involve them in a system of regular supervision and reporting. Equipped with a kit of basic supplies and instruments, the trained traditional birth attendant became a community resource of enormous value. In making basic health care available to mothers and children through the active participation of members of the community rather than through the intervention of health professionals, the policy represented a radical break with past practice.

usually an illiterate woman with no training at all in health or hygiene. In India and Pakistan these women were known as *dais*, in Indonesia as *dukun bayi*, in the Philippines as *bilots*, in the Arab world as *dayas*, in French-speaking Africa as *matronnes*, in Latin America as *parteras empiricas*. Many of their practices (such as vaginal examination, massaging the abdomen, and applying earth or even dung to the umbilical cord) were dangerous and caused the deaths of many mothers and newborn babies. They were thus scorned by the medical profession, but

The family planning debate

It is now recognized that family planning can do more to protect and promote the health of mothers and young children than virtually any other medical technology. Unfortunately, family planning was viewed initially as a method of population control rather than as a means of preventing deaths and promoting health. This resulted in a fierce international polemic, with opponents of family planning accusing its supporters of advocating “racial engineering”, of plotting
“to reduce the numbers of the poor”, and of encouraging people to commit a “sin against God”.

Even in WHO, family planning was still an unacceptable subject in the early 1960s. It finally appeared on the agenda in 1965 when, in a resolution co-sponsored by the governments of India, Trinidad and Tobago, and the United Kingdom, the World Health Assembly gave its approval to family planning on the grounds of its potential benefits to maternal and child health. Today, the wording of that resolution may seem unnecessarily cautious, but at the time it was an astute compromise, which preserved WHO’s organizational unity while enabling it to assist governments that wished to promote family planning as part of maternal and child health services.

Two years later, in 1967, the Secretary-General of the United Nations announced the creation of the United Nations Fund for Population Activities, to be funded by voluntary contributions from governments. UNFPA promoted the cause of family planning on population grounds, leaving WHO to concentrate on the less controversial—but no less important—area of research in the field of human reproduction and the medical aspects of fertility control. One of the major achievements of the research sponsored and coordinated by WHO was the first-ever evaluation of the safety and efficacy of injectable and oral contraceptives in various settings in the developing world. Other notable advances included the improvement of intrauterine devices and their use in the most suitable clinical situations.

Meanwhile, the terms of the family planning debate were being transformed. At the World Population Conference at Bucharest in 1974, WHO seized the opportunity of presenting the case for family planning on health grounds to an international audience in whose minds it had been almost synonymous with the controversial issue of population control. Strongly supported by UNICEF, WHO successfully argued in favour of family planning as a means of protecting and promoting the health of mothers and children. The resolutions and plan of action adopted by the Conference asserted the right of all parents to safe, modern methods of contraception as part of responsible parenthood. Through quiet advocacy backed up by solid research, WHO had helped to give family planning the international respectability it had so much needed.

Basic health services

The World Health Assembly of 1951 enthroned the “strengthening of national health administrations” as WHO’s first priority for the next five years. As we have seen, however, the 1950s were dominated by disease control campaigns. But WHO increasingly urged governments to integrate these campaigns with the general health services and helped them to do so.

Going a step further, the World Health Assembly of 1962 called for “the creation of a network of minimum basic health services” in response to the urgent needs of
developing countries, where often 80% or more of the population was without any modern health care at all. Such health services as did exist usually consisted of a kaleidoscope of single-disease campaigns, mobile teams, private practitioners, and urban-based hospitals, clinics, and MCH centres. In many countries the Ministry of Health controlled only a small proportion of health expenditure, facilities, and manpower resources, and some Latin American countries had up to 70 different institutions providing medical care of some kind.

In 1965 WHO came up with a basic health services model to rationalize this chaotic, wasteful use of scarce health resources. This was a scheme resembling a planetary system, with a hospital in the centre surrounded by three or four health centres, each with a group of health posts as their satellites—all under the control of the Ministry of Health. The health posts and health centres would be responsible for basic curative and preventive care, health education, and MCH services, while the hospital provided maternity care and more specialized treatment for serious illness and accidents.

To promote the basic health services model, WHO dispatched public health experts throughout the developing world, where they were helping health ministries to set up pilot projects which, it was hoped, would eventually be replicated on a national scale. UNICEF, in the usual pattern of collaboration with WHO, provided medical supplies, basic drugs, vaccines, laboratory equipment, refrigerators, and vehicles. By 1966, UNICEF was providing assistance to 90 basic health service projects, with which MCH services were integrated as far as possible. Some of the results were encouraging. In Penonomé, Panama, for example, the infant mortality rate fell by 25% in only three years after the integration of MCH activities with basic curative, preventive, and health educational activities.

But worldwide, it was clear by the late 1960s that the pilot-project approach to basic health services was failing. Grafted onto national health structures of which they were never truly an integral part, they were too costly, too dependent on highly trained (often expatriate) staff, and technologically inappropriate for the developing societies whose health needs they were intended to meet. WHO was now entering a period of self-examination, at times agonizing, and stretching over almost a decade, before finally emerging with a new concept of health care, which it would promote with something approaching the idealism and zeal that had inspired the mass campaigns of the 1950s and 60s.

The second and final part of this article will be published in the next issue.

References