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TWENTY-EIGHTH WORLD HEALTH ASSEMBLY

COMMITTEE A

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PROVISIONAL SUMMARY RECORD OF THE THIRTEENTH MEETING

Palais des Nations, Geneva
Monday, 26 May 1975, at 9.30 a.m.

CHAIRMAN: Dr Marcella DAVIES (Sierra Leone)

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Note: Corrections to this provisional summary record should reach the Chief, Editorial Services, World Health Organization, 1211 Geneva 27, Switzerland, before 9 July 1975.

DETAILED REVIEW OF THE PROGRAMME BUDGET FOR THE FINANCIAL YEARS 1976 AND 1977: Item 2.2.3 of the Agenda (Resolutions WHA27.57 and EB55.R22; Official Records Nos 220, 223 and 224; Documents A28/WP/2 and A28/WP/6) (continued)

Health statistics (programme sector 7.1)

Mr UEMURA (Director, Division of Health Statistics) said that the objective of the health statistics programme was to provide Member countries, directly and indirectly, with statistical services: directly, through the collection and dissemination of world health statistics and assistance to Member countries in improving their statistical systems; and indirectly, through the establishment of internationally agreed standards and guidelines and methodological support for all WHO programmes with a view to ensuring the statistical validity of activities under these programmes.

The importance of adequate information when decisions on public health had to be taken had been increasingly stressed, and most Member countries recognized that there were gaps in information. Accordingly, a number of changes had been introduced into WHO's health statistics programme, as reflected in Official Records No. 220 (pages 312-329).

The programme sector covered four areas: health statistical methodology; dissemination of statistical information; development of health statistical services; and the International Classification of Diseases.

The first area, health statistical methodology, provided statistical and mathematical support at all stages of WHO's various programme areas, from planning to execution and evaluation. Close collaboration with other programme sectors was therefore essential. Moreover the methodological support for regional research programmes was to be intensified, in line with the expansion of those programmes.

The second area, dissemination of statistical information, was undergoing considerable change. Data banks of world health statistics were being developed, and greater emphasis was being placed on processed, analysed and interpreted information. In 1974, a new programme had been started for the publication of articles based on the analysis of certain major health trends and differentials, e.g., world health trends up to the year 2000, world trends in medical manpower, and mortality trends in Europe. Further, WHO's policy on statistical publications was in the course of review, the purpose being to improve on the appropriateness, quality and relevance of the dissemination of statistical information. Steps were also being taken to involve the regional offices more closely in the collection and dissemination of statistics. It was hoped, by means of a coordinated approach, to relieve countries of the duplication of requests for data both from headquarters and from the regional office.

In regard to the third area, development of health statistical services, a systems analysis approach had been adopted. It included determining information needs, identifying information gaps and developing activities to fill such gaps. High priority would continue to be given to the developing countries, whose information needs were particularly acute, as regards both improvement of national health statistical services and personnel training.

Work on the final draft proposals for the ninth revision of the International Classification of Diseases (ICD) - the fourth area - was under way. Those proposals would be submitted to the International Revision Conference, to be held in Geneva during the autumn of 1975, and the Conference's recommendations would be submitted to the Twenty-ninth World Health Assembly for adoption.

A subject of particular importance to many developing countries, and one that would be emphasized in the future, was the development of a morbidity and mortality classification for use in communities with low medical density; it would consist of a classification of symptoms and signs that could be recorded by lay personnel.

In short, the main emphasis in the health statistics programme was on three areas. First, on emphasizing information rather than on providing crude statistical data; secondly, on developing the statistics programme as an integrated part of the overall WHO programme by strengthening cooperation with other programme sectors; and thirdly, on increasing the emphasis on programme activities geared to the needs of developing countries.

Programme planning and general activities (programme 7.1.1)

Dr JAKOVLJEVIC (Yugoslavia) said that there could be no effective management of a health programme without statistical data. He therefore fully supported the primary objective of the programme, which was to help countries to improve their health statistical services so that the necessary information was produced and was used effectively in assessing and monitoring the health situation of a country.

He also endorsed the principles that had been adopted with a view to modernizing the health statistics programme (page 312 of Official Records No. 220). Even where statistics were available, however, expert knowledge as to their use was often lacking and WHO's guidance in developing such knowledge, through training, was therefore urgently needed in developing and developed countries alike.

Lastly, he drew attention to the Executive Board's report (Official Records No. 223 page 175, paragraph 110) in which WHO was urged to "direct its attention towards analysing the vast quantity of information with a view to simplifying and rationalizing it". He considered such an analysis to be extremely important and would like to hear what steps might be taken to achieve it.

Dr GOMAA (Egypt) said that his delegation much appreciated all the phases of the programme on health statistics.

Any lack of health statistics in the developing countries was due partly to lack of interest - which stemmed from an inherent weakness in such statistics or from doubts as to their value - and partly to lack of the necessary machinery and expertise for their collection, analysis and publication. Nonetheless, statistics were of fundamental importance in the planning, programming and follow-up process and the developing countries were anxious to raise the level of their activities in that connexion. Any assistance from WHO would therefore be welcome.

He stressed the importance of having a sufficient number of statisticians engaged in the planning and evaluation process and of training them in the use of computers and modern scientific methods.

Dr SHRIVASTAV (India) said that health statistics were of vital importance at all stages of a health programme. Difficulties occurred, however, at the peripheral, or village, level where the data collected often proved unreliable owing to the health staff's lack of competence in diagnosing the cause of disease. It was therefore essential to think in terms of the relationship between the basic health services and the collection of crude data, and to strengthen the former so that data collected by the primary medical doctor or the medical health assistant would be as reliable as possible. Unless that was done, subsequent work on the data at a higher level would inevitably also be inaccurate.

Professor DAVIES (Israel) congratulated the Director-General on the recent trend towards using health statistical services as a tool in planning and evaluating health services.

Public health doctors tended to regard statistics with suspicion or as a subject that was foreign to the treatment of patients and the prevention of disease. The move towards a health information system might help to overcome a natural prejudice that was still to be seen even among medical students.

Countries at every stage of development needed WHO's guidance in overhauling the traditional systems for collecting statistics and, even more, in deciding what items of data should be collected and for what purpose. Moreover, once health services had been organized, the items of information required to enable them to be evaluated had to be determined. In that respect, WHO could assist in two ways. The first was in helping to prepare an outline of a health information system - or series of systems - suitable for countries at different stages of development and which could be used in planning and evaluating the health services. For example, it had been found in Israel that the items of information required for a health information system covering 300 000 people were the same as those for a system covering 30 million people.

The second way in which WHO could assist was in connexion with the possible use of proxy measurements: it might be possible to measure one or two items and, from them, to deduce other items that could not normally be measured directly, or only at great cost. The most important requirement, however, was constant analysis and feedback of very simple information at the most primitive level, failing which health statistics would simply continue to be fed to higher echelons and then forgotten.

Dr DAS (Nepal) was gratified at the emphasis placed by WHO on the collection, evaluation and processing of data.

Referring to Official Records No. 220, page 314, he noted that the total estimated obligations for the programme had dropped from $ 653 200 in 1975 to $ 639 530 in 1976; and, further, that under project PPH 001 (Support to country family planning programmes) (page 315), the total estimated obligations had dropped from $ 110 100 in 1975 to $ 71 000 in 1976. In his view, there should have been an increase, not a decrease, in those amounts.

Dr KUPFERSCHMIDT (German Democratic Republic) said that his delegation much appreciated the statistical and epidemiological information compiled by WHO, which helped to identify the main health problems and to analyse general health trends. International comparison of the total life expectation of the newborn, however, was no longer an adequate way of comparing the health status of populations: an easier way to determine general health trends would be to compare the life expectation of different age-groups and of patients suffering from certain widespread diseases, with and without treatment. He appreciated the difficulties in securing valid data but asked whether WHO could not compile some statistics on the basis of that consideration.

Dr ALFA (Niger) said that the use of statistics and epidemiological information posed enormous problems for most developing countries. When there were not enough doctors in the field but only paramedical staff with limited knowledge, and when there was no real statistical service, one must tread warily in matters pertaining to the collection and use of data.

The nature of the epidemiological data that developing countries were required to transmit to WHO was not rational, in his view. How could a country such as Niger - without a single laboratory that was adequately staffed or equipped - diagnose a specific type of viral hepatitis - say, leptospirosis or the rickettsial diseases? Such data as it did provide came mostly from nurses. How, on that basis, could WHO draw the right conclusions and, even more so, implement a campaign against a given disease? Even when there was the necessary infrastructure in terms of staff and equipment, the statistical services were often still virtually non-existent. He therefore considered that, as far as the developing countries were concerned, first things must come first. His country would continue as before to give information on certain diseases. But WHO should start by helping to train personnel and equip laboratories so that developing countries could meet the requests made of them - which was absolutely essential if the programmes proposed by WHO were to reach a successful conclusion.

Health statistical methodology (programme 7.1.2)

Professor KOSTRZEWSKI (Poland) said that health statistics would play an increasingly important role in WHO programmes, since the planning, implementation and evaluation of any public health activity required an effective information system. The need for reliable information on health was imperative, particularly in countries starting to plan and organize comprehensive medical care and where the health statistical information system had to be effective, simple and inexpensive.

There was much expertise and initiative in Member countries and also in WHO country projects - and it was of crucial importance for the latter to cooperate closely with regional offices and with headquarters. That experience could be drawn upon to improve health statistical methodology, the classification of diseases and health statistical services generally. Extremely interesting work was being done in Africa, particularly in Nigeria and Kenya. The Nairobi epidemiological surveillance centre, for example, was preparing a new health information system that could be applied to all health institutions, whether public or private. Such activities - which undoubtedly also went on in other regions - could serve as a feedback from Member countries and prove very useful for headquarters work.

Dissemination of statistical information (programme 7.1.3)

The CHAIRMAN invited consideration of the following draft resolution on health statistics related to alcohol:

> The Twenty-eighth World Health Assembly,
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> Recalling the recommendations made by the meeting of the WHO Expert Committee on Drug Dependence, held in Geneva from 8 to 13 October 1973;
>
> Noting the widespread trend toward increasing levels of alcohol consumption in some of the industrialized and the developing countries and the consequent health hazards which require new initiatives at the international and national levels;
>
> Noting the association between the level of alcohol consumption and certain forms of health damage;
>
> Recognizing that a basic ingredient in the formulation of a national public-health-oriented alcohol policy is reliable statistical information on alcohol consumption and certain forms of health damage;
>
> Bearing in mind the need to broaden the scope of health statistical information to comprise not only diagnostic disease entities but the entire variety of major determinants of health;

REQUESTS the Director-General

(1) to direct special attention in the future programme of WHO to the extent and seriousness of the individual, public health and social problems associated with the current use of alcohol in many countries of the world and the widespread trend toward higher levels of consumption;
(2) to take steps, in cooperation with competent international and national organization and bodies, to develop comparable information systems on alcohol consumption and other relevant data needed for a public-health-oriented alcohol policy;
(3) to study in depth, on the basis of such information, what measures could be taken in order to control the increase in alcohol consumption involving danger to public health;
(4) to report on this matter to a coming session of the World Health Assembly.

Dr LEPPO (Finland), introducing the draft resolution, said that it was based on three main considerations.

The first concerned the reason that the proposal was submitted under the heading of health statistics when a number of other programme sectors were involved. As stated in Official Records No. 220 (page 312), statistics should serve a defined purpose and be specifically oriented to user needs. To achieve that end, attention must be paid not only to the end-result in terms of disease or other factors but also to the risk factors or predisposing circumstances leading to such a result. For example, in the case of lung cancer and chronic respiratory disease, reliable statistical information on levels and patterns of tobacco consumption was an essential risk indicator and a sine qua non in any epidemiological appraisal or analysis of programme effectiveness. There was a similar situation with dental caries as regards the level and pattern of sugar consumption and fluoride intake by various population groups. Again, statistics on traffic accidents were of little value without the relevant background information; and morbidity and mortality statistics on enteric fever and other waterborne infections were significantly only if considered in relation to indicators of water supply conditions. That was the philosophy behind the last preambular paragraph in the draft resolution.

The second consideration - which related more specifically to the substance of the draft resolution - was that, despite the long recognition by WHO of drug dependence as an important public health problem, alcohol had not generally received enough attention. Recently, however, two reports had redressed the imbalance. The first, entitled "Alcohol control policy and public health", had been published by the European Regional Office (WHO/EURO Publication No. 5455). The second was the latest report of the WHO Expert Committee on Drug Dependence,[1] published in 1974. He quoted certain extracts from the Committee's report which stressed that the problems posed by alcohol consumption were often greater than those connected with other dependence-producing drugs; that alcohol-related illness had a considerable economic impact on the health services of various countries; and that it was essential to reverse the current trend towards the increasing use of alcohol. The Expert Committee's report also noted the association between levels of alcohol consumption and certain diseases and injuries. Those ideas were reflected in the second and third preambular paragraphs of the draft resolution.

The third consideration behind the draft resolution was to call attention to the way in which expert committee reports were dealt with in WHO. In his delegation's view, much work done by the best brains in public health received little notice: the reports referred to were prime examples of documents requiring critical scrutiny by every health administration and policy-making body faced with the problem in question.

The sponsors of the draft resolution hoped to provide WHO with additional support in tackling the problem of alcohol from a public health point of view, and in intensifying its action. At the same time, WHO should bear in mind the need to develop the kind of statistical and information system which would serve as the basis for a rational public health policy and the evaluation of such a policy.

Professor KOSTRZEWSKI (Poland) said that, as cosponsor of the resolutiom he would like to propose a few amendments.

He suggested that at the end of the third preambular paragraph, after the words "health damage", the following should be added:

"resulting in an increase of morbidity and mortality (e.g., mental diseases, acute or chronic liver diseases, alcoholic cardiomyopathies, accidents and injuries)".

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[1] WHO Technical Report Series No. 551, 1974.

Secondly, he suggested that in the fifth preambular paragraph, the words "diagnostic" should be deleted and the words "or specific conditions" should be addedd after "disease entities". In the same paragraph the phrase "the entire variety of" should be replaced by "also"; and that the following should be added after the words "of health" at the end of the paragraph: "and social wellbeing connected with alcoholic consumption". He further proposed the insertion of a new first operative paragraph to read:

> "1. URGES Member States to promote the development of information systems on alcohol consumption and other relevant data for a public-health-oriented alcoholic policy;"

The reason for inserting this new operative paragraph was that the WHO Secretariat would probably find it difficult to develop comparable information systems unless such systems were also developed in Member States. He suggested that the existing operative paragraphs of the resolution be combined into a single operative paragraph beginning: "2. REQUESTS the Director General", the subparagraphs being then renumbered (a), (b), (c) and (d).

Dr GOMAA (Egypt) said that his delegation was very pleased that an international medical gathering should be concerned with health hazards of alcohol consumption and the use of statistical information to combat those problems. Although the use of alcohol was not a social or health problem in Egypt, his delegation entirely supported the draft resolution.

Mr ASVALL (Norway) welcomed the efforts of the Secretariat to make health statistics more functional.

He thought there was general agreement that statistics could provide valuable feed-back for activities such as planning, production, control, evaluation, teaching, and research. The difficulties arose when the aim was to elaborate practical systems that could be used at local and regional as well as national levels. He was therefore in complete agreement with the views of the delegate of Israel and hoped that in future WHO would pay particular attention to the preparation of detailed manuals that would provide guidance on the social indicators needed for elaborating this type of system. Most countries must have experienced the great problem of available statistics, not being used, even when they were potentially very useful. In teaching students, therefore, motivating them to make use of the statistics available should be of particular concern.

With regard to the problem of alcohol consumption, he acknowledged the need for more statistics and emphasized the importance of coordinating the statistics concerning the effects of alcohol on health with those in related social fields. His delegation gave its full support to the draft resolution.

Professor REXED (Sweden) stated that damage to health owing to a high level of alcohol consumption was an important problem in Sweden and had been subject of several recent committee reports. His own department was engaged in work to clarify the situation and to help develop new means of prevention and therapy. The increased interest being shown by WHO in this problem was therefore warmly welcomed by Sweden. In the past, WHO and other international organizations had been very concerned about drug dependence of the classical type and had taken strong action to prevent its spread; but perhaps in the long run the use of alcohol would present a greater threat. He therefore believed that in the future WHO should consider alcohol consumption in a broader context than that of health statistics.

Dr ALFA (Niger) requested that the name of his delegation be included among the sponsors of the draft resolution.

Dr FREY (Switzerland) said that the situation in Sweden appeared to be very similar to that in Switzerland. About 2% of the population of Switzerland were chronic alcoholics - which meant that there were about 120 000 persons suffering from chronic alcoholism. He also felt that in Switzerland the problem of alcoholism was more serious than that of drug dependence. His delegation therefore wholeheartedly supported the draft resolution and wished to be included among the sponsors.

Dr ADAMAFIO (Ghana) supported the new operative paragraph that had been proposed by the delegate of Poland, which emphasized the need for Member States to develop their own health information systems. This implied training people in the developing countries to collect, analyse, and use health statistics. Hitherto, when a health statistics project was to be carried out in a developing country, it had been usual to bring in specialists from the developed countries or from WHO, and most of the money that had been allocated to the project was used to pay these specialists. Consequently, the actual

benefit of the project to the country was rather small. He believed that health information systems should be developed by personnel from the countries in which they were to be used.

Dr KILGOUR (United Kingdom of Great Britain and Northern Ireland) supported the draft resolution as proposed by Finland as amended by Poland. He expressed particular approval of the statement by the delegate of Sweden that the physical and social problems posed by the abuse of alcohol merited attention in their own right, and he hoped that future Health Assemblies would give more attention to that question.

Dr QUAMINA (Trinidad and Tobago) affirmed the great interest of her delegation in the health problems posed by the increased consumption of alcohol and requested that Trinidad and Tobago be included among the sponsors of the draft resolution. It was only by collecting statistical information of the kind proposed in the draft resolution that the full extent of the socioeconomic and health problems would be appreciated. In view of the numerous amendments that the delegate of Poland had proposed, however, she requested that the Committee be given the opportunity to review the amended resolution as a whole before a vote was taken.

Dr SHRIVASTAV (India) said that, although he was in full agreement with the spirit of the draft resolution, he would like clarification of a procedural point. There was a need for the collection of statistical data on the incidence of various diseases. He wondered however whether the resolutions themselves should be presented during the discussion of the health statistics programme or whether they should not rather be presented when the diseases in question were being discussed. He asked for guidance on this question in case he should wish to introduce a resolution relating to the collection of health statistics on a particular disease at some future Health Assembly.

Dr CHRISTENSEN (Secretary) replied that as far as possible the Secretariat had attempted to relate the draft resolutions to the programmes to which they referred. It sometimes happened, however, that the resolutions were not processed until the item concerned had already been dealt with in the discussion of the programme budget. This was the reason why the resolution on health statistics related to alcohol was being discussed at this point.

Dr EL-JERBI (Libyan Arab Republic) expressed the conviction that alcohol consumption had direct harmful influences not only on health but also on the economic and social development of the community. His delegation therefore fully supported the resolution.

Dr SENAULT (France) proposed two drafting changes to the French version of the draft resolution. He asked to have an opportunity of studying the new version of the draft resolution incorporating the amendments proposed by the delegate of Poland.

The CHAIRMAN announced that further consideration of the draft resolution would be deferred until a working party had produced a revised version.

Development of health statistical services (programme 7.1.4)

There were no comments.

International classification of diseases (programme 7.1.5)

Dr KILGOUR (United Kingdom of Great Britain and Northern Ireland) stated that the United Kingdom, like many other countries, had been considering how best to educate those concerned with using the ninth revision of the International Classification of Diseases. Obviously each country would want to undertake its own programme, but to avoid duplication he thought that some selective basic training should be organized centrally. He welcomed the initiative referred to on pages 327 and 329 of the programme budget, but wondered whether the budgetary resources would be adequate. Experts from the United Kingdom would be most willing to take part in any such preparatory activity should the Organization require external assistance.

Professor DAVIES (Israel) welcomed the efforts that were being undertaken to make the International Classification of Diseases more universal and more useful. He recalled the comments made by the delegate of Niger. Many countries were unable to collect sufficiently precise information to be able to make full use of the International Classification: he doubted whether any country was able to collect such precise data for every disease. He thought it probable that no single classification could be of universal use and urged the development of separate, "daughter", classifications of symptoms that could be used by those

responsible for primary health care delivery in places where facilities for making detailed laboratory investigations were lacking. These "daughter" classifications should be linked to the "mother" International Classification so as to yield comparative data, not only of events in countries at the same level of development of health services but also in countries at different levels.

Dr MASSÉ (International Epidemiological Association), speaking at the invitation of the CHAIRMAN, said that, as had already been pointed out by the delegate of Egypt, to ensure the regular collection of the health statistics that epidemiologists needed in order to measure morbidity and the efficacy of public health measures, an information system was required comprising a network of statisticians who had received a very special type of training. Medical and paramedical personnel needed additional training in statistical methodology, while statisticians needed to be trained in epidemiology. The International Epidemiological Association was prepared to make increased efforts to participate in such training by setting up training courses for teachers, organizing travelling seminars, and preparing manuals of methodology and training guides. It was able to call on 700 experts for this work, but would welcome collaboration with WHO.

Mr UEMURA (Director, Division of Health Statistics) thanked the delegates for their valuable suggestions and constructive criticisms of the health statistics programme.

Several delegates had stressed the importance of developing information systems to replace the traditional approach to the collection of statistics. The Organization was fully aware of the need for adopting a user-oriented approach emphasizing information rather than crude data. It was necessary first to identify the information that countries needed and then to undertake studies to supply the missing information.

WHO was trying to develop international standards and guidelines and also principles for the collection and analysis of information. Considerable changes had been made in the ninth revision of the International Classification of Diseases to improve its usefulness in the handling of morbidity data as opposed to mere cause-of-death coding. The Organization continued to attach importance to achieving international comparability of data, but it felt that rigid standards should not be imposed on countries. Any information system should be adapted to the specific needs of a country, and it was necessary to be flexible in this respect.

He assured the delegate of Poland that WHO in its statistical work was taking steps to develop close collaboration with basic health services, especially with regard to country health programming: the Division of Health Statistics was collaborating closely with the Division of Strengthening of Health Services, as previously discussed. He agreed with the delegates of India and Niger that there should be a basic structure for the collection of statistical information at the peripheral level. As suggested by the delegate of Israel, the Organization was endeavouring to develop a classification that was concerned much more with signs and symptoms.

Referring to the need for training programmes, as emphasized by the delegates of Egypt and Ghana, he stated that such programmes needed to be directed to both the producers and the users of information. The problem of the non-use of available statistics had been mentioned by the delegate of Norway. This question would be emphasized in future in the training of non-statisticians as well as in that of statisticians. WHO was developing a manual for teaching health statistics. He thanked the representative of the International Epidemiological Association for his comments and suggestions regarding taining in health statistics and epidemiology and said that WHO would be very happy to collaborate with the Association.

The delegates of both the German Democratic Republic and Norway had mentioned the importance of health indicators. The traditional indicators had been based mainly on mortality statistics. It would be necessary to develop new indicators based also on morbidity statistics and on health-related socioeconomic data. WHO was studying this problem in collaboration with the United Nations Statistical Office and OECD, in the context of the development of social indicators.

The delegate of Nepal had asked why funds for the interregional programme had decreased for 1976. The main reason was the uncertainty regarding sources of funds other than the regular budget, particularly UNFPA.

He was particularly grateful to the United Kingdom delegate for his offer of expert assistance in training activities related to the introduction of the ninth revision of the International Classification of Diseases.

With regard to the resolution on health statistics as related to alcohol, he assured the Committee that this problem would receive full attention and that in developing a programme the Division of Health Statistics would collaborate closely with the Office of Mental Health.

Dr GIVOVICH MERCIER (Chile) said he was particularly concerned about perinatal mortality. In some countries such a wide definition was given to "perinatal" that it was taken to cover almost the entire pathology of the newborn. For example, the term "perinatal haemolytic disease" was used, when in reality that condition arose considerably earlier than the perinatal period. (This was not merely a semantic distinction: in attempting to prevent morbidity it was particularly important to know the moment at which disease started.) In his own country the word "perinatal" also covered congenital malformations, malnutrition and also certain maternal conditions; in addition there were the real perinatal events, including hypoxia, birth injuries, the aspiration syndrome and cerebrospinal trauma, and also postnatal events. Confusion was also caused by the fact that the neonatal paediatrician was called the perinatologist, when in fact his functions extended well before and after the perinatal period.

Dr JOYCE (Ireland), referring to the forthcoming ninth revision of the International Classification of Diseases, suggested that undesirable terms which had to be included should be marked with an asterisk. Often those responsible for coding those terms did not fully understand their medical significance.

Promotion of environmental health (programme sector 6.1) (continued)

Food standards programme (programme 6.1.7) (continued)

Dr LU (Food Additives), replying to a question by the delegate of Egypt concerning the definitions of foods and drugs, said that foods were defined as substances consumed by man for the maintenance of normal physiological functions and to permit growth. This definition would not include drugs, which were defined as substances used for prophylactic, diagnostic, and therapeutic purposes. There was overlapping in some instances, however, as in the case of dietetic or fortified foods, e.g. foods of high-protein, high-calorie, low-calorie or low-sodium content, and infant formulas. These diets were dealt with by WHO in collaboration with FAO and government experts within the framework of the Codex Alimentarius Commission, which was responsible for standardizing foods to ensure that they complied with the claims made for them and contained no harmful substances.

Overlapping between foods and drugs also occurred in the case of veterinary drugs, which were used to stimulate growth in farm animals and for other purposes. They included such substances as anabolic hormones, antibiotics, and other chemotherapeutic substances, which often left residues in meat, eggs, and milk that might pose health hazards. These substances had been evaluated by the Joint FAO/WHO Expert Committee on Food Additives and by a workshop on antibiotics set up two years ago by the WHO Regional Office for Europe. The aim of those bodies was to ensure that the levels of the residues found in eggs, meat, etc., were within permissible limits.

Health literature services (programme sector 7.2)

Mr TAINE (Chief, Office of Library and Health Literature Services) said that the programme statement in Official Records No. 220 indicated a major change in the Organization's activities in the health literature service programme sector. The previous year's programme had been an essentially passive, traditionally orientated library operation primarily geared to providing service to WHO staff in Geneva and elsewhere, whereas the new programme was more dynamic and had acquired greater force.

Following resolution WHA25.26, which recommended that WHO "should assume a leading role in the development, coordination, and improvement of biomedical communications", a new and comprehensive global health literature programme had been initiated. The programme's fundamental objective was to assist developing countries in the construction of their own capabilities to obtain the vital information needed over the whole range of education, training, research and health care delivery activities. In furthering that objective, plans were being made for a "study by an international group of experts of the role of WHO in relation to modern problems of biomedical communications", as requested in the same resolution.

The health literature programme aimed to achieve a state of national self-sufficiency with regard to the many types of health literature needs found to exist locally. Although there would be significant differences from region to region and from country to country, there were also sufficiently common positive factors to make it possible to adopt a global approach.

The elements of the health literature programme had been selected and structured after extensive first-hand observation and study of conditions in many of the developing countries in various parts of the world. The programme planned to establish regional health literature centres to provide and coordinate a range of related services which would

be available in various countries. The further development of national infrastructures and capabilities would be an essential objective of those regional centres.

The centres would be concerned with providing effective training of manpower related to library and information matters, with improved delivery of library materials and equipment, with making available various remote sources of information, and with attempting to solve critical problems that had hindered satisfactory information transfer in the past. One of the components of the programme was the very successful MEDLINE service, now beginning its second year of operation. Planning of other components was well advanced, but dependent upon adequate funding for full scale development and implementation. Virtually all of the programme's financial support was expected to come from extrabudgetary sources, which had been vigorously solicited. However, it had been difficult to persuade potential donors of the profound importance of a programme such as the health literature programme, which until now had played a modest supporting role for virtually all other health programmes.

Within the Organization, the importance attached to the programme was reflected by the relocation of the WHO Library in the Office of the Director-General and its renaming as Office of Library and Health Literature Services. Effective implementation of the health literature programme would depend largely on the active support and priority that Member States chose to assign to it.

Professor SENAULT (France) considered the health literature service particularly important. Documentation provided by WHO to both developed and developing countries was an essential means of disseminating knowledge on the evolution of modern scientific thought. At a time when research in all countries was progressing at an extraordinary rate, it was vital for Member States to be kept informed of the advances made in various sectors of the health field. All those involved in education and training of health professionals as well as those actually working in the health services, knew the great value of WHO documentation.

Expense was an important consideration, and such documentation should therefore be distributed with discrimination in order to avoid wastage. He welcomed the new orientation of the health literature service, which laid emphasis on assistance to particular geographical areas.

Dr MARCIAL (Mexico) supported the views expressed by the delegate of France. The planning and implementation of a programme for organizing a network of biomedical documentation services was a priority need in many developing countries. Much of the documentation on the progress of biomedical science got no further than the information and documentation centres, since most libraries in the developing countries were obsolete and unable to subscribe to a sufficient number of periodicals. Medical literature services needed funds for subscriptions to periodicals, audiovisual and other equipment, trained professional and auxiliary staff, and technical assistance. The MEDLINE service offered great possibilities for countries of the Region of the Americas.

He was concerned that national information and documentation services should achieve autonomy, developing centres which would be part of a national network involving the participation of the health services and of the universities. He therefore drew attention to the urgent need for extending and improving literature services in all developing countries.

Dr MAFIAMBA (United Republic of Cameroon) welcomed the new MEDLINE service which had been made available to Member States. He was glad to see that steps were being taken to make WHO's health literature services better known to health workers in all countries, particularly in the African Region.

Dr TARIMO (United Republic of Tanzania) said that while he considered the objectives of WHO in establishing regional health literature centres were excellent, he was not clear precisely how such centres were going to work. In view of the difficulties of communication between countries, particularly in the African Region, he did not see how a single centre could serve a number of different countries. He wondered whether it would be more effective to use the office of the WHO country representative as a centre for the dissemination of health literature.

He urged that WHO should play a more active role in collecting and disseminating information on health activities to the developing countries.

Dr SADELER (Dahomey) supported the comments made by previous speakers. He requested the Director-General to provide assistance in strengthening services where they already existed, and in planning such services as a matter of urgency where they did not exist. Teaching and research, especially epidemiological research, could not make progress without a regularly updated documentation service. A basic infrastructure should be created for the developing countries, comprising university libraries stocked with the latest publications, and audiovisual equipment to facilitate the training or retraining of a country's health teams. The exchange of information between research centres and universities should be facilitated, both in developed and developing countries.

Dr ADAMAFIO (Ghana) said that for some years past WHO had been urging developing countries to rely more heavily on rural health centres for the delivery of health care. Such centres were run by health assistants or superintendants, who were not as highly qualified as doctors but were trained to perform multiple functions, including disease prevention and the giving of advice in family planning and nutrition. There was need for a comprehensive training manual to assist in the training of such personnel and also in the training of laboratory technicians.

In view of the ignorance of most of the general public on health matters it was vital to provide a good health education service. Unfortunately, the material used for that education (films, tapes, etc.), was not always relevant to local conditions and to rural communities, and he urged WHO to endeavour to make that material better fitted to local needs. There was a shortage of health educators in his country and he would be grateful for WHO assistance in training more such educators.

Dr SHRIVASTAV (India) said that care should be taken, when planning the health literature service, to avoid duplication with the large body of medical literature that was being issued independantly of WHO. On the other hand, there was a considerable shortage in many countries of such literature as training manuals for paramedical personnel and illustrative material for medical colleges, and WHO should concentrate on supplying that need.

Dr JOYCE (Ireland) said that WHO publications were not getting a wide enough distribution. He suggested that the Organization should circulate a list of its publications to all medical journals on a monthly or two monthly basis.

Mr TAINE (Chief, Office of Library and Health Literature Services) said one of the important features of the new programme would be variation from region to region and country to country, resulting in the kind of national development mentioned by the delegates of Mexico and Dahomey. In reply to the question raised by the delegate of Ghana, he said that the regional centres would be actively equipped to provide services to meet the particular needs of the various countries.

On the point raised by the delegate of India, he assured the Committee that WHO was endeavouring to coordinate activities and make use of already existing facilities to the fullest extent possible. Attention was being focused on the provision of those types of health literature that were not already being taken care of by others.

The meeting rose at 11.40 a.m.

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