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THIRTY-FOURTH WORLD HEALTH ASSEMBLY

COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE SEVENTH MEETING

Palais des Nations, Geneva
Friday, 15 May 1981, at 14h30

CHAIRMAN: Dr E. P. F. BRAGA (Brazil)

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SEVENTH MEETING

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PROPOSED PROGRAMME AND BUDGET AND REPORT OF THE EXECUTIVE BOARD THEREON: Item 19.1 of the Agenda (Resolutions WHA33.17, para. 4 (1), and WHA33.24, para.3; Documents PB/82-83; EB67/1981/REC/3, Chapters I and II, and A34/INF.DOC./2) (continued)

GENERAL PROGRAMME DEVELOPMENT, MANAGEMENT AND COORDINATION (Appropriation Section 2; Document PB/82-83, pages 65-89) (continued)

Research promotion and development (major programme 2.4) (continued)

DR ELIAS (Hungary), referring to paragraphs 41, 42, 45 and 48 of document EB67/1981/REC/3, said that he was glad to note the increasing involvement of the Director-General and the Secretariat in the coordination and promotion of research through the global and regional advisory committees on medical research and by other means aimed at ensuring that research was highly relevant to the main goal of health for all by the year 2000.

With regard to paragraph 42, he considered that research into the health problems of the developed countries should continue, though the amounts spent on such research might seem out of proportion. It should be remembered that diseases such as cancer, arteriosclerosis and rheumatism would also be of concern in the future to the developing countries. He endorsed the allocation of 75% of voluntary contributions to research in the developing countries, as mentioned in paragraph 45, and was pleased to see that the funds were used under strict scientific peer review. Nevertheless, countries might not always have the necessary capacity to use human and material resources and a measure of criticism should be exercised. He approved the statement made in paragraph 48 with regard to national research efforts; they constituted a major source of talent and facilities of which even greater use could be made.

Dr KRUISINGA (Netherlands) said that the programme was of the utmost importance and was essential as an instrument in reaching the goal of health for all by the year 2000 and in primary health care. He asked why the estimated obligations for 1982-1983 under the regular budget had been reduced to US$ 7 161 600, as compared with US$ 7 569 900 for the previous biennium, as it appeared from page 85 of document PB/82-83. Funds from other sources had also apparently decreased; if allowance was made for inflation, the total decrease was 15-20%.

He asked for more specific information to be provided on the relationship between the Executive Board and the global Advisory Committee on Medical Research (ACMR). What criteria were followed in the selection of scientists to serve on ACMR? It was stated in the document that, in one of the regions, a specific proportion of the funds allocated to medical research were spent on health services research, a subject to which his delegation attached great importance. Could information be provided on which regions had indicated a percentage figure for such research and on the targets which might be set.

He endorsed Professor Bergström's plea for the assessment of research results. The benefit-cost ratio for smallpox eradication, for example, must be much greater than 100:1. That should be brought to the notice of decision-makers so that they realized the value of medical research. He thought that the efforts being made to eradicate malaria and in the Expanded Programme on Immunization would bring comparable benefits. Any results of cost-benefit analysis would be very useful, and he wondered whether WHO had any plans to make such analyses.

The idea of WHO as a central coordinator of medical research, heading a network of State and other institutions, was not new - he recalled the initiatives of the former Director-General, Dr Candau, and Dr Kaplan, former Director of the Office of Research Promotion and Development, but he wondered what criteria were used in selecting the areas to which resources for health research were to be allocated. He had already referred to the importance of health services research, but there was also the question of the incidence of diseases caused by the environment; morbidity and mortality data showed that the incidence of cardiovascular diseases, cancer and psychosocial conditions was increasing. There was a need for further study of the incidence of those diseases, but what weight should be given to that in balancing

expenditure on health and medical research? That was a very important point which could be made the subject of a special document for the next World Health Assembly.

He believed that WHO should play a major role in coordinating intercountry research and in ensuring scientific cooperation between and within countries; there was often a lack of coordination of the research activities of universities, State laboratories, and government, intergovernmental and nongovernmental institutions.

In the field of occupational health, cooperation with ILO should be broadened, especially with regard to toxic chemicals, pesticides and additives. Cooperation with UNEP, FAO, UNESCO and IAEA was also desirable.

WHO also had a duty to support research activities on energy sources. In particular, it should look into the problem of the effects of radiation; alarming epidemiological data had been reported from the vicinity of nuclear power stations. The problem would soon become urgent; WHO should make a stand and use the weight of its authority.

The organizational impact of the research programmes under consideration would directly affect expenditure on the programme to be carried out over the next decade, which were so important in achieving the goal of health for all by the year 2000. He pleaded for more cooperation and coordination between universities, industry, State institutions, intergovernmental bodies such as the European Economic Community, the Council for Mutual Economic Assistance and the United Nations system, and nongovernmental organizations. Who was going to set priorities and decide how the research was to be carried out?

Better coordination of cancer research could be achieved by closer cooperation between ACMR and IARC. It was necessary to decide by whom and where research on epidemiology, prevention, early detection, therapy and after-care was to be carried out.

Dr KPOSSA-MAMADOU (Central African Republic) supported the remarks made by the delegates of USSR and Senegal at the preceeding meeting, especially concerning research aspects of technical cooperation among developing countries, and biomedical research. He said that the concept of national priorities should be given due consideration, especially by the developed countries and international organizations. A case in point was the very high infant mortality in the Central African Republic: when assistance had been requested in carrying out a study of that problem, the international organization concerned had replied that it would prefer to carry out research on the pygmies instead.

In general, he would like to see greater emphasis placed on traditional medicine; that was complementary to western medicine, and was capable of reaching the rural population which was largely inaccessible to conventional health services. His country would like to be closely associated with WHO's programme in that field. Traditional medicine was important in all developing countries; in addition, it should also be remembered that modern medicine tended to dehumanize the patient.

He noted the small percentage of the budget allocated to medical research in the biennium 1980-1981; the position was no better for 1982-1983, although certain countries believed that a number of fields required further study. An effort should therefore be made to find extra-budgetary sources of funds to make good the deficiencies.

Dr GURMUKH SINGH (Malaysia) asked for clarification with regard to the method of presenting major programme 2.4. He noted from page 85 of document PB/82-83 that there was a reduction of US$ 464 300 in the estimated obligations for the Western Pacific Region; the explanation given in paragraph 10 on the same page was that provision for certain research had been transferred to the individual technical programmes. His understanding was that, in programme budgeting, each programme was given a specific objective; in fact, the objective of programme 2.4 was clearly stated on page 84; namely "to promote and collaborate in the development and coordination of biomedical and health services research". Did the reduction in the allocation mean that such development and coordination was to be reduced in the Western Pacific Region? He suggested that, in future, where increases or reductions in allocations were shown in the programme budget, some account should be given of the scope of the activities correspondingly increased or reduced.

The programme budget under consideration was the first of its kind, so that it was inevitable that there should be some vagueness where programmes overlapped. He suggested that, in future, funds should not be transferred unless there was some real change in the scope or quantum of activities; that was the essence of programme budgeting. If there was really going to be a reduction in the research going on in the Western Pacific Region, there should be

measurable indicators to show that it had reached a more than adequate level. That would be in line with the emphasis placed on the development of such indicators by countries. Was such a procedure envisaged in the WHO programme budget?

Dr MKANDAWIRE (Malawi) said that his delegations noted with satisfaction WHO's efforts to develop research programmes, especially at the country level, and the strategy stimulating closer relations between health research councils and ministries of health. In Malawi, a National Research Council had been established and a Health Research Committee set up under its aegis. The main problem was the lack of trained research workers. He hoped, therefore, that WHO would accelerate the establishment of institutions for training research workers, especially in the African Region. Finally, his delegation was concerned to see that the allocation to that Region had been reduced by US$ 37 900 for the biennium 1982-1983. Could some explanation be given for that reduction?

Mrs MAKHWADE (Botswana) said that WHO's guidance was extremely important to developing countries in enabling them to develop confidence and self-reliance in research directed towards solving their pressing problems. Countries such as Botswana lacked the capability to undertake meaningful research because of manpower, financial and material constraints. Botswana's health care delivery system therefore lagged behind, for example, in operational and applied research. Her delegation consequently supported the efforts to strengthen national capabilities. She hoped that, during the biennium, WHO would do everything possible to make ministries of health and other national institutions aware of the need to identify areas of relevant research activities.

Her delegation approved the proposed estimates, but regretted the decrease in the allocation to the African Region; what was the explanation for that decrease?

Dr MARKIDES (Cyprus) asked what progress had been made in research on haemoglobinopathies, and on thalassaemia in particular. In 1980, WHO had planned to carry out research in Cyprus in that field. What progress had been made in that research?

Dr BARAKAMFITIYE (representative of the Executive Board) said that one of the most important functions of WHO was coordination in the area of research. The fact that the Director-General had set up a number of global and regional mechanisms in the hope that they would stimulate the establishment of similar mechanisms at the national level, particularly in developing countries, showed WHO's concern for coordination. The Executive Board fully recognized the importance of coordination and followed developments closely. Priorities in the field of research had to correspond to specific problems that had already been defined at the global, regional and national levels. WHO could not become a research institute; it had to promote research activities that would help to solve major health problems and would further the achievement of health for all.

In that connexion, he mentioned that the Programme Committee of the Executive Board and the global ACMR had held a meeting in 1979 which had been attended by chairmen of regional ACMRs and at which a useful exchange of views had taken place. On that occasion he had noted with satisfaction that, contrary to preconceived ideas about research workers, they were fully aware of the ways in which their work could be used to help the population. Major health problems such as primary health care, diarrhoeal diseases, malaria, immunization and nutrition were among their main preoccupations. The delegate of Nigeria was justified in urging that research should not be confined to a laboratory because the population and the problems that were the subject of research were not necessarily found there. In other words, applied research merited particular attention. Taking into account the complexity of the problem the Executive Board considered that WHO was on the right path.

With regard to developing countries, it was obvious that they would have to define their priorities in the research field if they wished to obtain maximum benefit from existing mechanisms and funds, and would have to make considerable efforts, in which WHO should support them at every stage, especially by setting up or enlarging collaborating centres and by developing their research methodology - as had been mentioned by the delegate of the German Democratic Republic - as well as by assisting in technical cooperation among developing countries.

The Executive Board had also considered the question of ethics in the field of research, and he agreed with the delegate of the USSR that it must constantly be kept in mind, because specialization could influence the humanist concept of medicine.

The DEPUTY DIRECTOR-GENERAL noted with satisfaction that the delegates had expressed considerable interest in research, which had become such an important part of WHO programmes at all levels, but it was extremely difficult for the Secretariat to reconcile all the different views. For example, some delegates queried reductions in the budget for research while others wished to confine WHO's activities to applied research.

The delegate of the Netherlands had listed some interesting areas for research which would call for greatly increased resources. In reply to the question he had raised, he said that the relationship between the Executive Board and ACMR was now very close. In the past, ACMR had been an advisory body to the Director-General and it was only in recent years that it had reported to the Executive Board and to the Health Assembly, so that they were now able to have direct contacts with the chairman and members of ACMR. He nevertheless agreed with the delegate of the Netherlands that the relationship could be strengthened.

In reply to the question asked by the delegate of the Netherlands on the criteria for selecting members of the global ACMR, he said that representation was not only on a geographical basis but every effort was also made to ensure that the most important disciplines were represented. Members were expected to be internationally recognized experts in their various fields who had contributed to research at the national or individual level. In addition, they were chosen so as to reflect a balance between the developing and developed countries, whose research programmes differed considerably. Some members whose international reputation did not appear to be as high as others had been chosen because of their considerable experience in a particular field. The criteria for selection were strict and standards were extremely high.

He informed the delegate of the Netherlands that at the sixty-seventh session of the Executive Board many questions had been asked about the reduction in funds. The problem was one of presentation and there was in fact no overall reduction; on the contrary, there had been a considerable increase in total investment in research. There were also instances in which extrabudgetary funds had been committed but not paid and those sums had not been included. The Netherlands was one of the traditional donors in the area of research.

WHO would carry out cost-benefit analyses and it fully recognized their potential benefit; however, it might be premature to undertake them at the present stage. Programmes such as the Special Programme for Research and Training in Tropical Diseases and the Special Programme of Research, Development and Research Training in Human Reproduction might profitably undertake cost-benefit analyses, but in other areas it could be done at the national or regional levels. Further investigation into morbidity and mortality was being undertaken and it was part of the work of most of the divisions and units. For example, epidemiology was one of the most important aspects of cancer and mental health research. Epidemiology was the first step before any effective action could be taken.

The delegate of the Netherlands had referred to the idea of a central coordinating body for medical research, as had originally been proposed by the former Director-General, Dr Candau, and Dr Kaplan, former Director of the Office of Research Promotion and Development, who had bequeathed so many ideas to WHO. They had brought research to the forefront and had thus made it easier for their successors. One of the functions of ACMR was to be a central coordinating body, but it was extremely difficult to coordinate research at the global level, it was even difficult to coordinate it within a country. Efforts were nevertheless being made, although coordination was probably easier in countries where research was directed by the State than in those where universities took their own decisions regardless of a country's priorities.

Interagency cooperation had made considerable progress and WHO had joint coordinating bodies with UNICEF, FAO, ILO and UNESCO. There were common areas of interest but a tendency existed for each agency to consider that it had priority in a particular field. On the whole, interagency cooperation worked well, and the annual meeting of Directors-General kept the situation under review.

Research programmes for future years were planned in the various programme areas. The Research Development Committee mentioned by Dr Sartorius at the previous meeting was working effectively and it had considerable impact on planning and coordination within WHO, probably an even greater impact than that of ACMR which was global. One of the most important tasks of the former was to give guidance and to ensure that research programmes that were becoming redundant were eliminated.

Cooperation between WHO and IARC would be commented on in greater detail by Dr Stjernswärd. In any case such cooperation would be improved in the years to come, since in many instances the original division of labour agreed upon between the two organizations had not been easy to enforce.

He shared the concern expressed by the delegate of the Soviet Union regarding basic research. WHO might in fact have to confine its activities to the application of research without involving itself in basic research. Nevertheless, the Organization had a very strong moral as well as technical obligation to encourage aspects of research in Member States, especially in the developing countries, where research activities were generally in an embryonic stage. In practice it was extremely difficult to separate basic research from applied research and to inform a government that it should concern itself with clinical research on cancer, malaria or drug testing without becoming involved in immunology, biochemistry or genetics. In particular, it was very hard to see how WHO could do anything in the field of thalassaemia and genetically provoked diseases without involving itself in all aspects of genetics.

The delegate of the Netherlands had asked what WHO could do to promote the international coordination of work by various institutions, including laboratories. Apart from the production of vaccines, it was difficult to envisage how the Organization could proceed in that field without having some small participation in basic research. It was therefore not possible to state that WHO was interested only in the applied findings of research and that it should remain inactive as far as basic research was concerned. Lists of the research centres involved, and of their programmes, could scarcely be included in the documentation submitted to the Health Assembly, but the information was available to any interested delegate. The regional offices had been extremely active in the field of research in the context of technical cooperation among developing countries, and the Regional Directors would no doubt be able to supply the Committee with information on the activities of their respective offices.

Dr BERGSTRÖM (Chairman of the global Advisory Committee on Medical Research) said that the global ACMR had already proposed the establishment of a subcommittee on cancer. Coordination of national efforts could be very productive; a figure of about US$ 2000 million was probably being spent on cancer research, mostly in the developed world, and the aim of the subcommittee would be to try to find cooperative schemes in which developing countries could be included using national funds so as to generate a substantial volume of activity without calling upon the regular budget.

From 1981 onwards no country would have more than one representative on the global ACMR, and regional distribution was now approaching a balanced proportion. Furthermore, the chairmen of each of the six regional ACMRs were also members of the global ACMR, thereby ensuring extensive cross-fertilization. The regional directors were under great pressure from the advisory committees on medical research to focus resources on regional and national priorities. Discussion in the global ACMR was centred on the problem of how to meet priority needs with the very limited funds available.

Training was very much dependent upon institutions having both continuity of research and resources, and that in turn depended on the national arrangements regarding careers for research workers. In the developing countries there was a clear need for a considerable increase in voluntary contributions on the basis of long-term commitments, since it took from five to ten years to build up a strong research institution. There already were indications that such a process would take place.

Dr KO KO (Regional Director for South-East Asia) explained that the reduction of US$ 818 300 for South-East Asia shown on page 85 of document PB/82-83 did not mean that the total sum to be spent on research in that Region would decrease. Funds had merely been redistributed for budgeting purposes among other specific programmes with research activities such as malaria, leprosy, nutrition and health services research. The reduction of US$ 818 300 related to intercountry activities only. Funds allocated to research at the country level were shown under the "Research" heading and totalled approximately US$ 1.6 million. The amount shown in the proposed programme budget could be used for promotion and development as a catalyst to attract funds from elsewhere. In the following biennium, when the Seventh General Programme of Work would be formulated and adopted, it would be preferable to revert to the previous practice of entering the funds for all research activities under Research promotion and development.

As far as technical cooperation among developing countries was concerned, research in the South-East Asia Region was mostly done on a cooperative basis as a collaborative effort. The most obvious case was the malaria programme, where a major problem was chloroquine resistance in malaria parasites. A collaborative programme covering seven countries was being implemented. Liver cancer was another serious problem; nine of the 10 countries in the Region were working together on it, each country covering some specific area of research. Following the discussions at the meeting of directors of medical research councils organized in 1979, a work plan had been formulated to carry out an increasing number of research activities in the context of technical cooperation among developing countries.

Dr ACUÑA (Regional Director for the Americas) replied to questions put by the delegates of the United States of America, Trinidad and Tobago and Cuba regarding health research in the Americas. He said that the Organization was placing great emphasis on its collaboration with governments with a view to establishing career structures in research. WHO's Special Programme for Research and Training in Tropical Diseases was a case in point, and useful work could be done through the Caribbean Epidemiology Centre, which operated in close cooperation with the Government of Trinidad and Tobago and with the University.

Experience gained in promoting the identification of research coordinating units in the Member States of the Region of the Americas had proved most valuable, as some governments had shown increased interest in learning what was occurring in health research in their countries. Research workers in a number of neighbouring countries were getting to know one another and the research activities in which they were engaged, thereby strengthening their countries' overall research programme. The attempt to carry out continent-wide activities of that kind had met with budgetary problems, and the Organization was seeking extrabudgetary funds for that purpose. Even if such activities were not feasible in 1981, in 1982 it would be possible to hold a regional meeting on national research promotion and coordination. In any case the valuable comments made by delegates would make it possible to establish better coordinat on between the Special Programme for Research and Training in Tropical Diseases, the Regional Office, and PAHO representatives/WHO country programme coordinators. In that connexion he recognized that the Special Programme's organizational arrangements were to some extent defective in so far as it had not been able to establish closer links with governments through WHO for the purpose of keeping them appropriately informed: in fact, visits were sometimes made to countries without either the government or the WHO programme coordinator being aware of them.

Dr NAKAJIMA (Regional Director for the Western Pacific) said that in his Region, too, the reduction of the amount allocated to research promotion and development in the proposed programme budget was due to the transfer of research activities to other individual programmes. The sum shown on page 85 of document PB/82-83 covered only the activities of the Western Pacific Advisory Committee on Medical Research and its Subcommittee, meetings such as those of the directors of national research councils, and a regional centre for research and training in tropical diseases located in Kuala Lumpur. Areas of research of regional importance included schistosomiasis, dengue haemorrhagic fever, acute respiratory infections, Pigbel (Enteritis necroticans), clonorchiasis, fish poisoning and poisonous snake bites.

Most of the research done was carried out in accordance with the principle of technical cooperation among developing countries, which involved interregional as well as intra-regional cooperation. For example, in fields such as viral haemorrhagic fever, information was constantly exchanged with the Regional Offices for South-East Asia and the Eastern Mediterranean. The spread of the virus to Europe could lead to cooperation with the European Region. The list of collaborating centres for research in the Western Pacific Region was regularly published and was available to any delegate who wished to have it.

Dr STJERNSWÄRD (Cancer) said that Dr Kruisinga had raised a very important point about the possibility of better coordination between ACMR and IARC. That was a timely question, since the stage had been reached in the field of cancer when considerable action could be taken in accordance with WHO's philosophy. The delegate of Hungary had pointed out that cancer was, indeed, a problem in developing countries; in fact, a very high number of the estimated 35 million cancer patients in the world were in developing countries. At present there was a separation between the work of the two bodies, IARC covering causation and epidemiology, with related research, while the WHO headquarters Cancer Unit, together with the six regional offices, covered cancer control, namely primary and secondary prevention (including detection),

therapy and after-care, and related health services research. There was now enough knowledge to take active measures. Over the past 15 years IARC had done important work, and data were now collected on which relevant health action could be taken. The present separation represented an artificial splitting-off of, e.g. prevention and detection from epidemiology. Epidemiology in itself was not an end in itself; it should hopefully lead to results on which cancer control action could be built. Needed now were, for example, target-directed epidemiological studies on the basis of which cancer control measures could be realized.

As the Nigerian delegate had said earlier in the day, not all research needed to be done in the laboratory. Society itself could be viewed as a laboratory. For example, not enough was known about how to change human behaviour and optimally implement in the community knowledge already gained. However, enough was currently known about cause-relationship for some major cancers and relationship with life-style habits to enable active measures to be taken, applying results from research in practice. Preventive measures specific to cancers that were preventable in the countries concerned, could be implemented, leading to a significant reduction in incidence of those cancers. It would be possible to develop a pragmatic programme, in accordance with WHO's health service philosophy, which could have a real impact if there was better coordination, as Dr Kruisinga had suggested, between IARC and ACMR. He would welcome such a development and believed that it would lead to great benefits for the cancer patients in Member States. There was no doubt that the present coordination could be improved.

The ACMR Subcommittee on Cancer that would meet in the autumn of 1981, with the mandate "to work with IARC and the secretariat of the WHO Cancer programme to develop research for the prevention of those cancers whose etiologies are known, for early diagnosis and for the optimization of treatment methods, with due regard to their efficacy and economic feasibility", was a step in that direction, in the search for better coordination.

Family health (major programme 3.2)

The CHAIRMAN said that since programmes 3.2.1, 3.2.2 and 3.3.3 (Maternal and child health, Nutrition, and Health education) were closely linked and were all for the benefit of the family, they might be considered together and that programme 3.2.3, (Special Programme of Research, Development and Research Training in Human Reproduction) might be taken separately.

It was so agreed.

Dr ÁLVAREZ-GUTIÉRREZ (representative of the Executive Board) said that the Board had noted that family health was one of the most important elements of primary health care. It had appreciated the way in which the activities were presented in the proposed programme budget and commended the approaches and lines of action planned to achieve the objectives. The presentation emphasized the holistic nature of the family health care concept in that it not only reflected the integrated nature of the components, but also the importance of the family in health and health care, including self-care, and the significance of social and health interactions. Attention was drawn to the attitudes and roles of all members of the family, particular emphasis being placed on the importance of women's social and economic status as it related to women's health and the health of the family. Women's heavy burden of work, both outside and inside the home, and their roles in child bearing and child rearing, constituted a complex situation of great concern. The major programme sought to expand its activities for improving women's health and nutrition in combination with actions to develop social measures for supporting women, and to strengthen their roles in primary health care. Thus high priority was placed on the promotion of family planning and maternal health care. Those activities were closely related with others dealing with the promotion of breastfeeding and adequate feeding of infants and young children. Those activities were currently being expanded within the programme and would continue to expand in the future.

Activities were also to be expanded in the area of health systems research for family health, specifically in the application of the risk approach in maternal and child health and family planning care, which was being extended and developed by various WHO regions in response to the keen interest shown by more and more countries in all regions. That approach had been found to be a particularly useful managerial tool for the development of maternal and child health and family planning within primary health care, as it provided the basis for a more effective way of ensuring adequate and appropriate care for all and more care for those in greater need.

With respect to nutrition the Executive Board had recognized the close relationship between nutrition and both health and socioeconomic development. Nutrition was seen as the main factor affecting the quality of human life in most developing countries. The programme presented priority activities within the health sector's competence, including the control of nutritional deficiency diseases, the surveillance of nutritional status at community level, and an action-oriented research and development programme for strengthening nutrition-related activities as part of primary health care with focus on vulnerable groups. The programme aimed to improve the nutritional status of communities in the context of existing situations with locally available and acceptable foods. The Board had also discussed WHO's collaboration with FAO in that area, especially concerning the Codex Alimentarius, and reaffirmed its support for that collaboration.

Programme 3.2.3 (Special Programme of Research, Development and Research Training in Human Reproduction), in 1980 had involved administators and scientists from 85 countries, including 57 developing countries. The programme concerned family planning, infertility and other aspects of human reproduction. A major part of it was the building up, in developing countries, of resources for research on the topics concerned, and the dissemination of information. Research in the programme was conducted on a collaborative basis, and related to the safety of methods of fertility regulation, the development of appropriate new technology, psychosocial aspects, operational status, and the prevention and treatment of infertility. The Executive Board had noted, in paragraph 109 of its report (document EB67/1981/REC/3), that the programme relied on extrabudgetary resources and that the funds shown under the 1982-1983 biennium in the programme budget document reflected hopes rather than commitments. By January 1981 it had become clear that the funds available for the 1980-1981 biennium had fallen over US$ 6 million short of those indicated in the table on page 127 of the programme budget volume. Some requests from Member States could therefore not be met, and research and development activities had had to be curtailed. Much more research on new methods of male fertility regulation could be carried out if funds were available.

In relation to programme 3.2.4 (Health education), the Board had commented on the difficulties of the activities in that field and stressed the need for increasing innovative activities and seeking new techniques using, inter alia, social psychology and behavioural science tools. That had been envisaged in the proposed programme on health education, which put more emphasis on community involvement and individual and family self-care and self-reliance, as well as on increasing links with other development sectors in such areas as the training of development workers in health subjects, and in communications and information strategies for primary health care.

In view of the complex social and economic factors influencing the problems addressed in the family health programme as a whole, the trend in that major programme, which the Board welcomed, would be towards more activities being developed as part of intersectoral approaches within the strategies for achieving health for all by the year 2000. Even more effort would be required than in the past to ensure coordination of that major programme with other health development programmes and with the programmes of other United Nations agencies and bodies, and nongovernmental organizations.

The CHAIRMAN said that since a large number of delegates would probably wish to speak on the subject of family health, he would appeal to them to confine their remarks to a review of the programme budget, as the time available was not sufficient to allow of lengthy statements.

Dr HYZLER (United Kingdom of Great Britain and Northern Ireland) endorsed the Chairman's appeal for brevity in view of the short time available and the possibility open to the Committee of taking up the major programme under item 24 of its agenda.

Professor JAKOVLJEVIĆ (Yugoslavia) said that the family health programme as a whole was very important as a core element in primary health care; as such, it was crucial to health for all by the year 2000. The family, as the basic biological, social and economic unit of any society, had been given its proper place within the approaches, with special attention to the mother as the first provider of care in the home in terms of health, life-style and environment. The major programme covered activities in over 90 countries, and it was gratifying that most of the budget would be spent on technical cooperation activities, in accordance with resolution WHA29.48.

One most important aim was to reduce maternal, perinatal and infant mortality. He endorsed the need for new approaches and new technologies directly related to the causes of

maternal and infant mortality to be based on simple and inexpensive, but scientifically effective, methods. In his country, studies had been carried out of the high infant mortality in developing areas, in cooperation with the United States national institute of statistics, and it had been found that simple measures provided by front-line health workers could be more effective than hospitals or specialists. His delegation fully supported the maternal and child health programme.

He believed that extrabudgetary resources would be available, as in the past, and welcomed the increase in the regular budget. He agreed with the Executive Board (paragraph 100 of its report) that the role of the family in primary health care systems could not be overemphasized, and endorsed the Board's appreciation of the way in which the programme was presented.

Dr BORGOÑO (Chile) said that he realized the reason for the reduction in extrabudgetary funds, namely that the agencies providing them were going through a financial crisis. However, he wished to draw attention to the fact that more than half the cut was being borne by the maternal and child health programme, while others were scarcely affected, or even had their funds increased, as was the case for family planning activities and research. That situation was unacceptable in his opinion despite the importance of family planning as part of the family health programme. He therefore strongly urged that efforts be made with donor agencies and countries to maintain a proper balance, even within available extrabudgetary funds, between the various components of the major programme. He hoped that the Secretariat would do all it could to see that the agencies or countries that provided funds for family planning research, a programme in which Chile was participating, also provided funds for the other programmes, since the major programme on family health should be regarded as an integrated whole.

He emphasized the importance of the high risk concept in maternal and child care and nutrition and of its application in priority programmes.

He also noted that in several countries the neonatal component in infant mortality was rising, and in some countries, while infant mortality as a whole was decreasing, the neonatal component, especially the premature birth component, had risen to over 60% of the total. The causes of that pattern were little known; more research was therefore needed so that primary prevention could be developed to obviate the need for action at the secondary or tertiary levels.

Dr BRYANT (United States of America) expressed his appreciation of the presentation of the major programme on family health, and of the maternal and child health programmes in particular, and his support for the programme as a whole.

He wished to draw attention to recent scientific developments concerning the interaction of maternal health and fetal and young infant development that had striking implications concerning the ways in which primary health care might help to improve the health of mothers and their infants. The Secretariat had pointed out in the past that 22 million low-birth-weight babies were born every year, 21 million of them in developing countries. Those infants were mainly small for date of gestation, and not merely premature, which meant they had suffered retardation of fetal growth. For them the likelihood of perinatal death or persisting disability was much greater than for normal-for-date infants, especially with those born at term. In some countries nearly half of all deliveries were of low-birth-weight infants. What were the causes of that phenomenon, and what action could be taken? Recent findings were promising, and he wished to comment on four of them.

One of the main causes of low birth weight was infection of the amniotic fluid, which was the main cause of perinatal mortality in both developed and developing countries, but occurred most often in conjunction with maternal malnutrition, poverty and hard physical labour. Some underlying causes of amniotic fluid infection, including lack of bacteriostatic qualities of the amniotic fluid of undernourished women, were being worked out. One interesting finding was that the lack could be due to a shortage of zinc, although that still had to be proved.

Maternal undernourishment and maternal hypertension also contributed to low birth weight, and both could lead to placental abnormalities which, in turn, could lead to lower maternal blood flow to the fetus. Maternal undernourishment and maternal hypertension could act, alone or together, to result in undernourished and undersized infants.

Undernourished infants could be immunologically deficient, a condition that could persist into childhood, rendering such infants and children more than normally susceptible to infection.

Those comments had focused on the causes of perinatal mortality associated with low birth weight, but it was important to point out that those and other causes of perinatal mortality also occurred in infants of normal birth weight, so it was not enough to concentrate solely on low birth weight.

Many of the conditions referred to were preventable, and the steps of prevention, when fully understood, could most appropriately be taken at the level of primary care. It was clear that maternal health, especially in pregnancy, was crucial to the life and health of the infant. He hoped that in future applied research and field studies would link with primary care to improve greatly the care for the women and infants at risk for the problems associated with low birth weight. He urged the Organization to continue to pursue those and other important problems in maternal and child health.

Mrs HOUSSEINI (Niger) emphasized the importance of the programme under discussion in that it related to the health of mothers and children - the two main pillars of the nation. In her delegation's view, however, programmes 3.1.3 and 3.1.4 should really be covered under major programme 3.2, since workers and the aged were also members of the family and there seemed no reason not to consider the family unit as a whole.

Her delegation was pleased to note the amount of resources allocated to family health programmes, and hoped that such allocations would increase in future.

In order to make maternal and child health care in Niger more comprehensive, family planning education had recently been started at the maternal and child health centre level. Family spacing was stressed for the elimination of the risks of pregnancies too close together, particularly malnutrition, as also the substitution of the family wellbeing concept for the traditional notion that the more children were born the better. Her Government was therefore awaiting very eagerly the beginning of construction work on the family health centre financed by UNFPA.

With reference to the Board's comments in paragraph 107 of its report, advisory committees at regional level on maternal and child health could be very useful, since each country could benefit from the experience of the others within the region concerned.

In conclusion she expressed her country's gratitude to UNICEF for the help given to Niger with regard to maternal and child care.

Professor LU Rushan (China) agreed that programme 3.2.1 (Maternal and child health) should be regarded as an important part of primary health care, since it was a key factor in the efforts to attain health for all by the year 2000. His delegation supported the proposed programme budget for that programme. In China a great deal of attention was given to maternal and child care, each district, commune or village having its own unit. Recently a campaign had been launched to give high priority to care of women in the phases of menstruation, childbirth and menopause. Priority was also given to technical help in nurseries. China hoped to benefit from other countries' experience in those fields, and his delegation hoped that WHO would arrange for further exchanges of experience among Member States, especially with regard to prenatal care.

Dr COELHO (Portugal), referring to programme 3.2.2, said that nutrition was one of the rare fields in which a multisectoral approach had been adopted. Some two years previously Portugal had established a national council on food and nutrition, under the Department of Health but with the collaboration of other ministries, to establish a national policy for food and nutrition. For that purpose a survey had been conducted based on a 10% sample population; preliminary results had revealed a situation better than had been expected, although a number of problems, stemming particularly from some very old and stereotyped dietary habits, had been noted. A large-scale campaign of health education was being conducted, with particular stress on mothers and schoolchildren. Since nutrition and maternal and child health were two national priorities, those two groups could obtain free food supplements wherever necessary. And since nutrition had such an important influence on the quality of life, Portugal welcomed WHO's efforts and supported the proposed budget increases for nutrition programmes.

Dr BAJAJ (India), referring to the major programme 3.2 (Family health), thought that some activities should have been included for the benefit of the health of men in view of its effect on the health and, in many cases, even the continued existence of the family unit.

His delegation generally supported programme 3.2.1 (Maternal and child health) but would like to know the extent of the proposed UNICEF collaboration with regard to the child health component. Referring to programme 3.2.2 (Nutrition), he said that India had begun a goitre control programme which included the distribution of iodized salt in the affected areas; good results had been obtained. With regard to programme 3.2.3 (Special Programme of Research, Development and Research Training in Human Reproduction), India was conducting an effective contraception programme based on laparoscopic tubectomy; his delegation commended the programme to WHO's attention. Health education (programme 3.2.4), as a component of family

health care, should receive equal emphasis with the other components at the level of implementation. The Regional Director for South-East Asia had recently circulated a document in that connexion to the countries of the Region, dealing with the integration of health education in family health care. In his delegation's view, health education should be incorporated in education programmes, both formal and informal, at all levels.

Professor SENAULT (France) said it was clear, from the documents before the Committee, how much attention the Executive Board had given to the problem of family health. His delegation welcomed the proposed programme: the family, as the basic biological, psychological and social unit of any society, offered particularly suitable terrain for all of WHO's action. Family health was a particularly useful lever, when put to proper use. In that connexion, it might be well to look again at health education methods, where some re-thinking would prove worthwhile.

An excellent balance had been achieved between programmes and budget allocations and his delegation noted with satisfaction the increased allocation for the European Region.

Professor LISICYN (Union of Soviet Socialist Republics) said that WHO had come very close to defining the correct approach for solving health problems. The programme budget and the records of the Executive Board's session had put forward a new approach involving approaching the family as a whole and taking into account all the social, psychological and other factors that influenced it. Such an approach should provide the basis for defining the various programmes and budgetary allocations. It would of course be ideal to obtain, on the basis of that approach, a coherent view of the problem, i.e. the impact of family characteristics on the level of health of individual family members. The Organization was moving in that direction, as could be seen from the growing emphasis laid on the risk approach.

He expressed the hope that the risk factors and their study, as reflected in the programmes planned, would include, not only specific factors, such as accommodation and nutrition, considered singly, but family psychosocial relationships considered as a whole. In various research projects being carried out in the Soviet Union, including some at the Institute of which he was head, that factor was viewed as a determinant of the many indicators of the level of health of family members. Even with regard to fertility that indicator was used.

Another factor in the proposed integrated approach was the demographic composition of the family. Soviet research on the subject had shown that the levels of health of family members, especially the mother, differed greatly according to family size. That factor should therefore be given greater attention in the programmes under consideration.

In the evaluation of the health status of the family as a whole, more sophisticated indicators would be needed. In that connexion, his delegation welcomed the studies on birth weight, particularly low birth weight, as a factor influencing health of the child.

Another important indicator, which had been successfully studied in the Soviet Union, took the form of a health index, i.e. the absence of morbidity in relation to the number of births over a given period; that indicator was positive rather than negative, in that it looked at situations from the point of view of health rather than pathology.

The family viewed as a single unit had perhaps received insufficient attention, particularly with regard to the impact of health services where the provision of health education to the family and its effects on certain health indicators relating to individual family members were concerned. One clear indicator would be child and perinatal mortality. Available data already showed that the number of women who attended medical institutions and the number of consultations during pregnancy had a considerable impact on perinatal morbidity.

Certain of the programmes - for example, that relating to the effects of contraception on the female reproductive system - had not been given sufficient emphasis. Nor had the question of infertility or the problem of nutrition in children, including over-nutrition.

Dr HADJ-LAKEHAL (Algeria) requested that item 23 of the agenda - Infant and young child feeding - be considered earlier in the Committee's timetable, than was at present planned owing to the considerable importance of that subject.

The CHAIRMAN thought that the topic could perhaps be considered at the Committee's next meeting.

The meeting rose at 17h30.

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