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COMMITTEE ON INFORMATION FROM NON-SELF-GOVERNING TERRITORIES

Sixth Session

SUMMARY RECORD OF THE HUNDRED AND TWENTIETH MEETING

Held at Headquarters, New York,
on Monday, 2 May 1955, at 2.45 p.m.

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PRESENT:

Chairman:	Mr. SCOTT	New Zealand
Members:	Mr. LOOMES	Australia
	Mr. FRAZAO	Brazil
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	Mr. YANG	China
	Mr. DENIAU Dr. BERNARD	France
	Mr. ARENALES	Guatemala
	Mr. JAIPAL	India
	Mr. KHALIDY	Iraq
	Mr. GRADER Mr. VIXSEBOXSE	Netherlands
	Mr. CALLE y CALLE	Peru
	Mr. GIDDEN Sir Eric PRIDIE	United Kingdom of Great Britain and Northern Ireland
	Mr. STRONG Mr. SEARS	United States of America
Representatives of specialized agencies:		
	Mr. GAVIN	International Labour Organisation
	Mr. AUTRET	United Nations Food and Agric re Organization
	Dr. COIGNY Dr. CAMBOURNAC	World Health Organization
Secretariat:	Mr. COHEN	Under-Secretary
	Mr. BENSON	Secretary of the Committee

SOCIAL CONDITIONS IN NON-SELF-GOVERNING TERRITORIES:
(g) PUBLIC HEALTH (continued): (i) TRENDS AND FACTORS IN RELATION TO MORTALITY (A/AC.35/L.190 and Corr.1); (ii) PRINCIPAL COMMUNICABLE DISEASES (A/AC.35/L.205); (iii) MAJOR DEVELOPMENTS IN PUBLIC HEALTH ADMINISTRATION (A/AC.35/L.203); (iv) TRAINING OF MEDICAL PERSONNEL (A/AC.35/L.192 and Corr.1); (v) ENVIRONMENTAL SANITATION (A/AC.35/L.204); (vi) NUTRITION AND HEALTH (A/AC.35/L.202)

Dr. COIGNY (World Health Organization) introduced Dr. Cambournac, Director of the WHO Africa Regional Office. Dr. Cambournac had been lecturer on hygiene and public health at the Lisbon Institute of Tropical Medicine, and Director of the Angola Institute of Epidemiology and the Lisbon Malaria Institute.

Dr. CAMBOURNAC (World Health Organization) thanked the Committee for inviting him to address it and stressed the interest of the three documents A/AC.35/L.202, A/AC.35/L.204 and A/AC.35/L.205.

He proposed to speak mainly of Africa. With regard to collaboration between FAO and WHO in the field of nutrition, joint conferences had been arranged in 1952 and a training course was to be held that year in Marseilles. Furthermore, the two agencies had participated in programmes instituted by the various Governments in the African territories (A/AC.35/L.202, paragraph 41).

WHO was glad to see that the administrations were able to collaborate, despite frontiers, and that the people were showing an ever-increasing interest in public health work.

Referring to the question of environmental sanitation, he read extracts from document A/AC.35/L.204, paragraphs 4 and 5, in order to emphasize the importance of a healthy environment. Throughout the African territories, there had been great progress in environmental sanitation in urban districts, but in spite of the work already carried out in rural areas, much remained to be done. The problem was not easy in some regions. For instance, water supplies sometimes raised problems which were difficult to solve, even in the abundantly watered areas of the tropical or equatorial zone, for the soil was often

(Dr. Cambournac, WHO)

extremely porous, which made it necessary to dig wells from 60 to 70 metres deep, particularly in the Gold Coast, the two Togolands and Nigeria. In areas which did not present such difficulties, it was easy to choose sites for wells, but they had to be protected and the distribution of water supplies in good condition had to be insured. It was a complicated matter, for needs were not uniform throughout Africa and water resources varied from one region to another. WHO had decided to convene a conference of experts in the following November or December, to study all aspects of environmental sanitation.

He went on to supply some information supplementary to that appearing in document A/AC.35/L.205 and dealt in succession with the principal communicable diseases in African territories.

All the territories had engaged in the campaign against leprosy and the use of sulphones had produced excellent results in recent years. The number of cases of the disease had not increased, as the document to which he had referred might imply; rather had the people come to realize how effective the treatment was. Mass campaigns had been instituted in several territories, with the collaboration of UNICEF and WHO.

Cases of tuberculosis was still on the increase and BCG vaccination campaigns had been undertaken in many areas. WHO thought that before undertaking larger scale campaigns, it would be necessary to send into the field survey teams provided by WHO, UNICEF and the Governments concerned. WHO had arranged a conference on tuberculosis and had sent two consultants, who were making an on-the-spot study of the methods used and would submit a report on their work for the use of the experts. Experts in African territories should meet more frequently in order to study the special situation in each of those territories.

Yaws was still very wide-spread in Africa. Many countries had undertaken campaigns against the disease, with WHO and UNICEF assistance, and satisfactory results were being obtained from the use of penicillin, but more attention must be paid to public health in general. An example had been set by Liberia, which was not a Non-Self-Governing Territory, and by Nigeria. In Bechuanaland,

(Dr. Cambournac, WHO)

UNICEF, WHO and the Administration had undertaken a joint campaign, to follow up the survey made in 1954.

Recent surveys had revealed that it was possible to combat bilharziasis, one of the commonest diseases in Africa, but more intensive research was needed before any mass campaigns could be undertaken. Some areas, such as those where large-scale irrigation work had been carried out or where the rainy season lasted for eight or nine months, were particularly favourable to the disease. WHO thought that it was better to proceed slowly; it had decided to convene a conference the following November to work out methods of combating the disease and to study its epidemiology.

Malaria had been almost entirely eradicated from the towns, where it was no longer necessary to take any special precautions. In the rural areas, very good results had been achieved, but much remained to be done, particularly in the matter of research. Generally speaking, the campaigns produced better results when they were conducted over a wide area.

Sleeping sickness was particularly prevalent in West Africa, where the campaign against vectors in some areas and the use of drugs against parasites were producing excellent results in a very wide area, but the protection af animals against trypanosomiasis was still a problem. In East Africa, stock-breeding was improving in many of the areas and the number of human beings affected by the disease was decreasing.

Onchocerciasis was very wide-spread but there were good means of combating it, as was shown by the fact that certain campaigns had led to the eradication of vectors in some countries. There had been a conference of all African and some American countries at Léopoldville in 1954 and its conclusions had been of great value in the mass campaigns which had just been undertaken.

The Regional Office was trying to improve the statistical services in Africa and was planning to convene a conference, in co-operation with the Commission for Technical Co-operation in Africa. In April 1954, a WHO expert

(Dr. Cambourniac, WHO)

had studied together with the authorities in the African Territories, the organization of health services and the use of statistics, with particular reference to malaria research. When the survey on which the WHO statisticians were at present engaged had been completed, a conference would be held to study the question of health statistics. All that work would be in vain, however, unless vigorous efforts were made to educate the inhabitants. To that end a conference on health education would be convened, after preparation by experts in that field.

He went on to give some particulars of what WHO was doing to supplement health personnel in the African territories. Experts had to be trained for each area of the continent, for the environment varied from one area to another. WHO was particularly interested in fellowships, the number it had awarded having risen from twenty-seven in 1953 to eighty-four in 1954. Candidates were chosen with care and efforts were made to train personnel who would eventually be capable of replacing WHO experts, establishing well organized services and undertaking mass campaigns. WHO was also arranging courses on nutrition, in collaboration with the services concerned and the international agencies, particularly FAO. There were also courses on malaria and rabies. The various courses were so popular that it was not always possible to accommodate all those wishing to attend. Former students were already being employed by the administrations to direct the anti-malaria services and to step up the campaigns.

Mr. ARENALES (Guatemala) said that he would leave it to delegation experts and representatives of the specialized agencies to make comments of a technical and statistical nature. He would merely make some general observations on the principles which should govern public health administration. His delegation had arrived at those principles after careful consideration and hoped that the Administering Powers would endorse them in order to gain a better understanding of public health problems and even to reformulate their policy.

He would first recall his country's position on public health, its relationship to social, economic and cultural development and the ultimate objective which was self-government.

(Mr. Arenales, Guatemala)

Firstly, the Guatemalan delegation reaffirmed that social development, like other forms of development, was an end in itself but that the Committee must not forget that self-government was the aim of the administration of the Non-Self-Governing Territories.

Secondly, Guatemala recognized the inter-relationship of all forms of progress in the Non-Self-Governing Territories; but an attempt must be made to find appropriate solutions to urgent problems without waiting for the preparation of co-ordinated plans which might delay their solutions unduly.

Thirdly, the seriousness and urgency of public health problems and the necessity of solving them, either individually or as part of the social welfare programme should be re-emphasized but without substituting an administrative policy of assistance for the more effective participation of the inhabitants in the study and solution of their difficulties.

The Committee had before it some reports which were well presented and satisfactory in that they brought out the relationship between public health programmes and general policy. Particularly to be noted were the Secretariat's report on the progress in public health administration and the joint FAO-WHO report on nutrition. Unfortunately the Guatemalan delegation had received the texts only very recently and hoped that, when the Committee's terms of reference were renewed, a time-limit would be fixed for the distribution of documents to delegations, so that they had sufficient time to communicate them to the ministries concerned in case expert advice was necessary. He regretted that he could not, therefore, make any technical contribution to the discussion, although the specialized agencies and the functional commissions of the Economic and Social Council were best qualified to make such a contribution to the Committee.

The Committee's role was to lay down general principles applicable to the Non-Self-Governing Territories and to determine to what extent technical programmes could be co-ordinated with the general policy of economic, social and cultural development.

(Mr. Arenales, Guatemala)

Turning to the actual principles which should govern public health administration, he noted the triumphs of medical science which required completely new policies and personnel, especially in the Non-Self-Governing Territories, where the remnants of colonization, whether aggressive or seemingly benevolent, must disappear.

In that connexion, he quoted a statement made at Toronto, Canada, in August 1954 by Sir Geoffrey Vickers at the International Congress on Mental Health, which had appeared in the British magazine The Lancet of 12 March 1955 and which pointed out that the main thing in the present-day world was not to help people, but to enable people to help themselves. In paragraph 76 of document A/AC.35/L.190, the Secretariat had come to similar conclusions. In 1952, the Committee had supported not only the increasing participation of the inhabitants in public health services, but also efforts to associate the villages with public health activities.

He wished to know what the experts taking part in the Committee's debates thought of those two points. Public health development must be integrated with community development. Public health administration, medical services, large hospitals, medical research and training could not, however, be run like rural services or turned over to the authorities in charge of community development. The scope of public health activities should therefore be broadened to include problems arising from developments in medicine, preventive medicine, nutrition, agriculture and town-planning. The medical officer in the service of the administration could help to define general standards of economic and social policy in the Territories and thus contribute to the political development of the peoples. Everyone recognized the excellent accomplishments of rural health units and travelling medical teams in combatting the main endemic diseases and epidemics, but that was not enough: the population must be made to meet their own public health needs. Failing that, paternalism in public health might prolong economic and political paternalism in the colonial Territories.

(Mr. Arenales, Guatemala)

The Guatemalan delegation stressed the need for co-ordinating public health policy with general policy. Successes in medicine must not divert attention from the social origin of certain diseases which those very successes made it possible to combat. The public health officer, the economist and the teacher must join together in triumphing over those scourges.

He hoped that the public health experts participating in the Committee's discussions would help it to formulate its health policy, so that public health might become an integral part of the economic and social advancement of the Non-Self-Governing Territories.

Mr. FRAZAO (Brazil) said that he had been much impressed by the documentation submitted to the Committee, as also by the United Kingdom and French experts' statements which he would like to see circulated as documents. He was only a layman so far as the technical problems under the heading of "public health" were concerned, but he could recognize their social and economic implications. Perusal of various informative articles and documents had raised certain doubts in his mind and he would like some enlightenment. In the 20-26 March issue of the Sunday Review, he had read an article entitled "The Politics of Bread", by Sir John Russell, a celebrated agronomist, who advocated a broader policy of public health based on improved food production. The article gave data on the cost of medical training in the colonial territories; it appeared that efforts were being made to train doctors in Africa, but that to train them there cost twelve times as much as to send students to the United Kingdom, where the training establishments were full.

In addition, an article in the Economist of 27 November stated that, at Ashimota (Gold Coast), tuition costs seemed likely to exceed 1,000 pounds per student per annum. The hospital at Ibadan, where a medical school recognized by the University of London was being created, would cost over 3,500,000 pounds or eight times that of another hospital in Africa. It cost 50,000 pounds to train an African doctor in Africa, more than five times the cost of training a doctor in London and twelve times the cost of sending a West African to the United Kingdom to study medicine.

(Mr. Frazao, Brazil)

He had consulted the report of the 1952 Commission of Inquiry which had been set up to ascertain the health needs of the Gold Coast. The Commission had recommended against the establishment of a Gold Coast medical school, for financial reasons. It had estimated the annual cost of the medical school at 231,200 pounds, excluding capital costs. The cost of training would amount to 5,780 pounds if the output were forty medical practitioners a year and 8,670 pounds if the output were twenty (paragraph 210). In the Commission's view, the cost of training a medical student in the United Kingdom was approximately 700 pounds a year for six years, which included travel expenses. Accordingly, the sum of 1,200,000 pounds proposed for a Gold Coast medical faculty could be used at three per cent per annum to maintain fifty medical students in the United Kingdom (paragraph 213).

He drew attention to the discrepancies in those figures. According to the calculations of the Commission of Inquiry, the cost of training a Gold Coast student in London was less than one tenth of the figure quoted by the Economist, but the Economist presumably included the cost of building quarters for the students.

He wondered why the cost of the hospital at Ibadan would be eight times greater than that of an ordinary hospital and whether it would have the same number of beds and offer the same treatment facilities as an ordinary hospital. If so, it would seem that the standard of services required of a teaching hospital bore no relation to the needs and possibilities of the Territory.

Turning to the less sensational figures given by the Commission of Inquiry, he regretted that, on its recommendation, the always enlightened Government of the Gold Coast had decided not to found a faculty of medicine. If, as it appeared, it cost 50 or 100 per cent more to train an African locally than to send him to the United Kingdom, it might be asked whether, in the first case, the basis for calculation was the total cost to the Gold Coast Government, whereas in the other case, all that was calculated was expenditure such as the personal expenses of the student and teaching fees but not the costs borne by the metropolitan Government, the university or the hospital endowment. He wondered

(Mr. Frazao, Brazil)

whether the Commission of Inquiry had considered also the social benefits which the improved health services, hospital services and dispensaries would bring for the inhabitants of the Territory following the establishment of a teaching hospital. In addition, the training of medical practitioners in a Territory where they would subsequently have to practise would give them an intimate knowledge of the technical facilities at their disposal. He also feared that the Gold Coast Government's decision might discourage the authorities of less developed African Territories which might be considering the establishment of medical schools.

He hoped that the Committee, or at least those concerned with the technical aspects of the matter, would try to determine the criteria for assessing the cost of medical training, and even of higher education in general, in the Non-Self-Governing Territories. If the figures which he had quoted were correct, it would be useful to stress the advantages accruing to a Territory from the establishment of medical training hospitals and also to undertake a much wider inquiry into medical training and higher education in order to develop them along lines which would be conducive to national economic development and would not create educated classes remote from the general life of the people.

Mr. GIDDEN (United Kingdom) pointed out that the Gold Coast decision regarding the establishment of a medical school had no doubt been taken on the grounds of financial economy, and that Governments had frequently to sacrifice desirable projects for such reasons.

Sir Eric PRIDIE (United Kingdom) said that it was very difficult to calculate the total cost of training a medical practitioner and that it was even more difficult to try to make comparisons among various countries in that connexion. Hospitals which were also to serve as teaching hospitals for faculties of medicine must be of very high standard and must have first-class teaching staff. They must also include additional accommodation for purposes of teaching. At Ibadan, the hospital itself would have more than 500 beds

(Sir Eric Pridie, United Kingdom)

and would therefore cost about 7,000 pounds per bed. This included of course the cost of premises which would have to be provided for a large hospital staff. By way of comparison he stated that a simple district hospital costs about 2,000 pounds a bed, and a provincial hospital in the same region had cost 4,000 pounds per bed.

The cost of training a student was usually in inverse proportion to the number of students to be trained. Usually those costs were therefore higher during the early years of the faculty.

As far as the Gold Coast was concerned, its long close medical links with the United Kingdom encouraged it to take advantage of the facilities for medical training available in the United Kingdom. He believed that a health service in a country of any size should have its own medical school for training doctors.

Mr. FRAZAO (Brazil) thanked the members of the United Kingdom delegation.

The meeting was suspended at 4 p.m. and resumed at 4.30 p.m.

Mr. GRADER (Netherlands) thought that public health might well be described as the art of combatting disease through organized community effort. It was not, however, the purely medical side of the question that the Committee was to consider and he would therefore dwell more upon the manner of integrating public health measures in the social environment.

In that respect statistics played an important part, for they made it possible to assess the health situation of a country and to determine the needs of its inhabitants. As a rule, the death-rate, and more still the infant mortality rate, provided a reliable indication. Unfortunately the accuracy of those statistics left much to be desired in a territory like Netherlands New Guinea, where the population was scattered over wide and often isolated areas. The same problem was found in more than half the world: reliable statistics were lacking for 85 per cent of Africa, 40 per cent of America, 70 per cent of Asia, 15 per cent of Oceania and 18 per cent of Europe. Moreover, census taking was difficult in under-developed countries. Nevertheless, a passage from the Committee's 1952 report on social conditions, which he quoted, showed that considerable progress had been made, mainly by the sampling method.

(Mr. Grader, Netherlands)

Recent data from Netherlands New Guinea revealed that in most cases there was a very large excess of births over deaths, especially in areas which had been under administrative control for some time. Taking the Territory as a whole, the infant mortality rate was high. Malaria was one of the main causes: it decimated the infant population and lowered the resistance to other infectious diseases of those who survived it.

Another important cause of death was food deficiencies. As the inhabitants were not capable of increasing their food production and living conditions were unfavourable, it could be assumed that the density of population had remained static for a very long time, perhaps even for centuries. Nevertheless, in areas where economic and social conditions had improved there was a noticeable increase in population. During 1953 and 1954 a Netherlands nutrition expert had made a rather extensive investigation. More recently, an expert from the South Pacific Commission and a medical officer of the Public Health Department of the Territory had devoted special attention to infant nutrition. In general, the diet was poor in proteins, and in some areas in vitamins, but it was fairly well suited to the needs of the people, at least so long as their way of life was not disturbed by any external factors. If, however, the head of the family, who did the hunting and fishing, went away for a while to do some paid work, his family would suffer from a lack of proteins. Hence demographic problems called for more than purely medical knowledge; a knowledge of the social, economic and educational factors was equally necessary.

Turning to the different diseases rampant in the Territory, he spoke first of malaria, which was the chief endemic disease. For entomological and climatic reasons, Netherlands New Guinea was one of the world's main reservoirs of parasites. The greater part of the population was scattered over swampy areas where it was impossible to destroy the larvae. Protection by mosquito nets or screens, or by chemoprophylaxis, was out of the question. In principle, malaria control should not disturb the natural process of immunization among the indigenous inhabitants. As was stated in document A/AC.35/L.190, Paragraph 36,

(Mr. Grader, Netherlands)

the development of immunity with age tended to make of malaria a children's disease. Accordingly, it was essential that new-born babies should be given quinine in small doses, which would mitigate the danger of a heavy attack without interfering with the process of immunization. It appeared likely, too, that good results could be obtained by indoor spraying of houses with DDT, but that idea was still in the experimental stage. Nevertheless, in the area where the experiment had been carried out the incidence of infection had been reduced by 90 per cent. In that connexion, he mentioned that UNICEF had made an allocation of $43,000 for a malaria control programme in the Territory.

UNICEF had also contributed a grant of $22,000 for a yaws control programme to be carried out in 1955 and 1956. Yaws was, after malaria, the most serious endemic disease in the Territory. It usually struck areas where there was a low standard of hygiene. It had little effect upon the mortality rate but it affected the energy of the population. The number of cases in the Territory was estimated at 50,000. The routine treatment with neo-salvarsan required a series of injections; since, however, the very first injection brought about a marked improvement, the patient was inclined to discontinue the treatment before the cure was completed. On the contrary, one single injection of penicillin PAM was sufficient for a complete cure. As it was difficult to induce the indigenous inhabitants to report to the treatment centres, the Administration had organized mobile teams which would tour the whole country at the end of the year. In the meantime, a project had been started in the Sentani Lake district; its objectives were to evolve methods of examination, treatment and post-treatment and to train the necessary personnel. After the campaign, which was to begin at the end of the year, samples would be taken to determine the results.

The indigenous inhabitants were particularly susceptible to pneumonia, especially when they left their homes to become wage-earners. Before the war that predisposition had had a disturbing effect on the industries of the Territory,

(Mr. Grader, Netherlands)

but penicillin had fortunately put a stop to that. There were influenza epidemics every year, sometimes causing a large number of deaths; the 1954 epidemic, however, had been of a mild character.

The indigenous inhabitants were also susceptible to tuberculosis, living as they often did in overcrowded and stuffy houses. In 1954, 103 new cases had been reported. The Administration was planning a BDG vaccination programme. It had awarded a fellowship to the head of the Tuberculosis Section of the Public Health Department, to enable him to study the question in Europe and to make preparations for the programme to be put into effect.

The Public Health Department had been reorganized in 1954 and it now consisted of six sections: public health administration, malaria control, leprosy control, yaws control, tuberculosis control and mother and child welfare. That reorganization was due to the progress achieved in the control of the major diseases through wider experience, the work of experts and the improvement of means of communication. Furthermore, the WHO fellowships gave the projects a sort of international recognition.

The number of doctors had increased from thirty-six in 1953 to forty-eight in 1954, or one doctor for every 8,300 inhabitants. In 1954, there had been forty-six indigenous nurses in the Territory, as against twenty-eight in 1952. The number of other indigenous medical personnel had increased from 305 in 1952 to 350 in 1954. There were at present thirteen hospitals, ten auxiliary hospitals and sixty-seven dispensaries in the Territory; others were being built, and the Administration was taking steps to improve the hospital equipment. The oil company in the Territory maintained a private hospital at Sorong. Indigenous nurses, both male and female, were trained at that hospital, as well as at the public hospital at Hollandia. Social welfare workers were being trained at Merauke and Hollandia. The Administration was circulating pamphlets to acquaint the population with the principles of public hygiene and malaria control. Educational shows on nutrition with coloured lantern slides were held in the villages. Lastly, WHO was going to place one public health fellowship at the Territory's disposal.

Mr. AUTRET (Food and Agriculture Organization) said that FAO worked in close co-operation with the Division of Information from Non-Self-Governing Territories and the Governments concerned all over the world. The nutritional problems of different areas always presented many common features: they were affected by human, ecological, agricultural, climatic and economic conditions and by scientific and material progress. The geographical distribution of those problems did not follow administrative or territorial boundaries: those to be found in the Non-Self-Governing Territories were common to all tropical and sub-tropical areas - the so-called economically under-developed areas. Territorial boundaries, however, did have an effect on the importance of a particular problem and on its solution.

He drew the Committee's attention to document A/AC.35/L.202, submitted jointly by FAO and WHO, and recalled the main nutritional problems of the Non-Self-Governing Territories, as set forth in Part I of that document. The k nd of staple foods consumed had a bearing on the causes of deficiency diseases and undernutrition. Those causes were poverty (lack of food resources owing to insufficient land or limited buying power); ignorance or custom, leading to failure to utilize existing resources to the full; and faulty distribution or preservation of foodstuffs (paragraph 20). Those problems and their causes had been studies by FAO in two reports previously submitted to the Committee: one presented in 1951 entitled "Food Consumption and Nutrition in Non-Self-Governing Territories", and the other - presented in 1954 - entitled "The Relative Progress of Production for Local Consumption and Export in Non-Self-Governing Territories". In Part II of document A/AC.35/L.202, the two specialized agencies set forth the joint action taken by FAO, WHO and UNICEF to improve nutrition in the Non-Self-Governing Territories. That improvement depended upon increased food production and buying power and upon better methods of conservation, utilization and distribution of resources: those were long-range tasks in respect of which Governmental programmes were being carried out in all the Territories. It was, however, possible, while awaiting the results of those programmes, to take steps to protect vulnerable groups and give the people nutritional education. In that connexion, FAO was pursuing regional or national projects, in co-operation with the Governments concerned - for FAO's policy was to help Governments to help themselves. It was

(Mr. Autret, FAO)

carrying out studies and investigations; collecting, analysing and disseminating information; encouraging workers; and outlining the problems and seeking solutions thereto; sometimes, it gave direct assistance by supplying personnel. Those projects were described in the programme of work published each year by FAO.

He gave some typical examples of the results achieved through the joint efforts of FAO and WHO with the assistance of UNICEF. Kwashiorkor was due to protein malnutrition, it was prevalent among small children and was caused by a protein deficiency which, in poor tropical countries, often followed weaning. Investigations had been made to determine the incidence of the disease. Medical services had taken steps to detect, treat and prevent kwashiorkor and to educate mothers. Powdered skimmed milk was being distributed in countries where the disease was prevalent. Experts had carried out research to discover foodstuffs which were both rich in protein and cheap enough for the people to buy, such as a whole range of fish-flours and oil-cakes. Thus, in five years results had been obtained which, without the stimulus and the material help of international organizations, would have taken a much longer period.

FAO was also helping Governments to train the necessary personnel. Indeed, there were no schools capable of teaching all the subjects needed in the training of a tropical food-analyst. In co-operation with a host country, FAO and WHO had therefore organized nutrition training centres, and in 1952 scholarships had been awarded to thirty doctors, biochemists, agriculturists and veterinarians, who had taken courses devoted especially to the problems of African territories. Thirty more would receive the same instruction during 1955. Those who had taken the first courses had already accomplished work of considerable value. Another joint FAO/WHO course, intended to train auxiliary personnel in nutrition and health education, was organized in 1955 in South East Asia. It would also be attended by representatives of the Non-Self-Governing Territories of the region.

A third example of FAO's work in the Non-Self-Governing Territories was to be found in the Caribbean Area where the home economics section of FAO had been working for five years with the Caribbean Commission to train home economics workers to reach the mother at home.

(Mr. Autret, FAO)

Thus FAO's activity in Non-Self-Governing Territories consisted of regional studies and projects in which it took the initiative of bilateral projects in co-operation with Governments, of consultations with specialists on various subjects or of work carried out in co-operation with inter-governmental organizations. This co-operation had been very active, and FAO was ready to redouble its efforts on both the regional and territorial levels.

The meeting rose at 6 p.m.