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TWENTY-NINTH WORLD HEALTH ASSEMBLY

COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE THIRD MEETING

Palais des Nations, Geneva
Monday, 10 May 1976, at 9.30 a.m.

CHAIRMAN: Professor F. RENGER (German Democratic Republic)

CONTENTS

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THIRD MEETING

Monday, 10 May 1976 at 9.30 a.m.

Chairman: Professor F. RENGER (German Democratic Republic)

REPORTS ON SPECIFIC TECHNICAL MATTERS: Item 2.5 of the Agenda (continued)

Psychosocial factors and health: Item 2.5.1 of the Agenda (Resolutions WHA28.50, EB55.R20 and EB57.R22; Document A29/8) (continued)

Dr FUNKE (Federal Republic of Germany) said that psychosocial factors entered into all aspects of health, as the document before the Committee showed. Health care was becoming more complex, and its effectiveness was being subjected to more critical scrutiny. Doctors and other health workers still took psychosocial factors too little into account, with the result that other workers dealt with psychosocial problems without consultation with the health agencies. That created a potential danger, and it was therefore essential that there should be more people in the health field who had the necessary training and experience and who adopted an integrated approach. The training of doctors and health workers must be modified so as to improve their knowledge and their attitudes towards their patients. Textbooks on the subject of psychosocial factors were lacking, and WHO should review the situation throughout the world and perhaps consider having a number of textbooks translated for the benefit of health workers. There should also be close cooperation between the health services and social and other services, in much the same way as WHO collaborated with ILO, UNESCO and UNHCR. In view of the small amount of money provided for the programme, there was little hope of its making a brilliant financial start, consequently the emphasis had to be on cooperation and on a limited number of priorities. In her view the stress should be on high-risk populations, particularly on migrant workers. It would be of great value to know how migration affected mental and somatic health and whether some countries were more successful in integrating migrants than others; a comparative study of migrant populations and of controls in their home country might perhaps be carried out. The subject received priority in her country and her Government offered its cooperation to WHO in any programme it proposed to undertake. It also supported the draft resolution prepared by the Executive Board.

Dr HASSOUN (Iraq) said that the aftermath of rapid industrialization and urbanization in Iraq was social disorganization and the disruption of family life. On the one hand, they brought slums, pollution, disease, malnutrition and an increase in the accident rate; and on the other, an increase in aggressivity, crime, suicide and alcoholism. As in most countries, psychiatric care lagged behind other forms of health care. The planners in his country had from the beginning stressed the integration of mental health care with other forms of care, and his Government would welcome advice that would help it to improve its health care delivery to communities faced with rapid social change, particularly in relation to training and to preparation for research.

Dr VILCHIS (Mexico) said that his Government had always regarded psychosocial factors as important, and that it had changed the curricula of the medical schools so as to give them due consideration. Psychosocial factors were coming to the fore as a result of modern life and modern civilization, and they played an important part in disease. The reason for the non-utilization of the services resides in the gulf between the public health personnel and the people receiving the services as well as the latter's mental condition. The document before the Committee deserved support for its approach to the problem.

Professor SENAULT (France) approved of the proposal in the report that existing knowledge in the psychosocial field should be applied to improve health care. Psychosocial factors had been neglected until recently, and they formed a new phase in WHO's work. It was essential that there should be collaboration between the health services and the social services, and such collaboration should take place from the lowest level so that support could be given to families and individuals.

In relation to the application of existing knowledge, evaluation was difficult but an essential part, not only for technical reasons but also for economic and social reasons. New information would improve scientific knowledge and also help improve the teaching of psychosocial factors in the medical schools, but because it involved considerable expense its acquisition was justified only if it lead to action. His delegation supported the report and the draft resolution. Member States should look favourably upon the programme, since it would help the health services to be aware of the importance of psychosocial factors and thereby improve the conditions of life for individuals and communities.

Sir Henry YELLOWLEES (United Kingdom of Great Britain and Northern Ireland) said that psychosocial factors affected all individuals and all aspects of health. Because countries were individual, methodologies could not be easily transferred from one to another. In his view it was essential to improve basic training in the importance of psychosocial factors for all disciplines in a way that would be suitable for each country and lead it to take due account of such factors in planning all its health programmes. An important question was which of existing or planned programmes would benefit most from knowledge about psychosocial factors. Fresh knowledge was obviously required, hence he approved of subparagraph (3) of the operative paragraph of the draft resolution. The programme was an important one, but he doubted whether it should be given overriding priority.

Miss ABDELLAH (United States of America) said that her delegation supported the resolution prepared by the Executive Board. The field was complex, and it was difficult to define psychosocial factors with specificity and identify WHO's role. It was essential to continue to seek greater clarity in identifying the mechanisms through which psychosocial factors were linked with physical and mental illness. Her delegation particularly approved of the creation of a data bank and information centre.

Dr VIOLAKI-PARASKEVAS (Greece) said that many of the health problems facing countries had been largely overcome, but in their place had come diseases of civilization, diseases associated with living and working conditions. She approved of the contents of the report. It would be an excellent thing if Member States, under the guidance of WHO, could initiate programmes of the type given in the document, integrating psychosocial factors into the existing health services but taking into account the scarcity of trained staff and resources.

Dr OSMAN (Sudan) said that in his country, as in other developing countries, social and economic development, urbanization and natural catastrophes such as drought created large-scale migration of people and considerable disruption of the kind that other delegates had mentioned. It appeared that mental disturbances occurred in migrants to an extent twice or three times as great as in people in the areas from which they came. The programme was therefore to be welcomed, since all knowledge obtained would be of value in countries in which industrialization was growing. One problem however that should engage the attention of the Health Assembly was the migration of doctors and other health workers, since it affected the public health situation.

Dr KLIVAROVÁ (Czechoslovakia) said that psychosocial factors played an important part in the incidence, course and treatment of many diseases, particularly the so-called "diseases of civilization". She agreed with the definition of psychosocial factors as those stemming from the psychology of the individual and the structure and function of social groups; however, she would stress the fact that they were also closely linked with the socio-political system. In Czechoslovakia this system was conducive to social wellbeing: its Constitution guaranteed the right to work and to education; the state played an important role in ensuring the welfare of the family, particularly families with children; medical services were free and no one needed to fear the social consequences of illness. In any country without a satisfactory overall system the effects of psychosocial factors on health could be dealt with only partially.

The Czechoslovak health services had recently undertaken a series of measures of particular social importance, including campaigns against tuberculosis and venereal diseases. Czechoslovakia, of course, had health problems - ischaemic heart disease, cerebrovascular diseases, mental illness and hypertension, for example. It would be pleased to cooperate with WHO in studies to establish the causes of these illnesses, to determine the role of the psychosocial factors concerned, and to find means of primary prevention and control. It had already collaborated with the Organization in the international study on schizophrenia (which had been completed the previous year with the publication of the final report), a study on the biosocial development of children born as a result of unwanted pregnancies, and a study on the role of psychosocial factors related to alcoholism.

The importance attached by Czechoslovakia to the psychosocial aspects of health and the primary prevention of psychological disturbances was demonstrated by the fact that a federal plan of research had been adopted for the years 1976-1980; it included research on the psychological problems of certain groups of the population, on the role of negative psychological effects of social and economic factors in cases of family conflicts, on alcoholism, and on the causes of mental illness leading to disability.

Her delegation supported the draft resolution.

Dr BAČVAROVA (Bulgaria) also stressed the link between the economic and social system and psychosocial factors. Bulgaria had achieved considerable success with malaria eradication and the control of a number of parasitic and other communicable diseases; there had been a striking reduction in the incidence of tuberculosis and infant and child morbidity and mortality as a result of health education, improvement in the general education of the population had helped to overcome superstitions and cultivate a positive attitude towards the health services.

Activities in the field of prophylaxis, which formed the basis of Bulgaria's health policy, included particular emphasis on psychosocial aspects - for example, with regard to cardiovascular diseases, mental health, alcoholism, and maternal and child health. Attention was being given to improvements in the training of medical and, especially, auxiliary health personnel, and to the intensification of research on such subjects as the effects of rapid industrialization and the specifically protective measures appropriate to a socialist society, the role of demographic and economic conditions in relation to mental health, hypertension, infarctus, and vascular diseases of the central nervous system.

As stated in the document before the Committee, more attention should be given to psychosocial factors in planning and in assessing the effectiveness of health measures. Her delegation supported the proposals regarding WHO's role in the training of health workers and administrators concerning psychosocial factors and health, in the establishment of a methodology for collecting timely and adequate information on the subject, and in the intensification of research in this field.

Professor SIASSI (Iran) said that in his country, as in many others, the medical profession had received much of its training in Europe and America, where until recently psychosocial factors had been neglected. Also the curricula in the medical schools of the developing countries often imitated those of Europe and America, and therefore did not pay adequate attention to the countries' specific psychosocial problems. The first essential therefore was that more attention should be given to those factors in the medical and public health curricula. As an aside, it was essential that medical schools in Europe and America should not give higher qualifications to students from the developing countries studying there unless they deserved them. There were too few highly qualified personnel in the developing countries and they therefore had to be true experts, whether in dealing with health in general or with psychosocial factors in health. He disagreed with the delegate of the United Kingdom in relation to the priority of the programme under discussion; in his view psychosocial factors were so important that no other programme could be more important. His country was planning a survey of mental health and it would be glad to receive the help of WHO and of any country that would be willing to help.

Dr GÁCS (Hungary) said that his country was seeking to study the psychosocial factors influencing health by concentrating on those endangering pregnant women, the newborn, people about to retire, those who had just retired, and those moving from rural to urban areas. It was carrying out research into the psychosocial factors in disease, among sick and elderly

people left alone during the day while their family was working, and it was seeking to find solutions to the problems thus created.

Dr THOMPSON (Nigeria) pointed out that four out of ten beds in some countries were occupied by mental health cases. Rapid development, population increase, migration and other problems in developing countries created stresses and mental disturbances, and there an early preventive approach was mandatory. All psychiatric care units in Nigeria have been taken over by the Federal Government in order to improve mental health care, and the Government was extending such care as widely as it could. The document before the Committee was therefore of great importance.

Dr KIVITS (Belgium) referred to the statement made during the third plenary meeting by Mr de Saeger, the Belgian Minister of Health, in emphasizing the importance which his country ascribed to psychosocial factors in community health. Collective cultural ideas and opinions, as well as individual attitudes, were sometimes unfavourable to health programmes. If these factors were not taken into account when the health programme was being devised, then the population affected might prove to be unreceptive to it: programmes to change dietary habits could be cited, among others, as examples of this problem. Research was therefore necessary to determine in the population the attitudes which influence the success of health programmes. His country would, thus, support any proposals for research on psychosocial factors and health.

Dr AL-DABBAGH (Saudi Arabia) felt that the complex problem of the interrelationship of psychosocial factors and health required further study and analysis. He therefore hoped that WHO would accord priority to this area. Countries should study the various factors affecting the health of their populations, with particular emphasis on psychosocial factors. The latter could be seen as a cause of some noncommunicable diseases such as heart diseases. In his country, assistance in this field was provided to promote the health and welfare of the population, and to rehabilitate the handicapped.

Dr QUAMINA (Trinidad and Tobago) welcomed the report on psychosocial factors and health, which had great relevance to her country. Primary care facilities in Trinidad and Tobago had been redesigned following WHO guidelines: it was now time to investigate and revise the orientation, attitudes and training of health workers, especially psychosocial workers. Trinidad and Tobago would welcome assistance in devising inservice training courses for these personnel and in establishing criteria for the selection of student nurses. It was well stated in the report (section 2.3, fifth paragraph) that the psychosocial characteristics of health workers were an important factor in the success of health programmes. A recent study in the Caribbean area showed that the contact between hospital staff and child patients was minimal. Trinidad and Tobago, with a population of one million, comprised three ethnic groups and three religions: consideration of psychosocial factors was thus of major importance. For example with the rapid population increase, investigations of the most appropriate and effective contraceptive advice were undertaken. It would also be worthwhile to look at the psychosocial factors associated with diabetes mellitus and hypertension. The present doctor/patient relationship did not sufficiently take into account social background factors. Trinidad and Tobago would participate in the programme on psychosocial factors and health, and endorse the resolution.

Mr STEENFELDT-FOSS (Norway) supported the remarks made by Dr Funke, whose warning he found most relevant. The medical profession had very largely held itself aloof from problems of a psychosocial nature with the result that non-medical professionals took over responsibility for patient groups thereby creating the risk that true medical factors were not taken into account. The importance of psychosocial factors in medicine was not a new discovery: it had been implicitly understood under the old family doctor system in Norway. Psychiatrists and psychiatric nurses were often reduced to an advisory role by other members of the medical profession: but the medical profession did have something to offer in the mental health field. A body of knowledge already existed on socio-cultural factors and health, but this requires coordination, so that a particular aspect of it could be strengthened.

The decision by WHO to press for progress in this field took great political courage, for consideration of the psychosocial characteristics of a country went to the heart of its political and economic structure. Norway would endorse a resolution on this subject. It was

wrong, however, to polarize priorities between programmes on biological and psychosocial factors. An understanding of cultural background was essential to any programme.

Dr OBIANG-OSSOUBITA (Gabon) approved the report on psychosocial factors and health. The complexity of the problem meant that progress would be difficult but the suggestions made by the delegate of France were particularly apposite. He felt that it was especially in the area of mental disorders that traditional African medicine was achieving success, and rather the question whether research on this subject be coordinated. The personality, cultural level and, above all, the traditional beliefs of the patient played an important role in his cure.

Turning to the subject of abusive or negligent hospitalization of persons with mental illness, Dr Obiang-Ossoubita asked whether WHO could not attempt to regulate current practices. Enforced hospitalization may be justified where the behaviour of the patient may be dangerous to himself or to society or where there is a particular psychopathology. In many countries, hospitalization was enforced solely on the criterion of the patients behaviour, thus infringing the liberty of the individual: it should be possible for the individual to have recourse to review by a higher authority. In other countries, especially in developing countries, many patients suffering from evident mental disorders wandered at large, as psychiatric hospitals were often substandard. Could WHO recommend that Member countries regulate their hospitalization practices for mental disorders, humanize their psychiatric hospitals and help certain developing countries to obtain chemotherapeutic remedies to deal with grave mental disorders?

Professor ŠČEPIN (Union of Soviet Socialist Republics) said that the subject under discussion involved a series of problems on which, as yet, insufficient information was available; for example, there were several different theories regarding the effects of psychosocial factors on health. WHO, with the collaboration of the world's leading experts in social health and in the philosophical problems of medicine, could make a useful contribution to the establishment of a really scientific basis for the subject, making a classification of the psychosocial factors concerned and underlining those calling for priority attention.

In planning and implementing its activities in this field - covering such problems as alcoholism, the abuse of drugs, sexually transmitted diseases, environmental health, and health services for children and the aged - it was important to bear in mind the fact that the same psychosocial factors manifested themselves in different ways, according to the social and economic systems and specific national characteristics of the various countries. That aspect should also be taken into consideration in the establishment of research centres. Stress should be laid on securing the cooperation of both the health personnel and the population in controlling drug abuse, alcoholism and sexually transmitted diseases, and on the effective use of the mass media for the promotion of health education.

His delegation supported the proposals of the Executive Board, as contained in the draft resolution before the Committee, but would emphasize that the proposed activities should be limited to the medico-social field.

Dr JOSHI (Nepal) pointed out that psychosocial factors were not a health problem in his country, perhaps for cultural or developmental reasons. For example, although marijuana addiction was experienced on a massive scale in the western world, there had been no significant increase in such addiction in Nepal. He suggested that WHO investigate this positive situation in his country, with a view to helping the rest of the world.

Professor LEOWSKI (Poland) said that the importance of psychosocial factors was recognized in his country, as throughout the world. It had been attempted, in Poland, to apply existing knowledge to present problems but it was not always known how to implement effective preventive action throughout the population as a whole.

Dr WADE (Senegal) recognized the importance to his country of the report on psychosocial factors and health. In Senegal the problem was being approached through training and health education. For example social workers were being trained to work with psychologists. Both preventive and curative treatments were being attempted, as far as possible allowing the patient to remain in his own social setting. The Senegal delegation supported the resolution.

Dr BARREIROS E SANTOS (Portugal) supported all the proposals contained in the report on psychosocial factors and health. He drew attention to the plight of migrant workers who had to face difficult new situations without psychosocial support they needed.

Dr DERBAN (Ghana) generally agreed with the points raised in the report on psychosocial factors and health. In particular, he emphasized that psychosocial problems required an interdisciplinary approach and suggested that WHO could help in compiling suitable training manuals: since methodology must be based on local conditions, countries might be provided with technical help to collect information on such conditions. Ghana would be interested in having this type of technical assistance. He noted that although onchocerciasis was receiving attention, other major problems (schistosomiasis, mental disorders, tuberculosis, drug and alcohol dependence, sexually transmitted diseases) remained.

Dr SARTORIUS (Office of Mental Health) pointed out that, perhaps even more than in other programmes, a programme in the field of psychosocial factors and health depended on a continuing dialogue and collaboration with countries and he was therefore encouraged by the expressions of many delegations of willingness to work with WHO. He thanked the delegate of Sweden for acknowledging the role played by the Deputy Director-General in initiating and guiding this programme. The psychosocial programme should be a continuous process of examination of health actions to determine how the input of psychosocial knowledge would make such actions more effective. He fully agreed with the many delegates who had stressed the need for the close integration of this programme with other WHO priority programmes. Further specific activities would only be developed with the help of countries. The present level and content of training and the scarcity of adequately trained manpower showed that training should be given priority, both as to quantity and quality. A workshop planned for October 1976 and organized in collaboration with the Government of Sweden and the WHO Collaborating Centre on Psychosocial Factors and Health in Stockholm would pay particular attention to this issue. He was pleased to learn from the delegate of France that a similar workshop is planned in 1977. As mentioned by a number of delegates, WHO hoped to develop research and training centres in all regions. On the question of textbooks, he felt that although WHO could provide technical assistance, each country should evaluate the suitability of the textbooks to local needs and adapt them as necessary. It was therefore essential that local expertise be developed.

He thanked the delegates of Bulgaria, France, Ghana, Mexico, Nigeria, Poland and the USSR for their comments on and support of the programme. The support for the whole area of collection and dissemination of information, which was first mentioned by the delegate of the United States of America, was very welcome. In the psychosocial field there were, however, difficulties concerning definitions and misunderstandings had in the past prevented adequate collection and utilization of data. It was thus necessary to develop standardized definitions and methods of measurement for the collection of information. The Secretariat had proposed two priorities for research and he was pleased that the delegates had supported both of them, particularly the proposal concerning migration which was remarked on especially by the delegates of Hungary, Portugal and the Sudan.

He thanked the delegate of Czechoslovakia for her comments and for the support the Secretariat had received over the years in its collaborative efforts with specialists from that country. The definition of psychosocial factors that the delegate of Czechoslovakia had mentioned was recognized in the Executive Board report EB57/22 (annexed to A29/8) page 3, second paragraph of section 2.2, where the interdependence of psychosocial factors and their relationship to the overall framework of the sociopolitical system was stressed.

He thanked the delegation of Belgium for their support and for the Belgian delegate's excellent presentation in a plenary session in which the attention of the Secretariat was drawn to the specific priorities that should be tackled. He also thanked the delegates of Belgium, Czechoslovakia, France, German Democratic Republic, Federal Republic of Germany, India, and Trinidad and Tobago who had offered help in the development of the programme. The delegate of Norway had reminded the Committee of the existence of the family doctor and in fact, the focus of the psychosocial programme was to redevelop "the other side of medicine" that was needed to complement the advances in technology.

Replying to the delegate of Gabon, he acknowledged the need for further work on traditional medicine and added that a programme had been started that would be considered later in the Health Assembly during the discussion on Health Manpower Development. In relation to his second point, Dr Sartorius said that WHO had initiated an international survey of legislation concerning the mentally ill and he would be pleased to provide delegations with further information. Regarding chemotherapy, he said that the Secretariat considered it a priority field and work was in progress to develop lists of the drugs that were most useful in this field.

In reply to the delegate of Nepal, who had raised the issue of why drug dependence was not a problem in his country, he said that increased emphasis was needed on research concerned with the positive and supportive elements of different cultures that could prevent the occurrence of certain conditions.

Professor KOSTRZEWSKI (representative of the Executive Board) thanked all the delegates who had commented on the Director-General's report and thanked all those who supported the draft resolution proposed by the Executive Board. The delegate of Sweden, Dr Tottie, had proposed an amendment to the draft resolution which he supported.

The CHAIRMAN then asked the Committee to consider the draft resolution, as amended by the delegate of Sweden, that read as follows

> The Twenty-ninth World Health Assembly,
>
> Noting with satisfaction the report of the Director-General on psychosocial factors and health;
>
> Considering the proposals made in the report to be of direct relevance to health needs at country level;
>
> Confirming the importance of the relationship between psychosocial factors and health, and their importance for health services;
>
> 1. REQUESTS the Director-General, in cooperation, where appropriate, with other organizations of the United Nations system, and the intergovernmental and nongovernmental organizations concerned, to implement the proposals in the report for a multidisciplinary programme on psychosocial factors and health, with the aim of:
>
> (1) applying existing knowledge in the psychosocial field to improve health care, particularly for those most in need;
>
> (2) developing methods in collaboration with countries, so that relevant psychosocial information can be made available to health planners; and
>
> (3) acquiring new knowledge on which health action can be based, particularly concerning the needs of uprooted people and changes in family functioning under conditions of rapid social change.
>
> 2. REQUESTS the Director-General to report to a subsequent Health Assembly on the developments in this field.

Decision: The draft resolution was approved.

Prevention of road traffic accidents: Item 2.5.2 of the Agenda (Handbook of Resolutions and Decisions, Vol. II, 1973-1974, p. 23, resolution WHA27.59; document A29/9)

Professor KOSTRZEWSKI (representative of the Executive Board) said that the prevention of road traffic accidents was a subject of increasing concern and resolution WHA27.59 requested the Director-General to report on the matter to the Executive Board and to the Twenty-ninth World Health Assembly.

The Director-General's report, contained in document A29/9, reviewed the activities undertaken by WHO in collaboration with intergovernmental and nongovernmental organizations, including the development of medical standards for the licensing of drivers, educational programmes, promotion and coordination of research on the human and medical factors involved, and the influence of alcohol and psychotropic drugs on drivers' skills and traffic accidents. The Regional Offices for the Americas and for Europe had developed programmes in that field.

The Executive Board had discussed thoroughly the problem of road traffic accidents, which were related to road conditions, vehicles, and man. It had been pointed out that the

areas for action in the prevention of road traffic accidents covered a wide range, from town planning and vehicle design, to education on road safety, and the development of appropriate medical standards and services. The Executive Board had also considered in broad outline a possible future programme for the prevention of road traffic accidents. The main lines would cover: (1) public health; (2) medical standards; (3) safe design of cars; (4) alcohol and drugs - their interaction with traffic accidents; (5) human and psychosocial aspects of accidents; (6) education and information; and (7) close coordination with intergovernmental and nongovernmental organizations.

While the Executive Board agreed with the importance of the subject, and with the broad outline of a future collaborative programme for the prevention of road traffic accidents, it felt that the Organization should now make an attempt to define more clearly its role and the specific activities that it should undertake. Accordingly, the Executive Board, in resolution EB57.R30 had requested the Director-General to develop the Organization's programme in the field of prevention of road traffic accidents, taking into account the comments and suggestions of the Executive Board.

Dr KAPRIO (Regional Director for Europe) said that document A29/9 was an enlarged version of the report presented to the Executive Board in January. The comments of the Executive Board had been taken into account, and the additions to the document were to be found in sections I(A), III(B), IV, and V. The original document had been a direct reply to resolution WHA27.59 concerning several specific questions but the Executive Board had felt that a more general approach should be developed. Although much additional information was still required, especially in relation to developing countries, clear objectives could now be presented within the framework of the Sixth General Programme of Work. The four main objectives of the programme would be:

(1) to stimulate the awareness of Member States of the increasing public health implications of road traffic accidents, and to assist public health authorities and other concerned agencies in the promotion and development of comprehensive traffic safety policies and of national programmes;

(2) to obtain, analyse, and disseminate information in the field of traffic safety;

(3) to promote, through appropriate coordination mechanisms, concerted planning and action between intergovernmental and nongovernmental organizations active in this field; and

(4) to promote research in the prevention and control of accidents.

In order to achieve those objectives a programme structure had been proposed (document A29/9, section V). That programme concentrated on two important areas, the reduction of incidence of road traffic accidents and the reduction of the consequences of accidents.

He assured delegates that the Director-General was giving much attention to the problem and that the point had been reached when the past experience of the European and American Regions could be used in a practical way and adapted to other areas. In the European Region there had been a conference on the epidemiology of road traffic accidents in Vienna in November 1975 that had been supported by the Government of Austria. That meeting had emphasized the need for continuing cooperation within the United Nations family and with other organizations such as the International Association for Accident and Traffic Medicine. In order to establish a solid base for preventive action more meetings were planned in the European Region in 1976. It was clear that WHO should deal not only with the curative aspects but should also be concerned with improving and developing traffic policies, aimed at preventing traffic accidents.

Dr LEPPO (Finland) said that the problem of road traffic accidents was of paramount importance to health authorities in the industrialized countries, and was increasingly affecting the developing countries also. In many industrialized countries, the elimination of traffic accidents as a cause of death would increase the average life expectancy more than the elimination of all deaths due to all forms of cancer. Although the total number of deaths due to traffic accidents was much smaller than the number due to cancer, the age-incidence of traffic accidents was concentrated in much younger age groups who should otherwise have had long healthy lives ahead of them. The severity and long duration of the handicaps produced by traffic accidents meant a heavy burden on health rehabilitation services, and the deaths and disabilities together represented a huge loss of working capacity in the society. Most important of all, there was also a tremendous amount of human suffering among the victims and their families.

Cancer experts stated that about 80% of cancer was caused by environmental factors, and that that had important implications for cancer control. They said that priority should be given to prevention, to controlling the environmental risk factors, such as tobacco smoking. But this had not been the usual path followed by governments and health authorities. Instead, the response to the challenge had been exactly the kind of capital-intensive and labour-intensive technology referred to by the Director-General in his address to the Health Assembly as placebo technology, or at best, palliative technology. The analogy with road traffic accidents was clear. The response to the growing challenge among the health professions had primarily been intensified development of curative services, first aid measures, and high-technology traumatological units. That was not enough, the real solution lay in prevention.

However, it was essential to ask "What were the causal factors involved and what were the preventive measures to be taken?" Even when the etiological agent was recognized, however, the means of controlling or eliminating it were not similar to the ones the health professions were accustomed to dealing with. As regards the prevention of road traffic accidents it was known that the increasing worldwide incidence of road traffic accidents, which had reached pandemic proportions, was caused by one major factor: the huge increase in road traffic and the kind of transportation technology involved. Just as the lung cancer epidemic was caused by one modern habit, tobacco smoking, so the traffic accident problem was caused by an essential feature of modern societies, the exponential increase in motor vehicle traffic in an environment where safety measures had not been given sufficient attention.

What could be done? Traffic policy was not the mandate of health authorities, and the whole field was related to such powerful economic and other interests that it would be naive and unrealistic to imagine that rapid and once-for-all solutions could be found. The problem was embedded in the essential structures and ways of living of modern societies. However, the health professions had an obligation to point out the gravity of the traffic accident problem from the health angle and to influence the decision-makers to give more value to human lives and people's health in their policy choices. Wide publicity should be given to the scientific evidence about the effects of simple preventive methods such as speed limits, safety belts, urban planning, and road construction. To say that those problems did not belong to the mandate of the medical profession or WHO, would be as absurd as to say that housing was not related to tuberculosis in spite of its direct relevance to the problem, or to say that combating smoking was a separate problem because medical cancer control techniques could not solve that problem. Just as malaria control involved vector biology, entomology, and social ecology, so the structure and function of traffic systems was of direct concern to the health professions in the prevention of road traffic accidents.

The responsibility of the health professions must include awareness-promotion and exerting an influence on those social sectors whose activities were relevant in determining the priority health problems. WHO should use all the knowledge available and all its authority in the fight for prevention of road traffic accidents. Authoritative statements on the association between various traffic safety measures and mortality, disability, and the health of populations could have a far-reaching social impact by alerting national and international opinion to health-oriented traffic safety measures, just as they have had in the case of the health consequences of smoking.

Recently when oil was in short supply and mandatory speed limits had to be introduced for purely economic reasons, there had been a remarkable drop in road traffic accidents and especially in deaths and serious injuries. If the scientific evidence based on that experience was not used as a basis for health-oriented traffic safety measures, there was only one conclusion to be drawn: that the societies in question were more concerned about saving money than saving human lives.

When the Director-General's report on road traffic accidents had been examined in the January session of the Executive Board, it had been criticized mainly on the grounds that it did not state clearly enough the characteristics and determinants of the problem nor present a clear conception of WHO's role in the field and that it was lacking an explicit policy geared towards priority problems in that area. That discussion was fully reported in the summary records of the Executive Board (Official Records No. 232, pp. 269-277).

The report had been revised since January and now contained an epidemiological appraisal of the situation and a new presentation of the programme structure. His delegation welcomed these improvements, and it seemed that the future programme would be on the right track. Some matters, however, such as medical examinations of drivers were being given too much attention compared with their potential impact on solving the real problems.

His delegation fully agreed with the proposals and future programme structure that appeared on pp. 9-10 of the Director-General's report, because they clearly reflected the broader approach towards the problem that was called for by the Executive Board. That was a good beginning. Here the problem was completely man-made and was not a natural scourge. Therefore in principle it could easily be affected. In practice, however, it would require the same philosophy and the same courage as combating smoking in cancer control: an effective combination of various educational, technical and restrictive measures.

A good practical starting point for the programme envisaged in the Director-General's report would be a comprehensive review of public health consequences of alternative traffic policies, in collaboration with other relevant international bodies. An expert committee could then be appointed to clarify WHO's role with regard to certain issues concerning the health aspects of traffic safety. An extremely useful and important step would be the preparation of a manual on road traffic accident prevention with the specific objective of helping developing countries to formulate their traffic policies so that they would not repeat the mistakes of affluent countries.

The meeting rose at 12 noon

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