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PROVISIONAL SUMMARY RECORD OF THE SIXTEENTH MEETING

WHO Headquarters, Geneva
Friday, 18 January 1985, at 9h30

CHAIRMAN: Dr G. TADESSE

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SIXTEENTH MEETING

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HEALTH SCIENCE AND TECHNOLOGY - HEALTH PROMOTION AND CARE (Appropriation section 3; Document PB/86-87, pages 106-199) (continued)

General health protection and promotion (programme 8)

Nutrition (programme 8.1)

Dr BELLA said that malnutrition constituted a great public health problem in Africa, and, as all were aware, was due to an unbalanced diet. As was rightly pointed out in paragraph 13, the formulation and implementation of national food and nutrition policies had yet to be systematically attempted in most developing countries, and their lack explained why the problem persisted. It was greatly to be hoped that WHO would complement the action already undertaken by stimulating nutrition education campaigns in countries through the regional offices.

Dr HAPSARA said that in Indonesia there was a close intersectoral relationship between actions in both health and agriculture, i.e. in the preparation, evaluation and monitoring of programmes. He asked for more information regarding FAO's part in nutrition work and the extent to which close links had been established with WHO. Clearly, such links should be developed as far as possible where they did not already exist.

Noting that the amount proposed for country programmes in the South-East Asia Region under the regular budget for 1986-1987 stood at US$ 831 500, which thus showed a marked increase in comparison with 1984-1985, he requested an explanation of that change.

Dr BORGOÑO, referring to paragraphs 12 and 14, observed that very great importance had come to be attached to monitoring and surveillance activities with the aim of obtaining a comprehensive picture of a given malnutrition situation in a country and making appropriate changes in nutrition programmes where necessary. In collaboration with the United Nations University, Chile was making considerable efforts in the training of specialist personnel, for other regions as well as its own. Such action was considered vital as a means of determining the scale and nature of the problem.

While malnutrition as a whole was obviously the most serious worldwide issue, the specific problems of imbalance or excess were only referred to in paragraph 20; disorders from those sources were, however, gaining importance in developing countries: the three main causes of death in Latin America and the Caribbean were the same as those in the developed countries, with diabetes also growing as a problem. He believed that insufficient attention had been accorded to that aspect of the malnutrition picture in the proposed programme budget.

He asked what action had been taken in implementation of resolution WHA37.18 on the prevention and control of vitamin A deficiency and xerophthalmia, and sought from the Regional Director for the Americas an explanation why proposed funds for country programmes in the Americas showed a decrease as compared with 1984-1985.

Dr SUDSUKH expressed appreciation of the joint WHO/UNICEF nutrition support programme referred to in paragraphs 11 and 22; perhaps the Board might be given some idea of the progress achieved during the past two years, and informed what lessons had been learned and whether, at the present stage, it would be possible to circulate the findings more widely.

With reference to the general guidelines on nutrition in primary health care mentioned in paragraph 16, he suggested that attention should be given to the need for different approaches relevant to the situation in different countries. Technical support and exchange of information were of great value; the guidelines to be developed should be widely disseminated among Member States and all the agencies concerned.

Dr OTOO said that WHO should be prepared to intervene in the face of worsening malnutrition in Africa as a result of the drought and ensuing famine. From the table on page 115, he could see that proposed allocation for country programmes in Africa under the regular budget was higher than that for 1984-1985; but the difference seemed inadequate, and he wondered whether further funds were anticipated from other sources.

Malnutrition was acknowledged to have various causes. Pointing out that in the eighteenth century, malnutriton had been reduced by the introduction of other staple foods from other countries, he suggested that a joint WHO/FAO effort along those lines, with the aim of correcting existing imbalances, in different parts of the world, would be helpful.

Professor BAH said that malnutrition in Africa was frequently a matter of poorly balanced diet. It was certainly the case in Guinea that people in rural areas were better nourished and enjoyed a greater variety of foodstuffs - provided of course that there was no drought - than urban populations, and particularly the inhabitants of the poorer peripheral zones. The introduction of rice as a convenient, easy-to-prepare foodstuff, coupled with higher bread consumption, had made for a monotonous diet and was one of the factors contributing to malnutrition.

Reference was made, in paragraph 7, to nutritional anaemias, especially as a result of iron and other deficiencies. The incidence of anaemia in pregnancy was high in Guinea, and he considered that a WHO monograph on that subject would be useful. Endemic goitre also constituted a problem in certain areas; information concerning its treatment and eradication in various countries, such as Switzerland and Poland, would be welcome.

Cooperation in nutritional matters between FAO and WHO was proceeding satisfactorily in Guinea. Two joint seminars for training nutrition experts for primary health care had been organized, and fellowships had been made available by WHO and USAID for nutrition courses. It was vital that such urgently needed nutrition workers should be trained essentially from the public health viewpoint rather than as dieticians, since the real need was for mass action covering the population as a whole.

Dr EL GAMAL recalled that when considering the proposed programme budget for 1984-1985, the Health Assembly had taken programmes 8, 9 and 13 jointly. However, the discussion of health promotion as a whole had not been conducive to a cohesive debate. He therefore welcomed the present, separate consideration by the Board of the various related programmes, and hoped that that procedure would also be followed at the forthcoming Health Assembly.

Dr KHALID BIN SAHAN said that malnutriton, a most serious matter, was due not only to poverty, inadequate food production and shortcomings in distribution, but also to ignorance. WHO's role was necessary restricted to certain aspects of the problem. He accordingly stressed the importance of the intersectoral approach indicated in paragraph 15, and asked how collaboration with FAO and other international agencies, aimed at obtaining a composite picture of the national food and nutrition situation, would be implemented.

Malnutrition might well be more extensive than was at present believed. In Malaysia, a survey carried out with a sample of three million children under seven years of age over a two-year period had shown a higher proportion with stunted growth than data provided by hospitals and health centres had seemed to indicate.

Mr VAN GINDERTAEL (adviser to Professor Lafontaine) said that WHO's action in the field of nutrition, which was to be commended, concerned matters of vital importance to the health-for-all objective. Belgium would continue to furnish its wholehearted support in that action.

With regard to paragraphs 8 and 9, he endorsed the proposed attention to what were called the "nutritional disorders of affluence", with obesity, diabetes, cardiovascular disorders and dental caries as examples. It might also be desirable for WHO to concern itself with the industrial processing of certain foodstuffs, i.e., the manufacture, distribution and presentation of new foods, and in particular the so-called "fast foods", which were increasingly in demand in developing and developed countries alike.

He further hoped that particular attention might be given to action with regard to iodine deficiency disorders, and above all to vitamin A deficiency and xerophthalmia.

Dr REGMI said that faced with the immensity of the problem of malnutrition, the health sector could play no more than a small role. WHO should thus endeavour to exercise an essentially catalytic function with regard to activities of other concerned agencies. He expressed special appreciation of the work being done under the joint WHO/UNICEF nutrition support programme in Nepal.

Dr KO KO (Regional Director for South-East Asia) agreed that there was an increase in country programmes under the regular budget in 1986-1987 of US$ 358 200 as compared with the 1984-1985 level, but the amount was very small in view of the tremendous importance of nutrition work in the Region. That increase took account of planned expansions, mainly in Burma and India. Efforts were being made to evolve an integrated programme, e.g. in Indonesia, since the approach to be followed was just as vital as the level of funds involved.

In reply to Dr Sudsukh, he said that actual programme content and procedures regarding the joint WHO/UNICEF nutrition support programme depended on the country concerned. For example, in Nepal, emphasis had been placed more on the coordinating mechanism and infrastructure for implementation of the programme and follow-up through the national planning commission coordinating all sectors, whereas, in Burma, greater attention had been given to epidemiological and clinical aspects of nutrition since the delivery of the service was done through the people's health programme, which was coordinated by people's councils at every level.

An awareness of the importance of nutrition had been achieved in the Region through self-analysis of the status of its populations by countries and through promotional activities by the Organization. The Regional Office was extremely conscious of the problem of vitamin A deficiency; and there would be a regional meeting on iodine deficiency diseases, as a programme covering the whole Region, in line with the Regional IDD programme following the directives given by the Regional Committee.

Dr GUERRA DE MACEDO (Regional Director for the Americas) said that the Americas Region had been familiar with the problem of nutrition and malnutrition for some time. Indeed, it was probably the most serious health problem in the Region, since approximately one-third of the population of the Caribbean and Latin America suffered from some form or other of malnutrition: that justified the importance attached by the Regional Office for seeking appropriate resources from the regular budget and also from other funds, which might have been specifically earmarked for the purpose in earlier budgets, but were as yet unconfirmed for 1986-1987. In reply to Dr Borgoño, he said that the Regional Office was considering organizational projects to be proposed to the sub-regions, where increasing importance was being attached to nutrition and food. Above all, the Regional Office hoped that funds from other sources for the Caribbean and Latin America in 1986-1987 would exceed those currently available.

Dr SAMBA (Officer-in-charge, Regional Office for Africa), replying to Dr Otoo, confirmed that the slight increase in the regional nutrition budget had been supplemented by the increased activity of the joint WHO/UNICEF nutrition support programme. It was also gratifying to note that in some 17 countries in the Region awareness of the nutrition problem was such that governments had considerably increased their budget allocations in that area.

Dr PRADILLA (Nutrition), replying to questions, said that he did not entirely agree with the statement that the role of the health sector in the prevention and control of malnutrition was very limited. In fact, every one of the relevant sectors had an important role to play, and not only nutritional action in the health sector, but other health activities could have a tremendous impact on the nutritional status of individuals. Thus,

not only specific nutritional deficiencies, but also the prevalence of diarrhoea and other infections had a great influence on child growth and nutritional status. The health sector thus had very concrete responsibilities in preventing malnutrition, and in a number of well-documented instances the situation had been greatly improved through purely health action.

With regard to intersectorality, despite long experience at the national, regional and global levels of food and nutrition policies, it was very difficult to implement in practice. After a world-wide review of the situation of various food and nutrition policies, the conclusion reached in several forums had been that a start could be made with sectoral strategy, and that only when one sector had a very specific strategy could there be any talk of a complete food and nutrition policy. Intersectorality was very clearly understood in WHO; as regards collaboration with FAO, the fact was that the role of the other sectors was handled by the FAO Nutrition Division, which found it difficult to convince other Divisions in FAO that they had a role to play in the improvement of nutritional status. Internal sectoral development was therefore required before the full commitment of all the sectors could be assured.

WHO also cooperated closely with the UN-ACC Sub-Committee on Nutrition which brought together all the United Nations agencies concerned. An attempt was made at those meetings to emphasize sectoral responsibilities, but there again, collaboration between the agencies was complicated by the fact that each had a different administrative structure, so that collaboration with some of them would be conducted at the headquarters level, with others at the regional level and with yet others at the national level. In that very complex undertaking, WHO was aiming at a system of common programming with FAO, with a view to reaching intersectoral programmes at the national level; that goal had not been reached, but efforts were being made in that direction.

With respect to the African Region, WHO was collaborating closely with USAID in the establishment of nutritional primary health care. At a meeting held three months previously, 17 African countries had supported the preparation of an integrated nutrition programme in primary health care to be financed by bilateral aid.

Monitoring and surveillance formed part of the core of the whole programme. The different magnitudes of the problem of stunting in the world, referred to by Dr Khalid bin Sahan, had been reported in the Director-General's report on infant and young child nutrition to the Thirty-seventh World Health Assembly, and the accumulated data given in the WHO Chronicle showed a high prevalence of stunting throughout the world. The prevalence of wasting was very significantly higher in Asia than anywhere else, much lower in Africa and very limited in South America; that was one illustration of the differences in types of malnutrition prevailing in the regions.

With regard to specific nutritional deficiencies, the WHA resolution on vitamin A had been followed up. A document on the subject had been distributed to experts for comments and suggestions and WHO was endeavouring to mobilize funds for the establishment of a control programme. Problems of goitre management and control had been studied for many years. The technology was available, and what was now needed was the widespread actual implementation of programmes in some places. There were at least three WHO monographs on goitre and several others had been published jointly with the International Nutritional and Anaemias' Group (INAG). The focal point for the programme on malnutrition due to excess or imbalance was the European Region, with which WHO headquarters collaborated closely. A meeting on the subject would be organized during 1985, to which representatives of other regions where the problem was also prevalent would be invited. Assistance might be expected from the Joint Nutritional Support Programme and perhaps the Belgium Survival Fund, but the development of the programme depended very much on the situation in each country. Indeed, the degree of progress achieved varied greatly from one country to another; in any case, all of them had already developed a plan of action, some of them had already started on its implementation and others were still trying to finalize the plan, but all trying to develop monitoring systems.

The content of the programmes also varied widely: one country concentrated essentially on diarrhoea management and another on support for primary health care, with some components which had a significant effect on nutritional status. Two countries in Africa were

strengthening local efforts to stop desertification, in which nutritional activities were closely linked with community action related to environmental considerations and health issues.

The global component of the programme was basically designed to encourage regional offices in their support of action at the country level. There was also a research component which was given priority at regional meetings on determinants of child rearing and feeding practices. Funds were now available and the preparation of projects was being stimulated.

Professor JAZBI fully endorsed the view that in the developing countries malnutrition, especially protein calorie malnutrition in children under five, contributed to a high mortality rate, and that in the developed countries malnutrition in the form of excess eating leading to obesity, diabetes and cardiovascular diseases was responsible for disability and significant mortality. Malnutrition in pregnant mothers was also very common in the developing countries and contributed significantly to high infant mortaliy rates. He could support all the proposed programme activities designed to correct nutritional imbalance, but wished to emphasize that, for integrating nutrition in primary health care, in addition to the joint UNICEF/WHO nutrition support programme, active involvement of the World Food Programme was also necessary, as was the collaboration of ministries of health with ministries of agriculture and commerce. He mentioned commerce because many developing countries exported their food commodities in order to earn foreign exchange, although from the nutritional point of view such products, especially dairy products and poultry, were not in fact surplus to local needs. Although such policies were essentially national and were influenced by the many pressing needs of the countries concerned, he wondered whether WHO could play a role in influencing international trade so as to ensure that no country could purchase food products from a country which had no surplus of them, even if the purchasing price was the lowest. That could perhaps be achieved through GATT or some other international agency. In any case, since the matter was primarily one for the conscience of the international community, it was vitally important that for dealing with nutrition problems alone, cooperation should be established between ministries of health, agriculture and trade.

Nutritional education was another important activity that should be undertaken, and for that WHO should not only conduct training programmes for national nutritionists, but should try to have the basic elements of nutrition incorporated in the curricula of all categories of health personnel, particularly those working in primary health care units. Health education materials highlighting appropriate weaning food according to the sociocultural pattern of each country, and education in eating habits suited to various social strata needed to be prepared. In developing countries, efforts might be directed towards control of parasitic diseases, which in itself would remove many of the nutritional deficiencies prevalent in the countries of his Region.

Dr PRADILLA (Nutrition) said that it was very difficult for a health organization to influence organizations dealing with agriculture or trade. In cooperating with other agencies, WHO's role must be one of advocacy. Most experts related the export of food items from developing and developed countries less to actual nutritional needs than to other issues, such as international trade and economic situations, on which WHO did not have sufficient expertise to become directly involved. All it could do would be to try to play an advocacy role regarding health and nutrition in influencing the policies concerned.

Professor JAZBI acknowledged that WHO could not play a direct part in changing those policies. He had raised the question because he thought that Board members themselves might make Member States aware of the problem, either in their individual capacities or as participants in government institutions or international organizations. If no action whatever was taken in that regard, much of the expensive effort that WHO put into the solution of nutritional problems might prove futile where the recipients were concerned.

Oral health (programme 8.2)

Dr KOINANGE said that WHO was to be commended for taking the initiative of drawing attention to the very rapidly growing problem of oral health, especially in the developing countries. While there could be no doubt that some natural water lacked fluoride, it was not always true that additional fluoride was beneficial for preventing dental caries. Indeed, in

some areas natural water contained an excess of fluorides, and the issue there was how to reduce it. Thus, undue stress was laid on fluorised dentifrices as a universal means of reducing dental caries, and too much was made of that concept by commercial firms. It was very important for WHO to give clear guidance on the matter. He was glad to see that the budget provision for oral health in the African Region had been increased, and considered that the statement in paragraph 9 concerning efforts that would be made to utilize traditional methods was very important, because in many rural communities where oral health had been satisfactory for some time it had deteriorated in the past few decades owing to the introduction of very different life-styles.

Dr NIGHTINGALE (alternate to Dr Gardner) said that the oral health objective was clear and was certainly consistent with general WHO objectives. He wished to point out, however, that the first target, although it might be achievable, seemed to be very ambitious. For 50% of the Member States to meet, by 1989, the global indicator of three or less decayed, missing or filled teeth (DMF) at the age of 12 appeared to be a difficult challenge in view of the fact that only 44% currently possessed that status. To meet the target, three additional countries per year would need to reach the goal, and that at a time when there were indications of a rise in the number of decayed, missing or filled teeth in the developing and the developed countries alike.

The situation analysis in paragraph 3 seemed to be accurate, but he considered that several other issues should have been mentioned, including oral cancer, dentofacial anomalies and - specifically - disfiguring dental fluorosis: the latter condition was not uncommon in the world and was important not only per se, as an indicator of other physical effects in certain environments, but also as a matter of public concern that too frequently overshadowed the very positive effects of fluoride within recommended levels. He noted that the issue was referred to in paragraph 17 of the Plan of Action.

Dr BORGOÑO agreed with Dr Nightingale that the oral health target was optimistic and would be difficult to meet. He stressed the importance of the programme at the country level: every effort should be made through global and regional mechanisms to reach that level, since it was only there that there could be any possible solution of a problem which was growing in the developing countries. The indicators normally used showed that whereas oral health was improving in the developed countries it was deteriorating in the developing countries - a state of affairs that would make it even more difficult to achieve the goal. Efforts must be made to eliminate the imbalance between prevention and rehabilitation, since in the overwhelming majority of country programme budgets expenditure on the extraction and filling of teeth prevailed over the prevention of dental caries in childhood and the preservation of good dentition. A great deal was being said on the subject, but little was being done, and there was a clear need for a change of approach.

Dental primary health care was most important and should be simplified. An effort in that direction was being made in the Region of the Americas, for which the budget had fortunately been increased. In the programme for that Region, auxiliary personnel had an important part to play, although it was not easy to bring about recognition of their role, professional dentists being naturally opposed to that kind of care; nevertheless, it provided the only effective solution whereby the goal could be achieved.

With regard to the epidemiology component of the programme, referred to in paragraph 12, he suggested that the approach should not be confined to prevalence rates; continued attempts should be made to determine the actual incidence of the phenomena, in order to give a clearer picture of the progress made in improving oral health.

Dr SAVEL'EV (adviser to Professor Isakov) drew attention to the emphasis placed on intercountry programme activities, and particularly the work of demonstration, training and research centres. He welcomed the recommendations for extension of the use of methodology for the management and evaluation of the activities of national stomatological services and for the continuation of research into the efficacy of new preventive and restorative methods.

Dr QUAMINA said that it was most appropriate that the oral health programme should be discussed immediately following the discussion on nutrition, particularly in view of the reversal of trends, mentioned in paragraph 4, resulting in a somewhat better oral health situation in the developed world than in the developing world, largely due to changes in nutrition and life styles in general.

Concerning paragraph 11, she favoured the development of organizational structures, particularly with a view to the integration of dental workers with other health professionals as equal members of primary health care teams. The profession - and in that she included both dentists and auxiliary dental workers - was suffering somewhat from isolation. Its members were scarcely represented at health meetings and there existed a sectorization of oral health which must be overcome. Health promotion and prevention for oral health could not be regarded as being separate. In order to achieve integration, which would be most effective at the primary health care level, a close look must be taken at the training of dentists and dental auxiliaries and an appreciation made of what other primary health care workers could achieve in the area of health promotion with regard to oral health.

It was unfortunate that budgetary provisions appeared to reflect the priorities which individual countries were able to give to oral health - as opposed to what they might wish to give - in the light of their general health situations. Nonetheless that should not prevent countries from giving high priority to its promotion, especially as a great deal of morbidity and misery occurred when oral health failed.

Dr SUDSUKH said that even though oral health problems were not a significant cause of mortality or disability, they remained a matter of concern in most countries: there was a high prevalence of dental caries in developing countries and of periodontal disease in industrialized countries. Although oral health programmes had been established in medical institutions in many developing countries, the main emphasis was still on curative dental services. Oral health through primary health care programmes had not been well developed. His own experience indicated that one reason for that was the lack of an appropriate methodology for the integration of oral health into primary health care programmes with a sense of community involvement. He suggested that relevant operational research should be undertaken, with WHO support, to work out appropriate and effective methodologies for the development of oral health through primary health care programmes in accordance with their specific situations of countries.

Dr MOLTO drew attention to the relevance of the programme within the proposed programme budget as a whole and, like Dr Quamina, noted that it was most appropriate that it should immediately follow the programme on nutrition, as the latter, together with fluoride deficiency, was an important factor in the problem of dental caries. He urged the Director-General to encourage those international bodies supporting drinking-water supply programmes to incorporate fluoridation into their activities.

Preventive programmes in schools were extremely important. However, in Panama, for example, the current method of topical application of fluoride was not very effective as it was by means of tablets which had to be kept in the mouth for 30 or 45 minutes in order to have any effect. He would be interested to have details of any alternative method which might be effectively adopted at the country level.

Efforts in prevention within the framework of primary health care must be complemented by recuperative and curative efforts. In that respect, the question of equipment and supplies was extremely important - and, of course, relevant to programme 15.4 (Equipment and supplies). The Organization, especially at Regional Office level, should continue to assist Member States in acquiring dental equipment, as costs could thereby be reduced, sometimes by more than half.

Dr REID, referring to paragraph 17, said that a vast amount of scientific and some highly unscientific literature had been published on the subject of the fluoridation of water supplies. In connection with WHO policy on fluoridation, which was long-standing and well known, he asked, firstly, what was the method of publication of the findings of the oral health review and research advisory group and, secondly, whether the Secretariat could confirm that in the considered view of the group there was no fresh scientific evidence which might in any way lead to the need to modify the Organization's policy.

Professor JAZBI strongly endorsed Dr Quamina's remarks; it was true that the oral health sector of the medical profession was seldom given due recognition, especially in the developing countries, and it was time that the importance of oral health was recognized as a matter which had a direct bearing on the attainment of the goal of health for all by the year 2000. Those in the profession must be given incentives, in the form of appreciation or recognition, so that they might take their proper place in the organizational structure.

He had noted the situation analyses made for Member States in the Eastern Mediterranean Region and would appreciate further details about the situation in the Region as a whole, since as he suspected that dental caries in children were on the increase in most countries there, due to a lack of education in oral hygiene. A health education programme conducted through the medium of primary health care would seem, once again, to be the only answer. However, a situation analysis report should first be made available, together with suggestions for steps to be taken by governments initiating programmes and, wherever required, with guidance and technical support from WHO.

Dr GARCÍA BATES said that oral health, like mental health and care for the disabled, was an area in which for various reasons action was traditionally delayed, both nationally and internationally. In the case of oral health the problem was especially serious because it was not merely a question of limited budgetary resources; economic interests were involved which induced those in the profession to undertake restorative rather than preventive measures, despite the fact that the technology and knowledge to achieve prevention was available. There was, for example, no doubt about the effect of the fluoridation of water supplies in reducing the prevalence of dental caries but there were none the less cases - in Argentina for example - where fluoridation plants had existed for some time but, for a variety of reasons, had never been brought into service. On one occasion in her country a consultant, when invited to talk on fluoridation, had first asked whether he should argue in favour or against it, since he could give either version depending on which was preferred.

Professional groups, teaching staff and those providing relevant social services in the oral health field should get together to agree on steps, such as the reduction of insurance costs, particularly for children under 15, for attention related to examination, diagnosis and initial prevention, which required no major economic outlay.

Another important change must be effected in the basic orientation of oral health teaching, which was still geared towards private practice, where the main source of income was naturally to be had from treatment. Changes in the curricular structure called for joint efforts by teaching staff, practising professionals and students if there was to be greater awarenesss of the need to increase budgetary resources and put such measures as fluoridation into practice.

Dr EL GAMAL said that there was no mention under programme 8.2 of the relationship between oral disease and other diseases, although it was well known that oral health problems could cause other problems. He asked whether any studies or research work had been carried out within the framework of the programme into that relationship.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean), replying to Professor Jazbi, said that reports on all surveys carried out in the Region would go to the Member States concerned, together with a proposed plan of action.

There had long been discussion on the possibility of producing a basic dental unit - as had been done in the case of the basic X-ray machinery developed by WHO - in the form of a standard, robust and less expensive unit for which spare parts would be generally available. Such a project seemed to him to be very worthwhile.

Professor JAZBI fully agreed as to the value of such a dental unit and urged that the matter be pursued. The X-ray equipment referred to had already shown its effectiveness and a similar project for a dental unit would be very useful.

Dr BARMES (Oral Health) said, in response to Dr Reid's questions, that as far as he was aware, no new body of information existed that would indicate that any change should be made in the Organization's policy on fluoridation and other uses of fluorides. The only aspect that might be described as having changed might be in relation to efforts to extend ways of using fluorides in order to achieve maximum versatility and respond to prevention strategies in a wide variety of cultural, social and oral health situations. There appeared, from time to time, studies which concerned the use of extremely high concentrations of fluoride that had caused adverse reactions as might be expected with unusually high concentrations of almost any substance. Unfortunately, claims made on the basis of such studies usually took several years to confirm or refute. One such study was currently being subjected to scrutiny but there was no evidence from it or any other that the Organization's policy on optimal use of fluorides should be modified.

Concerning publication of the reports of the oral health review and research advisory group, that body had effectively advised on programme development and annual reports had in the past been sent to members of the group, chief dental officers within countries, and other interested persons, but had not so far been formally published, although that could be done if so desired, in which case a wider circulation might be envisaged.

In reply to Dr Molto's question, he agreed that fluoride tablet administration required considerable organization and missed several years of a child's life that were important in tooth formation. Other procedures included the predominantly topical application by rinsing and the use of fluoride toothpaste. In connection with the latter, administrators should note Dr Koinange's comment about the use of fluoride toothpaste where fluoride was already in excess in water supplies. Guidelines were being prepared on that rather special situation. However, it should be emphasized that in normal circumstances fluoride toothpaste had been much more effective in reducing the prevalence of caries than had been expected. It was an excellent system which did not depend on a great deal of management and guidance if countries legislated to make fluoride toothpaste available.

Concerning fluorosis, data was being collected in the global data bank. Fluoride ingestion in different situations was being studied and simple methods of defluoridation were being studied, among them one which had been developed at the Chiang Mai Demonstration, Training and Research Centre for Oral Health in Thailand.

In reply to Professor Jazbi's question concerning Pakistan and other countries in the same Region, he said that the situation in regard to caries was, in general, that disease was low but approaching the 3 DMF level and in a few countries had passed that level. Some countries had a natural protection through fluorosis naturally available in their water supply. The level of peridontal disease was moderate to high in the Region but because almost all the countries in the Region had performed situation analyses, considerable activity was taking place and there were great hopes that the current trend in dental caries would be reversed.

WHO was looking into the development of basic dental units; one such unit was being developed by a group in Canada under the international collaborative oral health development programme (ICOHDP). Efforts were also being made to secure the cooperation of manufacturing interests.

Replying to Dr El Gamal, he said that a number of studies dealt with the effects of oral diseases on general health; the oral health unit did not, however, have the resources to carry out such studies itself. Instead, it had endeavoured to promote that type of study in research institutes and universities.

With regard to the need for a better balance between prevention and restorative and rehabilitative procedures, it should be borne in mind that the experience of highly industrialized countries clearly showed that prevention was effective and simple and relatively cheap but that management had to be superb. Management skills were difficult to find because dental professionals and specialists were paid for providing curative rather than preventive services. That was why appropriate remunerative procedures were necessary and why ICOHDP had been developed to channel requests; however, both WHO and bilateral agencies were still asked to provide new schools and high-technology equipment for preventive and primary health care projects. ICOHDP was indeed functioning, although the response from donor countries had been somewhat disappointing.

The integration of general health and oral health personnel was a central issue, particularly as far as primary health care and preventive procedures were concerned. He looked forward to the day when there would be no more dental auxiliaries but only auxiliaries involved in oral programmes, no more dentists but only oral physicians. For this to happen it would obviously be necessary to make changes in curricula at all levels. Nevertheless, the traditional courses continued to produce obsolete personnel both in the highly industrialized countries, where needs had dramatically changed, and in the developing countries, where quite different types of personnel were required. In other words, dental education was changing at too slow a pace.

He agreed that the goal of 3 DMF was ambitious but considered it a practical possibility in the light of current trends. In fact, some very remarkable turn-rounds in the oral health situation might well occur by the year 2000. There was a danger that, despite the growing interest in oral health, the lack of awareness in countries which had had no real experience of dental problems would mean that too little action would be taken too late unless more was done to promote the preventive approach. Moreover, the scandalous surplus of highly trained manpower in the most industrialized countries would assume even greater proportions unless prompt action was taken. Nevertheless, he sincerely hoped that those pessimistic prophecies would not be fulfilled.

Accident prevention (programme 8.3)

Professor JAZBI said that greater attention than ever before must be paid to accident prevention in the developing countries, where accidents, especially road accidents, were increasing in number as cities expanded in the wake of rapid industrialization. The programme activities designed to reduce the incidence of accidents and, whenever possible, to prevent them appeared to be very appropriate. There was, however, a need for research to ascertain the relationship between accidents and the consumption of alcohol and other psychoactive substances and specific behavioural types. It was his impression that traffic accidents were more common among teenagers than among middle-aged persons, and among males than among females. The background data needed to be established so that appropriate preventive action could be taken. The activities proposed in paragraph 12 of the programme statement were therefore worthy of support.

Professor FORGÁCS noted that accidents accounted for a high proportion of deaths in the industrialized countries, particularly among young males, and that they were apparently becoming a serious problem in the developing countries. He therefore supported the research work mentioned in paragraph 12 of the programme statement. There was a need to strengthen global and interregional research activities, especially with a view to identifying the socioeconomic, behavioural, sex and age factors contributing to accidents on the road, in the work place and in the home. Unfortunately, the decreased level of financial support, as indicated on page 398 in respect of project APR 216, would not be sufficient to provide adequate coverage.

Mr GRÍMSSON expressed the view that the programme on accident prevention should rank among the Organization's priority activities. He was therefore rather surprised to note that, except in the South-East Asia and Eastern Mediterranean Regions, the amount budgeted for country programmes was to be decreased. The programme itself rightly focused on youth and on the elderly, and it was very important that special attention should be paid to accidents in the home, which were of frequent occurrence and often fatal. He agreed with Professor Jazbi that the relationship between accidents and alcohol and drug abuse should be explored, since recent studies had revealed an increase in the number of accidental deaths resulting therefrom.

Dr MAKUTO said that an analysis of available morbidity and mortality statistics indicated that in many countries of the African Region accidents in the home were now among the top 10 causes of mortality in children under five years of age. Furthermore, in those countries road traffic accidents were increasingly important causes of death among the population at large, particularly in the most economically active age-groups. In Zimbabwe, for instance, bus accidents involving up to 50 persons sometimes occurred and high rates of accidental death and injury were recorded during public holidays.

Consequently, WHO's accident prevention programme was worthy of special attention, particularly in view of the fact that mortality and morbidity due to accidents could largely be prevented. He was dismayed to note that in the African Region the country budgetary provision for the accident prevention programme in 1986-1987 was zero and that the intercountry and regional provision had been decreased. Under these circumstances, the Regional Office should draw the attention of Member States to the importance of the programme, and should provide technical support to strengthen managerial capacities for situation assessment, programme planning and the implementation of appropriate and effective projects aimed at reducing mortality and morbidity due to accidents.

Dr SUDSUKH stressed the importance and complexity of accident prevention, which called for effective multidisciplinary cooperation and coordination. He sought information regarding the composition of the multisectoral task force referred to in paragraph 2 of the programme statement, and inquired what strategies it would adopt to fulfil its functions. He was glad to note that the budgetary allocation for the accident prevention programme in the South-East Asia Region was to be increased.

Dr KHALID BIN SAHAN said that the problem of road accidents was a very real one in many developing countries; in Malaysia it had assumed epidemic proportions and was the most frequent cause of hospital admissions and one of the most frequent causes of death, entailing a loss of economic productivity, an increase in the cost of health care, and placing a heavy burden on the country's accident emergency services.

Accidents were man-made and could therefore be prevented. In Malaysia the main cause of road accidents was the human factor. At present, alcoholism was not a problem but inconsiderate driving and disregard of traffic regulations resulted in many deaths. The problem had to be tackled at source - on the road, with the driver, and with the vehicle. Many serious road accidents involving public transport took place, more so in fact than accidents involving private cars.

He welcomed the proposal that a third interregional course on injury prevention and control should be held in 1987. The Secretariat might provide some further details in that connection. He hoped that the course would be attended not only by medical personnel but also by representatives of transport departments, public works agencies and traffic regulation enforcement officers, since the prevention of road traffic accidents was yet another area in which a multisectoral approach was required.

Dr BELLA agreed with Professor Jazbi that accidents constituted a serious problem in the developing as well as in the developed countries. The situation in the Ivory Coast was significant. All records for road traffic accidents had been beaten and draconian measures had had to be taken to control the epidemic. The provisions of the highway code had been strictly enforced, speed limits had been imposed on certain stretches of road and severe safety inspections had been instituted for all vehicles that had been in operation for more than three years, special attention being paid to such items as tyres, brakes and headlamps. He was therefore glad to note that WHO's accident prevention programme would promote the strengthening of operational research capabilities and support technical and health systems research in a number of countries.

Dr MOLTO fully agreed that the high mortality rates resulting from road traffic accidents constituted a growing problem in the developing countries. However, despite the Director-General's efforts to promote research into ways of preventing such accidents, the problem would be difficult to solve because of its intersectoral nature; the health sector was rarely entrusted with responsibility in the matter; sometimes it did not even have access to the relevant information. In Panama, strenuous efforts had been made over the past 10 years to achieve coordination with the police forces responsible for enforcing the traffic regulations and with the bodies concerned with on-the-spot operational research, with a view to exchanging information and providing mutual support. Could the Secretariat inform him whether any Member State had achieved such coordination in an effective manner and whether any information concerning agreements and conventions on the subject could be made available?

Dr SAMBA (Officer-in-charge, Regional Office for Africa), referring to the point made by Dr Makuto, said that the Regional Office for Africa had also been surprised that no country in the Region had requested that budgetary provision should be made for accident prevention. The table of estimated obligations shown on page 123 of the budget document had been compiled almost entirely in response to requests from countries. The situation had been brought to the attention of the Regional Committee, which had discussed it at length. It had been generally recognized that traffic and domestic accidents were in fact increasing at a faster rate in Africa than in the developed countries. The Regional Committee had taken note of the trend and it was hoped that the situation would be reflected in subsequent budget requests from countries. WHO would be only too pleased to provide its full collaboration at both the regional and global levels.

Dr ROMER (Accident Prevention) noted that the problem posed by the intersectoral nature of accident prevention had been referred to by several speakers. The problem did not arise only in the industrialized countries; it also affected the developing countries, which found themselves in more or less the same situation as that which had obtained in the industrialized countries 20 years earlier, before the introduction of appropriate regulations had led to an improvement in the situation, particularly in the OECD countries, where mortality rates had fallen by from 15 to 20 %, with regard to traffic safety improvement.

The extent and severity of the problem, as measured by mortality, was likely to be underestimated, as existing data showed the socioeconomic importance of injury morbidity and disability in many places; 1 to 2% of GNP was the average figure for the cost of road injuries in developed and developing countries.

Reliable morbidity and disablement statistics were, however, difficult to obtain, but the increasing use of certain medical services and the growing number of hospital beds occupied by accident victims provided some indication of the general trend; in some countries 20-30% of hospital admissions were due to bodily injuries. However, whatever scanty information was available was not always utilized in order to formulate the necessary prevention and control policies. At bottom there might be an absence of political will to tackle problems such as safety. In that connection a comparison could be made with what happened in the field of man-made disasters, such as those occurring in industry. For example, a recent study by OECD had shown that the compensation paid to private individuals or communities by polluting industries accounted for approximately 1% of the investment required for safety measures to prevent the accident from occurring. In the field of accident prevention, it very often happened that the investments required, to improve road safety for example, were not given the priority they deserved, especially in the developing countries, where safety was often the poor relation in transport development at a time of chronic economic crisis.

The WHO programme was now directed to promoting an awareness at governmental level of the need for accident prevention and to providing technical support for efforts to determine, or at least to form a more accurate idea of, the nature of the problem since it was important for health authorities to have a clear picture of the part they could usefully play in accident prevention.

In answer to Dr Molto, he said that some countries, though not many, had indeed developed mechanisms to improve intersectoral cooperation in such areas as road safety and the prevention of accidents to children, thus increasing the contribution health authorities made to accident prevention. The establishment of such collaborative procedures was of the utmost importance; to that end, the Organization was setting up at the regional and global levels the intersectoral groups mentioned in paragraph 9 of the programme analysis, which had been the subject of a question from a Board member. WHO could not take effective action on accident prevention on its own; it would have to work closely with the other bodies concerned, such as transport authorities, since a free exchange of views and data was needed to produce general policies. In several of the regions, intersectoral committees of pilot groups had already been set up and a global group was expected to be established during 1985. An important function of such groups would be to support the development of similar groups, in particular interministerial groups, at country level in order to prepare programmes and follow up their implementation.

A question had been raised about regional courses. These were multidisciplinary courses for senior staff in health and relevant non-health sectors aimed at providing decision-makers in all those sectors with pertinent information on accident prevention. The first course of that nature had been held two years previously; as a result, 70% of the participants had introduced activities related to injury prevention programmes in their countries in the year following the course.

Accident prevention was not a topic normally in the forefront of discussions at the Board and the Health Assembly since it was often the responsibilities of ministries other than health. Nevertheless, the health sector did have an important part to play in accident prevention, not least to highlight the repercussions high accident rates had on the health services and to draw attention to the need to include it in any intersectoral efforts to formulate prevention policies.

Protection and promotion of the health of specific population groups (programme 9)

Maternal and child health, including family planning (programme 9.1)

Dr HAPSARA noted with gratification the substantial and active efforts that WHO headquarters and the South-East Asia Region were devoting to maternal and child health care, including family planning. From the activities listed it was clear that the programme involved many interrelated activities such as the expanded programme on immunization; family planning; women, health and development; and nutrition, to name a few. That accorded well with the emphasis Indonesia placed on team work, as evidenced by its programme involving a family package of health care covering the following five aspects: strengthening maternal and child health services; strengthening family planning services; improving family nutrition, especially for pregnant and lactating women, infants and children; viral disease control; and strengthening of the expanded programme of immunization for mothers and children. He looked forward to the further strengthening of the maternal and child health programme in the future.

The programme activity described in paragraph 13 was expected to be closely related to a number of other programmes. He asked what specific form such collaboration and cooperation would take at the headquarters, regional and WHO programme coordinator level.

Dr BORGOÑO endorsed the programme description in its entirety, adding that he had a few comments to make.

Firstly, he felt that family planning was universally accepted as an integral part of maternal and child health; there was therefore no necessity to single that activity out in the programme title.

Secondly, low birth weight was a problem that should be highlighted. The figures quoted in the situation analysis for the rate of low birth rate were quite high; it should be noted that a number of developing countries, including his own, had succeeded, through the introduction of suitable programmes, in reducing their national rate to that prevailing in the developed countries. Attention to prenatal care in all its aspects, including nutrition, was fundamental to finding a solution to the problem of low birth weight, which accounted for a large proportion of infant mortality, especially neonatal mortality, in developing countries. In that context, efforts to strengthen joint efforts in the field by WHO and UNICEF would be most useful.

Collaboration with the Expanded Programme on Immunization and the role of sexually transmitted diseases during pregnancy had been mentioned among the programme activities (paragraph 20); however, there were other communicable diseases too that were major causes of high infant mortality, such as acute respiratory diseases and diarrhoeal diseases, and it was important for adequate resources to be allocated to the programme. In that context, joint work aimed at common goals could be very productive and should be given priority.

As far as child health, growth and development were concerned (paragraph 21), he asked what progress the joint programme with UNICEF was making and whether any problems had arisen with regard to the collaboration between the two agencies.

Finally, the problems associated with adolescent health were affecting an increasing portion of the population, not only in the developed countries but to a growing extent in the developing countries. They were particularly acute in Latin America and the Caribbean. There was therefore a need to consider all aspects of adolescent health together, rather than to deal with them separately under different programmes, and also to tackle the issue at regional and global level. In that respect, he would point out that there appeared to be some cutback in the overall funds allocated to maternal and child health activities for the Americas.

Mr ZHANG Yin E (alternate to Dr Xu Shouren) agreed with the emphasis the proposed programme budget placed on the maternal and child health programme. The outstanding results already achieved by WHO in that area were greatly appreciated. Women and children constituted a majority of the world population; the problems associated with maternal and child care, which affected many countries, especially the developing ones, were thus of major

importance. Maternal mortality and the infant mortality rate both remained high in some developing countries. He therefore felt that the programme's efforts to assist developing countries to strengthen their maternal and child health services and help them train health personnel for work in that area should be continued. WHO's cooperation in the field with UNICEF and UNFPA had been most effective and he hoped it would continue.

Dr SUDSUKH strongly endorsed the importance of the maternal and child health programme. In his country an integrated programme was being launched that incorporated into a single health care delivery package the following four primary health care components: maternal and child health, including family planning; simple medical care; availability of essential drugs; and the expanded programme on immunization. The programme was a very promising venture and he hoped to be able at a later date to report on its results to the Board.

Dr SAVEL'EV (adviser to Professor Isakov) said that programme 9.1 was one of the Organization's most important programmes and was directly linked to the introduction of primary health care and the implementation of the Declaration of Alma-Ata. A wide range of many different programme activities had been planned for the coming biennium to give countries technical assistance in determining and analysing their problems, implementing and evaluating their national programmes, manpower training, pregnancy and perinatal care, child growth monitoring and other issues.

The programme paid particular attention to research. Measures aimed at accelerating the developing and assessment of appropriate technology that was effective in and acceptable to developing countries could only be approved. One interesting aspect of the proposed research was the development of systems for the early detection and prevention of hypertensive disorders during pregnancy in association with correlated epidemiological studies and health systems research. At the same time, it should be noted, with regard to trends in child health research, that the status of health of the population as a whole was to a great extent determined by the health of the rising generation. It would therefore be useful to carry out studies on the prevalence and etiology of hypertension and respiratory disease in children, paying particular attention to the development of appropriate preventive measures.

Dr MAKUTO stressed the importance of the maternal and child health programme for the health-for-all strategy and endorsed the proposed programme activities. Since the programme catered for the largest population subgroup in most countries, especially developing countries such as his own where women, and children under 15, made up 75% of the total population, its successful execution was crucial and critical for the attainment of health for all by the year 2000. Zimbabwe had a very fruitful collaboration with WHO in the implementation of its national maternal and child health programme which encompassed most of the activities advocated by the Organization's programme. He was pleased to note that the 1986-1987 budget allocation for the programme to the African Region had been increased over that for the current biennium. However, there was a reduction in the extrabudgetary funds shown for programme 9.1 in Africa. That situation was stated (paragraph 31) to be only tentative, with the result that a much higher level of resources might ultimately be realized. He sincerely hoped that would be the case as the programme would need to be adequately funded if it was to realize its ambitious targets and enhance the possibility of attaining health for all.

Dr OTOO said that maternal and child health services formed the core of primary health care programmes. A number of significant health indicators, such as the infant mortality rate, the maternal mortality rate and life expectancy at birth, were affected by maternal and child health services. Hence the organization and delivery of maternal and child health services provided one of the most satisfying and challenging experiences in the delivery of primary health care.

In the maternal and child health programme linkages with a number of other programmes were indicated (paragraph 13). Because of the importance of maternal and child health services, he asked for more detailed information on what those linkages entailed and what they were supposed to achieve.

Dr REGMI also stressed the importance of maternal and child health and commended the programme that had been prepared. Many developing countries were engaged in vigorous campaigns to promote birth control activities. However, that aspect was of less importance

than maternal and child health activities proper and should be given a lower priority. The mother and child were the most important members of the family, and in the developing countries women and children made up a very large proportion of the population. Every effort should therefore be made to ensure that children had a safe childhood. Acute respiratory infections, diarrhoeal diseases, other communicable diseases and malnutrition were so many hurdles that barred the infant's path from childhood to adolescence, and those hazards made it a Herculean task to provide the necessary protection. In the context of health for all by the year 2000 through primary health care, the Organization should give top priority to the maternal and child health programme; the resources for that programme, from whatever source they came, should be stepped up.

Dr ADOU joined in commending the considerable attention given in the programme budget proposals to the most important subject of maternal and child health. With regard to the research activities envisaged (paragraph 19) under the programme, he asked for further information on non-literate instruction material for the promotion of clean delivery and on a surrogate measure for birth weight, since such material was of prime importance in many developing countries, such as his own, where many women who were the target of maternal and child health education were illiterate.

Dr EL GAMAL said that programme 9.1 could be considered to be one of the most important for the future of mankind. The comprehensive view of health and the coordination required between various sectors, referred to in the Introduction, led him to call for the adoption of an integrated programme to cover all aspects of child health, which he would call a child survival programme. The six main elements of such a programme would be: the Expanded Programme on Immunization; control of acute respiratory infections; control of diarrhoeal diseases; spacing of births; reduction of maternal mortality; and the control of malnutrition. He would be returning to the question when the UNICEF/WHO Joint Committee on Health Policy met just after the Board.

The meeting rose at 17h35.

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