

WORLD HEALTH  
ORGANIZATIONORGANISATION MONDIALE  
DE LA SANTÉ

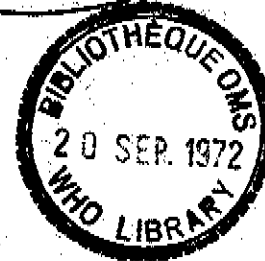
15 January 1952

RD/6/3

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## PROGRAMME PLANNING AND EVALUATION

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## I. THE SCOPE OF WHO

"Above all WHO must assist governments to ascertain the kind of assistance which can be absorbed by their countries and the pace at which they can absorb it, constantly emphasizing the close relationship of health and disease with economic and social conditions."<sup>1</sup>

There is hardly a document that expresses general policies or principles that does not contain the above or a comparable statement of the major task before WHO. Consistently and emphatically the nature of the broad purpose is repeated again and again.

In its earlier undertakings WHO selected and concentrated upon programmes that are regarded as traditional in public health practice, i.e., communicable disease control (malaria, tuberculosis, venereal diseases), maternal and child health, sanitation and public health organization. The selections cannot be criticized; each is important, each is firmly and safely anchored to the past experience and the past achievements of public health. However, it is a significant fact that the full purpose of WHO was neither fixed nor submerged by the traditional activities; from the very beginning of its work the process of expansion began.

The expansion highlights a conflict that is current in health work in many parts of the world. It is the familiar conflict between the past and the future, between a relatively narrow and restricting interpretation of the work of public health and the limitless possibilities of broad attacks on the total problem of

<sup>1</sup> Work of WHO, 1950. Annual Report of the Director-General, Off. Rec. World Health Org. 30, p.2 (under-scoring added).

health. The evidence of the conflict is seen in many countries where health activities, growing perforce in accordance with new scientific knowledge and the awareness of problems, have taken root in many national agencies other than the official health departments or health ministries.

It is in this light that the inclusive purpose of WHO, translated into action in the field, becomes immeasurably significant. In effect, WHO in its objectives and its programmes presents a new and realistic concept of what constitutes a health problem. None of the older definitions, and certainly no definition that emphasizes the artificial division between preventive and curative medicine, is broad enough to contain its work and its growth. Out of that work and growth a new definition emerges. A health problem is one where:

- (a) There is a condition or situation that results or may result in widespread mortality, morbidity,<sup>2</sup> or both;
- (b) Relative to the condition or situation there is a body of scientific knowledge<sup>3</sup> which, if applied, would result in prevention, cure or amelioration;
- (c) The scientific knowledge is not being applied or is being applied inadequately.

These are the "specifications" that, appearing anywhere in the world, arouse and attract the interest of WHO. The solutions of particular problems may be relatively simple and immediate; they may be complex and extended over a period of generations. But the specifications give to WHO a distinctive position as a health agency, flexible in its programme, adjustable to the advances of science, growing in accordance with the greater understanding of the meaning of health in any national culture. Whether it is a mission to improve medical education, the provision of personnel and facilities to introduce anaesthesiology or thoracic surgery, the development of an international pharmacopoeia, the improvement of work in maternal and child health, malaria control, etc. - all these and many more activities are accepted as falling within the province and the responsibilities of WHO "to improve physical, mental and social well-being".

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<sup>2</sup> Physical or psychological

<sup>3</sup> Biological, social or other.

## II. THE FORMATIVE PERIOD

During the formative period of WHO, and it is by no means completed, two major pressures influenced the policies and the work. The first need was the development of an organization, a structure, to carry out the functions and duties. Though the earlier emphasis was on an organization more or less centralized, in a short time the process of decentralization began. Much remains to be done in perfecting the organization but, thus far, six Regional Offices have been established in accordance with the principle that health work must be planned and performed in intimate association with national governments and their populations. One other step in the process of decentralization will be presented subsequently.

Concurrent with the pressure to develop a functioning organization was the even greater pressure to initiate actual work in the field. Thus, during the formative period many of the projects undertaken were selected and started in an atmosphere of emergency. The tasks were huge, the work had to begin and available funds had to be expended, if only as a demonstration of pressing need. Under the circumstances it was predictable and it should be accepted as a matter of course, that a curious and prevalent characteristic of health promotion should exhibit itself.

Among a large percentage of professional health personnel the principle is accepted that all health work is good. There are differing opinions about the relative values of specific activities, the opinions being based on the particular interests of those who differ. But, underlying the whole effort is the concept that health work, per se, is good.

The attitude provides a strong cohesive influence within health agencies and an enthusiasm for whatever is being done. But where, as has happened in many health agencies, it becomes too prominent, it endangers both the current work and the future objectives. The danger shows itself when health work in any special field or in all fields is equated with health progress, when intensive motion or the mere multiplication of health activities is confused with real and lasting achievement.

For example, it may be a very satisfying achievement to report that smallpox has been controlled among a million people, or that an anti-malaria campaign has doubled the work capacity of 100,000 people. When the rest of the story is told - that smallpox is not an immediate threat to a million people living in semi-starvation;

that malaria control has doubled the days of unavailable work - the real significance of the achievements, or the real gains in physical, mental and social well-being diminish.

There is no intention in the above to deflate the value of any aspect of health work. What is being stressed is the principle, so often endorsed and too seldom applied, that health is a complex of many factors - biological, economic, social, political, and others. In short, what cannot be over-stressed is the broad policy adopted and re-affirmed by the Assembly and repeated many times in the actions of the Board of Directors and the Executives of WHO.

Fortunately, there are certain influences that counteract what has been described as "a curious and prevalent characteristic of health promotion". In the case of WHO, the programmes and the progress are under the scrutiny of those who are competent to raise questions and render judgments. These include many members of the Assembly and the Regional Committees, to say nothing of health workers around the world. But far more important is the influence of a rising critical analysis of their own work and their own accomplishments by members of the WHO staff.

The evidence of such analysis and critical thinking is as unmistakable as it is healthy. It pervades the whole subject of future programme planning at Headquarters and in the Regional Offices. And there is adequate evidence, too, that the same influences are at work in the field. As an example, the recent report of a completed project merits attention.<sup>4</sup>

Simla, India, was selected as a venereal disease demonstration area because "it was estimated highly infected, although there were hardly any statistics of venereal disease available then".<sup>5</sup> The purposes of the programme were to survey the area, demonstrate control measures, further public education and train personnel. The project was started in 1949, which was a period of pressure. While the report is not presented or discussed as a cross-section example of past or current venereal disease activities, it is impressive because of its general bearing on certain of the current problems of WHO. Too, the project was selected for description in *The Work of WHO, 1950*.<sup>6</sup>

<sup>4</sup> WHO VD Demonstration Team, Simla, India, Annual Report, June 1950-May 1951

<sup>5</sup> *Ibid*, p.7

<sup>6</sup> *Work of WHO, 1950, Off.Rec.World Hlth Org.* 30, p.104

A notable feature of the report is a series of "suggestions" that compress the experience of more than two years in the field. Certain of the suggestions follow:

1. Duration of a VD Demonstration Team

"It is suggested that the duration period of a WHO VD team in an area should not be longer than one year."<sup>7</sup>

The suggestion excites many questions; apparently those who prepared the report either felt or they have supporting evidence that after the first year the diminished returns are not commensurate with the expenditures of efforts and funds.

2. Continuation of VD Work

"It is suggested that the future stability and continuity of a WHO programme in an area should be fully discussed prior to the establishment of an International Team. If no such programme is planned beforehand to carry out the future activities, the initial gains and efforts will be lost very soon thereafter."<sup>8</sup>

The suggestion goes to the very centre of WHO policy. It is true that full discussions and agreements are described as a part of WHO planning. But here is a project ending 31 August 1951 where, according to the report, the agreement was not clear. The reasons for the suggestion are not given, but perhaps there is a clue in the Monthly Progress Report of Regional Activities during August 1951 (No.28). The WHO personnel on the Simla Team included a chief medical adviser, a serologist, a public health nurse and a health educator. The Progress Report states (p.41) that the "training course at Simla ended 31 August. Work of the international team is to be wound up. The Himachal Pradesh Government have posted a serologist and clinician to take over the work on the withdrawal of the team."

<sup>7</sup> Simla VD Report, p.40

<sup>8</sup> Simla VD Report, p.40

3. VD included in other Public Health Programmes

"It is suggested that in areas where there are great needs for general health measures, VD activities should not be carried out in an isolated way, but as a part of general public health campaigns simultaneously with maternal and child health programmes."<sup>9</sup>

Again a suggestion is in conformity with the most fundamental tenet of health promotion. As an extension of this principle another suggestion states that "facilities for treatment of general cases should be provided by the VD Demonstration Team during the field surveys, as a high percentage of the population whose blood is negative otherwise, demands consultation and treatment for other than venereal diseases". Here is further evidence of the confusion created in the public mind by the arbitrary divisions of health activities. To the public, regardless of geographical location or the state of literacy, such sharp divisions of "health" into many minute and, by declaration, independent and exclusive components, is a physiological absurdity. Nowhere is the absurdity more glaring than in the welcome accorded "well babies" and the rejection of "sick babies", a prevalent practice in many health agencies.

The above report is only one example of many critical reviews expressed by field staff. Throughout the organization there is much evidence that a "tightening" process in the selection of projects is at work and much more attention is being given to the adequate justification of those projects that are recommended. In a later section on programme planning and evaluation (V), project selection will be considered further.

III. BALANCED NATIONAL DEVELOPMENT

When WHO stresses "the close relationship between health and disease and social and economic conditions", and, further, urges "balance in the development of national health services", what is meant? While the words serve as a general directive they also contain an admonition. The "close relationship" means that health activities cannot be developed successfully and grow as a force in human betterment in a sterile social and economic soil. Just as industry accepts the

<sup>9</sup> Ibid, p.42

fact that it must operate under a certain "irreducible overhead", so must health promotion face the fact that it requires a certain irreducible economic foundation if it is to build successful and lasting health programmes.

The reference to balance lends itself to a number of interpretations. It may mean balance of an internal type, i.e., the balance sought when maternal and child health are attached to malaria control through the medium of a nurse, or when another health activity is added to an array of projects to "round out" a programme in a specific country. How the awareness of balance in this sense is transformed into effective action calls for critical study. Little can be said for a policy of balance based on a fixed formula regardless of the relative needs and resources of different countries.

There is a second and more important meaning, however, that seems to be conveyed by the reference. It directs attention to the ability of a nation to absorb and continue what has been started by the aid that it has received. In effect, those who initiate and develop projects are warned that a nation, like an individual, may make unwise commitments and, ultimately, suffer from the results of too much or the wrong kind of instalment buying. Balance is not achieved by guess; neither is it reached by the transfer of a pattern of health service from one country to another, nor by the sheer weight of many projects supported by many sources of funds.

The recommendation is repeated many times in WHO documents that national surveys are vital to the delineation of health problems and, through the establishment of priorities, an orderly and balanced approach toward their solution. The point must be stressed, however, that in the light of the emphasis on the relationship of health, social and economic matters, such a survey cannot be made by those whose interests and vision of health are limited to one facet, the biologic. What are the values of learning, for example, that tuberculosis has a mortality rate of 250 per 100,000 people, that existing clinical facilities for its diagnosis must be multiplied 100 times, and that tuberculosis beds should be multiplied 25 times? Or, that a nation needs many more physicians, many more nurses, many more of all other types of health personnel and many multiplications of existing facilities and supplies? Yet these are the subjects that make up the major part of the usual health survey. Unrelated to social, economic and

political feasibility, with little attachment to the specific cultural possibilities and limitations, based upon standards that are often remote from the time and place of their proposed application, too many health surveys present frightening "ideals".

A new type of health survey is needed. One of the greatest contributions to orderly planning and orderly progress lies in the development of a pattern of national study by WHO, and the logical place to begin the development is in the Division of Organization of Public Health Services of the Department of Advisory Services.

To plan for the improvement of health in a specific country requires the collection of many types of information not usually considered within the province of health surveys of the past. Aside from the vital subjects of governmental structure, national income, national expenditures and the level of living, what are the agricultural plans that are being projected and how, as these plans develop, may health work accompany and grow with them? What is the educational situation and what are the plans for increasing the number of persons who will receive secondary and higher education? Until those plans become effected it may be hopeless to speak of "improving standards" of professional education. What are the facilities for communication and what are the plans for improving the accessibility of communities? Again, health plans may be geared to the development of roads and other means of communication. There is hardly a governmental activity that may not play a rôle in the long-range and solid plans to improve the health of a people.

What is being said does not visualize a national study by a mission of specialists. To suggest that type of study would be the equivalent of recommending that WHO become a survey-organization. When it is suggested that a health survey give attention to education, transportation, finance, welfare, agriculture, etc., it is not implied that the study will produce recommendations and plans covering these activities. Once that point is clarified the survey may be viewed in its proper perspective, i.e., a gathering of the pertinent facts that have a bearing on long-range plans to improve health. And the standards developed will be the standards for that country. As matters now stand, the problem of balance based on planning presents the greatest gap between a principle adopted by the Assembly

and its application in the member countries. Many of the existing problems of WHO have their origin in this gap.

The content of the health survey needs to be defined clearly. It is suggested, as one method, that consideration be given to the possibilities of inviting selected schools of public health to develop the new type of survey. Since schools of public health can draw upon other specialists in a University or other agencies close at hand, there would be reasonable assurance of the technical soundness of the content. Once their task is completed, and six months should be the limit, the chairman of each group might be asked to come to Geneva for a month of intensive work with the Division of Organization of Public Health Services in order to prepare the final document to be tested in the field.

How the survey would be made is another important consideration. Final judgment must be left open, since it is fairly certain that the method would vary in different countries. The most desirable method would be one where the Ministry of Health, in close association with a representative of WHO, made the survey and developed the long-range plans. Once the plans are formulated subsequent reviews might be made at intervals of three or five years.

One other valuable product of the survey and the plan should be mentioned. Governments are subject to change and when health programmes are vague they may be changed as often as a new government assumes control. The very existence of a health survey and a health plan gives fair assurance of stability and lends continuity to programmes that are a part of the plan.

#### IV. CO-ORDINATION OF HEALTH ACTIVITIES

The subject of co-ordination is not a specific part of this consultant's assignment. But, since the subject persists in obtruding itself, some observations cannot be avoided in any discussion of programme planning and evaluation.

Closely related to the national studies and firm health plans that contribute to balanced development is an orderly process whereby sources of support are integrated. Everyone agrees about the desirability of co-ordination; to disagree would be an endorsement of confusion. But, thus far, the search for an automatic and democratic mechanism to ensure co-ordination has met with small success.

Formal and informal committees and councils have been organized with too little effect on co-ordination in any real sense.

Perhaps the lack of co-ordination among international agencies of all types, UN, bilateral, multilateral, is a common characteristic of such agencies. In health work it appears to be particularly prevalent because so many agencies whose primary purpose is not health promotion engage in health activities of one type or another. Apparently health is one desirable and beckoning path by which many agencies may progress to achieve their purposes. This is a cheering fact to those whose primary function is health promotion, but at the same time the existence of many agencies, each with its own purposes, policies and methods, engenders confusion.

Little is to be gained by describing the numerous examples of what appear to be competition or conflict between agencies. In many cases the apparent competition arises from a complete unawareness on the part of one organization of what another is doing. Nor is it realistic to hope that a country needing aid will not seek it from the source that will provide it at the least financial cost to the country, even though real needs must at times be adjusted to fit the policy of the contributing agency.

It has been said many times that co-ordination is a problem that must be solved in the countries. No-one can argue with this statement about the ultimate solution. Yet, those who work in the countries are the representatives of international agencies. The will to co-ordinate starts at the top; little is accomplished when statements from the top emphasize the desirability of co-ordination but leave virtually the whole matter to personal judgments and interpretations at the bottom.

The search for more successful methods of co-ordination will go on, with WHO as a participant. Meanwhile, however, there is a more direct attack on this as well as certain other problems facing WHO. That attack was indicated in the previous comments concerning the process of decentralization.

## V. REGIONAL DECENTRALIZATION

The organization of six Regional Offices was in recognition of the dual nature of the work of WHO. Certain of the functions, being international, can be performed best by a strong central organization. Other programmes, though they may start centrally with a very strong impulse, lose much of their power and force by the time they reach the nations and their people. While centralization v. decentralization is an issue as old as public administration, health work has a history of progress as it has moved from central offices to where the people live.

In the organization of WHO, six Regional Offices do not solve the problem of decentralization. The Offices merely reduce distance from many thousands of miles to a few thousands or hundreds of miles. As far as the individual countries in an area are concerned, the Regional Office is an example of central authority and central administration. In the Americas, the attempt to further decentralize takes the form of zonal offices. Moreover, as a move to meet the problem generally, countries may request the services of WHO Advisers. Both of these actions give recognition to the fact that the leadership and the strength of WHO are dependent on clear and strong lines of communication and action between the countries, the Regional Offices, and Headquarters.

Health promotion is a day-to-day, on-the-job activity. It does not lend itself to sporadic visits and efforts. The need to place national representatives of WHO, via the Regional Offices, in many countries of the world is pressing. This is not to say that one pattern of WHO organization would fit all of the regions, or all parts of a region. Obviously, there are countries so small in area or population, that a combination of two or more would meet the need. Obviously too, there are financial considerations that must be taken into account. And on this subject it should be noted that where professional plans are clear and professional purposes are sharply apparent, finance is usually more than cooperative.

To require a country to make a formal request for an adviser is to create, in many instances, insurmountable obstacles. The word has a bad connotation; likewise the words "expert" and "consultant". On the other hand, to establish a Liaison Office and a Liaison Officer describes the real purposes of two-way communication and two-way action.

A. The Liaison Officer

Work in the field of international health and especially work with WHO demands special qualifications. Neither the academic training now available nor experience outside of international health qualify a man to serve as Liaison Officer. Grant that a man is fully qualified in the technical aspects of health work, that as a general health "practitioner" he is not uninformed with respect to tuberculosis and malaria control, maternal and child health, medical education, etc. As a Liaison Officer he must have much more if his work is to be effective. In the country where he functions he must know the governmental structure and the political developments; he must know the customs, the traditions and the beliefs of the people - those qualities that are such a vital part of the culture; he must know all the international agencies that are or might be working in the country - their programmes, their policies, their methods and how they might be utilized in health promotion. These are in addition to the personal and personable qualities necessary in all human associations.

Considering the above requirements there is only grim humour in the thought that a man subjected to a "briefing" period of two or three weeks is prepared for the tasks before him. It is a tribute to human adjustment that, in many cases, knowing so little he does so well. Or perhaps it is a tribute to the kindness and understanding of those with whom he works.

The recruitment of satisfactory staff is a major problem throughout all health agencies, and especially so for international work. "Send me men to match my problems" expresses a plea that is common to all Regional Directors. In general, for positions of responsibility - and the position of Liaison Officer is of that order - the recruitment has centred upon those whose reputations have been made. But often in the process they have lost a measure of the flexibility, the adjustment and the vigour that contributed to their rise. To recruit those with established reputations is the easy and the fairly safe course. What is needed is a more intensive and effective recruitment to bring in young men who will make their reputations in international health work?

With a working representative of WHO in a country it becomes possible to weave together so many of the loose ends of planning and progress. Given the pattern of the new type of study mentioned in Section III, it would be his responsibility to motivate, through his own work and his associations, the development of long-range plans for the country. His interest is in health and if it so happens that the health activities of a nation are the divided responsibilities of many national agencies, his latitude of work should be broad enough so that he serves as a cohesive influence.

Such a representative of WHO offers new and hopeful possibilities that the problem of co-ordination may be attacked with much more success. Starting with the fair assumption that discord in planning and conflict in projects are not intentional and wilful, that no agency chooses to duplicate the work of another or spend its money and effort unwisely, the conclusion is inevitable that co-ordination has not really been given a favourable chance to work. The time to co-ordinate is not when the projects of each agency have crystallized to the point of appearing on paper, i.e. when opinions and judgments require or are thought to require vigorous defense. Preceding that stage is the period of discussion and planning when co-ordination can be most effective. This may be called the "preventive stage" when tentative proposals may be re-shaped and in some cases abandoned.

It is vitally important that WHO, authorized by the nations that created it to exercise the functions of planning and co-ordination, develop the means of fulfilling those functions. The source of international funds to improve the health of a people is wholly secondary; no matter how large the total funds appear to be, the needs are infinitely greater. The tragedy arises when the full value of the available funds is not realised.

## VI. PROGRAMME PLANNING AND EVALUATION

### A. General considerations

What has been said previously involves long-range plans not only for the nations but for WHO as the health organization of the nations. If 1952 sees the preparation of a national study pattern, if 1953 sees its application by Liaison Officers working with official agencies in selected countries,

if 1952, 1953 and 1954 bring more satisfactory techniques of co-ordination, these will indeed be judged as major marks of orderly progress. And each step, critically analyzed, becomes the means of strengthening succeeding steps.

Meanwhile the health work of WHO must move forward. The projects for 1952 are under way and the projects for 1953 are in the stage of final approval. Of chief interest, therefore, are the projects for 1954 because these are the ones to be formulated during 1952.

In "The Work of WHO, 1950" there appears a number of impressive maps. They depict both the locations and the range of health projects throughout the world. While breadth is an important dimension it must be accompanied by reasonable depth if projects are to take hold and grow in their influence. Otherwise there is danger that the projects may become health episodes rather than health events. An episode, no matter how impressive or dramatic its occurrence may be, is something transitory; it happens and ends. An event contains almost a biological quality; it has in it the element of continuity, generating new events that continue without end.

The previous comment about the importance to health promotion of an irreducible economic foundation may lead to the question: must health work be postponed until economic advances have been made? The question implies that any attempt to push health work before a specific, predetermined national economic level is reached, would be fruitless. Such an interpretation is erroneous even for underdeveloped nations.

Actually, on a world map the WHO projects, viewed in perspective, would appear as tiny pin-points. In practically all countries and especially in the underdeveloped countries, attempts are being made to improve social and economic conditions. These attempts are in themselves projects and in large part do not blanket a country, but are localized. They, too, are pin-points. Wherever it is possible to bring the pin-points together, associating health projects and social and economic projects, the greatest and most lasting values may be expected to accrue.

There are scattered examples where the association is already apparent in the efforts to integrate health activities with agricultural projects and other forms of assistance from world organizations. But in addition there are

many other economic efforts - national, bilateral and multilateral - that create the soil and atmosphere conducive to successful and lasting health work. Thus, the question of postponing health work answers itself. The real problem lies in the limitation on the number of health projects that might be selected and supported by WHO and other agencies so that health may improve as social and economic advances are made.

The Colombo Plan, as an example, contains an enormous health potential. True, the announced blueprint is ambitious; much less than 5.5 billions of dollars may be expended and the six years' time may extend to 10 or 20 years. But here is a plan to put 13 million acres under irrigation, 13 million more acres under cultivation, increase grain production 10 per cent and electricity generating power 67 per cent. Neither the generating power nor the acres are going to be developed in a single block in any single country. The totals are composites of many local projects in South-East Asia. And the Plan is not limited to the above economic objectives; it has a direct interest, as well, in specific projects to improve health.

Somewhat comparable is the Ten Year Plan for the agricultural and economic improvement of the Belgian Congo. The plan includes research to develop chemical fertilizers for soil that is otherwise poor, so that more and better production will result. There is, also, a nutritional programme intended to reduce the existing shortage of animal proteins. And, among other objectives, 385,000 Belgian Congo families are to be settled on 3,000,000 hectares of good soil. Already the National Institute of Colonial Agricultural Research, located at Yangambi, is working intensively on these problems.

Whether it is a Colombo or Belgian Congo Plan, a Gezira irrigation project in the Sudan, an Indo-American Technical Co-operation Fund, all these and the many other efforts around the world contain immediate opportunities for the integration of effective, dynamic health work. It is not that a health agency would be trying to attach itself to a convenient form of "transportation". Far from it. In such an undertaking health assumes colour and form; it becomes a tangible means by which an economic programme achieves greater and more lasting success because people are able to live a more productive life. If health promotion requires a certain irreducible economic foundation so does economic promotion call for a certain irreducible level of health.

## B. Specific Projects

A project may be described as the sharp, penetrating edge of a policy. Therefore, in all projects - their planning, their operation, their results - basic policy should be the most prominent element. With this element either weak or submerged, the force of the project lacks direction.

The period of "crisis planning", a normal one under the conditions of intense pressures, is rapidly coming to a close. It will become completely historical when the long-range needs and the long-range plans of the different countries are defined. An intervening step is seen in the increasing insistence by WHO that sound justification accompany each project that is submitted for consideration. The time may come - at least, no permanent health organization has succeeded in avoiding the problem - when WHO will be in extremely keen competition with other agencies for funds. Both now and later the strength of WHO lies in the strength and quality of its specific projects.

In accordance with the central policy of WHO to strengthen national health services, the projects, with few exceptions, may be divided into four broad categories, i.e. the improvement of health is to be achieved through the following approaches:

1. More adequate organization and administration
2. More adequate personnel
3. More adequate facilities
4. More adequate knowledge

There are a number of subheads for each category, such as legislation under 1 and research or public education under 4; but when each project is examined one or more of the above purposes should appear clearly and prominently. Attached, also, to each project must be the answer to the question: Will people receive more adequate health protection or health services in accordance with their needs and resources? Later, after the project ends, will come the most crucial question of all: Are people receiving more adequate health services in accordance with their needs and resources?

The last question introduces the subject of evaluation. It is a truism that statistics can never be better than their source. It is equally true that evaluation, as a fundamental part of the work of WHO, can never achieve greater precision than that to be found in its source, the planning of projects. To justify itself and at the same time provide a means of evaluation, a project should fulfil three requirements.

1. The planning of a project that is intended to result in "more" (more adequate organization, more adequate personnel, etc.) must include information that will become, later, the starting point for any measure of accomplishments. When an effort is intended to produce "more", the natural question is "More than what?" The answer can emerge only if a project, meeting the first requirement, provides the necessary basic or base-line information concerning the condition or situation that warrants the proposal.

2. The second requirement of a project is a clear statement of its needs. In the existing projects this requirement has been met more fully than any other because needs are related to finance and finance must be expressed in precise terms. However, it should be emphasized that real needs are shown in the basic information; to the degree that the basic information is adequate, the needs may be justified.

3. It is the third requirement that many of the projects exhibit their greatest weakness, the lack of a sharp presentation of anticipated results. There is an understandable hesitation in recording specific, rather than general, anticipated results. Yet, no project proposal is complete without such a record. Projects have a broader purpose, for example, than the control of a specific disease in an area or the training of a fellow in a special field of work. These are not the ends in themselves; they are the means or the vehicles used to reach a predetermined point; they are the devices by which national services may be strengthened. How they will work to this end and how one may judge that the end has been approached or reached should appear in a project's anticipated results. Not only do such results provide a test of a project's value, they also contain the material for judging the knowledge, the experience and the imagination of those who proposed the project.

The comment is heard many times that so much that is done in the field of health promotion does not lend itself to evaluation or measurement. The statement is partially true and partially defensive. It might have been said that the health promotional impact of bringing a lecturer from the University of Iowa to Europe to present the subject of anaesthesiology was an immeasurable project. Yet the four years that have passed have produced results that are distinctly measurable, in terms of stronger and more effective national health services, and those effects might have been expressed four years ago as "anticipated results". Every activity has behind it specific objectives; unless the objectives are stated clearly and the evidence of progress is described there can never take place that continuing accumulation and refinement of knowledge that gives life and strength to the scientific method.

#### SUMMARY

The foregoing report is the result of an analysis of the background and development of WHO, a review of past and present projects and discussions with members of the staff throughout the organization.

THE SCOPE OF WHO has been emphasized because there appears to be some misunderstanding of its broad purposes and functions. As is being demonstrated by its activities, no problem of health is outside the framework of WHO consideration and, within the limits of its means, WHO action.

THE FORMATIVE PERIOD of WHO presents a phenomenon of almost unbelievable intensity during the few years of its existence. WHO was assigned the tasks of building a vehicle and at the same time using it to go places. And now, conforming to the best traditions of a scientific organization, little attention is being given to the fact that such apparently incompatible functions were performed with any measure of success. Chief attention is centred on the structural defects and on the means of achieving more consistent and more rapid progress.

In the section on BALANCED NATIONAL DEVELOPMENT it is suggested that WHO in accordance with its broad role and in conformity with the policy of the General Assembly, develop, test and refine a new type of national health survey.

The suggestion is stressed despite the growing aversion to the many fragmentary and energy-consuming surveys that do little more than support the aphorism that "the devil finds work for idle hands". Yet, without a new type of study that culminates in a plan, the quality of balance, related to resources and needs, will remain a distant objective.

CO-ORDINATION is a subject discussed almost as much as the weather, and if judgment were based on the present situation the analogy might be extended. The lack of co-ordination throws a deep shadow over the health work of many agencies in many countries. It is a hopeful fact that all agencies recognize and are disturbed by the failure to integrate their health work. Greater hope lies in a positive move by WHO to develop balanced planning and achieve integration at the point where plans should be formulated, i.e. the country.

To the end that the health services of the country shall be strengthened, REGIONAL DECENTRALIZATION, as a part of WHO organization to meet current and pressing problems, is suggested. This should be interpreted not as a fixed policy but rather as one that may be adjusted to future developments in a country. This is said because of the regrettable characteristic of some organizations to interpret progress in terms of increasing offices and personnel. The assignment of a Liaison Officer to a country should be with the studied intention of recalling him when the strength of the country - its own planning and development of health activities, its own co-ordination - makes his services unnecessary. At that time the services from the Regional Offices will become ample.

PROGRAMME PLANNING AND EVALUATION need to be sharpened. The attachment of a project to the real needs of a country and to the policies of WHO to strengthen national services should be direct and clear. The justification of a project should be based on those attachments and, therefore, each project should present three features:

1. The basic information and data that warrant the project.
2. The needs to conduct and complete the project.
3. The anticipated results of the project, with the results stated specifically rather than in general terms.

These are the features that provide the measurements by which the success of the project may be judged. In sum total the projects in a region measure the success of the Regional Office; in final total the projects in all Regions measure the success of the field activities of WHO.

To this observer the relative calmness and attention of WHO to its long-range functions in the face of the rise and growth of many international bilateral and multilateral health activities, is a refreshing demonstration of the stability of science. That WHO was not stampeded into many hurried, ill-advised, competitive and unproductive ventures is a major mark of the organization's distinction.