Folder Title:	Pan American Health Organization [PAHO] - Correspondence
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Series:	Director and Front Office records
Dates:	03/01/1980 - 04/02/1982
Fonds:	Records of the Population, Health, and Nutrition Sector
ISAD Reference Code:	WB IBRD/IDA WB_IBRD/IDA_89-06
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PAHO

April 22/82 P.A.H.O. Visit. O. Echeverria
S.D.N.
S.R.E.

Dr H. Acuña Director PAHO — Director
Dr. Paul Ehrlich Deputy Dir " — DD
Dr. Jose Salazar: - Inter agency Coordn — Colombia
Dr. Jorge Osuna: - MCH - Deputy Comp. Health — Colombia
Mark Schneider - Coordination (Emphasis sp.) Collabor. — US
Vicente Witt - Environmental Health Program

Acuña
PAHO reps provide continuity of representation in countries - PAHO subject to UN system: this ends up creating pilum of ↑ salaries. Budget plagued by growth/reductions suffering inflation.
10 special centres: INCAP, CAREC, Int'l Zoonoses Centre
\#People - 200, 70, 350
INCAP moved outside PAHO + → becomes inst. of countries

Ehrlich
Renewed Plan of Action: Each country supposed to adopt plan. Seminars + workshops for 5 nationals in latter ½ 1982 to lead to similar process in their own countries. Countries to report back in 1983.
Risk factor approach in selection of priorities (p18)

How to develop health + env. impact analysis for different types of econ. development projects, — ? role for coopn among agencies in developing these guidelines.

Continuing PAHO-PHW relations might
i financing & costs etc + impact analysis: J. Wanford
ii operational area : D. Pearce
Contact person - Paul Ehrlich.

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Dr. John D. Evans, Director, PHN DATE: April 19, 1982

FROM: Roberto Cuca, Acting Chief, Div. III, PHN

SUBJECT: Meeting PHN and PAHO - Arrangements

1. I met with Dr. Jose Maria Salazar, Head of Liaison Unit PAHO, to discuss the agenda of your meeting with Dr. Acuña and other persons from PAHO on April 22 at 12:30 p.m.

2. We have agreed that meeting should be for about two hours, with the following format.

(a) Doctor Acuña will talk for about half an hour about political framework, administrative structure and the role in Technical Assistance of PAHO;

(b) Dr. Evans will explain the organization, structure and PHN policy of the Bank; Call on D. Pearce.

(c) Dr. Ehrlich will then talk about the Plan of Action, recently approved and which will form the basis of PAHO activities in the foreseeable future;

(d) After this there will be a discussion about three basic points:

(i) Basis for future cooperation between IBRD and PAHO;

(ii) Adoption of policy and strategy of International Coordination; and

(iii) Adoption of policy and strategy for health components of Bank projects in other sectors.

3. Dr. Salazar will be calling you on 4/20/82 to ask you whether you consider that this meeting is with representative of PAHO only or it is supposed to be with PAHO/WHO. It is important for them to know this for purposes of internal communication between PAHO and WHO.

cc: Mr. J. North, PHN
Mr. D. Pearce, PHN (o/r)

RCUCA:MA

up to PAHO to decide. (No difference to Bank)

TO ROSE MARIE

April 9, 1982

PAHO - PHN/PAHO Meeting between Dr. Acuna and Dr. Evans

Dr. O'Colmain, PAHO, called me this morning to inform me about meeting PAHO-Bank. He made following points:

1. Meeting as agreed will begin with lunch and continue in afternoon of 4/22 for about two hours.

2. Six people from PAHO will be coming:

a.	Dr. Acuna	
b.	Dr. Paul Ehrlich	
c.	Dr. Vicente Witt	Acting Chief, Environment
d.	Dr. Mark Schneider	Office of Long Term Activities
e.	Dr. J.M. Salazar	
f.	Dr. Jorge Osuna	Acting Chief, Comprehensive Health Services

3. During first hour after lunch Dr. Acuña will make presentation:

   Overview of Organization Structure of PAHO

   During second hour Paul Ehrlich will go into the New Plan of Action.

R. Cuca

RC:MA

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Dr. John R. Evans, PHN

DATE: April 2, 1982

FROM: David Pearce, PHND3

SUBJECT: PAHO: Meeting with Director, Dr. Héctor R. Acuna

1. Following your exchange of letters with Dr. Acuna earlier this year, I met with Dr. Salazar, Head of Liaison Unit, on March 15 to discuss areas of mutual interest in LAC, to agree on means of exchanging information (a process that has already been initiated), and to arrange, at PAHO's request, a formal PHN/PAHO meeting between Dr. Acuna and yourself.

2. Regarding the latter, Dr. Acuna's office has just confirmed April 22 at 10:00 a.m. (one of the three days convenient to you both at that time). Dr. Acuna will be accompanied by Drs. Salazar and O'Colmain and two to four technical staff; and, Dr. Acuna plus one or two of the PAHO group have accepted your invitation for lunch that day. Dr. Salazar and I will meet again on April 19 (the day of my return from Bangladesh) to firm up the (informal) agenda, format and presentations to be made by PAHO and PHN.

3. As far as PHN participation is concerned, I recommend that Messrs. North and Warford be asked to attend together with two to three PHND3 staff.

cc: Mr. North, o/r
Mr. Warford
Mr. Cuca, o/r

DPearce:ap
PAHO

Changed to 12:30 w/ meeting after lunch

17 March 1982

LO/51/5.1

NOTE TO THE FILES

A meeting between PAHO and IBRD staff of the Population Health and Nutrition Department took place at 2 P.M. on March 15th, in the office of LO, present were:

Mr. David Pearce - Ar. Chief Division III
Dr. A. Measham - Public Health Specialist
Dr. J. M. Salazar - Chief, LO
Dr. C. O. Colmain - Office of LO

The purpose of the meeting was to discuss the feasibility of arranging an early meeting between high-level staff of PAHO and the new Latin American and Caribbean Division III of the World Bank. The need for, and content of an agenda was also discussed.

Mr. Pearce said the Bank, especially the new Division for Latin America and the Caribbean, recognized the need for the establishment of a systematic means for cooperation and coordination between IBRD and PAHO, both at HQ and field level. He envisaged this would involve information exchange on Bank Mission Schedules and the Bank Programs over the next eighteen months - detailing current and future programs in health.

Mr. Pearce agreed to make available to PAHO monthly copies of Economic and sector work undertaken in the countries by IBRD. He suggested appropriate PAHO staff might be invited to the monthly IBRD staff meetings in Washington.

Mr. Pearce was assured he could call on PAHO for technical assistance. PAHO could offer collaboration to the Bank at all levels particularly at country level and would welcome the opportunity of collaborating closely with IBRD in health activities and projects in the Region.

It was agreed the meeting might be held on 21-22 or 23rd of April at the Bank, subject to the approval of Dr. Acuña and Dr. Evans. The duration would be two hours followed by a luncheon at the Bank. The Bank would field the following staff for the meeting:

Dr. J.D. Evans - Director
Dr. J.D. North - Asst. Director
Dr. K. Kanagaratnam - Senior Advisor
Dr. Alan Berg - Senior Nutrition Adviser
Dr. David Pearce - Ag. Chief Division III

PAHO representation would be discussed with the Director.

Several areas were suggested by Mr. Pearce and Dr. Salazar that warranted discussion between the two organizations.

1. Adoption of a policy and strategy for health components of larger Bank supported projects.

2. Adoption of policy and strategy on intersectorial coordination.

3. Basis for future cooperation between IBRD and PAHO.

It was agreed the first meeting should be informal and that perhaphs both the Bank and PAHO should provide a resumé of their key activities in the Countries of Latin America and the Caribbean.

The duration of the meeting would be two hours allowing an hour to each Organization for its presentation and discussion.

Mr. Pearce agreed to send us an early copy of the Health Project Development Handbook prepared by Jeremy Warford, Chief of the Policy and Research Unit of the Population Health and Nutrition Department.

COC/mcm

March 9/82

For Karen / Denning – Division III

Dr Salazar meeting: Head of Liaison Unit PAHO

1. New policies + priorities for Latin America in view of budget pressure + new administration of Bank.
2. Effect of PAHO priorities on Bank activities in Latin America
3. Parallel to relationships of PAHO with IDB

Second meeting with results of first meeting with H. Acuna + J.R.E. added.

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

IN REPLY REFER TO: LO/63/5.3 TELEPHONE 861-3200

12 February 1982

Dr. John R. Evans
Director,
Population, Health and Nutrition Dept.
The World Bank
1818 H Street
Washington, D.C. 20433

Dear Dr. Evans:

Thank you for your letter of 23 January 1982, informing us of the establishment of a new operating division for Latin America and the Caribbean headed by Mr. Stephen Denning.

We look forward to an early meeting with Mr. Denning and his staff in order to discuss many areas of mutual interest in the Region. I will ask our Liaison Office to contact Mr. Denning and arrange for a meeting at a mutually convenient time.

Please accept my warm, personal wishes for the success of this new initiative and my assurance of continued close cooperation between PAHO and the Bank.

Sincerely yours,

Héctor R. Acuña
Director

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
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525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

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Please accept my warm, personal wishes for the success of this new initiative and my assurance of continued close cooperation between PAHO and the Bank.

Sincerely yours,

J. Paul Sherlock Jr.
for Héctor R. Acuña
Director

September 30, 1981

Dr. Hector R. Acuna
Director
Pan American Health Organization
Pan American Sanitary Bureau
525 Twenty-Third Street N.W.
Washington, D.C. 20037

Dear Dr. Acuna:

Thank you for your letter AH/V5/67/3/1660 addressed to Mr. Clausen, raising the possibility of World Bank support for developing a more coherent program to deal with foot and mouth disease in Latin America.

As you know the World Bank has financed and continues to finance animal health programs within the scope of its projects. We believe this is the most effective way for the Bank to operate and we shall continue to operate within this format. We look forward to continued cooperation with you within the scope of our project work.

In the light of the above and given our limited resources other than for project financing, we regret we see little gain or prospect in joining a consortium such as you suggest.

Yours sincerely,

Montague Yudelman
Director
Agriculture & Rural Development Department

cc: Messrs. Goffin LCP
Evans PHN
Lafourcade EMC
Sutherland AGR o.r. with incoming correspondence

MYudelman:sm

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

IN REPLY REFER TO: AH/V5/67/3/1660

TELEPHONE 223-4700

Mr. A. W. Clausen
President
International Bank for Reconstruction
and Development
1818 H Street N.W.
Washington, D.C. 20433

Sir,

I would like to bring to your attention the unique experience that the Pan American Health Organization, Regional Office of the World Health Organization (PAHO/WHO) has had through the years in establishing an effective relationship between the various sectors involved in health, agriculture and socioeconomic development in the Region of the Americas. As part of its integrated approach to human health problems, PAHO provides the required technical cooperation in animal health to the countries of Latin America and the Caribbean. The Special Program of Animal Health which includes two international centers, the Pan American Foot-and-Mouth Disease Center in Brazil and the Pan American Zoonoses Center in Argentina, forms an important component of our Organization's overall program of technical cooperation in health, aimed at combating human malnutrition and infection and promoting socioeconomic well-being.

Some tangible benefits have been reaped through the promotion of animal health programs in terms of availability of animal protein from meat, milk, eggs and other animal food products, and the reduction of human morbidity and mortality from animal diseases transmissible to humans. These benefits have contributed to the well-being of the population of the Region. Furthermore, if these beneficial gains are pursued more vigorously, they have the potential for making a broader and more significant impact on ensuring a socially satisfying and economically productive life, especially for the disadvantaged segment of the population. The Member Governments have, therefore, urged our Organization to coordinate a comprehensive effort to mobilize effectively the required resources in order to meet their requirements for technical cooperation in this field.

The Executive Committee of PAHO, during its 86th Meeting held in Washington, D.C., from 22 to 30 June 1981, has requested me to investigate all possible sources of funds and alternative mechanisms of financing in order to meet the requirements of the countries while, at the same time, maintaining the PAHO/WHO technical cooperation program in animal health at an efficient and ... effective level. I am enclosing for your information a copy of the 86th Executive Committee Meeting Resolution in relation to this request.

... I am also enclosing herewith, for your consideration, a "Proposal for a Five-Year Comprehensive Program for the Control and Eradication of Zoonoses and Foot-and-Mouth Disease in Latin America and the Caribbean," which has been expressly endorsed by the Ministers of Agriculture and the Ministers of Health of the Americas. They have expressed their collective desire that favorable consideration by your institution be given to this proposal.

I would like to stress briefly the problem of zoonoses and foot-and-mouth disease, because they impose a heavy burden on socioeconomic development in our Region. For example, in some twelve countries where precise estimates have been made, a total of some US$20 billion are lost annually due to these diseases; that is in addition to the human illness and suffering they cause. Since this problem is almost inextricably intertwined with human health, it must be confronted in its proper context in order to realize the meaningful gains that are expected to accrue from investments in health. Unlike investments in social services, investments in animal health with implications on human health have been shown to be financially attractive from the standpoint of return on investment.

While PAHO/WHO will invest some US$37 million of its budget for the bienniums 1982-1983 and 1984-1985 for technical cooperation in animal health, this amount will not suffice to meet the many and diverse requirements of the countries. We are, there- ... fore, sending you the enclosed proposal as a basis for discussing the various options possible for obtaining the necessary supplementary funds and for developing a more coherent financing program. The proposal contains the basic priority programmatic areas and their corresponding components and elements to serve as a guide in determining the various inputs required, bearing in mind the need for an integrated approach in order to optimize resources.

Apart from obtaining the needed supplementary funds for achieving the various programmatic components and elements outlined in the enclosed proposal, it is suggested that a formal mechanism be established that will ensure an adequate level of financing of the program over a period of several years, such as the establishment of a consortium of financing institutions that will serve as a grantor or as an agent for attracting grants and contributions from interested individuals and organizations, similar to that set up by the World Bank, the United Nations Development Program and the World Health Organization for the Tropical Disease Research Program.

I would very much like to explore the possibility of obtaining the assistance of your institution in mobilizing the necessary financial support required.

We look forward to hearing from you soon.

Sincerely yours,

Héctor R. Acuña, M.D., M.P.H.
Director

... Enclosures

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Mr. Montague Yudelman, Director, AGR DATE: Sept. 18, 1981

FROM: John R. Evans, Director, PHN JRE

SUBJECT: PAHO Special Program on Animal Health

The request for assistance is for five years, 1982-1986, but the eradication/control programs for the diseases are long term. Ninety percent of the funds are for personnel and equipment to strengthen field control of the diseases and for diagnostic laboratories; the research and development, training and surveillance functions are covered in the remainder.

No information is given on what is currently supported or the use of the $37 million budgetted by PAHO for 1982-85. No information is given on the evaluation of the current program.

The economic returns from investment in this program will be primarily in the agricultural sector. Health benefits would accrue but in terms of priorities for the health area these diseases would be relatively low down the list and the indirect benefits of greater availability of animal protein would not be a primary consideration in human malnutrition. In this respect it is noteworthy that the proposal for financing at country level is through the Ministry of Agriculture.

This proposal is from a region. Item 2.6 notes, however, that animal health center programs are now under consideration in three other regional offices of WHO. With the exception of the onchocerciasis program, the Bank's contribution to research development and training programs for CGIAR and the TDR has been on a global basis.

Conclusion

Support for this program cannot be recommended on the grounds of priorities for interventions in health in Latin America or on the grounds of solving problems which are unique to one region of the world.

Attachment

cc: Mr. Baum
Ms. Husain (with incoming)

JREvans/rmf

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

TELEPHONE 223-4700

IN REPLY REFER TO: AH/V5/67/3/1660

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President
International Bank for Reconstruction
and Development
1818 H Street N.W.
Washington, D.C. 20433

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Some tangible benefits have been reaped through the promotion of animal health programs in terms of availability of animal protein from meat, milk, eggs and other animal food products, and the reduction of human morbidity and mortality from animal diseases transmissible to humans. These benefits have contributed to the well-being of the population of the Region. Furthermore, if these beneficial gains are pursued more vigorously, they have the potential for making a broader and more significant impact on ensuring a socially satisfying and economically productive life, especially for the disadvantaged segment of the population. The Member Governments have, therefore, urged our Organization to coordinate a comprehensive effort to mobilize effectively the required resources in order to meet their requirements for technical cooperation in this field.

The Executive Committee of PAHO, during its 86th Meeting held in Washington, D.C., from 22 to 30 June 1981, has requested me to investigate all possible sources of funds and alternative mechanisms of financing in order to meet the requirements of the countries while, at the same time, maintaining the PAHO/WHO technical cooperation program in animal health at an efficient and effective level. I am enclosing for your information a copy of the 86th Executive Committee Meeting Resolution in relation to this request.

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While PAHO/WHO will invest some US$37 million of its budget for the bienniums 1982-1983 and 1984-1985 for technical cooperation in animal health, this amount will not suffice to meet the many and diverse requirements of the countries. We are, therefore, sending you the enclosed proposal as a basis for discussing the various options possible for obtaining the necessary supplementary funds and for developing a more coherent financing program. The proposal contains the basic priority programmatic areas and their corresponding components and elements to serve as a guide in determining the various inputs required, bearing in mind the need for an integrated approach in order to optimize resources.

Apart from obtaining the needed supplementary funds for achieving the various programmatic components and elements outlined in the enclosed proposal, it is suggested that a formal mechanism be established that will ensure an adequate level of financing of the program over a period of several years, such as the establishment of a consortium of financing institutions that will serve as a grantor or as an agent for attracting grants and contributions from interested individuals and organizations, similar to that set up by the World Bank, the United Nations Development Program and the World Health Organization for the Tropical Disease Research Program.

I would very much like to explore the possibility of obtaining the assistance of your institution in mobilizing the necessary financial support required.

We look forward to hearing from you soon.

Sincerely yours,

Héctor R. Acuña, M.D., M.P.H.
Director

Enclosures

RESOLUTION XIII

PROPOSED PLAN OF ACTION TO ESTABLISH DEPENDABLE SOURCES OF FINANCING FOR THE PAN AMERICAN ZOONOSES CENTER AND THE PAN AMERICAN FOOT-AND-MOUTH DISEASE CENTER OUTSIDE THE REGULAR PAHO BUDGET

THE EXECUTIVE COMMITTEE,

Considering that the Pan American Zoonoses Center and the Pan American Foot-and-Mouth Disease Center play a fundamental role in the promotion, support, and coordination of animal health and veterinary public health programs in the Hemisphere;

Cognizant of the significance of the effects of zoonoses and foot-and-mouth disease on the general welfare of human beings, and particularly on food production;

Bearing in mind the recommendations of the report of the External Evaluation Team of the Pan American Zoonoses and Pan American Foot-and-Mouth Disease Centers, appointed by the Director of the Pan American Sanitary Bureau; and

Having reviewed the "Proposal for a Five-Year Comprehensive Program for the Control and Eradication of Zoonoses and Foot-and-Mouth Disease in Latin America and the Caribbean,"

RESOLVES:

1. To endorse the objectives, activities and guidelines established in the "Proposal for a Five-Year Comprehensive Program for the Control and Eradication of Foot-and-Mouth Disease and Zoonoses in Latin America and the Caribbean."

2. To recommend to the national and international financial aid agencies that they give favorable consideration to requests they may receive in respect of this Program.

3. To urge all Member Countries, through the Ministers of Agriculture, to consider making their own extraordinary contributions to the Centers, under specific agreements with PAHO, in connection with the cooperation they require.

4. To request the Director to investigate the financing available in the various international, regional and national sources of credit for implementation of the Program.

(Approved at the ninth plenary session, 26 June 1981)

PAN AMERICAN HEALTH ORGANIZATION

II INTER-AMERICAN MEETING, AT THE MINISTERIAL LEVEL, ON ANIMAL HEALTH

WORLD HEALTH ORGANIZATION

Washington, D.C., USA, 30-31 March 1981

Provisional Agenda Item 4

RIMSA2/7 (Eng.)
13 March 1981
ORIGINAL: ENGLISH

PROPOSAL FOR A FIVE-YEAR COMPREHENSIVE PROGRAM FOR THE CONTROL AND ERADICATION OF ZOONOSES AND FOOT-AND-MOUTH DISEASE IN LATIN AMERICA AND THE CARIBBEAN

In compliance with Resolution XVIII of the XXVII Meeting of the Directing Council of PAHO in 1980, this project proposal was drafted as an attempt to provide the basic framework to attract more dependable sources of financing, on a long-term basis, of the technical cooperation activities required in animal health and veterinary public health in the Hemisphere. The project proposal puts forward a comprensive and integrated approach to the control and erradication of the major zoonoses and foot-and-mouth disease in Latin America and the Caribbean. The general objectives are, in addition to reducing the prevalence and expanding the disease-free areas, to support existing programs and to increase the supply and availability of proteins of animal origin to improve human nutrition. It will deal with rabies, brucellosis, tuberculosis, hydatidosis, leptospirosis, food-borne infections and intoxications, equine encephalitides and foot-and-mouth disease. It will also cover training and development of human resources, strengthening of laboratory support and diagnostic capabilities, strengthening field control activities, epidemiological surveillance, and research. The proposed project will be for a period of 5 years and will cost a total of US$20,459,900.

This project proposal is being presented to this meeting for the consideration of the Ministers of Agriculture of the Hemisphere. Following approval and endorsement, it will be submitted to various agencies for possible funding.

PROPOSAL FOR A FIVE-YEAR COMPREHENSIVE PROGRAM FOR THE CONTROL AND ERADICATION OF ZOONOSES AND FOOT-AND-MOUTH DISEASE IN LATIN AMERICA AND THE CARIBBEAN

I. SOCIOECONOMIC IMPORTANCE OF THE ZOONOSES AND FOOT-AND-MOUTH DISEASE

1. Significance

1.1 The zoonoses and foot-and-mouth disease (FMD) represent a major human and animal health problem in the Americas. The zoonoses (or those diseases transmissible between animals and humans) constitute a medically important group of diseases causing human illness and death. Most human infections discovered in the last 20 years are shared with lower animals. The zoonoses are responsible for occupational illnesses in both urban and rural workers and their families.

1.2 Some 273 million people in Latin America and the Caribbean are at risk to more than 150 known zoonoses. At least 50 per cent of this population, or some 186 million persons, will be infected with one or more zoonoses in their lifetime.

1.3 The zoonoses and FMD undermine animal health and reduce productivity, resulting in reduced meat, milk, eggs, and wool production and impairment of the working capacity of draft animals. Consequently, they exacebate the scarcity of animal protein for human consumption.

1.4 The interrelationship between human nutrition and infection is one of the important health problems confronting the world today. Precipitated by nutritional deficiencies resulting from malnutrition, the human body defense system undergoes atrophy, becomes less able to produce antibodies, and succumbs to infection. The Inter-American Investigation of Mortality in Childhood, which studied the death of 35,095 children under five years of age in 24 widely separated areas in the Americas, shows that malnutrition was directly or indirectly responsible for 53.2 per cent of all deaths. The cases were chiefly of marasmus or kwashiorkor or a combination of the two.

1.5 According to the analysis of the Ten-Year Health Plan for the Americas, protein malnutrition affected 28 million children under five years of age, or about 61.5 per cent of all children in that age group. Approximately 18.9 per cent suffered from moderate or advanced malnutrition. The consumption of calories and proteins was estimated to be 10-20 per cent below the recommended level, especially among the poorer segment of the population.

1.6 Infants and children during their pre- and postnatal period are the most vulnerable to protein deprivation since, if they survive, they often fail to achieve their optimum size and weight. Their intellectual capacity and potential vigor are often seriously reduced.

1.7 It is a fact that protein of animal origin--that from meat, milk and eggs--is not only palatable and easily digestible, but is also rich in the types of aminoacids that are usually either absent or deficient in plant protein. Animal products also provide vitamin B-12 that is lacking in an all-plant diet. Milk, for instance, continues to be the foundation for normal infant growth and development and for the treatment of severe protein-calorie malnutrition. It is one of the easiest of human foods to digest.

1.8 In 1970 it was estimated by FAO that over 30 million tons of milk are lost annually to animal diseases, which include the zoonoses and FMD. This quantity of milk could provide almost 200 million children with two daily glasses of milk.

1.9 The impairment in animal health due to the zoonoses and FMD encompasses the spectrum of underproductivity, infertility, abortion, and death. It was estimated in a study conducted by FAO/WHO/OIE that a loss in productivity of up to 40 per cent is sustained by countries with limited animal health programs due to diseases which include the zoonoses and FMD.

2. Economic Losses

2.1 The socioeconomic losses from the zoonoses in terms of human lives and suffering and from FMD by exacerbating the problem of malnutrition, are indeed significant, but difficult to quantify since, despite breakthroughs in technology and the application of economic theories, no mathematical equation or theoretical model has yet been developed that could predict the value of human lives and suffering. For instance, some 175,000 persons, mostly children between the ages of 1-7 and 8-14 years, annually undergo medical treatment for rabies, resulting in millions of man/hours work loss, while at least 300 persons die of the disease each year. In endemic areas, as high as 84.3 per 100,000 population have hydatidosis. Losses attributable solely to hospitalization of humans in these countries where the disease is prevalent are estimated at more than US$500,000 per year.

2.2 Losses related to animal diseases are easier to quantify than those due to human diseases, but there are many problems associated with the development of meaningful data on their social and economic impact for use as bases in policy decisions on resource allocation in development programs. The reasons for these are, inter alia, a dearth of accurate epidemiological data for many diseases, particularly in developing countries where the need for information is greatest; the limited experience in socioeconomic analysis for animal health programs; and the fact that most estimates assume a nonexistent perfect market.

2.3 Most meaningful data available on monetary losses from animal diseases relate to the developed countries. In developing countries, data are based on various rough estimates due to the lack of adequate data collection systems and inconsistencies in data reporting.

2.4 The estimated annual monetary losses from some zoonoses and FMD have been calculated at between several hundred thousands and millions of dollars. For instance:

	Disease	Annual Monetary Losses	Geographic Area
1.	Rabies (bovine)	US$ 50,000,000[1]/	Latin America
2.	Brucellosis (bovine)	25,000,000[2]/	U.S.A.
	" "	230,000,000[3]/	11 Latin American Countries
	" "	600,000,000[4]/	Latin America & Caribbean
	" "	100,000,000[5]/	Latin America & Caribbean
3.	Tuberculosis (bovine)	500,000*[6]/	South America
4.	Hydatidosis (human)	400,000,000[7]/	South America
5.	Foot-and mouth disease	600,000,000[8]/	Europe
	" " "	25,000,000[9]/	Brazil
	" " "	25,000,000[10]/	Philippines
	" " "	339,622,641[11]/	Great Britain
	" " "	12,000,000,000**[12]/	U.S.A.
	" " "	724,000,000***[13]/	Canada
6.	Cysticercosis (porcine)	67,787,250[14]/	Latin America
7.	Cysticercosis (bovine)	500,000 to 3,000,000[15]/	U.S.A. and various countries
8.	Fasciolasis (bovine)	98,076,923[16]/	Netherlands
	" "	112,359,550[17]/	France
9.	Mastitis (bovine)	600,000,000[18]/	U.S.A.
	" "	242,937[19]/	Ceylon

* Estimated annual cost of hospitalization alone in three countries where hydatidosis is prevalent.

** Projected losses in case the disease is introduced.

*** Includes direct and consequential losses due to one-year suspension of livestock trade. Actual administrative and compensation cost of eradication of the 1952 outbreak was US$1,000,000.

3. Economic Benefits of Control and Eradication Programs

3.1 The economic benefits of investments in zoonoses and FMD control programs have been shown to be highly profitable from the standpoint of return on investment. Again, the most meaningful available data relate to developed countries. In general, cost-benefit analysis of alternative programs versus no program is the method applied in measuring the profitability of investing money to finance animal disease control activities. The C/B ratio gives the net benefit (or loss) per dollar invested. In addition, the Internal Rate of Return (IRR) and Net Present Value (NPV) are also used in ranking various alternative policies in terms of their economic profitability.

3.2 The following are C/B ratios obtained from selected zoonoses and FMD control programs:

Disease	C/B Ratio	Country
1. Brucellosis (bovine)	1:5 to 8[12/]	U.S.A.
"	1:6 to 140[5/]	Latin America
2. Bovine tuberculosis	1:4[12/]	U.S.A.
3. Mastitis (bovine)	1:4[12/]	U.S.A.
4. Foot-and-mouth disease	1:4[9/]	Philippines
" " "	1:20-121[12/]	U.S.A.
" " "	1:14[9/]	Chile

3.3 Studies in Paraguay demonstrated that brucellosis, tuberculosis and bovine rabies control programs showed IRR's of 71%, 52%, and 84%, respectively, and that the overall national animal health program netted an IRR of 70 per cent.

3.4 In order to obtain more precise information on economic losses from animal diseases, PAHO/WHO, through PANAFTOSA, is undertaking a 3-year study on losses in cattle production and productivity due to FMD. Funds have been provided by the Inter-American Development Bank and the Government of Brazil. The investigations are being carried out jointly by veterinarians, economists and statisticians in order to obtain more meaningful information on economic losses, especially in developing countries.

3.5 The zoonoses and foot-and-mouth disease stunt the economic growth of the countries and the generation of needed capital for investments. By undermining animal health, many countries that depend heavily on the export of meat and other animal products are unable to generate the foreign exchange to meet their balance of payments and embark on meaningful social development programs. The opportunity cost loss and the consequential losses sustained by the countries of the Americas from the zoonoses and FMD are inestimable. Import restrictions, export losses, and unfavorable trade relations are but a few of the economic barriers caused by FMD and several of the zoonoses.

II. PAHO/WHO PROGRAM ON TECHNICAL COOPERATION

1. Special Program of Animal Health

1.1 A high priority of the PAHO/WHO program of technical cooperation is to respond to the needs of the countries in the Hemisphere regarding the problem of zoonoses and FMD.

1.2 Through its Special Program of Animal Health, PAHO/WHO provides the necessary technical cooperation in veterinary public health and animal health, which includes the prevention, control and eradication of major zoonoses and animal diseases of economic importance, such as rabies, brucellosis, tuberculosis, leptospirosis, cysticercosis, hydatidosis, the equine encephalitides, food-borne infections and intoxications, FMD, and vesicular diseases of animals.

1.3 Administratively, the Special Program is directly under the Director of PAHO/WHO, and has an expert human resource complement of some 105 professionals. It has in execution about 50 technical cooperation projects, of which 10 are regional and 40 are national.

2. International Centers for Animal Health

2.1 As part of its overall program of technical cooperation, PAHO/WHO has two international centers for animal health that provide support to the countries in the Hemisphere: the Pan American Zoonoses Center (CEPANZO), located in Argentina, and the Pan American Foot-and-Mouth Disease Center (PANAFTOSA), located in Brazil. The origin of these centers, like that of the other Pan American centers, stemmed from the basic recognition by the countries that a public health problem common to all of them could be addressed more effectively through a concentrated approach, with the centers serving as the focal point.

2.2 The primary goal of CEPANZO is to improve the control of diseases transmissible between animals and humans. PANAFTOSA, on the other hand, aims to eliminate FMD where it exists and to prevent its introduction into free areas.

2.3 It is through CEPANZO and PANAFTOSA that most field support to the technical cooperation program is carried out. Together, the two international animal health centers provide the link of activities in research, training, epidemiological surveillance and field control.

2.4 Since their inception, PANAFTOSA and CEPANZO have made an indelible contribution to the improvement of human health and socio-economic development in the Region. Among their significant contributions are the development of the new oil-adjuvanted vaccine against FMD, which provides better and longer periods of immunity and significantly reduces the cost of vaccination by more than 50 per cent; development of a highly effective and sensitive epidemiological surveillance system for FMD which enables the exact geographical pinpointing of any outbreak; development and improvement of the arc-5 method for more specific diagnosis of human hydatidosis, saving millions of dollars in unnecessary surgery; eradication of FMD in Chile, and successful control in many countries, thereby significantly reducing losses in meat and milk; the refinement and mass production of the suckling mouse brain rabies vaccine which altogether eliminates the irreversible vaccination accidents in humans following the use of the classical nervous tissue vaccine, and many others.

2.5 The technologies for all these new developments were effectively transferred to the countries through the extensive training programs conducted by the Centers, thus enabling each country to obtain the necessary technical capabilities to apply them to their respective national programs.

2.6 The significant contributions of CEPANZO and PANAFTOSA to both health and socioeconomic development of the countries of the Region have attracted worldwide attention, so much so that the World Health Organization is now attempting to establish similar centers in animal health in the other regions. Recently, the WHO Regional Office for the Eastern Mediterranean launched the Mediterranean Zoonoses Control Program in Athens, which was patterned after CEPANZO. Other similar programs are planned in the near future for the South-East Asian and Western Pacific Regions.

2.7 Effective control of zoonoses and foot-and-mouth disease require the full participation by all countries in the Region. For instance, the evaluation of the Ten-Year Health Plan for the Americas revealed that programs of varying effectiveness are carried out in only 15 countries and are planned in five others. Four countries lack control programs. The present situation requires a full-scale coordinated effort to overcome partial successes and to achieve significant permanent gains.

Many countries limit their efforts to certain zoonoses, e.g., rabies control, while the disease remains endemic in neighboring countries, posing a continuous threat of reintroduction. At present, coordination between the ministries of health and agriculture is considered satisfactory in only six of the 21 countries.

3. Need for Incremental Support

3.1 PAHO/WHO has established an infrastructure for technical cooperation in the control of zoonoses and FMD in the Hemisphere. PANAFTOSA and CEPANZO serve as the only reference laboratories in Latin America and the Caribbean for rabies, brucellosis, tuberculosis, hydatidosis, leptospirosis and FMD. In addition, CEPANZO serves as the only reference center in Latin America for BCG vaccine in humans, and is one of the few laboratories in the world working on human hydatidosis.

3.2 In order to achieve significant progress on a regional scale, maintain an effective level of implementation, and provide a sustained and continuing support to the program, additional resources are needed to supplement the contributions of the countries and PAHO/WHO.

III. PRIMARY HEALTH CARE (PHC) APPROACH

1. PHC and HFA/2000

1.1 Bearing in mind the concept of primary health care which will provide the fundamental basis for achieving the goal of health for all by the year 2000, this project aims to provide a unique opportunity of operationalizing its principles.

1.2 Intersectoral Collaboration. By the very nature of the zoonoses and the other animal diseases with human health and economic implications, their prevention and control require an intersectoral effort, especially between agriculture and health.

1.3 Use of Appropriate Technology. The technology needed to combat the zoonoses and FMD exist in most cases, and could be appropriately adapted to individual problems, depending on local epidemiologic patterns and available resources.

1.4 Technical Cooperation Among Countries. Some countries have successful control programs for zoonoses and FMD while others with similar problems and the same level of development have not. Technical cooperation among these countries will be promoted by drawing on their resources and successful experience.

1.5 Community Participation. Meaningful prevention of most of the zoonoses, such as rabies, leptospirosis, and food-borne diseases, could only be achieved by embarking on strong programs of community participation.

1.6 In primary health care recognition is given to the fact that health cannot be attained by the health sector alone. In developing countries in particular, economic development, anti-poverty measures, food production, water, sanitation, housing, environmental protection, and education all contribute to health, and have the same goal of human development. This project will attempt to operationalize the coordination at all levels between agriculture, health and the other sectors concerned in controlling the zoonoses and FMD.

IV. BACKGROUND INFORMATION AND PROJECT OBJECTIVES

1. It is envisioned that this project will provide an opportunity to build, on a modest scale, a successful program that will contribute directly to the socioeconomic development of the countries of Latin America and the Caribbean and to a significant improvement in human health.

2. General Objectives

2.1 Reduction in the prevalence of the major zoonoses in the Region;

2.2 Expansion of areas now free of them;

2.3 Support of existing programs; and

2.4 Increase in the supply and availability of protein of animal origin to improve human nutrition.

3. The Governments of the countries of the Americas have requested PAHO/WHO assistance in dealing with the following:

3.1 Rabies

3.2 Brucellosis

3.3 Tuberculosis

3.4 Hydatidosis

3.5 Leptospirosis

3.6 Food-borne infections and intoxications

3.7 Equine encephalitides

3.8 Foot-and-mouth disease.

4. Rabies

4.1 Despite successful efforts in some countries, rabies remains a problem in the Region. In North America, the incidence is low and limited to sylvatic and rural areas, rarely affecting humans. In Latin America, however, dog rabies continues to be widespread due to lack of a comprehensive regional and national control program. Some progress has been made in controlling the disease in a few countries, but even these gains are in jeopardy due to the continuous threat of introduction and spread from infected areas.

It is expected that the problem of rabies will be further compounded by the projected increase in urbanization.

4.2 Between 1977 and 1979, the reported incidence ranged between 0 and 793 cases per 100,000 dogs in the major cities. Annual averages in Latin America and the Caribbean in the decade of the '70s include more than 15,000 cases of dog rabies, more than 120,000 persons bitten by dogs and cats, and almost 175,000 post-exposure treatments resulting in millions of man/hours work loss. A total of more than 40,000 cases of bovine rabies were reported between 1970 and 1978, or an annual average of some 4,500 cases. In the 4-year period 1973-1976, 1,093 cases of human rabies were reported, or an average of 273 cases per year. This figure is just 10 cases fewer than the average for the previous 4-year period. The average annual number of human rabies cases for the decade in the Region was 300.

4.3 The number of dogs vaccinated against rabies in each of the country's large cities failed to reach the goal of 80 per cent, although three countries (Argentina, Brazil, and Colombia) came fairly close. The level of vaccination ranged from 1 to 75 per cent, with a median of 35 per cent, which is not sufficient to interrupt disease transmission. Control of stray dogs in large cities has not been successful. Figures from 10 countries reported between 7 and 60 per cent, or a median of 20 per cent.

4.4 Although wildlife populations, e.g., mongoose and vampire bats, serve as reservoirs of infection in some countries, human exposure almost always results from dog bites.

4.5 Rabies is a disease of antiquity. It is one of the most dreadful illnesses, causing immeasurable human anguish, anxiety, and suffering. The technology to prevent, control, and even eradicate this zoonoses exists. What is needed is additional and sustained support to carry out the program to completion.

4.6 Specific Objectives

4.6.1 Control and eventual eradication in the principal cities and communities of the Region;

4.6.2 Vaccination of at least 80 per cent of the dog population;

4.6.3 Control and/or elimination of stray dogs; and

4.6.4 Reduction of the sylvatic animal population in countries where it acts as a reservoir of infection.

5. Brucellosis

5.1 Brucellosis is widespread in animals and humans throughout Latin America and the Caribbean. It is conservatively estimated that in the Latin American countries brucellosis causes an annual economic loss of millions of dollars, with more than 3,000 human cases reported for 1977 alone. The actual number of human cases is perhaps 5-10 times more, due to inadequate reporting and lack of adequate laboratories for diagnostic confirmation of cases.

5.2 The economic benefits of investment directed at brucellosis prevention and control have been shown to be high. Cost-benefit ratios derived from such investments range between 1:6 and 1:140, depending upon conditions prevailing in a particular country. This means that for every dollar spent for control, a net benefit of $6-140 can be expected.

5.3 As reported in the initial evaluation of the Ten-Year Health Plan, 11 of the 15 countries that responded had patterned their national goals on the regional goals. A general downward trend is evident in the rates of prevalence, but not to the extent projected. Only 2 of 16 countries came close to or achieved the regional goals.

5.4 Brucellosis causes abortion, infertility, and underproductivity in animals, and at the same time is an important occupational human illness.

5.5 The technology exists to control and eradicate bovine brucellosis, a disease that not only causes human illness but undermines meat and milk production, vital for correcting the problem of malnutrition in the Region. Some countries, Jamaica for instance, are now in the final stages of eradicating brucellosis. Given adequate support and momentum, the objective of brucellosis eradication in the Region remains feasible and achievable.

5.6 Specific Objectives

5.6.1 Eradication in countries where national prevalence is 1 per cent or less; and

5.6.2 Control and reduction of prevalence to below 2 per cent in countries where brucellosis is a problem.

6. Tuberculosis

6.1 Bovine tuberculosis continues to be widespread in Latin America and the Caribbean. In certain areas, about 5 per cent of cattle show lesions on slaughter, resulting in the condemnation of hundreds of tons of meat each year. Some 3 per cent of human tuberculosis in one area surveyed revealed it to be caused by the bovine type of tuberculosis bacillus. It is estimated that the total direct economic losses from bovine tuberculosis in the Americas, excluding the cost of control programs, amount to some US$100 million per year.

6.2 In the first evaluation of the Ten-Year Health Plan, 15 of the 22 countries expressed concern over the problem of bovine tuberculosis; the reported prevalence ranged from 0.1 to 14.6 per cent. Judging from the response of the 16 countries that recognized the existence of this problem, the goals set forth were not met, except in one country. Bovine tuberculosis remains prevalent in most of these countries, albeit to a lesser extent. In six of the countries that reported its presence the prevalence exceeded 1 per cent; in the remaining 10, it was below 1 per cent.

6.3 The technology exists to control and eradicate bovine tuberculosis. Eradication is the economically feasible option for countries with a prevalence rate of 1 per cent or less. Some countries, like Jamaica, are now in the final stages of eradication after less than five years of sustained efforts. With technical cooperation from PAHO/WHO, and UNDP funding, the overall incidence has been reduced by more than 80 per cent to a level of 0.01 per cent, with only one infected herd remaining in the whole country.

6.4 Aside from causing human illness, bovine tuberculosis undermines meat and milk production, essential in correcting the problem of malnutrition in the Region.

6.5 Specific Objectives

6.5.1 Eradication in countries where the national prevalence is 1 per cent or less; and

6.5.2 Control and reduction of prevalence to below 1 per cent in countries where bovine tuberculosis is a problem.

7. Hydatidosis

7.1 Hydatidosis is a serious human illness in southern Latin America. Surgery remains the only recourse for the hundreds of human cases which occur each year. Hundreds of tons of liver from infected animals are condemned annually. In 1977 alone, some 1,000 human cases were diagnosed.

7.2 There has been little response from the countries concerning the problem of hydatidosis. Nevertheless, it is known to exist to a marked degree in South America, where an annual average of some 1,316 human cases was reported over the 4-year period 1973-1976. These cases were diagnosed primarily in Argentina, Uruguay, Chile and Peru. Only five countries reported the prevalence of this parasite in animals in 1977. In only one of these countries was there an appreciable decline in the level of infection from that at the start of the decade.

7.3 CEPANZO, in Argentina, is one of only a handful of reference laboratories throughout the world, and the only center of PAHO/WHO working on this serious human illness. There is need to continue working on hydatidosis, in the provision of diagnostic services, training, and research activities dealing with control programs and immunodiagnosis.

7.4 Specific Objectives

7.4.1 Reduction in the prevalence of infection; and

7.4.2 Control and supervision of all slaughterhouses and places, both public and private, where food animals are slaughtered.

8. Leptospirosis

8.1 Leptospirosis is a zoonoses whose importance is underestimated due to the nature of the illness it causes and the lack of diagnostic capabilities in many countries. In most instances, leptospirosis is diagnosed as some kind of febrile illness of unknown etiology. Work on this disease has been confined to the laboratory, and no field operations of any significance are being pursued.

8.2 Leptospirosis appears to be a significant health problem in the Americas, in particular in the Caribbean, for both humans and animals. It has almost always been shown to be an underlying zoonotic problem whenever and wherever attempts have been made to diagnose the disease. It is an important occupational health hazard among those whose occupation brings them in close contact with water contaminated with animal urine, such as the sugarcane farmers in Jamaica.

8.3 Human leptospirosis averages 122 cases per year, as reported between 1971-1976. Fifty-four per cent of these cases were reported from North America, and 46 per cent from the islands of and around the Caribbean. Some of these countries also reported the infection in animals. Rodents, such as the mongoose, serve as a reservoir of infection in some of the islands of the Caribbean.

8.4 Little progress has been made in obtaining better information about the problem of leptospirosis and thus in evaluating its scope and magnitude.

8.5 Specific Objectives

8.5.1 Evaluation of the nature, scope and magnitude of the problem; and

8.5.2 Prevention and control of infection in humans and in economically important animals.

9. Food-borne Infections and Intoxications

9.1 Thousands of cases of food-borne infections occur in Latin America and the Caribbean annually. The diarrheas, largely caused by this group of infections, are the major cause of morbidity and mortality in infants and children.

9.2 Foods of animal origin constitute a significant proportion of the cause of food-borne illnesses. Awareness of the microbiological hazards arising from the consumption of contaminated and infected food has grown in recent years, resulting in the intensification of national and international food hygiene programs.

9.3 Food protection serves a dual purpose: to protect the health of the consumer and to prevent food losses due to mishandling. Most countries have no national policy for food protection, especially programs for inspection of meat and other foods of animal origin. These foods serve as important vehicles for such zoonoses as salmonellosis, Clostridium infection and intoxication, and staphylococcal food poisoning.

9.4 Specific Objectives

9.4.1 Reduction of human illness and economic losses caused by infected and contaminated foods of animal origin; and

9.4.2 Development of national intersectoral food protection programs that encompass all critical points from production to distribution, with special reference to foods of animal origin.

10. Equine Encephalitides

10.1 The sporadic outbreaks of equine encephalitides pose serious problems to both humans and animals in the Region. Little is known of the precise extent and magnitude of the problem. In 1977, only three countries submitted information on the prevalence of equine encephalitides. Venezuela, Cuba, and the Dominican Republic reported 45, 23, and 1 cases per 1,000 horses, respectively. These figures signify a decrease from 1971, but there is no way of assessing the actual trends in the other countries because of lack of information.

10.2 None of the countries where equine encephalitides is endemic achieved the recommended goal of vaccinating 80 per cent of the equine population.

10.3 Specific Objectives

10.3.1 Evaluation of the scope, nature and magnitude of the problem; and

10.3.2 Periodic vaccination of at least 80 per cent of the equine population in known endemic areas.

11. Foot-and-Mouth Disease and Other Vesicular Animal Diseases

11.1 PAHO/WHO assistance has been requested by all the countries of the Region in dealing with FMD, an important animal disease (which may occasionally cause human infection) that causes severe economic losses and livestock underproductivity. Livestock plays a central role in the economy of several countries of the Americas. Foot-and-mouth disease is a continuous deterrent to the development of the livestock industry and trade, both regional and international, and contributes significantly to the level of availability of animal protein for human nutrition.

11.2 Despite efforts to confront this disease, FMD remains endemic in most of South America.

11.3 Due to measures instituted by the countries, in cooperation with PAHO/WHO, North America, Central America and the Caribbean continues to be free of FMD, but the threat of introduction persists. For instance, FMD was introduced into Canada in 1952 and Mexico in 1954, causing tragic economic consequences. The Government of Canada spent US$1 million in administrative and compensation costs to eradicate the outbreak. But the overall loss, including a one-year suspension of livestock trade following the outbreak, was estimated at US$724 million.

11.4 The United States of America has been free of FMD since 1929. It has been estimated by the United States Department of Agriculture that a projected loss of US$12 billion would be incurred should FMD accidentally enter the continental U.S.A.

11.5 Chile, with PAHO/WHO technical cooperation, successfully eradicated FMD and was officially declared free of the disease on 16 January 1981. Paraguay has reported that 85 per cent of its territory is now free of FMD.

11.6 Through PANAFTOSA, PAHO/WHO provides support to national control programs in South America, where a large percentage of the cattle population has been systematically vaccinated against foot-and-mouth disease during the past few years.

11.7 The problems of vaccine potency and duration of immunity have caused some setbacks to what otherwise would have been a successful program. PANAFTOSA recently developed a new oil-adjuvanted vaccine which provides a better and longer-lasting immunity. Cost-wise, FMD oil-adjuvanted vaccine cuts the cost of administration alone by more than 50 per cent.

11.8 The effective transfer of technology for the production of the new FMD oil-adjuvanted vaccine is now being provided to the countries of the Region for use in their national programs. The new FMD oil-adjuvanted vaccine will greatly enhance the effectiveness of national field control and eradication programs, while at the same time reducing their cost. So far, the new vaccine has had wide acceptance among the countries of the Region. In order to expand its production and application, and thus ensure eventual eradication of FMD in the Region, additional support is needed to set-up and carry out a comprehensive eradication program to its successful completion.

11.9 At present, the FMD virus poses a continuous threat of introduction and spread into FMD-free areas of the Region due to contiguity and large-scale movements of humans and animals. Countries free of FMD have to spend millions of dollars to keep it out, while animal health restrictions limit the trade of animal products and cause losses in the millions of dollars.

11.10 Specific Objectives

11.10.1 Reduction in the prevalence to 1 per cent or less, and eradication in countries where the incidence is sporadic; and

11.10.2 Prevention of introduction into FMD-free areas.

V. PROPOSED PROJECT APPROACH

1. This project will attempt to address the problem of the zoonoses and FMD in the Region in a comprehensive, coordinated, and sustained fashion. It will be built upon the infrastructure of the PAHO/WHO program for technical cooperation in animal health and veterinary public health and the intrastructure for animal health services of the countries.

2. Where there are existing programs for zoonoses and FMD control, coverage will be expanded and support activities will be fortified. When there are none, programs will be developed and implemented. The general approach will be to mount well-planned, tightly coordinated, integrated national programs aimed at all the major zoonoses and FMD. Activities will be stimulated at all levels, from program planning to field implementation and program evaluation. Given the necessary incremental support, the activities will be maintained at an efficient and effective level.

3. Programs for the prevention, control and eradication of FMD will be consolidated. At the same time, studies on the characterization of vesicular disease will be intensified. Prevention activities will be expanded to include other exotic animal diseases in the Continent. The FMD control program for South America will be restructured. Programs in the control phase will be accelerated to achieve complete eradication in countries such as Peru and Uruguay and in areas of some other countries, such as the eastern part of Argentina, southern Brazil, northern Paraguay, and the northwestern region of Colombia. It will be necessary to strengthen and expand integrated programs in countries that share common epidemiologic profiles, within the process of national characterization of FMD initiated earlier.

4. The element of time is central to any strategic financial gains that would accrue from disease control and/or eradication programs. Aggregate financial gains realized from prolonged programs are generally discounted away. Long drawn-out programs usually end up in complacency, and a waning of government and public support and interest. Furthermore, capital tied up in short programs is quickly released, freeing it for investment in other programs. This project will have a time frame of five years. Previous experiences have shown that disease control and/or eradication programs planned within this time period provide the necessary sustained momentum, interject a sense of urgency, and maximize economic benefit.

5. In order to meet the needs of the underserved population and thus extend program coverage, this project will be developed along the following lines:

5.1 Improvement of existing systems rather than development of an entirely new infrastructure and facilities;

5.2 More realistic assessment of the human, technical and material resources available in the country and the community; and

5.3 Research efforts directed towards development of appropriate technology for each situation based on already existing methodology.

6. This project will provide the incremental support necessary to maintain the PAHO/WHO technical cooperation program in animal health and veterinary public health at an efficient level and to carry out the activities needed by the countries of the Region to control, and ultimately eradicate, the major zoonoses and FMD. This project will include:

6.1 Training and development of human resources;

6.2 Strengthening of laboratory support and diagnostic capabilities;

6.3 Strengthening of field control activities;

6.4 Epidemiological surveillance; and

6.5 Research.

7. The institutional development and infrastructure strengthening approach will be utilized as the basis for elaborating the project activities, which will include:

7.1 Development and improvement of laboratory diagnostic capabilities;

7.2 Production and control of vaccines and biologicals;

7.3 Planning, organization and evaluation of field control programs;

7.4 Strengthening of programs to prevent introduction of exotic animal diseases and development of a contingency plan of emergency mobilization for their containment and eradication; and

7.5 Development of national programs for protection of meat and other foods of animal origin.

8. The project activities will be planned and executed to support the following specific areas of action:

8.1 Rabies prevention/control;

8.2 Brucellosis control/eradication;

8.3 Tuberculosis control/eradication;

8.4 Hydatidosis prevention and control/eradication;

8.5 Leptospirosis epidemiological surveillance, prevention and control;

8.6 Prevention and control of food-borne infections and intoxications;

8.7 Equine encephalitides surveillance and control; and

8.8 Surveillance and control of FMD and other vesicular diseases.

A uniform, comprehensive strategy with an accompanying plan of action based on the above framework will be developed with each of the countries in order to deal with individual national priorities. Accordingly, this will be developed around the existing national infrastructure for animal health and veterinary public health, bearing in mind the principles laid out earlier in the concept of primary health care.

9. In the past, the tendency has been to support projects or activities which dealt with specific zoonoses problems and had short-term objectives. While some benefits were derived using this approach, the problems reverted back to their original level once support was withdrawn. It has been shown that in order to achieve significant gains in any disease control program it is necessary to provide sustained financial and technical support over a period of years.

10. The strategies for the control of the different zoonoses and FMD are inextricably interrelated and complementary. The infrastructure corresponds to the animal health services that exist in the countries. Common laboratory equipment and facilities could be strengthened and developed to support the different specific areas of action. For instance, a rabies or FMD diagnostic laboratory could be expanded to cover the diagnosis of other viral animal diseases, at present inadequate in most countries in Latin America and the Caribbean. The same human resources base that has been trained in the concepts of preventive medicine and the principles of disease control could be utilized in different program areas. With proper coordination and planning, field control

programs could be addressed simultaneously to different problems, for instance, tuberculosis and brucellosis testing, leptospirosis surveillance, and vaccination against major diseases could be achieved in a single field operation using the same personnel and physical resources.

11. Well-planned and efficiently executed medium-term programs envisioned to provide sustained support for the solution of problems associated with a group of diseases with broad social and economic implications will normally have a greater impact on development. While the initial investment may seem sizeable, the long-term social and economic benefits are greater due to more significant gains, in this case improved livestock productivity, increased production of foods of animal origin, an increase in exports and a corollary decrease in food imports, expansion of the animal industry, and a concomitant increase in employment opportunities in this sector.

12. Human resources development and strengthening of the institutional infrastructure in animal health and veterinary public health, in addition to the control and eradication of the major zoonoses and FMD, will be the ultimate result of this project. Consequently, the financial investments will be significantly translated into meaningful national development, which would be effectively absorbed by the countries towards the end of the project. On the one hand, the social and economic losses from the zoonoses will be significantly reduced, barring unforeseen circumstances; on the other, each of the countries will have improved animal programs and an adequately trained pool of human resources.

13. One of the direct benefits of this project will be the reduction of losses in food animal productivity and the consequent availability of animal protein such as meat, milk and eggs. Assuming that there will be an effective program of social intervention that will ensure a more equitable distribution of animal protein among the highly vulnerable, socially and economically disadvantaged segment of the population, an immediate human health benefit of this project will be the amelioration of human malnutrition, which is one of the most important problems confronting the world today.

VI. PROJECT ACTIVITIES

1. Training and Human Resources Development

Conduct local, national and regional training courses, seminars and workshops; provide individual fellowships

1.1 Training in laboratory diagnostic methods:

1.1.1 Rabies

1.1.2 Tuberculosis

1.1.3 Leptospirosis

1.1.4 Food-borne infections and intoxications

1.1.5 Equine encephalitides

1.1.6 Foot-and-mouth disease

1.1.7 Other viral diseases

1.2 Training in the production and control of vaccines:

1.2.1 Rabies

1.2.2 Brucellosis

1.2.3 Equine encephalitides

1.2.4 Foot-and-mouth disease

1.2.5 Other diseases

1.3 Training in the production and standardization of diagnostic reagents:

1.3.1 Rabies

1.3.2 Brucellosis

1.3.3 Tuberculosis

1.3.4 Leptospirosis

1.3.5 Hydatidosis

1.3.6 Other diseases

1.4 Training in the planning, organization, execution, management and evaluation of field control programs:

1.4.1 Urban and sylvatic rabies

1.4.2 Brucellosis

1.4.3 Tuberculosis

1.4.4 Hydatidosis

1.4.5 Foot-and-mouth disease

1.4.6 Leptospirosis

1.4.7 Equine encephalitides

1.4.8 Other diseases

1.5 Training in the methods of prevention of entry of exotic animal diseases, and eradication procedures (in case of introduction)

1.6 Training in the control of rodents, dogs, and other stray animals

1.7 Training in epidemiological surveillance

1.8 Training in food protection and food control

1.8.1 Meat inspection

1.8.2 Slaughterhouse management and operation

1.8.3 Food microbiology

2. Strengthening of Laboratory Diagnostic and Support Services

2.1 Provide technical cooperation in the establishment and strengthening of laboratory diagnostic capabilities:

2.1.1 Rabies

2.1.2 Brucellosis

2.1.3 Tuberculosis

2.1.4 Leptospirosis

2.1.5 Hydatidosis

2.1.6 Food-borne infections and intoxications

2.1.7 Equine encephalitides

2.1.8 Foot-and-mouth disease

2.2 Provide technical cooperation in the establishment and development of laboratories for vaccine production and control:

2.2.1 Rabies

2.2.2 Brucellosis

2.2.3 Equine encephalitides

2.2.4 Foot-and-mouth disease

2.2.5 Other diseases

2.3 Provide technical cooperation in the establishment and development of laboratories for production and standardization of diagnostic reagents:

2.3.1 Rabies

2.3.2 Brucellosis

2.3.3 Tuberculosis

2.3.4 Leptospirosis

2.3.5 Hydatidosis

2.3.6 Other diseases

2.4 Provide technical cooperation in the development and strengthening of laboratory support services for food protection programs:

2.4.1 Laboratory control of quality

2.4.2 Food microbiology

2.4.3 Monitoring of toxic chemical and antibiotic residues

2.4.4 Establishment of baseline laboratory standards for foods of animal origin

3. Strengthening of Field Control Services

3.1 Provide technical cooperation in the planning, organization, execution, management, and evaluation of field control/eradication programs:

3.1.1 Rabies

3.1.2 Brucellosis

3.1.3 Tuberculosis

3.1.4 Leptospirosis

3.1.5 Hydatidosis

3.1.6 Equine encephalitides

3.2 Provide technical cooperation in generating community participation and mobilizing local resources to support field control activities:

3.2.1 Organization of community-based rodent control programs

3.2.2 Organization of community-based stray dog control and mass antirabies vaccination programs

3.3 Provide technical cooperation in the development of national and regional emergency animal disease preparedness plans:

3.3.1 Strengthening of programs to prevent introduction of exotic animal diseases

3.3.2 Development of a contingency plan for emergency mobilization in the containment and eradication of exotic animal diseases, in case of introduction

3.4 Provide technical cooperation for development of food protection and control programs, with emphasis on foods of animal origin:

3.4.1 Jointly with other sectors catalyze the organization of national intersectoral committees or commissions for food protection

3.4.2 Develop policies and enactment of legislation for food protection and control

3.4.3 Develop uniform guidelines for meat inspection and protection and the processing of foods of animal origin, using appropriate technology

3.4.4 Develop facilities for the hygienic slaughtering of food animals and processing of foods of animal origin

3.4.5 Extend the coverage of food protection programs for the highly vulnerable and socially disadvantaged segments of urban and rural populations through development of small-scale cooperative and integrated programs, e.g., cooperative production, slaughtering and processing of small food animal species, and cooperative production, processing and handling of milk.

4. Epidemiological Surveillance

4.1 Provide technical cooperation in the development and strengthening of the national and regional infrastructure for zoonoses and FMD reporting and monitoring:

4.1.1 Develop a network of information systems

4.1.2 Promote effective use of valid information for planning and evaluation of field control programs

4.1.3 Develop farmer and community-based systems of disease notification and reporting

5. Research

5.1 Provide technical cooperation in the conduct of field investigations:

5.1.1 Studies on economic losses from zoonoses and FMD

5.1.2 Development of appropriate technology for control and eradication

5.1.3 Sociocultural determinants for effective community participation in zoonoses and FMD control programs

5.1.4 Investigation in alternative control strategies, e.g., production of ovicidal drugs for hydatidosis, ecological studies and behavior of urban dogs, relationship between urban and wildlife rabies, etc.

VII. PROPOSED BUDGET*

PROGRAMS

PROJECT ACTIVITIES	RABIES	BRUCELLOSIS	TUBER-CULOSIS	LEPTOS-PIROSIS	HYDATI-DOSIS	FOOD-BORNE INF. & INTOX.	EQUINE ENCE-PHALITIDES	FMD	TOTAL
1. Training and Human Resources Development.									
1.1 Individual Fellowships.	107,700	107,700	107,700	107,700	107,700	107,700	107,700	107,700	861,600
1.2 National and Regional Training Courses, Seminars, Workshops.	107,700	107,700	107,700	107,700	107,700	107,700	107,700	107,700	861,600
2. Strengthening of Laboratory Support and Diagnostic Services.									
2.1 Equipment	100,000	60,000	60,000	60,000	50,000	100,000	50,000	100,000	580,000
2.2 Supplies and Materials	100,000	30,000	30,000	60,000	100,000	50,000	60,000	60,000	490,000
2.3 Personnel									
2.3.1 Experts	666,000	668,100	-	339,300	668,100	-	-	-	2,341,500
2.3.2 Support Staff	679,500	679,500	226,500	679,500	1,132,500	679,500	453,000	679,500	5,209,500
2.3.3 Short-Term Consultants	-	-	293,800	-	-	-	-	-	293,800
3. Strengthening of Field Control Services.									
3.1 Equipment	50,000	20,000	25,000	25,000	25,000	25,000	25,000	25,000	220,000
3.2 Supplies and Materials	70,000	10,000	10,000	20,000	25,000	25,000	20,000	20,000	200,000
3.3 Travel	61,050	40,000	25,000	40,000	40,000	70,000	30,000	70,000	376,050
3.4 Experts	1,846,600	352,500	668,200	339,300	330,600	1,688,600	497,200	2,407,100	8,130,200
4. Epidemiologic Surveillance									
4.1 Equipment	50,000	20,000	25,000	25,000	25,000	25,000	25,000	25,000	220,000
4.2 Supplies and Materials	80,000	10,000	10,000	20,000	25,000	25,000	20,000	20,000	210,000
4.3 Publications	25,000	7,500	7,500	10,000	10,000	10,000	10,000	10,000	90,000
4.4 Travel	61,050	33,100	25,000	33,300	33,300	80,000	30,000	80,000	375,750
TOTAL	$4,004,600	$2,146,100	$1,621,400	$1,866,800	$2,679,900	$2,993,500	$1,435,600	$3,712,000	$20,459,900

* Rough estimates of total costs only covering a period of 5 years. Does not include project support cost. Break-down of budget by program, by year and by elements is reflected in specific program cost estimates.

PROGRAM: RABIES

PROPOSED BUDGET
(By year, excluding Program Support Cost).

ELEMENT	1982	1983	1984	1985	1986	5-YEAR TOTAL
1. Personnel						
1.1 Expert *	426,400	464,300	500,600	541,000	580,300	2,512,600
1.2 Support Staff **	110,700	123,300	135,900	148,500	161,100	679,500
2. Training						
2.1 Individual Fellowship	-	22,500	25,200	28,500	31,500	107,700
2.2 Group Training (Courses, Seminars, Workshops).	-	35,000	35,900	36,800	-	107,700
3. Travel	20,000	22,000	24,200	26,600	29,300	122,100
4. Equipment ***	-	100,000	50,000	50,000	0	200,000
5. Supplies and Materials****	50,000	50,000	50,000	50,000	50,000	250,000
6. Miscellaneous	5,000	5,000	5,000	5,000	5,000	25,000
TOTAL	612,100	822,100	826,800	886,400	857,200	$4,004,600

* Include 6 experts (P.4), one in each of the 5 areas to coordinate field activities and one in CEPANZO to coordinate the laboratory activities.

** Include 3 laboratory technicians (G.6) to work in vaccine production/quality control and diagnosis.

*** Include FA microscope, laminar flow hoods, ultra-centrifuge, REVCO Deep Freeze, etc.

**** Include supplies for vaccine production and quality control, diagnosis, etc.

PROGRAM: BRUCELLOSIS

PROPOSED BUDGET
(By year, excluding Program Support Cost).

ELEMENT	1982	1983	1984	1985	1986	5-YEAR TOTAL
1. Personnel						
1.1 Expert *	169,200	186,600	204,000	221,400	239,400	1,020,600
1.2 Support Staff **	110,700	123,300	135,900	148,500	161,100	679,500
2. Training						
2.1 Individual Fellowship	-	22,500	25,200	28,500	31,500	107,700
2.2 Group Training (Courses, Seminars, Workshops).	-	35,000	35,900	36,800	-	107,700
3. Travel	12,000	13,000	14,500	16,000	17,600	73,100
4. Equipment ***	-	50,000	25,500	25,000	-	100,000
5. Supplies and Materials****	-	25,000	10,000	10,000	5,000	50,000
6. Miscellaneous	1,500	1,500	1,500	1,500	1,500	7,500
TOTAL	293,400	456,900	452,000	487,700	456,100	2,146,100

* Include 2 experts (P.4), 1 to coordinate field activities and 1 in CEPANZO to coordinate laboratory activities.

** Include 3 Laboratory Technicians (G.6) to work in the production/control of antigen, control vaccine and laboratory diagnostic.

*** Include CO_2 incubators, ultra-centrifuge, laminar flow hoods, Revco deep freeze, microscope, continous flow culture tanks.

**** Syringes, test tubes, CO_2 vials, glass plates, culture media, etc.

PROGRAM: TUBERCULOSIS

PROPOSED BUDGET
(By year, excluding Program Support Cost).

ELEMENT	1982	1983	1984	1985	1986	5-YEAR TOTAL
1. Personnel						
1.1 Expert *	108,400	121,000	133,500	146,100	159,200	668,200
1.2 Support Staff **	36,900	41,100	45,300	49,500	53,700	226,500
1.3 STC	-	54,700	65,700	78,800	94,600	293,800
2. Training						
2.1 Individual Fellowship	-	22,500	25,200	28,500	31,500	107,700
2.2 Group Training (Courses, Seminars, Workshops).	-	35,000	35,900	36,800		107,700
3. Travel	8,000	9,000	10,000	11,000	12,000	50,000
4. Equipment ***	-	38,000	37,000	35,000	-	110,000
5. Supplies and Materials ****	-	25,000	10,000	10,000	5,000	50,000
6. Miscellaneous	1,500	1,500	1,500	1,500	1,500	7,500
TOTAL	154,800	347,800	364,100	397,200	357,500	$1,621,400

* Include 1 full-time expert (P.4) to coordinate field programs, and 24 m/m STC to assist in development and strengthening of national programs.

** Include 1 Laboratory Technician (G.6) to assist in tuberculosis control and standarization, and isolation and typing of strains.

*** Microscopes, incubators, laminar flow-hoods, centrifuge refrigerators, etc.

**** Tuberculin syringes, media, laboratory supplies.

PROGRAM: HYDATIDOSIS

PROPOSED BUDGET
(By year, excluding Program Support Cost).

ELEMENT	1982	1983	1984	1985	1986	5-YEAR TOTAL
1. Personnel						
1.1 Expert *	166,400	183,000	199,600	216,200	233,500	998,700
1.2 Support Staff **	184,500	205,500	226,500	247,500	268,500	1,132,500
2. Training						
2.1 Individual Fellowship	-	22,500	25,200	28,500	31,500	107,700
2.2 Group Training (Courses, Seminars, Workshops).	-	24,600	26,100	27,700	29,300	107,700
3. Travel	12,000	13,200	14,500	16,000	17,600	73,300
4. Equipment ***	-	50,000	25,000	25,000	-	100,000
5. Supplies and Materials ****	50,000	25,000	25,000	25,000	25,000	150,000
6. Miscellaneous	2,000	2,000	2,000	2,000	2,000	10,000
TOTAL	414,900	525,800	543,900	587,900	607,400	$ 2,679,900

* Include 2 full-time experts (P.4) to coordinate field programs.
** Include 5 Laboratory Technicians (G.6) to produce antigens, perform tests, standarize control serum, and collaborate with field activities.
*** Microscopes, steroscopes, centrifuges, refrigerators, vehicles, autoclaves, etc.
**** Centrifuge tubes, taeniciades, wire sieves, rabbits, etc.

PROGRAM: LEPTOSPIROSIS

PROPOSED BUDGET
(By year, excluding Program Support Cost).

ELEMENT	1982	1983	1984	1985	1986	5-YEAR TOTAL
1. Personnel						
1.1 Expert *	119,400	127,300	135,500	143,900	152,500	678,600
1.2 Support Staff **	110,700	123,300	135,900	148,500	161,100	679,500
2. Training						
2.1 Individual Fellowship	-	22,500	25,200	28,500	31,500	107,700
2.2 Group Training (Courses, Seminars, Workshops).	-	24,600	26,100	27,700	29,300	107,700
3. Travel	12,000	13,200	14,500	16,000	17,600	73,300
4. Equipment ***	50,000	15,000	15,000	15,000	15,000	110,000
5. Supplies and Materials****	20,000	20,000	20,000	20,000	20,000	100,000
6. Miscellaneous	2,000	2,000	2,000	2,000	2,000	10,000
TOTAL	314,100	347,900	374,200	401,600	429,000	$ 1,866,800

* Include 2 experts (P.4) to coordinate field activities and 1 to coordinate laboratory activities.

** Include 3 Laboratory Technicians (G.6) to maintain serovars, do diagnostic tests, prepare reference serums and store cultures, etc.

*** Dark field microscope, CO_2 incubators, laminar flow hoods, Revco deep freeze nitrogen bank, etc.

**** Culture media, tubes, laboratory supplies, hamsters, etc.

PROGRAM: FOOD-BORNE INFECTIONS AND INTOXICATIONS

PROPOSED BUDGET
(By year, excluding Program Support Cost).

ELEMENT	1982	1983	1984	1985	1986	5-YEAR TOTAL
1. Personnel						
1.1 Expert *	295,400	316,100	337,500	358,900	380,700	1.688,600
1.2 Support Staff **	110,700	123,300	135,900	148,500	161,100	679,500
2. Training						
2.1 Individual Fellowship	-	22,500	25,200	28,500	31,500	107,700
2.2 Group Training (Courses, Seminars, Workshops).	-	24,600	26,100	27,700	29,300	107,700
3. Travel	20,000	25,000	30,000	35,000	40,000	150,000
4. Equipment ***	50,000	30,000	30,000	20,000	20,000	150,000
5. Supplies and Materials ****	20,000	20,000	20,000	20,000	20,000	100,000
6. Miscellaneous	2,000	2,000	2,000	2,000	2,000	10,000
TOTAL	498,100	563,500	606,700	640,600	684,600	$ 2,993,500

* Include 5 experts (P.4), 1 for each area to coordinate field activities.
** Include 3 Laboratory Technicians (G.6) to assist in providing laboratory support, including isolation of food-borne microorganisms, development of standards, and preparing test antisera.
*** Microscopes, refrigerators, audio-visual equipment, homogenizers, etc.
**** Sample containers, culture media, teaching supplies, petri dishes, mortar and pestles, etc.

PROGRAM: EQUINE ENCEPHALITIDES

PROPOSED BUDGET
(By year, excluding Program Support Cost).

ELEMENT	1982	1983	1984	1985	1986	5-YEAR TOTAL
1. Personnel						
1.1 Expert *	82,300	90,900	99,400	108,000	116,600	497,200
1.2 Support Staff **	73,800	82,200	90,600	99,000	107,400	453,000
2. Training						
2.1 Individual Fellowship	-	22,500	25,200	28,500	31,500	107,700
2.2 Group Training (Courses, Seminars, Workshops).	-	24,600	26,100	27,700	29,300	107,700
3. Travel	10,000	11,000	12,000	13,000	14,000	60,000
4. Equipment ***	30,000	20,000	20,000	15,000	15,000	100,000
5. Supplies and Materials	20,000	20,000	20,000	20,000	20,000	100,000
6. Miscellaneous	2,000	2,000	2,000	2,000	2,000	10,000
TOTAL	218,100	273,200	295,300	313,200	335,800	$ 1,435,600

* Include 1 full-time expert (P.4) to coordinate field surveillance and control activities.
** Include 2 Laboratory Technicians (G.6) to assist in laboratory diagnosis and isolation to support surveillance program.
*** Microscopes, ultra-centrifuge, revco deep freeze, laminar flow hoods, autoclave, etc.
**** Tissue culture supplies and materials, mice and rabbits, culture media, etc.

PROGRAM: FOOT-AND-MOUTH DISEASE

PROPOSED BUDGET
(By year, excluding Program Support Cost).

ELEMENT	1982	1983	1984	1985	1986	5-YEAR TOTAL
1. Personnel						
1.1 Expert *	369,300	403,200	437,300	540,800	656,500	2,407,100
1.2 Support Staff **	110,700	123,300	135,900	148,500	161,100	679,500
2. Training						
2.1 Individual Fellowship	-	22,500	25,200	28,500	31,500	107,700
2.2 Group Training (Courses, Seminars, Workshops).	-	24,600	26,100	27,700	29,300	107,700
3. Travel	20,000	25,000	30,000	35,000	40,000	150,000
4. Equipment ***	50,000	30,000	30,000	20,000	20,000	150,000
5. Supplies and Materials ****	20,000	20,000	20,000	20,000	20,000	100,000
6. Miscellaneous	2,000	2,000	2,000	2,000	2,000	10,000
TOTAL	572,000	650,600	706,500	822,500	960,400	$3,712,000

* Include 5 experts (P.4) to coordinate field control activities, to be stationed at CPC, Guatemala, Peru and Argentina.

** Include 3 Laboratory Technicians (G-6) to assist in providing the necessary laboratory support.

*** Microscopes, autoclaves, refrigerators, audio-visual equipment, Revco deep freeze, ultra-centrifuge, etc.

**** Tissue culture supplies and materials, culture media, other laboratory supplies.

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PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

TELEPHONE 861-3200

IN REPLY REFER TO: HRC/AMRO/8900/21/5

5 November 1980

Dr. John Evans
Chief, Population, Nutrition
and Health Department
World Bank
1818 18th St. NW
Washington, DC 20433

File

Dear Dr. Evans:

... I am pleased to enclose herewith one copy of the Report to the Director of the XIX PAHO/ACMR Meeting, held in San José, Costa Rica, from 9 to 13 June 1980.

Yours sincerely,

José R. Ferreira, Chief
Division of Human Resources
and Research

... Encl.

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Division of Human Resources
and Research

... Encl.

Ms. Arlene Fonaroff, PHN

June 18, 1980

John R. Evans, PHN

Social Science Research Working Group PAHO/ACMR

I appreciate your report on the discussions with Dr. Badgley. By all means, gather representative materials for him. I think one should reserve judgment on any formal relationship to the group at PAHO. It probably would be very time consuming and I think only provide marginally greater if as great benefits as informal relationships with selected people in their group.

I also have your note about the November meeting in Manila. I have circulated it to the Divisions but I would not expect that it would be a high priority for attendance for a member from this Department. I would wonder whether it is the highest priority for the use of your time. If you feel it is, let's review it further.

Thank you also for your comments on the inter-sectoral action for the Rural Child and Development. I would be grateful if you would keep a file on this to assist in future work of Dr. Hammad's group.

cc: Mr. North

JREvans/rmf

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

D7

TO: Dr. John R. Evans, PHN

DATE: June 17, 1980

FROM: Arlene Fonaroff, PHN

SUBJECT: Social Science Research Working Group PAHO/ACMR

1. At your suggestion (and that of Dr. Cesar Garcia, PAHO), I met with Dr. Badgley who chairs the above group. Dr. Badgley was interested in learning about how socio-cultural and behavioral aspects of PHN were dealt with; and past, current and future research in this area.

2. Dr. Badgley was informed that most sector-related research has been handled through DED and that I would send him the most recent publictaion on the Bank's research activities. Dr. Badgley was also informed that when the Department's Policy and Research Unit become operative, planning would begin on the scope and direction of departmental research. He would like to be informed of progress.

3. In discussing the nature of Bank operations, it seemed desirable that Dr. Badgley have opportunity to review selected Bank reports so as to ascertain the extent to which social and behavioral factors are considered in program and project work; and to identify viable recommended areas of research. Dr. Badgley asked if I might select some Latin American reports to serve these purposes. If you have no objection, I can draw together some materials next month since he will not be ready to examine them before mid-August.

4. We also discussed the PAHO/ACMR Report on Social Science Health Research. Evidently you had made the some comment as I to Dr. Badgley on the desirability for a more specific and dynamic presentation, and one that linked area of Social Science Health Research with potential pragmatic application to organization, management and evaluation of health services.

5. Dr. Badgley asked that I explore with you the possibility of my participating in future activities of the Advisory Group. The possible course(s) of action by the Group will depend on the ACMR reception of the paper in Costa Rica. Both he and Dr. Cesar Garcia (PAHO) have suggested that I participate in future site visits to Latin America to gain first-hand knowledge of skills, interests, direction and potential of social science health research in the Region.

AFonaroff/mlo

The World Bank / 1818 H Street, N.W., Washington, D.C. 20433, U.S.A. • Telephone: (202) 477-1234 • Cables: INTBAFRAD

June 10, 1980

James H. Rust, Ph.D.
Regional Advisor Enteric Diseases
Pan American Health Organization
525 23rd Street, NW
Washington, DC 20037

Dear Jim Rust,

This is a belated note of thanks for sending me copies of the PAHO annotated bibliography on oral rehydration. It is a most useful compilation and will help those of us who are called on to suggest appropriateness of ORT Methods as well as those of us who are interested in generating epidemiologic and evaluation studies.

With best personal regards,

Sincerely,

Arlene Fonaroff
Population, Health and
Nutrition Department

AFonaroff:rk

CC: Dr. Evans
Mr. North
Mr. Berg

PAHO

June 30, 1980

Dr. Hector R. Acuna
Director
Pan American Health Organization
525 - 23rd Street, N.W.
Washington, D.C. 20037

Dear Dr. Acuna,

I am very pleased to be informed of the theme for Technical Discussions at the meeting in September. We are extremely interested in the question of Community Health Education and would be pleased to have a member of the Department attend the meeting.

We appreciate your invitation to be present.

Sincerely,

John R. Evans
Director
Population, Health and Nutrition Department

cc: Ms. K. Lashman)
Ms. A. Fonaroff (o.r.)) With incoming. Please advise on who should attend.

JREvans/rmf

PAN AMERICAN HEALTH ORGANIZATION
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WORLD HEALTH ORGANIZATION

525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

IN REPLY REFER TO: CHS/CMR/49/3 TELEPHONE 861-3200

23 June 1980

Dear Dr. Evans:

As you may be aware, the World Health Assembly declared in Resolution WHA.30.43 that "Health for All by the Year 2000" is the most important social goal for the Member Governments in the coming decades, in order to achieve a level of health that will permit the citizens of the world to lead socially and economically productive lives. The basic strategies needed to reach this goal are community participation, intersectoral articulation, appropriate technology and primary health care. Health education is an extremely important and integral part of these strategies, and essential for the promotion of primary health care goals and priorities.

The theme for the 1980 Technical Discussions during the XXVII meeting of the Directing Council of the Pan American Health Organization (PAHO), will be "Community Health Education: Evaluation of Present Programs, New Approaches and Strategies." These discussions are tentatively planned to take place in Washington, D. C., on 26 and 27 September 1980, subject to confirmation by the PAHO Executive Committee. Given the timeliness of these discussions in the light of attempts to extend coverage of services and to promote primary and participatory health care in the world's population, we would be very pleased to have your organization represented at this meeting, which will provide an opportunity for a much needed exchange of ideas.

./..

Dr. John Evans
Chief, Population, Health and Nutrition
International Bank for Reconstruction
and Development (World Bank)
1818 H Street, N. W.
Washington, D. C. 20433

We will send you shortly a document containing background information for the Technical Discussions, and will confirm the dates on which they will take place.

Sincerely yours,

J. Paul Sherlock Jr.

Héctor R. Acuña, M.D., M.P.H.
Director

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

Dr. John R. Evans

With the compliments of

José Roberto Ferreira, M.D.
Chief, Division of Human Resources
and Research

WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

EB65/1980/REC/1 (OP/2)

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RESOLUTIONS AND DECISIONS - ANNEXES

ANNEX 6

ORGANIZATIONAL STUDY ON THE ROLE OF WHO EXPERT ADVISORY PANELS AND COMMITTEES AND COLLABORATING CENTRES IN MEETING THE NEEDS OF WHO REGARDING EXPERT ADVICE AND IN CARRYING OUT TECHNICAL ACTIVITIES OF WHO

ANNEX 6

ORGANIZATIONAL STUDY ON THE ROLE OF WHO EXPERT ADVISORY PANELS AND COMMITTEES AND COLLABORATING CENTRES IN MEETING THE NEEDS OF WHO REGARDING EXPERT ADVICE AND IN CARRYING OUT TECHNICAL ACTIVITIES OF WHO[1]

/EB65/25 - 20 November 1979/

The working group[2] for this organizational study was set up by the Executive Board at its sixty-first session (January 1978) in response to resolution WHA30.17 (May 1977).

Under the chairmanship of Professor K. Spies, the working group met four times in Geneva between January 1978 and January 1979. It interviewed 16 directors and senior officers of the headquarters Secretariat, and the Regional Directors participated in its third and fourth sessions. Three of its members visited 18 WHO collaborating centres in the WHO European Region and Region of the Americas. Its Chairman attended the 1978 sessions of the global Advisory Committee on Medical Research (ACMR) and the regional ACMR for Europe. One member also attended the 1978 session of the regional ACMR for Africa.

The Executive Board considered a progress report at its sixty-third session (January 1979) and recommended that the presentation of the final report of the study should be deferred to the Thirty-third World Health Assembly in May 1980. A recommendation to this effect was subsequently endorsed by the Thirty-second World Health Assembly (decision 12).[3]

In 1979, the working group held three more meetings, including one convened in Bangkok, Thailand, to afford members of the group an opportunity to visit three WHO collaborating institutions in the South-East Asia and Western Pacific Regions. Two members also participated in sessions of the regional ACMRs in the same regions, and the Chairman attended the twenty-first session of the global ACMR.

At these working sessions and in the light of these country visits and discussions in the Board and at sessions of ACMRs, the working group prepared this study which it hereby submits to the Executive Board.[4]

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[1] See resolution EB65.R14.

[2] Between January 1978 and January 1980, the membership of the working group has included: Professor K. Spies (Chairman), Dr A. N. Acosta, Professor E. Aujaleu (Vice-Chairman), Dr I. D. Bajaj and Dr D. B. Bisht (alternates to Mr Prasad), Dr J. H. Bryant (Rapporteur), Dr S. Butera, Dr R. de Caires (alternate to Dr S. P. Ehrlich jr, and subsequently to Dr J. H. Bryant), Dr A. M. Correia da Piedade, Dr Z. M. Dlamini, Dr R. Fortuine (alternate to Dr J. H. Bryant), Dr U. Fresta, Dr C. K. Hasan, Dr S. Hasan (alternate to Dr A. A. Shah and subsequently to Dr C. K. Hasan), Dr H. J. H. Hiddlestone, Dr G. A. Leyliabadi (alternate to Dr K. Sami), Mr R. Prasad, Dr L. G. Sambo, Dr Sharad Kumar and Mr N. N. Vohra (alternates to Mr R. Prasad).

[3] Document WHA32/1979/REC/1, p. 45.

[4] The recommendations and conclusions are shown as indented paragraphs between vertical lines, at appropriate points in the text.

CONTENTS

I. INTRODUCTION

1. The development and scope of the study

The WHO Executive Board has always attached great importance to the Organization's expert advisory panels and expert committees, as an essential instrument of programme development.

In keeping with the "Regulations for expert advisory panels and committees" adopted by the World Health Assembly,[1] and as a well-established tradition, the Board considered, at each of its sessions,[2] reports by the Director-General on: (a) appointments to expert advisory panels and expert committees; and (b) reports of expert committees.

The Board's interest has centred on the constitution and functioning of expert advisory panels and committees and on their usefulness to the Organization and to its Member States, with particular regard to:

(a) the composition of the panels and the geographical balance of their membership;[3]

(b) the appointment, reappointment or termination of experts,[3] including the setting of the age limit of 65 beyond which reappointment becomes exceptional, and the ways in which experts on the panels are called upon to collaborate; and

(c) the dissemination of the scientific and technical information emanating from WHO's pool of expertise, including the distribution and utilization of expert committee reports.[4]

At the Board's request, the Director-General prepared a special report on the subject of advisory panels[5] which the Board considered at its fifty-sixth session, in 1975. That report referred to the new conception and orientation of the role of WHO and outlined some new approaches to the collection and use of expert advice.

Again, at its fifty-eighth session, in 1976, the Board requested the Director-General to report "on the steps being taken to improve, where necessary, the efficiency of the expert advisory panels and committees and /to/ consider their future role".[6] The Director-General's report[7] was considered by the Board at its fifty-ninth session, in January 1977. The Board concurred with the suggestion that a question of such fundamental importance should be studied in depth, and consequently recommended to the World Health Assembly that it be made the subject of the Board's next organizational study. The scope of the subject was actually broadened to include the WHO collaborating centres, as well as the expert advisory panels and committees, and to cover the role of these various instruments not only in the gathering of scientific and technical information but also in the carrying out of WHO's technical activities. The Thirtieth World Health Assembly approved that recommendation and decided[8] that the subject of the next organizational study by the Board would be "The role of WHO expert advisory panels and committees and collaborating centres in meeting the needs of WHO regarding expert advice and in carrying out technical activities of WHO". It further requested the Board to report on the study to the Thirty-second World Health Assembly.

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[1] WHO Basic Documents, 30th edition, 1980, pp. 89-97.

[2] Until its fifty-ninth session, in 1977, when it decided to consider appointments to expert advisory panels and committees only once, instead of twice, annually - at its January session.

[3] Resolution EB37.R2 (1966).

[4] Resolutions EB37.R8, EB38.R10, EB41.R12, EB42.R12, EB47.R25, EB49.R2 and EB56.R5, adopted from 1966 to 1975.

[5] WHO Official Records, No. 228, 1975, Annex 1.

[6] Resolution EB58.R4 (1976).

[7] Expert advisory panels and committees, Report of the Director-General (document EB59/3).

[8] Resolution WHA30.17 (1977).

Indeed, while the study emanates from the Board's original concern over the functioning of the WHO expert advisory panels and committees, both the Board and the Health Assembly have come to see it in a much broader perspective. As indicated by resolution EB58.R4, the question is no longer simply to improve the efficiency of the expert advisory panels and committees but to "consider their future role" so as to adjust them to the new perspectives of the WHO programme. In the title of the study, the expert advisory panels and committees are associated for the first time with the WHO collaborating centres, one of the mechanisms WHO is using for the promotion and development of research. In fact, the WHO expert advisory panels, expert committees and collaborating centres all form part of a larger and more complex machinery and can hardly be considered separately from each other or from other components of the WHO system of expertise, including the various forms of research expertise.

For the first time, too, reference is made, in the title of the study, to the role of the WHO expert advisory panels, expert committees and collaborating centres not only in the provision of expert advice, but also in the carrying out of the technical activities of WHO. This further broadens the conception of expertise and gives the study a new dimension; it brings into the picture the WHO regions and the countries themselves, which are in the front-line of WHO's programme delivery and from which, of course, all expertise is derived.

The Organization, today more than ever before, must keep abreast of scientific, technological and social advances of relevance to its mission and provide its Member States with the information they need. To that end it must secure expert advice, but the question arises as to the kind of advice it requires and what system can provide it in the most effective way.

The organizational study, consequently, seeks to analyse the subject in a much wider context than its title indicates and addresses itself to three major issues:

(a) the amount and type of expertise the Organization requires;

(b) the source of such expertise; and

(c) the ways and means of securing it and of bringing it to bear, in a coherent and efficient manner, on the entire spectrum of WHO's activities at its different levels of operation, with appropriate consideration of the needs of its Member States, its governing bodies and its Secretariat.

The WHO system for the synthesis of scientific, technical and programme information, through appropriate channels and mechanisms of expertise, must be in harmony with the overall structure and functions of the Organization. It must involve all levels of operation and, under the new policy and strategy of technical cooperation, be intimately linked with the programme activities it is meant to support. It was felt, therefore, that the study should be conducted in full cognizance of, and in harmony with, other developments on which it could exert a positive influence or from which it could benefit.

One such development is the current analysis of "WHO's structures in the light of its functions", which aims at "the possible restructuring of WHO in relation to its role in attaining an acceptable level of health for all by the year 2000".[1] This restructuring cannot but have an important bearing on the use of expert resources, in particular:

- at the national level, through the establishment or strengthening of national health councils, national centres for health development and, where appropriate, national health research councils;

- at the regional level, through the setting up of regional health development advisory councils and regional networks of health development centres, as well as regional mechanisms for the promotion of technical cooperation among countries; and

[1] See document WHA32/1979/REC/1, p. 78 (para. 132).

- at the global level, through the establishment of the global health development advisory council.

The Executive Board has stressed in its preliminary document to the Health Assembly on "Formulating strategies for health for all by the year 2000"[1] that the organizational study "will have important implications for the use of national expertise in formulating and implementing regional and global strategies".

Because of the fact that any expert works in a national context, and of the role of expertise in support of technical cooperation, the organizational study also had to refer to the previous study by the Executive Board on "WHO's role at the country level, particularly the role of the WHO representatives".[2]

Furthermore, the organizational study had to take into account current developments in the field of research planning and management, in particular:

- the growing role of the global and regional advisory committees on medical research (ACMRs);
- the study by the Programme Committee of the Executive Board of the "Development and coordination of biomedical and health services research" and the Executive Board's views thereof;[3] and
- the "plan for the management of research in WHO"[4] adopted by the Secretariat's Global Programme Committee for an initial trial period of two years and subject to the conclusions of the present organizational study.

The importance of establishing the scientific bases for the long-term development of research in WHO, in accordance with resolution WHA32.15,[5] has led to new forms of expert consultation and participation of direct interest to the study.

In that broad perspective, the study endeavours to analyse critically WHO's use of expertise with a view to eliminating approaches and procedures which can no longer be considered as highly relevant to the needs of the Organization, retaining those which remain responsive to these needs, acknowledging or proposing innovative formulas, and designing the overall, integrated system of expertise that could, in the view of the Executive Board, best meet the requirements of the Organization in the coming decades.

Such an endeavour called for an exhaustive and careful analysis of past experience, current trends and foreseeable needs which could not be completed in the time initially assigned to the study. On the recommendation of the Executive Board, the Thirty-second World Health Assembly agreed that the period allowed for the study should be extended by one year and that the final text of the study should be presented to the Thirty-third World Health Assembly, in May 1980 (decision 12).[6]

2. The definition of WHO expertise

2.1 The primary function of WHO, as stated in Article 2(a) of its Constitution, is "to act as the directing and coordinating authority on international health work". This function imposes upon the Organization the duty of securing for itself - that is, for the world community it represents and serves - the widest possible spectrum and the highest possible standards of knowledge, which is mainly, but not exclusively, scientific and technical in the medical and health fields.

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[1] Document WHA32/1979/REC/1, Annex 2.

[2] WHO Official Records, No. 244, 1978, Annex 7.

[3] Documents EB63/49, 1979, Appendix 2; EB63/50, 1979, pp. 207-214.

[4] Document DGO/78.2, 1978.

[5] Document WHA32/1979/REC/1, p. 14.

[6] Document WHA32/1979/REC/1, p. 45.

The above statement, however, cannot go without qualification. Firstly, the knowledge WHO needs is specific; it relates to well-defined domains of endeavour and to the disciplines on which the work of the Organization is based. Secondly, there can be no question of WHO - or, for that matter, the WHO Secretariat - accumulating that knowledge for example in the form of some overall central information service:[1] rather, the Organization must plan, set up and operate such mechanisms as will allow it to develop and manage to the best advantage a worldwide network or reservoir of expertise from which information can be derived as required.

WHO experts should make the constantly growing treasure of national experience available to the Organization as a whole. WHO Member States are the providers as well as the beneficiaries of such expertise. WHO's role is to collect, distil and transfer the information that is the most appropriate to the health needs of the countries.

2.2 Expertise is not an end in itself. It is one of the tools the Organization is using in the furtherance of its constitutional aims and objectives; it must, therefore, be dependent upon and relevant to the way in which WHO's role is conceived.

Expertise has been seen, in the first two decades of existence of the Organization, mainly as a central function. In the Executive Board's organizational study on the "Interrelationships between the central technical services of WHO and programmes of direct assistance to Member States",[2] it is stated that "WHO headquarters plays a central role in providing the scientific and technical basis for the Organization's programme as a whole" and, further on, under the heading "Central expertise and guidance", that "WHO headquarters represents, in the various programme areas, a body of expertise permanently available to WHO regional offices, representatives and field staff, as well as to Member States. It has the responsibility of keeping abreast of current knowledge, promoting its application and coordinating research". Research is specifically mentioned as developing, too, "as a centrally-directed activity".

The same study, however, after having analysed the positive and negative aspects of this situation, deliberately outlines a new conception according to which expertise would be used not only at the central level for the "building up of a doctrine" and as a basis for overall scientific and technical programme guidance but, as much if not more, in direct support of technical cooperation for national health development. The two objectives are, of course, closely interrelated, if not complementary, and if WHO's programme is to be truly integrated both types of expertise will be needed concurrently and in a variety of associations.

The expertise provided by the expert advisory panels and committees must be adapted to the needs of each country. These panels and committees must be geared to the genuine exchange of knowledge and experience gained in different socioeconomic settings so as to provide such options as will allow the countries themselves to select the most appropriate ways and means of solving their health problems. Fortunately, experts who are close to the health realities of the people they serve are emerging in growing numbers in the developing countries.

Clearly, the necessary reorientation of the use of experts by WHO must therefore be accompanied by parallel modifications in the other mechanisms the Organization is utilizing in the implementation of its programme.

2.3 An enlarged conception of the role of expertise leads to a much broader definition of the nature of expertise. It is commonplace to affirm that WHO must rely on the "highest possible technical standards" of expert advice. For the advancement of knowledge WHO must of course continue to seek the contribution of the most highly qualified scientists of the world, and it is in a unique position to do so. The quality of the work accomplished by WHO experts and specialized staff for more than a quarter of a century has decisively contributed to establishing the reputation of scientific and technical excellence which the Organization has gained the world over. Such quality should be not only sustained but also further enhanced in the years to come as an essential ingredient for the fulfilment of WHO's constitutional objectives.

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[1] Attempts in that direction, such as the WHO Biomedical Research Information Service (WHO/BRIS), despite positive aspects, have proved difficult to operate, too costly, and largely ineffective; they would lack relevance to WHO's mission as envisaged today.

[2] WHO Official Records, No. 223, 1975, Annex 7.

But expertise in WHO cannot be confined to doctrinal and predominantly scientific and technical knowledge: it must extend to a wide range of public health experience, acquired in an extreme variety of social and economic settings. Similarly, expert guidance must not be sought only for the solution of specific programme issues; it is equally required for sound programme planning and for programme evaluation.

2.4 Thus, the definition of a WHO expert[1] must also be a much broader one than has been commonly accepted until now:

Any worker in the medical and health professions, and in other disciplines related to health and social development, who possesses the required qualifications and experience either in science or in health and social practice, in any country and at varied levels of professional responsibility, may be called upon to provide expert support to the Organization.

Most of those workers who have acquired first-hand public health experience, and therefore are more able than others to advise on how health programmes can achieve a social impact, so far have not been appropriately recognized, particularly workers at the peripheral levels and in the developing countries. They should be sought out and called upon to participate in the work of the Organization. The collaboration between experts from all geographical and scientific horizons, with all types of medical and public health experience, should be mutually beneficial. Through it the pool of expertise formed by WHO should acquire greater significance and usefulness in regard to world health needs.

Furthermore, knowledge, for a WHO expert, is not all: qualifications and experience must be allied to the readiness and ability to communicate, and thereby to contribute effectively and efficiently to international technical cooperation. WHO experts are living links between countries and WHO and can, in no small measure, foster greater involvement of Member States in the work of the Organization. It is the right and duty of all Member States to put at WHO's disposal the resources of knowledge and experience they possess.

II. WHO MECHANISMS OF EXPERT CONSULTATION AND PARTICIPATION

3. General outline

This section, as its title indicates, is intended only to provide a preliminary synopsis of the various mechanisms in question. Each of these mechanisms is analysed in detail in the subsequent sections 4-7.

3.1 Expertise in WHO is being sought, in varying forms and proportions, at the different levels at which the Organization operates.

Expertise at the global level has been given pride of place in the system in the first three decades of the life of WHO and remains, of course, of crucial importance.

Growing emphasis has been laid on the need for expert guidance at the regional level and a wealth of expert knowledge on regional problems has been accumulating, as testified by numerous WHO regional publications.

It has always been a fundamental aim of the Organization to provide expert support to health development at the national level. This has been done mainly through the assignment of WHO staff and of short-term consultants.

Apart from the individual consultation of experts, to which the Organization has recourse in appropriate circumstances, the mechanisms described in this section of the study relate to the collective consultation of experts, through meetings which act in a collegiate manner and formulate jointly agreed conclusions and recommendations.

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[1] The wording here is intentional. No attempt is being made to define the word "expert", which can be understood in many different ways; what must be defined, in relation to the study, is the "WHO expert", i.e. the expert whose services WHO is using for the development of its programme.

3.2 WHO's global system of expertise was not originally planned as a whole. It has tended to become so from the progressive coalescence of two parallel developments, one concerning what may be termed general technical expertise, the other bearing specifically on research. The former started with the life of the Organization, as part of initial efforts to establish its work on a firm technical basis; the latter was initiated at a later stage and reached its full momentum with the intensification of the WHO research programme.

Formal expertise is derived from the activity of expert bodies governed by formal regulations or by resolutions of the Health Assembly and the Executive Board; but there are informal ways for the Director-General to seek expertise, as required, in the pursuit of the Organization's work.

General technical expertise is secured, formally, through the expert advisory panels and committees and, in a subsidiary manner, through the study groups; it also originates, informally, from ad hoc individual or group consultations. Scientific expertise in relation to the WHO research programme is sought in a variety of ways, including the global Advisory Committee on Medical Research, the scientific groups and other types of scientific gatherings such as meetings of investigators, and ad hoc consultations.

In the last decade or so, new needs have emerged and new avenues have been explored, leading to innovative experiments which, in many respects, appear susceptible of broader application. This has been the case inter alia for the Special Programme of Research, Development and Research Training in Human Reproduction and, more recently, for the Special Programme for Research and Training in Tropical Diseases. The study endeavours to draw the lessons of these programmes and to determine which of their new approaches could be more generally adopted.

3.3 At the regional level, regional lists[1] of experts have been drawn up and meetings of experts of various kinds are being convened to deal with health problems of regional interest.

Regional advisory committees on medical research represent a key element of scientific and technical expertise at that level.

3.4 At the country level, WHO's input has, for years, been essentially conceived in terms of outside expertise for the provision of technical "assistance". Technical "cooperation" today, with its emphasis on the development of national self-reliance in health and the cooperative solution of national health problems, imposes a new approach whereby the countries themselves contribute to a much broader extent.

3.5 Experts consulted individually or called upon to participate in WHO meetings do not represent the sum total of expertise available to the Organization.

Nongovernmental organizations in official relations with WHO, or with which working contacts are being developed, constitute a valuable source of expertise. Some are collaborating closely with the Organization, others not. As pointed out in its first report of the Programme Committee of the Executive Board,[2] greater use of the nongovernmental organizations can "increase programme effectiveness while reducing WHO's staff establishment and the expenditure of the Organization's resources" and help "to ensure worldwide involvement in the programmes concerned".

Nongovernmental organizations are invited to participate in expert meetings but their technical contribution is sought in other ways too, including continuing working association with the Secretariat and the undertaking of specific tasks which, as nongovernmental institutions, they are in a favourable position to perform.

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[1] The term "panel" is not used here in order to avoid confusion with the "expert advisory panels" which are global in nature and governed by formal regulations. Some of the regional lists, however, are known as "regional expert panels".

[2] WHO Official Records, No. 238, 1977, p. 189, section 3.5.3.

3.6 The staff of the WHO Secretariat also constitutes a valuable source of expert advice; in addition, it serves as an agent of coordination of the many sources and channels of expertise. The Executive Board has noted, in the organizational study already mentioned,[1] that "the selection of key technical staff at headquarters in the various programme areas has been largely influenced by their research activity, their international scientific standing and their close relationships with research institutions in various countries". What is said here about headquarters staff will no doubt increasingly apply to WHO regional and country staff as current programme trends develop. Mention must also be made of the role played by scientists of repute whom the Secretariat is associating with its work for periods of time, whether on secondment or loan from their governments, universities or institutes or during sabbatical leave.

4. Expert advisory panels

4.1 The WHO expert advisory panels and committees have been considered, for over a quarter of a century, as the most important of the mechanisms through which the Organization secures expert advice.

It is not always remembered today that, chronologically, expert committees preceded expert advisory panels. The First World Health Assembly, on the recommendation of the WHO Interim Commission, established in 1948 several expert committees to deal with the subjects it had singled out for priority attention, such as malaria, tuberculosis, venereal diseases, maternal and child health and nutrition. It adopted regulations and rules of procedure for expert committees and their subcommittees. These expert committees were conceived, at that time, as bodies of a rather permanent character with more or less the same membership from one session to another, on the principle that continuity of their work was of primary importance.

Experience rapidly demonstrated, however, that such permanence entailed a danger of self-perpetuation and, moreover, that it imposed too narrow limits on the scope of expertise sought by the Organization. These considerations, strengthened by the rapid expansion of the programme of WHO and the growing need for diversified expert advice, led to the establishment of the expert advisory panels. Expert committees were maintained, but as one-time emanations of the corresponding panel, their membership being determined for each individual meeting according to the specific subjects to be discussed. No longer were there series of sessions of the same expert committee for a given subject, but, instead, a numbered sequence of expert committees, the membership of which was drawn each time from the panels.

The new procedures were embodied in "Regulations for expert advisory panels and committees",[2] which were adopted by the Fourth World Health Assembly in 1951. These Regulations, as amended by the Thirteenth World Health Assembly, have remained in force until now.

4.2 There are at the present time (July 1979) 47 WHO expert advisory panels[3] (Appendix 1). Thirty panels had already been established as early as 1954, mostly in the field of disease prevention and control; thereafter, their number increased moderately, especially in relation to environmental health and to the development of comprehensive health services (see Appendices 2 and 3). Three panels, on rickettsioses, yellow fever and antibiotics, have been abolished; however, the experts on these panels have been transferred to other panels, such as the panel on virus diseases in the case of yellow fever.

There were, on 1 January 1979, 2562 experts on the panels. The panels' membership doubled in fifteen years, rising from 1267 to 2582 between 1954 and 1969, but over the following ten years it has remained practically unchanged. (Appendix 4 gives the distribution of membership among the different panels and its evolution between 1954 and 1979, while Appendix 5 shows the distribution of members of the WHO expert advisory panels by WHO region and by panel on 1 January 1979.)

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[1] WHO Official Records, No. 223, 1975, Annex 7, pp. 77-78.

[2] WHO Basic Documents, 30th ed., 1980, pp. 89-97.

[3] Not including the global Advisory Committee on Medical Research (ACMR), which the World Health Assembly decided, for all intents and purposes, to treat as a panel - a legitimate decision in its time, the validity of which today is open to question, but which illustrates the close relation of the ACMR to the WHO system of expertise.

There were on 1 January 1979 193 women on the panels, representing 7.5% of the total membership; that number has shown no sign of increase in recent years. There are women, although in small proportions, in 37 panels out of 47, whereas 10 panels have no female membership. The largest numbers of women are found in the panels on nursing and maternal and child health, 60 and 15 respectively. (See Appendices 6 and 7.)

The age and sex distribution for the panels as a whole, on 1 January 1979, is given, globally and for each of the six WHO regions, in Appendix 7.

By far the largest proportion of experts (70.3%) falls within the age group 45-64 years; 23.7% are over 65 and only 6% under 45 years of age.

The distribution of experts by regions varies from a minimum of 5.9% for Africa to a maximum of 46.5% for Europe. Europe and the Americas alone account for 68.9% of all panel members; the remaining 31.1% is divided between the other four regions.

Of WHO's Member and Associate Member States, 111 have experts on the panels: 26 in the African Region, 22 in the Americas, 8 in South-East Asia, 31 in Europe, 14 in the Eastern Mediterranean and 10 in the Western Pacific. The number of experts appointed to the panels, however, varies considerably from one country to another. Four Member States (France, the United Kingdom of Great Britain and Northern Ireland, the United States of America, and the USSR) have by far the largest number of experts; the largest number of countries (87) provide only from one to 20 experts; 43 countries have none. The numbers of experts serving on the WHO expert advisory panels, by region and country, can be found in document EB65/2 of 28 December 1979.

All these data not only allow for an assessment of the present situation; they also provide a useful baseline against which the future evolution of panel membership can be assessed, from the points of view of age, sex, and interregional distribution.

4.3 The shortcomings in the structure and composition of expert panels

4.3.1 First the panels, as constituted at present, are not fully representative of world expertise, in both technical and geographical terms.

Geographical balance of the panels has been a constant concern of the Director-General, the Board and the Health Assembly. Looking at the development of the panels in retrospect, doubtless their membership at the beginning was drawn overwhelmingly from advanced countries, mainly in Europe and North America, because it was in those parts of the world that most advances had been made and that the larger pool of expertise existed, and also because the primary concern of the Organization, at that time, was with the building up of the scientific and technological bases of its programme.

Over the years, more experts from other parts of the world have been appointed to the panels but progress has been admittedly slow, giving rise to the widespread feeling, in particular among developing countries, that the Organization was not paying sufficient attention to the enlarged expert resources becoming available to it. While evolution towards better geographical balance has more recently proceeded at a faster pace, it has not yet reached what could be considered as an optimal distribution of expertise.

4.3.2 The world reservoir of expertise available to WHO is of vast dimensions; never will the Organization be able, nor may it be necessary in any system, to comprehend it all. Moreover, world expertise is a moving reality, in constant and rapid evolution. Any panel of experts is, of necessity, selective and, once established with a given composition, more or less rapidly ceases to reflect the expert resources actually available.

4.3.3 There are considerable differences in the scope of the various panels. For example, distinct panels have been set up for leprosy, rabies, food hygiene, and smoking and health, while others cover the whole field of acute bacterial diseases or virus diseases, public health administration, or health manpower. Such differences, though understandable, are not always justified; indeed some panels have been subdivided in order to be more manageable. Also, the expert panels have mostly been set up according to disciplines or nosology, i.e.,

largely following the existing programme management structure at WHO headquarters. They tend to lose part of their significance with the advent of socially-oriented, multidisciplinary action programmes.

4.3.4 Under the present Regulations, expert panel members are appointed "for such period as the Director-General may determine, but not exceeding five years". In fact, for the sake of uniformity and to simplify the procedure, apart from rare exceptions all initial appointments and reappointments (up to the age of 65) are made for a period of five years. It is interesting to note that, in this case, the Regulations allow for more flexibility than was actually used. This practice did not conform to the needs of a programme in constant evolution and has no doubt contributed to the inadequacy of the mechanism.

4.3.5 Routine reappointment of panel members has become the rule instead of being an exception justified by specific programme requirements. The status of panel member has thereby acquired a character of permanence contrary to the spirit of the Regulations and has come to be considered by the experts themselves as an established right and a recognition of individual merit more than as an obligation to cooperate in the activities of the Organization.

4.3.6 It was in consideration of the above that the Board recommended[1] that members of the panels who have reached the age of 65 be reappointed only in exceptional cases and for periods not exceeding two years at a time. However legitimate the motives of the Board may have been, the recommendation, despite honest efforts, had only partially achieved its objective. Experience has demonstrated that older experts very often contribute as actively as younger ones and many of them have brilliantly demonstrated their value to the Organization beyond the age of 65. The real solution to the problem of rejuvenation of the panels is to appoint younger experts in greater numbers.

4.3.7 Outside the "traditional" domains of nursing and maternal and child health, the proportion of women on the panels is much too low. Indeed, the question is not only one of equality of status or "equitable distribution by sex"; it is of much deeper significance for the work of the Organization. Women have a different outlook on health problems and on their solution and their participation in the panels is qualitatively most important. It is obvious that the proportion of women could be increased in panels where they have been insufficiently represented until now and that female experts could be added to some, if not all, of the 10 panels in which they are not represented at all. It is equally obvious that any progress to be made in this respect will depend in no small measure on the promotion of women in the countries themselves.

4.4 The difficulties encountered in the functioning of expert panels

The panels, once established, do not work on their own; they must be made to function. Until now they have been dealt with centrally: for each panel, the professional technical officer responsible for the corresponding programme area at the global level has been designated as panel secretary.

4.4.1 While it is difficult to formulate in general terms a fair assessment in this regard, if only because of the widely differing nature of the various panels, it must be admitted that the mechanism has yielded meagre returns, considering its size and the considerable wealth of human expertise it is supposed to draw upon. A recent survey has shown that the proportion of experts on the panels actually cooperating with the Secretariat ranges among the various panels from 20% to 50% at the most: the largest proportion of experts do not take an active part in the work of the panels. Why does such a situation prevail?

The panel secretaries have shouldered the heavy task of maintaining contact with the experts, by correspondence or otherwise. The number of these experts has been constantly increasing and that task has become more and more demanding for the persons concerned, particularly as it is added to many other Secretariat duties. Panel secretaries, consulted on the matter, frankly confess that they are not able to maintain adequate contact with all the experts on a panel; they themselves recognize that to make a panel work would necessitate much more time than they can afford.

[1] Resolution EB37.R2 (1966).

On the other hand spontaneous contributions from the experts are rather exceptional although, in accepting appointment, the expert undertakes "to contribute by correspondence and without remuneration technical information or reports on developments within his own field, either periodically or on request from the Director-General".[1] A number of panel experts even fail to respond to "requests from the Director-General".

This reveals a communication gap which any reform should seek to fill. It must be admitted in this regard that most experts are inadequately informed about WHO's aim and general objectives as well as on its programme and programme management policies, on its resources and on the modalities of its technical cooperation with Member States. They lack the overall view of WHO's work that would enable them to see their own contribution in perspective and give them a better sense of purpose. This situation has frequently led to a misunderstanding of the function of the expert advisory panels, which have come to be considered as some kind of a "waiting list" for experts to be invited to participate in expert committees, instead of being seen - in their true role - as a pool of expertise continuously available to the Organization and in which all experts have equal opportunities and possibilities to contribute (see also, in this connexion, section 5.2).

4.4.2 On the other hand, all panel secretaries will agree that they maintain sustained contacts with and receive active collaboration from experts who are not on the panels. It is of interest to note, in this connexion, that it has been common practice on the part of the panel secretaries to request the appointment to the panels of experts from this "unrecognized pool" when they wish to propose members of an expert committee, because the Regulations make it mandatory for such members to be drawn from the panels. The fact that expertise is thus derived from both inside and outside the panels has tended to lessen confidence in the panels as instruments for promoting the work of the Organization.

4.4.3 The WHO regions have, from the beginning, used their own sources of expertise as a basis for the development of WHO's support to country health programmes and of intercountry activities. Interestingly enough, the expertise used in the regions does not always coincide with that covered by the global WHO panels and even shows notable differences from them. This, it seems, can be explained by the fact that the sources and channels of information are not the same, but even more by the difference in the programme needs which prompt the request for advice; these are more general and mostly of a highly scientific and technical nature at the global level, and more specific and action-oriented in the regions. It is to be noted, in this connexion, that sometimes experts who are rather inactive at the global level, or even unresponsive when solicited, prove quite cooperative in their region, possibly because of a greater sense of purpose.

4.5 Are expert panels a worthwhile means for WHO to secure expertise?

The expert advisory panels no doubt occupy an important place in the Organization. It would be excessive to deny the role they have played in its activity. However, their many shortcomings prevent them from being as useful as they should be.

Consideration was given to the possibility of abolishing the expert advisory panels. Abolition would have the advantage of eliminating somewhat complex and cumbersome administrative procedures and of remedying, once and for all, the shortcomings of the panels; it would, however, carry disadvantages. First, it might be misconstrued as a criticism by experts at present on the panels and, by antagonizing these experts, adversely affect the relations of WHO with the workers and institutions that are so vital to its programme. Secondly, it would thwart the efforts the WHO regions have been encouraged to make and are currently developing for the utilization of the expertise available in the region for regional purposes, inter alia, through the drawing up of regional lists of experts. Thirdly, it would deprive the Executive Board of a means of control over the constitution and utilization of the pool of WHO expertise, to which it has attached, until now, considerable importance.

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[1] Regulations for Expert Advisory Panels and Committees (WHO Basic Documents, 30th ed., 1980, pp. 89-97).

After due consideration of the matter and of the pros and cons of the various solutions envisaged it was unanimously agreed that expert panels should be maintained, with such modifications as would make them more responsive and relevant to the future needs of the Organization.

4.6 How can expert advisory panels best be structured and function?

4.6.1 An expert panel must be set up to secure a body of expertise in a given field, which the Organization can call upon to provide technical guidance and support in relation to the development of the programme, with particular regard to the General Programmes of Work covering specific periods and to the attainment of specific objectives derived from those programmes.

4.6.2 Expert panels must be drawn from the worldwide pool of national expertise and be utilized by the Organization as a whole at whatever level the demand exists for guidance and support.

In addition, contributions may be sought from persons outside the panels if their advice is deemed to be useful to the Organization. The Regional Directors, in particular, may wish to enlist such broad-based cooperation in various forms - and they are already doing so - for the analysis and solution of problems of a specifically regional nature.

This two-tier mechanism would be intended to ensure the unity, equality and coherence of the system for the Organization as a whole and its flexibility at each of the operating levels involved.

4.6.3 The panels should be as limited in number as possible: that number could be determined, for example, in relation to the "major programme" headings of the WHO classification structure, to their main subdivisions, or to their objective-oriented components (e.g., immunization, diarrhoeal diseases control, etc.). As before, the services of any expert on any panel could be used across the board if need be.

4.6.4 There is no need for the panels to cover systematically and exhaustively all fields of activity of the Organization. A panel should be constituted only if required by the development of the programme and mainly in relation to programme objectives. This means, in particular, that the panel system will vary in nature and in function as among its regional components, because of different programme needs.

4.6.5 The composition of the panels should be based on a broader definition of WHO expertise and on a wider geographical selection of experts, the two processes being closely related and interacting.

As stated above (see section 2.4), any worker in the medical and health professions (or in other disciplines related to health and social development), in any country, possessing the required qualifications and experience could be invited to contribute to the work of the Organization at any moment, in any respect and at any level of operation, as an expert panel member.

4.6.6 Ideally, to follow the principle outlined above that selection of experts should be made in relation to actual programme needs, the term of office of an expert as member of a panel should depend upon the time period during which expert advice is expected to be required, either for overall scientific or technical guidance or in relation to the carrying out of programme activities. However, such an approach might create more problems than it would solve because no term of office would be similar to another and the composition of the panels would be so fluid that it would hardly lend itself to any assessment of lasting validity. The practical, though arbitrary, solution to this difficulty is to fix the duration of an appointment for a period of years as has been done so far.

It is recommended that the two approaches be combined and that the term of office of an expert be fixed for a period of four years, or for the actual duration of a definite programme activity if that duration is shorter.

4.6.7 At the expiration of the term, the appointment would automatically end and appointees would be advised when they are first appointed to expect this as the normal course of action.

Termination should no longer be a source of disappointment or even resentment on the part of the experts, as is too often the case under the present system; it would not mean that the expert's contribution is no longer considered of value to the Organization but simply that it is no longer required, for the time being, for the development of the programme. It would be made clear that renewed appointments would always be possible at a future time, as and when the evolution of the programme warranted it, but that regular rotation of experts was planned to ensure the continuous flow of new experience. In any case, experts might be called upon to contribute to the work of the Organization, on an informal basis, before and after their period of membership of a panel.

4.6.8 Renewal of appointment, which until now has been the normal practice, would become exceptional. It would be granted only if justified by (a) continuing programme requirements, (b) the active contribution of the expert, and (c) the need for maintaining an adequate geographical balance of the panel. This latter criterion is of particular importance, as automatic termination might otherwise be detrimental to experts from the developing countries. The duration of a renewed appointment would depend on requirements but, for simplicity, should be fixed on a yearly basis.

4.6.9 Reference to age in the selection of panel members should be abolished. The recommendation of the Board[1] that members of the panels who have reached the age of 65 be reappointed only in exceptional cases was prompted, at the time, by the fear that more or less automatic reappointment would lead to a inordinate proportion of older experts. The new approach envisaged, without reference to age, would meet the Board's concern much more efficiently.

4.6.10 A greater number of women should serve on the panels, especially in disciplines and programme areas where they have

[1] Resolution EB37.R2 (1966).

become increasingly available and still are insufficiently or unrepresented. This will depend, of course, on the promotion of the professional training of women by the Member States themselves.

4.7 A renewed approach to the management of the panels

4.7.1 The mechanisms of expert consultation generally, and the expert panels in particular, must from now on constitute an organization-wide system. The management of the panels will inevitably be more complex as, instead of one, there will be three levels of operational involvement: global, regional and national. But the interplay between these three levels is precisely what is desired to adapt the use of expertise to the needs of the Organization.

It is incumbent upon the Director-General to devise such management procedures as will ensure both the effectiveness of the mechanism and its coherence between the various operational echelons involved. The oneness of the Organization in this respect is essential.

4.7.2 The principle, laid down in the Regulations, that the Director-General is responsible for the appointment of experts to the panels should be maintained.

In the discharge of that responsibility, the Director-General must enlist the broadest possible participation of all sources of information on the availability and suitability of experts: national authorities, scientific and educational institutions, primarily in the medical and health fields, and individual scientists, including panel members and WHO staff at all levels, with particular emphasis on the role of the Regional Directors and of the WHO programme coordinators in the countries. The question for the Director-General is not only to collect information as a basis for his decisions but to stimulate initiative and active collaboration in the building up of the panels, particularly on the part of the Member States concerned, who must henceforward play a dynamic role in this respect.

It is the Director-General's duty to make an independent decision, on behalf of the community of those Member States, which must be able to rely on that independence. It is the Director-General's obligation regularly to inform the Executive Board of his decisions, the status of the panels, the evolution of their membership, etc., so as to allow the Board to provide its guidance and to voice its criticisms as appropriate.

4.7.3 A major role now devolves upon the Regional Directors, acting on behalf of the Director-General and in cooperation with the Member States, in the search for expertise, using all sources of information on the availability and suitability of experts in the regions and with the active collaboration of all those concerned in the countries themselves.

It is the Regional Directors' duty to draw up, in consultation with the panel secretary as required, proposals for appointments to the panels, for consideration by the Director-General. Once the Director-General has made his decision, all relevant administrative steps must be the Regional Directors' responsibility.

The role of the Regional Directors in the management of the regional components of the panels, once these have been established, is even more important. It is for them to ensure, with the support of the panel secretaries, continuing contact with the experts and their effective involvement in the Organization's activities of interest to them and for which their advice is deemed useful.

4.7.4 WHO senior programme officers with global responsibility should continue to act as panel secretaries. Regional programme officers should be designated by the Regional Director, in each region, to deal with the regional component of the panels.

The panel secretaries and the regional officers involved would be expected to maintain close contact between themselves and with the staff concerned at their respective levels. These officers should freely correspond with the experts, but keeping each other informed in order to avoid approaching the experts in an uncoordinated manner.

4.7.5 The WHO programme coordinators at the country level should also participate in the setting up of expert panels, as appropriate. Again, there is great advantage in involving in the process the countries themselves, where the experts originate and which are the ultimate beneficiaries of WHO expertise.

5. Expert committees

5.1 Among the many types of expert meetings used by WHO for the development of its programme, expert committees have a status of their own. As indicated above (see section 4) they are, in the same way as the expert advisory panels, governed by formal Regulations. The World Health Assembly and the Executive Board have always attached considerable importance to these committees and to their reports.

The question that arises, in the context of this study, is whether expert committees still constitute today a key element of the WHO system of expertise and, if so, whether the manner in which they are conceived still corresponds to the needs of the Organization.

5.2 Four hundred and one expert committee meetings were held from 1947 to 1978, i.e. in slightly over three decades. The number of committees meeting per year has varied between a minimum of seven and a maximum of 21, with a yearly average of 13 (Appendix 8). There has been a downward trend in the number of expert committee meetings each year in the last five to six years.

In the 11-year period extending from 1968 to 1978 - for which data are more readily available and which can be considered as representative of recent trends - 133 expert committees were held, for which 1189 invitations were issued to expert panel members; 56 of these experts were unable to attend the meetings. On the average, there were during that period 12 expert committees per year, in which 108 expert panel members - an average of nine experts per committee - were invited to participate and in which five experts were unable to attend, or about one expert for every second committee.

The same experts are often invited to more than one expert committee meeting; during the period 1968-1978 there were 205 such experts, against 600 experts invited only once. In other words, the number of different panel members invited to participate in expert committees during that period did not exceed 805, out of a total of 1189 invitations: this represents 32% or about one-third of the total number of experts on the panels. At this rate, three decades or more might be necessary for the number of experts invited to participate in expert committees to equal the number of experts on the panels.

The fact that about 25% of the experts invited are called upon to participate in more than one committee is explained, essentially, by the need to secure the necessary continuity in a sequence of expert committees on the same subject, the membership being only partially renewed each time, particularly where the setting of standards and the development of nomenclatures are concerned.

One consequence is that the probability of an expert panel member participating in an expert committee during his/her term of appointment is low. Participation in an expert committee, therefore, cannot be considered as the justification for appointment to an expert advisory panel; it is only one of the ways in which expert panel members may be consulted (see, in this connexion, section 4.4.1).

The tables contained in Appendices 9 and 10 for the same period (1968-1978) show (a) the distribution of expert committee members by WHO region of origin, and (b) the frequency of regional representation in expert committees. The largest number of expert committee members still come from the European Region and the Americas.

Forty-two per cent. of the expert committees held during that period included experts from five of the WHO regions; 83% included experts from four or more WHO regions.

Three hundred and ninety-eight expert committee reports have been published out of a total of 401. The first 18 reports, from 1947 to 1949, were printed in the WHO Official Records; from 1950 onwards the reports have been issued in the WHO Technical Report Series.

By the end of 1978, 632 volumes had been issued in the Series, including many reports of scientific groups, study groups and other expert meetings. Trends in the distribution of the Series, which apply inter alia to the distribution of expert committee reports, are illustrated by the following table:

Period	Number of TRS issues	Total press runs*	Average distribution per issue
1950-1959	184	1 145 350	6 224
1960-1969	254	2 339 950	9 212
1970-1978	194	2 449 700	12 630
Total for 1950-1978	632	5 935 000	9 390

* These figures concern only the English, French and Spanish editions of the reports, distributed from headquarters; they do not cover editions in Russian, Arabic, or other languages, which are published under special arrangements.

Some expert committee reports are published in a greater number of copies than others, at the Organization's initiative or in response to government or public demand. This has been the case in recent years, for example, for the reports of expert committees on smoking and its effects on health, essential drugs and arterial hypertension.[1]

5.3 The Technical Report Series, in which most expert committee reports have been published, has accumulated over the last 30 years a wealth of knowledge that is impressive and for which tribute must be paid to the experts who have taken part in the committees and helped in "the building up of a doctrine in public health" of unprecedented scope, on an unprecedented scale. It is only fair to add that the expert committees could not have

[1] WHO Technical Report Series, No. 568, 1975; No. 615, 1977, and No. 628, 1978, respectively.

achieved their aim without the support of WHO staff who have played a key role in the preparation of the meetings, in the meetings themselves, and in the preparation of their reports.

Expert committee reports, on the whole, have become an authoritative source of expert guidance the world over. They are extensively quoted and commented upon, sometimes very critically, in the world scientific journals; their main features, as summarized in WHO's press releases, are widely reproduced in the general press and they have no doubt contributed to the reputation of WHO.

Expert committees have played a major role in the so-called "central technical activities", many of which entailed the establishment of norms and standards and called for authoritative central guidance. Norms and standards have also been provided by expert committees in technological fields of direct interest to public health programmes, as in the case of insecticides and insecticide equipment. Moreover, no one can deny that expert committee reports have had a direct influence on "the carrying out of the activities of WHO" and, what matters more, on the carrying out of national health development programmes.

5.4 Against such positive aspects, however, expert committees have had their shortcomings. How these shortcomings could be corrected so as to enhance the intrinsic value of the reports and their usefulness to the Organization and to the world health community is, obviously, one of the questions this study should seek to answer.

Not all expert committee reports are of equal value. This is, of course, to be expected: the output of an expert committee depends on many factors such as the committee's membership, the timing of its meeting, the quality of Secretariat support received and, most important, the nature and scope of its subject.

5.4.1 The overriding consideration is that of the technical balance and internationally representative character of a committee's membership.

The Regulations state that, in selecting the members of expert committees, "the Director-General shall consider primarily their ability and technical experience. Subject to this primary consideration, he shall also endeavour to secure adequate geographical distribution". It has not been an easy task to reconcile these sometimes conflicting requirements. For some highly specialized subjects, involving a predominant basic research component or the establishment of standards or specifications, an "adequate geographical distribution" is often extremely difficult to achieve. Committees dealing with the social solutions of problems of health care, disease control or environmental health, for example, lend themselves to a much broader and equitable expert participation.

The Board has expressed constant concern over the Secretariat's performance in regard to geographical distribution. It has not been able to escape the feeling that a lot more could be done to improve the balance in the committees' membership. In its opinion opportunities to broaden the basis of expertise have been missed, the same experts from a limited number of advanced countries being called time and again as if they had a kind of monopoly. No doubt has ever been cast upon the individual ability of the experts, and the intrinsic value of their collective conclusions is generally recognized; it is simply felt that they do not represent broadly enough the world expertise in the field concerned.

Imbalance in the composition of a committee is often aggravated by the adjunction to the committee's secretariat of one or several consultants or temporary advisers of the same nationality as committee members. Here, it seems, a valuable opportunity to broaden the geographical, or international, basis of the committee is being missed.

A further constraint has resulted from the language problem. Not infrequently, there has been a tendency to restrict the committee's membership to experts using not more than one or two working languages so as to utilize the budgetary provision available for technical purposes rather than for interpretation. Although understandable from the point of view of the technical output of a committee, such a practice runs counter to the principle stated in the Introduction to the Regulations, that experts must adequately represent the various

branches of knowledge and the diversified forms of local experience and trends of thought prevailing in the various parts of the world.

Now the time is clearly ripe for taking a radical turn towards a more adequate balance of expertise. The ever growing pool of talents and experience in an increasing number of countries, the enlarged conception of expertise in relation to WHO's aim and objectives, the new orientation of WHO's programme towards technical cooperation with and between Member States, all open the way to a much broader participation of experts in the work of these committees. The opportunity must not be lost.

5.4.2 One good means of making the committees' work more representative of world trends, both technically and internationally, is to circulate in advance to all interested expert panel members the information prepared for any given committee, or even a precise questionnaire, and ask for their reactions and contributions. This may be one of the best ways of making the panels a living and productive advisory mechanism.

5.4.3 Another essential factor to be taken into account is the timeliness of an expert committee meeting in relation to its subject. There are, in all fields of endeavour, critical points in time when the "state of the art" can most opportunely be reviewed, for example when the sum of acquired experience lends itself to fruitful comparative evaluation or if a breakthrough in science or technology opens new perspectives for action. Too many expert committees have been planned in the past years without sufficient attention to their timeliness, which has undoubtedly weakened their sense of purpose and their practical value.

Because of the importance attached, particularly by the Executive Board, to the expert committees, and the prestige these committees derive from it, there has perhaps been a tendency on the part of the headquarters Secretariat, over the years, to multiply the committee meetings beyond what could be considered an optimal number in relation to their timing. This tendency has been definitely curbed in recent years, because of a lack of budgetary resources but also as an effect of the profound evolution in the conception of the Organization's aim.

5.4.4 The nature and scope of the subject-matter proposed for discussion in an expert committee have a direct influence on the usefulness of the committee's conclusions: if it is too broad the committee tends to confine itself to generalities and its report lacks relevance to the specific needs of its potential users; if it is too narrowly specialized its worldwide utilization may be considerably lessened. Here too, there is a critical point to be determined, which is not always easy.

A WHO expert committee report must not be conceived merely as a scientific and technical monograph or a chapter of a treatise on public health. It is an original and unique summing up of world knowledge and experience on a given subject at a given time, leading to practical conclusions of worldwide significance. It may also propose standards and specifications susceptible of worldwide application.

5.4.5 It may be considered surprising that most, if not all, expert committee meetings so far have been of practically equal length and covered by an identical budgetary provision. It would seem that at least some of the subjects treated might call for more extended discussions or necessitate more time for the preparation of the report. A degree of flexibility should be introduced in programming and budgeting for expert committees in the future.

5.4.6 A similar need for flexibility may be felt in regard to the number of experts invited to participate in a committee. The Regulations give the Health Assembly and the Executive Board the authority to fix the number of expert committee members, the Director-General being allowed to invite not more than two additional experts beyond this authorized membership. This rigid rule has created constant problems for the Secretariat and should be abandoned altogether. The Director-General should retain authority for determining in each case the number of committee members, due account being taken of the necessity to achieve an optimal technical and geographical balance in the group. In any case, the Director-General should report to the Executive Board on the decision made for each committee and on the justifications for it.

5.4.7 The question has often been raised as to whether it is reasonable to expect an expert committee meeting, in the short time available to it, to produce a final report without detracting from the substance of its discussions. The Regulations stipulate that the report "shall be approved by the committee before the end of the session"; this practice has always been strictly observed. The sessions of the committees usually extend over the weekend to allow for the draft report to be prepared by the rapporteur and the Secretariat.

It has been objected that the Secretariat, often with the help of consultants, prepares beforehand most of the material used in the drafting of the report, which is then more a compilation than the genuine reflection of an expert debate. The objection does not stand up to examination; the "state of the art" is known, from individual consultations with experts (including the ones invited to take part in the meeting) well before the committee actually convenes. What the committee does is to discuss each topic on the basis of the documentation provided, to examine that documentation critically, modify it or add to it in the light of the very latest information available, and reach a consensus on the conclusions to be drawn from it. Hard work is put into the preparation of the report, every day and night, by the rapporteur and the Secretariat. The report is generally concise, the supporting documentation usually being annexed to it.

5.4.8 The expert committee reports only represent "the collective views of an international group of experts" and "not necessarily the decisions or the stated policy of the World Health Organization"; all reports are published under that disclaimer. The Executive Board, when it considers an expert committee report, does not approve or disapprove it as such; it takes note of it, but it also deals with the consequences the report may have for the Organization or for its Member States.

Publication of an expert committee report depends on the authorization of the Director-General. The Director-General may or may not authorize publication, although as an almost constant practice until now publication has been authorized.

5.4.9 Last but not least, the question arises as to whether the reports of expert committees could be put to better use; this has been a constant concern on the part of the Executive Board. In its resolution EB37.R8 (1966) it invited the regional committees, whenever possible, to discuss the reports of the expert committees and suggested that national expert panels be established to consider the recommendations of these committees. The Nineteenth World Health Assembly, in resolution WHA19.51 (1966), endorsed the suggestion "so that the best use may be made of such recommendations in the context of the development of . . . national health programmes".

While no exhaustive review of the series of expert committee reports, from this point of view, has ever been performed, two evaluation studies have been carried out, at the Board's request, the first in 1968 on "the practical use of expert committee reports",[1] the second in 1972 on the 22 reports on malaria published in the Technical Report Series since 1950.[2] The first of these studies, which was of more general scope, was based on evidence provided by the written records of the Organization, the critique of the Secretariat and the comments made by Member States and other recipients of the reports; its conclusions will be found in Appendix 11 to the present document. At later sessions, the Board again requested the Director-General "to bring to the attention of the regional committees the importance and practical use of reports of expert committees" and "to study . . . how best to evaluate the expert committee reports, including their overall impact on national health programmes".[3] The Board thereby unequivocally expressed its intention to maintain a system of undoubted value and to adapt it to make it bear not only on a global synthesis of scientific and technical knowledge but on the promotion of national health development programmes.

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[1] Report by the Director-General (document EB41/23, Corr.1 and Add.1, 1968).

[2] See WHO Chronicle, 26: 496 (1972).

[3] Resolutions EB42.R12 (1968) and EB47.R25 (1971).

It is quite encouraging to note that the distribution of the Technical Report Series, including reprints, has constantly grown in the three decades of the life of the Organization (see the table in section 5.2 above), but increased dissemination is not the only answer to the problem. It remains to ascertain whether such dissemination is adequate, i.e., whether the reports reach those who need them and can put them to best use.

5.5 One important point to be made at this juncture is that the above shortcomings relate to the expert committees as they have been conceived and utilized until now, that is as a global mechanism of overall expert guidance. The recent evolution of the Organization towards a new approach integrating its global, regional and national levels of operation in most aspects of its work poses the question whether expert committees should not now be seen in this broader perspective, in other words whether expert committees could not be convened at either of the three operating levels: at the global level, as before, to provide overall expert guidance on problems of worldwide interest; at the regional level to deal with issues of a specifically regional nature; and at the national or intercountry level to tackle even more specific and circumscribed health situations.

The international commissions which have been convened by the Organization in a number of countries to certify the eradication of smallpox were expert bodies in the fullest sense of the word, dealing with a national issue of crucial importance for the world, and they might well have deserved formal recognition as expert committees. There is little doubt that in the future such matters as primary health care, the provision of essential drugs and the role of traditional medicine will call for an organized ensemble of expert meetings held at the national, regional and global levels as appropriate.

It will be of great importance for such an ensemble, where deemed necessary, to constitute a single whole integrating the expert advice received at the various echelons into a coordinated effort, based on a two-way information flow: dissemination of general scientific and technical guidance from the centre to the periphery, coupled with information feedback from the national and regional echelons for a global synthesis.

5.6 The following recommendations are made on the future use of expert committees:

(i) Expert committees at the global level should remain a key element of the WHO system of expertise. They would continue to review from time to time the status of knowledge in their respective fields from a broad international point of view and to formulate pertinent technical recommendations, including the setting of international standards and specifications, thereby providing to the Member States of the Organization technical bases on which to develop their health programmes.

(ii) In addition, expert committee meetings held at the regional level should tackle issues of predominantly regional character, while at the national or intercountry level the convening of such committees might be justified by even more circumscribed or specific health problems.

These various types of expert committees should be planned in a coordinated manner so as to complement each other, avoid duplication, and ensure maximum effectiveness and coherence in the output of the mechanism as a whole.

(iii) The number and periodicity of expert committee meetings in any given field should be determined in such a way as to achieve the greatest possible impact of the committees' findings and recommendations on the activities of the Organization as well as on national health development in its Member States.

(iv) Without detracting from the primary importance which should continue to be attached to their technical standards, expert committees should be so composed as to ensure the most adequate international representation of "the diversified forms of local experience and trends of thought prevailing in the various parts of the world".[1] This necessity should be taken into account in fixing the number of their members.

Consultants and temporary advisers assigned to assist a committee in its work should be selected, as far as possible, from countries not represented in the committee's membership.

(v) No limitation in the membership of expert committees should result from considerations of language.

(vi) Members of expert committees should continue to be selected from among expert panel members. To secure appropriate interdisciplinary balance of expert committees, members of different panels might be invited to any given committee.

(vii) To provide a committee with the broadest possible spectrum of knowledge and experience, experts of panels particularly concerned with the subject under discussion should be supplied in advance with the main working documents prepared for the committee, or a questionnaire, and be asked for their comments.

(viii) Expert committees should, as has so far been the constant practice, approve their reports before the end of their session.

(ix) While the Director-General should continue to include in his proposed programme budget the expert committees it is intended to convene in a biennium, whether global or regional, for consideration and approval by the Board and the Health Assembly, he should have full authority, for each committee held at the global level, to fix the number of experts to be invited, to determine the length of the meeting, generally to take any action which may facilitate the work of the committee and ensure its greatest possible efficiency, and to authorize the publication of its report.

Where expert committees held at the regional, intercountry or national level are concerned, such authority may be exercised by the Regional Director, in consultation with the Director-General to ensure coordinated action.

(x) Continued attention should be given to the dissemination and utilization of expert committee reports, as part of the evaluation effort of the Organization, and, most importantly, to their "overall impact on national health programmes".[2] The role of the WHO regions is of the utmost importance in this regard.

(xi) The Director-General should continue to submit the reports of the expert committees to the Executive Board and to keep it informed of the efforts made and of the results achieved, in particular, towards a more adequate balance in the committees' membership and a wider and more effective utilization of the expert committee reports.

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[1] Introduction to the Regulations for Expert Advisory Panels and Committees (WHO Basic Documents, 30th ed., 1980, pp. 89-97).

[2] Resolution EB47.R25 (1971).

6. Other expert meetings dealing with the programme in general

6.1 In addition to expert committees, other expert meetings are convened, formally or informally, to secure expert advice in support of WHO's programme as a whole.

It may be worth mentioning here that many other types of meetings serving WHO's programme, such as seminars, symposia and workshops, are not referred to in this study. They are essentially educational in nature. They are held, in large numbers, on a regional or interregional basis, not to mention those with WHO support related to national endeavours. They no doubt involve expertise, if only within their teaching faculties, but they are not fundamentally constituted for the provision of expertise. While they might deserve the Board's attention in their own right, it was not felt that they should be included in this organizational study. Clearly, however, the principles and procedures concerning experts and expert meetings developed in the study could be largely reflected in the conception and management of these educational meetings.

6.2 The study groups were established by the Executive Board in 1956. Their characteristics are defined so explicitly in resolution EB17.R13 of that year that it is cited below almost in toto:

> The Executive Board,
>
> . . .
>
> 1. BELIEVES that study groups are necessary, in addition to expert committees, in order to enable the Director-General to discharge his task normally;
>
> 2. IS OF THE OPINION that, in principle, the convening of a study group is preferable to the convening of an expert committee if one or more of the following conditions are present:
>
> (a) the scientific or technical knowledge of the question to be studied is still too uncertain, and the opinions of competent specialists too diverse, for there to be a reasonable expectation of practical conclusions which can be immediately utilized by the Organization;
>
> (b) the study envisaged concerns a strictly limited aspect of a general problem, which may or may not come within the purview of an expert committee;
>
> (c) the study envisaged implies the collaboration of narrowly specialized participants who may belong to very different disciplines and on whom the Organization occasionally calls without its being necessary, however, to include them in its expert advisory panels;
>
> (d) certain non-technical factors render unsuitable an expert committee meeting, which would be too official in character;
>
> (e) urgent or exceptional circumstances call for some administrative procedure which will be simpler and more rapidly applicable than that involved in meetings of expert committees;
>
> 3. EMPHASIZES that the meetings of study groups and expert committees should be, within the same field of activity, closely complementary and should form part of the development of a coordinated programme;
>
> 4. REQUESTS the Director-General to communicate the reports of study groups to the Board, accompanied by any remarks that may be useful, so that the Board will be able to take any decision it may deem opportune with regard to such reports; and
>
> 5. AUTHORIZES the Director-General to convene any study group he may consider necessary, even when such study group has not been provided for in the corresponding programme and budget estimates, it being understood that he will report on any such step to the Board at its next session.

The Board's decision has undoubtedly proved useful; it has responded to a felt need for more flexibility in the convening of expert meetings. The Director-General has availed himself of that new possibility and study groups have produced valuable reports, most of which have been published in the Technical Report Series.

In the course of time, however, study groups have tended to become more formal and to look somewhat like "second-class" expert committees; they have regularly been included in the proposed programme budget, though the Director-General is allowed, under resolution EB17.R13, "to convene any study group he may consider necessary, even when such study group has not been provided for in the corresponding programme and budget estimates".

This evolution can be explained, in part at least, by the advantages of a type of meeting carrying no restriction as to the choice of participants[1] and having, otherwise, the same advantages as expert committees. The borderline between the two meetings has thus become less and less distinct over the years. It seems that this situation could be usefully redressed, in a simple way, by coming back to resolution EB17.R13 and by observing more strictly the conditions outlined in operative paragraph 2 of that resolution, so that study groups again become what they should never have ceased to be: a complement to expert committees.

> It is consequently recommended that study groups, as defined in resolution EB17.R13, should be maintained as formal meetings complementary to those of expert committees. Their management, however, should be made more flexible, greater freedom of initiative being given to the Director-General. More specifically, study groups could be convened, when one or more of the conditions outlined in operative paragraph 2 of the Board's resolution were met, at the discretion of the Director-General, who would decide on the nature and scope of their subject, their timing and length, their membership and, afterwards, whether or not their report should be published.[2] In so doing, the Director-General would follow, as far as practicable, the principles applicable to expert committees, with particular regard to an adequate technical and international balance.

Reports of study groups would continue to be submitted to the Executive Board, as has been the practice until now, the Director-General indicating the implications their recommendations might have for the work of the Organization as well as any step he may have taken for their dissemination (including publication of their reports) or as a result of their recommendations.

6.3 The need for the Director-General to convene groups of experts to advise him on programme issues or to help him to respond to demands from Member States, from the scientific community or from international public opinion, under varied circumstances and particularly under the pressure of time, has led to the increased use of informal meetings or consultations.

These meetings, in fact, respond to the conditions outlined in the Board's resolution on study groups, with the difference that their conclusions are submitted to the Director-General, informally, and are not reported to the Board. There is no doubt that such informal consultations are useful instruments for the development of WHO's programme; they contribute to establishing a spontaneous and productive partnership between the experts and the WHO Secretariat.

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[1] As indicated above (see section 4.4.2), membership of an expert committee must be drawn from the expert advisory panels. For all other meetings, including study groups, any expert, panel member or not, can be invited to participate.

[2] The comments in sections 5.2 and 5.4 above on the dissemination and use of expert committee reports apply also to the publication of reports of study groups.

> It is recommended that informal consultations be acknowledged as a means in the hands of the Director-General to be used by him in legitimate circumstances, especially to meet emergency requirements. While the rules governing formal meetings are not applicable, in their letter, to these consultations, their spirit should guide the Director-General in his actions, especially concerning the adequate participation of experts from various disciplines and from various parts of the world.

6.4 In the WHO regions, a large number of expert meetings of various types are convened to deal with regional issues. The Regional Directors also make use of informal consultations.

> The Regional Directors should from now on avail themselves of the possibility of holding meetings analogous to study groups and make use of informal consultations as required. Care should be taken in each region, however, to ensure optimal correlation of meetings of study groups with those planned on the same or related subjects in other regions or at the global level of the Organization.

7. Expert meetings dealing with research

7.1 Although expert committees, study groups and informal consultations deal with the research aspects of their subjects, it has been found necessary, for the sound development of WHO's research activities, to set up specific mechanisms involving research expertise.

7.2 Scientific groups play a role in the research field fully comparable to that of the expert committees and study groups for the programme in general. Indeed, published reports of these three types of meetings compose, almost in its entirety, the Technical Report Series, in which reports of scientific groups began to be published in 1963.

The scientific groups are described in the WHO Manual[1] as follows:

> Scientific groups have the function of assisting the Organization in reviewing a designated field of medical research, assessing the existing state of knowledge in that field, and determining how this may best be advanced and extended. Members of scientific groups are preferably but not necessarily selected from WHO expert advisory panels. When a scientific group considers the existing state and requirements of research in a broad field, it should include one or more experts with wide experience in the organization of research. Scientific groups are convened by the Director-General and do not require the specific approval of the World Health Assembly, although they are normally included in the proposed programme budget. The reports of scientific groups, whether printed in the Technical Report Series or reproduced as offset documents, are submitted to the Advisory Committee on Medical Research.

Scientific groups have covered a vast field of research related to the development of WHO's programme, as demonstrated by the 111 reports of scientific groups that were published in the Technical Report Series between 1963 and 1978. Scientific groups have made a useful contribution to the progress of research on a worldwide scale, particularly by providing the expert committees with the research data and guidance on which these committees have largely based their own recommendations.

While scientific groups are not subjected to the strict rules applying to expert committees, they have been managed in a similar, though more flexible, way, especially with regard to their composition.

7.3 In the research field, too, the need has been felt to use the collective talent of experts in a less formal way.

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[1] WHO Manual, Part V, Section 4, para. 80. The WHO Manual is an internal Secretariat document containing all instructions on policies and procedures applicable to the work of the Organization, as determined by the Director-General for the activities of the Secretariat in compliance with the resolutions and decisions of the Health Assembly and the Executive Board.

Meetings of investigators engaged in collaborative research schemes initiated and/or supported by WHO and also meetings of directors of collaborating centres held at regular intervals have very positively influenced the research programme of the Organization, as have the research institutions and the scientists involved.

These informal research meetings, besides their intrinsic scientific value, have had the important effect of initiating a new type of international collaboration based on a planned sequence of activities and meetings, over a period of years, for the formulation, implementation and evaluation of agreed research plans. This new approach contained, in germ, the more recent developments described hereafter.

7.4 In recent years, indeed, new mechanisms of WHO expertise have evolved and been used to a rapidly growing extent in response to the needs of new research programmes. The programmes in question are the Special Programme of Research, Development and Research Training in Human Reproduction and the Special Programme for Research and Training in Tropical Diseases.

The Special Programme of Research, Development and Research Training in Human Reproduction was conceived as long ago as 1970 and became operational in 1972. The Special Programme for Research and Training in Tropical Diseases was devised in 1973 but its implementation started, after a rather prolonged initial phase of planning and pilot operations, only in 1977.

Although dealing with totally different areas of research, these programmes have common characteristics. They both have a strong orientation towards the objective of finding the health answers to the problems posed on one side by the size and growth of human populations, in relation to the wellbeing of the family and the community, on the other by the prevalence of major communicable diseases in tropical areas of the world. Neither diverges from the accepted principle that research in WHO must be considered not as a separate endeavour but as part and parcel of the programme. In fact, their aim is precisely to provide action programmes with new, more efficient tools and, to that end, to enhance research capabilities wherever possible and necessary. Although they are identified as separate programme entities they must be seen in their correlation with the programme as a whole.

Multidisciplinary groups of scientists have been set up, on a worldwide basis, under the name of task forces or scientific working groups to define research objectives, devise a strategic plan to achieve them, follow up the implementation of the plan and monitor progress. Each task force or scientific working group has a steering committee, with a more restricted number of scientists, which guides the group's activities towards its objectives. Incidentally, it is unfortunate that two different appellations are being used to designate the same mechanism. Also, "scientific working groups" may well be mistaken for the "scientific groups" described in section 7.2. Serious consideration should be given to the possibility of using a unified designation in the future.

In addition, the Special Programme of Research, Development and Research Training in Human Reproduction has established:

- an advisory group of 12 members, meeting once a year, to recommend strategies, mechanisms and overall budgetary allocations for research, and to review progress; and

- a review group of 25 members, meeting twice a year, to assess individual activities from the technical, ethical and budgetary viewpoints.

The Special Programme for Research and Training in Tropical Diseases has set up a Scientific and Technical Advisory Committee (STAC) similarly responsible for providing overall stimulation and guidance to the Programme. The same device has been adopted by the diarrhoeal diseases control programme, an action programme with a research component.

These new mechanisms allow for a clear initial definition of programme goals and of the steps necessary to achieve them, assembled into a time-related strategic plan of action. Ultimate goals rarely change, but the feasibility and relative priority of various lines of research evolve as work progresses, new information is obtained or new problems emerge. This evolution may result in the phasing out of one line of activity and the adoption of an

entirely new approach; such changes must be reflected in the strategic plan which remains the basis on which task forces or scientific working groups operate.

The most novel feature of the task forces and scientific working groups is the much closer and more permanent involvement of the world scientific community in the activity of the WHO Secretariat. That activity acquires a new dimension, well in line with the overall move of the Organization towards more genuine forms of technical cooperation. It is likely that the formula will be reproduced, mutatis mutandis, in other programme sectors, when the necessary conditions are met, and then gain ground step by step. The new diarrhoeal diseases control programme is already making use of the "scientific working group" approach.

7.5 The expert meetings used by WHO for the development of research form a rather composite picture at the present time. Scientific groups have a long record of achievement as the research complement of expert committees. Meetings of investigators and similar informal groups have given notable impetus to the research activities of the Organization. The new approaches just described are, indeed, promising. They seem, in their conception, better to respond to the present orientation of the Organization's programme policy and strategy. They have already been subjected to evaluation in the field of human reproduction and that evaluation has been positive. It is too early to express an opinion regarding tropical diseases and only the coming years will tell whether such approaches can lead to optimal efficiency and, moreover, whether they lend themselves to wider application.

In any event, it is essential that the general principles concerning expert advisory panels and committees, as well as the other types of expert meetings analysed in this study, should be fully applied to the task forces, the scientific working groups and their steering committees, especially in respect to a balanced membership from the technical and international points of view.

Research is an area in which the Organization's activity will undergo rapid change, which cannot be entirely foreseen at this stage. Hence the importance of the role to be played by the advisory committees on medical research (ACMRs) at the global as well as at the regional level. These committees receive and analyse information on all research activities of the Organization, including the reports of the scientific groups. They advise the Director-General and the Regional Directors on research policy and the overall orientation of the research programme; they propose research priorities and review in depth selected aspects of the programme.

Particular attention is being given to the ways of ensuring the necessary coordination and mutually supportive action between the regional ACMRs and the global ACMR, so that decentralization of this research mechanism, which is meant to increase efficiency, does not result in fragmentation of efforts and contradictory approaches.

7.6 It is recommended that:

(i) scientific groups should continue to be convened to deal with research issues related to the development of WHO's programme;

(ii) scientific groups should follow in their composition and in their work, mutatis mutandis, the general principles applicable to expert committees, except that their membership need not necessarily be drawn from the expert advisory panels;

(iii) reports of scientific groups should continue to be submitted for review to the global Advisory Committee on Medical Research;

(iv) scientific groups should be planned and managed, under the authority of the Director-General, in the same way as expert committees;

(v) other types of expert meetings dealing with research, such as meetings of investigators or of directors of collaborating centres, as well as the task forces or scientific working groups of the Special Programmes, should also be planned and managed in keeping with the general principles applicable to expert committees, particularly concerning technical and international membership;

(vi) the Director-General should be requested to analyse these various approaches in depth with the advice of the global and regional ACMRs, and report in due course to the Executive Board on how best they could be associated or interact with each other for maximum programme effectiveness.

7.7 Seen in overall perspective, the system described above may lack balance and cohesion. Old-established, strictly governed and rather rigid global mechanisms conflict with newer and more flexible approaches and are being challenged by regional initiative. The mechanisms for general technical expertise and research may well overlap. While the network of global and regional advisory committees on medical research deals with the synthesis of WHO's research activities, there has been so far no comparable advisory mechanism for the WHO programme as a whole; such a mechanism for overall programme review, however, is now being envisaged by the Executive Board. A most striking defect in the system is the poor utilization made of the expertise available in the countries and for the countries in the development of national health programmes. Each of the components of the system, however, has played a definite role in the development of WHO's activities. Moreover, all these different mechanisms should promote the unrestricted participation and contribution of all Member States and full mobilization of the world's resources of wisdom, knowledge and technical experience.

III. WHO MECHANISMS OF INSTITUTIONAL COLLABORATION

8. WHO collaborating centres

8.1 The idea of using national institutions for international purposes dates back to the days of the League of Nations, when national laboratories were first designated as reference centres for the standardization of biological products. As soon as WHO was established, it appointed more reference centres, starting in 1947 with the World Influenza Centre in London for worldwide epidemiological surveillance. The number of such centres rapidly increased from 1958 onwards, with the expansion of WHO's intensified programme of medical research.

By analogy with the WHO expert advisory panels, the worldwide networks of WHO collaborating centres may be taken, in a sense, as the Organization's "institutional panels" of expertise. As will be seen, the two mechanisms have much in common and strengthening their association can be of great benefit to the Organization and to its Member States.

8.2 In 1968, there were 168 WHO collaborating centres, distributed among 34 countries. At the end of 1978, there were 582 centres in 62 countries.

These centres today cover a broad range of programme activities, particularly in research. Their distribution among five main programme budget headings is as follows:

Development of comprehensive health services (DCHS)	141
Health manpower development (HMD)	8
Disease prevention and control (DPC)	300
Promotion of environmental health (PEH)	125
Health information (HI)	8
Total	582

The following table further indicates, under the same headings, the distribution of the centres among the six WHO regions:

Major programme	WHO regions						Total
	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	
DCHS	7	35	13	66	9	11	141
HMD	-	2	-	3	3	-	8
DPC	12	82	7	164	12	23	300
PEH	9	33	7	57	10	9	125
HI	-	3	-	4	1	-	8
Total	28	155	27	294	35	43	582

The diagram and graph in Appendices 12 and 13 show (a) the distribution of the WHO collaborating centres by WHO regions in 1978, and (b) the evolution of that distribution from 1948 to 1978.

There are in two regions, Europe and the Americas together, no less than 449 centres, operating in 35 countries; the three countries with the largest number of centres (the United States of America, the United Kingdom of Great Britain and Northern Ireland, and the USSR) have very nearly one-third of the total number - 193 out of 582. The four other regions together total 133 centres, operating in 27 countries. Of the countries where there are centres, the majority (34) have between 1 and 5 centres; 13 countries have between 6 and 10 centres, and 10 countries between 11 and 20. Ninety-one countries have no centres. Appendix 14 gives the number of WHO collaborating centres by region and country as at 31 December 1978.

With respect to programme area, the absolute majority (300 or 51.5%) of the centres deal with disease prevention and control. Thereafter come the development of comprehensive health services (141 or 24.2%) and the promotion of environmental health (125 or 21.5%). Health manpower development and health information lag far behind, with eight centres each.

As in the case of expert panels, these data provide a useful baseline for the future evaluation of the role and utilization of collaborating centres in the programmes of the Organization, especially where research is concerned.

8.3 Advantages and disadvantages of the mechanism as it now operates

8.3.1 The present networks of WHO collaborating centres have played and are continuing to play an important role in the development of WHO's programme, and particularly its research component.

8.3.2 The most positive feature of this mechanism is, perhaps, that all these centres have been created in already existing institutions. As early as 1949, the Second World Health Assembly laid down the policy (which has been constantly followed since) that the Organization should not consider "the establishment, under its own auspices, of international research institutions" and that "research in the field of health is best advanced by assisting, coordinating and making use of the activities of existing institutions".[1] All WHO collaborating centres, whether they deal with research or not (most of them do), have been designated under that policy, which has undoubtedly enhanced national participation in the Organization's activities. There is, however, an exception to that policy, in the WHO Region of the Americas, where a number of "international health centres", some with regional (hemisphere-wide), others with subregional functions, have been set up, and are financed and administered by the Pan American Health Organization, the regional organization of WHO for the Americas. A summary description of these centres, which form part of the WHO system of expertise, is contained in Appendix 15.

[1] Resolutions WHA2.19 and WHA2.32 (1949).

8.3.3 WHO collaborating centres have been selected until now mostly from among institutions of high scientific and technical standing, or at least from institutions having already acquired a good scientific reputation. This is understandable and, indeed, appropriate on the part of the world's "directing and coordinating authority on international health work": it had to secure for itself the best expertise available. Moreover, the networks of collaborating centres were expected to deal primarily with biomedical research and reference and information services of a highly technical character. These reasons explain the quite uneven distribution of the centres among the countries and the WHO regions, the most being in Europe and, although relatively fewer, in the Americas, the remainder being divided between the other four regions (see section 8.2 above and Appendix 12).

The real answer to the problem lies in a broader definition of the nature and functions of the centres in keeping with the Organization's policy of technical cooperation, much more emphasis being laid from now on on the strengthening of institutions, particularly in the developing countries. It is, for instance, characteristic of developments up to now that by far the largest proportion of WHO collaborating centres working on tropical diseases is situated in Europe and North America. While these centres should no doubt continue to contribute to WHO's programmes in this area, every effort should be made from now on to develop the capability of institutions working on those diseases in the tropical parts of the world.

8.3.4 The distribution of the centres by discipline or programme area is also uneven. To an extent this is understandable, as the needs differ from one discipline or area to another; as already pointed out the needs, until now, have been predominantly scientific and technological in nature, which explains the pride of place given in the system to disease prevention and control. There are unmistakable signs that WHO collaborating centres will be used in a much broader context in the future, particularly in relation to appropriate technology and health services research. Here again, meeting the growing need for institutional support to technical cooperation programmes at the country level should lead to considerable improvement in overall balance.

8.3.5 The distribution of functions necessarily varies from one centre to another and a measure of flexibility should be preserved so that each centre may provide the type of collaborative work which its programme objectives require. However, the considerable differences existing at present do not always appear justifiable and due attention should be given to the possibility of reducing them.

8.3.6 Until recently the centres' relations with the Organization have been developed exclusively at the central level with the Geneva headquarters. They have been generally good and mutually appreciated, although, like expert advisory panel members, some centres have collaborated more effectively than others. Their relations with the WHO regional offices, on the other hand, have generally remained very weak or non-existent. The situation will change substantially now that the regions participate in the full range of WHO's programme activities, including research, and that major responsibility has been delegated by the Director-General to the Regional Directors with regard to the work of the collaborating centres.

8.3.7 The extent of the financial support WHO accords to different collaborating centres, in remuneration for their services, varies greatly. Whereas programmes endowed with substantial extrabudgetary funding allocate quite sizeable sums of money to collaborating institutions, WHO's support to others, under its regular budget, is small or only nominal; moreover, quite a number of centres do not receive financial aid at all, even though they contribute significantly to the work of the Organization.

It has often been said, with truth, that WHO's money serves primarily as a catalyst, to attract sometimes considerably greater amounts of money from national and other international sources, and that the Organization receives, in services, dividends greatly in excess of its small investments. Every attempt should be made to maintain such a favourable cost-benefit ratio wherever possible, but it seems likely that larger investments on the part of WHO will be required in the future to give the necessary impetus to objective-oriented collaborative activities. In that way WHO should achieve a more specific and focused use of its resources. The foreseeable increase in the number of collaborating centres in developing countries, whose institutions will require stronger support for a longer duration, will inevitably reflect on the volume of those investments.

8.3.8 While activities in which the WHO collaborating centres cooperate are assessed individually, in relation to specific programmes, there is no comprehensive evaluation mechanism generally applicable to the work of the centres. No uniform or even comparable criteria are used for the granting of contracts and for determining their optimal duration. It is a heavy task to follow up on the execution of a large number of contractual agreements in many countries all over the world; the involvement of the WHO regional offices in the process in close cooperation with the Geneva headquarters should permit easier and more frequent contacts with the centres and facilitate such evaluation.

8.3.9 According to present practice, an institution is designated initially for a term of three years; the designation may be renewed for a further period of three years. However, in most cases, the designation is in fact renewed for several periods and the tendency has developed, among directors of the centres, to take periodic redesignations for granted (much like expert panel members who generally expect repeated renewals of appointment). This may be a strength in that it ensures long-term support to and the development of a closer scientific partnership with the Organization (and also perfectly justifiable in a number of cases, as in worldwide epidemiological surveillance programmes and in most aspects of standardization), but it may constitute a weakness, in that automatic renewal risks perpetuating activities which are unproductive or, in cost-benefit terms, not worth prolonged support.

New programmes, with a strong goal orientation and substantial extrabudgetary funding, have established elaborate mechanisms for scientific and technical review and monitoring of activities, particularly as all cooperating parties (whether beneficiaries or financial contributors) must be reassured that these activities are conducted both efficiently and economically. This new approach might well acquire preeminent importance in the future, but even smaller investments should be submitted to adequate technical and financial evaluation.

8.3.10 The above remarks offer a number of analogies with those made in regard to expert advisory panels (see section 4 above). This is not surprising as both mechanisms are geared to the same end, namely to distil from a vast reservoir of expertise the optimal qualitative and quantitative support WHO needs in the accomplishment of its tasks. Indeed, most of the directors of WHO collaborating centres are members of a WHO expert advisory panel, and collaborative activities are developed by the centres under the guidance of periodic meetings of experts, such as the meetings of directors of collaborating centres. One of the objectives of the present organizational study is to open the way to even closer and more systematic correlation among the individual, collegiate and institutional elements of the WHO system of expertise.

8.4 An enlarged conception of the WHO collaborating centre

By definition, a WHO collaborating centre forms part of an inter-institutional collaborative network set up by WHO in support of its programme at the country, intercountry, regional, interregional and global levels, as appropriate. But there is more to it than that. In line with the present WHO policy and strategy of technical cooperation, a WHO collaborating centre must also participate in the strengthening of country resources, in terms of information, services, research and training, in support of national health development.

> While institutions of high scientific and technical standing should retain their legitimate place in the system, to qualify as a WHO collaborating centre an institution need no longer attain such a level of international recognition. Institutions, particularly in developing countries, which have a potential for excellence but still require strengthening to varying extents and for varying periods of time, may also qualify for designation as WHO collaborating centres if it is considered that they can play a role in national and/or international health development. One of the merits of the denomination of "WHO collaborating centre" is precisely that it does not prejudge the capability of the institution concerned, except in its potential to collaborate.

The mechanism of WHO collaborating centres will, from now on, cover a broader spectrum of institutional capability. Due care, of course, will have to be taken to determine the basic

conditions an institution must satisfy to be considered for designation. In the most advanced institutions, WHO's input will be minimal for maximal returns (as has been the case until now): in the less advanced, WHO's support, in terms of manpower and manpower training as well as of equipment, supplies and grants, will be maximal for minimal initial gains. A variety of intermediate situations, calling for great flexibility in WHO's involvement, can be envisaged between these two extremes.

8.5 Functions of the WHO collaborating centres

The functions of the WHO collaborating centres are manifold. The WHO Manual lists a number of them as examples of the types of functions that may be carried out by the centres, with the proviso that the list should not be regarded as comprehensive. It seems, however, that these functions can be logically grouped under a few major headings.

8.5.1 The WHO collaborating centres participate in the synthesis and dissemination of information, namely: (a) the scientific and technical information they need for the conduct of their activities and which these activities generate; and (b) information of interest to the country's national health development and/or to WHO in the implementation of its programme.

Special importance must be attached to the exchange of scientific, technical and programme information between the centres and other concerned institutions within or outside the country, particularly those forming part of the same WHO collaborative network.

8.5.2 The WHO collaborating centres are used, in various fields, for the purpose of standardization of terminology and nomenclature, of diagnostic, therapeutic and prophylactic substances, of technologies, methods and procedures, etc.

Standardization is typically a global function, devolving upon the central echelon of the WHO Secretariat, but it benefits all Member States by developing common denominators and a universal language allowing for better international understanding and easier comparison of data on a worldwide basis.

Many examples of collaborative work undertaken for the purpose of standardization under WHO's aegis may be cited, inter alia:

- the international classification of diseases;
- the establishment of international standards and reference preparations for biological substances used in human and veterinary medicine;
- the production of chemical reference substances in relation to the International Pharmacopoeia and the national pharmacopoeias;
- the international histopathological nomenclature and classification of tumours (in which no less than 16 centres, each dealing with a particular type or site of tumour, have been involved);
- the setting of standards for the pathology of atherosclerosis.

8.5.3 The WHO collaborating centres provide services under two major aspects.

The first aspect is a traditional, long-established one: it concerns services provided to the Organization in support of programmes of global interest. In the worldwide programme of epidemiological surveillance of influenza, for instance, two WHO collaborating centres receive from 101 national laboratories in 72 countries epidemiological information on outbreaks of influenza, which is made available to all Member States through WHO's permanent telex service and the Weekly Epidemiological Record, and new strains of the virus for characterization and advice as to their possible use in vaccine preparation. In turn, the centres distribute to these laboratories the reagents, antigens and antisera they need, and to vaccine producers high-yielding recombinant viruses for the preparation of the vaccine.

This distribution of reference substances is an important and often ignored aspect of the service function of the centres. To quote only one example, in the WHO programme of virus diseases, in 1975-1976, the centres supplied to national laboratories and centres in more than 30 countries about 4000 strains of virus, 30 000 ml of antigens, 9000 ml of corresponding sera, 4000 ml of receptor-destroying enzyme, and 50 different tissue cultures.

The evaluation and testing of new insecticides is another type of service in which WHO collaborating centres for vector biology and control have been deeply involved.

Collaborating centres have been a constant source of support to the Organization and to its Member States in epidemics, for epidemiological surveillance, for the identification of the causal agent(s), and for the development of preventive measures.

The second aspect of the service function of the centres remains to be fully developed, but it is of the greatest significance for their future: the centres' involvement in technical cooperation for national health development.

By their permanent linkage with cooperating institutions in the countries, the centres can and must play a decisive role in institutional development. Positive results have already been obtained in this respect, for example in the influenza programme already mentioned, which, by involving 45 institutions in 38 developing countries, has had undeniably stimulating effects on the development of virus laboratories in these countries. The special programme on human reproduction, inter alia, has had a significant impact, through its collaborating centres, on research and training, as well as on action programmes in the developing countries.

The WHO collaborating centres in the future must become more directly effective instruments of technical cooperation in support of the Organization's overall effort towards the attainment of better levels of health for all.

8.5.4 Since the inception in 1958 of WHO's intensified programme of medical research, the research function of the WHO collaborating centres has acquired a growing and rapidly predominant importance. It can be said without exaggeration that the approximately threefold increase in the number of centres in the course of the last two decades has been due mainly to the development of the research component of WHO's programme.

There is nothing objectionable in this evolution; on the contrary, it is a positive fact that a large number of WHO collaborating centres already exist which can be used by the WHO regions in support of research activities of regional scope or undertaken in the countries of the region. The research orientation of the centres will have to be adjusted to these new regional requirements, but without prejudice to the role which they should continue to play in programmes of global interest.

The WHO collaborating centres will therefore be the keystones of the collaborative research efforts developed under WHO's leadership at all levels; they should form, for each specific research objective in the various programme sectors, a closely knit functional network.

The activities of the networks should be planned, monitored and evaluated with the active and continued participation of the scientific community, at the national, regional and global levels. Meetings of directors of collaborating centres in the past, and the task forces or scientific working groups of the special programmes today, exemplify this process which gives to the research functions of the centres the added dimensions of research planning and research monitoring and evaluation.

Here again it appears that no arbitrary distinction can be made between the individual expertise secured through the various types of expert meetings and the institutional expertise afforded by the collaborating centres. Both mechanisms must be used together and it is through their interplay that real collaboration can be fostered.

8.5.5 Last but not least, the WHO collaborating centres play an essential role in training and particularly in research training. With the present emphasis on the strengthening of institutions, especially research institutions, in the developing countries, this role appears all the more important.

As an illustration, when WHO decided to expand its activity in the field of immunology, it first set up "research and training centres" because no real progress could be envisaged without a minimal core of qualified immunologists in the countries themselves. This is not an isolated example and, since then, the special programmes on human reproduction and tropical diseases have been based on the strong, intimate association of research and training.

The most advanced among the WHO collaborating centres constitute ideal "resource centres" for training and research training, the less developed ideal grounds for progressive enrichment in qualified manpower, pari passu with the qualitative and quantitative growth of research activities.

8.5.6 To these intrinsic functions of the collaborating centres must be added, for some centres, a function of coordination. Where the centres of a given network participate in a collaborative scheme it may be necessary to assign to one or more of them, chosen in consideration of their quality and experience, the task of promoting, supporting and harmonizing the work undertaken in common.

8.5.7 In conclusion, the profile of any WHO collaborating centre will consist of a specific set of functions selected from among the types described above, namely: information synthesis and dissemination; standardization; reference services and programme development support; research, including research planning, the performance of research, research monitoring and evaluation; training and coordination.

Before an institution is considered for designation as a WHO collaborating centre, its individual profile should be drawn up in the light of the criteria defined in section 8.7 below. That profile would be used thereafter to assess the progress made in the development of the centre's capability as well as in its work performance.

Although no one centre is identical to another and the individual profiles would form a highly varied spectrum of capabilities and performances, it might well be possible to group the centres under a limited number of characteristic profiles. Only an in-depth analysis could demonstrate whether such a possibility, which would clarify and simplify the picture, exists.

8.6 How were the centres named?

The name of the centres has varied over the years. For more than two decades they were known as "WHO reference centres", though their activities extended far beyond the "reference" services they were initially expected to provide. Some were "international", others "regional"; they differed in geographical scope but their functions were very similar. Two types of centres were set up, in varying numbers and proportions, in the different sectors of activity of the Organization, to constitute global networks of collaborating institutions. The WHO programme of immunology created, under the name of "research and training centres", regional reference centres with a major research and training role.

As time went by, it appeared more and more artificial - and sometimes misleading - to maintain distinct labels for centres whose reference, research and training functions were closely interwoven and which for the most part worked in response to national, regional or global demand. In 1973, the overall term "WHO collaborating centre" was adopted, the title of each centre specifying its domain of activity.[1]

First, the question arises as to whether a single appellation should be used to cover all types and aspects of WHO's collaboration with national institutions. One is tempted to answer in the affirmative, for the sake of simplicity and uniformity, on the understanding, however, that the use of a single appellation does not mean that all centres are expected to play an identical role.

[1] It should be no surprise, however, that in practice the former names have been routinely retained by some centres; these do not affect the nature of their functions and are likely to be abandoned in the course of time.

On the other hand, should the denomination of "WHO collaborating centre" be retained? That designation is by no means ideal, but no better one has been found. It seems, therefore, that it should be retained, as it is universally used and accepted, and again on the understanding that it carries no structural connotation and simply designates a focus or base for collaborative programmes developed by WHO. A "centre" can be an institution, a laboratory or department in an institution, or a set of reference, research or training facilities belonging to different institutions, one of them acting as the focal point for relations with WHO.

WHO's needs for institutional expertise and support are diverse. The single term "WHO collaborating centre" covers a wide variety of situations, of purposes and of functions: there may not be two identical collaborating centres.

It is recommended that all institutions formally designated to participate in WHO's international cooperative programmes should be named "WHO collaborating centres" and that their title should further specify their sphere of activity, e.g., WHO collaborating centre for the immunopathology of dengue haemorrhagic fever.

8.7 Criteria for the selection of WHO collaborating centres

Criteria for the selection of institutions in the countries as WHO collaborating centres must be defined and applied with flexibility. Not all of them are likely to be applicable in any given case. They must be given different weights according to the specific set of functions ascribed to a particular centre. A widely recognized high scientific and technical standing is essential, for instance, for a centre required to develop internationally acceptable standards or reference substances.

The following criteria should be taken into consideration:

(i) the scientific and technical standing of the institution concerned at the national and international levels, with particular reference to its recent record of achievement and its ongoing activities;

(ii) the place the institution occupies in the country's health, scientific or educational structures and its relations with the national authorities concerned, in terms of both its contribution to national health development programmes and the governmental support it receives;

(iii) the quality of its scientific and technical leadership, the number and qualifications of its staff, and the adequacy of its equipment, laboratory or teaching premises and other facilities;

(iv) the institution's prospective stability in terms of personnel, activity and funding;

(v) the working relationship which the institution has developed with other institutions in the country as well as at the intercountry, regional and global levels;

(vi) the institution's ability, capacity and readiness to contribute to WHO programme activities, whether in support of country programmes or by participating in international collaborative schemes;

(vii) the institution's will, where appropriate, to develop its potential with the scientific and technical support of WHO;

(viii) the ability and readiness of the institution to provide services over a sufficient period of time and not only for a single, limited task.

8.8 Procedures for the selection, designation and management of WHO collaborating centres

While the centres should continue to fulfil the role previously assigned to them on a global basis, in keeping with continuing global programme requirements, new procedures should take into account the spreading of planning, operational and evaluative responsibility, in the development of WHO's programme, from the global to the regional and national echelons, particularly in relation to the strengthening of institutions in developing countries.

8.8.1 These procedures should be so designed as to allow for: (a) the proper selection of institutions, on the basis of the criteria formulated in section 8.7 above; (b) their designation, on the basis of the functions to be performed, as enumerated in section 8.5; and (c) the most effective management of the collaborative activities in which they will be involved on WHO's behalf.

8.8.2 As in the case of expert advisory panels, the Director-General has the ultimate responsibility for designating WHO collaborating centres. Only in this way is he able to ensure the cohesion of the national, regional and global dimensions of the programme and be fully accountable to the Executive Board and the Health Assembly for the technical and international distribution and balance of the centres in a global perspective.

The Regional Directors, in consultation with the governments concerned, are responsible for making proposals to the Director-General for the designation of the centres, and for all procedural steps subsequent to the Director-General's approval. They are also responsible for the management of WHO's collaboration with the centres, it being understood that collaborative networks of global purport must retain their functional links with the global unit responsible for the corresponding programme (e.g., in programmes of worldwide epidemiological surveillance).

In discharging their responsibility the Regional Directors use the services of any Secretariat staff members, whatever their place of assignment, if their advice and support are deemed necessary. For example, just as regional staff can be called upon to participate in activities of global scope, Regional Directors can use technical staff at the global level to help them in the regions, e.g., in the selection of institutions in the countries that may qualify for designation as WHO collaborating centres.

Such an integrated approach, in which all sectors and all levels of the Secretariat cooperate, must be viewed as the best means of preventing conflicts of authority, competence or interests. The ultimate decision of the Director-General will therefore always be the end-point of a process of intimate intra-Secretariat collaboration.

8.8.3 The procedure for selection and designation of a WHO collaborating centre may be initiated in response to a government proposal or at the Organization's initiative in full agreement with the government. In any event, such selection must be based

on a broad range of information and consultations, including site visits and consultations with national authorities. The Regional Director must secure appropriate justification as to: (1) the suitability of the institution concerned, on the basis of the selection criteria, and (2) the programme requirements to which the prospective centre is expected to respond, preferably in the form of a tentative plan of action developed jointly by WHO and the institution in consultation with the national authorities concerned.

Formal designation of the centre is only the starting point of a dynamic process of collaboration involving active working contacts, a process which it should be incumbent upon the national authorities and the Regional Director to stimulate and to monitor.

8.8.4 Although the length of the period for which an institution is designated as a WHO collaborating centre should ideally depend on the duration of the programme requirements which have prompted the designation, it appears more practical to envisage a uniform period of designation for all centres. All the more so as one of the criteria retained for selection (see section 8.7 (viii)) is the possibility for the institution "to provide services over a sufficient period of time".

It is relevant to note that a significant period of time may be necessary for WHO to justify its investment in manpower and equipment; this investment, which has been rather nominal in most cases until now, is likely to reach much larger proportions in the future with the growing importance attached to institution strengthening.

It is recommended that the length of the period of designation should be set at four years, and that it should be renewable for equal or shorter periods, depending on programme requirements. A centre whose period of collaboration has ended may be designated again at a later date, for the same or another purpose. The decision on renewal or new designation should be based on a thorough assessment of the functioning of the centre and of the relevance of its activity to the Organization's programme.

9. Other institutions involved in WHO collaborative activities

9.1 The institutions designated as WHO collaborating centres are the backbone of WHO's system of institutional collaboration. They constitute what may be called an inner circle of institutional resources just as expert panels do for individual expertise. They do not, however, represent the sum total of these resources.

In several fields the need has been felt, in addition to the WHO collaborating centres, for an outer circle of institutions designated by the countries themselves to perform specific limited tasks related to the activity of the Organization. These institutions are "recognized by WHO" as "national centres" participating in collaborative activities.

Moreover, the possibility should be left open for the Organization to make use, in agreement with the national authorities concerned, of any institution in any country that is able and willing to participate in collaborative efforts. What is essential for the Member States and the Organization is the assurance that the capacity of national institutions, at any moment, is used to the full.

9.2 There were, on 30 June 1979, 401 such national centres recognized by WHO, the distribution of which, by programme area and by region, is indicated in the following table:

NUMBER AND DISTRIBUTION OF THE WHO RECOGNIZED NATIONAL CENTRES

Programme area	Region						Total
	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	
Bacterial diseases	19	47	13	90	34	32	235
Virus diseases (influenza)	8	18	7	44	7	17	101
Veterinary public health				1			1
Mental health				7			7
Immunology		1		1			2
Health laboratory technology	1	3	2	21		3	30
Promotion of environmental health (technology and support)		9	5	7	3	1	25
Total	28	78	27	171	44	53	401

The table clearly shows that institutions of this type have been set up, primarily, in the fields of bacterial and virus diseases, health laboratory technology and environmental health technology and support, where they prove most useful instruments of programme development. As can be seen, their utilization in other programme areas has remained very limited.

9.3 The 401 national centres are distributed among 93 countries of the six WHO regions: 30 countries in Europe, 21 in the Americas, 12 each in the African, Eastern Mediterranean and Western Pacific Regions, and six in the South-East Asia Region.

As can be seen, the proportion of countries involved is much higher than for the WHO collaborating centres, particularly in the case of developing countries, where recognition of such national institutions may be the first step in a long-term collaborative association.

The purpose and functions of the WHO recognized national centres are best illustrated by the WHO influenza programme, which has already been mentioned (see section 8.5.3) and is described in greater detail in Appendix 16 of this study.

9.4 While there would be no point in systematically extending the use of such centres, they should be maintained where they have been set up in response to a felt need and are operating satisfactorily. The question arises, however, as to whether the rather hybrid designation of "national centres recognized by WHO" should be retained. In the present perspective of WHO's policy and strategy, it would seem incumbent upon the national authorities themselves to grant such recognition.

> It is recommended that, wherever there exists a demonstrated need for institutions additional to WHO collaborating centres, e.g., in an organized network of global epidemiological surveillance, such institutions should be formally recognized as "national cooperating institutions", and so designated by the national authorities concerned in agreement with WHO.

Such agreement would bear on the functions to be performed by the designated institution in relation to WHO collaborative activities. It would specify: (a) the obligation of the institution to provide WHO, and in particular the WHO collaborating centre(s) of the corresponding network, with all necessary information and material contribution; and (b) the institution's entitlement to the information and material support it requires from WHO in the pursuit of its task.

These national institutions should be entitled to direct cooperation with WHO at the national, regional and/or global level and, in particular, with the WHO collaborating centres in their area of interest. This is indispensable for the speedy and efficient functioning of the system, especially in programmes of epidemiological surveillance. Furthermore, such cooperation has repeatedly demonstrated its value for the strengthening of the technical capability of the national institutions involved.

9.5 All actions on WHO's part concerning designation of and collaboration with national cooperating institutions must normally be the responsibility of the Regional Director, acting in consultation with the governments and with the support of WHO's staff at all levels, particularly the responsible programme officers at WHO headquarters for programmes of global scope, such as the influenza programme. Direct working contacts with the institutions from the global level of the Organization are essential in such programmes, it being understood that both the national authorities and the Regional Director concerned should be kept fully informed of developments.

10. New developments in institutional collaboration

10.1 In the many areas of activity in which WHO is engaged, each programme has its own logic and its own requirements. This naturally leads to different approaches to institutional collaboration.

To quote only one example, the WHO mental health programme has set up - so far in two places (Chandigarh, India, and Cali, Colombia) "WHO mental health resource centres". These mental health resource centres are expected to provide leadership in the developing countries for the formulation and implementation of mental health policies at the national and regional levels. They may develop functions which closely relate to the services which it is now envisaged that the WHO collaborating centres could provide in support of technical cooperation.

Indeed, in developing such functions these centres may broaden the scope of the "classical" WHO collaborating centres and contribute to the enlarged definition of the WHO collaborating centres advocated in this study.

10.2 Further, the new orientation of WHO's policy and strategy has undoubtedly stimulated considerable efforts, particularly in the WHO regions, to enlist broader and more adequate participation from institutions in the countries. Such a tendency to build up collaborative networks, which can be found in every region, appears promising and should be carefully evaluated in the future.

10.3 Special approaches have been developed which are at variance with traditional mechanisms and procedures. For example, multidisciplinary centres of an unusual type have been set up in two WHO regions, one in Ndola, Zambia, the other in Kuala Lumpur, Malaysia. Contrary to the usual procedure for WHO collaborating centres, which are designated by agreement between WHO and the institution concerned after consultation with the government, both centres have been established by agreement between WHO (WHO Regional Offices for Africa and the Western Pacific) and the governments, within the framework of traditional WHO country projects. Should such a procedure be utilized more generally, in particular where institution strengthening is involved?

In the case of Kuala Lumpur, there existed an institute of medical research, covering a broad range of activities, including service, training and research functions. By agreement between WHO (WHO Regional Office for the Western Pacific) and the Government, following a recommendation made by the WHO regional ACMR, the institute has been designated as a WHO regional centre for tropical diseases. The regional label does not alter the national status of the centre, and it is understood to mean that the centre's activities will be oriented towards the fulfilment of regional needs. It may also be considered to have some characteristics of a WHO collaborating centre.

10.4 All these new developments must be acknowledged positively. They are prompted by real needs and testify to the desire of the Organization to find innovative formulas of institutional involvement, particularly on the part of the WHO regions and special programmes with a strong objective orientation. They belong to areas of growth in a living organism and, as such, merit sympathetic attention.

> Due care should be taken, however, not to run into anarchy, by the undue proliferation of approaches, definitions and labels, thereby endangering the unity, cohesion and effectiveness of the entire system. A calculated risk may well be taken in giving effect to new ideas and encouraging initiatives, even if they appear fundamentally divergent from established practices; but developments must be followed and monitored with a view to retaining their positive aspects and eliminating the negative ones which can only create confusion. In this way a dynamic, efficient, well-correlated and mutually supportive system of institutional collaboration will be evolved for the Organization as a whole.

IV. LEGAL FRAMEWORK AND CONTRACTUAL BASES OF THE WHO SYSTEM OF EXPERTISE

11. Legal framework

The various mechanisms of expert consultation and institutional collaboration described in sections 3-10 above operate on different legal bases. Expert advisory panels and committees are governed by formal Regulations[1] adopted by the World Health Assembly.[2] Study groups, as already indicated, were created by resolution of the Executive Board.[3] Scientific groups and other forms of expert consultation as well as the WHO collaborating centres have been set up at the initiative of the Director-General and given recognition by subsequent resolutions of the Assembly and the Board. Such diversity is certainly understandable historically but the time may have come to revise this rather uneven legal framework, to make it more coherent, and to adjust it to the new approaches proposed for securing the expert advice and guidance the Organization will need in the implementation of its new programme policy and strategy.

First of all, are formal regulations, such as those governing expert panels and committees, any longer needed? While it is clear that these Regulations, adopted in 1951, do not respond to the needs of the Organization in 1979, the Board has reiterated fairly recently, in resolution EB56.R5 (1975), its belief that "the basic principles in the Regulations remain fundamentally sound and should be maintained". This statement reflected, inter alia, the Board's concern over the technical and geographical balance of the expert panels and committees.

Two courses of action might be considered, either to abolish the Regulations altogether and let the expert advisory panels and committees be governed by appropriate resolutions of the Board and the Health Assembly, or to revise the Regulations and enlarge their scope to include the WHO system of expertise as a whole.

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1 WHO Basic Documents, 30th ed., 1980, pp. 89-97.

2 Resolutions WHA4.14 (1951) and WHA13.49 (1960).

3 See section 6.2 above.

Regulations have their advantages. They emanate from the supreme governing body of WHO and provide the most authoritative legal basis for action. A series of resolutions of the Health Assembly and the Board could not achieve the same organic coherence as regulations in a unified text; also, it might be much less economical than the adoption, once and for all, of a single legal instrument susceptible of general application. On the other hand, regulations are less amenable to amendment than mere resolutions and, by the fact that they are adopted and can be amended only by the Health Assembly, entail an obvious limitation of the initiative of the Executive Board.

It seems that these pros and cons could be easily reconciled by reserving for Regulations fundamental definitions and principles, while detailed procedures and rules of practice would be left to the initiative of the Executive Board or the Director-General, in the form of resolutions or decisions aimed at the efficient application of the Regulations.

> It is recommended that, following the completion of this organizational study, a new text of the Regulations be drawn up, to govern WHO's mechanisms of expert consultation and institutional collaboration as a whole. That text would be consequently submitted by the Executive Board to the World Health Assembly for adoption.
>
> Pertinent resolutions should be adopted by the Executive Board, according to what is required for the application of the Regulations, e.g., for amending resolution EB17.R13 on study groups.

12. Contractual bases for collaborative activities

12.1 The main instrument used by WHO to set the terms and conditions under which given tasks will be performed by the institutions with which the Organization collaborates, and remunerated, is the contractual technical services (CTS) agreement.

Where such a formal agreement does not seem justified by the importance or duration of the work to be done, an ad hoc arrangement is concluded in the form of a letter of agreement.

Training and research training, which are essential elements of institution-strengthening, are based on fellowships and research training grants of various types.

CTS agreements have so far covered the largest part of WHO's collaborative activities and of its financial support to collaborating institutions.

12.2 In accordance with the provisions of the WHO Manual, a CTS agreement is formally concluded by the signature, on behalf of WHO and of the institution concerned, of two documents.

The agreement proper specifies the institution, the type of technical service it is expected to provide, the project title, and the sum to be granted by the Organization.

A "statement on research or other technical service to be rendered" outlines the present stage of work in the institution concerned and the particulars of the work proposed under the agreement. Detailed technical justifications are given in attachments. The statement also outlines (a) the contribution expected from the institution and/or other sources to the work evisaged, in terms of staff, supplies and equipment, and (b) the estimated contribution of WHO for the current year and, if appropriate, for subsequent years, subject to the availability of funds.

CTS agreements are concluded either with WHO collaborating centres - whose designation in itself does not entail financial support - or with other institutions involved in WHO's collaborative activities. Financial support is provided either in remuneration for specific tasks performed during an agreed period or to strengthen the institution's capability.

12.3 As an indication of orders of magnitude, in 1978 CTS agreements for research purposes (excluding those of the special programmes on human reproduction and on tropical diseases) were concluded with WHO collaborating centres and other institutions in amounts totalling some US$ 3.5 million financed from WHO regular budget and extrabudgetary resources. The major programmes of communicable and noncommunicable diseases account for by far the largest investments, followed, although at some distance, by the programme of maternal and child health.

CTS agreements - and the corresponding financial inputs - are unevenly distributed between the WHO regions and between different countries in the regions. This clearly reflects the uneven distribution of the WHO collaborating centres (see section 8.2 above) and other institutions engaged in WHO's collaborative activities. As more institutions in more countries are called upon to cooperate, WHO support will become more evenly distributed.

The two special programmes already mentioned, with their emphasis on development and on the strengthening of institutional capability, are likely to play a considerable role in that regard, both qualitatively and quantitatively. The special programme on human reproduction already enlists the cooperation of a large number of institutions in the developing countries; the one on tropical diseases is basing its action on the strengthening of institutions in those countries. Both programmes have at their disposal considerably larger funds than the Organization normally allocates to CTS agreements. It is probable that a similar trend will develop in relation to other mission-oriented endeavours, such as the Expanded Programme on Immunization, the diarrhoeal diseases control programme and the programme for the prevention of blindness.

12.4 The procedural steps involved in the management of CTS agreements, from their initial formulation throughout their implementation to their final evaluation, are numerous and complex. It is not the purpose of this study to enter into a detailed analysis, but they should be worked out in keeping with the following principles:

(i) the management of CTS agreements, which is a major responsibility of the WHO Secretariat, must be viewed in the same perspective as all other aspects of the mechanisms of expert consultation and participation or institutional collaboration; with the reorientation of the programme and the reallocation of budgetary resources in response to resolution WHA29.48, considerably increased sums of money have become available in the regional budgets which may be used for financing collaborative research, particularly through CTS agreements at the regional level;

(ii) the formulation of research activities to be undertaken at the global or regional level under such agreements is a continuing work commitment of the expert groups through which the Organization is now involving the scientific and health community at large in its collaborative research efforts, notably in the special programmes mentioned above. The same will apply, in due course, to the evaluation of the activities performed under the agreements;

(iii) the preparation, negotiation, conclusion and execution of a CTS agreement, as far as WHO is concerned, devolve upon the level of the Organization which has technical and financial responsibility for the collaborative research to which the agreement relates. Such responsibility is defined in the Sixth General Programme of Work covering a specific period (1978-1983), which spells out criteria for determining the organizational level or levels for implementation of programme activities.[1]

12.5 The financing of CTS agreements, among other forms of financial support to WHO's activities involving expert guidance and institutional collaboration, does not expressly fall within the mandate of this organizational study. It might be reviewed in depth, following the completion of the study.

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[1] WHO Official Records, No. 233, 1976, Annex 7, p. 80.

V. CONCLUSIONS

13.1 Expert guidance and support is indispensable for the Organization to develop its programme with the high quality and efficiency expected from it. The system of expertise built up over the years to that end now comprises a variety of mechanisms through which WHO seeks the collaboration of experts, individually and collectively, and of institutions. The main purpose of the system is to make available to WHO as a whole the constantly growing fund of national experience in biomedical and health services research as well as in the planning and delivery of health services. It is also its aim to provide appropriate guidance to research and health workers as well as at the political level on matters of topical importance for scientific progress and for the solution of national health problems.

The object of the study was to review and analyse the present situation in this regard and to determine in which way it should be modified to respond to the future requirements of the Organization in the pursuit of its programme policy and strategy.

13.2 This policy and strategy has itself undergone a significant change in recent years, the major emphasis being laid on technical cooperation with and among Member States. Following the International Conference on Primary Health Care, Alma-Ata, 1978, the Thirty-second World Health Assembly has formulated strategies for achieving health for all by the year 2000,[1] essentially through the development of the primary health care concept, and the Organization is now directing its efforts towards making health care accessible to all people by the end of the century. The promotion of biomedical and health services research and the application of its results[2] are decisive factors for attaining that goal. The WHO system of expertise must be seen in that perspective and adjusted to serve these aims.

13.3 The present WHO system of expertise combines old-established, traditional mechanisms of expert consultation and institutional collaboration with a variety of new approaches prompted in part by the urge to respond to emerging programme needs, as illustrated by the Organization's special programmes.

After more than 30 years of experience, practically all traditional mechanisms have proved useful instruments of programme development and can continue to be used. These mechanisms and their utilization, however, have had shortcomings which must be corrected; they must be adapted to the new orientation of WHO's programme and programme management, with due emphasis on technical cooperation for national health development. On the other hand, while certain new approaches have proved worthwhile in several programme sectors, it is not yet known whether they are conducive to optimal efficiency and susceptible to wider application. Therefore their use must continue to be monitored and evaluated.

13.4 The new orientation implies a much broader definition of expertise than was used in the past, for both experts and institutions.

Any worker in the medical and health professions, and in other disciplines related to health and social development, who possesses the required qualifications and experience either in science or in health and social practice, in any country and at varied levels of professional responsibility, might be called upon to provide expert support to the Organization. Many of the recommendations made on the various mechanisms of expertise depend on this conception, which calls upon WHO Member States in the future to provide expert support to the Organization over a much broader range of skills and experience than before.

According to the broadened criteria set forth in the study, national institutions may qualify for designation as a WHO collaborating centre if it is considered that they can play a role in national or international health development, even if they still require strengthening to varying extents and for varying periods of time. Such a definition substantially opens the way for more institutions in more countries, especially in developing areas of the world, to participate in the work of the Organization.

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[1] Document WHA32/1979/REC/1, resolution WHA32.30 and Annex 2.

[2] Document WHA32/1979/REC/1, resolution WHA32.15.

13.5 Whatever the mechanism, utmost importance must be attached to the balance of the contributions sought from the experts or the institutions, from both the technical and the international points of view. WHO's expertise must do full justice to "the various branches of knowledge" and "the diversified forms of local experience and trends of thought prevailing in the various parts of the world".[1] It must also be appropriate to the needs of the programme and to the high standards of achievement expected from the Organization.

The broader definition of WHO expertise and the wider international selection of experts, under the new policy of technical cooperation, should foster more equitable representation in the coming years. The Member States themselves have an essential role to play in this regard. It is, indeed, their right and duty to put at WHO's disposal the people and the institutions who possess the required qualification and experience to participate in its work and to act as living links between the Organization and the countries it serves. In this way WHO will more fully comply with the principles of universality and equality on which it is founded.

13.6 The sum total of WHO expertise must be managed as a unified system to provide guidance and support to the Organization at whatever level the demand exists for such guidance and support.

The Director-General has overall responsibility for the establishment and the management of the system. Appropriate authority is delegated by him to the Regional Directors for the active search for eligible experts and institutions and for the management of regional components of the various mechanisms involved.

Strong emphasis must be laid on the role of the Member States themselves in the establishment, functioning and evaluation of the system, not only through their participation in the Health Assembly, the Executive Board and the regional committees, but also by their initiatives and active collaboration with the Secretariat, at all levels, for the optimal use of their expert and institutional resources.

13.7 It is proposed to maintain expert advisory panels, but to include a more universal selection of experts. Furthermore, irrespective of the participation of their members in expert committees, panels should become more active instruments in the provision of expertise than they have been so far.

A greater number of women should serve on a larger number of panels, not only for the sake of a more equitable distribution by sex but also because women's views and advice on health and social issues are of particular importance.

In order to make the greatest possible use of expert resources available, contributions may be sought also from individuals outside the panels if their advice is deemed to be useful to the Organization.

13.8 All expert meetings called by the Organization, whether formally or informally, and including the task forces and scientific working groups of the special programmes, should be established in keeping with the general principle of equitable international and technical representation. Special effort should be devoted to monitoring adherence to this principle.

13.9 WHO derives considerable strength from collaboration with institutions in its Member States which are formally designated as WHO collaborating centres and provide information, reference, research and training services in a variety of fields.

Under the enlarged conception of these centres, such collaboration will involve, henceforth, a greater number of institutions in more countries, with particular reference to the strengthening of institutions in the developing countries.

There should be, however, no restriction on the possibility for the Organization to make use, upon the proposal of the national authorities concerned, of any institutions in any country that would be able and willing to participate in its collaborative efforts. Where

[1] Introduction to the Regulations for Expert Advisory Panels and Committees (WHO Basic Documents, 30th ed., 1980, p. 89).

such institutions form part of an organized network, as for example in global epidemiological surveillance, it is proposed that they may be formally recognized as "national cooperating institutions".

13.10 The study formulates principles according to which the Organization's system of expertise can be adapted to, and brought to bear on, the evolving policy and strategy of WHO. It contains a number of practical recommendations to that effect.[1] After the World Health Assembly has considered the study, and subject to its expressed views, it will be incumbent upon the Executive Board and the Director-General to take appropriate action, with particular reference to the following points:

(a) the drawing up of new regulations to govern not only the WHO expert advisory panels and committees but WHO's mechanisms for expert consultations and institutional collaboration as a whole. It is recommended in that connexion that the regulations should deal with fundamental definitions, principles and criteria, with detailed rules of practice and management procedures being left to the decision of the Executive Board or of the Director-General, as appropriate. In this way the necessary flexibility and efficiency in the operation of the system and in its adaptation to the evolution of the programme of the Organization can be ensured;

(b) the formulation by the Director-General of a plan of action to adjust the system, as now envisaged, to the needs of WHO's programme, and in particular to programme priorities as determined under the General Programmes of Work for specific periods and to the medium- and long-term development of biomedical and health services research;

(c) the creation of monitoring and evaluation mechanisms and procedures at both the Secretariat and the Executive Board levels, to ensure continuous follow-up of the operation of the system;

(d) the further review of matters which are touched on in the study but did not fall expressly within its terms of reference, such as the financing from various sources of collaborative efforts involving expert support, e.g., through CTS agreements and grants in the research field.

13.11 In summary, the dynamic evolution of priorities and policies within the Organization at the present time and the more substantive involvement of Member States demand a truly responsive system to ensure balanced expert advice and collaboration. The present system can be modified to provide such advisory inputs and programme linkages. Periodic monitoring and evaluation of the system are of particular importance.

---

[1] These recommendations appear in the relevant parts of the study as follows:

(a) on expert advisory panels, in sections 4.5, 4.6.1-4.6.10 and 4.7.1-4.7.5;
(b) on expert committees, in section 5.6 (i)-(xi);
(c) on other expert meetings dealing with the programme in general, particularly study groups, in sections 6.2-6.4;
(d) on expert meetings dealing with research, in section 7.6;
(e) on WHO collaborating centres, in sections 8.4, 8.6, 8.7 and 8.8;
(f) on other institutions involved in WHO collaborative activities, in sections 9.4 and 9.5; and
(g) on new developments in institutional collaboration, in section 10.4.

Appendix 1

LIST OF WHO EXPERT ADVISORY PANELS

1. Acute Bacterial Diseases
2. Acute Diarrhoeal Diseases and other Enteric Infections
3. Biological Standardization
4. Brucellosis
5. Cancer
6. Cardiovascular Diseases
7. Chronic Degenerative Diseases
   - Diabetes
   - Rheumatic Diseases
8. Drug Dependence and Alcohol Problems
9. Drug Evaluation
10. Environmental Health
11. Environmental Pollution and Hazards
12. Food Additives and Contaminants
13. Food Hygiene
14. Health Education
15. Health Laboratory Services
16. Health Manpower
17. Health of Seafarers
18. Health Statistics
19. Human Blood Products and Related Substances
20. Human Genetics
21. Human Reproduction
22. Immunology
23. International Pharmacopoeia and Pharmaceutical Preparations
24. International Surveillance of Communicable Diseases
25. Leprosy
26. Malaria

27. Maternal and Child Health

28. Mental Health

29. Neurosciences

30. Nursing

31. Nutrition

32. Occupational Health

33. Oral Health

34. Organization of Medical Care

35. Parasitic Diseases

    Schistosomiasis

    Filarial Infections

    General Parasitology

    Trypanosomiases

36. Public Health Administration

37. Rabies

38. Radiation

39. Rehabilitation

40. Smoking and Health

41. Trachoma and Prevention of Blindness

42. Traditional Medicine

43. Tuberculosis and Respiratory Diseases

44. Vector Biology and Control

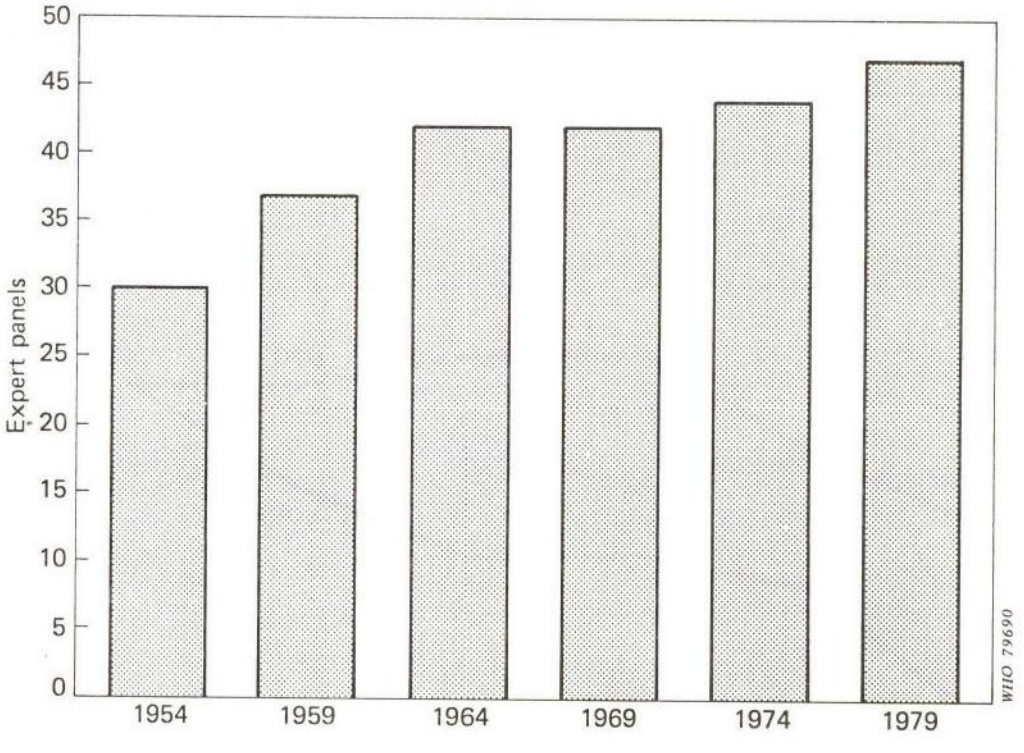
45. Venereal Diseases, Treponematoses and Neisseria Infections

46. Virus Diseases

47. Zoonoses

Appendix 2

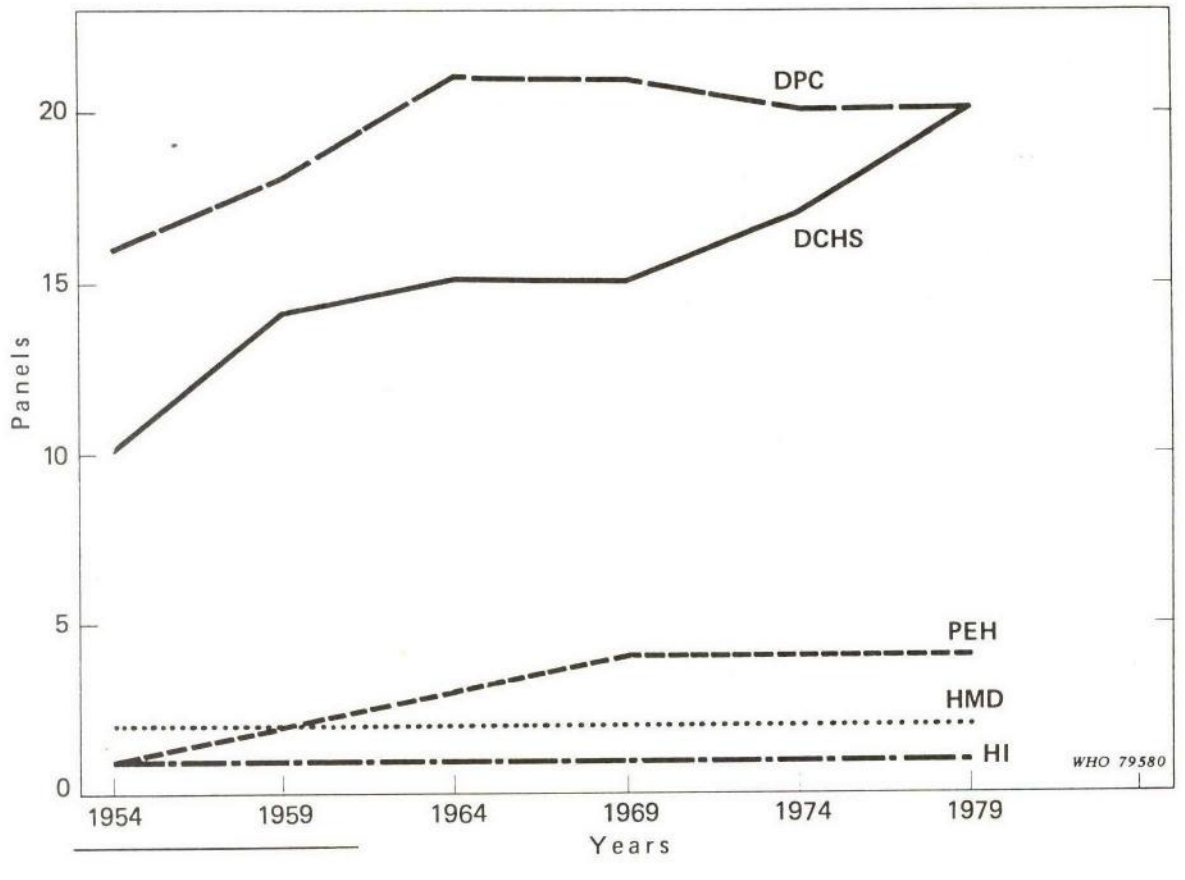
TOTAL NUMBER OF WHO EXPERT ADVISORY PANELS
(AT FIVE-YEAR INTERVALS), 1954 – 1979



Appendix 3

DISTRIBUTION OF WHO EXPERT ADVISORY PANELS BY MAJOR PROGRAMME BUDGET HEADINGS (AT FIVE-YEAR INTERVALS), 1954-1979

Major programme[1]	1954	1959	1964	1969	1974	1979
DCHS	10	14	15	15	17	20
DPC	16	18	21	21	20	20
PEH	1	2	3	4	4	4
HMD	2	2	2	2	2	2
HI	1	1	1	1	1	1
Total	30	37	42	42	44	47



[1] DPC = Disease Prevention and Control
DCHS = Development of Comprehensive Health Services
PEH = Promotion of Environmental Health
HMD = Health Manpower Development
HI = Health Information

Appendix 4

NUMBER OF MEMBERS OF THE WHO EXPERT ADVISORY PANELS
(AT FIVE-YEAR INTERVALS - ON 1 JANUARY OF EACH YEAR), 1954-1979

Panel No.*	1954	1959	1964	1969	1974	1979
1	36	34	30	68	92	56
2	--	--	22	26	--	38
3	25	48	47	49	70	81
4	21	39	30	23	18	20
5	--	12	52	63	94	114
6	--	--	68	71	116	109
7	--	39	56	61	46	32
8	35	36	30	29	41	34
9	9	12	20	23	16	33
10	72	94	102	142	124	88
11	--	--	29	44	38	26
12	--	22	48	63	65	76
13	--	--	--	19	32	33
14	26	32	28	30	29	22
15	--	17	31	47	50	34
16	40	57	80	78	96	62
17	--	--	18	17	11	16
18	45	61	68	74	64	70
19	--	--	--	--	--	--
20	--	--	22	35	51	49
21	--	--	--	--	29	21
22	--	--	28	68	99	100
23	32	54	67	67	65	73
24	111	99	69	63	49	35
25	19	22	32	44	53	51
26	75	89	92	91	77	71
27	37	45	68	79	70	76
28	43	65	100	117	104	86
29	--	--	--	--	19	16
30	39	60	78	88	75	62
31	28	35	51	61	76	69
32	67	53	62	61	94	79
33	--	53	67	63	67	53
34	--	44	42	49	53	39
35	67	72	109	175	164	142
36	61	57	69	76	73	100
37	24	27	20	22	21	18
38	--	55	74	84	74	63
39	--	32	30	27	25	23
40	--	--	--	--	--	32
41	17	28	34	34	24	31
42	--	--	--	--	--	--
43	42	52	47	62	47	43
44	76	84	91	71	70	95
45	111	91	77	59	40	39
46	75	89	117	124	123	114
47	34	43	37	35	40	38
Global	1 267	1 752	2 242	2 582	2 584	2 562

* For the names of panels, see Appendix 1 under the appropriate number.

Appendix 5

DISTRIBUTION OF MEMBERS OF THE WHO EXPERT ADVISORY PANELS BY REGION AND BY PANEL ON 1 JANUARY 1979

Panel No.*	AFR	AMR	SEAR	EUR	EMR	WPR	Total
1	2	14	6	27	4	3	56
2	1	7	4	19	-	7	38
3	1	11	7	49	2	11	81
4	-	5	2	11	1	1	20
5	4	24	7	60	12	7	114
6	5	21	6	54	6	17	109
7	1	6	2	22	-	1	32
8	-	10	1	14	5	4	34
9	1	7	5	16	3	1	33
10	8	25	2	36	11	6	88
11	-	3	1	15	2	5	26
12	-	19	3	45	3	6	76
13	-	9	3	15	3	3	33
14	1	8	1	4	4	4	22
15	2	8	5	10	5	4	34
16	10	11	10	18	11	2	62
17	-	1	-	13	1	1	16
18	4	11	5	37	5	8	70
19	-	-	-	-	-	-	-
20	2	12	1	29	2	3	49
21	1	5	1	9	2	3	21
22	1	24	2	57	4	12	100
23	6	10	4	41	3	9	73
24	2	9	4	16	1	3	35
25	1	19	9	17	-	5	51
26	2	20	9	27	6	7	71
27	10	10	7	31	10	8	76
28	10	22	4	38	6	6	86
29	2	4	2	6	1	1	16
30	7	8	6	25	11	5	62
31	5	21	5	26	6	6	69
32	3	13	5	44	8	7	79
33	3	12	7	23	2	6	53
34	1	8	2	21	2	5	39
35	8	42	8	70	6	8	142
36	14	21	11	30	13	11	100
37	-	10	1	5	1	1	18
38	3	15	3	34	4	4	63
39	1	3	5	8	3	3	23
40	3	3	2	20	-	4	32
41	2	5	8	8	6	2	31
42	-	-	-	-	-	-	-
43	3	9	5	15	4	7	43
44	14	19	8	33	5	16	95
45	1	9	6	20	1	2	39
46	4	32	8	57	2	11	114
47	2	9	3	18	3	3	38
Total	151	574	206	1 192	190	249	2 562
%	5.9	22.4	8.1	46.5	7.4	9.7	100.0

* For the names of panels, see Appendix 1 under the appropriate number.

Appendix 6

NUMBER OF WOMEN MEMBERS OF WHO EXPERT ADVISORY PANELS
ON 1 JANUARY 1974 AND 1 JANUARY 1979

Panel No.*	1974		1979	
	Expert panel members		Expert panel members	
	Women	Total	Women	Total
1	10	92	9	56
2	-	-	3	38
3	4	70	4	81
4	3	18	3	20
5	2	94	4	114
6	5	116	4	109
7	-	46	1	32
8	1	41	-	34
9	-	16	-	33
10	3	124	1	88
11	1	38	1	26
12	3	65	4	76
13	3	32	3	33
14	11	29	6	22
15	1	50	1	34
16	3	96	2	62
17	-	11	-	16
18	2	64	2	70
19	-	-	-	-
20	2	51	2	49
21	3	29	2	21
22	3	99	3	100
23	2	65	5	73
24	1	49	1	35
25	-	53	-	51
26	2	77	3	71
27	11	70	15	76
28	4	104	7	86
29	-	19	-	16
30	72	75	60	62
31	3	76	3	69
32	2	94	4	79
33	2	67	1	53
34	-	53	1	39
35	4	164	4	142
36	3	73	3	100
37	-	21	-	18
38	1	74	-	63
39	1	25	1	23
40	-	-	2	32
41	3	24	2	31
42	-	-	-	-
43	1	47	1	43
44	4	70	8	95
45	2	40	5	39
46	10	123	12	114
47	2	40	-	38
Total	190	2 584	193	2 562

* For the names of panels, see Appendix 1 under the appropriate number.

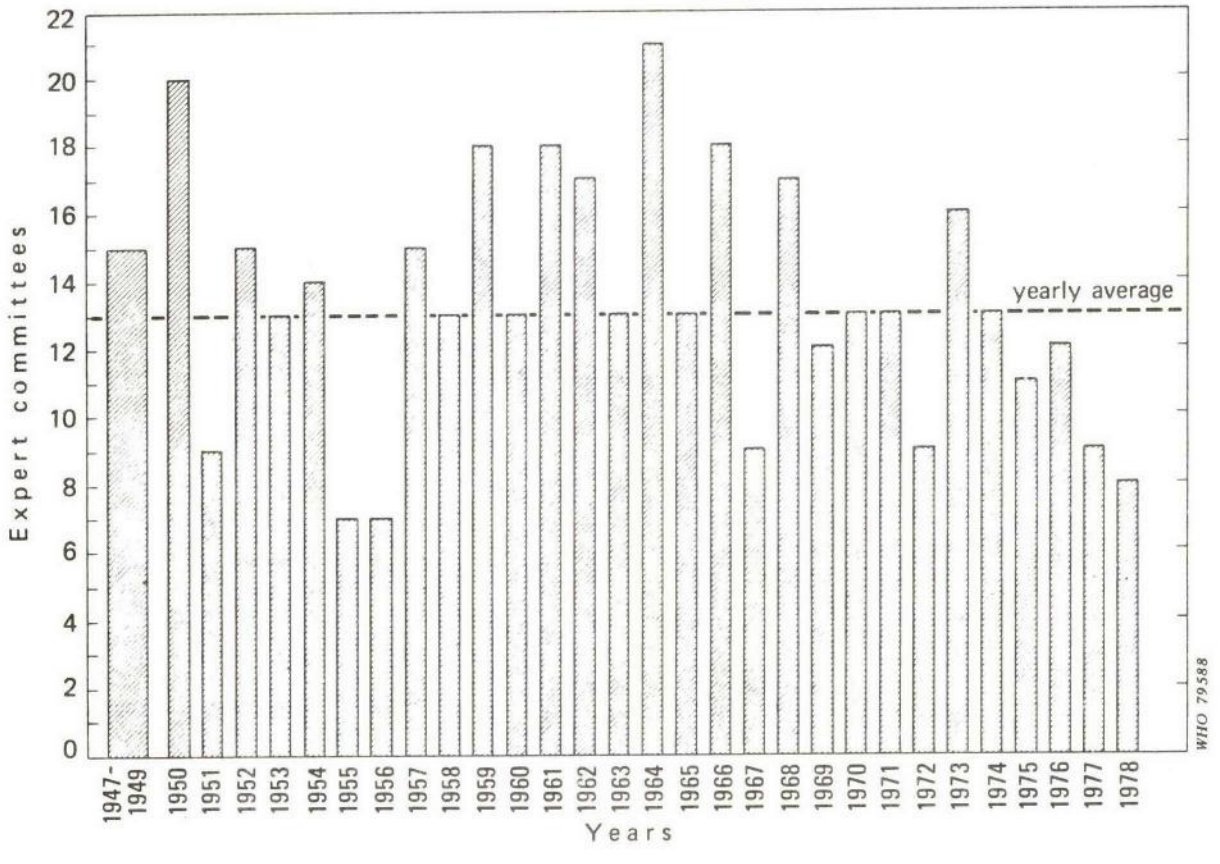
Appendix 7

DISTRIBUTION OF MEMBERS OF WHO EXPERT ADVISORY PANELS BY AGE, SEX AND REGION ON 1 JANUARY 1979

WHO region	Male					Female					All experts					% by region
	Age-groups					Age-groups					Age-groups					
	-45	45-64	65-69	70+	All ages	-45	45-64	65-69	70+	All ages	-45	45-64	65-69	70+	All ages	
AFR	32	102	3	1	138	1	11	-	1	13	33	113	3	2	151	5.9
AMR	24	359	121	46	550	2	19	2	1	24	26	378	123	47	574	22.4
SEAR	5	153	19	7	184	1	20	1	-	22	6	173	20	7	206	8.1
EUR	56	747	204	84	1 091	2	72	24	3	101	58	819	228	87	1 092	46.5
EMR	10	130	30	3	173	3	13	1	-	17	13	143	31	3	190	7.4
WPR	20	164	37	12	233	1	12	1	2	16	21	176	38	14	249	9.7
Total	147	1 655	414	153	2 369	10	147	29	7	193	157	1 802	443	160	2 562	100.0
% by age and sex	6.2	69.9	17.5	6.4	92.5	5.2	76.2	15.0	3.6	7.5	6.0	70.3	17.4	6.3	100.0	

Appendix 8

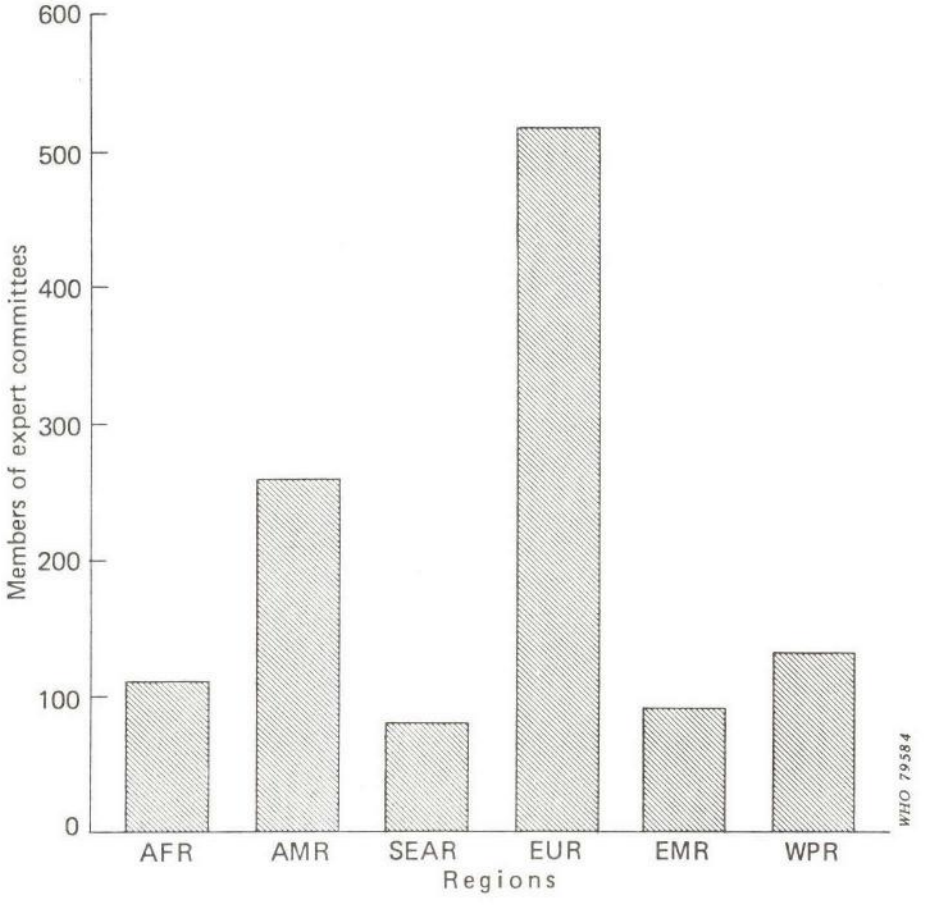
TOTAL NUMBER OF EXPERT COMMITTEES HELD SINCE 1947



Appendix 9

DISTRIBUTION OF EXPERT COMMITTEE MEMBERS BY WHO REGION
(1968-1978)

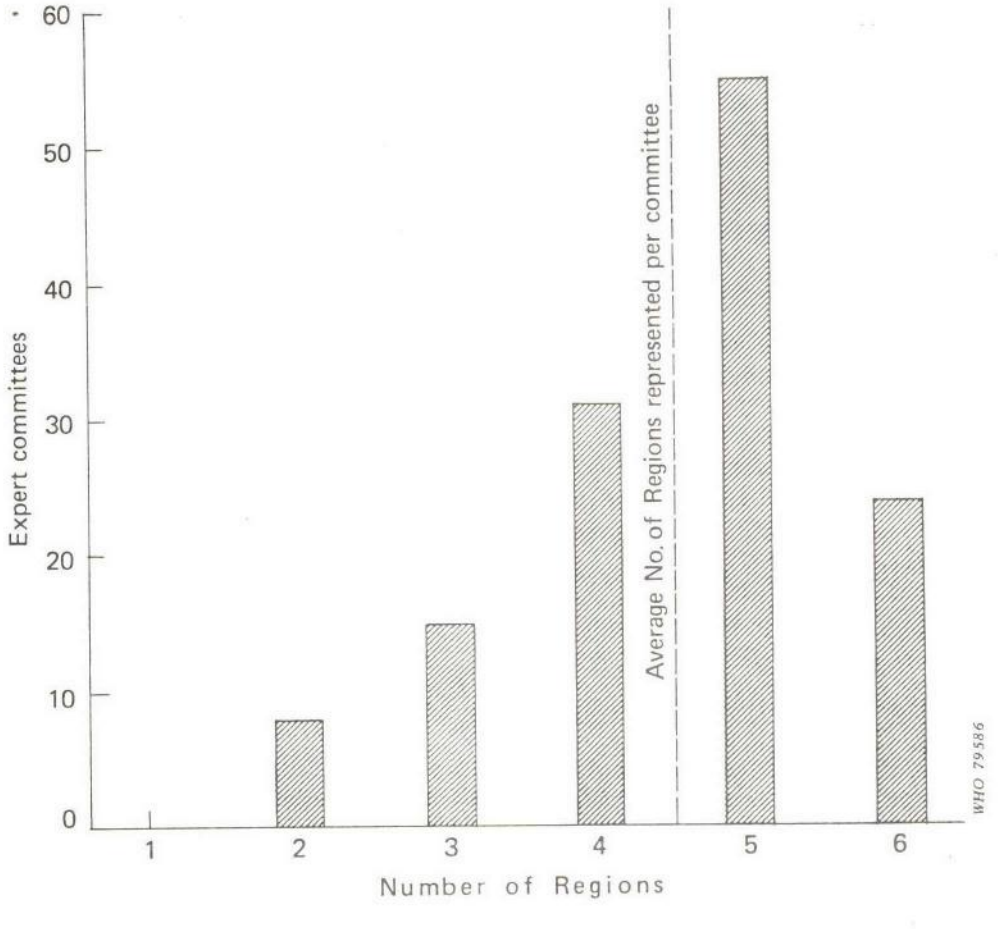
Year	Region						Total
	AFR	AMR	SEAR	EUR	EMR	WPR	
1968	13	29	8	71	9	10	140
1969	10	24	8	52	10	8	112
1970	8	31	12	53	7	14	125
1971	11	27	11	54	9	11	123
1972	5	21	3	39	7	10	85
1973	13	31	12	61	13	17	147
1974	14	23	11	49	9	17	123
1975	10	19	4	38	7	11	89
1976	13	24	7	41	7	12	104
1977	6	15	4	29	7	8	69
1978	7	15	1	32	4	13	72
Total	110	259	81	519	89	131	1 189



Appendix 10

REGIONAL REPRESENTATION IN EXPERT COMMITTEES
(1968-1978)

Year	Number of expert committees held	Number of regions represented per committee					
		1	2	3	4	5	6
1968	17	-	1	2	5	8	1
1969	12	-	-	2	2	4	4
1970	13	-	-	3	3	5	2
1971	13	-	1	1	4	2	5
1972	9	-	-	1	3	3	2
1973	16	-	-	2	1	11	2
1974	13	-	-	2	2	9	-
1975	11	-	1	2	2	3	3
1976	12	-	3	-	2	5	2
1977	9	-	2	-	2	3	2
1978	8	-	-	-	5	2	1
Total	133	-	8	15	31	55	24
Per cent.	100%	-	6%	11%	23%	42%	18%



Appendix 11

CONCLUSIONS FROM AN EVALUATION STUDY OF THE PRACTICAL USE OF EXPERT COMMITTEE REPORTS[1]

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PART V

CONCLUSIONS

The evidence analysed for the purpose of this evaluation study of the use of the Technical Report Series of the World Health Organization has been of three kinds:

1. the written records concerning the Technical Report Series that had accumulated over the years before the study was requested by the Executive Board;

2. the appraisal of the Series by the Secretariat which, according to the Regulations, constitutes the primary beneficiary group of the Series; and

3. the opinion of Member governments who have sanctioned and paid for the Series as well as that of some important groups which have made the widest use of it.

1. Conclusions from the analysis of the written records

The examination of the written records that existed before the study was requested by the Executive Board has demonstrated:

(1) that the World Health Assembly and the Executive Board attach "considerable importance and great value" to the Technical Report Series;

(2) that, as the Director-General has regularly reported to the Executive Board, the implications of the Technical Report Series for the work of the Organization cover all aspects of its programme, namely its formulation, planning, implementation, evaluation, as well as the reformulation of the policy and planning in the light of the evaluation;

(3) that the trend of distribution and sales of the Technical Report Series points to a rapidly increasing demand for these publications which is as yet far from saturation point;

(4) that medical literature in general has accorded in its reviews of the Technical Report Series a measure of value, stressing very often the topicality of the subjects chosen and the need thereby fulfilled for an international authoritative opinion on them; and

(5) that, from a public information aspect, these reports have, for the most part, generated a reaction indicative of their topicality and wide public interest.

2. Conclusions from the analysis of the critique by the Secretariat

The replies to the questionnaire received from the staff of WHO at all levels have confirmed that expert and allied committees and their reports constitute an important basis for the development of the Organization's programme at headquarters and at regional level.

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[1] Extract from document EB41/23, "An Evaluation Study of the Practical Use of Expert Committee Reports" - Report by the Director-General to the forty-first session of the Executive Board, January 1968.

The expert committee system has become an integral part of the World Health Organization, guiding its advisory services to countries, providing it with a channel for its centralized worldwide services and stimulating and orientating its role of coordination of medical research at the international level.

The Secretariat's appraisal of the Series has not been devoid of criticism. This in itself is a healthy sign, for the staff are closest to the Series, more familiar with it as a system, and need it most. It is well, therefore, that the comments of the staff show no evidence of complacency. Their unanimous warm appreciation of the services rendered by the Technical Report Series has been tempered by an awareness of the need for improving it in certain respects.

This criticism notwithstanding, the comments received from headquarters and the regions show that the Technical Report Series is an important element in the development, execution and review of the WHO programme.

3. Conclusions from the analysis of comments by Member States

While expert committees have fulfilled their role of advising the World Health Organization on the latest developments in health, the publication of their reports has been instrumental in adding a significant contribution to the fulfilment of the WHO constitutional objective of raising the standards of health everywhere.

The replies from Member States show that, over the years, the Technical Report Series has developed into an authoritative guide in the field of public health whose impact, transcending differences of all kinds, is being felt in developing as well as in developed countries.

The significance of this conclusion is self-evident. From an evaluation point of view, it is also noteworthy that in the face of the profusion of medical literature generated by the communications revolution of our time, the Technical Report Series has managed to attain a distinctive place in the public health literature and to reap health benefits out of proportion to the investment made in it.

4. Conclusions from the analysis of comments by other recipients

Health departments, universities, libraries, institutions and general practitioners have, in their replies, shown a high regard for the Technical Report Series and a desire to see it more widely known, and acknowledged it as a fruitful source of reference for health work of all kinds, including research.

5. Areas of improvement suggested

Despite the significant achievement, the Series is clearly susceptible to improvement. In this connexion, the suggestions and recommendations received can be summarized as reflecting the need for:

(a) a more discriminating selection and less broad treatment of the subject matter in some fields;

(b) a greater measure of elasticity in the composition of certain groups with regard to geographical distribution and a wider representation of disciplines that could contribute to certain subjects;

(c) a smaller degree of reliance on compromise in dealing with controversial subjects, presenting differing points of view rather than using, at times, incomprehensible phraseology or platitudinous conclusions;

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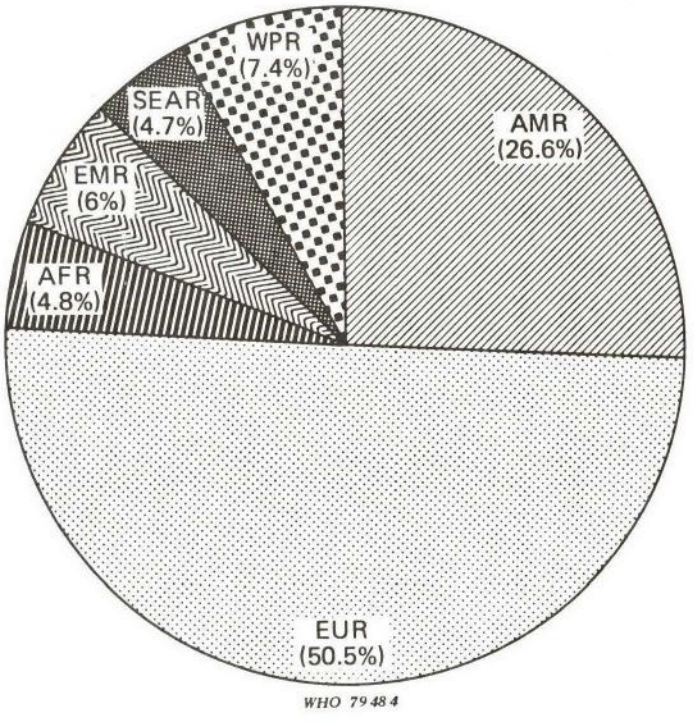
Appendix 12

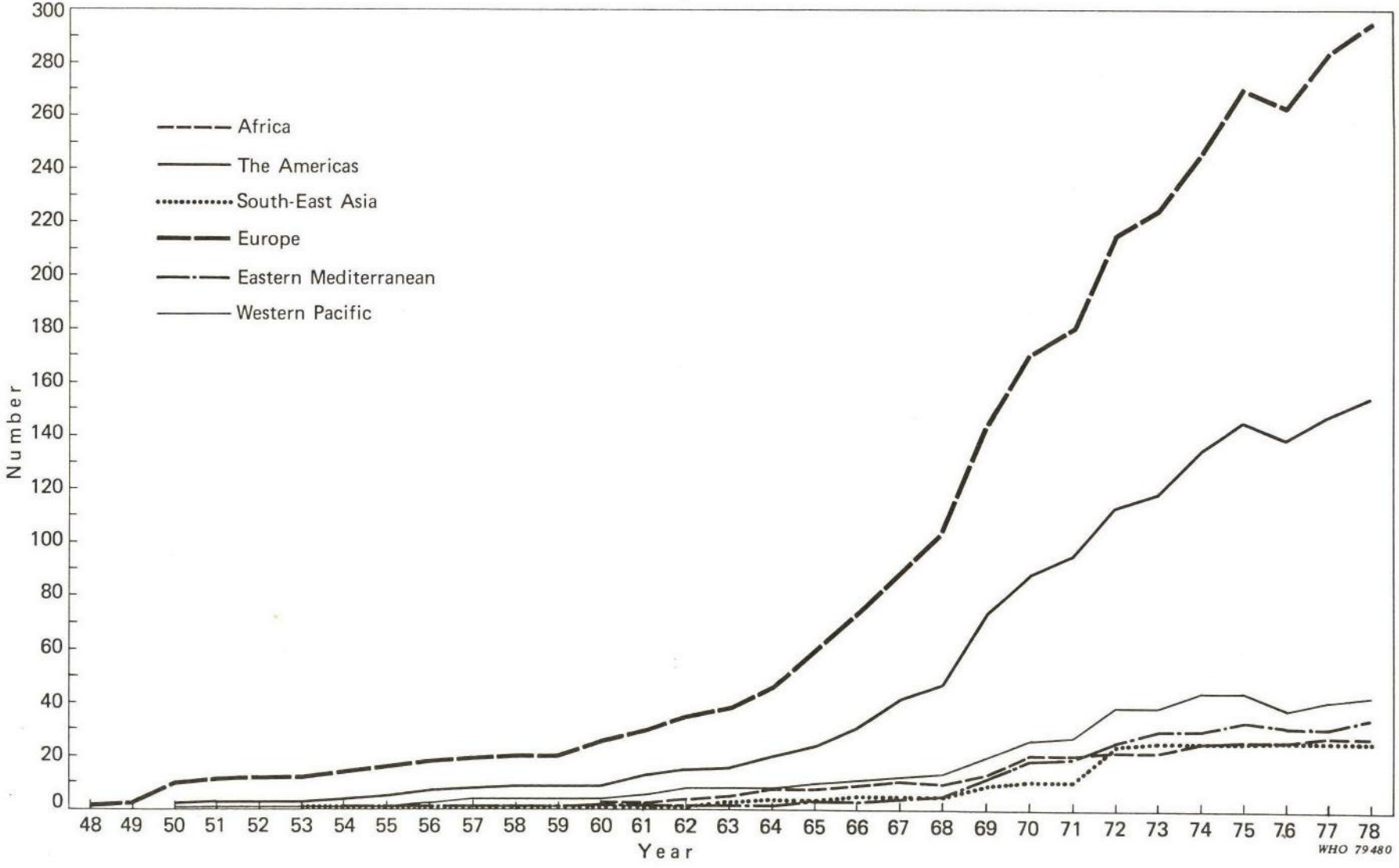
DISTRIBUTION OF WHO COLLABORATING CENTRES IN OPERATION IN 1978, BY REGION



WHO 79484

Appendix 13

NUMBER OF WHO COLLABORATING CENTRES IN OPERATION, BY REGION AND BY YEAR (1948 – 1978)



Appendix 14

NUMBER OF WHO COLLABORATING CENTRES BY REGION AND COUNTRY
AS AT 31 DECEMBER 1978

Country	Number
African Region	
Angola	0
Benin	1
Botswana	0
Burundi	0
Cape Verde	0
Central African Republic	0
Chad	0
Comoros	0
Congo	0
Ethiopia	1
Gabon	0
Gambia	0
Ghana	4
Guinea	0
Guinea-Bissau	0
Ivory Coast	0
Kenya	3
Lesotho	0
Liberia	0
Madagascar	0
Malawi	0
Mali	0
Mauritania	0
Mauritius	0
Mozambique	0
Niger	0
Nigeria	10
Rwanda	0
Sao Tome and Principe	0
Senegal	2
Sierra Leone	0
South Africa	1
Swaziland	0
Togo	0
Uganda	3
United Republic of Cameroon	0
United Republic of Tanzania	0
Upper Volta	1
Zaire	1
Zambia	1
Namibia	0
Southern Rhodesia	0
Total	28
Region of the Americas	
Argentina	4
Bahamas	0
Barbados	0
Bolivia	0
Brazil	12
Canada	17
Chile	2
Colombia	1
Costa Rica	0
Cuba	1
Dominican Republic	0
Ecuador	0
El Salvador	0
Grenada	0
Guatemala	1
Guyana	0
Haiti	0
Honduras	0
Jamaica	2
Mexico	10
Nicaragua	0

Country	Number
Panama	0
Paraguay	0
Peru	5
Suriname	0
Trinidad and Tobago	0
United States of America	93
Uruguay	0
Venezuela	7
Total	155
South-East Asia Region	
Bangladesh	0
Burma	0
Democratic People's Republic of Korea	0
India	17
Indonesia	2
Maldives	0
Mongolia	0
Nepal	0
Sri Lanka	0
Thailand	8
Total	27
European Region	
Albania	0
Algeria	0
Austria	3
Belgium	6
Bulgaria	4
Byelorussian SSR	0
Czechoslovakia	19
Denmark	21
Finland	2
France	26
German Democratic Republic*	1
Germany, Federal Republic of*	20
Greece	1
Hungary	6
Iceland	0
Ireland	1
Italy	10
Luxembourg	0
Malta	0
Monaco	0
Morocco	0
Netherlands	19
Norway	3
Poland	4
Portugal	0
Romania	6
Spain	0
Sweden	12
Switzerland	20
Turkey	3
Ukrainian SSR	0
Union of Soviet Socialist Republics	38
United Kingdom of Great Britain and Northern Ireland	62
Yugoslavia	7
Total	294
Eastern Mediterranean Region	
Afghanistan	0
Bahrain	0
Cyprus	0
Democratic Yemen	0

* The data which relate to the Federal Republic of Germany and the German Democratic Republic include the relevant data relating to Berlin for which separate data have not been supplied. That is without prejudice to any question of status which may be involved.

Country	Number
Djibouti	0
Egypt	8
Iran	11
Iraq	0
Israel	10
Jordan	0
Kuwait	0
Lebanon	1
Libyan Arab Jamahiriya	0
Oman	0
Pakistan	3
Qatar	0
Saudi Arabia	0
Somalia	0
Sudan	2
Syrian Arab Republic	0
Tunisia	0
United Arab Emirates	0
Yemen	0
Total	35

Western Pacific Region

Country	Number
Australia	9
China	0
Democratic Kampuchea	0
Fiji	0
Japan	19
Lao People's Democratic Republic	0
Malaysia	0
New Zealand	4
Papua New Guinea	0
Philippines	1
Republic of Korea	2
Samoa	0
Singapore	7
Tonga	0
Viet Nam	0
Hong Kong	1
Total	43

Appendix 15

PAN AMERICAN CENTRES[1]

1. The Pan American Health Organization has developed a complex network of centres of various types, which are instrumental in the development of WHO's programme in the Region of the Americas.

1.1 Ten Pan American centres have been set up as international institutions administered by the Pan American Sanitary Bureau/WHO Regional Office for the Americas; seven of these centres are "hemisphere wide", three are of more limited subregional scope. The centres are located in eight different countries of the Region; they deal with a variety of subjects, including disease prevention and control,[2] nutrition,[3] environmental health,[4] maternal and child health,[5] the teaching of biomedical technology,[6] biomedical information[7] and the impact on health of economic and industrial development.[8]

1.2 The Organization has also enlisted the cooperation of associated national centres of three types:

Type I: a national centre with some international involvement, e.g. the Training Centre in Immunology, Mexico.

Type II: a national centre carrying out a substantial international function, e.g., the Research and Training Centre for Leprosy and Tropical Diseases, Caracas.

Type III: a centre performing an international function, including service to the host country, essentially similar to the Pan American centres, e.g. the Research and Reference Centre on Vector Biology and Control, Maracay, Venezuela.

1.3 There are 155 WHO collaborating centres in the Region of the Americas: 110 in North America, 13 in middle America and 32 in South America.

1.4 A number of projects in the WHO/PAHO programme provide "centre type" services, whether or not they are called centres, e.g. the food hygiene training "centre", Bogotá, or the research "project" on insecticides, resistance and new control methodology, Managua.

2. All these centres, or similar "projects", perform functions identical to those described in the study (see section 8.5) for the WHO collaborating centres in the perspective of the Organization's new policy and strategy.

A major difference, however, lies in the status of the Pan American Centres and of some of the associated national centres of Type III, which form an integral part of the Pan American Health Organization, by which they are funded and administered and to which they are responsible, notwithstanding a degree of qualified operational autonomy.

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[1] The summary data in this appendix are extracted from document CSP20/3 submitted in September - October 1978 to the XX Pan American Sanitary Conference/Thirtieth session of the WHO Regional Committee for the Americas.

[2] Foot-and-mouth disease: Pan American Foot-and-Mouth Disease Centre (PANAFTOSA), Rio de Janeiro; Zoonoses: Pan American Zoonoses Centre (CEPANZO), Buenos Aires; Epidemiology and surveillance: Caribbean Epidemiology Centre (CAREC), Port of Spain.

[3] Institute of Nutrition of Central America and Panama (INCAP), Guatemala City, and Caribbean Food and Nutrition Institute (CFNI), Kingston.

[4] Pan American Centre for Sanitary Engineering and Environmental Sciences (CEPIS), Lima.

[5] Latin American Centre for Perinatology and Human Development (CLAP), Montevideo.

[6] Latin American Centre of Educational Technology for Health (CLATES), Rio de Janeiro

[7] Regional Library of Medicine and the Health Sciences (BIREME), São Paulo.

[8] Pan American Centre for Human Ecology and Health (ECO), Mexico.

The relation of such a centre with the country in which it is located is that of an international institution to its host government; it is determined by a cooperative agreement stipulating the commitment of both parties.

3. The report submitted to the Pan American Sanitary Conference/WHO Regional Committee for the Americas in 1978 concluded that "the existing centres are performing useful and important services and help significantly in fulfilling PAHO's mission". It also emphasized that "a centre is but a method of carrying out the programme and must be coordinated with other methods"; as to the decision "whether a centre is a useful part of the action programme . . . each situation must be examined on its own merits" depending on "how much effort should be invested in a programme area".

Finally, it stated that "adapting a national centre to a broader international role by a cooperative arrangement", whether through a Pan American or an associated national centre, is "a way for a country to share its expertise abroad" and "an effective illustration of the concept of technical cooperation among developing countries".

Appendix 16

THE WHO INFLUENZA PROGRAMME

The need for international collaboration

For centuries, the facility with which influenza spreads in epidemics from country to country has been recognized as one of its most characteristic features; the ability of influenza to spread has been attributed to antigenic mutability of the viruses and to the waning of antibodies in the population. Although other factors are also involved, antigenic mutation is the only readily identifiable marker of epidemic potential; it forms the basis for influenza virus surveillance.

Minor changes in the antigenic structure of influenza A virus are frequently associated with epidemics of varying impact which occur without any regular periodicity. Less frequently major antigenic changes of influenza A virus can occur: such changes have been associated with influenza pandemics, the most recent of which occurred in 1957 and in 1968. The pandemic of 1918, attributed to what is now known as swine influenza virus, was the largest in recent history, causing an estimated 20 million deaths worldwide. Influenza B viruses undergo only minor changes. Recently, the situation has been further complicated by a return to historic viruses. They caused a limited resurgence of the swine influenza virus strain in the United States of America in 1976, and in 1977-1978 influenza A virus strains which had been prevalent in 1947 reappeared.

Minor antigenic changes appear to occur through selection of pre-existing mutants by pressure of increasing immunity in the human population. Major antigenic changes are not as easily explained, but "new" viruses might arise from reservoirs of influenza A viruses in horses, pigs, or birds, or through genetic recombination of such strains with current human strains. The study of the ecology of influenza virus in lower animals is consequently an important step in developing an effective surveillance system for viruses in humans.

The practical significance of antigenic changes in influenza A viruses was first recognized in 1947, when it was observed that persons receiving the then-current vaccine, which was prepared from a 1934 strain, were not protected from the new epidemic strain. Ideally, influenza vaccines must be formulated with viral antigens which match as closely as possible the strains which are in circulation. In the past five years, antigenic drift in the A and B strains has necessitated changes in vaccine formulation on four occasions.

The WHO influenza programme

Since its constitution in 1947, the World Health Organization has been collecting and disseminating information on the current influenza viruses and on the extent of epidemics. This has been done in collaboration with health authorities in WHO Member States and with

two international laboratories (the WHO Collaborating Centres for Reference and Research on Influenza in Atlanta, USA, and London) and national influenza centres. The WHO influenza programme serves two major purposes. First, it provides an early warning system on the emergence of new or altered antigenic subtypes. Second, it provides global documentation on the epidemiological behaviour and antigenic character of prevalent virus strains, the knowledge of which is essential for the further understanding of influenza.

The main emphasis in the WHO influenza programme is on the rapid isolation of strains in national laboratories and their speedy final characterization in the international influenza centres, particularly at the beginning of epidemics, and on the rapid collection and dissemination of epidemiological information. The efficacy of the programme was recently demonstrated on the occasion of the appearance of the A/New Jersey/76 strain. The virus was isolated by the state laboratory in New Jersey, USA, and sent promptly to the WHO Collaborating Centre in Atlanta, where it was identified as being similar to the swine influenza virus. Within the week, this information was made available simultaneously by WHO and the United States public health authorities. Further information was subsequently issued in the WHO Weekly Epidemiological Record and through circular letters to national influenza centres, in which those centres were asked to reinforce surveillance. Within three weeks, inactivated swine influenza antigen and specific antisera were distributed to all national influenza centres and candidate vaccine strains were made available to manufacturers. Subsequent reports from the global network of laboratories confirmed that swine influenza virus infection of humans appeared to be confined to the United States of America and occurred only rarely there. In the light of this information, countries were able to develop individual vaccination policies.

The WHO influenza surveillance network

Global surveillance of influenza is maintained through the efforts of 102 national influenza centres in 71 countries in collaboration with the World Health Organization in Geneva and with the two WHO Collaborating Centres for Reference and Research on Influenza in Atlanta and London. The network of national influenza centres covers nearly all parts of the world: 46 laboratories are located in 39 developing countries and 56 laboratories are in 33 industrially developed countries. The national influenza centres provide the foundation of the network. They are designated by national health authorities and are brought into the WHO programme through formal recognition by WHO.

More than one laboratory may be recognized as a national influenza centre in a country. The number depends in general on the size of the country, on the density of the population and on the number of competent virus laboratories in existence. Though no limit to the number in any one country has been set, it is obviously unnecessary to have a large number of centres in a single country. It is hoped that in time all countries will have a designated laboratory with which the Organization and the international centres can communicate.

Functions of the WHO Collaborating Centres for Reference and Research on Influenza, Atlanta and London

- to obtain, fully characterize and preserve representative strains from outbreaks in different parts of the world and distribute them to research and vaccine production laboratories;

- to advise on the strains which should be included in influenza vaccines;

- to arrange for the training of research workers in specialized techniques;

- in collaboration with the Virus and Epidemiological Surveillance units at WHO in Geneva, to collect and distribute epidemiological information about the prevalence of influenza in different parts of the world.

The WHO Collaborating Centre for Reference and Research on Influenza in Atlanta has a contractual technical services agreement with WHO to provide reagent kits for the national influenza centres.

Functions of the WHO national influenza centres

(1) to isolate influenza viruses from patients;

(2) to reliably perform serodiagnoses of influenza;

(3) to send freshly isolated representative strains from each outbreak very quickly to one of the international centres; and

(4) to provide virological and epidemiological information to WHO in Geneva and to the international centres.

National influenza centres encounter many difficulties in fulfilling their functions, particularly at the beginning of epidemics when specimens may be few in number and the virus may grow poorly. But an effective planned programme of surveillance is of the greatest practical value to health authorities all over the world, particularly when a current strain of virus A is rapidly changing its antigenic structure.

Laboratory studies at the WHO Collaborating Centres for Reference and Research on Influenza, Atlanta and London

Viruses received at the international centres are examined for their antigenic composition and other characteristics as soon as possible, subject to the urgency indicated by the epidemiological information accompanying the specimen. Viruses showing unusual characteristics will be exchanged between the international centres without delay, and a report sent immediately to the WHO Virus Diseases unit and to the laboratory of origin and other national influenza centres. Should it prove necessary, such strains will immediately be made available to influenza vaccine manufacturers and to interested influenza centres or other research workers. Where there is less urgency, the characterization of the strains may not be completed immediately, but all strains characterized which appear to be of interest or value will be held in the international centres and made available on request to cooperating laboratories.

Recent developments

With the advent of the WHO technical cooperation programme on acute respiratory diseases, the possibility of extending the functions of the national influenza centres to other viral respiratory diseases was raised. A WHO scientific group on viral respiratory diseases held in Geneva from 2 to 6 April 1979 recommended that "use be made of already existing national influenza centres to extend the diagnostic work to cover other viral aetiological agents".[1]

The impact of viral respiratory infections on child health was highlighted by the severe respiratory syncytial virus outbreak in Naples early in the same year. The importance of viral respiratory diseases was further reiterated at the Thirty-second World Health Assembly (resolution WHA32.33).[2]

The Directors of the WHO Collaborating Centres for Reference and Research on Influenza have warmly welcomed the idea of extending the activities of national influenza centres and guaranteed full support and cooperation in the scheme. However, an agreement on optimal laboratory methods for diagnosis of viral respiratory diseases other than influenza is needed. Guidelines based on these methods will be required for the training of directors and senior technicians of the national influenza centres. Action to those ends is under way.

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[1] See WHO Technical Report Series, No. 642, 1979.

[2] Document WHA32/1979/REC/1, p. 31.

23 May 1980

ORGANIZATIONAL STUDY ON THE "ROLE OF WHO EXPERT ADVISORY PANELS AND COMMITTEES AND COLLABORATING CENTRES IN MEETING THE NEEDS OF WHO REGARDING EXPERT ADVICE AND IN CARRYING OUT TECHNICAL ACTIVITIES OF WHO"

The Thirty-third World Health Assembly,

Having considered the Executive Board's organizational study on the role of WHO expert advisory panels and committees and collaborating centres in meeting the needs of WHO regarding expert advice and in carrying out technical activities of WHO;[1]

Recalling resolutions EB59.R34 and WHA30.17;

Believing that the organizational study provides a constructive basis for the future use of experts and institutions in support of WHO's work;

Believing further that the study positively contributes to the review of WHO's structures in the light of its functions and will have important implications for the formulation and implementation of national, regional and global strategies for health for all by the year 2000;

1. CONGRATULATES the Executive Board on its study on the role of WHO expert advisory panels and committees and collaborating centres in meeting the needs of WHO regarding expert advice and in carrying out technical activities of WHO;

2. NOTES with appreciation and concurs with its findings, conclusions and recommendations, especially with regard to

(a) the broader definition of the WHO expert and the enlarged conception of the role of the WHO collaborating centre;

(b) the wider selection of experts and institutions being called upon to cooperate with the Organization to ensure an adequate scientific, technical and international balance of the WHO system of expertise as a whole, and

(c) the major role being devolved upon the WHO Regions in the building up and operation of the system through the active collaboration of the Member countries themselves;

3. URGES Member States to give every possible support to the Organization in the development of its expert resources, by making available to it national health staff and institutions able to contribute to its activities;

4. REQUESTS the Director-General to take the action required to give effect to the conclusions and recommendations of the study, especially concerning

(a) the drawing up of new regulations, to be adopted by the Health Assembly, to govern WHO's mechanisms of expert consultation and institutional collaboration as a whole,

(b) the formulation of a plan of action to adjust the system as now envisaged to the needs of WHO's programme and in particular to programme priorities as determined under the Sixth General Programme of Work, and to the medium- and long-term development of biomedical and health services research;

5. FURTHER REQUESTS the Director-General to report to the Executive Board and to the Health Assembly, as appropriate, on the progress made in following up on the organizational study.

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[1] Document EB65/1980/REC/1, Annex 6, p. 84.

Seventeenth plenary meeting, 23 May 1980
A33/VR/17

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PAN AMERICAN HEALTH ORGANIZATION

ADVISORY COMMITTEE ON MEDICAL RESEARCH

NINETEENTH MEETING

9-13 JUNE 1979

SAN JOSE, COSTA RICA

REPORT TO THE DIRECTOR

Ref. HRC 19/1

30 June 1980

PAN AMERICAN HEALTH ORGANIZATION

Pan American Sanitary Bureau, Regional Office of the

WORLD HEALTH ORGANIZATION

Washington, D.C.

Pan American Health Organization
Advisory Committee on Medical Research

Nineteenth Meeting

9-13 June 1980 San Jose, Costa Rica

REPORT TO THE DIRECTOR

Ref: HRC 19/1
20 June 1980

Pan American Health Organization

XIX MEETING OF THE
PAHO ADVISORY COMMITTEE ON MEDICAL RESEARCH

San Jose, Costa Rica
9-13 June 1980

LIST OF PARTICIPANTS

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DR. LEONARDO MATA	Catedrático y Director Instituto de Investigaciones en Salud - INISA San José, Costa Rica
DR. GERALD ROSENTHAL	Director National Center for Health Services Research Dept. of Health, Education and Welfare Maryland, USA
DR. KERR WHITE	Deputy Director Division of Health Sciences The Rockefeller Foundation New York, USA

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DR. SUNE BERGSTROM	Chairman, WHO/ACMR Karolinska Institutet Stockholm, Sweden
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NINETEENTH MEETING OF THE
PAHO ADVISORY COMMITTEE ON MEDICAL RESEARCH

Report to the Director
1980

INAUGURAL SESSION

Dr. Joaquin Cravioto, President of the Advisory Committee on Medical Research (ACMR), opened the XIX Annual Meeting of the Committee and introduced Dr. Hector Acuña, Director of the Pan American Health Organization. The Director indicated that the selection of Costa Rica to host the meeting has been in recognition for the great support given by that country to scientific research in health as an instrument for realizing national goals and as the best solution to its problems. He mentioned the structural and legal changes that had taken place in Costa Rica lately, which could permit Costa Rica to reach the goal of health for All by the year 2000, before other Latin American countries.

He introduced the Acting President of the Republic to the Committee and referred to its structure, function and the policy of selection of the Members. Following, he commented briefly on the agenda, thanked those Members that were retiring this year, and welcomed the new Members: Dr. Carlos Celso de Amaral e Silva from Brazil, Dr. Luis Vargas from Chile, and Dr. David Hamburg from the USA.

He indicated that this year was the end of the term of Dr. Joaquin Cravioto as President of the ACMR and that he would be succeded by Dr. George Alleyne. He thanked Dr. Cravioto and wished Dr. Alleyne a successful term.

Finally, he thanked the Government of Costa Rica and particularly the Instituto de Investigaciones y Enseñanza en Nutrición y Salud (INCIENSA) for all the facilities given to host the meeting.

Dr. S. Bergstrom, Chairman of the global ACMR, spoke briefly and brought greetings from Dr. H. Malher, Director General of WHO.

Representing the Government of Costa Rica, Dr. Carmelo Calvosa, Minister of Health, addressed the Committee, indicating his satisfaction that

Costa Rica had been selected to host the XIX Meeting of the ACMR and that a Member of the Committee was a distinguished Costarican professional.

Dr. Calvosa indicated that it was not an easy task for a Committee to put science at the service of the countries of the Americas where problems were so different and so great.

The Minister also indicated the need to develop the research potential of the countries of the Region and he commented that the level of health reached in Costa Rica forced the Government to maintain it and increase it. This implied the utilization of all available resources and they were counting on the support and the guidance of committees such as the ACMR.

Finally, Dr. Calvosa wished the Members a successful meeting.

Dr. Rodrigo Altman, First Vice-President of the Republic of Costa Rica, and President ad interim, addressed the Committee and expressed the satisfaction of the Government of the country of Costa Rica at being host to the PAHO/ACMR. He referred to the benefits derived from medical research in the improvement of the health conditions of Costa Rica and the meeting success.

He declared the meeting open.

SESSION I

1. Malnutrition, mental development, behavior and learning

Dr. Cravioto presented his work in this area. He said that the strategies research workers has used to study the consequences of malnutrition on mental development, behavior and learning had been derived from their conceptualization of human malnutrition. Workers who considered that malnutrition was an acute disturbance rather well delimited in time, had conducted studies which endeavoured to quantify the contribution of malnutrition as a chronic process that might or might not be acutely exacerbated both by physiologic conditions and the social circumstances of the individual at risk. These workers had attempted to correlate sequelae along a time axis.

With the focus of attention on the young individuals because of their high vulnerability three models on approaches had been used in trying to

clarify the causal factors and the consequences, both short and long term, of protein-energy malnutrition: 1) the deprivation model; 2) the intervention model; and 3) the ecological or natural history model.

The ecological model used over a sufficiently long period of time made it possible to identify age-specific risk conditions, to relate causes and consequences at different periods or stages of development of the individual, and to set up scales of biological and social time. Since it also permited the selection by the research worker of levels of macro or micro-environment in order to ascertain the interaction of biologic and social variables, it was decided to employ that model with the interrelations between nutrition, health and social factors over time in one and the same population.

Longitudinal data on the effects of macro and micro-environmental variables on the performance levels of sensory-motor development, motor abilities (coordination, strength, agility and velocity, flexibility, and equilibrium), intersensory organization related to prerequisites for learning to read and write, perceptual-motor decoding and audio-vocal encoding, clearly showed that the environment in which infants and young children at risk of malnutrition lived was highly negative for mental development and learning. Children raised in this milieu had a high probability of exhibiting poor performance in all the aspects studied. The presence of a super-imposed episode of severe malnutrition increased the chances of scoring at values even lower. With the exception of auditory-visual intersensory integration the lower performance levels of the survivors of severe malnutrition of all other tests persisted when these children were matched with children of the same birth cohort for income per capit, main source of family income, percentage of total family expenditures devouted to food procurement, sanitary facilities of the home, and total score of home stimulation. The difference in auditory-visual competence between survivors of severe malnutrition disappeared when the survivors were matched with children having the same low scores of home stimulation.

With the longitudinal data available it is now becoming possible to tease out the specific contributions and interactions to the cognitive

development of children of the lack of nutrients, the inadequate stimulation, the diminution of experiencial opportunities, as well as other health and social factors.

Dr. Cravioto was congratulated on his presentation. Dr. Acuña raised the issue of mental health and neuropsychiatric research. He was concerned that note should be taken of possible areas of evaluation in this field. There was also concern that there was a decline in nutrition research even within the Americas and it appeared that mental health appeared to have a low priority for research. In this context Dr. Acuña pointed out that the Global ACMR had established a Subcommittee on Mental Health and Dr. Hamburg was a member of that subcommittee.

2. Research activities of the Latin American Center of Perinatology

Dr. Caldeyro-Barcia presented this report. It was an extensive review of the work of the Center in establishing norms for various aspects of perinatal physiology. There was convincing evidence that the more physiological position for child birth was for the mother to be erect. It was shown that there was greater parental bonding, less use of analgesics, shorter labor and a healthier baby. Various chemical parameters were measured, including factors such as acid-base status and these all indicated the physiological superiority of the vertical position. Data were also presented on the care of the newborn babies and the studies which the Center was doing in the area of breastfeeding. Several data for newborns were presented, emphasizing the need for obtaining locally relevant norms.

Of the interesting points which arose in the discussion, one of the most prominent was the resistance of physicians to change. In spite of the demonstration of the superiority of the methods used in the Center, there was still considerable physician resistance. It was noted also that these methods could not be applied exclusively in hospitals, but could be practiced by peripheral workers.

SESSION II

Research on Diarrheal Diseases

3. Report of the PAHO Subcommittee on Diarrheal Diseases Research

The Committee received a progress report of the Diarrheal Research Subcommittee.

The report of the Subcommittee reviewed: (1) the current knowledge on oral rehydration; and (2) the etiology and epidemiology of the diarrheas of viral, bacterial and parasitic origin.

Regarding oral rehydration, the Subcommittee recommended that this method be adopted by the countries as soon as possible and in order to do that, demonstration programs in hospitals be established. The composition and packaging of the salt mixture was recognized as was the need to improve rehydration schemes and the need to answer questions on sodium load adrenal function. It was recommended that operational research on oral rehydration programs be conducted, with special emphasis on transfer of technology to the home.

In respect to the etiology and the epidemiology of diarrheas of viral, bacterial and parasitic origin, current knowledge was reviewed. It was recommended that: epidemiologic surveillance of rotaviruses be with an undertaken emphasis on the identification of serotypes; a search by started for other viruses, at present not culturables; an investigation be initiated of vibrio cholerae and other vibrios in Latin America; and research be carried out on the prevalence and association of bacterial colonization factors and enterotoxin production; and an investigation mounted dealing with zimotypes of Entamoeba histolytica.

The Subcommittee saw the need to generalize the use of the ELISA for rotaviruses research; PAHO has antisera and reagents for that purpose. The Subcommittee recommended that the laboratories at IVIC (Venezuela) and INISA (Costa Rica) be considered respectively as regional training centers on the molecular biology and the diagnosis of rotaviruses. Also, the Gorgas Memorial Laboratory (Panama) could serve as a diagnostic center for Vibrio parahemoliticus, Edwarsiella and Yersinia

New techniques for the demonstration of Salmonellae antigens in feces and urine and of endotoxin in the blood were recommended. It was thought important to develop a better diagnostic method for giardiasis and other intestinal infections.

4. Epidemiologic perspective of diarrheal disease in Costa Rica

The Committee also was told of Costa Rica's participation in the diarrheal program.

The first section of the report describes the marked decline in diarrheal diseases mortality which began in the 1940's. After a period of arrest during 1948-1964, this decline continued reaching very low figures in 1977 (12 per 100,000 population). The report suggests that the decrease in mortality due to diarrhea coincided with concurrent social reforms in the country. This stagnation correlated with social unrest (civil war), substantial population growth and reduction of levels of health and the quality of life.

The second part of the report dealt with advances in research on the etiology and the treatment of diarrhea in Costa Rica, and in particular on how oral rehydration affected infant health. The research done in Costa Rica established that rotavirus, and to a lesser extent, bacteria, are the main agents of diarrhea. On the other hand, it was found that oral rehydration was a safe and effective way to treat moderate and severe dehydration in diarrheas of viral and bacterial origin. Other findings indicated: the need to increase the concentration of potassium in oral solutions; sucrose was equally as effective as glucose; and solutions and rehidration schemes were equally effective in the treatment of both neonates and older children.

The final section reviewed current efforts to prevent diarrhea and death at the national level with special attention given to rural areas. The report describes the distribution of packs of salts at the national level and the efforts made to transfer technology to the mothers to permit rehydration in the home. Secondly, through a long-term prospective field study conducted by INISA in Puriscal, a drastic change in the pattern of breastfeeding has occurred. More than 60 percent of mothers continued the breastfeeding of their children after the fifth month, a level which contrasted with the 95 percent

of infants weaned as recorded in the country by two recent surveys carried out by the Ministry of Health. The increase in breastfeeding may be related to the rooming-in and the promotion of breastfeeding in the hospital. The survival and physical growth and nutrition of the child exceeded the expected levels for the rural area.

Research in Costa Rica was currently conducted at the National Children's Hospital and at the Institute for Health Research of the University of Costa Rica (INISA) where the emphasis was on studies of oral rehydration, the transfer of technology on oral rehydration, the search for new etiologic agents, and the epidemiologic understanding of the problem in the community.

Both presentations were discussed simultaneously. The Committee was informed that infants were not usually given oral rehydration when they were moderately dehydrated, simply because they refused such treatment. It was noted that the criteria for diagnosis of dehydration were easily taught to many levels of health workers. There were comments on the design of studies in which social variables were estimated along with studies of biological phenomena.

The Committee was reminded of the necessity of considering the global program on diarrheal diseases. There had already been some twenty meetings in the various regions: at these meetings there had been wide ranging discussion on problems of etiologic agents and firm proposals and recommendations had been presented to the Director of WHO. The funding requirements for this global program would be considerable and it was essential that there be national contributions.

5. Research Program in the Activities of PASCCAP (The Community Health Training Program of Central America and Panama)

The background and justification for this program were clearly set out. At the XXIV Meeting of the PAHO Directing Council held in Mexico, early in 1976, the Government of Costa Rica had submitted a proposal for the establishment of a Pan American Center for Training in Community Health. The program began operations in March 1979 in San Jose, Costa Rica. The three main areas

of activities have been research, educational development and support sectors.

The research subprogram which was of major interest to the Committee had as its general purpose the promotion, at country level, of research applied to the expansion of coverage with the emphasis being on primary care strategy. Within this regional purpose, there were research programs specific for each country.

The Committee discussed this presentation briefly, and the attention of PASCCAP was drawn to the possibility of having some of the facilities of the UN Office for Statistics available. It was felt that it might be possible to field test some of the health components from this office. As PASCCAP was new, it was pointed out that attention should also be paid to the facility for analyzing as well as collecting data.

6. Progress report on the history of health research institutes in Latin America

Dr. Garcia introduced this study which had been aimed at dicovering the laws and factors which affected scientific productivity. Except for Brazil, this kind of study was almost nonexistent in Latin America. The data covered the great majority of Latin American countries and covered the period starting at the end of the 19th Century and extending up to 1930. The development of Ministries of Health was traced as well as the formation of agencies of social securities. Much of the change in the research institutes have been focused on problems of rural inhabitants and marginal areas. It seemed that bacteriological and parasitological research had developed to the detriment of physiological research. It appears that basic research started in quantity after 1930 and was influenced by many private individuals outside of large institutional groups.

The discussion brought out other work which had been omitted and it was pointed out that the study was preliminary. It was hoped that many of the results of this study would be widely disseminated, especially to younger research workers.

SESSION III

7. Report by the Health Sciences Research Subcommittee

The ACMR received the report of the Working Group on Social Science Health Research. In 1979, the ACMR had called for an assessment of the use and the efficacy of social health indicators. To identify the nature of the work done along these lines in Latin America, a broader review of social science health research was initiated and reported upon. Based on the premise that constituent disciplines where strengthening was indicated could contribute more effectively to health services research, a number of recommendations were listed.

The Working Group's recommendations were: (1) the establishing of an advisory committee to contribute to the strengthening of the work done in those fields by PAHO; (2) the augmentation of PAHO's resources assigned to this area; (3) expansion of the 1400 items social science health research inventory; (4) the convening during 1980/81 of one or more interdisciplinary working parties to review what social science health research had been done and what social health indicators might be developed related to designated health problems, e.g. specific tropical diseases or tradicional medicine; (5) to seek greater completeness in appraising what had been done, the circulation of the revised report with a request for commentary.

The Working Group also tabled a number of long-term objectives intended to strengthen the work involving the social sciences to health services research. These steps included: (1) the development of a directory of researchers in this area for Latin America; (2) the preparation and the distribution of research bibliographies related to specific health problems; (3) the establishment of regional depositories of social science health research studies; (4) based on the work done by workshops dealing with specific issues (recommendation No. 4), a broader review be undertaken of the development and the utility of social health indicators and establishing a central depository for these research tools; and (5) the strengthening of research done in the field by the provision of expert consultants, where requested.

The Working Group tabled its recommendations and long-term objectives

as a provisional appraisal. It requested the ACMR's counsel and that of the PAHO Secretariat about the next steps to be given priority.

The Committee heard comments on the report.

One view was that in regard to social sciences research applied to health and perhaps in other areas of investigation as well, researchers had to be concerned with doing useful research and making the research useful. It was felt that the work and ideas set out in the report were most useful. It was agreed that the goals of the program should be to develop young researchers, develop inventories of research and easier access to existing data as well as legitimizing the whole field of social science research. The effort in this area should be part of a general commitment to health services research and not a separate set of functions. There was a need to integrate with other PAHO research support strategies.

Another comment pointed out that in some quarters there was ambiguity about the best possible role of social research in health. Social research in health could be adjunctive or "free-standing". It was likely that health planners would prefer the type of research which was specifically directed towards a single problem. The view was expressed that the formation of an Advisory Committee might not be the ideal way of achieving the objectives.

In general, the kind of social science research undertaken needs to be sensitive to demographic and health status differentials in populations.

It was agreed that the Latin American Bibliography on Social Sciences Applied to Health was an excellent document which should be up-dated annually. The Bibliography rather than assessing quality should simply report the source of the publication. It was not felt that the mammoth task of annotation of a compiled bibliography would be worthwhile.

A final comment related to the usefulness of research to the administrator who had to make rapid decisions. Attention must be paid to the practicability and availability to the user of the results of the research.

In general discussion by the Committee, it was agreed that the report was a valuable document. Social and organization research, had to be seen and studied with relation to the other two components of health services research, i.e., epidemiology/demography and operational research.

Dr. Acuña pointed out that many activities of PAHO fell under the theme of health sciences research. He pointed out that in the discussions on this and other topics, the whole range of PAHO activities must be considered and not simply the work of a particular division.

It was argued that the PAHO/ACMR should avoid the danger of having health services research becoming non-specific and directed primarily at institutional rather than community problem. The various programs themselves should be media through which health services research was promoted and the diarrheal diseases program was a good example of this.

The Committee thanked Dr. Badgley and the group for the report.

8. Preliminary Design of a Program of Research for the Development of the Health Services

This was introduced by Dr. Gonzalez who described the basic principles of the program. Its general objective was to help extend the coverage, lower the costs and enhance the effectiveness and efficiency of health services. The research component of the program would promote and support action oriented studies based on the practical needs of the health services of the different countries. For this reason, simple epidemiological methods would be used and practical methods of systems analysis would be employed. Even at the stage of designing the research ways will have to be found for disseminating the results or benefits through the region. In all aspects of the program appropriate emphasis will be placed on the primary care aspect of health services and the inter relationship between the various levels.

It was proposed that the program be launched in 1981 and extended over a period of six years in three stages of two years each. One part of the program might emphasize the interdivisional preparation of protocols with exploratory operations research models in the areas of drug administration in health centers and hospitals, administration materials, sterilization facilities and infection control at health centers and hospitals and the development of appropriate technology for maintenance of health institutions.

The regional seminar on operation research would form part of the program. It is anticipated that before any active health services research

could be initiated in any country, these countries should have well defined national health policies and these governments should be committed to participating in the program. The program proposed would naturally be consonant with the activities of the global ACMR in this field.

The Committee thanked the Subcommittee for the work done and the program which had been proposed. It was stressed that there should be a record of the studies which had been done and workers in this field should intensify relationships with other disciplines and other aspects of health services research. There was a request for more programs in communities rather than in institutions.

9. Report of the Regional Seminar on Operations Research in Health

This was introduced by Eng. Ortiz who described briefly the start and the early development of operations research in health services as a part of the academic programs of industrial engineering and systems schools in Latin American universities. Some of this research had been done with financial support from the PAHO Research Grant Program.

These studies were carried out by workgroups formed by students of the last year of Industrial Engineer and Systems, professors, health administrators and physicians of differents health institutions.

Because of the experience acquired by some pioneer groups in operations research in health in Latin America it was decided to start promotion meetings of health services research with a Seminar on Operations Research in Health, held in Washington, D. C., from 13 to 19 November 1979.

The basic purpose of this seminar had been to bring health services research to the attention of the personnel in academic programs of industrial and systems engineering and also to the executives of institutions in the health sector. Specifically, the seminar was aimed at generating an awareness of prospective applications for operations research in the health sector and setting up methods for exchange of research among the different countries in the Western Hemisphere.

The first session of the seminar dealt with the philosophy, history and methods of operations research in health. Subsequent sessions focussed on experiences of operations research in Latin American health services and on problems areas of institutional and program administration which could be subject of operations research in health.

A document was prepared which contained the general bases for a regional health services research (HSR) program. In one session there was a visit to the National Center for Health Services Research of the United States, where the Director and his staff exchanged ideas with the participants about the development of HSR in the United States. The final session was devoted to a general discussion based on the different ideas and the experience of the several participants. Recommendations were presented for different aspects of the promotion, training and conduct of operations research on health services in Latin American and the Caribbean.

The Committee received the report and in the discussion which followed it was again stressed that operations research as a part of health services research should move from institutions to communities. Dr. Acuña developed the theme of appropriate technology in relation to operations research. He said that the Division of Comprehensive Health Services would be sponsoring a meeting on this topic of appropriate technology. The aim had to be that use should be made of those technologies which were already in existence.

SESSION IV

10. A Working plan of the National Center for Health Services in collaboration with Mexico in the Borderline area

This presentation by Dr. Rosenthal first surveyed the role of the health services research as a growing area of research priority. It was proposed that if expenditure on health services research were increased within the same structures and strategies as for support of medical research, generally, little improvement in health or health care could be expected. It was suggested that biomedical research strategy was focussed on disciplines whereas health services research was not. In most instances in health services research, the unique nature of the data used would always place qualifications, limits and constraints on the generalizability of the results of any specific

study. An efficient and effective health services research effort required specific strategies to deal with the inherent absence of an orderly communication network among the diverse and disparate research community. Stress was laid on the methods of dissemination and application of research findings in this field as no orderly linkage between research and users was possible. It was felt that the health research effort needed to produce priorities which reflected identified information needs of the user community, an integrated portfolio of research findings and a system whereby users could have access to the relevant findings.

The National Center for Health Services Research was committed to implement all the aspects of a broad Health Services Research Program. Because of the committment the Center was involved in the US-Mexico Border health initiative. The initiative would integrate the recommendations as far as health services research was concerned, it would develop projects with shared training and analysis and could fund workshops.

In the discussion it was pointed out that attention had to be paid to the placebo and other such effects. It was also said that polarization of biomedical and health services research was in some ways artificial because both disciplines should follow a similar scientific method if the research was going to be worthwhile.

11. Action-oriented research on nutrition through primary health services

In this report Dr. Daza pointed out that it had been realized that although in the last 30 years there had been significant development in the knowledge about nutrition there had not been an equivalent increase in the application of that knowledge. Many of the things which might improve nutrition practices had not been adapted to the local prevailing conditions. Appropriate technology needed to be developed in nutrition in order to allow much of this available knowledge to be applied at a primary level perhaps using a community approach. In the majority of the places in which malnutrition was prevalent it was already possible to improve the situation by using locally available foods. This was specially important in children. If this strategy of using locally available foods for children was pursued, there were two approaches -to attack the problem during the first 3 years of life and in the prenatal period and to make the maximum use of local

foods using readily available acceptable items as food supplements until the child could consume the foods from the regular family diet. There is urgency in the countries of the Region which have problems with malnutrition about carrying out operational research in which much of the knowledge already available was applied and evaluated.

It was made clear that the principal objectives of a program of action research in nutrition was to identify and facilitate practical actions which could be carried out at the level of the community and within the prevailing economic and social limitations. It was also necessary to disseminate knowledge about nutrition which could be used by all levels of workers in health and other related disciplines.

The committee accepted the report and recommended its implementation on a regional basis.

12. PAHO guidelines and review procedures for the protection of human subjects in medical research

At the 18th Meeting of the ACMR, the activities of the PAHO Research Ethics Review Committee were considered. In view of increasing emphasis on ethical review with lay representation and on the need to avoid conflict of interest, the ACMR has established a subcommittee, including PAHO staff, to make recommendations. Dr. Groot and Dr. Weller of the ACMR met with PAHO staff for this purpose.

The report presented by Dr. Weller set out the background to the problem of ethical review and described the possible role of WHO/PAHO. The PAHO Committee was established to provide a mechanism for assessment of ethical implications not only in projects submitted to PAHO but also to advise on the review procedure in PAHO centers. This report did not give guidelines on the vexed question of informed consent but concentrated on the appropriateness of the process whereby the experimental subject is informed before he signs a consent form. The report gave specific proposals as to the membership of the review committee. Stress was laid on the fact that local committee at PAHO centers as well as the PAHO committee at headquarters would include lay members and the PAHO committee would include established clinical research workers drawn from outside PAHO temporary consultants would be used in the process as needed.

A timetable for the review process was prepared and details were given of the review procedure which should be followed by individual researchers or PAHO centers. It was emphasized that the review should not add undue delays to the process of having grant applications considered. The working group pointed out that the whole matter of ethics was being considered in WHO and the Council of International Organization of Medical Sciences.

The ACMR received the report and thanked the working group. From the discussion which followed it was agreed that all committees should contain women but there was no concensus as to the necessity of having lawyers. There was a suggestion that the title of the report be changed to indicate that only clinical investigation was being considered but this was resisted since it was felt that the whole range of investigation involving humans singly or in groups should be subject to ethical review. It was agreed that whenever local review procedures existed, international collaborative research would have to satisfy both review processes. In those countries in which there was no review mechanism difficulty clearly arose and perhaps the only safeguard would be the experience, peer group confidence in and personal integrity of the individual investigators.

The problem of research in communities was extensively discussed with particular reference to epidemiological studies, the trial of drugs and vaccines. The tropical diseases research program is specially concerned about these issues, and is in the process of developing guidelines on the ethical problems related to such studies. There was no ready answer but it was felt that it was impossible not to relate directly to the individual who was being affected.

It was noted that many countries expected very clear guidelines on a wide range of ethical matters even involving appropriateness of doing trials in developing areas of the world. The current activities in WHO might provide such clear recommendations. The PAHO proposals in this field would contribute to the final international recommendations.

13. The Special Program for Research and Training in Tropical Diseases

A report on this program was presented by Dr. A. Lucas. Since the details of the program had been presented to the ACMR on previous occasions, Dr. Lucas briefly reviewed the various activities and how they had developed over the past 3-4 years. There were multiple activities which were directed towards the same goal. He pointed out that there were already a number of informal networks of collaborative research work and communication among scientists and institutions in various parts of the world. Initially, most of the work, specially the basic studies were being done in the developed world, but there had been a steady rise in the proportion of funds granted to scientists and institutions in developing countries. Particular mention was made of the training and institutional grants which aim at strengthen the research capability of the developing countries of the world. The whole world was being regarded as providing the laboratories and the training experience for the program as a whole. One of the newer activities was the rapid publication of the results of workshops. Special attention was also made of the principle of selling up working groups across the diseases; groups dealing with common problems of vector control, biomedical science and epidemiology.

There was some discussion on the funding for the program. WHO only contributed 4% of the budget from regular funds. Fund raising was the responsibility of WHO and its co-sponsors of the Program. The World Bank particularly was active in raising funds for the program. The problems of manpower were discussed and it was noted that specifically in developing countries scientists were in short supply and the most acute need was in the area of field research.

SESSION V

14. Development of a continental program of applied field research in Malaria

Dr. Najera analyzed the evolution of the antimalarial programs in the Americas, emphasizing the lack of progress and even deterioration of the situation during the last years possibly as a result of rapidly increasing

costs of control programs. The governments concerned and the Directing Bodies of PAHO/WHO have recommended the revision of antimalarial strategies and the formulation of a new continental plan of action against malaria. Essential components of this plan were the intensification of epidemiological studies, the participation of the community and the primary health care services and the development of coordinated regional programs of research and training.

It was recognized that serious efforts to promote and support research in malaria had been made by various countries and the Organization, particularly since the establishment of the TDR program. Although there had been great achievements in the development of laboratory based research, field oriented research in epidemiology and control methodologies was still very limited and poorly coordinated.

Among the causes of this slow development were the attitudes of anti-malarial programs which were not conducive to the formulation of collaborative research between control and research workers. There was also the loss of interest of the scientists in a disease which was considered eradicable, the high costs of field research, the lack of trained malaria epidemiologists, and the overwhelming demand for quick short-term solutions to field problems.

It was recognized that the possibility of future progress in malaria control was dependent on a better knowledge of the epidemiological, ecological and sociocultural factors which make malaria a problem and there was an urgent need to develop a field research program which would respond to the problems and the long-term needs of malaria control.

The support of the ACMR was needed for the promotion of such research program and the training on which it would depend. Epidemiological research on malaria had to be given a high priority within the plans for biomedical research in all countries where malaria continued to be a serious public health problem.

15. World plan on malaria field research and its regional projection

Dr. Lepes introduced this topic and pointed out that the resurgence of malaria in some countries of South East Asia, Central and some countries of South America since the early 1970's had prompted political reaction by a number of affected countries and numerous steps had been taken by governments and the World Health Organization to remedy the situation. The Director General of WHO responding to requests made by Member States had presented to the 31st. World Health Assembly on May 1978, a Malaria Control Strategy which had been endorsed by the Assembly. The proposed strategy had taken into account all possible ecological situations and the infra-structural support required. It indicated four possible levels of control ranging from reduction and prevention of mortality to eradicating the disease. The strategy postulated that four conditions should be satisfied if malaria control/eradication programs were to be successful. These were:

1) that there should be a national will and the political decision to undertake malaria control/eradication programs;

2) that the governments should decide on long-term support for anti-malaria activities;

3) that any malaria control/eradication program must be an integral part of a country's health program; and

4) that community participation must be secured and these should be multisectorial and multidisciplinary cooperation at central, intermediate and peripheral levels.

It was further postulated that for the implementation of a malaria control strategy, flexibility and an epidemiological approach should fully be applied.

Dr. Lepes said that the reaction of Member States to the resurgence of malaria and steps subsequently taken had resulted in a reduction of reported cases of malaria from more than 8 million in 1976 to slightly over 4 million in 1979. Nevertheless, a detailed analysis indicated that

with exception of few countries like India, Sri Lanka and Turkey, where this reduction was quite evident, in other parts of the world there was generally stagnation.

At this stage of the development of malaria control/eradication programs there were four types of activities that should be carried out simultaneously. These were: 1) control of epidemics and prevention of further spreading; 2) preparation of long-term malaria control/ eradication programs; 3) training; and 4) research.

The development of national expertise was critical since without it, it would be difficult to undertake those applied field research activities required for the development of long-term malaria control programs. However, laboratory based research undertaken to develop new tools in terms of antimalarial drugs, vaccines or chemical or biological products and agents for the control of the vector, should provide greater possibilities for malaria control in the future.

Antimalarial activities had to be carried out within the social targets of all Member States and with the primary health care system as principal functionary. The present type of malaria control could easily lead to the failure not only of malaria control programs per se but also to the failure of one of the principal functions of the primary health care system that is the control of locally prevailing communicable diseases.

There was discussion on both topics together. It was not generally realized that there was a great deal of ignorance of vector biology in this area. It was possible that this decrease in malaria was a result of mass distribution of drugs which reduced the mortality and perhaps led to a fall in reporting of cases. It was also pointed out that the research effort in this area was very sparce. In some of the countries the degree of control varied with such things as population density and migration.

A point which was brought out forcibly was that in many countries there was often little collaboration between the health services in general and malaria eradication programs. It was felt that the health services

needed to make malaria control an integral part of their programs. It was even suggested that there should be a study to determine the reasons why there was so little collaboration between administration of health services and directors of malaria control programs.

Another reason for the lack of research workers, in malaria specifically and in infectious diseases in general, was the failure of some universities of the region to place emphasis on these topics in their basic teaching programs.

It was stressed that many of the mistakes made in the field of malaria control was as a result of failure to apply basic epidemiologic techniques. Not only was there a lack of appreciation of epidemiological methods but also there was a marked shortage of field workers to apply these methods. Special note was taken of the fact that it was necessary to change the attitude of some health workers to eradication of malaria. The community as a whole had to be prepared for the new methods for control of malaria. It was pleasing to see attention being paid to knowledge of the mores and beliefs of the communities in the current approaches to malaria eradication.

16. Health and biomedical information

Dr. Ferreira introduced the subject and made a brief review of the establishment of BIREME in 1966. This had been based on recommendation of the PAHO/ACMR.

Among the achievements of that initiative was the improvement of BIREME's collection and technical capacity, the installation of the Medlars data base, and the development of an indexing capacity which lead to the production of the Latin American Index Medicus. These efforts, though representing a considerable advance were not enough to keep pace with the growing demand and rapid development of information. It was possible to estimate a 300% increase in the potential users of biomedical information. At the same time a 2000% increase was being estimated in the cost of subscriptions by the year 2000.

The Scientific Advisory Committee of BIREME reviewed this situation in 1979 and pointed out the following concerns in relation to future developments in this area:

a) growing operational cost
b) need of technological adjustment to the new configuration of Medlars
c) potential developments in the field of telecommunications which should be taken into account in order to improve the network
d) lack of parallel development of the library system in other Latin American countries.

A working group was then created to analyze these problems and propose adequate solutions. Site visits to selected countries were made to review the situation at local level, and four meetings were held which brought together some 50 experts to study the problem.

17. Information for health development - Its importance in research

Dr. Sonis further amplified the work of BIREME in this area. The concept of "health development" was increasingly being proposed to express some of the trends in the concepts and goals of the health programs. If the community was viewed as a whole it was possible to determine the factors which hampered this "health development." Some of the factors were to be found in any sector, not necessarily in health.

Access to relevant and necessary information was one of the factors which might affect this development. Therefore, data had to be screened and adequate information had to be given to the appropriate users to allow them to put into practice certain alternatives which might increase the possibility of solving the health problems. The most fundamental activities in laboratories and the most sophisticated ones for primary health care all required information. Eventhough the information for each kind of research was not the same nor were the means to disseminate it, usually the periodic publication continued to be the main source. Since the cost of these periodicals was high it was difficult for some institutions

in Latin America to maintain extensive collections. It was therefore necessary to have a facility which would analyze the utilization of information, determine which information was needed for each institution and establish traditional or non traditional means of providing it.

18. A health information and documentation network for Latin America and the Caribbean Area

Dr. White completed the presentation on this subject.

A long range working group established by the Scientific Advisory Committee of BIREME had prepared specific plans for expanding the availability of bibliographic documentation resources in the Region. During four meetings involving over 50 individuals and consultants from Latin America, Canada, England, and the USA, it had considered many working papers and detailed analysis of the bibliographic requests received by BIREME. The essential facts were that one medical library in the Region had over 1,000 journals: 23 libraries or 10% had over 300 journals, one library had gone from 300 periodicals to 22 in three years. About half of the requests could be satisfied with 100 titles, and 97% with 500.

The recommendations were guided by the principles of selectivity in assembling specific core collections for both peripheral and more central supporting libraries, resource sharing through union lists and catalogues using mini-computers and telex communications, and adaptability to the realities of limited resources and the need of various users. Although the ultimate objective was to involve 1,000 libraries in the Region, it was only realistic to start modestly. Accordingly, 45 basic libraries were considered suitable for initial expansion and participation in the first five subregional networks. These would be linked to nodes and to BIREME by telex. Some of the libraries might be in institutions with little or nothing, and five years of basic periodicals (retrospectively and prospectively) would be supplied on microfiche. A revolving fund would be used to purchase periodicals in bulk and cost-sharing by users at all levels would be introduced. Over four years, the full program was estimated to cost about US$6 million. Dr. White contended that the cost of information was high but the cost of ignorance was greater.

The Committee received all the reports on this topic and was enthusiastic about possible means of continuing and amplifying the service offered by BIREME. In the discussion it was suggested that the postal services might give some special preference to documents coming to or going from BIREME. This was possibly not the ideal way to proceed as all the postal services in the Region left much to be desired. It was noted that one of the most effective ways of improving the system was by "strengthening the BIREME network at the periphery." It was clear that newer methods of data transmission would have to be considered for the future. There were difficulties in such areas as the social sciences, since the classification systems were often inadequate, but this was being rectified. Studies were being done to develop methods of retrieving data based on the method used by the investigator to make the request.

EXECUTIVE SESSION

Dr. Alleyne reported on the meeting of the Global ACMR which was held in Geneva in November 1979. He commented on the remarks by the Deputy Director General with regard to the role which WHO was expecting research to play in the development of a new economic order and in the attainment of health for all by the year 2000. The Global ACMR had received and discussed the reports from the six regional ACMRs. There were many points of similarity specially in the movement towards working through subcommittees or working groups.

Health services research continued to be a priority in all the regions. Coordination between ACMRs might be achieved by interchange of reports and attendance of chairmen of ACMRs at other ACMR meetings. Dr. Alleyne commented specifically on the approach of the Global ACMR to subcommittees. These had finite lives and once an adequate level of activity had been stimulated and the necessary programs had been introduced, when it was time for that sub-committee to be disbanded and attention focussed on some other area which

needed to be developed. The Global ACMR had discussed the research aspect of "health for all by the year 2000" and had considered three major relevant themes. These were disease oriented research programs, health services research and health promotion research.

Dr. Bergstrom, Chairman of the Global ACMR, amplified the above points and noted the formation of two new subcommittes on mental health and research administration. He pointed out again the short life of the subcommittees. The one on diarrheal diseases had established the direction of the program which had now reached the stage at which extrabudgetary funds were being obtained. It was clear that all regions were in agreement on the need for information but none had gone as far as PAHO in providing a good system. Mention was made of the quarterly Bibliography of Tropical Diseases, which was being circulated to all persons in developing countries who receive the Newsletter. Something similar was being planned in the area of diarrheal diseases. It was pointed out that the proposed booklet on health services research would soon be completed.

The Committee discussed the program of activities for 1980/81. It was agreed that there were two areas of activities which should be pursued through scientific subcommittees or working groups. It was agreed that the Subcommittee on Diarrheal Diseases had done valuable work during the year, however the position on diarrheal diseases had changed globally. The Director General of WHO was in the process of securing extra budgetary funds for diarrheal diseases and it had been agreed that these funds would not be disbursed through the regional offices, but through regional scientific working groups. It was therefore necessary to make preparations in this Region to so reorganize the present subcommittee that it could be transformed into the kind of working group which would participate effectively in the global program.

It was agreed that the areas of health services research which had been covered under the heading of social science research and operational research, both had important roles to play in all the fields of investigation discussed.

It was agreed that Dr. Badgley would continue to be the Chairman of the group on social science aspects of health services research and Dr. Flagle would be Chairman of the subcommittee on health services research.

It was also agreed that operations research resources develop their research strategies in conjunction with the complementary work of the social sciences, recognizing both fields as major and essential components of the broader area of health services research.

RECOMMENDATIONS TO THE DIRECTOR

The Committee commented on all of the reports presented, but it was felt that there should be a separate section summarized with the discussions and recommendations.

1. Child nutrition and mental development

The Committee received this report with enthusiasm, noting the wide range of activities which had been covered and the fundamental importance of the findings.

Recommendation: The Committee recommended that a mechanism should be found to ensure the widest publication of these findings.

2. Research activities in the Latin American Center of Perinatology

The committee received this report and noted with satisfaction the important work of this center which had become the most important training center in perinatology in the Latin American Region.

Recommendation: The Committee recommended that support be continued for this excellent program.

3. The history of health research institutes in Latin America

The Committee expressed interest in this work. It was relevant and the results should be of interest specially to young researchers.

Recommendation: The Committee recommended that means be found to disseminate the essential findings of this study widely and the further work should be brought to the attention of a future meeting of the ACMR.

4. Diarrheal diseases

The Committee received and discussed the two reports in this field. It noted the excellent work being done in Costa Rica and in addition commented on the activities of the Diarrheal Diseases Subcommittee.

Recommendation: The Committee recommended that the ACMR Subcommittee on Diarrheal Diseases be strengthened by the addition of social and operational research capabilities.

5. Health services research

The Committee heard and discussed the several reports and presentations in this field. The Committee was specially interested in the proposed activities of PASCCAP in this area. It was noted that although PASCCAP was new, its proposed research activities showed promise of being of inmense value to the Region it serves. The Committee also reviewed the report of the working group on social science health research and congratulated the group on the amount of effort which had been made and the results which had been obtained to date. The Committee also paid special attention to the report of the 1979 PAHO Seminar on Operations Research.

Recommendation: The Committee recommended:

a) That the research activities of PASCCAP be supported and continued.

b) That the Director, as a method of strengthening health services research find specific funds for this activity. Budget proposals to the Directing Council should contain a specific amount to be directed towards health services research.

c) That the working group on social sciences continue its work and be asked to:

   i) coordinate its activities within the specific program priorities of the organization;

   ii) further develop and complete the social sciences health research inventory;

   iii) be responsible for identifying the potential imput of the social sciences by means of interdisciplinary subgroups in the fields of diarrheal diseases and malaria;

iv) extract from the inventory references applicable to specified program areas and prepare an annotated bibliographic series on these matters;

v) as a long-term objective and under the aegis of BIREME to prepare annotated social science health research bibliographics dealing with specific diseases and health problems. These bibliographies would be included in BREMES's program of selective dissemination of information.

d) That in the area of operations research a seminar or similar activity be organized by PAHO during 1980/81. This would focus on the application of operations research to primary health care and review the relationships between alternatives in the allocation of resources and potential outcomes in primary health care programs.

6. Action oriented research in nutrition through primary health services

The Committee accepted the report and endorsed the proposed strategies for implementing new lines of applied research in nutrition. The approaches contained the basic approach of built-in action interventions for the solution of problems at a community level, using locally available resources and focussing initially on activities related to infant and child feeding.

Recommendation: The Committee recommended that means be found to implement a regional research program in nutrition along these lines, taking into consideration the conclusions and recommendations of the PAHO/WHO Technical Group Meeting on this subject to be held in Bogotá, Colombia, 16-20 June 1980.

7. PAHO guidelines and review procedures for the protection of human subjects in medical research

The Committee received, discussed and made minor amendments to this document. It was agreed that this was a most useful definition of the procedures which would serve to protect the interests of the individual as well as safeguard the reputation of PAHO and its centers.

Recommendation: The Committee recommended that report and its proposals be implemented immediately.

8. Regional activities vis-a-vis the Special Program for Research and Training in Tropical Diseases

The Committee heard with interest of the further development of the above program. There was special interest in its growth and the security of funding for the future. Note was also taken of the facility for extending training into areas not specifically covered by the six diseases.

Recommendation: The Committee agreed to recommend that a subcommittee on tropical diseases research be established in the ACMR.

9. Research on Malaria

The Committee received two reports which gave the outlines of the research and the problems related to control of malaria at the regional and global levels. There was concensus that the major problems were a lack of epidemiological data and a shortage of field research.

Recommendation: The Committee, taking into consideration the urgent need for field research as a basic component of malaria eradication and control activities recommends the strengthening and enlargement of the training programs for personnel capable of conducting such research. The Committee further recommends that means should be found for encouraging individual countries to expand substantially their research programs on malaria.

10. Health information systems

The Committee heard the presentations on this important topic and agreed that top priority must be placed on mechanisms by which appropriate information can be provided to the potential users. The Committee congratulated the Scientific Advisory Committee of BIREME for the work done in this area.

Recommendation: The Committee recommended that the report be accepted immediately and the program be pursued as proposed.

The World Bank / 1818 H Street, N.W., Washington, D.C. 20433, U.S.A. • Telephone: (202) 477-1234 • Cables: INTBAFRAD

May 20, 1980

Luis Carlos Ochoa, M.D., M.P.A.
Chief, Division of Disease
Prevention and Control
Pan American Health Organization
525 23rd Street, N.W.
Washington, D.C. 20037

Dear Dr. Ochoa:

It was good to see you in Geneva, albeit briefly. As you predicted, your letter of April 22 inviting my participation at the meeting on Economics of Blindness Prevention to be held at PAHO, July 7-10, was on my desk when I returned to Washington.

The agenda and participants suggest that the meeting will be both stimulating and productive. I regret, however, that I will be on leave in July and unable to attend. I have talked with Dr. Bond, who was also disappointed that Bank representation from the Population, Health and Nutrition Department appeared unlikely. He is hoping, however, that Bank representation will be possible. I believe he plans to extend an invitation to the Division of Population and Human Resources, Development Economics Department, which is part of the Bank's Development Policy Staff.

I extend best wishes for a successful meeting, and I will plan to talk with Dr. Bond to learn of the outcome and proposed future steps. I would appreciate receiving a copy of the meeting report.

With best personal regards,

Sincerely,

Arlene Fonaroff
Population, Health and
Nutrition Department

cc: Dr. John R. Evans, PHN
Dr. James Bond, PAHO

May 7, 1980

Dr. Luis Carlos Ochoa
Chief
Division of Disease
Prevention and Control
Pan American Health Organization
524 - 23rd Street, N.W.
Washington, D.C. 20433

Ref: AMRO-1275/85/2

Dear Dr. Ochoa,

I am honored to be invited to join the task force dealing with the economic implications of blindness prevention. I regret, however, that I will not be available in Washington between the 7th and 10th of July 1980 and therefore will be unable to accept the invitation.

The subject of the meeting is of very substantial interest to our Department at the Bank and I would be grateful to be included in the distribution of the report from the meeting.

Thank you very much for considering me as a member of the meeting.

Sincerely,

John R. Evans
Director
Population, Health and Nutrition Department

JREvans/rmf

File: PAHO

(D5) JRE(m)

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

TELEPHONE 223-4700

IN REPLY REFER TO: AMRO-1275/85/2

22 April 1980

Dr. John Evans, Director
Division of Population Health and Nutrition
World Bank
1818 H St. N.W.
Washington, D.C. 20433

Dear Dr. Evans:

As part of the activities of the WHO/PAHO programme, a task force on the economic implications of blindness prevention will be convened at the headquarters of the Pan American Health Organization in Washington, D.C., from 7 to 10 July, 1980.

This task force will be composed of persons with experience and expertise in health economics and in the prevention of blindness, and is expected to prepare a document which could provide a basic reference for priorities setting in health and social planning in this connexion. A provisional agenda is enclosed. The working language of the meeting will be English.

We have the pleasure to invite you to participate in this meeting. Should you be able to accept this invitation, we would like to receive from you a short working paper on one or more of the topics to be covered, by the end of May at the latest.

We would appreciate receiving your reply at your earliest convenience, so that the necessary arrangements may be started.

Sincerely yours,

Luis Carlos Ochoa, M.D., M.P.H.
Chief, Division of Disease
Prevention and Control

... Attachment

WHO Task Force on Economic Implications
of Blindness Prevention

DRAFT AGENDA

Opening of the Meeting

Appointment of officers

Approval of the Agenda

1. Purpose of the meeting
2. Economic implications of blindness
3. Approaches to prevention and treatment
4. Cost/benefit considerations
5. Priorities in health and social planning
6. Conclusions and recommendations
7. Approval of report

Closure of the meeting

* * *

WHO Task Force Meeting on Economic
Implications of Blindness Prevention

Washington, 7 - 10 July 1980

Draft

Proposed Participants

Professor A. Nakajima, Department of Ophthalmology, Juntendo University School of Medicine, Tokyo, Japan

Dr P. Ruderman, Dean, University of Halifax, Halifax, Canada

Sir John Wilson, President, International Agency for the Prevention of Blindness, Haywards Heath, England

Professor L. Ofoso-Amaah, Department of Community Health, Ghana Medical School, Accra, Ghana

Representatives of other organizations

Dr J. Evans, Director of the Division of Population Health and Nutrition, World Bank, Washington, DC, United States of America

Dr A. Fonaroff, Division of Population Health and Nutrition, World Bank, Washington, DC United States of America

Dr A. Drobny, Inter-American Development Bank, Washington DC, United States of America

Mr M. Gómez, Economist, Inter-American Development Bank, Washington DC, United States of America

Observers

Dr A. Buck, Agency for International Development, Washington, DC, United States of America

Dr D.A. Henderson, Dean, School of Hygiene and Public Health, Johns Hopkins University, Baltimore, United States of America

Dr C. Kupfer, Director, National Eye Institute, National Institutes of Health, Bethesda, United States of America

Dr A. Sommer, Director, The International Center for Epidemiological and Preventive Ophthalmology, The Wilmer Institute, Johns Hopkins Hospital, Baltimore, United States of America

Representative of the World Council for the Welfare of the Blind

Secretariat

Mr M. Bazin, Programme Director, Onchocerciasis Control Programme, Ouagadougou, Upper Volta

Dr L.C. Ochoa, PAHO/AMRO, Washington, DC, United States of America

Dr J. Bond, PAHO/AMRO, Washington, DC, United States of America

Dr J. Litvak, PAHO/AMRO, Washington, DC, United States of America

Dr M.L. Tarizzo (Secretary), WHO, Geneva, Switzerland

4/7/80

HWM: ✓ at 4/7

I called Dr. Acuna's office today and told them Dr. Evans would not be able to attend as he is out of the country.

RMF ✓

RF
? Any fourteen action required ?
I think not

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

TELEPHONE 861-3201 ~~223-4700~~

IN REPLY REFER TO: AMRO-5203/85/1

4 April 1980

Dr. John Evans
Director
Population, Health, and Nutrition Department
International Bank for Reconstruction and Development
1818 H Street, N.W.
Washington, D.C. 20433

Dear ~~Dr. Evans:~~ John

We would like to extend an invitation to you to attend the Subregional Seminar on Programming, Development and Maintenance of Health Care Facilities, which the Pan American Health Organization and the Convenio Hipólito Unánue are organizing in Caracas, Venezuela, from 21 to 30 April 1980, at the initiative of the countries of the Andean Region, with the financial support of the United Nations Development Program.

All Spanish-speaking countries in the hemisphere have been invited to participate, with a larger representation coming from the countries of the Andean Region, who have committed themselves to a major collaborative undertaking to strengthen their capabilities. This will enable them to respond effectively to the need for the development of health care facilities and to assess their approaches in selecting sound, technical and financial solutions to their common problems.

Discussions at the Seminar will focus on the analysis of methodological and operational approaches to programming and developing health care facilities; their impact on the social target of health for all by the year 2000 through the use of primary health care strategies, and the selection of appropriate technologies.

./.

We trust you will find it possible to accept this invitation and look forward to hearing from you in this regard.

Sincerely,

H Acuña

Héctor R. Acuña, M.D., M.P.H.
Director

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

TELEPHONE 861-3200

IN REPLY REFER TO: HRO-5203/85/1

4 April 1980

Dr. John Evans
Director
Population, Health, and Nutrition Department
International Bank for Reconstruction and Development
1818 H Street, N.W.
Washington, D.C. 20433

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./.

We trust you will find it possible to accept this invitation and look forward to hearing from you in this regard.

Sincerely,

Héctor R. Acuña, M.D., M.P.H.
Director

April 28, 1980

Dr. Jose R. Ferreira
Chief
Division of Human
Resources and Research
Pan American Health Organization
525 - 23rd Street, N.W.
Washington, D.C. 20037

Dear Dr. Ferreira,

I was in the Philippines on April 17 and 18 and was unable to attend the meeting of the ACMR Working Group. Unfortunately I did not receive the report of Dr. Badgley until April 25.

The report is extremely useful and I congratulate Dr. Badgely on his contribution. The theme of strengthening the social science element of health research is most important. I would prefer, however, to see the strengthening on a broader base related to health services and health systems research. This would include epidemiology, systems analysis and management services among other disciplines. This comment is not to derogate social services but to achieve the integration of social services with the other disciplines so important to the next phase of development of health policy and services.

Secondly, I would prefer to see recommendations which lead to action rather than advice. What are the obstacles which now limit useful health research and what specific actions might be taken to overcome these obstacles and increase the likelihood of the results being used in health policy and management decisions?

Sincerely,

John R. Evans
Director
Population, Health and Nutrition Department

cc: Dr. Liese

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION
525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN
TELEPHONE 223-4700

IN REPLY REFER TO: HRE/AMRO/8900/21/1 (ACMR-GAR)

1 April 1980

Dr. John R. Evans
58 Highland Ave
Toronto, Canada
M4 W 2A3

Dear Dr. Evans:

The Pan American Health Organization is having a meeting of the Advisory Committee on Medical Research (ACMR) Working Group on social science health research during 17 and 18 April. The purpose of this meeting is to analyze the enclosed report prepared by Dr. Robin Badgley, which is to be presented at the XIX Meeting of the ACMR/PAHO in June 1980.

As a member of the above mentioned Working Group, we hope that you will be able to participate in the 17-18 April meeting. However, if for any reason you are unable to attend, we would greatly appreciate receiving your written comments for consideration by the Working Group.

We thank you in advance for your collaboration and remain,

Sincerely yours,

José R. Ferreira, M.D.
Chief, Division of Human
Resources and Research

Encl.

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José R. Ferreira, M.D.
Chief, Division of Human Resources and Research

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M4 W 2A3

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We thank you in advance for your collaboration and remain,

Sincerely yours,

José R. Ferreira, M.D.
Chief, Division of Human
Resources and Research

Encl.

FILE PAHO

March 28, 1980

Dr. S. Paul Ehrlich
Deputy Director
Pan American Health
Organization
525 - 25th Street, N.W.
Washington, D.C. 20037

Dear Paul,

Thank you very much for inviting me to participate in the small working group at PAHO headquarters on psychosocial aspects of primary health. I would very much like to participate in order to learn more about the area but my commitments from March 31 to April 4 preclude this. If by any chance there is a resume of some of the conclusions of the meeting, I would certainly welcome having a chance to look at it.

Thank you for considering me. With best wishes.

Sincerely,

John R. Evans
Director
Population, Health and Nutrition Department

D

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

TELEPHONE 861-3200

IN REPLY REFER TO: DMH/49/1

20 March 1980

Dr. John Evans
Population Health and
Nutrition Department
World Bank
1818 H Street N.W.
Washington, D.C., 20433

Dear John:

PAHO's Mental Health Unit is convening a small working group at PAHO headquarters from 31 March to 4 April 1980.

Their task is consideration of the psychosocial aspects of primary health care in Latin America. Its focus is more on the strategies of implementation of services and programs than on research and thus appears to nicely interdigitate with the recent Institute of Medicine (IOM) meeting on mental health research in developing countries.

Dr. René González told me how much he enjoyed the IOM meeting and your ideas on the subject.

If you are interested, we would be pleased to have your participation in this PAHO meeting.

There would be no preliminary preparation for you. The meeting is structured to allow as much discussion as possible.

... I have enclosed some general information, participant list, and agenda for your consideration.

I am looking forward to further participation and collaboration with you and the World Bank.

Sincerely,

S. Paul Ehrlich, M.D.
Deputy Director

... Enclosures

Working Group Meeting for the Integration of Psychosocial Components into Primary Health Care

Washington, D.C. 31 March - 4 April 1980

Purpose: This working meeting is proposed to bring a small group of Latin American health workers together to provide stimulation of ideas, dialogue, and discussion of strategies and tactics to consider implementation of some psychosocial components into the primary health care settings in their countries.

Format and Content: This five day workshop will involve discussions, presentations, field examples of psychosocial components of primary health care and service delivery.

In the first two days, urban and rural psychosocial problems will be considered in the context of four levels of program/service organization: i.e. the government/policy level; the linkage/program level; the primary health care level; and the community organization/education level. Within these four levels of organization; issues such as government priorities and policies; multisectorial (e.g. health, agriculture, nutrition) participation; funding, manpower and training, research and evaluation; primary health care worker support, quality control of service delivery; involvement, participation and organization of the community about its psychosocial problems and health care delivery system.

The next two days will try to consider the feasibility and problems of implementation of these services.

The last day will be one of summation and integration of the previous four days work.

Outcome: As a result of this meeting, a working paper will be written whose purpose is to provide stimulation and focus for Latin American countries to consider implementation of psychosocial components into their primary health care systems.

WORKING GROUP FOR THE INTEGRATION OF PSYCHOSOCIAL COMPONENTS INTO PRIMARY HEALTH CARE

31 March to 4 April 1980

List of Participants

Dr. Renato Alarcón
Department of Psychiatry
University of Alabama, U.H. 3N
University Station
Birmingham, Alabama 35294

Dr. Mario Argandoña
Vice-Rector
Universidad Mayor de San Simón
Casilla No. 992
Cochabamba, Bolivia

Dr. Jaime Arroyo
Viceministro de Salud
Ministerio de Salud
Apartado 2048
Panamá, Panamá

Dr. Barbara Burns
National Institute of Mental Health, 18C 10
5600 Fishers Lane
Rockville, Md. 20857

Dr. Ellis Busnello
Rua Luciana de Abreu 210, Apt. 602
90,000 Porto Alegre, RS, Brasil

Dr. Raquel Cohen
Lindemann Mental Health Center
Government Center
Boston, Massachusetts 02114

Dr. Enrique Freer
Subdirector, División Ejecutiva
Ministerio de Salud
San José, Costa Rica

Sra. María Elena de García
Departamento de Salud Mental
Ministerio de Salud Pública
Tegucigalpa, Honduras

Dr. William Hollister
Department of Psychiatry
School of Medicine
University of North Carolina
Chapel Hill, N.C.

Dr. Robert Klein
Instituto de Nutrición de Centro
América y Panamá
Carretera Roosevelt, Zona 11
Guatemala, Guatemala

Dr. Carlos A. León
Director
Centro Colaborador de la OMS
Hospital Universitario del Valle
Apartado Aéreo 1418
Cali, Colombia

Dr. Emilio López Vidal
Oficina de Salud Pública Internacional
Ministerio de Sanidad y Asistencia
Social
Caracas, Venezuela

Dr. Romeo Lucas
Departamento de Salud Mental
Ministerio de Salud Pública
y Asistencia Social
Guatemala, Guatemala

Dr. Angel Alberto Paz Cojulún
Director General
Dirección General de Servicios de Salud
Ministerio de Salud y Asistencia Social
9a. Ave., 14-65, Zona 1
Guatemala, Guatemala.

Conference Room C

WORKING GROUP FOR THE INTEGRATION OF PSYCHOSOCIAL COMPONENTS INTO PRIMARY HEALTH CARE

31 March to 4 April 1980

Monday
31 March Topic: Health Service Delivery in Urban Slums

9:00	Welcome/opening address	Dr. P. Ehrlich	PAHO
9:30	Overview of meeting: Objectives, focus, format of meeting	Dr. R. González	PAHO
10:00	Break		
10:20	A framework for the development of psychosocial components into primary health care	Group leaders: Dr. E. Busnello	Brazil
11:00	The problems of implementation of clinical services in urban community	Dr. J. Arroyo	Panamá
12:00	Lunch		
13:30	An example of urban community mobilization, participation	Ms. M.E. de García	Honduras
14:30	Discussion of important urban psychosocial problems in Latin American countries	Dr. M. Argandoña	Bolivia
15:30	Break		
16:00	Discussion of day's objectives 1. identify important psychosocial problems 2. community awareness and mobilization 3. linkage/program problems 4. government short range planning	Dr. R. Alarcón	Perú
17:00	Adjournment.		

PAHO/WHO Day 2

Tuesday
1 April Topic: How to reach the rural community

9:00	Brief recapitulation and orientation for day	Dr. R. Alarcón	Perú
9:20	Rural community involvement; government health policies for rural areas	Group leaders: Dr. A. Paz C.	Guatemala
10:20	Break		
10:40	Psychosocial training for rural primary health care workers	Dr. C. León	Colombia
12:00	Lunch		
13:30	Manpower development - horizontal and vertical linkage	Dr. B. Burns	NIMH, USA
15:00	Break		
15:20	Morale and economic support for community health care workers - quality control of service delivery	Dr. E. López V.	Venezuela
16:30	Discussion of day's objectives rural: 1. priority of policies 2. linkage issues manpower and training, funding 3. community development 4. quality control service delivery	Dr. W. Hollister	USA
17:30	Adjournment.		

PAHO/WHO Day 3

Wednesday
2 April Topic: Implementation of services

9:00	Brief recapitulation and orientation for day	Dr. W. Hollister	USA
9:20	Policy strategies: priorities, funding, multisectorial linkage	Group leaders: Dr. R. Klein	Guatemala
10:20	Break		
10:40	Linkage strategies: - teaching the teachers - training primary health care workers - service development	Dr. R. Cohen	USA
12:00	Lunch		
13:30	Community strategies: - community organization	Dr. W. Hollister	USA
15:00	Break		
15:20	Integration of services at four organizational levels	Dr. E. Freer	Costa Ric
16:30	Review of day's objectives: 1. policy strategies 2. linkage strategies 3. community strategies	Dr. J. Arroyo	Panamá
17:30	Adjournment.		

PAHO/WHO Day 4

Thursday
3 April Topic: Implementation of Programs

9:00	Brief recapitulation and orientation for day	Dr. J. Arroyo	Panamá
9:20	Policy strategies: - funding - justification of services	Group leaders: Dr. R. Alarcón	Perú
10:30	Break		
10:50	Linkage strategies: - follow up of teaching skills - program development	Dr. R. Cohen	USA
12:00	Lunch		
13:30	Primary health care strategies - net-working workers - in-service training - service delivery evaluation	Dr. E. Busnello	Brazil
15:00	Break		
15:20	Review of day's objectives: - research and evaluation strategies at: 1. policy level 2. linkage level 3. primary health care level	Dr. C. León	Colombia
17:30	Adjournment		

PAHO/WHO Day 5

Friday
4 April Morning recess for all members except small working group, entire group to reconvene at 15:00 hours

	Small group time table	Small group
9:00	Brief recapitulation and orientation of tasks	Dr. R. Cohen Dr. E. Busnello
9:20	Review and summary of issues involving urban slums	Dr. R. Alarcón Dr. C. León
10:20	Break	Dr. M. Argandoña
10:40	Review and summary of rural mental health care	
12:00	Lunch	
13:30	Review and summary of strategies for implementation of services, education, training research and evaluation	
15:00	Final session (entire group) - Presentation of summary and resolutions, amendments	
16:30	Adjournment	

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

IN REPLY REFER TO: DMH/49/1 TELEPHONE 861-3200

20 March 1980

Dr. John Evans
Population Health and
Nutrition Department
World Bank
1818 H Street N.W.
Washington, D.C., 20433

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... I have enclosed some general information, participant list, and agenda for your consideration.

I am looking forward to further participation and collaboration with you and the World Bank.

Sincerely,

S. Paul Ehrlich, M.D.
Deputy Director

... Enclosures

March 5, 1980

Dr. Hector R. Acuna
Director
Pan American Health
Organization
525 - 23rd Street, NW
Washington, D.C. 20037

Dear Dr. Acuna:

Once again, thank you for including me in your program for country officers and centre director and for your hospitality at luncheon. It was a splendid opportunity for me to explain the World Bank's intentions in health and to meet informally members of your staff.

I appreciate greatly the warm spirit of cooperation which you have encouraged and hope that through close collaboration we can achieve more rapidly and effectively, the goals of health for all by the year 2000.

Sincerely,

John R. Evans
Director
Population, Health and Nutrition Department

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

TELEPHONE 223-4700

IN REPLY REFER TO: DD/33/80

25 February 1980

Dr. John Evans
Director
Population, Health and
Nutrition Department
World Bank
1818 H Street, N.W.
Washington, D.C. 20433

Dear Dr. Evans:

Thank you very much for agreeing to participate in our meeting with PAHO field managers on Wednesday March 5 at 11:00 am. I know that our field managers will be most interested to hear from you the new Health Policy of the World Bank, and the role that Country Representatives might be able to play in assisting the bank in the implementation of its policy.

I look forward to seeing you on the 5th of March.

Sincerely,

Hector R. Acuña, M.D.
Director

ORGANIZACION PANAMERICANA DE LA SALUD
Oficina Sanitaria Panamericana, Oficina Regional de la
ORGANIZACION MUNDIAL DE LA SALUD

Cortesía del

Dr. José Roberto Ferreira
Jefe, División de Recursos Humanos
e Investigación

REPORT

OF THE EM ADVISORY COMMITTEE

ON BIOMEDICAL RESEARCH

FIFTH MEETING

Nicosia, 10 - 12 September 1980

WORLD HEALTH ORGANIZATION

EM/RSR/13
EM/5TH.MTG.ACMR/17
October 1980

REPORT ON THE EM REGIONAL ADVISORY COMMITTEE ON BIOMEDICAL RESEARCH FIFTH MEETING

Nicosia, 10 - 12 September 1980

The views expressed in this report do not necessarily reflect the official policy of the World Health Organization.

TABLE OF CONTENTS

I INTRODUCTION

The Fifth Meeting of the Eastern Mediterranean Advisory Committee on Biomedical Research was held in Nicosia, Cyprus, from 10 to 12 September 1980. It was attended by members of the Committee, resource experts and WHO staff members from the Regional and Geneva Offices. The List of Participants is given in Annex I.

II OPENING OF THE MEETING

The Meeting was opened by Mr Kleanthis Vakis, the Director-General of Health, Ministry of Health, Government of Cyprus, on behalf of the Minister of Health. The Minister in his welcome address which was read by Mr Vakis pointed out the importance of biomedical research in the fight against diseases and the achievement of health. In view of the increasing cost, coordination of research on a regional basis had become necessary. This was specially applicable to a Region such as this, where the size of the countries and availability of facilities do not permit optimal utilization of human resources and familiarization of results of research carried out within and outside the Region. The Minister was confident that this Committee, comprised of eminent experts, will substantially contribute to the increase and application of knowledge in the Region and assist in the achievement of the global goal of Health for All by the Year 2000. He added that in Cyprus there were limited opportunities for research; however, given the appropriate guidance and encouragement, scientists in this country would be willing to undertake research. In this connection he mentioned the establishment of a Centre for study and control of Thalassaemia syndromes. He wished the members of the Committee a pleasant stay in Cyprus and had great pleasure in declaring the Meeting open.

Dr A.H. Taba, Director, WHO Eastern Mediterranean Region, in his opening address (Annex II), while welcoming the participants to this meeting, expressed his thanks to H.E. The Minister of Health of Cyprus for hosting the meeting and making excellent arrangements for holding it.

Dr Taba informed the members of the progress made in the further promotion and development of Health Services Research capability in the Region, including implementation of the three-country coverage study, and Regional Course in Health Services Research and Community Medicine held at the Department of Community Health, University of Nottingham, earlier this year. He felt that now, as a considerable number of nationals had been oriented to Health Services Research methodology, an intensive follow-up action at country level was required, and he would like the Committee members to suggest how this can best be done.

Following the Committee's recommendation at one of its earlier sessions, a working paper on the research manpower situation in the Region had been prepared for discussion. In order to strengthen national capabilities for managing medical research a consultation had been held to advise on the planning and organization of a training programme in research management.

During last year, meetings of three scientific working groups were held dealing with liver diseases, malaria and diarrhoeal diseases. The Committee would be reviewing their reports during this session. The Committee would also be reviewing the research component of the Regional programmes in Cancer and Mental Health.

In view of the important role of research in the attainment of the goal of Health for All by the Year 2000, it was considered timely that the EMACMR discuss and re-examine the priorities laid down at its first session, and identify research topics most relevant to the goal of HFA/2000.

The Special Programme for Research, Development and Research Training in Human Reproduction has made valuable contribution to the development of research capability in this field in the Region. This Committee would have an opportunity to review the activities of the programme during this Meeting, and would as well review the progress in the Region related to the other WHO Special Programme of Research in Tropical Diseases.

Finally Dr Taba stressed the possible contributions that members can make to the development of research within their own countries and he added that the Organization will be pleased to collaborate with them in this effort.

III ELECTION OF OFFICERS AND ADOPTION OF THE AGENDA

The following Officers were unanimously elected:

Chairman	Dr M. Abdussalam, Director, International and Scientific Cooperation, Institute of Veterinary Medicine, Berlin (West);
Rapporteur	Dr A.M. El Hassan, Director, Institute of Tropical Medicine, Medical Research Council, Khartoum, Sudan.

The Chairman in his opening remarks said it was evident from the Regional Director's address and the documentation placed before the Committee, that the regional Research programme has continued to develop. On behalf of the Committee he expressed his appreciation of the support being provided to this programme by the Regional Director, and assured him that the Committee members would try to do full justice to the items placed before them for consideration.

The Provisional Agenda was approved (Annex III).

IV TECHNICAL MATTERS

1. Three-Country Coverage[1] Study (Agenda item 4a)

The purpose of the three-country (Bahrain, Egypt, Yemen Arab Republic) coverage study is to suggest, on the basis of research findings, policy options and service strategies which would lead to effective coverage by the year 2000. Effective coverage, for purposes of the study, refers to Health Services Delivery Systems (HSDS) which:

- ensure availability of services which are socially and economically accessible to actual and potential users,
- are responsive to the actual and perceived health needs of the intended beneficiaries, and
- are utilized by the population at risk.

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[1] For the criteria used in selection of the three countries, reference may be made to the Report of the Fourth Meeting of the EM/ACMR (EM/RSR/8).

The study is being conducted at three levels in each country - the National, the Intermediate and the Community.

National level

The analysis of macro-level aggregate data at the national level yielded demographic, socioeconomic data as well as health policy statements. The countries share common problems of rapid population growth and high infant mortality. Even though there were great differences in GNP per capita they all had relatively low quality of life which was measured by the Physical Quality of Life Index (PQLI)[1] a measure of the level of progress in meeting basic human needs.

Similarities likewise exist in formulation of health policy, which in all three countries is perceived as the function of the Government. All three countries share concern with primary health care and have enunciated policy statements with respect to it.

Intermediate level

The Intermediate level survey is designed to provide "real world" information on the structural capability of the HSDS in each country. The data collection instrument used was designed to obtain the information through direct interview with a provider of service at sampled units offering basic health services in each country. Systematic sampling of such units was done in each country but the size of the sample varied, i.e., 33 percent of all units offering basic health services in Bahrain, 5 percent in Egypt and 38 percent in the Yemen Arab Republic.

Community level

Three to four typical communities in each country which have a fully functioning health unit designated for the provision of basic services are studied in depth in order to provide knowledge about the functional capability of the HSDS, its responsiveness to

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[1] The PQLI combines infant mortality, life expectancy at age one (or at birth) and literacy into a single composite index. See Todd K. Greentree and Rosemarie Philips "The PQLI and the DRR - New Tools for Measuring Development Progress" Communiqué (Washington D.C. - Overseas Development Council, 1979, p.4)

intended beneficiaries, treatment-seeking behaviour of the community, environmental and other sector activities (e.g., education, social welfare, economic activities) related to illness, pattern of care, and community definitions of health. Community level data generate knowledge about the interface between formal and informal providers of care, and actual and potential beneficiaries. A variety of data collection approaches are used - both quantitative and qualitative. Three surveys and two direct observation studies are being implemented, i.e., community environment and observation studies, household survey and household environment observations, observations of service provision at the unit and in the community, and interviews with providers of health care. The latter will be studied in depth using the ethnographic approach, i.e., participant observation and intensive but non-directed interviewing to identify attitudes towards responses to and utilization of treatment-providing personnel and institutions in the community.

The ethnographic study of the community complements and corrects quantitative data. While the former is not amenable to statistical manipulation it is essential in health services research for it is better to be approximately right than precisely wrong.

The Coverage Study makes three important contributions - new and accurate knowledge, a practical example of integration of the quantitative and qualitative research methods, and development of manpower capabilities.

The outcomes of the national, intermediate and community level studies provide data for within-country comparison. Data obtained from the "real world" as a result of the studies are used in policy analysis, and to suggest alternative policy options and service strategies to achieve coverage by the year 2000. Because of the common research design between countries, comparisons can also be made which can be used by country health policy makers.

The coverage study uses a multidisciplinary participative design in which core consultants serve as resource persons, and nationals are active in all phases of design and implementation. Use of three levels of analysis provides a more complete and realistic picture of the factors affecting health services delivery. The integration of quantitative and qualitative research methods yields information on the interaction between providers

of care and the population at risk. Expert opinion, survey research, direct observation and intensive follow-up of the typical communities clarify, complement or correct findings from the national and intermediate level studies so as to minimize time and cost.

The coverage study also serves as an experiment in health manpower development for Health Services Research. The intermediate and community level studies are the laboratory for training country nationals in developmental health services research. Training workshops are held in each country and workshop participants pilot test study instruments before application. All trainees are involved in implementation of the research.

Thus, the coverage study provides:

- real world data on the structural and functional capabilities of the HSDS relevant to the coverage issue in each country and between countries;
- a model design incorporating many disciplines and research methods, which is being successfully used, and which other countries in the Region and elsewhere may wish to use to undertake health policy analysis for achieving effective coverage with basic health services by the year 2000;
- a model for development of research capabilities of health manpower.

Among the products the coverage study would generate are:

- viable suggestions for enhancing the possibility of achieving coverage by the year 2000, and
- a nucleus of people trained in developmental health services research.

The Committee was satisfied with the design and progress of the study. It was thought advisable to await the results of the study before similar projects are undertaken in other countries.

During the discussion the role of traditional healers in primary health care was raised. It was realized that the attitude of Governments in the Region towards traditional healers varied all the way from benign neglect to resistance to attempts at their integration into the health delivery system. It was agreed that, if properly trained, the traditional healers were a potential manpower source that could be utilized in the health

delivery system and it is up to national health authorities to give them the place it considers that they deserve.

The Committee recommended that the study should continue to be supported.

2. Regional Course in Community Medicine and Health Services Research (Agenda item 4b)

The Regional Course in Community Medicine and Health Services Research, sponsored by WHO/EMRO,was conducted by the Department of Community Health, University of Nottingham, England. It was attended by 18 participants from 5 countries and lasted 10 weeks.

This Course brought together two strands of development within the Region:

(i) Health Services Research
(ii) Community Medicine Training.

In the field of Health Services Research, it directly followed the Pre-Course Workshop held in Cairo in 1978, and the Workshops held in Alexandria and Islamabad in 1979. With regard to Community Medicine, while it was deemed relevant to developments in several countries, it was specially designed to meet the needs of those preparing for the Fellowship in Community Medicine of the College of Physicians and Surgeons of Pakistan.

The aims of the Course were that participants should return to their own countries with:

1. An awareness of current trends in Community Medicine on an international basis.
2. The ability to plan, design, initiate and implement health service research projects in their own country.
3. The ability to assess the quality of research projects and published work undertaken by others.
4. The ability to adopt a developmental approach to the training of health personnel and the planning of health services.

The Committee was informed that the participants felt that the objectives of the Course had been fulfilled and that they had benefited from it. Many felt that their

outlook and attitudes had changed during the Course. The preparation of individual projects with guidance from the faculty have been considered to be especially valuable.

The staff associated with the Course felt that there was need to ensure adequate and continuing follow-up, both with regard to the individual research projects and the further development of interest and skills in Community Medicine and Health Services Research. This might be achieved by encouraging the participants to organize Workshops where they could report on their research, help and advise their colleagues and generally stimulate health service research within the country.

In the discussion it was agreed that emphasis should now be placed on follow-up. This should include feedback from the participants as to what they actually achieved after the Course, the need for close coordination between WHO and the relevant national research organizations, such as the Medical Research Councils, to support and encourage initiatives and to work together in planning further training courses. It was felt strongly that the Course should not be seen as an isolated event, but an important part of a planned development. Some continuing support for the participants might come from the staff at Nottingham, but this must inevitably be limited. The Committee suggested that the learning material used during the Course be considered for being adapted as a training manual, to be used by the participants of the Course and other relevant authorities in organizing national courses. It was also suggested that in future courses, every effort should be made to make available all relevant country data and to utilize them extensively for formulating research projects, so that they are related to national priorities.

The Committee members recommended that for future Courses, the selection of participants should be made by designated national authorities in consultation with the Medical Research Councils or the analogous national body.

In this connection, it was noted that copies of communications on matters dealing with medical research and research training addressed to the Ministries of Health will be sent to the Research Councils, where these exist in the Region - and vice versa, and also to concerned universities.

3. Directory of Research Institutions in the EM Region (Agenda item 5)

The Committee was informed that as the Fifth Edition of the World Directory of Medical Schools and the EMRO Directory of Education and Training Programmes of Health Personnel have been recently brought out, it was therefore felt that the Directory of the Research Institutions which had previously listed many Medical Schools, should now include only selected institutions, actively engaged in Biomedical Research. Hence, the Directory placed before the Committee listed only 63 institutions as compared to 229 previously, and the information given therein was brief.

The members appreciated the problems involved in compiling a Directory, containing up-to-date, accurate and reliable information. It was felt that in countries where Research Councils or analogous bodies exist, they should be encouraged and supported to establish a system for listing ongoing research and also the resources available for Biomedical Research in the country. As far as possible, an attempt should be made to compile this information in a standard format throughout the Region.

The Committee recommended that another effort be made to improve the content and coverage of the Directory, and EMACMR members would actively collaborate with the Secretariat in this task.

4. Research Manpower Situation in the Region (Agenda item 6)

The subject of research manpower and creation of an adequate career structure for research workers in developing countries has assumed considerable importance during the recent past, on account of the efforts being made by WHO and through bilateral agreement in some countries to develop and strengthen national capabilities for research. It is obvious that these efforts will, at best, have only a temporary beneficial effect, unless the countries themselves take steps to provide medical research workers with some assurance of sustained career opportunities.

This matter was brought to the attention of the Member States at the Meeting of Sub-Committee A, 29th Session of the Regional Committee for the EM Region, held in October 1979. The Sub-Committee in its resolution EM/RC29A/R.6, amongst other things,

urged Member States to ensure that suitable manpower is retained in countries through the creation of a career structure for scientists engaged in research.

A preliminary situation analysis of the research manpower situation in some countries of the Region showed a paucity of full-time medical research workers, even in the presence of an adequate career structure in countries. In the countries surveyed there were no comprehensive plans for developing research manpower.

It appears that in the prevailing economic situation it would not be possible to attract many scientists for a full-time career in research, especially those who are medically qualified. Therefore greater attention should be paid to involving scientists from the medical and allied fields on a part-time basis.

From the discussion that took place on this item it would appear that there is no single solution to this problem in the countries of the Region. In fact a variety of innovative approaches will have to be tried out. Some of these are: the involvement of medical students during their summer vacations in some research; making the acquisition of a postgraduate research degree desirable for academic appointments; assisting young scientists in preparation of protocols and writing papers, and according research workers adequate social recognition to compensate for monetary losses.

The Committee was also informed of the facilities available under various WHO collaborative programmes for developing research manpower.

It was agreed to recommend the following steps for improvement and further development of research manpower in the Region:

a. The Regional Office should draw the attention of the relevant authorities in countries (Ministries of Health, Higher Education, National Research Councils) to the need to establish a pool of research scientists and to provide a suitable career structure for them.

b. Information on various measures adopted (including legislation) in different countries of the world for improving the conditions of service of full-time medical research workers can be collected and disseminated to Ministries of Health and Education and Research Institutions and Organizations in the Region.

c. National research programming exercises should be promoted. Planning for the development of research manpower will be an important element of these programming exercises.

d. In countries where national research organizations have yet to be established or where human and financial resources are scarce, an attempt can be made to establish a nucleus of research workers, by means such as creating tenured research posts in Universities and Health Institutions, to carry out commissioned research; establishment of research units/institutes with full-time staff; grants of long-term research fellowships or career development awards to carefully selected young research workers.

e. Recognizing the difficulty of the development of a cadre of full-time medical research workers in the near future in most of the countries of the Region, it is proposed that approaches involving existing health personnel, in both teaching and service positions, in medical research activities, be developed and implemented in the countries. One of such approaches would be the holding of broad Research Methodology Courses (with emphasis on epidemiology, statistics, evaluation of various health-related interventions), and subsequently following up such courses by implementation of small, time-limited research projects by course participants.

5. Training Programme in Research Management (Agenda item 7)

The Committee had before it the report of the Consultation convened by the Regional Office to advise on the planning and organization of a training programme in research management.

The Committee endorsed the recommendation of the Consultation that as an initial step a Regional Workshop be planned and organized, and the objectives proposed and the topics to be covered during the Workshop (Annex IV) were considered appropriate and relevant. The Committee also agreed with the criteria for selection of participants in the Regional Workshop.

It was further decided to recommend that a case-study based on the management of research in diarrhoeal diseases be included in the Workshop.

6. Report on a Scientific Working Group on Liver Diseases held in Karachi, 17-19 December 1979 (Agenda item 8a)

The Committee reviewed the report of the Scientific Group on Liver Diseases, and endorsed the research needs identified and the plans of action for meeting these needs (Annex V). The Committee was informed of the steps so far taken by the Secretariat to implement the recommendations of this Group, including the organization of a Regional Workshop to standardize the histological criteria for the diagnosis of liver disease, to be held in February 1981.

7. Malaria Research Programme in the Region (Agenda item 8b)

The EM/ACMR at its fourth session last year, had reviewed and endorsed the regional programme for research, especially field research in malaria.

The Committee at this session reviewed the report of the meeting of the Scientific Working Group on Malaria held in November 1979 and endorsed the priority areas for research delineated by the Group (Annex VI).

The Committee stressed the importance of Research to assess the integration of malaria control programme with the delivery of primary health care.

The members were also informed of the potentialities of research and training in the comprehensive project for the control of water-associated diseases in the Gezira province in the Sudan, and the possibility of WHO facilitating the visit of any of the Committee members to this project, should they so desire.

The Committee was pleased to note the efforts being made to train nationals in the Region in the assessment of P. falciparum response to drugs by the micro in vitro technique.

8. Report of the Scientific Working Group on Diarrhoeal Diseases (Agenda item 8c)

The Committee, while reviewing the report of the first meeting of the Regional Scientific Group on Diarrhoeal Diseases, considered this subject of great importance in view of diarrhoeal diseases being a major cause of infant mortality and morbidity. The

topics of research delineated by this Group, pertaining to epidemiology, programme implementation, utilization and evaluation (Annex VII) were endorsed. It agreed with the Group that it is difficult to rank the recommended area, as its relative priority depends upon the status of diarrhoeal diseases programme development in the countries of the Region. The Committee also agreed with the steps suggested by the Group for managing the research programme in diarrhoeal diseases in the Regional Office.

The Committee emphasized that while there was an awareness of the magnitude of the problem of diarrhoeal diseases in the Region, it was not matched by action. In particular there was a reluctance on the part of paediatricians to accept and use the WHO/UNICEF formula for oral rehydration therapy. In view of the efficacy and practicality of using ORS in the treatment of diarrhoeal diseases, the Committee recommended research efforts for exploring innovative methods of promoting the use of ORS. Such methods must include the use of various conventional health workers and other motivated individuals who enjoy acceptability by the community, such as traditional midwives and religious leaders.

The Committee further recommended that the Regional Office actively follow up the implementation of the plans prepared by the Scientific Working Group in interested member countries.

9. Research in the Regional Cancer Programme (Agenda item 9a)

The Committee reviewed the cancer situation in the Region, and also the report of the Regional Advisory Panel on Cancer. It agreed with the Advisory Panel that strengthening and extension of hospital-based registries be continued.

In view of the association of the use of tobacco, particularly cigarette smoking, with carcinoma of bronchus, oesophagus, hypopharynx, larynx and bladder, and considering that primary prevention of these cancers is possible, the Committee recommended that socio-behavioural studies on smoking should be encouraged including the impact of health education, particularly in young people.

The Committee agreed with the Panel's proposal to extend the programme of early detection of cancers of the breast, bladder and cervix.

The recommendations of the Regional Advisory Panel on Cancer, which were endorsed by the Committee, are given in Annex VIII.

10. Research in the Regional Programme of Mental Health (Agenda item 9b)

A survey initiated by the Regional Office in 1972 clearly demonstrated the deficiencies in the provision of mental health care, the scarcity of resources and the lack of information on the prevalence of mental illness. The findings of the survey had been submitted to a Group Meeting on Mental Health* and two major areas of mental health research had been identified, namely: (a) clinical research, and (b) epidemiological research. The latter type of research would aim at trying to answer questions such as: What kind of mental diseases are prevalent and which population groups are affected? What kind of people currently avail themselves of psychiatric help? In which way are the services planned or organized, and which resources are available? and so forth. This type of research is required for improving the planning and development of the mental health services.

In order to stimulate the countries to utilize epidemiological methods and improve the system of data collection and information, WHO/EMRO organized in 1975 a Seminar on the Application of Psychiatric Epidemiology. In essence, the Seminar was designed as an innovative activity, the main objective being to provide participants with up-to-date knowledge of epidemiological psychiatry and help them acquire skills in mental health research. Among the practical exercises was the designing of a mental health programme and the possibilities for use of the epidemiological method in this process. Other activities included the preparation of more appropriate data sheets for outpatient and inpatient services.

Since 1975 and within the WHO medium-term mental health programme, Consultation and coordination between countries and also between Regional and Central Offices on research activities have grown considerably. The thrust of the programme has been mainly directed towards the utilization of the potential forces of research for the better understanding

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*EM/GR.MT.MH/17

of the nature and extent of mental illness and the development of more effective ways and means of prevention and treatment measures.

The major areas of study in which countries in EMR have collaborated include:

1. strategies for extending mental health care,
2. monitoring of mental health needs,
3. assessment of psychosocial disabilities,
4. child mental health and psychosocial development,
5. a number of other areas, e.g., studies on drug abuse, mental legislations, etc.

The WHO Collaborative Study on Strategies for Extending Mental Health care was initiated in 1976 and is conducted in 7 geographically defined areas: Brazil, Colombia, Egypt, India, Philippines, Senegal and Sudan. The aim of this research work is to develop and evaluate alternative and low cost methods for extending mental health care. The studies in Egypt and Sudan are now in their final phase. The results have given further information regarding the extent of mental disorders and indicated an overall frequency of 13.9 percent among patients presenting at the primary level of health care. In brief, the study has helped to set the priorities for the management of mentally ill persons and explored possibilities for effective community participation and integration of mental health into the health system.

The WHO-coordinated project on Monitoring of Mental Health Needs is also a global project and includes Kuwait as the study area in this Region. Essentially the project aims at demonstrating ways in which mental health information can be used for the better provision and more effective development of mental health services. The second phase of this project in Kuwait has been finalized and the collected information has a wide range of implications for future planning and programming for the delivery of mental health care.

The experience gained in Kuwait has proved to be extremely valuable and the project is generally promising for future activities. It is envisaged that other countries in the Region, namely Libya, Saudi Arabia and Sudan, which have already expressed interest in the development of mental health information system, be involved in this study and

make use of the experience gained in Kuwait. It is also proposed that a national Workshop with WHO inputs take place in 1981/82 in Kuwait to review the findings of the third phase and discuss the use of the new knowledge and information for the further development of mental health care.

In the field of child mental health, a preliminary study has been carried out in Egypt and it is planned that more in-depth studies be carried out in selected countries of EMR. The aim of these studies would be to improve the prevention and treatment of childhood mental health problems and promote children's psychosocial development.

The Committee appreciated the progress made in this field, and agreed in principle with the research proposals submitted by the Secretariat. However, it was recommended that these proposals be submitted to a Scientific Working Group for further scrutiny and refining.

11. Regional Biomedical and Health Services Research Priorities with Special Reference to "Health for All by the Year 2000" (Agenda item 10)

The Committee reviewed and discussed the research priorities for the Eastern Mediterranean Region established by the EMACMR at its first meeting in 1976, taking into consideration the need to attain HFA/2000 through primary health care as a means to achieve effective health coverage. The complexities and difficulties involved in focusing on a few selected research priority areas which can most effectively enhance the achievement of HFA/2000 with the limited WHO resources were recognized during the discussion, and the Committee suggested the following main themes around which priorities should be set rather than trying to pinpoint such priorities:

1. Behavioural and attitudinal changes required by both providers and consumers for achieving HFA/2000 and the institutionalization of primary health care.
   a. Ways and means to enhance political commitment.
   b. Community involvement (participation) in development of health policies, planning and implementation of PHC.
   c. Integration of formal and informal (traditional) healing resources in order to achieve coverage with the available limited resources.

d. Health education and promotion of self-care approach in order to rationalize the utilization of available health services.

e. Changes in health professional education necessary to produce health personnel who are community-oriented rather than health system-oriented and who are problem solvers rather than disease-oriented.

2. Organizational and managerial modifications required for the effective implementation of primary health care.

   a. Participative management of health services in which the community plays a positive role.

   b. Enhancement of intersectoral cooperation.

   c. Reallocation of resources to maximize the impact of health services on the community health status.

   d. Early evaluation of PHC programmes.

3. Economic and technological obstacles which may inhibit the development of effective primary health care.

   a. The rising cost of drugs.

   b. The development of appropriate technology.

   c. The economics of disease control including health and health-related interventions.

   d. The high health and fertility reduction returns of improving MCH services.

4. Major diseases.

   The Committee emphasized the need for research in major diseases (high morbidity and/or mortality) prevalent in the Region taking into consideration both present and expected future disease patterns. Viral hepatitis, diarrhoeal diseases and schistosomiasis were highlighted as important examples.

With the establishment of the above major themes, the Committee recommended that the task of refining the priorities should be assigned to a WHO Consultation which should define research areas and develop guidelines for research protocols in those areas. These guidelines will help scientists and research institutions in the countries of the EM Region to formulate suitable research proposals.

12. Progress Report on WHO Special Programme for Research and Research Training in Tropical Diseases (Agenda item 11a)

Amongst the diseases covered by the Special Programme for Research and Research Training in Tropical Diseases (TDR), malaria and schistosomiasis were the most relevant to this Region, as a whole, onchocerciasis and leprosy constituting a problem only in some countries.

The TDR is currently supporting 35 projects in Institutions in 7 countries of the Region, and another 16 are pending for consideration by the concerned Scientific Groups. A number of projects (42) submitted by investigators have been rejected, as they were often not presented in an appropriate manner or did not relate to the priority areas delineated by the Scientific Working Groups.

Attempts are being made to stimulate interest in a few research institutions to expand their activities into the TDR priority areas and, if required, formulate proposals which may be acceptable for institution strengthening and for training research workers.

The Committee noted with concern that the quantum of support received through TDR in the Region is small, and recommended that the Regional Office actively collaborate with scientists and institutions in formulating and writing up of research projects for submission to the Programme.

13. WHO Special Programme for Research, Development and Research Training in Human Reproduction (Agenda item 11b)

In response to recommendations of the World Health Assembly, the Advisory Group of the Special Programme, WHO regional offices, national authorities and panels of scientific experts, the Special Programme of Research, Development and Research Training in Human Reproduction from its inception has continued to evolve in order to meet the reproductive health needs of the Member States of WHO. Whereas, initially, major emphasis was on research and development of new methods of fertility regulations and psychosocial research as a guide for new technology, the Programme has added a major emphasis on the safety and effectiveness of existing methods; psychosocial research and health services research

in family planning; research on infertility and on the strengthening of national research resources to provide a critical mass of researchers and facilities in the field of human reproduction.

The scope of the programme was reviewed in terms of subject matter, both in the global programme and within the Region. Within the Region the 75 HRP-supported research projects, involving 25 institutions, included studies on the relationships between fertility and health; epidemiological studies of infertility; clinical studies of the safety of existing methods, such as the use of oral contraceptives among women with schistosomiasis; service research comparing the safety, effectiveness, acceptability and relative costs of midwives and physicians inserting intrauterine devices; studies on the perception of menstrual bleeding; the synthesis of new steroidal preparations, and comparative trials for the treatment of infertility.

In addition to individual projects the WHO Collaborating Centres for Clinical Research in the Region (Chatby Maternity Hospital, Alexandria, and National Research Institute for Fertility Control, Karachi) participate in a large number of multicentred collaborative clinical trials.

The mechanisms of the programme's operations also were reviewed, particularly noting the involvement of the scientists from the Region in the Advisory Groups and the Task Forces. Note was also made as to the criteria for priority setting in the programme which involves, among other elements, consultations with national health and family planning authorities, WHO Regional Offices, recommendations of the WHA and the Advisory Group. The programme is problem-solving and goal-directed, drawing upon an expanding global network of scientists representing such disciplines as endocrinology, biochemistry, clinical medicine, epidemiology, public health administration, social and behavioural sciences, economics, etc.

The research resource strengthening component of the programme has received more attention in recent years. These efforts are directed at creating a critical mass of facilities and scientists in a number of institutions to serve as centres of excellence

at the national and regional level as well as to serve significant contributors to the global programme. Despite extensive institution strengthening efforts in the Region, including the awarding of over 70 research training grants covering laboratory, clinical and epidemiological aspects of human reproduction, the impact and response on the national and regional level has been limited.

In the discussions it was emphasized that it was important to build a research component into the delivery of family planning and MCH services, which among other things could monitor the effects and safety of new drugs and examine such issues as increasing the acceptability of family planning by the community. It was also noted that it was important to involve all medical and health professionals in family planning activities.

The Programme has emphasized its willingness and desire to continue and to increase its collaboration with national authorities, research councils and institutions in the Eastern Mediterranean Region in developing a strategy of institution strengthening and resource development and in the planning and implementation of family planning research, including research on infertility, in those areas of highest concern to national authorities and the global programme in human reproduction.

V CONCLUSIONS AND RECOMMENDATIONS

The Committee noted with appreciation the progress being made in research in the Region and thanked the Regional Director for his continuing interest and support for the Regional endeavour in this field. The main conclusions and recommendations of the Committee are summarized below:

1. The three-country coverage study should continue to be supported and similar studies in other countries of the Region should be initiated after the results of the present study have been evaluated.
2. The national participants in the recently held course in community medicine and HSR methodology should be encouraged and supported to implement the research projects

prepared by them during the course, and organize national training programmes in HSR methodology for various categories of health workers.

3. It was recommended that renewed efforts be made to improve the coverage and contents of the Regional Directory of Institutions engaged in biomedical research. In countries where medical research councils or analogous bodies exist, they should be encouraged to compile a national directory.

4. The attention of the relevant authorities in the Region should be drawn to the need for establishing a suitable career structure for research workers and to employ innovative means to attract and retain them.

5. In order to orient and attract a larger number of persons to medical research, broad research methodology courses should be organized with emphasis on planning, implementation and publication of research results.

6. In order to upgrade and develop national expertise in research management, a Regional Workshop should be held in this field. It should be followed by similar national workshops.

7. The Committee endorsed the recommendations of the Regional Scientific Working Groups on Liver Diseases, Malaria and Diarrhoeal Diseases and of the Regional Advisory Panel on Cancer, and further recommended that the Regional Office follow up with the appropriate national authorities in the interested countries the implementation of these recommendations. In addition, the Committee made the following specific recommendations:

   a. The Research in Malaria should include and emphasize studies dealing with the evaluation of the integration of malaria control programmes and primary health care.

   b. The Committee recommended that research studies be encouraged and supported for exploring innovative methods of promoting the use of ORS, involving the various categories of health workers and other motivated individuals who enjoy acceptability by the community.

c. Appreciating the harmful effects of cigarette smoking in relation to certain types of cancer and other chronic diseases, it was recommended that socio-behavioural studies on smoking be encouraged, including evaluation of the impact of health education particularly in young people.

8. The Committee agreed in principle with the research proposals in the field of Mental Health submitted to it by the Secretariat, and recommended that they be submitted to a Scientific Working Group for further scrunity and refining.

9. In view of the importance of research in attaining the goal of HFA/2000, it was recommended that the Regional Office should convene a consultation to identify and plan research on a limited number of topics considered most relevant to this goal, and to develop guidelines for research protocols in the identified areas.

10. It was recommended that the TDR resources be fully utilized and the Regional Office actively collaborate with investigators and institutions in the Region for formulating and writing up proposals for submission to TDR.

11. The Committee appreciated the support being provided by WHO/HRP to develop research and training activities in the field of Human Reproduction within the Region, and recommended that the Regional Office with HRP actively collaborate with national health authorities and research councils in the strengthening of research resources and promoting research projects in family planning aspects of MCH, including infertility.

ANNEX I

LIST OF PARTICIPANTS

COMMITTEE MEMBERS

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ANNEX II

ADDRESS BY DR A.H. TABA
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WHO EASTERN MEDITERRANEAN REGION

at the

FIFTH MEETING OF THE EM ADVISORY
COMMITTEE ON BIOMEDICAL RESEARCH

NICOSIA, 10 - 12 September 1980

Excellency, dear Colleagues,

It gives me great pleasure to welcome you at the Fifth Meeting of the Eastern Mediterranean Advisory Committee on Biomedical Research, and would like to thank you for sparing the time to travel to Cyprus and attend this Meeting. I am most grateful to His Excellency the Minister of Health of Cyprus for hosting this Meeting.

While welcoming our new members, I would like to express my appreciation of the contributions made by those members whose terms expired during the preceding year, and wish to invite them to continue our collaboration.

Soon after the meeting last year, the "Three-country Coverage Study" was initiated and substantial progress has been made. Dr Hassouna, the Principal Investigator and Study Coordinator, and his group at the Institute of National Planning, Cairo, are to be commended for their efforts. Dr Hassouna will be talking to us about the results achieved so far.

In our continuing efforts to orient and train nationals in Health Services Research Methodology, a ten-weeks long Regional Course was held earlier this year, at the Department of Community Health, University of Nottingham, U.K., and was attended by 18 participants. As you will recall, we have enjoyed a close and continuing relationship with the Department for some time now and the inputs by its staff, particularly

Professor Backett and Dr McEwen, in the development of the Regional Health Services Research Programme, has been valuable. My staff and myself are deeply appreciative of this Department's contribution in organizing and running this Course. Dr McEwen is here with us and will present a preliminary report.

We feel now that a reasonable number of nationals have been exposed to HSR methodology, an intensive follow-up action is required at the country level, and would like to have your views on how best we may collaborate with national authorities in this connection.

The Directory of the Medical Research Institutions in the Region has been updated and is being presented to you in a somewhat abridged form. The quality of the information contained in such Directories is really dependent on the information provided to the Regional Office by the Institutions given in the Directory. I feel that in countries where a Medical Research Council or an analogous body exists, it should carry the responsibility of developing a suitable information system, and we will be glad to collaborate, if requested, in such an effort.

The Committee, at one of its previous sessions, had expressed concern about the manpower available for medical research in the countries of this Region. A preliminary situation analysis has been carried out and a working paper has been prepared for your consideration. I look forward to your suggestions about how the Organization can collaborate with the countries in improving the existing situation.

During the preceding two days, some of you have been busy discussing the planning and organization of a training programme in Research Management. Development of competence in this field will go a long way towards establishing and strengthening national infrastructures for medical research, and ensuring maximum utilization of available resources for research on socially relevant issues.

Since we last met a year ago, meetings of three Scientific Working Groups have been held, dealing with Liver Diseases, Malaria and Diarrhoeal Diseases. You will have an

opportunity, during this meeting, to review their reports and make recommendations about further development of research in these areas.

Continuing the practice established last year, we would like you to review the Regional Programmes of Research in Cancer and Mental Health, at this Session. In both these areas, considerable research and training activities have taken place over the years.

You must all be very familiar with the Organization's goal of Health for All by the Year 2000, and aware of the efforts being made in our Member Countries to formulate strategies and plans for achieving this goal. As you can indeed well appreciate, research has a very important role to play in this connection. Therefore, it was considered appropriate and timely, that the EMACMR at this Session discuss and review the regional priorities for medical research which were established at the first session in 1976. I hope that you will be able to identify for us the research topics most relevant to the goal HFA/2000, so that our limited resources for research can be most effectively utilized.

The Special Programme of Research, Development and Research Training in Human Reproduction has, since its establishment in 1971, made valuable inputs in strengthening research capability in this field, in some countries of our Region. Dr Belsey, deputizing for Dr Kessler, the Director of this Programme, will present a brief overview of the programme with special attention to activities in this Region.

As you will note from these brief remarks, the Regional Biomedical Research Programme has continued to develop and advance, perhaps not at a pace which, I am sure, you, as members of the EM/ACMR would have liked it to do.This, I feel, is in a large measure due to the inadequate attention being paid to the development of medical research in the countries. Here, I would like to repeat what I said at the opening session of the EMACMR last year. I quote "even though you are here as individuals rather than representatives of your country, you can make a valuable contribution to the development

of research in your own countries, and if we can be of any assistance to you in this connection, please let us know".

There is no separate agenda item dealing with steps for promotion of research at country level, but should you so wish, we will be glad to discuss it during the next three days.

Before concluding, I wish, once again, to thank the health authorities of Cyprus for hosting this meeting and all of you for being with us to guide and counsel.

ANNEX III

AGENDA

1. Opening of the Meeting
2. Election of Officers
3. Adoption of Agenda
4. Health Services Research
   (a) Three-country Coverage Study
   (b) Regional Course in Community Medicine and Health Services Research, Nottingham
5. Directory of Research Institutions in the EM Region
6. Research Manpower Situation in the EM Region
7. Training Programme in Research Management
8. Reports of the meetings of:
   (a) Scientific Working Group on Liver Diseases, Karachi, 17-19 December 1979
   (b) Scientific Working Group on Malaria, Nicosia, 27-29 November 1979
   (c) Scientific Working Group on Diarrhoeal Diseases, Alexandria, 19-22 August 1980
9. Regional Programme of Research and Research Training activities in the field of:
   (a) Cancer
   (b) Mental Health
10. Review of regional priorities for Medical Research and Research Training with special reference to the goal "Health for All by the Year 2000"
11. Progress Report on WHO Global Research Programme
    (a) Special Programme for Research and Training in Tropical Diseases (TDR)
    (b) Special Programme of Research, Development and Research Training in Human Reproduction (HRP)
12. Summary Report
    Conclusions and Recommendations.

ANNEX IV

THE OBJECTIVES, CONTENTS, AND CRITERIA FOR SELECTION OF PARTICIPANTS FOR THE REGIONAL WORKSHOP IN RESEARCH MANAGEMENT

A. OBJECTIVES

At the end of the Workshop the participants will:

1. appreciate the scientific approach to the management of medical research and be committed to promote and implement this in their own countries;
2. have acquired relevant up-to-date knowledge of the elements of research management and be able to apply and disseminate this knowledge in their own work;
3. have developed appropriate criteria for the assessment of research management practices in their own institutions or countries; and
4. have acquired the ability to organize and conduct national Workshops on research management.

B. CONTENTS

The main purpose of the workshop in research management will be to formulate systematic approaches which would be adapted to the nature of managerial tasks required in the field of medical research. Such approaches have to take into account the following four major functions:

a. Research Promotion and Development which deal, inter alia, with policies and strategies.
b. Research Implementation, which deals with all factors concerned with implementation, such as research workers, facilities, logistics, etc.
c. Research Monitoring, where information and methodology play a predominant role.
d. Research Evaluation, perhaps the most difficult of all functions, where not only relevant techniques must be brought to bear, but also where experience and judgement must be used in the most judicious way.

In view of these functions, the workshop would comprise a number of discrete components, which may conveniently be structured as follows:

1. Relationship between medical research and national development and the impact of development on research.
   1.1 Appreciation of the role and contribution of medical research to the development of comprehensive health services in the overall context of socioeconomic development.
   1.2 Expectation from and attitudes towards medical research: emphasizing the educational effect of research in upgrading the quality of health personnel at various levels.
2. Problems related to research policy.
   2.1 Procedures for formulation of national research policy.
   2.2 Defining broad research themes for the solution of prevailing and expected health problems.
   2.3 Ranking priorities in the defined research themes.
   2.4 Determination and organization of individual and cluster of research projects as components of a research programme with defined goals.
   2.5 Coordination between various national policy-making bodies and research organizations/institutions.
3. Assessment and development of research potential in the country for undertaking the identified research.
   3.1 Manpower resources, training, emphasizing the use of team approach in research.
   3.2 Physical resources, such as equipment and supplies.
   3.3 Economic resources, recruitment and promotion procedures, incentives.
4. Generation, formulation, execution and evaluation of research projects. Establishment of systems for:
   4.1 Generation and appraisal of new research proposals and their modification.

4.2 Monitoring and evaluating of ongoing research activities.

5. Mechanisms for the exchange and application of research information.

5.1 Systems for acquisition, processing, utilization and dissemination of research information.

5.2 Systems for the effective application of research information and research findings.

6. Introduction to select management techniques, e.g., network analysis, programme planning and budgeting, delphi, and their application in managing medical research.

C. CRITERIA FOR SELECTION OF PARTICIPANTS

1. Nominations for participants in this activity should be invited from those countries in the Region which have an existing infrastructure for medical research, i.e., Egypt, Iran, Iraq, Lebanon, Pakistan and Sudan.
2. Three participants from each country who, on return, can work together to organize national courses.
3. The participants should preferably be holding one of the following positions in their own countries:
   a. Chief or Deputy Chief Executive Officer of the National Medical Research Council or analogous body.
   b. The principal scientist in charge of research in a medical institution, where the students have to carry out a research project as a part of their training.
   c. Directors (or their Deputies) from institutions, such as Public Health Laboratories, Research Institutes, specialized teaching hospitals and institutions, with an active research programme, relevant to health.
   d. A Senior Health Planner with responsibility for medical research.

ANNEX V

EXCERPT FROM THE REPORT[1] OF THE MEETING OF THE SCIENTIFIC GROUP MEETING ON LIVER DISEASES, HELD IN DECEMBER 1979, WITH IDENTIFICATION AND ASSESSMENT OF RESEARCH NEEDS AND THE PLAN OF ACTION FORMULATED TO MEET THESE NEEDS

"IDENTIFICATION AND ASSESSMENT OF THE RESEARCH NEEDS IN RELATION TO LIVER DISEASE

A. There was a consensus of opinion that attempts should be made to continue generation of reliable information on common forms of liver disease in the Region, using standard terminology and techniques. This information, from the Member States of the Region, should be periodically collected at a central place, collated, reviewed and disseminated.

B. Suitably designed clinical and epidemiological studies should be carried out to identify the aetiology of chronic liver disease.

C. Asymptomatic carriers of HBsAg, particularly in the younger age groups, should be followed up to determine the extent to which the carrier state is associated with emergence of chronic liver disease.

D. Studies should be carried out to determine the role of genetic differences in the development of the carrier state of HBsAg and chronic liver disease.

E. The susceptibility of pregnant women to hepatitis and the prognostic features of the disease amongst them should be evaluated.

F. The possible interactions between HBV and schistosomiasis, and between HBV and malaria in the causation of acute and chronic liver disease should be studied. It was

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[1] EM/SCF.GR.MTG.LIV.DIS./12
EM/RSR/11

emphasized that, due to the complex nature of this interaction, special efforts will be needed to design and implement such studies, so that the results are scientifically valid.

G. The infectivity of HBsAg carriers in the family environment and in other settings must be evaluated.

H. The importance of traditional (scarification and tattooing) and modern (vaccination) medical practices in the spread of HBV should be evaluated.

I. Prospective studies should be undertaken of post-transfusion hepatitis.

J. Studies to determine the frequency of perinatal transmission, and its long-term effects on infected infants with regard to the development of chronic liver disease, should be undertaken.

K. The incidence of HCC should be estimated and the importance of the suggested aetiological factors should be evaluated.

L. Properly randomised clinical trials for evaluating prophylactic and therapeutic interventions and for monitoring side effects of such therapeutic interventions should be performed.

The group felt that the standardization of laboratory techniques and criteria for diagnostic, clinical and histological diagnosis of various forms of liver disease was essential to ensure the implementation of studies on the above-mentioned topics along scientific lines and for generating comparable information from the different countries of the Region.

FORMULATION OF A REGIONAL PLAN OF ACTION TO MEET RESEARCH NEEDS

WHO EMRO should continue to foster and promote research in liver diseases within the Region.

The Ministries of Health in the Member States should be encouraged to establish multidisciplinary national committees for liver diseases, and to plan and to implement national programmes for research in liver diseases with a view to further define all aspects of these diseases and to monitor changes in infectivity, attack rate, and in results of passive and active prophylactic measures.

Collection of an adequate data base should be supported with special attention to the following three aspects:

A. Data collecting procedures, including:
   (i) characterization of the population from which samples are drawn;
   (ii) sampling procedure (e.g., random or specified criteria);
   (iii) use of proformas;
   (iv) quality control (e.g., observer variation); and
   (v) data analysis.

B. Standardization of laboratory techniques, particularly concerning serological markers of hepatitis.

   This implies:
   (i) provision of apparatus, reagents and reference material;
   (ii) training of doctors and technicians; and
   (iii) establishing reference centres for standardization of reagents and procedures, in collaboration with international centres (e.g., American Red Cross and Centre for Disease Control, Atlanta).

C. Standardization of nomenclature and diagnostic criteria concerning evaluation of liver biopsy material. This may be achieved by establishing regional panels of pathologists in close collaboration with interested clinicians.

WHO EMRO may assist in this development through use of existing reference centres, programming experts to visit each other, and by organization of national and regional workshops."

ANNEX VI

RECOMMENDATIONS OF SCIENTIFIC WORKING GROUP ON MALARIA[1] HELD IN NOVEMBER 1979 DEALING WITH RESEARCH

RESEARCH

A component cell dedicated exclusively to research and training should be an integral part of every malaria control programme.

A Regional Workshop should be organized on research methodology so that research field projects may be carried out according to recognized scientific criteria. It has been proposed to have such a Workshop during the year 1980.

RECOMMENDATIONS ON SPECIFIC RESEARCH PROJECTS

1. Epidemiology, epidemiological surveillance including sero-diagnostic studies.
   1.1 Sero-epidemiological studies should be made to detect residual immune response in areas of advanced control or eradication (Syria, Jordan, Lebanon).
   1.2 Sero-epidemiological studies are required in both nomadic and stable populations, using the immuno-fluorescent technique (Iran).

   For the purpose of carrying out sero-epidemiological studies (including ISA and ELISA) in the field, the continuous in vitro cultivation of P. falciparum will be established in Iran.
   1.3 Cost effectiveness studies should be made of active case detection and its comparison with other methods of surveillance (Jordan).
   1.4 A surveillance mechanism should be developed enabling the monitoring of the possible introduction of non-indigenous vectors (Cyprus, Egypt).

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[1] EM/SCT.WRK.GR.MAL/16
EM/MAL/172

1.5 A search should take place for a practical methodology for the detection of symptomless parasite carriers entering areas which have been freed from malaria.

2. The Plasmodium

2.1 With respect to testing of P. falciparum for resistance to chloroquine:
the in vivo testing should begin immediately; and
the in vitro testing should begin as soon as the micro test has been sufficiently perfected to be used in the field.

A Regional course to teach the technique in vitro testing of P. falciparum sensitivity to chloroquine (Sudan) is required to enable the above field research.

3. The Vectors

3.1 Cytogenetic and possibly electrophoresis gene-enzyme studies should be made to discern the particular patterns of behaviour in the following anopheline vectors of malaria, in collaboration with the laboratory/laboratories especially equipped for this purpose:

3.1.1 A. gambiae complex (Sudan, Somalia, Saudi Arabia, Yemen and Democratic Yemen);

3.1.2 A. pharoensis (Egypt, Sudan);

3.1.3 A. superpictus (Iran, both desertic and mountainous);

3.1.4 A. sacharovi (Syria, Iraq, in comparison with the A. sacharovi population in Turkey);

3.1.5 A. stephensi (Iran, Saudi Arabia, Pakistan urban and Pakistan rural);

3.1.6 A. culicifacies (Pakistan, Yemen).

3.2 The effect of irrigation systems in rice cultivation on the bionomics of malaria vectors (Sudan, Egypt) should be determined.

4. Chemical Control

4.1 Studies are required to assess whether the alternate use of chemically unrelated insecticides may delay the spread of malathion resistance (Sudan).

4.2 Epidemiological assessment of the impact of malathion utilized in the emulsion concentrate formulation on malaria transmission should be made (Syria).

4.3 Trials should be begun to assess the epidemiological value of the application, during the winter, of ULV malathion by fogging operations (Syria, Iran).

4.4 Stage V/VI Field trials, as recommended by WHO, using the newer organophosphorous carbamates and pyrethroids insecticides should commence (Iran, Sudan).

4.4.1 Cost effectiveness trials of permethrin emulsion concentrate on malaria transmission, as compared with malathion, should be initiated (Syria).

4.4.2 Epidemiological assessment of the cost effectiveness of propoxur in comparison with that of malathion should be carried out (Iran).

4.5 Assessment of the safe use of the insecticides mentioned in 4.4 should be established.

5. Equipment

5.1 Simple hand or power driven equipment which would be used for clearing and cleansing canals should be tested (Sudan).

5.2 Various types of ULV fogging equipment and electrophoretic sprayers, which have been recommended by WHO for use in malaria control programmes, should also undergo testing (Egypt, Iraq, Sudan).

In connection with field research related to the equipment, investigation of the possibility of establishing a WHO collaborating centre for testing tools and improving techniques for the application of insecticides was recommended.

6. Antimalarial Drugs

Epidemiological assessment should be made of a cost effectiveness trial comparing

the effect on malaria transmission of Metakelfin prophylaxis, pyrimethamine prophylaxis, and malathion spraying, used respectively in adjacent epidemiologically homogenous areas of vivax malaria (Afghanistan).

7. Biological Control

7.1 The feasibility of utilizing local larvivorous fish in antimalarial programmes should be researched, identified and studied (all countries).

7.2 The epidemiological impact and cost-effectiveness of larvivorous fish in controlling malaria transmission should be investigated, namely, among:

7.2.1 Aphanius dispar (Oman);

7.2.2 Chinese Grass carp (White Amur) - Non-larvivorous, but affecting larvae habitat with its harbivorous habits (Sudan); and

7.2.3 Nothobranchius (Somalia).

7.3 Trials with mosquito pathogens, such as B. sphaericus, B. thuringiensis serotype 14 (Egypt) should be carried out.

7.4 Field trials of Insect Growth Regulators (IGR), using the methodology as recommended by WHO, are recommended (Egypt, Saudi Arabia).

8. Environmental Management (E.M.)

8.1 Studies to identify simple and inexpensive methods of E.M. using local manpower (community participation), material and equipment should be made (all countries).

8.2 Cost-effectiveness studies of E.M. in arid and semi-arid areas are required (Iran).

N.B. The SWG also recognized the need to establish environmental management as an integral part of Municipality Sanitation, and, in order to recognize E.M. more efficiently, a WHO-sponsored environmental collaborating centre should be established.

9. Community Participation

Assessment of the epidemiological significance of personnel protection measures against malaria such as wide-mesh bed nets or of normal mesh impregnated with

mosquito repellants or with insecticides, the use of pyrethrum coils, and partial proofing of houses against the entry of vector mosquitoes were recommended (Iran, Sudan).

10. Comprehensive Health Services

Alternative methods of malaria control, through the establishment of a comprehensive health service in Iran, in an area where control of malaria by the vertical antimalarial service has proved too expensive, were suggested for trial purposes.

11. Integrated Control

11.1 Studies on the methodology for detailed planning of integrated control in antimalarial programmes were recommended (Sudan).

11.2 Trials on a comprehensive approach to the control of malaria and schistosomiasis have been planned (Sudan).

ANNEX VII

EXCERPT FROM THE REPORT OF THE FIRST MEETING OF THE SCIENTIFIC WORKING GROUP ON DIARRHOEAL DISEASES[1], DEALING WITH RECOMMENDATION FOR RESEARCH

The group recommended that a research component for the Regional Diarrhoeal Disease Control Programme be established to complement the action-oriented implementation programme and respond to the operational needs of national diarrhoeal disease control programmes. The research component should include the following epidemiological studies and studies related to implementation, utilization and evaluation of national CDD programmes.

"1. Epidemiological Studies

The group feels that epidemiological studies should be given particular attention and high priority especially as epidemiology is the essential tool for planning, implementation and evaluation of Diarrhoeal Diseases Programmes, through providing information on the incidence and aetiology of diarrhoeal diseases in different population groups.

The following areas of research were recommended:

1.1 Studies on the epidemiological pattern of diarrhoeal diseases under different ecological and cultural conditions particularly with regard to identification of children at highest risk.

1.2 Studies to identify the relative importance of aetiologic agents of diarrhoea (viral, bacterial and parasitic) in different countries of the Region. These studies should be carried out in conjunction with other related aspects, such as clinical features and sensitivity to anti-microbial agents with the objective of identifying

[1] EM/5TH.MTG.ACMR/11

possible correlation which can be used for clinical management.

1.3 Studies on the modes of transmission. Although they need rather sophisticated designs and laboratory support, the group feels that such studies should be undertaken as they will indicate possible intervention tools. These should be undertaken with the relevant Global Scientific Working Groups.

1.4 Studies directed towards development of simplified and reliable methods of surveillance of diarrhoeal diseases, in time for action, including simplified methods of identifying pathogens.

1.5 The association between malaria and diarrhoea which was recently observed needs further investigation.

2. Studies Related to CDD Programme Implementation

A number of research issues were identified that were felt to be directly related to implementation of national CDD programmes.

2.1 Strategies for Oral Rehydration Therapy

2.1.1 Complete Formula

There is universal agreement that the complete rehydration formula recommended by WHO/UNICEF is ideal for treatment and prevention of clinically apparent dehydration and that priority in all national CDD programmes should be directed towards delivery of the complete formulation to the mothers via the most efficient method throughout the national health services, using all available approaches (e.g., WHO/UNICEF type packets, cottage industry packets, etc.). Studies should be done to determine optimal methods for mixing preparation of the solution. In countries where paediatricians are still questioning the well-established safety of the WHO-recommended composition for use in infants, studies should be done again to demonstrate in a local situation the safety and efficacy of this solution in treatment of infantile diarrhoea.

2.1.2 Early Home Therapy

Studies are needed to determine the safest and most effective way by which mothers can give oral rehydration therapy at the household level early in diarrhoea. This includes comparative evaluation of the safety and efficacy of liquids readily available in the home (such as rice water, tea, egg albumin water, etc.), with special "Salt and Sugar" solutions made by different methods (e.g., domestic spoons, pinch and scoop, plastic spoons) and the complete formulation.

2.2 Approaches for Post-Diarrhoeal Rehabilitation

Three approaches have been used for post-diarrhoeal (nutritional) rehabilitation: hospitalization, nutrition rehabilitation centres and ambulatory treatment and surveillance. The relative cost-effectiveness of these methods needs to be compared under different situations. Related studies should also be done to determine the best means to ensure that locally available foods are best utilized for feeding during and after a diarrhoeal episode.

2.3 Pharmacological Treatment of Diarrhoea

In many countries anti-diarrhoeal mixtures and antibiotics are routinely distributed and used for treatment of diarrhoea. These should be evaluated for their efficacy and to determine whether a considerable amount of money can be saved to national health budgets by stopping the utilization of those drugs which prove useless.

2.4 Evaluation of Traditional Diarrhoea Remedies

A number of traditional remedies are used in different countries for the treatment of diarrhoea. These should be evaluated for their safety and efficacy.

2.5 Methods and Materials for Training

Research is needed into the attitudes and practices of medical and other health staff related to diarrhoeal disease treatment and prevention. This information should be used to develop training methodologies and materials for national diarrhoeal disease control programmes and should be used in evaluating the utility and benefit of the methodologies and materials so developed.

2.6 Sewage Treatment

Studies are needed to devise and assess low-cost technologies for treatment of sewage in the countries of the Region. These should include those looking at the dissemination of faecal pathogens through excreta re-use systems.

2.7 Economic Studies

A limited number of economic studies is recommended to be undertaken to demonstrate the potential savings from instituting oral rehydration therapy programmes and the alternative ways by which the delivery of oral rehydration can be linked with other health interventions and programmes such as the Expanded Programme of Immunization (EPI).

3. Studies Related to CDD Programme Utilization

In the area of CDD national programme utilization, two research areas were identified.

3.1 Beliefs and Practices

Information is needed on (a) - the inter-relationship between individual and family behaviour patterns of defaecation, water usage, food preparation, child hygiene and infant feeding practices and the risk of developing diarrhoeal diseases, and, (b) - the beliefs and practices followed in treatment of diarrhoea. This information should be based both on observed and expressed behaviour. The effect of established intervention programmes on diarrhoea-related behaviour should be measured. Standardized research designs should be used.

3.2 Breast-Feeding

The epidemiological characteristics of breast-feeding patterns in the countries of the Region and the impact of breast-feeding promotional programmes need to be measured. Reasons for lactation failures, in particular, need to be determined and ways of preventing and reversing these failures assessed. (It is recognized that this research area may primarily be undertaken by the Scientific Working Group on Breast Feeding being organized in the Region in early 1981).

4. CDD Programme Evaluation

It is recognized that national CDD programmes will be regularly evaluating their impact on diarrhoeal diseases mortality and morbidity and revising programme targets as required. These activities should not be considered "research" but rather as an inherent part of national programmes. However, there are two related research areas that are related to programme evaluation.

4.1 Survey Design

Some research is required to determine the best survey techniques for evaluating national programmes. This should include studies to determine how evaluation of other national health programmes (e.g., EPI) can be linked to evaluation of CDD programmes.

4.2 Environmental Health Impact Studies

It is anticipated that during the coming International Drinking Water Supply and Sanitation Decade, a number of water and sanitation development and improvement projects will be undertaken in the Region. In such circumstances the impact of these projects on diarrhoeal disease morbidity should be assessed, especially when they might provide answers to specific questions.

The group recommends close liaison between diarrhoeal disease control activities including research and the opportunities available within the International Drinking Water Supply and Sanitation Decade."

ANNEX VIII

RECOMMENDATIONS OF THE FIFTH MEETING OF THE REGIONAL ADVISORY PANEL ON CANCER, 8-9 SEPTEMBER 1980[1]

1. Strengthening of the data collecting base by improving its quality and coverage. The use of ICD-O classification by all centres in the Region was emphasized. Need for training programmes of clerical staff engaged in cancer registration work and clinical data management was proposed.

2. WHO should prepare guidelines for the countries of the Region planning to set up new cancer treatment facilities. These should cover such questions as the size of the population to be served, availability of trained personnel and cost/benefit analysis.

3. A more vigorous anti-smoking campaign was urgently needed as it was linked to a significant number of cancer cases occurring in males of the Region, cancers which can be prevented by curbing the habit. The need for social studies on attitudes to smoking was outlined and it was felt that some pilot studies on the effectiveness of a health education programme directed towards school children were required.

4. As cancer of the cervix is common in many countries of the Region, the need was felt to set up and/or extend the cervical screening programme. It was suggested that, wherever possible, the programme should be linked with the family planning clinics. More national and regional courses for training of cytotechnologists should be held.

5. A publication outlining the activities of the regional countries in the field of cancer should be started for dissemination of information.

6. Professional education in the field of oncology was felt to be an important need in the Region. It was suggested that a small booklet be produced for this purpose.

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[1] EM/FIFTH.MTG.REG.ADV.PNL.CAN.PR/1

7. Emphasis was made of the need for cooperative studies on common cancers in the Region to be undertaken by the various centres.

8. Reprints of publications from the Region should be forwarded to the Regional Adviser for distribution and dissemination to all the Member countries.

9. Workshop for cytologists to be organized for uniformity and standardization of cytological interpretation to be held in Tunis.

10. Workshop for pathologists for standardization and classification and nomenclature of lymphoma to be held in Kuwait.

11. WHO will arrange training of personnel from this Region to enable them to establish steroid receptors in breast cancer in reputed centres.

12. Cooperative case-control studies in different centres of the Region on tumours of breast, cervix, bronchus, larynx, lymphomas and bladder to be started. Any centre having the requirements of such a cooperative study will be able to join it.

13. Establishment of more hospital-based cancer registries with WHO assistance in the Region.

14. Early detection surveys to be set up for cervical and bladder cancers with the help of cytology and urine esterase estimation.

15. Kuwait Cancer Registry to be critically reviewed and if found suitable, to be considered for conversion into a RRC for Data Collection and Analysis.

16. The Panel should be wide-based to include all specialties, the composition to be preferably of eight members.

ANNEX IX

WHO/EMRO SECRETARIAT'S PROPOSALS FOR RESEARCH IN THE FIELD OF MENTAL HEALTH

1. Further support should be given to the ongoing studies, particularly research strategies for the extension of mental health care and to the monitoring of mental health needs.

2. Special efforts should be made to enhance relevant training programmes and development of mental health research workers.

3. Appropriate inputs should be provided to develop collaborative research centres in selected countries of EMR.

4. Mental health research should be carried out in the following areas:

   (a) Epidemiological studies
   - studies on the prevalence of psychiatric disorders in defined communities (including comparative investigations of rural and urban communities, nomadic and settled populations, etc.).
   - surveys of mental health in samples of children with special emphasis on emotional and conduct disorders and bed-wetting.

   (b) Psycho-social studies
   - studies of migrant labourers
   - mass movement and human settlement.

   (c) Mental health services research
   - studies of long-stay patients
   - determinations of admission and re-admission into psychiatric institutions
   - use of long-acting (depot injection) in the management of psychiatric patients
   - the role of traditional healers in the delivery of mental health care.

ANNEX X

LIST OF BASIC AND BACKGROUND DOCUMENTS

Basic Documents

Provisional Agenda	EM/5TH.MTG.ACMR/1 Rev.1
Provisional Programme	EM/5TH.MTG.ACMR/2
Provisional List of Participants	EM/5TH.MTG.ACMR/3
Three-Country Coverage Study Agenda item 4(a)	EM/5TH.MTG.ACMR/4
Regional Course in Community Medicine and Health Services Research Agenda item 4(b)	EM/5TH.MTG.ACMR/5
Directory of Research Institutions in the EM Region Agenda item 5	EM/5TH.MTG.ACMR/6
A Preliminary Situation Analysis of the Research Manpower Situation in the Region Agenda item 6	EM/5TH.MTG.ACMR/7
Training Programme in Research Management Agenda item 7	EM/5TH.MTG.ACMR/8
Scientific Working Group on Liver Diseases held in Karachi, 17-19 December 1979 Agenda item 8(a)	EM/5TH.MTG.ACMR/9
Malaria Research Programme in the Region Agenda item 8(b)	EM/5TH.MTG.ACMR/10
Scientific Working Group on Diarrhoeal Diseases Agenda item 8(c)	EM/5TH.MTG.ACMR/11
Research in the Regional Cancer Programme Agenda item 9(a)	EM/5TH.MTG.ACMR/12
Research in the Regional Programme of Mental Health Agenda item 9(b)	EM/5TH.MTG.ACMR/13
Regional Biomedical and Health Services Research Priorities with Special Reference to "Health for All by the Year 2000" Agenda item 10	EM/5TH.MTG.ACMR/14

Basic Documents (cont'd.)

Progress Report on WHO Special Programme for Research Training in Tropical Diseases Agenda item 11(a)	EM/5TH.MTG.ACMR/15
WHO Special Programme for Research, Development and Research Training in Human Reproduction Agenda item 11(b)	EM/5TH.MTG.ACMR/16

Background Documents

1. REPORT ON A SCIENTIFIC WORKING GROUP MEETING ON MALARIA Nicosia, 27-29 November 1979	EM/MAL/172
2. REPORT ON A SCIENTIFIC GROUP MEETING ON LIVER DISEASES Karachi, 17-19 December 1979	EM/RSR/11
3. PRELIMINARY REPORT ON A SCIENTIFIC WORKING GROUP MEETING ON DIARRHOEAL DISEASES Alexandria, 19-22 August 1980	EM/SC.WG.DDR/5
4. DIRECTORY OF SELECTED INSTITUTIONS ACTIVELY ENGAGED IN BIOMEDICAL RESEARCH WHO EMRO 1980	
5. WHO SPECIAL PROGRAMME OF RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION Geneva, December 1979	8TH ANNUAL REPORT

Dr. Kiser Bernard:

Do you wish to attend?
If not should someone else
do so?

4/24

discussed w/ JE
no participation
required.

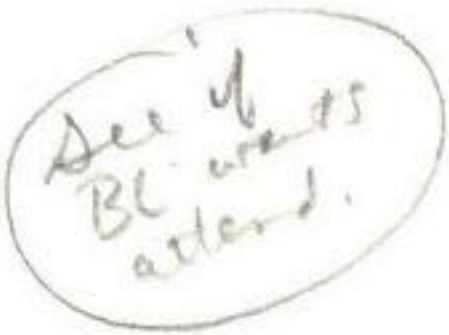
4/28/80 BHK.

April 22

HWM:

I spoke with Dr. Ferreira's secretary to tell her that JRE would be in Geneva and would not be able to attend. I think it would also be a good idea to write them. Do you know if anyone else should attend since JRE can't?

RMF



PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

IN REPLY REFER TO: HRE/AMR/8900/21/1 (ACMR-GAR) TELEPHONE 861-3200 ~~223-4700~~

15 April 1980

Dr. John R. Evans
Director
Population Health and Nutrition Department
1818 - H Street N.W.
Room N-340
Washington, D. C. 20433

Dear Dr. Evans:

This is in reference to our previous letter, dated 1 April 1980, regarding a meeting of the Advisory Committee on Medical Research Working Group, of which I am enclosing copy for easy reference.

Since time is running short, we are postponing the meeting which will be held in Toronto, Canada from 1-2 May.

In order for us to make the corresponding administrative procedure, we would appreciate your letting us know whether you will be attending this meeting, at your earliest possible time.

Hoping to hear from you soon, I remain,

Sincerely yours,

José R. Ferreira, M. D.
Chief, Division of Human
Resources and Research

Encl.

PAN AMERICAN SANITARY BUREAU

HRE/AMRO/8900/21/1 (ACMR-GAR)

1 April 1980

Dr. John R. Evans
58 Highland Ave
Toronto, Canada
M4 W 2A3

c/o Population Health & Nutrition Dept
World Bank
1818 - H St N.W
Room N-3440
W.D. 20433

Dear Dr. Evans:

The Pan American Health Organization is having a meeting of the Advisory Committee on Medical Research (ACMR) Working Group on social science health research during 17 and 18 April. The purpose of this meeting is to analyze the enclosed report prepared by Dr. Robin Badgley, which is to be presented at the XIX Meeting of the ACMR/PAHO in June 1980.

As a member of the above mentioned Working Group, we hope that you will be able to participate in the 17-18 April meeting. However, if for any reason you are unable to attend, we would greatly appreciate receiving your written comments for consideration by the Working Group.

We thank you in advance for your collaboration and remain,

Sincerely yours,

José R. Ferreira, M.D.
Chief, Division of Human
Resources and Research

Encl.

cc: Dr. R. Badgley

JCG/vo

CLEARANCES: INFORMATION ONLY:

OFFICE	INITIALS	DATE	OFFICE	INITIALS	DATE
HRE					
HRC		4/1/80			
HR					

FILE COPY

PAHO 105
6-73

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

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Hoping to hear from you soon, I remain,

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Chief, Division of Human
Resources and Research

Encl.

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Files

DATE: April 4, 1980

FROM: John R. Evans, PHN JRE

SUBJECT: Visit to Costa Rica and Relationship of Health Center to New Agricultural Rural Development Center there for the Six Central American Countries.

PAHO with UNDP's support has established a Center in premises provided by the Ministry of Health for a six country unit on health information and manpower training. The Director and five staff are in place.

The Bank is serving as executive agency for a UNDP supported agricultural and rural development project to be based in Costa Rica. The proposed outputs would be institutional development, project preparation assistance, training.

In view of the fact that both units will be located in San Jose and that there are some over-lapping areas of interest it is suggested that there be a brief meeting of Bank and PAHO representatives in Washington in May and that at the time of the proposed health services research committee meeting in Costa Rica in early June, that representatives of the two centers discuss possible beneficial inter-actions on site in San Jose.

Actions to be taken:

1. JRE to set up a meeting of Lari, Ferreira of PAHO and any others they wish to bring to discuss this in May.

2. JRE to advance time of visit to Costa Rica to Friday, June 6 in order to participate in joint meeting. Or alternatively, if this is not possible to recommend that a separate meeting be held on June 9 or 10 at the same time as the Health Services Research meeting. The latter is probably preferable.

JREvans/rmf

Draft for Revision

REPORT OF THE ACMR WORKING GROUP

ON SOCIAL SCIENCE HEALTH RESEARCH

For presentation to XIX Meeting of ACMR/PAHO, June, 1980.

March, 1980

CONTENTS

CONTENTS (Continued)

Report of ACMR Working Group on Social Science Health Research

Review of Working Group's Activities

In recent years the ACMR has reviewed a number of questions involving the nature of the actual and the potential contribution of the social sciences to various branches of health research. In 1978 the ACMR recommended that a review be undertaken "to assess the scope of social indicators in evaluating the results of health services as well as their use and efficiency in health services' research". At its XVIII Meeting in 1979, the ACMR received a report which called for the establishment of an interdisciplinary Working Group to consider the present state of the field as it related to a number of PAHO/WHO designed priority areas in primary health care.[1] The Working Group's functions, it was proposed, could include: the assembling and the critical evaluation of existing research in the field; an examination of demonstration research models as they might relate to these designated research problems; and the development of proposals concerning the further extension of this field. The results of this review should be submitted to future meetings of the PAHO/ACMR with a timetable of 2-3 years envisioned for completion.

This report to the 1980 XIX Meeting of the ACMR lists: the specific mandate assigned to the Working Group; its membership; the work completed to date; a general review of the field outlining some of the trends and problems involving social science research dealing with health problems; and its principal recommendations.

Terms of Reference. At the Executive Session of the XVIII ACMR Meeting in 1979, the recommendation was endorsed that a Working Group be established.

> "This Group would continue to assess the scope of social indicators in evaluating the results of health services, as well as their use and efficiency in health services' research; and concentrate on a limited number of problems rather than attempt to cover the whole field."

As consideration was given by the Working Group to implementing this recommendation, it was recognized that before sufficient and detailed appraisal could be provided of the current use and potential utility of social health indicators, several basic prior steps were required to assemble information about the general state of research undertaken in this field in Latin America. Once these necessary steps had been completed, and work during the year was started along these lines, it was deemed that it would then be feasible to fulfill the more specific terms set by the ACMR recommendations.

Membership. The Working Group which was initially struck to undertake this review included: Dr. George Alleyne (Vice Chairman, PAHO/ACMR); Dr. John R. Evans (Chairman, Subcommittee on Health Services Research of the Global WHO/ACMR); Dr. R.F. Badgley (Chairman of the Working Group); and Dr. J.C. Garcia (PAHO Division of Human Resources and Research). The work of this review was augmented when Dr. Guillarmo Arbona joined the Committee.

Work Undertaken. In order to assemble a baseline of social science health research done in Latin America which could be used to assess the current and the potential use of social health indicators,

the Working group undertook the following activities during 1979-1980.

- all PAHO/ACMR members were contacted with a request to provide information about health research which was known to have included social information or had used social science research methods

- similar enquiries were sent to: a number of major international foundations supporting health research; the World Bank; branches of the U.S. National Institutes of Health and divisions of the U.S. Department of Health, Education and Welfare; a number of established researchers and major research centres in Latin America; and a number of WHO Special Programmes

- bibliographical indexing systems such as Medlars and BIREME provided listings of catalogued research involving social science related issues of work done in Latin America. The Director of BIREME and the Chief Librarian of PAHO Headquarters Library provided valuable assistance to this inquiry

- review of social science health research for Latin America published in approximately a dozen major publications for the field of social science and health was undertaken for a period, 1975-80

- to put the current review in context of prior major work sponsored by WHO/PAHO, a synopsis of support provided in the past was initiated

- a start was made to assemble a listing of social science health research for Latin America. This information was entered into the computer indexing system of the PAHO Headquarters' Library. PAHO assigned a temporary staff member to assist with this work

- site visits were made by two members of the Working Group to about 20 major teaching and research programs involving social scientists in four nations (Mexico, Venezuela, Brazil and Ecuador).

Based on the work which has been completed or is underway, the Working Group is moving toward a position where during 1980-81 it will have available a relatively comprehensive listing of social science health research completed in Latin America. When this is done, it will

then be possible to analyze in greater detail the research pertaining to a limited number of problems, as requested in the Terms of Reference set for the Working Group, and to consider more specifically the scope and utility of social health indicators.

Recommendations of Working Group. Stemming from the work done to date and its review of trends occurring in this field, the Working Group concludes that there are a number of ways whereby PAHO could strengthen substantially the contribution made by social science health research done in Latin America. The recommendations listed here and the points tabled for future consideration are in general accord with the priorities set for the PAHO Regional Health Services Research Programme. These activities reported to the Global ACMR Subcommittee on Health Services Research held in Alexandria, June 1979, dealt with "problem areas that are common to all countries or to some groups of countries." In particular, it was indicated that work was ongoing or would be fostered in the Region of the Americas involving:[2]

- research directed towards population needs, use of services and community participation
- strengthening the relations between health and other sectors
- the involvement of the social and political sciences including economics
- the identification of health services research as a discrete topic in Index Medicus, BIREME
- the organization of regional and subregional activities
- the preparation of registers of researchers of training programs
- the creation and the strengthening of health services research centers

- the scheduling of seminars where researchers can exchange experience
- the stimulation of the development of demonstration research projects

The recommendations of the Working Group are in line with activities listed above which are being sponsored by PAHO for Health Services Research. To accelerate the strengthening of the social science component of this work, the Working Group believes that special measures relating to these disciplines are indicated and at this stage to accelerate their development, they should be specifically identified and not subsumed under these general programs.

The following recommendations are submitted for consideration by the XIX ACMR Meeting:

1. That the responsibilities of the ACMR Working Group be redefined as an Advisory Committee on Social Science Training and Health Research. The functions of this Advisory Committee reporting to the ACMR would be to serve as a senior external advisory group concerning the social science activities undertaken by PAHO, to develop policies and guidelines concerning training fellowships and research submission in this field, and to seek ways to foster the general strengthening of social science health research. The Advisory Committee would report annually on its work to the ACMR.

2. That to coordinate and to keep informed about the wide range of social science health related activities undertaken by WHO/PAHO, international agencies and the member nations in the Region, and to provide the necessary secretariat support for the Advisory Committee, the resources and facilities assigned to the PAHO staff officer responsible for the social sciences be substantially strengthened.

3. That the Advisory Committee during 1980-81 be responsible for:
   (i) the further development of the social science health research inventory

(ii) the convening of one or more specialist working parties to review research related to specific health problems

(iii) submitting of a report of its activities to the XX ACMR Meeting

The rationale underlying these recommendations is contained in the following sections of this Report. Underlying the first two recommendations is a recognition that during the past 25 years and particularly during the 1970's, a remarkable expansion has taken place involving all aspects of social science health related activities in Latin America. A point has been reached here where it would now be valuable to consolidate and review this existing body of social science health research and to consider ways that these efforts might be strengthened. Unless such a mechanism is established, the work which is being done will continue to be fragmented, the dissemination of findings and research methods will be limited, and the priorities set by WHO/PAHO will be only partially met. The third recommendation represents work which the Working Group believes it would be feasible to accomplish during 1980-81.

In addition to its principal recommendations the Working Group believes there are a number of additional ways in terms of the long term development of this field where technical assistance is warranted. These points are raised in this Report, but are not put forward as recommendations at this time since their feasibility and utility requires further consideration. The Working Group seeks the counsel of the ACMR on these matters and requests its approval to proceed in terms of the major recommendations submitted for consideration.

WHO/PAHO Activities Involving the Social Sciences

WHO Support. Since it was established in 1948, WHO has given considerable support to the incorporation of the social sciences in its training program and to their inclusion in basic and applied health research. This endorsement came initially from health scientists serving on advisory committees in different Special Programs at a time when only a modest start had taken place in many countries in the actual recruitment of these disciplines as teachers or researchers. Since this time both the support by WHO in this regard has increased as has the involvement of the social sciences in a wide range of health-related activities in many countries.

During the 1950's and the 1960's WHO called upon a number of social scientists as short-term consultants to a number of its programs. Some Secretariat staff with training in these disciplines were appointed. The work in this area became more sharply focussed following the establishment of a Behavioural Science Unit in the WHO Division of Research in Epidemiology and Communication Sciences (R.E.C.S.) in the late 1960's. Under the aegis of this unit several inquiries directly involving social scientists were initiated, as for instance the convening of two advisory meetings of social scientists and social medicine specialists to consider questions affecting professional education. At its first meeting (1969) the Advisory Group on Sociology of Professional Training in Health Manpower outlined 11 issues where social science inquiry might be undertaken involving the recruitment and the training of health workers. At its second meeting (1970) the

Advisory Committee submitted a detailed research design for an international comparative review of medical student selection and academic progress. It was recommended that external funding be obtained for the inquiry to be done under the sponsorship of WHO. Before an extensive study be undertaken, the Advisory Committee recommended that steps be taken to compile and evaluate the research already completed dealing with these questions.

As this approach is being brought to the attention of the 1980 PAHO/ACMR meeting, the concerns of the 1969-70 WHO Advisory Committee merit relisting since some of the problems cited still occur in the Region of the Americas.

> We see as an essential first step the critical evaluation of the existing literature... we advocate that an annotated and critical bibliography be made of the growing volume of published and mimeographed materials now available... there is a particular need to integrate the papers now appearing from non-English speaking sources with those from the United States and other countries which, until recently, contributed most of the material in this field.
>
> Attention should be paid... first to the question of methodology. By this, we mean that each paper should be evaluated from the standpoint of determining the reliability of the instruments used, the validity of the results obtained, the time span of the study, the comparability of the results with those studies done elsewhere... and the validity of the sampling frame.[3]

WHO subsequently increased its support of the social sciences in several of its Special Programs. For instance the International Collaborative Study on Medical Care Utilization started in 1964 was given WHO cosponsorship in 1967.[4] This multidisciplinary study involving 11 study areas in seven nations (including Argentina, Canada

and the United States) included a sizeable number of social scientists. A number of social health indicators were extensively pre-tested and used in the analysis of: the recognition of the symptoms of illness and disease; the attitudes, knowledge and perceptions associated with the use and the accessibility of services; and the relation of social and economic factors affecting the differential use of a range of health services. In a number of Latin American research centers the findings and the methods of this extensive report are not now well known either as a basis for replication or modification in comparable investigations.

This perspective of the social sciences was also drawn upon by WHO in the Report of its first Scientific Group on the Development of Studies on Health Manpower (1970).[5] The draft of the final Report was based partially on the work of a social scientist Special Consultant. In 1972, the WHO/R.E.C.S. Division completed a working document on a Framework to Improve Planning and the Development of Health Services.[6] Written by Secretariat and consultant social scientists, this document focussed on the organization and priorities of national health planning activities. Its principal concern was with an orderly appraisal of "ways of deliberately bringing about social change so as to effectively develop and use scarce resources (human and material) in ways which will enhance health."

The work initiated by the RECS Division was subsequently amalgamated into other activities of WHO. Its initiative involving the contribution of the social sciences in health services research was reaffirmed in the 1979 Report of the Global ACMR Subcommittee on

Health Services Research. Concerns involving social science input included: the definition of social health indicators; a people's health behaviour; the role of community participation; and effective means of information dissemination.

The WHO Special Programme for Research and Training in Tropical Diseases was established in 1976 to foster research involving six tropical diseases (malaria, schistosomiasis, filariasis, trypanosomiasis, leprosy and leishmaniasis). Work involving the social and economic factors affecting the occurrence and the control of these diseases was recommended by a Working Group in 1971. It called for inter alia:

- a review of the relevant social science research literature relative to these diseases
- an analysis of research findings involving 19 socio-economic variables associated with the transmission and the control of parasitic diseases
- based on the previous two steps, the initiation of data collection research dealing with information found to be missing
- the appointment of an inter-disciplinary WHO steering group to evaluate progress, secure needed consultations, suggest priorities and future steps, and to report periodically as requested .[7,8]

A listing of a number of studies dealing with the socio-economic aspects of parasitic diseases was completed in 1975.[9,10] This brief bibliography was extended further to include 31 annotated studies in 1979.[11] Four reports in the 1979 listing referred to Latin America (schistosomiasis--St. Lucia; Chagas disease--Brazil (2); and Colombia). Additional steps involving the social science input in this Special Programme were recommended by temporary consultants and Secretariat

staff. These recommendations included:

- assignment of post-doctoral research training fellowships for social scientists studying these tropical diseases
- encouraging the establishment of full-time positions for social scientists in national research institutes or programs
- a compilation of more comprehensive biblographies of social science research relevant to the occurrence and control of parasitic diseases
- fostering interdisciplinary, collaborative research.

In 1979 WHO convened two meetings of a Scientific Working Group on Social and Economic Research (S.E.R.) under its Special Programme for Research and Training in Tropical Diseases.[12, 13] The activities initiated by the SER Working Group included:

- two literature reviews, one on behavioural science methods for use in tropical disease control, the second dealing with economic studies of malaria, filaiasis and human trypanosomiasis
- initiation of three feasibility studies
- review of the social perception of these diseases and the role of community participation in their control
- the identification and listing of researchers and institutions involved in these types of research activities in the member countries
- the involvement of temporary consultants at an early stage to advise upon the social science component of tropical diseases' research.

The SER Working Group of the Special Program served as a grants' review body for research applications with an assigned budget of U.S. $489,000 for 1979 and projected budgets of U.S. $489,000 for 1980 and U.S. $750,000 for 1981.

The WHO Special Programme of Research Development and Training in Human Reproduction established in 1972 has drawn extensively upon

findings and research methods of the social sciences in its program and investigations. The Seventh Annual Report (1978) of this program cited the need for basic social information about family planning decisions, the acceptability of how services were provided and the social values of families.[14] Under this Special Programme work has also been undertaken focussing on the psychosocial aspects and the health services' implications relating to induced abortion.

In its 1976 Report the WHO Mental Health Programme cited three objectives to be attained relating to the psychosocial factors affecting mental health.[15] These were:

- to apply existing research knowledge to improve health care
- to develop techniques to facilitate the dissemination of relevant psychosocial information to health planners
- to assemble information upon which action programs could be based concerning the health needs of uprooted and migrant people or those experiencing rapid social change.

This partial inventory of WHO activities during the past decade involving the social sciences indicates the nature of the commitment that has been made to strengthen training and research activities involving these disciplines. This involvement receives the support of a number of other special program areas such as: maternal and child health; the effects of mass campaigns; and the role of traditional medicine in primary health care.[16]

PAHO Support. The social sciences have been a part of PAHO's programs since the fifties and their use in PAHO has been influenced by their general situation as related to health at any given juncture. During the fifties, cultural anthropology was introduced to ascertain the factors that prevented or hindered the adoption of public health measures. In the late fifties and early sixties it was the turn of economics to contribute to their adoption of those measures in the framework of economic development and planning. In the mid-sixties social psychology and sociology were brought into manpower training, and in the seventies the social sciences made an incursion analysis of the State medicine, and there was a revival of traditional medicine in connection with extending the coverage of health services.

One of the first attempts to make use of the social sciences in PAHO programs was the hiring of an anthropologist by INCAP in 1950 for a project to determine the nutrients needed to improve the diet of five Indian villages. The difficulties that had been placed in the way of the program by the resistance of some of these populations prompted recourse to the social sciences to study the obstacles encountered. The anthropologist in charge of the study concluded that: "Theis case has shown that many of the problems that arise during the course of a research program using human subjects can be solved successfully if adequate knowledge of the culture of both the subject population and the project personnel is available and is applied." [16] As a result of this first experiment, and intercountry program was launched to study the culture of several countries; thus, from 1953 to 1956 an anthropological survey was conducted in the countries of Central America and Panama which resulted

in a series of publications and indications on health programs.[17] However, these experiments were not without their own difficulties, as shown by the report of a sociologist hired to analyse the situation: "There had been differences between anthropologists and administrators over matters of appropriate responsibility, recognition and prestige, freedom of publication, usefulness of reports, and advice. After one rather hectic separation, the Director-General, concerned about the utilization of social science in the agency, decided to retain a consultant. As first stated to me, the retained consultant reported, the problem was to account for the Bureau's experiences with anthropolgoy and anthropologists.[18] The consultant sociologist worked from 1956 to 1958 and proposed a plan for the establishment of a permanent research service with four components: 1) the place of social research in Bureau operations should be spelled out, both philosophically and administratively. Primarily, social scientists would be employed to serve health programs as research specialists and not as health administrators or health specialists; 2) two kinds of social science positions were recommended; headquarters and field positions, where personnel would be attached to the regional staff and assigned for research to specific operating projects and programs, respectively; 3) by working with foundations, national governments, graduate schools of medicine and public health throughout the Americas, and especially in Latin America, to improve social science education and the education of social scientists, the Bureau might well help to alter certain general conditions of science and society which now have a negative effect on the performance of its mission; 4) finally, the Director-General of the Bureau should have an outside social science advisory committee to guide and support the matters

noted above. This committee should be composed of distinguished social scientists from Latin America and elsewhere, and a minority of distinguished health professionals with social-medicine orientations.[18] These recommendations were not taken up because of a variety of circumstances, one of which, according to the consultant, was that "the new Director-General, for perfectly good reasons, was occupied with health and economy questions for some time." Indeed, the early sixties did see the inclusion of economy in the operations of PAHO in the context of health planning as related to general planning for economic development as had been proposed in the Alliance for Progress Program.

It was not until the middle of the sixties that some of the recommendations made in the fifties were acted upon, and particularly the one "to improve social science education and the education of social scientists." In this area the Milbank Fund Memorial Fund played a fundamental part by sponsoring first a national study of human resources in Colombia with the collaboration of the Government and of PAHO, and later by helping PAHO in the performance of a study of medical education in Latin America.

In 1963 the Pan American Health Organization and the Fund sponsored a Round Table on Health Manpower and Medical Education in Latin America. In March 1964 the Government of Colombia and the Association of Colombian Faculties of Medicine, with the support of the Pan American Health Organization and the Milbank Memorial Fund, assumed responsiblity for a survery of medical educàtion and health manpower in that country. These studies included medical and nursing education, the supply of health manpower, an inventory of health facilities, analysis of mortality and morbidity, and economic analysis of health services, and a national health survey. These

studies were completed in 1967, and the methodology and preliminary findings were presented to representatives of all countries in the Americas at the International Conference on Health Manpower and Medical Education held in Venezuela in 1967 and to the National Conference on the Results of the Health Manpower Study held in Colombia in 1967. That same year the Milbank Memorial Fund arranged a Round Table on Social Science and Health Planning for the purpose of subjecting the methods and selected findings of the National Health Survey phase of the broader manpower study to review by scholars experienced in social science or public health research.[19]

In 1956 the Milbank Memorial Fund put up the funds to enable PAHO to perform a study on the teaching of preventive and social medicine after ten years of the seminars held in Viña del Mar y Tehoacán sponsored by the Organization. A social scientist with experience in comparative research was hired, and the preliminary studies revealed the need to extend the study to encompass all of medical education in order to explain the development of the preventive and social aspects of medical education. This was the beginning of a research enterprise of hemispheric scope whose results were published by PAHO in 1972 under the title of Medical Education in Latin America.[20]

During the analysis it was confirmed that the behavioral sciences, defined as those comprised in sociology, anthropology and social psychology, were taught in 79 per cent of the ful-course medical schools, with an average of 44 hours per student of which only 30 per cent was practical work. These findings lent weight to the view that PAHO should collaborate with the countries in improving the teaching of these disciplines and in the training of social scientists. The outcome was that in 1969 the Organization set up with intercountry regular funds a program designated

AMRO-6216, Behavioral Sciences in Training of Health Personnel; the purpose was to develop and promote the application of norms, principles, models, and materials for the teaching of behavioral sciences and to train health professors in their use, to evaluate health science shcools in the organization and development of instruction in the health sciences, and to promote and collaborate in the development of research projects in behavioral sciences applied to health problems related to teaching.

In 1971 a project in support of the teaching of the behavioral sciences was presented to the UNDP for financing, and approved in 1972, thus setting in motion the program AMRO-6223, Teaching Behavioral Sciences, which continued until 1975. In those three years a series of activities were carried on that greatly bolstered the development of the social sciences. Traveling seminars were conducted along with working meetings of experts in social sciences and advisory services to medical schools, and teaching materials were supplied and fellowships awarded. It was under this program that the Organization collaborated in setting up the first graduate course in social medicine in Latin America, at the Institute of Social Medicine of Guanabara State University, Brazil, in 1973. This program was designed with the technical and financial assistance of PAHO and the W. K. Kellogg Foundation. The course was geared to physicians and was the first to train specialists in social medicine in a Latin American setting; a good many of these specialists began to participate in government medicine while teaching at the University.

It was also in 1972 that a group of Latin American Social scientists working in the health field met for the first time at Cuenca, Ecuador to

consider the role of these disciplines in relation to the needs and characteristics of Latin American social formations. This meeting was attended by representatives of 10 countries and sponsored by PAHO under the UNDP financed program.[21] Starting in 1972, PAHO convened several meetings of social scientists to analyze different aspects of education and research in the social sciences.

On 29 September 1975 a program toward a Master's Degree in Social Medicine was launched -with PAHO's collaboration- at the Metropolitan Autonomous University at Xochimilco, México. This program was designed to generate theoretical and practical output on the socio-economic aspects of health and, in addition, to develop human resources trained in research, planning and teaching. It is geared to students in different professions and institutions in Mexico and other Latin American countries, and is being conducted under an agreement between the Department of Health and Welfare of Mexico, the Pan American Health Organization and the Metropolitan Autonomous University; this agreement allows the participation of Latin American fellowship holders and provides for teachnical and academic support by PAHO/WHO.

There was a noteworthy increase in funds in the early seventies in the program on teaching behavioral sciences, which in 1976 changed its name to Education and Research in Social Sciences Applied to Health. The addition of research in this program coincided with a renewal of interest in PAHO, in the second half of the seventies, in supporting and collaborating with the countries in drawing up national research plans.

This same phenomenon of support to research in the social sciences is observable in other areas associated with primary care and coverage extension that began to be reflected in the Program and Budget of PAHO in 1977 with the establishment of AMRO-5170, Promotion of Primary Health Services, and AMRO-5100, Health Services to Rural Areas. In 1979 a new project came out which makes explicit the involvement of the social sciences in programs of research on the extension of coverage -AMRO-5101, Study of Methods for Promoting Community Participation in Primary Health Care. The purpose of this project is to develop methods by which the Government may understand the characteristics of their communities and the sociocultural factors that hinder popular participation in health actions, and to refine appropriate technologies for assuring community participation in the delivery of health services. It will also develop technologies for determining the characteristics and internal dynamics of the traditional community systems in the countries. There has thus been a revival of the interest that that had been seen during the fifties in traditional medicine, though now not only to discover the factors hindering the acceptance of health measures but essentially to promote the participation of the traditional system in health programs. Thus, once again, anthropologists are called upon to collaborate in these studies, though now the contribution comes primarily from the phenomenological schools that predominated in the anthropology of the seventies instead of the positivistic schools that were dominant during the fifties.

There has been a patent growth in applications of the social sciences to health in its various forms, disciplines and schools in Latin America, and PAHO has participated in the process. Interest in the social sciences has grown considerably in Latin America, as is evidenced by the fellowships PAHO has granted and by the success of the two graduate programs in social medicine which the Organization has sponsored.

Trends in the Field: 1955 - 80

Overview. Since the first regional seminar on the teaching of preventive medicine was held in Vina del Mar in 1955, the field of social science involved in health training and research has expanded sharply, experienced a number of internal disciplinary cleavages and continued to face some problems which still persist. During this period it has also made a growing and substantial contribution to research knowledge about a broad range of health problems. The dilemmas initially faced by this field were the paucity of well trained social scientists, a general lack of research experience in health matters and the scarcity of established institutional teaching and research positions where this type of work could be carried on. While at first during this period the social sciences applied to health were seen by many medical observers as a single academic discipline, there has been a growing recognition of the different conceptual and research strategies followed in anthropology, social psychology and sociology, and also within each of these fields, the co-existance of different approaches which may be incompatible under the same listing. The expectation of medicine that the new field should deal with problems of an applied nature has not always been easily accepted by social scientists who on occasion have chosen to ask different questions or who have looked at different facets of a particular health problem.

Internally within the social sciences generally, and in particular in the application to health training and research, a cleavage has evolved in terms of the conceptual formulation of issues and the

range of what constitutes acceptable research strategies to deal with these matters. On the one hand there is a broad approach which defines health problems in terms of a functional anlysis of cultural values or the organization of institutions and systems, and based on this perspective analyzes the occurance and the social meaning of disease, the use of services or the organization of health care. Until recently, these broad concepts constituted the predominant approach adopted in social science health training and research. Starting in the early 1970's, different models for training and research were proposed for Latin America which rejected the previous work as tools of the establishment merely reinforcing the status quo. In particular, the predominant approach was seen as an expedient response to the demand for "informacion empirica rapida para solucion de los problemas" which contributed "una descripcion formalista de la relacion entre dichos problemas y otras esferas de los proceses productivos".

In contrast to the more broadly established and traditional social science approaches to the training of health professionals and analysis of health problems, a new alternative was endorsed in 1972 at a meeting of social medicine specialists and social scientists held in Cuenca, Ecuador.[23] It was concluded that: "un marco teorico alternativo debe formularse a base de fundamentos cientificos". This approach was defined as "la explicacion del cambio como proceso historico que permite mantener una "conciencia critica y autocritica" y la necesidad constante de problematizar sus propias categorias". Based on this model the means of economic production and the formation of social classes became integral to the analysis of health

values and behaviour, the use of services and the organization of medical care. Since the 1972 meeting a growing body of academic work dealing with health problems in Latin America has been published based upon these conceptual premises, enunciated at Cuenca.

Unlike the mid 1950's the present situation of the social sciences related to health research is one where a considerable body of work has been completed which represents mixed interests and emphases. These groupings of interests co-exist in terms of: basic and applied research; micro or macro analyses; the separate sub-disciplinary approaches of anthropology, social psychology and sociology; a functional and systems approach in sociology versus a Marxist conceptual framework; styles of research alternately emphasizing detailed social survey research techniques, ethno-methodological appraisals or analysis anchored in class divisions and the mode of economic production. While there has been a vigorous expansion generally involving the social sciences in health matters, these divisions have curtailed any broad sense of unity or direction from emerging up to the present time. Some of these splinter academic interest groups have only a limited dialogue with each other, and may not know or choose to ignore each other's major research work. This situation is apparent for instance in the selective historical documenting of the work done in the field with different accounts emphasizing a favoured perspective while excluding other materials. One important implication of the current situation affecting the social sciences in Latin America is that external assistance programs may be unaware of both the extent and the diversity of the work which has been done.

Inadvertantly, they may become "locked in" to support a particular approach and because of its conceptually parochial perimeters, valuable research done by other social scientists is not drawn upon by choice or scholarly ignorance. Beyond these matters is the fact that the Region encompasses 32 nations and for the Latin American nations there are no established or widely used means of circulating the results of social science health research inquiries.

Before turning to a more sequential consideration of how the field has grown in the past 25 years, it is apparent that two of the central needs are (i) to consolidate what has been done; and (ii) to develop steps involving the critical review of social science health research relating to specific health problems. These steps would transcend and would be of benefit to all member nations since none has the means to undertake such a comparative assessment, and in some instances this may be precluded by other considerations. The consolidation and critical review which is called for here would not resolve some of the dilemmas now characterizing the field, but it would provide a more solid benchmark to determine the means and the conditions of more effective ways of providing assistance to health research involving the social sciences.

Vina del Mar, 1955. At least three broad factors have served to stimulate and develop social science health training and research in recent years in Latin America. These factors have included the stimulus provided by: (i) the universities and governments of the member nations; (ii) the impetus given by four international seminars convened by PAHO between 1955-1974 on the teaching of social

and preventive medicine; and (iii) the special technical assistance rendered by a number of international agencies (e.g., UNESCO, World Bank, FAO, or the Special Programmes of PAHO/WHO) and the programs of some internationally-oriented philanthropic foundations (e.g., Ford, Milbank, Social Science Research Council, Rockefeller, etc.).

In their consideration of the medical curriculum and the recommendations which were made, the seminars on the teaching of social and preventive medicine sponsored by PAHO (1955, 1956, 1968 and 1974) provided an assessment of the expanded role envisioned through a period of 20 years for the contribution of the social sciences.[24] Interest in this field grew from an initial general endorsement of these topics to specific recommendations about the strengthening of the social science component. At the 1955 Vina del Mar seminar a short list of social science curriculum topics was identified such as: medical social problems of the family and the community; knowledge about health services; and the utility of including the concepts of social anthropology and ecology in the curriculum. No social scientists were designated either as part of the "nucleo minimo de un buen departamento" or as part of a part-time teaching staff of a model department.

The second PAHO sponsored seminar held at Tehuacan in 1956 identified the need in "los contenidos minimos de la ensenaza de medicina preventiva y social" of a consideration of the general concepts of social psychology, general sociology, ecology and social anthropology. The curriculum materials to be dealt with included:

general ideas about social problems; and social, economic and cultural attributes of a region or a country. Social scientists were not included in the listing of core academic staff, but social anthropology was listed among the disciplines to be drawn upon on a part-time basis from other university departments.

Milbank Conference, 1965. As part of its program "to further the use of the Social Sciences in relation to health and medicine", the Milbank Memorial Fund initiated its program of support for training and research in the Americas. Particularly during the decade of the 1960's, this foundation's activities involving Latin America included:

- The awarding of training and faculty fellowships for social scientists (e.g., Claudio Jimeno, Chile; Jose Alvarez Manilla, Mexico; Reginaldo Zacarra de Campos, Brasil; Jorge Segovia, Argentina)
- reviews of the teaching of the social sciences in schools of public health (Rodriguez, 1966-67) and faculties of medicine and schools of public health (Piovesan, 1967)
- convening of seminars to review teaching and research (Social Science and Medical Education in Latin America, 1965; and Social Science and Health Planning, 1967)
- interuniversity travel grants for social scientist teachers and researchers
- social science consultants to particular programs (e.g., R. Elling, S. Bloom, J. Elinson, M.I. Roemer, E. Suchman)
- financial support of the Colombian National Health Manpower Survey which involved social scientists
- financial support for the position of a full-time social scientist on the staff of PAHO (1966-68)
- joint financial support with PAHO of a comparative analysis of medical education in Latin America, 1967-68 (J.C. Garcia, La Educacion Medica en la America Latina, OPS, No. 255, 1972).

In 1965 the Milbank Memorial Fund convened a Round Table Conference on the Social Sciences and Medical Education in Latin America.[25] Attended by 21 participants, 18 of whom were Latin American teachers and researchers, a review included the scope of the social science curriculum in the training of the health professions and the major directions taken in research. The meeting drew upon information obtained from a survey of approximately half of the medical schools in Latin America and a bibliography of about 200 studies was used as a basis for the review of trends in research. Among the themes considered at this meeting were:

- general review of the social sciences in Latin America (Stavenhagen)
- overview of research on social science and medicine in Latin America (Sepulveda)
- four research case studies on: culture and norms of disease (de Pineda); child-rearing practices, nutrition and social status (Gonzalez and Behar); social status and illness in Brasil (Iutaka); and planned social change and health programs (Wellin)
- four studies on the sociology of medical education including: medical student selection and appraisal (Goes and Castro); quality of medical care (Albo and de Gasparini); evaluation of public health training programs (de Medina); and the relation of medical training in professional practice (Berdichewsky)
- review of three teaching programs involving social science, respectively: anthropology in preventive medicine (Abita and Zayas); sociology in an integrated clinical setting (Molina and Jimeno); and a social science program in a school of public health (Vallejo and Garcia).

The appraisal of the social science health research relating to Latin America, most of which had been completed in the previous decade,

included a substantial body of work done by North American scholars. Few studies written at that time by Latin American social scientists had been published in the widely circulated North American or European journals. The periodicals which were used had a limited circulation or were published on an irregular basis. The content of the research dealt predominantly with anthropological studies of the role of traditional medical care. Few social health surveys had been completed. Little attention was then paid to topics such as the recognition of disease symptoms, the interface between traditional and modern medicine, the actual use of health services, the health of urban populations or the organization of health and welfare services. Based on this review of fifteen years ago, only a handful of social scientists were known to be employed by government health ministries or in academic medical research institutes. The research then being done was undertaken for the most part by a few social scientists attached to departments of preventive medicine in medical schools, to a lesser extent such scholars working in schools of public health and there were only then a few instances involving academic departments of social science where an interest was taken in health issues.

The 1965 Milbank Conference cited a number of problems faced by social scientists involved in health research. These included:

> "Inadequate financial support, the limitations imposed by part-time teaching positions, the scarcity of quantitative resource materials, the threat often posed by the findings of social surveys to the guardians of traditional values, and the often inadequate academic training of social scientists."

Interdisciplinary research involving physicians, other health workers and social scientists had rarely been tried. At this conference

the issue of collaborative work provoked a debate involving the analogy of a marriage.

> The social sciences were likened to a very young bridegroom who had just wed an old bride, medicine. The propriety of the match, the nature of the dowry and the wife's dominant position and impregnability to change were all questioned by social scientists. Medicine could provide the union with prestige and financial stability, but fear was expressed that medical imperialism and the imposition of pragmatic and action-oriented standards would reduce social scientists to the position of subservient technicians.
>
> Some physicians felt the honeymoon should be short and that the social scientists should assume responsibilities comparable to those shouldered by medicine. They urged the social sciences "to grow up", to tackle those problems of pressing concern for the welfare of society".

The major conclusion reached by this conference was that "few social scientists worked in Latin America, and only a handful of these scholars have been concerned with the field of health." The Report of the meeting also noted that "often working in professional isolation, these scholars are frequently severed from the growing literature in the field. In turn, their own endeavours in teaching and research too often remain unknown beyond national boundaries." The participants recommended that: more meetings reviewing research methods and findings be convened; liaison links be established with interested international organizations; a clearinghouse or depository of research documents be set up to be used as a general resource for this field; and training programs for graduate and post-graduate studies be developed.

Study on Medical Education in Latin America, 1967-68. Three further assessments of the field were undertaken between 1967-68. PAHO convened an expert group to review a report on the teaching of preventive medicine completed by Shepard and Roney in the United States and to consider how a comparable inquiry could be undertaken in Latin America. Based on the recommendations of this meeting, a jointly sponsored PAHO/Milbank review was undertaken of medical education in 100 schools in 21 nations between 1967-68.[26] The findings of this unique comparative review by Juan Cesar Garcia indicated that most faculties (79 percent) included some social science instruction for medical students which averaged about 44 hours of curriculum time. The majority of social science instruction was given under the aegis of preventive medicine although certain components were also included with paediatrics and psychiatry. The number of social scientists involved in this instruction was small, probably totalling under 50 individuals. The more common procedure was for social science instruction to be given by physicians.

The 1967-68 PAHO study on medical education identified the major components in the social science curriculum and the extent to which these materials were presented. The four main areas dealt with in the 100 medical schools were:

	%
. conceptos basicos	78
. etiologia y medio ambiente	58
. conducta preventiva	55
. la profesion y los servicios	39

The study concluded that: "Pocas escuelas ensenan los determinantes sociales de las enfermedades, y cuando lo hacen, es integrandolo con epidemiologia. Pocas escuelas ensenan el tema de la conducta preventiva en estado de salud y enfermeded, y cuando lo hacen, es en forma parcial, ocupando la mayor parte del tiempo en el estudio de la relacion medico - paciente. La profesion medica y los servicios de salud se tratan junto con los aspectos administrativos, y en muy pocos casos la docencia tiene un enfoque sociologico."

Esta "imagen" de las ciencias sociales como parte de la ensenanza basica y orientada a produciv cambios de actitudes y comportamientos generales, ha obstaculizado los intentos de aplicacion de estas disciplinas a la solucion de problemas medicos concretos".

In addition to the baseline information which was collected about the scope of social science instruction in the medical curriculum, the 1967-68 PAHO study was a valuable example itself involving social science principles in the analysis of a complex institution - medical education and the organization of medical faculties.

About the time that the comprehensive PAHO review of medical education started, two other assessments of the teaching of the social sciences were also completed. Between 1966-67 Rafaela Rodriguez obtained extensive information on social science instruction provided at nine of 10 Latin American schools of public health.[27] Each school included this field in its curriculum and three had autonomous departments of social science. This report found little uniformity in the concepts or the research findings presented to students. Rodriguez called for more research to be undertaken, a commitment which she

found was absent in most programs. There was a need to document the "regularidades sociales, psicologicas y culturales en las classes, y asi hacer mas concreta y practica la ensenanza de estas ciencias." She noted" "hay un gran necesidad de libros en Ciencias Sociales en las bibliotecas de las escuelas." The most crucial deficiency, however, was the shortage of social scientists who were experienced as teachers, well trained in research, and were firmly established academically to provide continuity in these efforts.

Based on a review in 1967 of social science instruction and research in the medical faculties and schools of public health in six Latin American countries, Armando Piovesan of the University of Sao Paulo confirmed the findings of other studies about the shortage of experienced social scientists working as teachers and researchers, the scarcity of studies dealing with major health problems and the difficulties in obtaining required bibliographical references.[28] Piovesan recommended among other steps the establishment of a Latin American Center of Social Sciences Applied to Health which would serve as an information clearinghouse, coordinate research materials and strengthen the field by convening meetings dealing with training and research.

Textbooks for Preventive Medicine. As part of its continuing program to strengthen the teaching of social and preventive medicine, PAHO convened working groups in 1968 and 1974 to consider the need for textbooks for this field. The 1968 Committee outlined the curriculum components for several of the subdisciplines comprising social and preventive medicine. For the social sciences the curriculum was

designated to include:

- basic concepts applied to health problems - human growth and development, learning and motivation, the family and small group behaviour, social stratification, social values and attitudes
- social etiology and social epidemiology - stress and illness behaviour, and social factors affecting the course of illness
- preventive health behaviour - concepts of health and disease, health behaviour related to health promotion programs and disease prevention, doctor-patient relations, rehabilitation, disability and death
- social-psychological aspects of medical care - the work and organization of the health professions, the organization of medical practice and health services.

The 1968 Committee's major recommendation was that textbooks be prepared which were adapted and relevant to Latin American experience. For the social sciences the Committee observed that: "no se ha preparado material para estudiantes de medicina". It recommended that a subcommittee be established to develop a program which would assist in the assembling of relevant teaching materials.

Cuenca Meeting, 1972. Following these prior meetings, PAHO initiated a series of activities intended to implement some of their recommendations. Special funding for a program to strengthen the social sciences was obtained in 1971 and a year later the first of a series of meetings was held in Cuenca, Ecuador involving 14 participants from 11 nations. The general objectives of the several meetings held between 1972-74 were:

- to prepare curriculum models for the teaching of the social sciences applied to medical problems
- to develop teaching materials
- to stimulate the development of: (i) the application of social sciences to medical problems; and (ii) the use of

research methods among social scientists working in health faculties

- to provide consultation for research studies investigating the relation of social factors and health problems
- to stimulate the development of postgraduate courses in social medicine
- to distribute and systematize research involving the social sciences under the aegis of PAHO, and to translate and circulate important documents in this field.

In 1974 PAHO convened its second working group dealing with textbooks for preventive medicine and its sub-disciplines. Since the 1955 Vina del Mar meeting, the participants noted that the concern of two decades ago with comprehensive patient care had expanded to include an emphasis on health institutions and systems which affected the provision of medical care and the dynamics of health action programs. The social sciences were listed as one of the five principal components of the preventive medicine curriculum. "Especificamente, el comite recomendo delegar al Comite de Ciencias Sociales Aplicades a la Salud la responsabilidad de la seleccion inicial de articules, asi como la preparacion de una propuesta de mecanismo de communicacion que permita el intercambio de bibliografia en esa area".

State of the Field, 1980. The stimulus provided by earlier substantial support sustained the continued expansion of the field with an increasing number of social scientists being involved in the teaching of health professions, undertaking health related research

and assuming senior academic staff posts, and on occasion, administrative positions in government programs. The broad range of these activities was exemplified in the work of social scientists who were met on a visit by subcommittee members in early 1980. These activities included:

- Faculties of Medicine. Most medical schools in Venezeula now have one or more social scientists; in 1976, 30 of the 545 professors in Brasilian departments of preventive medicine were sociologists or psychologists.

- Graduate Programs in Social Science. Both in Mexico (Universidad Autonoma Metropolitana) and Brasil (Universidad Estado de Rio de Janeiro), graduate training leading to a master's degree involve social scientist faculty members.

- National Ministries of Health/Welfare. The Venezuelan Ministry of Health employs 40 sociologists, 20 psychologists and 4 anthropologists. Its Division of Research and Evaluation is directed by a sociologist. The Venezuelan Central Office for Coordination and Planning (Cordiplan) is also headed by a social scientist. Eleven of 26 staff members are social scientists in the Planning and Development Division of the Brasilian National Council for Scientific Development. The National Institute of Nutrition Research and Social Medicine of the Ministry of Public Health of Ecuador has a complement of staff of social scientists.

- Research Institutes. A full-time staff anthropologist and social scientist consultants have contributed to the work of the Mexican Institute for Research on Medicinal Herbs; in Ecuador, the Centre for Health Research and Evaluation employs a full-time sociologist and has drawn upon social scientist consultants.

- Schools of Public Health. Most have social scientist faculty members and some have autonomous departments of social science, e.g., UNAM-Mexico; Fundaco Oswaldo Cruz - Brazil.

These examples indicate a broadening acceptance of social science in health affairs and through time their appointment to senior administration positions (e.g., Associate Dean, National School of Public Health, Oswaldo Cruz Foundation (Brazil); Director, Division of Research and Evaluation, Venezuelan Ministry of Health; or membership

(Peru) on the WHO Scientific Working Group on Social and Economic Research, Special Programme for Research and Training in Tropical Diseases).

While solid gains have been achieved in terms of the growth of social scientist manpower involved in health affairs, like some other major areas of medical scientific inquiry, a number of problems still persist and limit the potential contribution of this field, particularly in the area of its input to health research. In some other fields for instance there is no firm information about the number of basic medical scientists working in particular areas, their location and the nature of the facilities available to them. This is also now the situation relative to social science health-related manpower. It is not known accurately for instance how many social scientists are involved in research, the extent to which their training prepares them for such investigation, what their actual direct research experience is, what disciplines are involved (e.g., anthropology, social psychology, sociology, etc.) or what types of health-related research have been undertaken. In this situation when external efforts are started to initiate particular types of research on specific diseases or health problems, the existing capacity and resources to do this type of work may be unknown and a mis-matching of interests and experience can, and on occasion, does occur. The initiation of research involving the social sciences on the occurrence and control of specific tropical or parasitic diseases may presuppose that there is an interest in these issues, that social survey experience may be drawn upon in such investigation, and that staff positions providing for a continuity

of involvement have been established. Often, none of these conditions may occur.

At the present time both WHO and PAHO have established program developments and research priorities which involve the social sciences. In terms of effectively implementing these research policies involving input from the social sciences and in setting guidelines for the research to be undertaken, there is a need to know more about the capacity of existing social science manpower resources and facilities which are available to meet these objectives. If more extensive work along these lines is to be undertaken, as appears to be indicated, particularly in a number of WHO/PAHO special programmes, then a number of basic steps which would contribute to the overall strengthening and consolidation of the field are indicated. These steps include: (i) the establishing of a central register of social scientists involved in health research; (ii) an inventory listing of completed and ongoing research in this field; (iii) an apprisal of the "state of the field" of social science research related to specific health problems, e.g., primary health care; the occurrance, understanding and control of certain diseases (viz., tropical parasitic); and (iv) an assessment of the social science research methods used and which might be used (viz., social health indicators).

At the present time a substantial body of social science health related research in Latin America has emerged. While unquestionably there is a need for more financial support to expand these efforts, there is an even more overriding need to consolidate and assess what has been done and to prepare guidelines to assist the

development of this type of research in the future. There is a need for "bridging" links to be established which bring together and review such research from an international perspective. For instance, scholars who may be interested in or who might contribute effectively to certain programs may be inadvertently uninformed about them, and in turn, be unknown to those initiating them. On the site visits to some 24 teaching and research programs in 1980, only two social scientists were familiar with the program objectives of the WHO-SER Working Group under the TDR Special Program, only a few knew of the research initiated by the WHO Special Program in Human Reproduction and only one scholar was aware of WHO's concern with Traditional Medicine as a component of Primary Health Care. The absence of a register of social scientist health researchers may also mean that the full range of capable and experienced individuals may not always be turned to when externally sponsored investigation is being undertaken. On occasion, the selective support given to some groups has not accorded well with their recognition in their own nations or has involved the importing of external consultants for work which could have been handled locally.

The compartmentalization of the social sciences to deal with specific diseases or health problems entails both advantages for this type of inquiry as well as having certain drawbacks. This approach permits attention to be directed to these specific social and economic factors which may be involved in the etiology or the control of a particular disease. By this means attention may be concentrated on a number of limited factors of immediate concern and the extent to which

social participation programs may modify particular outcomes. At the present time the standard procedure is to start with a specific disease or health problem, and then to survey the research literature for studies involving an analysis of social and economic factors. An inherent dilemma in this commonly used approach is that it starts from the disease and not the people or the society where it occurs. Relevant social science research which falls outside of a particular disease or health problem listing as indexed in a bibliographical cataloguing system may remain unknown or not be drawn upon. In some instances while little direct research may have been done about the role of community participation in the control of a specific disease, parallel inquiries may be available which indicate under what conditions people participate or do not take part in a broader range of voluntary or public programs, what values are associated with the acceptance or the rejection of social innovation, and under what circumstances a sustained involvement is maintained. Likewise, more broadly guaged research findings may be available about how people in general recognize disease, who they turn to for assistance, how they use services and what influences accessibility. A balance is indicated between these two approaches, the one more disease-oriented, the other based on the existing social values and the organization of society. If the former is stressed to the exclusion of the latter it may result in "operationally manageable" research, but as a result of its "tunnel vision" it may "miss its mark" in terms of the social dynamics of how people live, what they do generally about their health care and the broader conditions affecting how health services are paid for

and provided.

The reviews of social science health research initiated in the past decade by WHO, other international agencies and some university and research centres constitute a useful start in documenting what has been done. However, throughout these several reports there is a constant theme stressing the need for a more detailed and analytical assessment of this work. Each of the available compilations is incomplete in its scope and no thorough review has been done which assesses the concepts and the methods of these inquiries, or the utility of the findings to specific health problems.

The scope of the social science health research being done by 1980 had evolved to include a broad range of health problems dealing with basic social values and social and economic factors associated with the occurrence of specific diseases to a consideration of the organization of health systems. The initial emphasis upon ethno-methodological and anthropological types of inquiry is now complemented by a more extensive use of social survey research techniques, the development and use of scaled social health indicators and detailed studies of the use and provision of health services. At the present time no central coordinating focus brings together this sizeable reservoir of research findings or methodologies.

(J.C. Garcia to add materials on a synopsis from the biblographical listing).

In 1980 unlike a quarter of a century earlier it is no longer a question of whether the social sciences appled to health research

will or will not be supported by international agencies, universities and the governments of member countries. That decision appears to have been answered firmly and positively. But the issue which has not been so directly dealt with is how such assistance can be most effectively provided to these emerging disciplines involved in health research.

Program Support for Social Science Health Research

Based upon its review of social science health research in Latin America the ACMR Subcommittee proposes that support be given here over a period of years in terms of a general framework of development. The short-term objectives listed include means to foster the co-ordination, the consolidation and a review of these research activities. Upon the completion of these preliminary steps, consideration could then be given to a number of long-term objectives. The Subcommittee lists a number of long range objectives which would be subject to modification or extension as the work proceeded based upon the initial review.

Four steps are proposed for consideration under the Short Term Objectives with their completion to be scheduled within the two years (1980-82). These steps are the establishment of: (1) An Advisory Committee on Social Science Health Research; (2) Strengthening the Position of the PAHO Officer Responsible for Social Science Training and Research; (3) Development of a Social Science Health Research Bibliography for Latin America; and (4) An Evaluation of Research Methods used in the Analysis of 2-3 Designated Diseases or Health Problems.

Based on the work carried out to meet the short-term objectives, consideration could be given to the feasibility of implementing a number of long-term objectives which would include: (5) the preparation of a Directory of Social Scientist Health Researchers; (6) the Preparation and Distribution of Research Bibliographies; (7) the establishing of Depositories of Research Reports; (8) the review of Social

Health Indicators; and (9) the use of Social Science Research Consultants.

I. Short-Term Objectives

1. Advisory Committee on Social Science Health Training and Research. At the present time there is no central review body within PAHO which is charged specifically with the development and the review of the diverse social science activities in training and research which are now supported. The need for such co-ordination has been recommended in several reports. The establishment of a designated Advisory Committee would provide an external, prestigious and informed resource which is now not available. Based on the site visits to some programs in 1980 it is apparent that there were some contrasting perspectives about the role of international agencies involved in the support of the social sciences. In some quarters for instance it is felt that PAHO had a sizeable research funding capacity, a situation which does not obtain. Questions have also been raised about the basis for the assignment of existing research funds with the terms set for such review not being well known. The establishment of an Advisory Committee would be a positive step in assisting the social science activities of PAHO and serving as an external "sounding board" in the review of specific programs.

In the area of training fellowships the Advisory Committee's responsibilities could include the review of policies and guidelines for support provided to the social sciences. Among the matters to be considered could be: designation of review criteria for each category of fellowship; the balance to be achieved between pre and post doctoral

support; a consideration of the allocation between sub disciplinary fields (e.g., anthropology, social psychology, sociology, etc.); the identification of outstanding training programs in Latin America and elsewhere; the establishing of curriculum training standards for pre and post doctoral studies (e.g., course categories, dissertation requirements, etc.); consideration of the number of fellowships required; the intra-regional distribution of fellowships; and the balance between training fellowships, travel awards, and faculty exchange programs.

The membership of the Advisory Committee should include distinguished researchers representing the social sciences and the health professions. This Advisory Committee could be struck to report directly to the ACMR. Its specific functions would include: a review of guidelines and policies for PAHO training and research programs for the social sciences; serving as an external review body for research grants for these fields; and the preparation of annual reports to the ACMR on the state of the field.

2. PAHO Officer Responsible for Social Science Training and Research. Between 1966-68 PAHO appointed on a pilot basis a social scientist to its Headquarter's staff. Since 1968, this position has been incorporated as a full-time staff position. The activities undertaken under this aegis by PAHO have been listed. They represent a sizeable commitment and much valuable technical assistance has been provided. Most of the emphasis in the past has been to foster training programs for social scientists attached to health professional faculties, the development of model curriculae, and the dissemination of relevant literature. To a much lesser extent attention has been given

to the direct fostering of social science health research in Latin America.

The Budget Estimates listed for the next four years (1980-83) indicate the balance of program priorities set for Education and Research in the Social Sciences Applied to Health.[29] The AMRO - 8970 budget listing specifies:

		1980-81	1982-83
Total	PR	181,000	201,400
Personnel - posts		149,200	170,400
Personnel - consultants		10,800	10,400
Staff Duty Travel		10,000	10,000
Contractual Services		11,000	10,600

The statement of program objectives stipulated for the social sciences between 1980-83 was:

> "This project is primarily designed to assist the Member Countries in promoting and conducting research on the social factors involved in the occurence and distribution of diseases as well as those that aid or hinder the extension of health services, the incorporation of social sciences into the training of health personnel, and the organization and conduct of post-graduate studies in social medicine.
>
> A large part of the cooperation in 1979 will be focussed on a study of the impact of research on the health field, including the collection and publication of information on researcher workers, research institutes and on-going projects in Latin American countries."

The Working Group endorses this statement of program objectives. However, it believes that if a substantial effort is to be launched in strengthening the component of social science health research, then additional financial resources need to be assigned for this purpose.

For the two fiscal years, 1980 and 1981, a maximum of $11,000 or 6.1 percent of the assigned budget, is available for contractual services, and a total of $10,800 or 5.9 percent of the assigned budget for consultants. If both of these budget line categories were to be designated only to assist in promoting and conducting research, they would represent 12.0 percent of the assigned budget (or a total of $10,900 each year for 1980 and 1981).

Pending the consideration of the Working Group's Report to the ACMR and the decisions then reached, these assigned funds would appear to permit only a modest commitment to be made in strengthening social science health research. The Working Group strongly and unanimously recommends that consideration be given to augmenting substantially these budget categories for the years 1980-83.

The full-time position of a PAHO staff officer responsible for Education and Research in the Social Sciences Applied to Health is indispensable to the general development of this field. This position is integral to the ongoing collation of program information about training and research involving the social sciences, the development of a research bibliography, the planning and convening of research evaluation seminars and, in general, to keeping informed about current activities in the Americas. If the recommendation concerning the appointment of an Advisory Committee is endorsed, this PAHO staff officer would serve as the principal program co-ordinator for the Committee's activities.

3. Development of Research Bibliography. The mandate set for the ACMR Subcommittee in June 1979 dealt specifically with the place

of social health indicators in health research, the methodologies used and their potential application. In the initial review of the work to be done it became clear that before such an assessment was feasible, several prior steps were required which involved assembling information about the extent and the types of research which had been done. This work started on a preliminary and pilot basis indicated the feasibility of developing a more comprehensive and stadardized listing. Much of what is done tends to fall between the established classificatory systems or is published in not readily retrieved sources. The valuable indexing of health research for Latin America undertaken by BIREME for instance documents the references listed in the major medical and scientific journals in the Region and elsewhere. By definition, these sources are unlikely to contain much work representing social science-oriented health research. In its first volume (January-July 1979) this source listed: one article on health services' research; one article on traditional medicine; two articles on the health of Latin American Indian peoples; and seven articles listing some form of socio-economic analysis of health care. Likewise, some of the standard social science and health texts list studies done in the United States, Great Britain or Europe. For example only 18 or 2286 references in Freeman's Handbook of Medical Sociology or 6 of 795 references in Mechanic's Medical Sociology refer to studies involving Latin America, and of these citations, virtually all were written by non-resident scholars.

Based on visits to a number of major training and research centers there appears to be a strong and widespread interest among both social scientists and medical researchers in the compilation and

the circulation of a research bibliography of Latin American studies. Undertaken by PAHO staff in conjunction with the Advisory Committee's counsel, this work would involve:

(i) Compilation of Existing Sources. A preliminary search during 1979-80 was facilitated by the PAHO Headquarters' Library, BIREME, the contributions of a number of researchers and the assignment by PAHO of a temporary staff position. Standard medical and social science bibliographical sources were drawn upon and these materials have been augmented by listings of major manuscripts, special reports and graduate research dissertations. Most of these assembled materials have not yet been classified or annotated. The Subcommittee recommends that this work be extended and continued during 1980-81.

(ii) Classification. As different listings are used in medical and social science research, no uniform classification codes have evolved for social science health research. The assistance of librarians specializing in the codification of references is needed to develop an information listing and retrieval system which is congruent with existing schemes and reflects reliably the major substantive areas.

(iii) Annotation. Following the more extensive compilation and the initial review of a system of classification, the annotation of the major research reports should be undertaken. The counsel of the Advisory Committee would be useful in developing a uniform basis for this annotation, e.g., major concepts dealt with; types of health problems or diseases; sources of information; questions asked or hypotheses; research methods used; major findings obtained, etc.

(iv) Computerized Listing. Facilities for the computerized

listing and retrieval of bibliographical references are established at PAHO Headquarters Library, BIREME and some major universities. Some of the materials already obtained have been entered into this system on a trial basis. As more references are assembled, special social science health research discs can be assigned which provide an efficient and economical means of information storage and retrieval. Information contained here can be provided on a computer printout basis to meet specific requests and these sources can be continually updated.

4. Research Evaluation Workshops. Pending a more complete compilation of social science health research, on the basis of what is now available it is apparent that several broad categories of health problems have been studied by social scientists. These include: primary health care; traditional medicine; social epidemiology relating to specific diseases; the utilization of health services; community participation; work and health; and the organization and provision of health services. Upon the completion of the general research bibliography, one or more small interdisciplinary workshops could be convened to evaluate the research which had been done in terms of: the concepts and research methods used; the questions asked; the utility of the work done; and to develop research protocols for work to be done in the future. Stemming from the reviews made by these workshops, research review articles could be prepared which could be published in widely circulated publications such as the PAHO Bulletin or as a series of short monographs, could be assembled and would summarize the current state of knowledge about social and economic

factors related, for instance, to specific tropical or parasitic diseases or other issues. Drawing upon an interdisciplinary evaluation, these reviews could serve to stimulate further inquiry into areas which correspond to priorities established by WHO/PAHO and serve as a means to pinpoint areas meriting further analysis. Unlike a negative grants review procedure, these reviews could be a positive means of mounting strongly based interdisciplinary inquiries through the development of demonstration research protocols.

II. Long-Term Objectives

The following points are listed by the Working Group as further ways that social science health research could be strengthened in the future. They are not presented at this time as recommendations but rather as matters whose feasiblity and utility could be considered by an Advisory Committee if such a body is established. In the Working Group's judgment these steps are not costly, and their implementation would serve to consolidate and disseminate the social science health research which is being done.

5. Directory of Social Scientist Health Researchers. No listing has been established of Latin American social scientists involved in health research. The establishing of a directory of this group (which would not be sizeable) would serve two purposes. First, it would facilitate the more widespread circulation of materials to potential users; and secondly, this source could be drawn upon as a means of updating annually the bibliographical listing of social science health research. Through this process the referencing system maintained by BEREME would become more useful to researchers dealing with these

issues and in turn would be seen to be a useful resource. This does not now appear to be the case. Since it was established, BIREME has not received requests for studies dealing with psychological reviews, socioeconomic research or health promotion.

6. Preparation and Distribution of Research Bibliographies. One of the major problems cited in appraisals of the field is the issue of convenient and direct access to relevant research sources. To resolve this problem the Advisory Committee may consider a number of feasible steps which include the preparation of special purpose bibliographies, their circulation, and the establishment of research report depositories.

The efficient offset rotoprinting system linked to its computerized bibliographical listings now maintained by BIREME makes it feasible to produce quickly and economically bibliographies dealing with special research issues. This system could be adapted to the preparation of annotated social science health research bibliographies dealing with specific diseases or health problems. The availability of these especially prepared bibliographies could be listed in the volumes published by BIREME and provided to major Latin American libraries and research centres.

7. Depositories of Research Reports. Even if relevant research references may be known, direct access to these materials may be difficult due to the limited reference holdings of many libraries. This situation extends to the listing of the addresses of researchers or journals which might be contacted to obtain copies of reports. One step which it may be useful to consider in the future

would be the actual assembling of the major research documents as original materials, copies or on microfilm. By means of external technical assistance programs, depositories of these research materials could be provided to major university, research institute and government programs involved in social science health research.

8. Social Health Indicators. In recent years considerable attention has been paid to the development of social health indicators which can be used to assess, inter alia: different aspects of health behaviour; patient-therapist communication; health values and attitudes; social and economic circumstances; social risk factors related to health, work and employment status; the use and accessibility to health services; and factors involved in individual and community participation. A general listing of health indicators including social health measures is compiled by the Clearinghouse on Health Indexes, U.S. Public Health Service.[30] In addition, a detailed appraisal of the concepts and methods involved in a number of widely used social health indicators was completed by Elinson, Mooney and Siegmann in 1977.[31]

At the present pending the completion of the Social Science Health Research Bibliography, no accurate assessment can be given of the current use of social health indicators in this type of research in Latin America. A review along these lines and a consideration of their potential use could be appropriately undertaken in the more detailed reviews which are recommended of available social science research dealing with specific diseases or health problems. In the Working Group's judgment there is considerable potential here to extend

the scope of the analysis now being done. As is the case for the general situation of this field in Latin America, a persistent dilemma is the absence of an accessible source of information about the full range of potential analytical tools, and how they are used and analyzed. Requests for such information were made at some of the research centers which were visited.

As the general work consolidating social science health research proceeds, consideration could be given by the Advisory Committee to several steps relating to research use of social health indicators. These could include: (i) a consideration of their current and potential use in research relating to specific diseases or health problems; (ii) the assembling of a depository of the details of the methods used, e.g., what measures are used, how information is obtained and analyzed; and (iii) the publication of a listing of the social health indicators and how copies of these materials may be obtained in the PAHO Bulletin with a depository established at the PAHO Headquarters Library.

9. Social Science Research Consultants. A broad diversity of social science research methods has evolved in recent years. Particularly in the analysis of statistical findings, a number of specialized procedures have been developed in the classification and definition of commonly used terms in social and community health surveys, the measures used to assess social and economic conditions, scales to assess attitudes and values, the extension of social health indicators and the adoption of statistical computer packages designed for social science inquiries. While these tools have not yet been

extensively used in social science health research in Latin America, it is apparent that there is a growing momentum along these lines which parallels the more widespread use of quantitative social survey research techniques adopted in North America and Europe. This type of social science analysis is complementary to the type of research used in epidemiology and medical research which incorporates statistical analysis, careful attention to sampling and controls and the operational definition of terms. It is still the exception rather than the rule for social scientists being trained in Latin America to have a grounding in multivariate probability statistics, computer programming or actual experience in large-scale social or community health surveys. In a number of instances where extensive sources of relevant secondary statistical data are available, their use by social scientists is partially precluded due to a lack of familiarity with the appropriate analytical procedures. In some of the work being done there is an unnecessary duplication of effort devoted to the design of surveys or the operational definition of items where substantial comparable work has already been completed elsewhere.

At a number of centers conducting social science health research visited in 1980, the question was raised of the possibility of WHO/PAHO providing short-term external consultants who could work with researchers in the design and the analysis of their research. The principle of providing such support has been adopted in facilitating social science research being fostered under some of WHO's Special Programmes. An extension of this principle to augment this field in Latin America, when such assistance is requested, merits consideration by the Advisory Committee.

Summary of Recommendations and Long-Term Program Objectives

This Report of the ACMR Working Group appointed at the XVIII Meeting in 1979 concludes that a strengthening by PAHO in the area of social science health research is feasible, not costly, and warranted. Technical assistance along these lines would be congruent with achieving a number of program priorities established for the 1980's by WHO/PAHO.

The Working Group submits four recommendations for immediate consideration and five matters for review in the future as part of an integrated strategy for the development and the strengthening of social science health research in Latin America. The first two recommendations relate to the administration by PAHO of this program through the establishing of an Advisory Committee and a reinforcing of the resources assigned by PAHO for these purposes. Recommendations Three and Four and the five long-term objectives are listed as specific ways that may be considered to develop these efforts. In summary, the program recommended by the Working Group includes:

I. Recommendations

1. Establishing an Advisory Committee on Social Science Training and Health Research.

> That the responsibilities of the ACMR Working Group be redefined as an Advisory Committee on Social Science Training and Health Research. The functions of this Advisory Committee reporting to the ACMR would be to serve as a senior external advisory group concerning the social science activities undertaken by PAHO, to develop policies and guidelines concerning training fellowships and research submission in this field, and to seek ways

to foster the general strengthening of social science health research. The Advisory Committee would report annually on its work to the ACMR.

2. Strengthening Resources Assigned to the PAHO Officer Responsible for Social Science Training and Research.

That to coordinate and to keep informed about the wide range of social science health related activities undertaken by WHO/PAHO, international agencies and the member nations in the Region, and to provide the necessary secretariat support for the Advisory Committee, the resources and facilities assigned to the PAHO staff officer responsible for the social sciences be substantially strengthened.

3. Development of Research Inventory

That the Advisory Committee during 1980-81 be responsible for the further development of the social science health research inventory.

4. Research Evaluation Workshops

That the Advisory Committee during 1980-81 be responsible for the convening of one or more interdisciplinary specialist working parties to review research related to specific health problems.

II. Long-Term Objectives

5. Directory of Social Scientist Health Researchers.

That a directory of Latin American social scientists involved in health research be established as a means of more widely distributing reports and of maintaining an ongoing inventory of current research.

6. Preparation and Distribution of Research Bibliographies.

That under the aegis of BIREME annotated social science health research bibliographies be prepared dealing with specific diseases or health problems, be listed in BIREME's index of medical research, and made available to major libraries and research centres in the Region.

7. Depositories of Research Reports.

That major social science health research documents be assembled, and by means of external technical assistance, depositories of these materials be established at major university, research institute and government programs involved in social science health research.

8. Social Health Indicators.

That a review of current social health indicators be undertaken considering their actual and potential use relative to research dealing with specific diseases or health problems, a PAHO depository of these measures be established as a general resource for investigators, and a publication listing these measures be undertaken.

9. Social Science Research Consultants.

That active consideration be given to providing short-term consultants to assist in the design and analysis of proposed or ongoing social science health research, where such assistance is requested.

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