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EXECUTIVE BOARD

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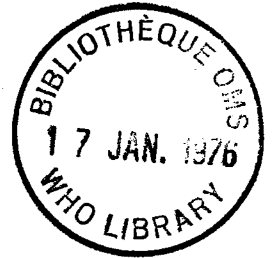

PROVISIONAL SUMMARY RECORD OF THE FIRST MEETING

WHO Headquarters, Geneva
Wednesday, 14 January 1976, at 10 a.m.

CHAIRMAN: Professor J. KOSTRZEWSKI

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MEMBERS AND OTHER PARTICIPANTS

(For list of members and other participants at the fifty-seventh session, see separately issued document of 15 January 1976.)

FIRST MEETING

Wednesday, 14 January 1976, at 10 a.m.

Chairman: Professor J. KOSTRZEWSKI

1. OPENING OF THE SESSION: Item 1 of the Provisional Agenda

The CHAIRMAN declared the session open. He welcomed all members, their alternates and advisers, and extended a special welcome to the new members of the Board. He also welcomed the representatives of the United Nations, the specialized agencies, the International Atomic Energy Agency and the other United Nations bodies attending the session, as well as of inter-governmental and nongovernmental organizations in official relations with WHO, whose presence at the session was further evidence of their close and fruitful association with the Organization.

The January session of the Board was an important event in the work of WHO and the main task before it was to prepare recommendations together with the Director-General on the 1976-77 programme budget for examination by the Health Assembly.

Whilst the Director-General's target of "Health for all by the year 2000" might have little significance for those countries, particularly in Europe, where that target was within easy reach, in parts of Africa, the Americas or Asia, it was redolent of a Utopia that was unlikely to be realized in the last quarter of the century, unless account were taken of the potential of human wisdom and skill and of the imponderable forces at play throughout the world. Then, "Health for all by the year 2000" would cease to be a Utopian dream and would become a realistic goal capable of practical achievement. The Sixth General Programme of Work should provide a driving force in that connexion.

2. ELECTION OF RAPPORTEURS

The CHAIRMAN, noting that the English-language and French-language Rapporteurs elected at the previous session were no longer members of the Board, called first for nominations for the post of English-speaking Rapporteur.

Dr DIBA proposed Dr Mukhtar, the proposal being seconded by Dr SHAMI and Dr CUMMING.

Decision: Dr Mukhtar was elected English-speaking Rapporteur.

The CHAIRMAN then called for nominations for the post of French-speaking Rapporteur.

Dr CHILEMBA proposed Dr Butera, the proposal being seconded by Sir Harold WALTER and Professor AUJALEU.

Decision: Dr Butera was elected French-speaking Rapporteur.

3. ADOPTION OF THE AGENDA: Item 2 of the Provisional Agenda (Document EB57/1 Rev.1)

The CHAIRMAN said that the words "if any" should be deleted from provisional agenda items 6, 7 and 11.2 and that item 9 should be deleted. A new sub-item 11.5, "Assessment of Bangladesh", should be added.

Dr CUMMING was a little surprised to note that there had been a change in the normal presentation of the agenda, whereby items had been grouped under a series of headings relating to connected activities. He considered, in particular, that it would be advisable to consider items 25, 26 and 27 at least consecutively, since they were normally taken up after the discussion on collection of contributions, and also items 24 and 29.

The DIRECTOR-GENERAL said that, while a certain sequence had admittedly been adopted for the agenda in the past, it had not been altogether logical nor had it been closely

followed by the Board. The Secretariat therefore felt that it would be preferable to allow the Board complete flexibility in deciding on the order in which they would deal with agenda items as and when they were taken up.

Sir Harold WALTER suggested that the Board should deal first with non-controversial items, leaving more difficult items to the last part of the agenda. That would make for a harmonious start to the proceedings. He considered that some thought should also have been given to the fact that there were certain items of a sensitive nature which, in his opinion, should only be discussed by members of the Board in closed session.

The DIRECTOR-GENERAL said that, under its Rules of Procedure, the Board was perfectly free to decide that it wished to discuss a particular item in closed session and it could do so at the time when the item in question came up for consideration.

Decision: The provisional agenda, as amended, was adopted.

4. HOURS OF WORK

The CHAIRMAN suggested that the Board should meet daily from 9.30 a.m. to 12.30 p.m. and from 2.30 p.m. to 5.30 p.m.

It was so agreed.

5. PROGRAMME OF WORK

The CHAIRMAN said that, in addition to the Standing Committee on Nongovernmental Organizations, the following committees would meet during the Board's fifty-seventh session: The Léon Bernard Foundation Committee, the Dr A. T. Shousha Foundation Committee, the Jacques Parisot Foundation Committee and the WHO Staff Pension Committee. The dates of the meetings would be announced later. The *ad hoc* Committee on Malaria and the Working Group on the Sixth General Programme of Work, which had already met, would submit their reports to the Board in due course.

The Board might wish to follow the practice it had adopted in 1975 and to consider item 10 on the revised programme budget proposals for 1977 at the beginning of the session but after dealing with certain items of an administrative and financial nature. He therefore suggested that the Board proceed forthwith to consider items 3, 4 and 5 and thereafter to take up items 6, 7, 36, 27, 8 and 11, together with the five sub-items of item 11. On completion of those items, the Board could then consider item 10. Supplementary agenda item 3, "Dr A. T. Shousha Foundation Committee filling of a vacancy", would be dealt with by that Committee at a convenient time during the session.

It was so agreed.

6. REPORT ON APPOINTMENTS TO EXPERT ADVISORY PANELS AND COMMITTEES: Item 3 of the Agenda (Document EB57/2).

The DEPUTY DIRECTOR-GENERAL, introducing the report (document EB57/2) said that it had been prepared simultaneously in English, French, Russian and Spanish, but suggested that, since it referred solely to established titles of expert advisory panels and names of experts, an English/French version would suffice for future sessions of the Board.

Part I of the report listed the appointments made since 1 May 1975 while Part II consisted of a summary, by WHO Region, of all the changes that had taken place in the membership of the panels since that date. The Annex to the report contained the names of experts invited to participate in meetings that had been convened since the Board's fifty-sixth session; namely the seventeenth session of the Advisory Committee on Medical Research (ACMR),

six expert committees and three joint expert committee meetings. During 1975, eleven expert or joint expert committee meetings and one session of the ACMR had been held: 108 experts from 39 different countries, selected from 27 panels, had been invited to attend, seven of them unfortunately having been unable to do so.

The number of existing panels, which now totalled 43 excluding the Advisory Committee on Medical Research, had been reduced by one with the de facto disestablishment of the Panel on Antibiotics, the membership of which had been incorporated into that of the Panel on Biological Standardization. The title of the Panel on Insecticides had been changed to "Expert Advisory Panel on Vector Biology and Control".

There were 2683 experts appointed to expert advisory panels at 31 December 1974 and 2691, or an increase of eight members, at the end of 1975. There had been 191 new appointments and nine reinstatements; 192 members had completed their period of appointment, 136 of whom had not been reappointed; 12 had been suspended; 19 had resigned; and 25 had died.

In pursuance of the recommendations contained in resolution EB37.R2, the Director-General had extended the appointment of 180 experts for a period of two years during 1975, and had terminated the membership of 112 experts aged 65 years or over.

A comparison of those figures with previous years underlined the effect of the Board's consideration of the special report of the Director-General (document EB56/4) on the question of WHO's use of the knowledge, expertise and experience of its panel members and attested to the intensive and critical attention which the matter had received in the Organization at all levels. The contribution of the Regional Directors and WHO Representatives had been particularly significant: for example, for the Region for the Americas, 31 new appointments had been made in 1975, 40 panel members having been terminated. The same trend was to be seen in the figures for the European Region where, despite 67 new appointments, there had been a net decrease of 25 panel members. In the other four Regions there was an increase in the number of their panel members during the year, SEAR alone adding 34.

A working group had recently been established and was due to meet in the near future to study and implement the recommendations in document EB56/4.

Dr VENEDIKTOV noted that, although there was little change in the total number of experts, there was some redistribution in terms of specialities, countries and regions and, particularly, age. He was pleased to see that expert committee reports were being published more quickly and that the Board's views were being taken fully into account. In view of the importance of expert advisory panels and committees to the Organization he would like to know what further steps were contemplated in order to improve the contribution of their members to the work of WHO, which should include aspects other than participation in meetings.

The DEPUTY DIRECTOR-GENERAL said that there would be no problem in providing additional information. The working group would explore all the areas to which Dr Venediktov had alluded.

Dr BUTERA (Rapporteur) read out the following draft resolution:

The Executive Board

NOTES the report of the Director-General on appointments to expert advisory panels and committees.

Decision: The resolution was adopted.

7. REPORT ON EXPERT COMMITTEE MEETINGS: Item 4 of the Agenda (Document EB57/3 and Add.1)

The CHAIRMAN reminded the Board of its decision to postpone to the current session consideration of the expert committee reports submitted to its previous session.[1]

[1] See summary records of the Board's fifty-sixth session, first meeting section 6 (WHO Official Records No. 228, 1975, p. 37).

There being no general comments, he pointed out that, in response to the Board's wishes, for each committee report the Director-General had included in the document EB57/3 a section describing its implications for the Organization's programme, in addition to the usual summary of the substance and recommendations, and comments by the Secretariat.

Services for Cardiovascular Emergencies - Report of a WHO Expert Committee (Technical Report Series No. 562)

Professor JAKOVLJEVIĆ said that the report was well structured and would be of practical use to health care planners and to the health services themselves. He considered it a very good document.

Dr VENEDIKTOV agreed with that assessment. The subject of sudden death, including deaths during heart attacks, and the provision of emergency care was being studied in the Soviet Union and when the results were available they would be placed at the Organization's disposal.

Professor AUJALEU shared the views of the previous speakers on the usefulness of the report. He called the Board's attention to recent claims by reputable cardiologists that emergency treatment of myocardial infarction could now be undertaken in the home with results for all practical purposes as good as those achieved in intensive care units of hospitals and believed that the Organization should perhaps investigate those claims.

Dr EHRLICH agreed that the report brought together a great deal of very useful information. In connexion with the recommendation that cardiovascular patients should carry with them a brief report of their medical status to speed up diagnosis in the case of an emergency, together with the proposed content of that report (Recommendation No. 6, page 58 and Annex 1, page 61), he asked whether the suggestion was that only cardiovascular patients should carry such reports or whether a more general recommendation should not be that such patients and others should carry a more general health record.

Dr TARIMO asked what was the Board's role in relation to expert committee reports. He understood that it was to review the Director-General's report on them, rather than the substance of the reports themselves.

The CHAIRMAN said that it was customary for the Director-General to assist the Board by reporting individually on the expert committee reports, giving an account of their substance and recommendations, together with his comments and now, for the first time, a description of their implications for WHO programme. In view of their importance in that respect, the Board was called upon to give its opinion and note the reports.

Quoting Regulations 10.6 and 10.7 of the Regulations for Expert Advisory Panels and Committees,[1] the DIRECTOR-GENERAL explained that the Board's comments of agreement or disagreement should provide him with guidance on the emphasis or priority to be given at the level of implementation, since the Board decided upon matters relating to the overall execution of the policies laid down by the Health Assembly.

In the light of this explanation, Dr TARIMO considered the Director-General's comments valid when applied to countries with established health services, but in areas where there were no established health services, the recommendations would need to be more general. The Director-General's comment on the difficulty of influencing the general mortality from myocardial infarction in the community owing to the delay in administering skilled medical attention, seemed less valid. He wondered whether the reduction of the delay would have any impact on mortality in the community, as distinct from its impact on deaths of individuals.

Sir Harold WALTER informed the Board that a comparative study of emergency care given to 25 cases in hospital intensive care units and to 25 in the home had shown that the latter

[1] WHO Basic Documents, 25th ed., 1975, p. 93.

outlived the former, so that he wondered whether speed was the decisive factor. He would welcome any information from the United States of America and the Soviet Union on the effectiveness of the various systems of emergency treatment, in particular that administered in the United States by mobile units. He was aware however that such a solution would not be open to the poorer countries. Any documentation which could be provided by these two countries would be of great value to smaller countries.

Professor AUJALEU warned the Board that emergency treatment in the home should not be represented as a less expensive solution than intensive care in hospital. Since the equipment and staff concerned could not care for more than one patient at a time, home treatment might well prove the more expensive and so a possible solution only for richer countries.

Dr EHRLICH said that cardiovascular emergency transportation systems had so far been used only on a pilot basis and their results, as far as reduction of early mortality in the community was concerned, were still equivocal. Possibly the Soviet Union with similarly advanced services might be able to provide further information.

Dr VENEDIKTOV noted that the expert committee reports contained the collective views of international groups of experts and did not necessarily represent the decisions or the stated policy of WHO. Sir Harold Walter and Professor Aujaleu had already warned that one of the possible solutions to the emergency care problem might prove not to be a panacea.

In reply to Sir Harold, he said that comparisons were being made of the various emergency care systems under the programme of bilateral cooperation between the United States of America and the Soviet Union. No information was yet available on which of the systems on trial was likely to be the best. The results of those studies would be made available to all Member States of WHO in due course. The Secretariat might perhaps note that cardiac emergencies were not the only ones requiring rapid treatment; others included shock and haemorrhage.

Dr PIŠA (Cardiovascular Diseases) said that statistics collected in 1971 and 1972 in 21 population areas where infarction was systematically registered and all cases of sudden death investigated for all patients under 65 years had provided a total of 9000 cases, male and female. Mortality during the first year averaged 45%. Early mortality was distributed as follows: 33% of the total mortality occurred during the first half hour; an additional 6% during the second; another 5% during the second hour and a further 5% during the third hour. Thus 49% of the total mortality occurred during the first three hours. The study showed that the average time taken to summon a physician was one hour, a further half hour elapsing before he could treat the patient, so that 73% of the 24-hour mortality, or 58% of the 4-week mortality, occurred before the patient could be medically examined.

On that basis, the Organization was considering what advice to give on the provision of care and how much emergency services could really do to decrease mortality. If early death were to be avoided, it would enable a large number of patients to live a normal life for many years. The early mortality was mainly due to arrhythmias producing ventricular fibrillation which bore no relation to the gravity of the ischaemia and could occur when the slight damage to the heart would otherwise heal with time. In view of the discrepancy between high early mortality and the delays in administering treatment doubt might be cast whether a comparison of home and hospital treatment would be useful at the present time. The problem was that the comparison was based on the studies of patients seen sometime after the onset of symptoms when the mortality was lower, so that the results were inconclusive. There had been a great deal of pre-selection of patients in a British study of home as against hospital treatment. Only 28% of the patients in the areas concerned had been admitted to the study, the rest being considered not eligible or merely sent to hospital because their physician considered their state too dangerous for them to remain at home.

A cardiovascular patient identity card was being issued on an experimental basis in Australia; it would of course be advantageous for all high-risk cardiac patients to carry such a card.

In reply to the request for results of studies, he said that those of a pre-hospital emergency care system in Seattle, WA, USA were to be found in Annex 4 of the expert committee report (page 112).

Dr DLAMINI said that the expert committee reports were very useful to the developing countries where health personnel were in short supply and health services were inadequate. It would be useful for health administrations faced with requests to set up costly intensive care units to know that real results in terms of mortality in the community could at the moment only be achieved by prevention. He would like to know how many of the resuscitated patients had an early second attack.

Dr PIŠA (Cardiovascular Diseases) said that a Finnish study in which patients resuscitated after circulatory stoppage were followed up for over three years showed that 30% were still leading a normal life after that time.

Sir Harold WALTER asked whether the advantages of not causing a patient to become a cardiac invalid had been demonstrated by those studies.

Dr PIŠA (Cardiovascular Diseases) said rehabilitation should be incorporated in treatment from the first contact with the patient. Studies had shown that patients who stopped smoking had half as frequent recurrence of myocardial infarction than those who did not. Statistics showed that 80-95% of survivors if properly rehabilitated were able to lead a normal life.

Professor NORO said that treatment involving a great deal of activity at an early stage was important to survival and to the quality of life after survival. He hoped that due prominence was given to rehabilitation of that kind in WHO programme.

The CHAIRMAN noted that the discussion had endorsed the general lines of the Director-General's report.

Ecology and Control of Vectors in Public Health - Twenty-first Report of the WHO Expert Committee on Insecticides (Technical Report Series No. 561)

Professor VON MANGER-KOENIG stressed the importance of the findings of the expert committee which were characterized by a departure from global strategy in favour of a rational approach, utilizing techniques that gave results with minimum costs under the local circumstances. Emphasis was laid on far-reaching economy. In developing countries vector control was to be approached from the social and ecological angle rather than from the humanitarian angle. Priorities were to be determined by means of cost/benefit analysis when financing was secured. That shift in strategy was necessary in view of the diminution of the financial means available and of difficulties in insecticide supply.

A realistic assessment of current vector control methods showed that insecticides would have to remain the major weapon for many years. However other possible measures, such as those of environmental, genetic and biological control were dealt with too summarily in the report. For instance on page 22 after a brief account of the trials of genetic methods of control so far, it was suggested that those methods were effective in small field trials but that it was uncertain whether they could be applied in larger areas. Again on page 23, it was suggested that genetic control could be used for the management of population but not for the complete elimination of the vector or large-scale reduction of density. Finally it was suggested that complete elimination of the vector was possible only in a completely isolated situation. Those three statements were in his opinion misleading and went against experience so far gained, even though that was still limited.

The emphasis on pages 28/29 on chemical control and its problems was too strong recommending that every encouragement be given to the world chemical industry to intensify the search for new chemical control agents (Recommendation No. 5) while scientists of related disciplines were merely to be encouraged to play a part in the solution of vector-borne disease problems (Recommendation No. 11). However he appreciated that the name and terms of reference of the expert committee had been changed and that greater emphasis was to be laid on the whole spectrum of vector control measures, so that in future a better balance would be obtained.

Dr VENEDIKTOV asked how the recommendations of the Committee could be applied to studies on the control of onchocerciasis and other parasitic diseases where the problems were acute. Were the recommendations considered a step forward from what was already known?

Dr DEL CID PERALTA pointed out that, even if new insecticides were discovered, the same resistance problem would once again arise as had arisen with DDT if their use in agriculture was not controlled. An in-depth study was also needed on control methods other than insecticides, especially with regard to onchocerciasis.

Dr HAMON (Director, Division of Vector Biology and Control) said that the evaluation of genetic control methods for practical uses had not yet reached the stage at which they could be used for controlling disease vectors. Further evidence of their usefulness in public health, including cost/benefit analysis, should be available later in 1976. Laboratory studies showed that a number of mechanisms could be used, each having advantages and disadvantages. The problems were the mass production of sterile males of the vectors to be controlled and a better understanding of the regulation of their population density. A joint large-scale evaluation was being carried out by two American Member States and within a year the operational feasibility of using a genetic control method against a malaria vector would be known.

Over a number of years studies were being carried out on the important aspects of vector ecology. It is now recognized that any methodology for vector control must be adjusted to the human population as well as the vector. That was why stress was laid on the production of new chemicals. The situation was becoming critical because the number of really new chemicals submitted to WHO for screening had declined from an average of 100 per year to only 6 in 1975. Unless new compounds were produced, the insecticide resistance problem would worsen in the coming years jeopardizing vector control operations.

Organization of Mental Health Services in Developing Countries - Sixteenth Report of the WHO Expert Committee on Mental Health (Technical Report Series No. 564)

Professor AUJALEU welcomed the trend in the report to go beyond the strict limits of psychiatry to include aspects of neurology and physical illness. It should be remembered, however, that there were two categories of developing countries, the traditionally poor countries and those which had become richer and were developing almost too quickly. The latter group of countries has given rise to special mental health problems which deserved particular attention.

Dr CUMMING said that the report was so practical and comprehensive that its recommendations would be useful in developed as well as developing countries. He welcomed the reference to infectious diseases and malnutrition as causes of mental disabilities. However, he shared the Director-General's view that further work was needed to follow up those implications concerning physically based illnesses.

Professor VON MANGER-KOENIG said that the report, differing from its predecessor, contained a glimpse of a new psychiatry, with its emphasis on decentralization of mental health services, integration of general health services, training of all health professionals in basic mental health skills and the need for updated legislation. He asked whether the report reflected only the opinion of the Expert Committee members of whether it indicated a welcome change in the Organization's policy in matters of mental health. The theoretical basis of and practical preconditions of psychiatric practice were still under discussion throughout the world. In the United States of America the more extreme demands for community-integrated psychiatry were being severely criticized. There might be reasons for concern that the advocates of the new forms of psychiatry no longer understood the subject as one way of improving man's life but demanded changes in that life. WHO should observe those trends very carefully.

Dr DLAMINI said that the report should serve as a handbook for every psychiatrist working in developing countries. The idea that psychiatrists should obtain help from their colleagues in the general medical services was very valuable. While traditional healers could be very helpful in psychiatric illnesses, they were not trained in diagnosis and in differentiating between organic illnesses and serious psychiatric disorders. Cases of suicide often occurred after healers told individuals that they were bewitched.

Dr TARIMO said that the recommendations in the report were unexpected because they emphasized the need for basic mental health services to become part of general health services, which was the only way of reaching people in outlying districts. The recommendation concerning mental health legislation was particularly apposite because most present legislation was out of date. He hoped that future reports dealing with specific diseases would approach the problem from a similar viewpoint of its relation with general health care.

Dr VALLADARES pointed out that the first word of the third line of the Comment on paragraph 3.1 should be "services" rather than "studies". The further work by WHO referred to in the Comments on paragraphs 3.3 and 3.4 would be very useful.

The CHAIRMAN, speaking in a personal capacity, said that two major points of the report were the newly developed concept of integration with general health services, and the mobilization of community resources. With regard to the Director-General's comment under paragraph 3.4, his view was that the relation between mental health and community should not be confined to integrating mental health services to the general health services, but should go beyond that and explore the wide array of sectors in the community which have direct or indirect influence on mental health. He also thought that the report was valid, not only for developing countries but for organizers of mental health care in developed countries, who could learn much from it.

Dr SARTORIUS (Office of Mental Health) said that the report did in fact represent a new development in WHO's thinking. The Organization was very much aware of the distinction between poor and richer developing countries and the socioeconomic consequences were being considered within the programme on psychosocial factors and their influence on health. WHO was also fully aware of the need for further work on issues raised in the report. That was being done within a framework of activities which had taken place since the report had been drafted. Another activity was a collaborative study which had been started in four developing countries in defined areas in which alternative strategies along the lines of the report were being tried out. The reservation about traditional healers was important and investigations were to be made into where and how that community resource could be used. Model training manuals and methods which would help the introduction of medical health care into general health care were being prepared. For instance several position papers on the rational use of psychotropic drugs were already available and in March 1976, the use of drugs in treatment of neuropsychiatric disorders within the context of the general health services was to be discussed.

Extrabudgetary support had been obtained for a review of mental health legislations with particular emphasis on the operational aspects of legislation and the way in which it could be used to facilitate the provision of care.

Sir Harold WALTER said that while the report's emphasis on the integration of mental health into the general health services was very important, there was relatively little reference to children. Children's mental health should be followed from the moment they entered school and they should have regular examinations by a psychiatrist. In that connexion, advantage should be taken of the comprehensive study carried out in Mauritius which was nearing completion. The Committee might wish to examine the possibilities of its being taken up in other countries.

He also wished to ask the Director-General what emergency action WHO was taking about the outbreak of cholera in Kenya.

Dr BUTERA welcomed the report's recommendation that mental health should be integrated into the general health services at all levels. He had learnt from experience that mental health should form part of the general medical training. The diagnostic difficulties encountered at the Rwanda psychiatric centre showed that there should be a referral system at each hospital and health centre. Patients sent to psychiatric centres were often wrongly treated because there had been no collaboration with a general practitioner. In developing countries the treatment of chronic patients imposed a heavy burden on the national budget. He had not understood the method recommended in the report. More emphasis should be laid on the education of the public and the previous employers concerning the possibility of curing mental disabilities, in order that ex-patients could once more contribute to national economic and social life.

Dr DEL CID PERALTA said that the most important part of the report was that concerning the integration of mental health work into the general health services. He was especially interested in the statement on regular psychiatric examinations of children, but that would be impossible in the developing countries at their present stage. He also welcomed the recommendations concerning the inclusion of modern methods of mental health treatment in general medical training and the use of mental health professionals to train non-specialized health workers, especially in the use of psychotropic drugs and rehabilitation.

Dr SARTORIUS (Office of Mental Health) confirmed that the word "services" should replace "studies" in the third line of the Comment on paragraph 3.1.

An expert committee on child mental health and psychosocial development was being planned for October 1976, less attention had therefore been paid to the question of children in the report under discussion than would normally have been the case.

In rehabilitation of the patient community participation was undoubtedly important and WHO was already looking into ways of promoting such participation.

With regard to mental health training for the general practitioner and other health workers, several seminars had been held, the most recent for the African countries, in which the state of training of psychiatry in medical and nursing schools had been reviewed.

Sir Harold WALTER suggested that WHO should invite someone from Mauritius to discuss the method and results of the study of children's mental health in order to prepare a paper for the meeting in October 1976.

The meeting rose at 12.40 p.m.