Chapter 2

The Health, Poverty, and Development Merry-Go-Round

The Tribulations of WHO

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INTRODUCTION

The role of better health in socio-economic development has long been argued, as has the need for getting other development sectors to contribute to health development. However, as illustrated below, considerable tension has existed throughout public health history between those who believe that improving health is the key to pulling people out of their misery, and those who argue the contrary, namely, that people need to be economically and socially better-off before they can aspire to better health.

When the World Health Organization (WHO) came into existence in 1948,it inherited this more than one-century-old argument that divided the world of public health. This did not prevent the organization from seeking to control various diseases, operating under the firm belief that such control would be a positive force for human development. Even the evidence provided by the population explosion that followed the control of malaria did not prevent the global malaria eradication campaign from being launched in 1956. Yet despite the past controversies, no effort was made to make a careful accounting of the impact of malaria control/eradication on socio-economic development during the 1950s and 1960s, when the global eradication campaign dominated WHO's agenda.

There have been calls, here and there, for greater attention to evaluating the socio-economic impact of health programmes, but these have rarely been followed up on with field studies of any significance. More revealingly, policy

makers have suppressed opinions not favorable to their own so to not jeopardize confidence in the policies which had been decided upon. Thus, WHO rarely treated seriously those who opposed the decision to seek the eradication of malaria. In such a context, it is not surprising that this and similar policies have been pursued without the benefit of any further evidence to judge whether they yielded the results expected.

Given this long history of shaky evidence and poor evaluation, the issue of health, poverty and development is hardly any better understood today than it was 50 years ago. Instead of keeping a steady focus on the subject, WHO has let it come and go, largely as a reaction to external pressures and funding issues. It is currently again on the agenda of WHO. This time, it can be hoped that serious, in-depth evaluation will take place over the coming decades. The framework for such evaluation should not be driven by any one ideological position or by any central bureaucracy that is not open to opposing views. Conflicting opinions should be used to expand the evaluation criteria examined, so that evidence gathered over time helps resolve differences. In short, it is time to learn from experience rather than hold onto beliefs that may, in fact, be wrong.

SOME HISTORICAL BENCHMARKS

Chadwick and the Sanitary Movement (Litsios, 2005)

Edwin Chadwick is credited with having launched England's sanitary movement in the 1830s. He did so in the belief that effective drainage and sewerage would reduce ill-health; improving the health of the English common man would mean less poverty; and less poverty would mean reduced charges on the Poor Rates. As secretary to the Poor Law Commission, his motivations were largely economic.

In the course of his famous study on the sanitary conditions of the lives of England's working class, Chadwick asked William P. Alison, a Scottish physician, "whether the destitution without the filth, or the filth without the destitution, is more effectual in the production or extension of fever." Alison replied that in Scotland, "we have no destitution without filth; but we have many examples of filth without destitution." From his experience "fever neither makes its way into such (non-destitute) families with the same facility, nor extends through them with the same rapidity and certainty, as in the case of the unemployed, or partially employed, disabled, and destitute poor." In fact:

> As long as the condition and habits of the poorest of the people, and their resources when reduced by any cause of destitution . . . continue as at present . . . removal of various nuisances will be perfectly ineffectual.

Alison had reversed the argument. More government spending was needed to reduce poverty before any benefits from sanitary action could be realized.

It took several years for Chadwick to gather the material that he used in his report on the sanitary conditions of the working class. The report itself is made up largely of testimony he obtained from medical officers throughout Great Britain. Recognizing that Alison's views on the subject directly undermined his faith in the economic benefits to be obtained by sanitary reform, Chadwick chose *not* to make explicit use of Alison's views in his report.

Hermann Biggs and the International Red Cross (Litsios, 2005)

Moving ahead nearly a century, to a meeting held in Cannes, France, in 1919, to consider the establishment of an International Red Cross (IRC), Hermann Biggs, a leading American public health specialist, prepared a "statement of general purpose and scope of work" for the IRC, which included:

- As the prevalence of disease, unsanitary conditions and excessive death rates are almost universally and inseparably connected with poverty and ignorance and as these conditions are interdependent, the IRC . . . should also initiate aid and direct measures among less forward nations looking to the promotion of education especially along vocational lines and to the improvement of economic conditions so that the productivity of the soil and the productivity of labor may be increased.
- The IRC should create a bureau for the collection, analysis, publication and distribution of information on public health and sanitation including dietetics and soil pollution. It should also collect and distribute similar information in relation to the cultivation of the soil, agricultural machinery and similar topics and should arrange for and conduct demonstrations in those countries where they are most needed.

Biggs wrote to his wife:

> We have been working hard and with great results, I think . . . It (the first draft of our scheme) is really mine and I drew this up. It provides for a great international philanthropic organization to aid in giving health and equality of opportunity to the nations of the world. Perhaps they will discard it at Cannes as being too broad and too Utopian.

Biggs was right; a much watered down program was adopted and, when funding proved difficult to obtain, the resulting organization (the League of Red Cross Societies) performed mostly as an international health education organization.

The Divided Pre-World War II World of Malariology (Litsios, 1997)

The impetus to do something in the field of international health following World War I did lead to the creation of the Health Organization of the League of Nations, which, in turn, established a Malaria Commission, owing to the importance of this disease in Europe at the time (1923).

Despite the discovery by Ronald Ross in 1898 of mosquitoes' role in malaria transmission, many of the Commission's members were convinced that socio-economic development was needed before malaria could be controlled. The leading protagonist for this position was C. Price James, who earlier in his career had crossed swords with Ross. He questioned the value of Ross' discovery, as witness this claim made in 1927:

> When the discovery of the mosquito cycle of the parasite was made it was almost universally believed that a single, simple method had been put within our grasp, capable of application in all malarious districts. Since then three decades have passed, and such a method is still to seek.

Of course it was anti-mosquito methods that had eliminated malaria from the Panama canal, but the cost had been extravagant, well beyond the means of any one country. Even the successes that had been achieved on numerous plantations around the world, where the presence of malaria cut into profits, could not be afforded by the average rural community.

Lacking any 'simple method', James concluded that the "*correct way*" of combating malaria is:

> . . . to introduce agricultural schemes which aim primarily at improving the economic prosperity of the people . . . accompanied by progressive arrangements for adequate medical attention in sickness, for technical and elementary school education and for simple sanitary measures of housing, water-supply, conservancy and general welfare.

Lewis Hackett, one of the leading Rockefeller Foundation malariologists and proponents for anti-mosquito measures, challenged James' views whenever he could. He believed:

> . . . the causes of malaria, at least, are in the main independent of the ignorance and poverty of its victims and can be separately handled. It is easier to believe that release from the burden of malaria will help to bring prosperity and knowledge than that a higher standard of living and education must precede the eradication of malaria.

China's Pre-World War II Rural Reconstruction Program (Litsios, 2005)

Several years later, in a different situation (China), the same organizations, that is, the League's Health Committee and the Rockefeller Foundation, found themselves struggling to assist China to develop the rudiments of a rural health infrastructure. The key advisor from the League's side was Andrija Sampar and from the Foundation side Selskar Gunn, a Vice-President.

This time, the two organizations did not differ in their views. Both cooperated at "raising the educational, social, and economic standards of rural China." The program was interrupted by the 1937 invasion of China by Japan. However, by then, it had become clear that extensive land reform was a prerequisite for success, something the ruling powers refused to carry out.

Gunn built on this experience in his introduction of a report of a League meeting on rural hygiene in 1937 in Bandoeng where he wrote:

- One thing is certain . . . unless the economic and cultural level of the rural populations can be raised, there can be no hope of employing curative or preventive measures with any degree of success.
- If this problem (land reform) is neglected, programmes of rural reconstruction not only will be greatly retarded, but will not be able to rest on a permanent basis.

Stampar brought together the results of his China and earlier Yugoslavia experience in a lecture that he gave in 1938 at Harvard at which he concluded:

- Successful health work is not possible in areas where the standard of living falls below the level of tolerable existence. The removal of social grievances, such as the sense of exploitation by others, is of the greatest importance. For social and health services depend for their success on the cooperation of the people, and this will only be given by a population which is reasonably optimistic concerning the future, and which is willing to give at least qualified acceptance of the social order.
- The social ills of rural areas are concerned with a large group of social problems of a medical kind, such as bad housing, social diseases and malnutrition, which cannot be properly understood until their connection with social conditions is realized. Such investigations cannot be conducted in laboratories alone, but involve probing into every smallest part of the people's life and the closest scrutiny of the habits and customs and of the particular sections of the community.
- Successful health work can be attained only if it is correlated with other activities for the improvement of rural life. This naturally depends on a

> successful collaboration of the people and their free participation in public affairs. A rural health worker must therefore be a promoter of a social, political and economic peace. For these factors are fundamental requisites to the success of rural health work.

Gunn died in 1944, leaving it to Stampar alone to bring pre-World War II rural health and development experience to the newly established World Health Organization.

Post-World War II Malaria Control and Rural Development (Litsios, 1997)

Malaria was by far the most important disease affecting rural communities around the world. For this reason Selskar Gunn did not hesitate to write in his introduction to the report of the 1938 Bandoeng conference, referred to above:

> Malaria in badly infected areas forms a considerable barrier to the development of other welfare activities and oftentimes must be checked before other types of work become possible.

At the same time, he added: "Malaria is a health and social problem; it must be attacked simultaneously from both these angles."

The conclusions reached at the Bandoeng conference under the leadership of Paul Russell, the senior malariologist of the Rockefeller Foundation, were confined strictly to the health 'angle', as witness:

> In those areas where malaria is the outstanding social and health problem, the resources of the health administration, specially augmented where necessary, should be directed chiefly towards malaria control, even if this should entail the restriction of other public health activities, until malaria is no longer of major importance.

Yes, malaria was a health and social problem, but rather than proposing that it be addressed from both of these 'angles,' the malariologists believed that it was essentially the job of the health administrators to control the disease, augmenting as necessary the resources available, until malaria was reduced to a level where it no longer interfered with community well-being.

Also, malariologists argued that malaria control could serve as an entry point for other public health activities. Hackett gave the example of how malaria stations in Albania were being transformed into health centers "with general programmes of health protection," while at the same time the malaria field directors were "turned into health officers" by winter training and grants for study provided by the Rockefeller Foundation.

Before the arrival of DDT, the tools available to malariologists to control malaria (by interfering with the life-cycle of the malaria-carrying anophelines),

could not be afforded. Nevertheless, sufficient knowledge had been gained concerning the biology of the important malaria vectors to suggest that peasants could themselves undertake small measures to control mosquito breeding. Such measures were 'naturalistic methods' and consisted of a variety of means of controlling two basic factors critical to each mosquito species—the nature of the water used for breeding, for example, free flowing versus stagnant, and whether their eggs need shade or sunlight to hatch.

Although there were several successful experiments using such methods, the arrival of DDT in the early 1940s effectively put a stop to such 'natural' methods. The arrival of DDT, however, did not immediately push malariologists to argue that the only reasonable approach was to seek the eradication of the disease. A decade would pass before the global campaign was launched, and during that decade a serious effort was undertaken to develop a cooperative program between WHO and the Food and Agriculture Organization (FAO) to demonstrate that by controlling malaria, agricultural production would increase.

World War II had led to severe malnutrition in countries where extensive fighting had taken place, so much so that in 1948 the Economic and Social Council (ECOSOC) of the United Nations invited the specialized agencies "to study suitable measures to bring about an increase in food production." The US representative to the World Health Assembly had earlier cited malaria as "a direct and important contributing cause of the current world food shortage." The WHO Expert Committee for Malaria, which had already been established in 1947, agreed that "a mass attack on malaria in selected areas of food-producing countries should be carried out as soon as possible."

A joint FAO-WHO Working Party on Food Production and Malaria Control was established in 1949, with Paul Russell and Fred Soper as members. Soper, who previously was with the Rockefeller Foundation, was now Director of the Pan-American Sanitary Bureau (PASB), a post to which he was elected in early 1947. Various possibilities were discussed and actively pursued, but in a few years' time the whole effort collapsed. Although part of the reason was the financial crisis that WHO was undergoing at the time, owing to the loss of a guaranteed percentage of UN Technical Assistance funds, the major reason for the collapse was because the FAO wished to develop projects on a scale far greater than WHO was prepared to participate in, and, more importantly, their (FAO) claim that malaria was just one small element in a complex mesh of factors that needed to be addressed to improve agricultural production in the developing world.

One measure of this complexity can be seen in the design of a Health Demonstration Area in El Salvador, one of the countries chosen for joint action. Milton Roemer visited this country in late 1950 to help design a program for improving "health services as well as activities in related fields." He highlighted the importance of the agricultural sector, noting that the FAO had concluded "that the first need for the Area was a complete Agricultural Survey which would require a number

of personnel working for about one year." Only after the survey would they be in a position to develop "an extension educational program."

The survey envisaged by the FAO touched on all aspects of rural welfare: forestation, grazing, family farming, road systems, agricultural marketing and supply facilities, electric power facilities, extension service, and agricultural research. The expertise needed for the project included a forester, a specialist in land utilization and classification, a rural sociologist, an agricultural engineer, several experts in soil and water conservation, an extension agronomist, an extension specialist in animal husbandry, an extension specialist in economic entomology, an agricultural librarian, an agronomist (cereals and row crops), and an agricultural economist.

One can easily imagine the malariologists involved in negotiating joint action with the FAO coming quickly to the conclusion that 'going it alone' made more sense, especially when the FAO began to question whether the population explosion following the control of malaria, as was witnessed in Ceylon and India in the late 1940s and early 50s, didn't exacerbate their task rather than ease it. As Sir Herbert Broadley, Deputy Director General of the FAO, bluntly put it in 1952 to the WHA: "The more successful you are in reaching your goal, the more difficult FAO's task becomes."

It was the dramatic success of DDT that pushed the issue of family planning to the forefront in the late 1940s. The alarming population situation led many public health leaders to call upon WHO to enter this field. However, the Vatican was so opposed to family planning that it was successful in mobilizing countries (Italy, Ireland, and Belgium taking the lead) to oppose WHO taking any action. So fierce was their opposition that in 1952 they even prevented the establishment of an Expert Panel to study the health aspects of the population problem.

Milton Siegel, who was an Assistant Director General under Brock Chisholm, the first WHO Director General, advised Chisholm not to back down when in 1952 the Assembly approached the point where it was being asked to vote on two resolutions, one in favor of the Expert Panel, the other against. Instead, after a 'coffee break' called by the chairman, both resolutions were withdrawn and the matter was closed. According to Siegel, this prevented WHO from doing anything about family planning for somewhere between seven and nine years, thereby forcing the United Nations division of social affairs to take action in a field that they felt was more appropriate for WHO to provide the leadership.

Rural Health

Stampar has been called the 'father of WHO' by some. In any case, it was a WHO event that provided him with perhaps his last major opportunity to plead the case for a broad developmental approach to improving the health of the rural poor. This was at the World Health Assembly Technical Discussions on the subject of rural health, which took place over two years—1954 and 1955.

In a background paper that he prepared in 1954, Stampar reminded his readers how the experts at the League of Nations by the end of the 1930s, "felt more and more strongly that the questions of rural hygiene should be examined in their natural setting because any real amelioration of the standard of health in the rural environment must depend, in the first place, upon the improvement of living conditions generally." However, in the ensuing two decades, the situation of the rural population had gotten "increasingly worse." Paradoxically, this could in part be blamed on the rapidly increasing rural population brought about by the dramatic reduction of disease. He described this development in the following revealing terms:

> The rural population is enjoying the first fruits of social medicine. This cannot stop at the first step. The responsibility of social medicine is to carry on and improve their lives. It cannot let die from hunger people whose lives have been saved from disease. (Stampar, 1954)

One can imagine Stampar's frustration in the technical discussions of 1954 and 1955 concerning rural health in which no debate of the impact of population on health could take place. Nevertheless, the discussions did indicate that a "multi-purpose programme for the community development and for the integrated programmes for the general improvement of the community offers the best approach," and that "health matters should be a part of the welfare community services." (WHO, 1955)

The Launching of the Global Malaria Eradication Campaign

Ironically enough, the 1955 WHA that called for "integrated programmes" was the same Assembly that launched the highly vertical global malaria eradication campaign. Paul Russell was brought on board as a consultant by WHO to convince the WHA to launch a global program, Fred Soper having already done so for the region of the Americas. So confident was Russell that eradication was at hand that he literally threatened WHO by noting that "whatever WHO decided to do, a campaign for world-wide malaria eradication was already under way." WHO should "not be left behind."

The rationale for launching the campaign was based on several assumptions, the most important of which was that the prolonged use of DDT could be expected to lead to mosquito resistance. So it was very important, as Russell put it, "to eradicate the disease before the vector anophelines became resistant to the insecticide." Ideally, spraying could stop after three or four years to be followed by "systematic surveillance and use of antimalaria drugs for four or five more years." (WHO, 1955)

Once launched, all thoughts of linking malaria control/eradication with the goals of agriculture or any other non-health interest were pushed aside. Only

within the last 10 or 15 years has it again become fashionable to argue the case for malaria control on economic grounds.

To what degree 'eradication' was in the air when WHO was finally established in 1948 is difficult to judge. Soper, having moved quickly in his capacity as Director of PASB to develop campaigns against diseases including malaria in the American region, was claiming by 1951 that "one cannot doubt that malaria eradication is imminent in Venezuela," and that "it is not too much to anticipate that the rest of the job (eradication of malaria in the Americas) can be done during the next five years." Despite this claim, malaria was never eradicated in Venezuela. Nevertheless, it was added to the list of countries in which eradication was announced to have occurred!

The leader of the Venezuela eradication campaign, Arnoldo Gabaldón, one of the most important malariologists at the time, proposed in 1959 to the PASB Directing Council that an official register be created that listed areas where malaria eradication had been achieved. This was accepted by the WHA in 1960. The criteria of success proposed by Venezuela were those that had been developed in 1950 by the National Malaria Society of the U.S.A. However, the criteria defined by the WHO Malaria Expert Committee, which met in 1961, differed to such a degree that Venezuela no longer qualified. Rather than make an issue of the whole matter, the certification of eradication in "areas of Venezuela" was recognized as a "special case," justified by the fact that the evaluation had been made at the end of 1959, in other words, more than one year before the Expert Committee on Malaria, and WHO instructions to the Governments, had become available. (Litsios, 1998)

There were malariologists who believed that eradication was an impossible goal. To prevent their voices from being heard, they were simply never chosen to participate in the meeting of the Malaria Expert Committee that provided technical guidance to WHO between 1956 and 1969, the year the Assembly chose to bring the global campaign to an end. Lacking a voice in the Expert Committee, opponents were forced to find other ways to make their concerns known, for example, meetings organized outside the WHO context.

A potentially more divisive development was Soper concluding that WHO's revised approach to eradication would not work (Litsios, 2000). Having retired as Director of the PASB in early 1959, Soper embarked on a two-month tour of Asia as a consultant for the Rockefeller Foundation to determine if they might have a useful role to play "to help define the problems that do exist as the final stages of eradication are reached." During this visit he examined the eradication programmes in Taiwan, the Philippines, Ceylon, and India. There he had found that "there had been a shift in technique," a shift that he believed made it impossible for the global goal of eradication to be achieved. The shift involved a "switch from an attack on the malaria parasite in the mosquito with residual insecticides to a campaign against the plasmodium in the human host based on searching out and treating all infected persons," a shift which in no uncertain terms he said "may well be disastrous in its effect on the eradication program."

Essentially, Soper believed that developing countries did not have sufficient resources to develop *both* a spraying program that covered all areas where any malaria risk was present and a surveillance program that checked on the parasite status in the population at risk. He believed that the resources that were available had to concentrate on spraying continuously increasing areas until whole regions were freed of malaria. In his mind, relying on surveillance was admittance of defeat.

As late as 1964 Soper was hoping that matters would be corrected. In May of that year he wrote:

> I refuse to be pessimistic regarding the future... the measures which are building up will eventually force the World Health Organization to abandon the Alvarado, Gonzales proposal for rural health infrastructures and will lead to the development of more highly specialized malaria eradication efforts with adequate technical and administrative support for efficient and honest services.

Alvarado was Director of WHO's Division of Malaria Eradication, having taken over that responsibility in November 1958. Gonzalez was a consultant who prepared the background paper for the 9th Expert Committee meeting in 1962, which laid out the importance of a rural health infrastructure to fulfil the surveillance requirements of the eradication program, especially in Africa.

Whereas the voices of malariologists who opposed the eradication program were denied access to WHO–run meetings, Soper found himself in the awkward position of having launched the campaign and now disagreeing with the approach that WHO had taken. Rather than risk having his opinion used by opponents of the program, he kept most of his criticism confined to his diary notes, from which all of his quotes have been taken. One consequence was the global campaign lasted longer than it probably would have, had his opposing ideas been made public.

When voices calling for an end to the eradication campaign began to dominate the WHA discussions in the second half of the 1960s, WHO temporised with a 2-year study to evaluate the socio-economic benefits that had been achieved by the campaign. Nine countries were studied—Cuba, West Malaysia, Nicaragua, Niger, East Pakistan, Philippines, Syria, Thailand, and Venezuela. Four types of social and economic benefits were identified:

- Increased volume and quality of the working population
- Increased incentive to save
- It rendered the population more receptive to modern technology and the changes involved and
- It had a substantial beneficial effect on all economic development, particularly agricultural development, land settlement, mining, and forestry programmes.

However, "it was extremely difficult to quantify these results due to the absence of the necessary economic studies." The group urged "unceasing efforts to be made in this direction" with WHO stimulating such studies. It was recognized that the evaluation of the socio-economic benefits deriving from antimalaria activities "requires an appropriate methodology, which has yet to be developed." (WHO, 1974) These benefits "need to be studied in the field, and appropriate methods of assessment should be developed." (WHO, 1979) However, as malaria control methods shifted from area-wide anti-mosquito measures to making better use of individual preventive and treatment methods, the call to evaluate the socio-economic benefits of malaria control disappeared, only to be revived in the last decade, as discussed below.

Primary Health Care (Litsios 2002, 2004)

As it became more and more evident that malaria eradication would not be achieved, priority again returned to the question of how to develop rural health services. In 1967, the then–Director-General of WHO, Dr. Marcolino Candau, noted that WHO "was able to make disappointingly little headway in assisting developing countries to establish or strengthen even basic national health services. Yet, in the final analysis, the success of practically all the Organization's activities depends upon the effectiveness of these very services." (WHO, 1967) In 1968, Candau again highlighted the importance of the essential basic health services and called for a comprehensive health plan, within which an integrated approach to preventive and curative services could be developed.

In January 1971, the Executive Board chose as the its next organisational study the subject of methods of promoting the development of basic health services. To facilitate this study, the WHO secretariat prepared in 1972 a background document for the Board's deliberations. In introducing this document, Halfdan Mahler, who in July 1973 took over the position of Director-General from Candau, noted that "there were sufficient financial and intellectual resources available in the world to meet the basic health aspirations of all peoples," and suggested that "there was a need for an aggressive plan for worldwide action to improve this unsatisfactory situation."

The Board's report, prepared for the January 1973 session, concluded that no single or best pattern existed for developing a health services structure capable of providing wide coverage and meeting the varying needs of the population being served—"Each country will have to possess the national ability to consider its own position (problems and resources), assess the alternatives available to it, decide upon its resource allocation and priorities, and implement its own decisions." (WHO, official Records No. 206)

WHO should serve as a "world health conscience" thereby providing a forum where new ideas could be discussed as well as a "mechanism which can point to directions in which Member States should go." To fulfil this role, WHO needed

to make better use of the resources available to it and should concentrate on those projects that were likely to "show major returns and . . . result in a long-term national capability for dealing with primary problems."

In May 1973, the 26th World Health Assembly, after a long discussion of the report of the Board, adopted resolution WHA26.35 (Organizational study on methods of promoting the development of basic health services), which, *inter alia*, confirmed the high priority to be given to the development of health services that were "both accessible and acceptable to the total population, suited to its needs and to the socio-economic conditions of the country, and at the level of health technology considered necessary to meet the problems of that country at a given time." (WHO, 1973–1984)

Shortly after Mahler assumed the post of Director-General, a WHO/UNICEF inter-secretariat discussion decided that a document should be prepared under the title "Alternative Approaches to Meeting Basic Health Needs of Populations in Developing Countries." Efforts were initiated to seek out "promising approaches to meeting basic health needs," and among the characteristics that might be considered one finds specific mention of "community involvement in financing and controlling health services, in projects to solve local health problems, in health-related development work, or other relevant ways." (Dorolle, 1973)

The search for new approaches led to two important WHO publications: "Alternative Approaches to Meeting Basic Health Needs of Populations in Developing Countries" and "Health by the People." (Djukanovic & Mach, 1975) Both were published in early 1975. Both highlighted developments in various countries, for example, China, Cuba, Tanzania, and Venezuela, including one community-based project in India. But Newell extended his analysis by including two additional community-based projects.

All three community-based projects undertook activities that Stampar, no doubt, would have whole-heartily approved. One project featured goat and chicken farming to increase the income available to the poorest members of the community. In another project, a community where farmers had lost their cows was aided in finding funds for introducing tractors and for installing deep tube-wells. In the third project, community health promoters were trained as community catalysts, working in areas other than curative medicine, for instance, literacy programmes, family planning, the organization of men's and women's clubs, agricultural extension, the introduction of new fertilizers, new crops and better seeds, chicken projects, and improving animal husbandry.

While Dr. Kenneth Newell, editor of *Health by the People* and Director of WHO's Division of Strengthening of Health Services, expressed excitement at what had been demonstrated in all of these projects, he was particularly enthusiastic about what had been achieved related to community development. He contrasted issues such as improving productivity of resources to enable people to eat and be educated, and the sense of community responsibility, pride, and dignity obtained by such action with the more traditional public health activities of malaria control

and the provision of water supplies. The challenge for people in the health field was to accept these wider developmental goals as legitimate ones for them to pursue, even going so far as to admit *that "without them there must be failure*." (Emphasis added.)

Resolution WHA27.44, adopted by the 27th World Health Assembly in July 1974, called upon WHO to report to the 55th session of the Executive Board in January 1975 on steps undertaken by WHO "to assist governments to direct their health service programmes towards their major health objectives, with priority being given to the rapid and effective development of the health delivery system. . . . " (WHO, 1973–1984) This provided Mahler and Newell with the opportunity of introducing primary health care (PHC) in a comprehensive manner drawing upon the work of the previous two years.

The paper presented to the Board argued that what was needed was that the "resources available to the community" be brought into "harmony" with "the resources available to the health services." For this to happen "a radical departure from conventional health services approach is required," one that builds new services "out of a series of peripheral structures that are designed for the context they are to serve." Such design efforts should: (a) shape PHC "around the life patterns of the population"; (b) involve the local population; (c) place a "maximum reliance on available community resources" while remaining within cost limitations; (d) provide for an "integrated approach of preventive, curative and promotive services for both the community and the individual"; (e) provide for all interventions to be undertaken "at the most peripheral practicable level of the health services by the worker most simply trained for this activity"; (f) provide for other echelons of services to be designed in support of the needs of the peripheral level; and (g) be "fully integrated with the services of the other sectors involved in community development."

Four general courses of national action were outlined with the expectation that each country would respond to its need in a unique manner. These were:

1. The development of a new tier of primary health care;
2. The rapid expansion of existing health services with priority being given to primary health care;
3. The reorientation of existing health services so as to establish a unified approach to primary health care;
4. Making maximum use of ongoing community activities, especially developmental ones, for the promotion of primary health care. (WHO, 1975)

First presented in 1975 to the World Health Assembly, a more ambitious direction was outlined in 1976, when the Assembly was asked to consider a Secretariat paper on Primary Health Care and Rural Development. The 1976 WHA discussion focussed on two issues together, "promotion of national health services

relating to primary health care and rural development" and "health technology relating to primary health care and rural development. The resolution adopted (WHA29.74) requested the Director-General, *inter alia*, "to take appropriate steps to ensure that WHO takes an active part, jointly with other international agencies, in supporting national planning of rural development aimed at the relief of poverty and the improvement of the quality of life." On the surface, it would seem that the organization had returned to the position that Stampar had outlined some 20 years earlier. But this was not to be the case; this policy direction never materialized.

Despite the strong advocacy of the new Director-General, Halfdan Mahler, the political and technical leaders of the world strongly resisted moving in the direction indicated. The words were there, but not the commitment. Two episodes illustrate this. First, the position paper presented by the Secretariat to the 1976 WHA on rural development and primary health care elicited no interest whatsoever; there was no discussion of the issues presented. Instead, most delegates chose to inform the Assembly of progress in their countries and indicate their support of the upcoming Alma-Ata conference on primary health care. Secondly, at Alma-Ata itself, where the discussion was divided among three parallel sessions, the session that addressed 'health and development' was very poorly attended. There were literally only a handful of participants who chose to attend that session as opposed to the hundreds who followed the other two. Nevertheless, PHC was identified as the "key" to achieving Health for All by the Year 2000, a social target defined as the attainment by all peoples of the world of a "level of health that will permit them to lead a socially and economically productive life."

Developments which followed Alma-Ata confirmed that the political will supposedly demonstrated by the unanimous adoption of the Declaration of Alma-Ata was not present. Primary health care rapidly gave way to selective PHC with its much narrower focus.

MORE RECENT DEVELOPMENTS

The rapid ascendancy of selective PHC over comprehensive PHC coincided with a shift from an evaluation framework that featured socio-economic gains (as formulated at Alma-Ata) to one that focussed more on traditional health benefits (reduced morbidity, mortality, and disability). This shift, which took place in the 1980s, favored the emergence of the concept of 'burden of disease,' which seeks to measure, in a quantitative and context-free manner, the relative importance of different diseases, chronic illnesses, and disability conditions throughout the world. This has no doubt led to a more complete listing, from a biological perspective, of what constitutes 'ill-health.' In the process, conditions that normally have been associated with the developed world, for example, smoking and mental illness, have been shown to have world-wide importance.

The more complete listing and global accounting of disease burden has led to strong competition among the various public health programmes with which international organizations deal. Much of this effort has been directed to generating numbers that satisfy the 'analytic' criteria that have been adopted. Although this approach has been criticized by many, the numbers generated have attracted the attention of a new generation of economists who, in turn, have explored the question of to what degree investing in health can contribute to economic development.

In January 2000, WHO established a Commission on Macroeconomics and Health to assess the place of health in global economic development. Its report was published in December 2001. Its key findings included:

- The role of health in economic growth has been greatly undervalued.
- A few health conditions account for a high proportion of avoidable deaths.
- Poverty will be more effectively reduced if investment in other sectors is increased as well.
- To achieve an impact on health of the poor will require increased investment in global public goods.
- The recommended increase in spending is large, but so is the potential return. (WHO, 2002)

Malaria control again finds itself at the center of the debate of whether investing in health can be justified on economic grounds. Jeffrey Sachs, who chaired the WHO Commission, has been the leading proponent for this position. His arguments resemble many of those used back in the 1950s but, in the modern context, they may have a greater relevance than ever before. To begin with, burden of disease studies demonstrate what has long been believed, namely, that "where malaria prospers most, human societies have prospered least." (Sachs & Malancy, 2002) Going one step further, Sachs argues that the "causal link from malaria to underdevelopment (is) much more powerful than is generally appreciated." If this is the case, then investing in malaria control should provide economic benefits.

At the household level, reducing childhood deaths in highly endemic countries should translate into greater human capital development. At the macroeconomic level, less malaria risk should have favorable repercussions on trade, tourism, and foreign direct investment. Sachs goes so far as to argue, "Suppressing malaria in poor, highly malarious regions, especially in sub-Saharan Africa, offers the potential to initiate a virtuous cycle in which improved health spurs economic growth, and rising income furthers benefits human health."

The work of this Commission has attracted considerable attention, not all favorable. Some of the criticism reflects the earlier battle lines of public health, for example, the focus on individual diseases, as reflected in the example of malaria, "revives the vertical approach" that has characterized the pre–as well as post–PHC era. (Waitkin, 2003) Of greater importance is the question of to what degree

investing in health can lead to more equitable development on both health and economic grounds. When malaria was controlled in the tea and rubber plantations in the early decades of the 20th century, it is true that the plantation workers were healthier, but the economic benefits went to the plantation owners; no "virtuous cycle" was initiated by such investments.

There is considerable concern among some critics of the WHO Commission that its recommendations will further undermine the principles of self-reliance and community participation that were hammered out at Alma-Ata, and in the process create a "new version of colonialism and imperialism." Making available the needed drugs, vaccines, and even bednets, on terms that are economically acceptable to global investors, risks the "imposition on the world's poor of prefabricated, selectively chosen, market- and technology-driven, externally monitored, and dependence-producing programmes." (Banerji, 2002)

A WAY AHEAD

Of the eight Millennium Development Goals set at the United Nations Millennium Summit in September 2000, four relate to health. The work of the WHO Commission on Macroeconomics will no doubt help shape WHO's contribution to the achievement of those goals. If history is any guide, however, the year 2015 will come and few, if any, of the goals will have been achieved. Today, for example, despite the Roll Back Malaria program launched by WHO in 1998, malaria is again on the rise.

History also has taught us, as suggested by the brief overview provided above, that we have not yet learned how to gain a greater understanding and knowledge of the complex dynamics involved wherein better health serves as a lever for development, especially among the world's poorest people. The ideological gap that divides the public health community, which is as great today as it has ever been, has not facilitated matters.

WHO cannot afford to take sides, as it has unfortunately often done in the past. When malaria eradication was on top, the advocates of comprehensive-holistic approaches to health development were largely left out. When the tide turned, and PHC took command (on paper at least), the advocates of sharply defined health programmes (vertical or otherwise) were kept at abeyance (for a very brief time). Today, WHO is trying to keep its options open, but since the vast bulk of international funding lies outside its control, its options are operationally very constrained.

In this context, WHO should seek to develop a global program of evaluation specifically geared to shedding light on the issues that have been covered in this paper and that have divided the public health community for so long. WHO should be in the position of ensuring that all programmes that have human

development as their focus, whether specifically geared to gains in health, contribute to a collective global health learning experience. Opposing voices or results that contradict strongly held views should not be silenced as they have so often been in the past. Instead, means need to be found that channel competing energies into constructive work in countries and lead to a better understanding of the merits and faults of different sides of any argument. Only in this way, when the next round of international development goals is initiated, will there be a more solid empirical base to argue the case for investing in human health.

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