

Special chapter

The evolution of WHO

In 1948 the scars of the second world war had barely begun to heal. Massive recovery and reconstruction activities were being launched in Europe and Japan. The colonial era was coming to an end, and many countries were in the process of liberation. Added to the huge numbers of people killed or disabled during the war, millions were dying from preventable diseases. In the world community's cautious quest for new international relationships that might lead to a better future, improving the health of humanity emerged as a common bond.

The First World Health Assembly, in June 1948, approved a programme of work that listed its top priorities in the following order: malaria, maternal and child health, tuberculosis, venereal diseases, nutrition and environmental sanitation.

Today, 47 years later, in spite of significant improvements in human health, particularly in terms of mortality reduction, great burdens of suffering and disease are still with us. Half a century of lessons learned in eradicating and controlling diseases, expanding health care coverage and making the best use of available resources have guided the world community, including WHO, on the way to further progress. This special chapter presents a review of international health and the evolution of WHO.

Ancient scourges in a modern world

Measured against the life span of diseases that have plagued the world throughout recorded history, WHO today is still in its early infancy. In Ancient Egypt as

long ago as 3000 BC, diseases such as tuberculosis, poliomyelitis and syphilis were rampant. Leprosy is at least as ancient. Researchers have found traces in Egyptian mummies of schistosomiasis, a parasitic waterborne disease. Today that same disease affects some 200 million people.

Smallpox and measles were recognized in Asia at least 1 000 years ago. In the course of some 30 years during the 14th century bubonic plague killed perhaps as many as a quarter of the population of Europe, leading to the introduction by the city state of Venice of the first systematic quarantine regulations.

The eradication of smallpox in the late 1970s is regarded as one of WHO's greatest achievements, and measles has been eliminated from much of the industrialized world. But plague, as the outbreak in India in 1994 vividly illustrated, still persists in a number of countries with well-known natural foci. Close and continuous surveillance of this and other major diseases is today an important part of the International Health Regulations.

The cholera pandemic which invaded Europe in 1830 from India through Russia caused death on a massive scale. This, together with the tolls inflicted by plague and yellow fever, prompted in the late 1840s a greater recognition among affected countries of the need for international collaboration to prevent disease, essentially through the quarantine approach. One hundred years later the establishment of WHO was a major step towards fulfilling that need.

There were other important steps along the way. In 1864 the Red Cross, the first international humanitarian

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agency, was founded with the aim of giving emergency aid to the wounded of wars without choosing sides. The rapid expansion of scientific knowledge and the consequent need to coordinate research and exchange information prompted the establishment of the Pan American Sanitary Bureau in 1902, and the *Bureau international d'Hygiène publique* (OIHP) in 1907. In 1920 a constitution was drafted for a new health organization under the League of Nations, itself formed as a consequence of the first world war. This health organization collaborated closely with OIHP for many years, collecting and distributing epidemiological information, until the second world war prevented their continued functioning.

When the war ended, the majority of the world's population were still living in extreme poverty and suffering from chronic malnutrition, communicable diseases and parasitic infections to name a few. Children were at particularly high risk. Many of the existing health services, for instance in cities in Europe, northern Africa and Asia, had been severely disrupted. Structured health services were in any case rare, and where they did exist huge segments of the population – usually the most vulnerable people who could not pay for the often questionable care that was available – were excluded.

The need for a world health organization

Against this background the imperative need was recognized for a new world body capable of grouping resources for health, setting health goals and providing a forum for the exchange of health information and experience. But in the immediate postwar years no international health agency could do other than make an all-out effort to alleviate the epidemics that were sweeping the war-ravaged developed countries, colonial territories and some newly independent nations.

There were some models of national health services, usually based on the principle of compulsory health insur-

ance, with the state taking responsibility for the poorest people, and individuals contributing according to their means. But it soon became clear that such models would not work in countries where virtually no medical treatment was available, where trained health workers were scarce, and where most people would never be able to make the financial contributions required to support health services. A crucial task of a new body would therefore be to help countries build up or reconstruct broadly-based health services and see how best to organize them so as to bring health care to the people.

An international conference in San Francisco in 1945 drew up guidelines for the functioning of the United Nations. During those discussions emerged the memorable statement attributed to the United States archbishop, later Cardinal Spellman, that “medicine is one of the pillars of peace”. The United Nations set up a technical preparatory committee to establish the specialized agency that would emerge as WHO. An international health conference in June 1946 was dominated by new aspirations for a better world and better health for the peoples of the world.

In a message read to the conference on his behalf, United States President Harry S. Truman said: “Modern transportation has made it impossible for a nation to protect itself against the introduction of disease by quarantine. This makes it necessary to develop strong health services in every country which must be coordinated through international action. The new health organization will serve in this field. Just as international cooperation in science played a most important part in winning the war, so will such cooperation win the battle against disease and malnutrition”.

The conference agreed that the new body would be known as the World Health Organization and produced a constitution for it, specifying that its role would be to act as the directing and coordinating authority in international health, giving assistance to governments on request. People and their right to

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health were to be at the centre of the development process. International solidarity in the fight for health would replace the basically quarantine-inspired approach of earlier international health initiatives. WHO now comprises six regions (see *Map 7*).

The First World Health Assembly in 1948 was attended by 53 delegates from WHO's 55 Member States, the majority in the industrialized world. Its top priorities are listed at the beginning of this chapter, but there was some emphasis too on the socioeconomic, cultural and political dimensions of health. The main stress, however, was on the control of disease, and WHO's first two decades were dominated by mass campaigns in country after country against tuberculosis, malaria, yaws, syphilis, smallpox and leprosy, among others.

Declaring war on disease: victories and defeats

At the beginning of the 1950s there were believed to be around 20 million cases worldwide of yaws, a tropical disease mainly affecting the skin and bones. A single injection of penicillin was enough to cure it. Between 1950 when the first yaws campaign was launched in Haiti and 1965, a total of 46 million patients in 49 countries were successfully treated, and the disease was no longer a significant public health problem in most of the developing world. But the success of the campaign was misleading. It created an ill-founded optimism among health workers that other diseases could be controlled as easily.

In 1951 WHO took on the responsibility of coordinating a worldwide tuberculosis campaign largely funded by UNICEF. Initially the campaign concentrated on vaccinating children with BCG. By 1960 serious doubts about the campaign approach began to surface. The campaign was 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

therefore raised in favour of integrating BCG vaccination with other preventive and curative components of health services.

Also in 1951 WHO teams were at work in 22 malaria control projects, mostly in Asia, again with huge support from UNICEF. Malaria had been identified as the world's gravest threat to public health. The initial results were extremely encouraging. By 1955 the number of cases worldwide had dropped by at least one-third. The Health Assembly that year urged Member States to abandon malaria control and make eradication of the disease a priority of the highest order and urgency. But by 1966 the situation looked much less promising. Although 60% of the population of the originally malarious regions of the world were now living in areas where the disease had been eradicated or was no longer a major health problem, there were innumerable setbacks. In Africa virtually no progress had been made. Poorly developed health services were unable to cope, and in many countries the cost of antimalarial efforts was unbearable. In 1970 the Health Assembly recognized that malaria eradication was generally impracticable, and called instead for malaria control programmes to be reintroduced. Today WHO still gives high priority to the battle against the disease. But there is now a sense of realism about what can be achieved, especially in Africa, where improvements in economic and social conditions and in access to primary health care have been slow; 1970 was thus a turning point in the malaria battle.

1966 saw the opening of a new front, this time against smallpox. Against a background of widespread disenchantment with mass campaigns against a single disease, the Health Assembly nevertheless voted to make an all-out effort to eradicate smallpox within the next 10 years. At that time smallpox victims were estimated to number 10-15 million a year worldwide, of whom 1.5-2 million died. The disease was endemic in 30 countries. Eradication of smallpox was made possible by a combination of factors. There were no

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known animal reservoirs, and no long-term carriers of the smallpox virus. Patients who recovered had essentially life-long immunity. People with subclinical infections did not transmit the disease. Case detection was relatively simple. Above all a highly effective, stable and easily administered vaccine that conferred long-term protection was available. The smallpox campaign was the first global effort that has succeeded in eradicating a major disease. The achievement of this goal was certified in May 1980.

Box 18. Primary Health Care

In 1978, the International Conference on Primary Health Care held in Alma-Ata identified the following eight essential elements of primary health care:

- education concerning prevailing health problems and methods for addressing them
- promotion of food supply and proper nutrition
- provision of an adequate supply of safe water and basic sanitation
- maternal and child health care, including family planning
- immunization against the major infectious diseases
- prevention and control of locally endemic diseases
- appropriate treatment of common diseases and injuries
- provision of essential drugs.

Immunization programmes

The mass campaigns against single diseases of the first decades gave way to WHO's Expanded Programme on Immunization aimed at protecting by the year 2000 all children against six vaccine-preventable diseases – measles, diphtheria, pertussis, tetanus, poliomyelitis and tuberculosis – in their first year of life. Global coverage with the vaccines reached its peak at the end of 1990 when the goal of immunizing 80% of all children by the age of 1 year was achieved. The main factors inhibiting further progress have been insufficient political commitment by countries, civil unrest, donor fatigue and lack of resources.

After smallpox the next vaccine-preventable disease targeted for eradication is poliomyelitis. In 1992 no cases were reported in the western hemisphere. By maintaining surveillance in the poliomyelitis-free areas and intensifying control measures elsewhere, WHO expects the disease to be eradicated by the year 2000.

In 1994 WHO established a global programme for vaccines and immunization aimed at coordinating all activities in this field carried out within the Organization and by other agencies. The programme is also responsible for WHO's contribution to the multiagency children's vaccine initiative, launched in 1990 to stimulate the provision of improved, safe, reliable and affordable vaccines for the developing world and which can be given in a single procedure. The long-term goal is to achieve a world where all people at risk are protected against vaccine-preventable diseases.

Health for all by the year 2000

Ever since its inception WHO has pursued as its overriding goal the achievement of better health for all people everywhere, in the sense not simply of survival, but of enhanced quality of life. Yet a review in the early 1970s showed that more than half the population of the globe did not have access to adequate health care. The gap between developed and developing countries in levels of health was widening. Gaps were also evident between different groups of populations within countries.

In 1977 the Health Assembly resolved that the main social target for governments and WHO in the coming decades should be "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life".

In September 1978 delegates from 134 countries and 67 United Nations bodies and nongovernmental organizations met at Alma-Ata (Kazakhstan) for an international conference on primary

health care. This led to the Declaration of Alma-Ata, unanimously endorsed by the Health Assembly in 1979. Every one of WHO's Member States was now committed to a form of public health action that implied fundamental changes in the distribution and use of resources and in the responsibilities within the health care system, government and society.

The declaration, a landmark document in the history of international health, stated that primary health care was to be the key to attaining the target of health for all by the year 2000 as part of overall development and in the spirit of human justice. It called on all governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors (Box 18).

In 1981 the Health Assembly approved the definitive global strategy for health for all by the year 2000. Global targets for health were established for the year 2000, and have since been the criteria against which all health development efforts have been measured. At a conference in Riga in 1988, attended by ministers of health, finance and planning, it was noted that primary health care coverage had greatly improved in many countries, but that there were still many deficiencies.

WHO sets the standards

The establishment of standards in such fields as vaccines, drugs and laboratory tests has been a permanent part of WHO's work. These instruments have been universally accepted as representing the best available technical advice of the moment and have been the basis for the Organization's reputation as the undisputed authority in health matters.

In pursuance of WHO's constitutional functions in regard to the standardization particularly of biological and pharmaceutical products, the WHO Expert Committee on Biological Standardization has been meeting every year since 1951 to formulate standards which

are recognized worldwide. They enable drug and vaccine manufacturers to ensure the availability of safe and efficacious biologicals as well as standard product dosage and diagnostic tests. Because of the scientific credibility of WHO, this gives confidence to patients, doctors and other health personnel for using drugs of proven efficacy and valid diagnostic procedures.

WHO's contribution to the Codex Alimentarius Commission on food standards and the International Code of Marketing of Breast-milk Substitutes are an example of the Organization using

Box 19. *The International Classification of Diseases*

The International Statistical Classification of Diseases and Related Health Problems (ICD), under different names, has so far undergone 10 revisions. The first ICD or ICD-zero was prepared in 1893 by Jacques Bertillon of France under a mandate given to the International Statistical Institute. Subsequent revision conferences were convened by France in 1900 (ICD-1), 1909 (ICD-2), 1920 (ICD-3), 1929 (ICD-4) and 1938 (ICD-5), the latter two under the auspices of the institute and the Health Organisation of the League of Nations. The international conference for the sixth revision was convened in Paris in 1948 with the collaboration of the Interim Commission of the World Health Organization. WHO has thus been responsible for the last five revisions of the classification.

Before ICD-6 the classification was used only for mortality statistics. That revision was expanded to make it suitable for the collection of morbidity statistics. ICD-7 in 1955 was limited to essential changes and amendments of errors and inconsistencies. ICD-8 in 1965 was more radical than ICD-7, but left unchanged the basic structure of the classification and the general philosophy of classifying diseases, whenever possible, according to their etiology rather than a particular manifestation.

In 1975 ICD-9 retained the same basic structure, although with much additional detail, and introduced classifications of impairments, disabilities and handicaps (ICIDH), and of procedures in medicine as supplements. ICIDH seeks to establish, for international acceptance and use, uniform definitions and terminology — often confused and misused — in the field of rehabilitation. In the course of successive revisions ICD has thus expanded to cover the whole spectrum of health.

ICD-10, the 21st century classification, was adopted by the Health Assembly in 1990. It initiated the use of an alphanumeric coding scheme of one letter followed by three numbers at the four-character level, and constitutes the "core" of a family of disease- and health-related classifications. The purpose of the classification is to serve as a tool for comparisons between countries at the same point in time, and within and between countries over time, thus enabling the compilation of comparable statistics for decision-making in disease prevention and health care, and facilitating the collection of epidemiological data for research purposes.

its moral and technical authority to help different interest groups to reach a consensus.

Another type of standard relates to the classification of diseases (Box 19). The recently published tenth revision of the *International Classification of Diseases* (ICD-10) is intended to serve as a tool for facilitating the collection of epidemiological data for comparisons between countries at the same point in time, and within and between countries over time, and thus enabling the compilation of comparable statistics for decision-making in disease prevention and for research purposes.

Human resources for health

Training physicians and raising the standards of medical schools in developing countries, helping countries organize schools for nurses and midwives and launching training courses for allied health personnel have always been an important part of WHO's work. The concept of primary health care has switched much of the emphasis to training directed towards a wide range of health care workers at community level, particularly in developing countries, rather than towards health professionals as such.

Managing health development

WHO's role in health planning has changed over the years, reflecting the Organization's evolving policy on health development in general.

Before 1965 planning was carried out as a routine function of public health administration. Between 1965 and 1970 WHO supported the development of specific concepts and methods of national health planning. The next five years saw the application of the systems approach, exploration of computer modelling and the introduction of health project planning and management.

The period 1975 to 1980 saw the advent of health sector programming (also

referred to as country health programming) and the initiation of the managerial process for national health development. Since 1990 WHO has stressed the importance of evaluation, with little attention paid to health planning as such.

Meanwhile, futures studies used in other sectors and for national planning development in some countries, began to be used in the health sector. The futures approach utilizes such methods as visioning, alternative scenario development, trend analysis and forecasting, and dynamic modelling, and may well be the basis for health planning in the 21st century.

The contribution of NGOs

The 1945 San Francisco conference which drew up the Charter of the United Nations recognized the advantages to be found in the enthusiasm, knowledge and experience of international associations, and authorized the Economic and Social Council of the UN to consult with, and make effective use of, nongovernmental organizations (NGOs). WHO's constitution goes a step further, authorizing not only consultation but cooperation with NGOs in health matters. Official relationship is granted by WHO's Executive Board to NGOs that deal with matters falling within the competence of the Organization and pursue aims and purposes in conformity with the spirit, purposes and principles of its constitution.

At the end of 1957 some 40 NGOs were in official relations with WHO. During the first years most of them dealt with a particular branch of medical science or research and represented professional groups; only a few had a more general interest in health. Nevertheless it was recognized that collaboration with these organizations was useful for obtaining information, making WHO's objectives known and stimulating interest in international health work. 1959 saw the first admission to official relations of an NGO representing persons

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suffering from a specific health problem, namely the World Federation of the Deaf. By January 1994 the total had reached 184 (Annex 2).

Being relatively unbound by the legislative and policy constraints of governments, NGOs have the flexibility to experiment with innovative and alternative approaches to solving health problems. Many can effectively mobilize large numbers of volunteers and thus play a dynamic role in national health development. Growing numbers of NGOs are becoming involved in advocacy, health promotion and technical cooperation, as well as fund-raising and provision of resources both for national health development and for WHO's technical programmes, often working closely with them. In 1990 the WHO Executive Board noted a rapid growth of NGOs and stressed that among the most important criteria for admission into official relations with WHO must be that a major part of the NGO's work is relevant to and has bearing on the achievement of health for all.

The political context

When the movement for health for all was launched, it was assumed that economic growth would continue nearly everywhere and that richer countries would give substantial assistance to the poorer nations provided their case was well presented. The global economic crisis of the late 1970s and early 1980s undermined both those assumptions. The break-up of the USSR, with the emergence of many newly independent states, the end of the cold war and the demise of communism led to more emphasis being placed on privatization, decentralization and liberalization. In turn the accompanying changes in health care systems led to new problems and distortions, and to moves for more central control of health care in some countries. Equity in health and health care, health as a human right and ethical issues became a concern in many countries.

The post-cold war period prompted hopes of a "peace dividend" from the reduction in military spending. But it failed to materialize. Instead global recession, the seemingly never-ending rise in health costs and growing expectations for health care created serious funding problems and necessitated painful cut-backs in health care, even in rich countries. As global East-West tensions subsided, armed conflicts between and within countries seemed to take on new dimensions.

WHO has learned that health cannot be divorced from politics. Until recently few political leaders believed that health was a worthwhile economic or political investment. The strategy of health for all has been endorsed at the highest political level, but a gap remains between what is preached and what is practised. In many countries the health sector wields little political power or influence in decisions about the allocation of public funds. Expenditure on health care has tended to be viewed simply as a drain on scarce resources, rather than as an investment in the nation's future.

Professional and financial interests, bureaucratic resistance to change and political considerations have been underlying reasons for the sometimes slow application of WHO guidelines; yet the Organization's position as the health technical agency and the health conscience of the world has helped to ensure acceptance of its advice over time. The eradication of smallpox was made possible by close collaboration under WHO's auspices by a great many countries without regard to political differences. WHO's advocacy of the concept of health for all has been accepted by governments worldwide.

The emphasis in public health has swung away from the technical and scientific thrust of the early disease-oriented campaigns towards understanding the underlying determinants of health, and seeking to influence them in a positive way through health promotion directed at individuals, communities and

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governments. This unfortunately diluted traditional and effective measures such as the maintenance of adequate surveillance systems to trigger effective action for the control of communicable diseases.

The way ahead

WHO's general programmes of work, now covering periods of six years, give principles and policies for the functioning of the Organization. They also provide a framework for detailed workplans and budgeting. Over the years the programmes have responded to, and of-

ten anticipated, the major health concerns of Member countries. The ninth programme (1996-2001) fixes goals and targets for WHO's global health action. It focuses on lessening of inequities in health, control of rising costs, the eradication or elimination of selected infectious diseases, the fight against chronic diseases, and the promotion of healthy behaviour and a healthy environment.

The challenge for the future is to mobilize WHO's Member States to adopt policies and plans that will guarantee the provision of comprehensive integrated health services to each and every member of the community.

Map 7. WHO regions and the areas they serve as of December 1994

