WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

A36/A/SR/9
11 May 1983

THIRTY-SIXTH WORLD HEALTH ASSEMBLY

COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE NINTH MEETING

Palais des Nations, Geneva
Wednesday, 11 May 1983, at 9h00

CHAIRMAN: Dr J. M. SOTELO (Peru)

CONTENTS

Note

This summary record is provisional only. The summaries of statements have not yet been approved by the speakers, and the text should not be quoted.

Corrections for inclusion in the final version should be handed in to the Conference Officer or sent to the Records Service (Room 4013, WHO headquarters), in writing, before the end of the Health Assembly. Alternatively, they may be forwarded to Chief, Office of Publications, World Health Organization, 1211 Geneva 27, Switzerland, before 1 July 1983.

The final text will appear subsequently in Thirty-sixth World Health Assembly: Summary records of committees (document WHA36/1983/REC/3).

NINTH MEETING

Wednesday, 11 May, at 9h00

Chairman: Dr J. M. SOTELO (Peru)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1984-1985: Item 20 of the Agenda (Documents PB/84-85 and EB71/1983/REC/1, Part I, Resolution EB71.R3 and Annex I, and Part II) (continued)

Programme policy matters: Item 20.2 of the Agenda (Resolutions WHA33.17, paragraph 4 (1), WHA33.24, paragraph 3, and WHA35.25, paragraph 5 (3); Documents EB71/1983/REC/1, Part II, Chapter II; A36/5, A36/6, A36/INF.DOC./2, A36/INF.DOC./5) (continued)

Health science and technology - Health promotion and care (Appropriation Section 3; Documents PB/84-85, pages 119-218, and EB71/1983/REC/1, Part II, Chapter II) (continued)

Dr ARIF (Division of Mental Health), replying to points raised in the debate, also thanked delegates for the support, guidance and advice they had given concerning programme 10.2 (Prevention and control of alcohol and drug abuse).

Analysis of the trends in frequency and severity of the problem of drug abuse and drug dependency showed a significant and constant increase in both developed and developing countries.

The delegate of Sweden had referred at the sixth meeting to the discussion of the drug problem in the United Nations Commission on Narcotic Drugs at its 1983 February session and to the alarming increase of drug abuse in many countries of the world. Subsequent to several earlier Health Assembly resolutions and a report by the Director-General to the Thirty-third World Health Assembly, resolution WHA33.27 had been adopted in 1980 affirming that drug abuse constituted a serious health hazard of steadily growing proportions in developing nations as well as industrialized countries, and encouraging Member States when developing their national strategies for health for all by the year 2000 to integrate drug abuse control into their primary health care programmes. That resolution provided the Organization with directives for policy and programming to collaborate with Member States in integrating drug abuse control into their programmes and plans and to develop further activities for the prevention and control of health problems related to drug abuse. The resolution also acknowledged United Nations General Assembly resolution 34/177, which urged greater action by WHO and other United Nations agencies to implement drug abuse control programmes.

In response to that resolution, WHO had developed a global programme in collaboration with Member States. One of the principal strategies in developing the programme was cooperation with other United Nations agencies and with WHO collaborating centres on research and training on drug dependence and alcohol-related problems. Excellent cooperation had been established with those bodies. In the past three years an ad hoc interagencies coordinating meeting had been held regularly; the next meeting would be held at WHO headquarters in Geneva in August of the current year with the participation of the United Nations Division of Narcotic Drugs, the United Nations Fund for Drug Abuse Control and other specialized agencies such as ILO, FAO and UNESCO.

The WHO global programme on alcohol and drug abuse had two major components: the first was the integrated multisectoral drug abuse control country programmes currently being implemented in Burma, Pakistan, Thailand and other countries. The health elements of these programmes were executed by WHO; other elements were vocational rehabilitation executed by ILO, crop substitution by FAO and UNDP, law enforcement and supply control by the United Nations Division of Narcotic Drugs and, occasionally, educational preventive measures by UNESCO. The second major component of the programme was the development of technologies, including research to support the country programme.

In the integrated multisectoral drug abuse control country programmes the major emphasis was placed on the development of effective treatment and preventive programmes in the framework of existing social and health care systems using operational health service research to optimize resources. As countries could not afford to develop a vertical programme, those activities were integrated into the primary health care and basic social and health services of the country programme.

Details of the development of the technology component of the programme were described on page 169 of document PB/84-85 and included the development of guidelines and strategies for the prevention of drug dependence, for the evaluation of treatment programmes and for reviewing and revising national legislation. Manuals for teaching in health institutions about the problem of drug and alcohol dependence problems were being developed, and the role of primary health care in the prevention and management of drug- and alcohol-related problems were being defined. The assessment of the role of methadone in the management of drug dependence was an example of a project in the area of the development of treatment techniques. Most of those projects had already been started and would continue during the 1984-1985 biennium.

The programme was partly financed from the WHO regular budget, which was very limited, but most of the financial support came from extrabudgetary resources, principally from the United Nations Fund for Drug Abuse Control. In implementing the programme, WHO staff at headquarters, regional and country level were actively cooperating with national authorities and other international agencies.

The delegate of Egypt had referred to the need to include measures for the prevention and management of drug abuse in primary health care. In 1983 WHO was implementing a project on the role of primary health care in that field. A WHO advisory group would meet during the coming week to discuss the topic with representatives of countries from various regions, including Egypt. He was sure Egypt's rich experience in the Fayoum project on the extension of mental care to the community, including drug abuse prevention and control, would be of value to participants in the meeting.

Dr DIETERICH (Director, Division of Environmental Health) said that the Committee's discussion had clearly shown that the promotion of environmental health involved problems ranging from very old to very new ones. No country had only one environmental health problem to deal with, as had been illustrated by the statements made by the delegates of Sri Lanka, Nigeria, Kenya, Yemen and others on the subject of toxic chemicals, which could no longer be ignored, either in the industrial world or in developing countries.

The other important aspect of a general nature which had been recognized during the discussion was the intersectoral nature of environmental health. The delegates from Egypt, United States of America and others who had referred to the need to promote environmental health in urban and rural development projects had made it clear that health agencies had a vital role to play vis-à-vis many other agencies - an advocate role, but also a role of technical cooperation. No meaningful environmental impact assessment of such development projects could be prepared without the health agencies; nor could assessment be translated into preventive programmes without competent environmental health staff in health agencies, the need for whom had been stressed by the delegate of Romania and others. He confirmed that WHO would pursue the intersectoral concept in implementing the new programme 11.2, environmental health in urban and rural development and housing.

In reply to questions by several delegates he stated that in the control of environmental hazards (programme 11.3), three sets of activities were now in the forefront of the work of the Organization: the evaluation of the efffect of chemicals on health as part of the International Programme on Chemical Safety; human exposure assessment; and use of the resulting information in planning and implementing preventive control, of which a good example was the safe disposal of toxic wastes, as mentioned by several delegates.

In response to a point made by the delegate of the USSR, he confirmed that WHO was assuming a central role in the programme which was concerned primarily with monitoring the health aspects in the control of environmental hazards. But in order to enable the Organization to play that role, and keeping in mind that the programme was heavily dependent on national resources and national scientific research, it was important that those Member States having such scientific information at their disposal should make a commitment vis-à-vis WHO and confirm - also when collaborating with other, non-health international organizations

in matters of the environment - that WHO would be the Organization responsible at the international level for the health aspects. It was important also that ministries of health stimulate ministries for labour and environment to join them in support of the programmes of chemical safety and human exposure assessment as, at the international level, UNDP and ILO joined WHO.

Again in response to a question by the delegate of the USSR, the International Programme on Chemical Safety would depend to a large measure on extrabudgetary resources, but the Director-General had noted the suggestion that the contribution from the regular budget of the Organization was important. Nevertheless, taking into account that international trade in chemicals exceeded US$ 50 000 million annually, one could not but wonder why it should not be possible to raise the extrabudgetary funds to support the increasingly important International Programme on Chemical Safety as well as the work on human exposure assessment.

Again it had been pointed out that food safety was a multi-faceted problem; the time when developing countries were faced with only biological contamination of food had long passed, although that was still a major cause of diarrhoeal disease. In reply to the delegate of Spain and others, he confirmed that chemical residues in food had become a global problem, among other things, because of the use of pesticides in agriculture. The delegate of Cuba had asked how WHO and FAO collaborated and how Member States could take advantage of that collaboration in respect of the safety of food. The major mechanisms for collaboration between the two organizations were the Codex Alimentarius Commission, the meetings of the Joint FAO/WHO Expert Committee on Food Additives and the joint meetings on pesticides residues (both annual thus far), and their activities in food and animal feed monitoring and food control. Member States could utilize that collaboration in three ways, namely: by participation in the Codex committees on specific topics and commodities, by participation in the regional coordinating committees of the Codex and by accepting the standards set by the Codex Alimentarius. As mentioned by the delegate of Yemen, hormones were now recognized as an important aspect of food safety. A meeting convened by the Regional Office for Europe in 1982 on the health consequences of anabolic agents, and the twenty-seventh meeting of the Joint FAO/WHO Expert Committee on Food Additives in April 1983, had considered that question.

The International Drinking Water Supply and Sanitation Decade was not a programme of WHO, but it had been reported to the Thirty-sixth World Health Assembly for the reasons explained in paragraph 2 of document A36/5: the opportunity of the Decade for health improvement must not be missed. In response to questions as well as comments by the delegates of Sri Lanka and Chile, Egypt, the United States of America, the United Kingdom, the Federal Republic of Germany and others, it should perhaps be reiterated that 1983 was not yet the time for sounding the alarm. But the Director-General had been of the opinion that the World Health Assembly should be informed that achievement of the target of the Decade would be neither automatic nor possible unless a very strenuous effort was made at the present time by all concerned. If the Decade was not successful, would it not be difficult to achieve health for all by the year 2000 and improve aspects of environmental health such as food safety, housing and protection against environmental hazards? Health agencies must not wash their hands of the Decade by saying that operational responsibility rested with other agencies. That would be disastrous; national health agencies had a critical role to play and needed to allocate manpower and resources to it. They could promote the Decade as part of primary health care, as had been pointed out in paragraph 34 of document A36/5.

As the delegate of Indonesia and others had indicated, there was a problem of finance that could not be over-emphasized. The cooperation which had been initiated between WHO and UNDP was seen as an attempt to alleviate it, and the Director-General wished to take the opportunity to acknowledge the efforts made by Mr Arthur Brown, the Deputy Administrator of UNDP, in fostering coordination among international agencies so that Member States could make the maximum use of the resources available to them in the various international organizations with Decade programmes. The Director-General hoped that all bilateral and multilateral support agencies would continue to work with WHO, particularly with a view to maximizing the health benefits from their investments and to give more support to the building of infrastructure and manpower for operation and maintenance.

Finally, in response to the delegates of the United States of America, Zambia, the United Kingdom and others, the Director-General wished to confirm that the Organization's overall objective in the Decade was to improve health. The expected benefits to health would not automatically accrue unless certain factors were taken into account in the design of national programmes and projects. National health agencies and WHO had a major function to fulfil in providing methodologies to other agencies on how best to ensure that. As

indicated in document A36/5, WHO had published a paper for evaluation with the aim of improving those methods by focusing on sociocultural factors, but also taking into account factors with a direct impact on health. WHO was devising a method for appraising proposed programmes and projects in respect to the health impact expected of them. That type of appraisal would supplement the traditional approach to project appraisal which normally dealt exclusively with engineering, finance and economics. The Centers for Disease Control in Atlanta, Georgia, USA should be thanked for their cooperation in the development of that particular methodology. He also thanked all delegates for the many other comments and suggestions, which would help the Secretariat in further developing and implementing the work.

Dr COHEN (Director-General's Office), commenting on the Action Programme on Essential Drugs, first mentioned the reference made by the delegates of the Federal Republic of Germany and Sweden concerning the report to be submitted to the Health Assembly in 1984. In 1982, the Health Assembly had requested the Executive Board to monitor the evolution of the programme and to provide it with a report. The Director-General would provide the Executive Board with the information required for it to monitor the programme and it was therefore the Board's report which would be submitted to the Health Assembly in 1984.

The delegate of Sweden, speaking on behalf of the Nordic countries at the seventh meeting, had referred to the priority which the Health Assembly had asked to be accorded to the programme on essential drugs when it had discussed the matter in 1982. Reference to the proposals in the 1984-1985 programme budget would show that, as compared with 1982-1983, the appropriation for the regions had slightly more than doubled and that for the African Region it had slightly more than quadrupled. That seemed to him to be an implementation of the Health Assembly's wishes. Action was now required at the national level with regional support, for additional discussion at the global level could not take the programme further.

The delegate of Chile had asked what was happening, especially in the countries of Africa. A comment by the Swedish delegate, describing the support being given to the programme by the Nordic group of countries, might supply part of the answer. That support was an illustration of what the Director-General had called "enlightened bilateral support", because the Nordic countries were supporting developing countries in carrying out policies agreed by the Health Assembly. This support was not only financial but included the provision of technical and human resources. An example was provided by the programme established by the Government of Kenya with the support of the Danish and Swedish Governments, WHO and the World Bank. That programme, to ensure the provision of essential drugs to primary health care, could serve as a model which others could adapt to their needs. A workshop had been held in Kenya with Danish and WHO support to which other countries from Africa and from all other regions had been invited.

The delegate from Yugoslavia had referred to technical cooperation among developing countries (TCDC), and the Kenya programme was a good example of it. The experience gained by Kenya had been placed at the disposal of other countries and there were signs that they were taking it up. It should be noted that support by bilateral agencies was not only financial but included the provision of technical and human resources.

Another example of TCDC could be seen in the United Republic of Tanzania, where the experience of Kenya was being applied. The Danish Government was providing substantial support to the Government of Tanzania through UNICEF as the executing agency and in cooperation with WHO, and the four partners: the Government of Tanzania, the Danish Government, UNICEF and WHO were working together on the programme. In a few weeks' time the results of the offer of members of the International Federation of Pharmaceutical Manufacturers Associations (IFPMA) to provide drugs at non-commercial prices for countries like the United Republic of Tanzania would be known. An international tender was under way, but it was not yet ready.

A further example of bilateral support was provided by the help being given by the Italian Government in the development of essential drugs programmes in five African countries of which the programme in Upper Volta had just started. A last example was the provision by the Arab Gulf Programme for the United Nations Development Organizations of three million dollars' worth of chloroquine for ten countries in Africa.

The delegate of Chile had asked what the pharmaceutical industry was doing to help meet the needs of countries in Africa. On that point, he had nothing to add to what the IFPMA representative had stated the previous day; the Tanzanian experience, however, would show to what extent the industry was helping in the provision of cheaper drugs. The delegate of Chile had also asked what was being done to ensure a constant supply of drugs for countries

which did not produce them. In theory, a sound solution to that problem was pool procurement, but in practice there were a number of obstacles to that solution, notably in securing the necessary legal, administrative and financial agreements between countries. The South Pacific Islands were currently attempting to operate a system of pool procurement, but difficulties had been encountered in deciding on the location of the central warehouse; an unexpected proposal to use the Regional Office for the purpose had been made. Progress was thus being made on a pragmatic basis, learning from experience. In the African Region there was an unusually ambitious programme for a system of pool procurement between 18 countries, and work had started with a view to overcoming the many obstacles. One of these had been the setting-up of a revolving fund; quite apart from the administrative and financial problems inherent in managing such a fund it had been found from experience that 25% of its annual volume (in the case of Africa a sum amounting to US$ 25 million) would need to be made available from the outset.

The delegate of United Republic of Cameroon had raised the question of the purchase of vaccines on a reimbursable basis. Here the same considerations applied; in other words, a substantial amount of capital was needed to make the initial purchase, and subsequently more funds had to be added to replenish that capital. WHO had been able to help on one occasion, but its budget would not allow it to continue to do so. He believed that the solution would be to set up revolving funds within the countries themselves, and he appealed for bilateral support in helping to set up such funds. It should not be too difficult to provide developing countries with long-term loans, soft loans, or outright donations to enable them to raise the capital for revolving funds for the purchase of vaccines and then to replenish their funds. He pointed out that even countries which produced their own drugs faced great problems, chiefly in finding ways of ensuring the regular supply and proper use of such drugs. For example, Peru had recently asked for WHO's cooperation in that connection, and Cuba had done so for the dissemination of accurate information on drugs to the medical profession and quality control.

In conclusion, he stressed that UNICEF was cooperating fully in the programme, and was fulfilling its responsibilities admirably. He had felt it right to bring that point to the Committee's attention so that UNICEF should get the credit it deserved.

Dr PETROS-BARVAZIAN (Director, Division of Family Health) said that a number of delegates, notably those of the USSR, Yugoslavia and Sri Lanka, referring to maternal and child health including family planning (programme 9.1), had pointed out that unless adequate resources, both human and financial, were made available, the targets of 75% of all births to be attended by trained health workers, and 80% of all children having access to essential health care, would not be attained. They had expressed their concern that in the table on page 148 of the programme budget document, extrabudgetary resources for 1984-1985 were shown as approximately US$ 10 million less than in the previous biennium. The explanation for that lay in the fact that the resources concerned came mainly from the United Nations Fund for Population Activities (UNFPA), whose budgetary cycle for country-level programmes was not the same as that of WHO. It was thus quite possible that in the course of the coming year there would be an increase in the funds concerned. In reply to a further question on that point by the delegate of USSR, it was true that over the last few years there had been a tendency for UNFPA funding resources to remain at the same level; however, two points should be borne in mind in that connection. The first was that the UNDP Governing Council had recently reaffirmed that among activities supported by the UNFPA the highest priority should be given to services and education and training aimed at child spacing and family planning. Hence while the overall budget was expected to remain at the same level, it was likely that family planning in the context of maternal and child health and primary health care would have increasing funding possibilities at country level. The second point was that the UNDP Governing Council had strongly recommended that by 1984 funds used at interregional and regional level should not exceed 25% of the total programme budget resources of UNFPA. Thus it was likely that expectations of interregional and regional funding from UNFPA might suffer, but she was optimisitc, in view of the excellent collaboration that WHO enjoyed with UNFPA and the priority given in the overall population field to family planning, that UNFPA would continue to support the maternal and child health/family planning programme, and that if any additional resources become available to UNFPA, WHO would receive increased support.

Finally, the delegate of Kenya had raised a point connected with women in health and development. In 1985, Kenya would be hosting an international conference for the review

and appraisal of progress made in implementing the Plan of Action for the second half of the United Nations Decade for Women. The Organization indeed would be pleased to collaborate closely with women's nongovernmental organizations, as Kenya had suggested, in helping to promote primary health care in the context of health for all.

Dr SANKARAN (Director, Division of Diagnostic, Therapeutic and Rehabilitative Technology) said that on clinical, laboratory and radiological technology for health systems based on primary health care (programme 12.1) the delegate of Sri Lanka had made the point that in his country attainment of the targets defined in paragraphs 4, 5 and 6 of the programme statement would involve not only first-level referral hospitals but also intermediate referral hospitals. In that connection, two meetings on identification of surgical and medical procedures for intermediate-level hospitals were planned, and it was expected that the recommendations would be finalized by the end of 1985 or early 1986.

The delegate of India had drawn attention to the need for improvements in the training of technicians at primary health care level if the infrastructure was to be strengthened. Currently, support of laboratory services and training programmes was aimed at developing improved expertise through the establishment of a network of small, low-cost laboratories. The results of field trials of the effectiveness of peripheral laboratories should be available by the end of 1984, and at that time it was hoped to hold a meeting of field study directors in order to prepare guidelines for developing peripheral laboratories on the basis of experience acquired.

The delegate of Venezuela had expressed his concern at the fragile nature of the link represented by the intermediate network, and had warned against the negative attitude shown by academics and professionals. It was in order to combat that attitude that the programme was seeking the collaboration of professional bodies and nongovernmental organizations, and was attempting to stregnthen the intermediate network by building up a successive chain of command. Efforts were also being made to improve the managerial skills of intermediate-level health workers.

The delegate of Romania had raised the question of the adequacy of budgetary support for the programme of clinical technology. He pointed out that for the 1984-1985 biennium that support had been increased. The Organization was most grateful for a donation of US$ 406 000 from Denmark for the biennium 1982-1983 for the running of courses on laboratory services. Similar support had been requested for 1984-1985.

The delegate of Egypt had highlighted two major problems at first referral level, sterilization and blood transfusion. WHO was in touch with manufacturers with a view to securing sterilizers suitable for use in developing countries, and was particularly interested in a low-cost model now being developed by the Department of Engineering of the University of Strathclyde. As far as blood transfusion technology was concerned, WHO, together with the League of Red Cross Societies and the Regional Office for the Eastern Mediterranean, was planning a seminar on blood transfusion with emphasis on the peripheral level. The Organization, again in collaboration with the League of Red Cross Societies had also published monographs on the setting up of blood transfusion units, and had in 1981 issued specifications on blood and blood products. A training course on the management of blood transfusion services was being organized in Budapest with the support of UNDP, and Romania had also offered its help in establishing a programme of collaboration in blood transfusion services. Many Member States from developing countries had taken part in a symposium on blood and blood products in 1982, cosponsored by UNIDO, WHO and the Government of Sweden.

The delegate of Algeria had referred to the problem of the proper use of technology for primary health care. Efforts were being made to design and develop equipment suitable for such use; in that connection, great interest was being taken in the field trials of a basic radiological unit using constant geometry currently taking place at Lund.

The delegate of the Netherlands had drawn attention to resolution WHA28.72, and to the discussion thereon held at the seventy-first session of the Executive Board. The regional committees could be expected to discuss that question in the course of 1984, and their reports would be forwarded for discussion to the Executive Board in 1985, for eventual submission to the Thirty-seventh World Health Assembly in 1984.

The delegate of Spain had stressed the need for an epidemiological basis for building up technological support for the referral hospitals; such a basis would indeed be essential for any referral system.

On drug and vaccine quality, safety and efficacy (programme 12.3), the delegate of Sri Lanka had suggested the setting-up of a regional quality control laboratory; the Regional

Director could perhaps respond to that suggestion. On the suggestion made by the delegate of the Netherlands, he pointed out that the Expert Committee on Biological Standardization met yearly to standardize information on biological standards for dissemination to Member States; the reports of that committee were reviewed by the Executive Board. In addition, a number of scientific groups met frequently to standardize methods of production of recently introduced vaccines. He assured the Netherlands delegate that transfer of information on drugs remained a high priority. In accordance with a recent recommendation by the WHO Expert Committee on the Use of Essential Drugs,[1] work on data sheets for such drugs was far advanced. In addition, regular production of the WHO Drug Information Bulletin would recommence shortly.

The delegate of Chile had suggested better training in the quality control of drugs, and further research on adverse reaction to drugs. In that connection, training of candidates from developing countries, with the collaboration of IFPMA, had begun. The delegate of Saudi Arabia had made some specific suggestions on effective control and safety measures, and on the exchange of information on side-effects; he pointed out that any information obtained was impartially presented in the Drug Information Bulletin.

WHO was grateful to the Government of Sweden for helping to sponsor the forthcoming Third International Conference of Drug Regulatory Authorities, which he was sure would be attended by a large number of participants from developing countries. He also wished to express thanks to the Government of Italy for hosting the second conference on that subject in Rome; the conference had made possible a valuable exchange of information.

The delegate of the USSR had drawn attention to the need to avoid confusion between the purpose of basic tests of pharmaceutical substances and the purpose of monographs in the International Pharmacopoeia. He confirmed that when the results of those basic tests were published, it would be clear that they were intended only for identifying pharmaceutical substances, and were in no way a substitute for specifications in the Pharmacopoeia, which were intended as indications of potency and purity.

On programme 12.4 (Traditional medicine), the delegate of Ghana had drawn attention to a discrepancy between the aims of and allocations for the programme. Traditional medicine was a relatively new field, and programme activities were still in course of development. It was hoped to attract extrabudgetary support from donors. There had been no decrease in the regular budgetary allocation for traditional medicine since 1982-1983; indeed, the allocation for research activities showed an increase of US$ 42 600.

On programme 12.5 (Rehabilitation) he pointed out that the international classification of impairments, disabilities and handicaps published by WHO in 1980, referred to by the delegate of Sweden, had been an experimental edition, intended for trial purposes. It was intended to revise it after a certain period, probably in 1985 or 1986. The current classification was being tested in a number of countries, and experience gained would be discussed at a number of meetings; one such meeting would be the working group on standardization of measurements of impairments, disabilities and handicaps, which would be convened in October by the Regional Office for Europe. He assured the delegate of Sweden that his comments would be taken into account in the process of revising the classification, and expressed his thanks to the Swedish Government for the support it was giving to WHO policies on disability, particularly to community-based rehabilitation, which was seen as an important element of primary health care.

In conclusion, he thanked the delegate of Japan for his generous comments and for his endorsement of the rehabilitation programme.

Health science and technology - Disease prevention and control
(Appropriation Section 4; Documents PB/84-85, pages 219-297, and EB71/1983/REC/1, Part I, resolution EB71.R11 and Annexes 4 and 5; Part II, paragraphs 42-46)

The CHAIRMAN introduced appropriation section 4, drawing attention to the relevant documents, particularly Annexes 4 and 5 of document EB71/1983/REC/1 concerning evaluation of the Special Programme for Research and Training on Tropical Diseases, and on tuberculosis control, which later was also the subject of a resolution recommended in resolution EB71.R11 of the Board.

---

[1] WHO Technical Report Series, No. 685, 1983.

Dr OLDFIELD (representative of the Executive Board) said that a common problem throughout the disease prevention and control programmes was how to ensure proper transfer and application of technology through the health delivery system based on primary health care.

Having identified what was already known for application, it is also incumbent on WHO and Member States to identify what was not known but was of high priority for research. The Board believed that research on resistance of plasmodia to drugs and of vectors to chemicals should remain a priority under programme 13.3 (Malaria).

The Executive Board commended the evaluation made by the External Review Committee of the first five years of operations of the Special Programme for Research and Training in Tropical Diseases. The Board shared the Committee's conclusions that results achieved were encouraging but was worried about future funding; the need to maintain a level which would permit the long-term study of promising developments - for example, field-testing of a potential leprosy vaccine - was stressed. The Board's conclusions were reflected in resolution EB71.R10.

The Board considered that programme 13.6 (Diarrhoeal diseases) was sound and the focus on mortality reduction appropriate; nevertheless, there was an overriding need to continue developing a strategy for prevention, particularly in children under five years of age; improved environmental sanitation coupled with appropriate health education could have enormous impact, and Member States were urged to intensify their efforts towards the attainment of the goals of the International Drinking Water Supply and Sanitation Decade as enunciated under programme 11.1 (Community water supply and sanitation).

The Board endorsed the report of its Programme Committee on "Tuberculosis control in the world - situation analysis" emphasizing the fact that tuberculosis remained a major public health problem, particularly in the developing countries. The International Union against Tuberculosis was working closely with WHO in defining the main contents of control programmes, including BCG immunization of children as part of programme 13.1 (Immunization). Overall improvement in socioeconomic conditions was an essential contributory factor in the control of tuberculosis. The Board's recommendations were reflected in resolution EB71.R11.

On the basis of its review of programme 13.16 (Cardiovascular diseases) and the report of the WHO Expert Committee on the Prevention of Coronary Heart Disease, the Board agreed that prevention of coronary heart disease was a matter of substantial importance both to developed and to developing countries, and that there was a firm scientific basis for accelerating that component of the programme. It was another area where the Board feels there may be an imbalance of resources available, and additional funding might be used, particularly in support of development of preventive strategies in countries.

Dr WILLIAMS (Nigeria) said in connection with tropical disease research (programme 13.5) that the Special Programme for Research and Training in Tropical Diseases had achieved tremendous impact worldwide both within Member States and throughout the scientific community. His delegation fervently hoped that the programme would soon facilitate solutions to the problems of major diseases facing tropical countries. It fully agreed that the review and evaluation mechanisms applied in the tropical disease research programme should be extended to other programmes. Drawing attention to a recent publication of the mass media indicating that a breakthrough was expected in the development of a malaria vaccine and at the same time warning that patent rights might hinder progress, he hoped that further information would be made available on the subject.

Concerning sexually transmitted diseases (programme 13.11), his delegation believed the plan of action to be realistic and was hopeful that it would result in a significant reduction in morbidity from such diseases. It was, however, rather surprising that no mention had been made of genital herpes, despite the widespread publicity in the mass media and the considerable fear it was arousing. It would be useful to know what plans WHO had for confronting that very serious problem.

Dr ROUILLON (International Union against Tuberculosis) said that the International Union, a body grouping official and voluntary bodies involved in the fight against tuberculosis in 117 countries, was committed to continued close collaboration with WHO in its programme. The Union had been pleased to note that Member States were showing renewed interest in action against tuberculosis and found particularly significant the fact that a developing country - India - had been among the countries most active in developing relevant technology and had in 1980 proposed that the problem of tuberculosis should be reconsidered, thus expressing an

unspoken concern of many countries. Such a renewal of interest was justified: on the one hand, the numbers of those suffering from tuberculosis in the world was greater than ever, 95% of them being in the developing countries, where it had reached a level 20 to 30 times greater than in the developed countries; and, on the other hand, the triumphs and failures in the fight against tuberculosis had been recorded in detail and were well known, and they served as a basis for a model which could well be extended to other fields. It was, of course, necessary, when introducing new measures in the fight against tuberculosis, to avoid mere vertical action and to situate action within the concept of primary health care.

Tuberculosis was a specific example of a disease which required long-term treatment and for which a considerable degree of expertise was necessary, but that was not to say that its treatment could not become part of primary health care; indeed, it provided an important opportunity to increase the effectiveness of the latter. For tuberculosis - unlike many diseases - the cause, diagnosis, effective drugs and means of prevention were known, measures against it were acceptable to both the population and governments and had been standardized in manuals for use even by less qualified health personnel, so that the impact of measures both on the individual and the community could be evaluated quantitatively and qualitatively, and such aspects as effectiveness of the laboratory network, quality control, improvements in treatment, diagnosis, health education, sociological background, and improved communication between official and other bodies were already under study.

Tuberculosis was a disease of which man was almost the sole agent of contagion, and specific measures could therefore be applied making possible effective and immediate action to a considerable extent independent of environment. Action against tuberculosis also provided considerable opportunity to study questions such as provision of essential drugs, the creation of a pool of national and international experts, the influence of health education, and the role of basic and applied research. Action against the disease could, therefore, be a means of achieving and maintaining an effective level of primary health care. At the same time, the past record of international solidarity in the fight against tuberculosis provided additional potential for essential collaboration between developed and developing countries, both for research and for practical application.

Dr ÉLIÁS (Hungary) supported the objective, targets and programme activities for programme 13.8 (tuberculosis). It was perhaps significant that before the second world war the disease had also been known also as Morbus hungaricus. In the early 1950's a national antituberculosis campaign had been launched with the result that tuberculosis in children had become only a sporadic disease and for many years there had been no cases of tuberculous meningitis among children. In the period 1965-1975, the incidence of pulmonary tuberculosis had decreased each year by some 9% and by 1975 was 23 per 100 000. Subsequently, that downward trend had come to a halt and the programme had had to be modified. Consequently, differences between geographic areas and age groups were closely studied with special reference, for example, to BCG vaccination history, previous tuberculosis infection, and presence of residual pulmonary lesions. Priority was given to detection of direct bacillary cases, particularly in men over 40 years of age and in socially handicapped population groups. BCG vaccination of newborn children was being continued, and revaccination of adolescents was to be modified to prolong protection. Early detection and treatment of contacts was to be intensified, while passive and active case-finding methods would be improved and intensified. Regular X-ray screening - which had been compulsory for some decades in the case of certain population groups - and tuberculin testing were to be intensified in closed communities, such as workers' and student hostels. Regular screening of the elderly by means of sputum bacteriological tests would be carried out to detect early reactivation of previous infections.

Hungary had therefore accumulated considerable experience and expertise which it believed could be most effectively shared to alleviate human suffering caused by tuberculosis through participation in the WHO programme.

Dr GRECH (Malta) supported, in particular, programmes 13.5 (Tropical disease research) and 13.8 (Tuberculosis), and agreed with the Executive Board in its request for an increase in those activities.

It also supported the recommendation by the Board to increase funding for programme 13.16 (Cardiovascular diseases), particularly since such diseases were fast assuming greater significance in developing countries. Whereas in a number of industrialized countries mortality rates as a result of cardiovascular diseases had levelled off or in some cases decreased during the 1970s - possibly because of a greater awareness in those countries of the risk

factors involved, rates had increased markedly in developing countries - no doubt reflecting improvement in socioeconomic conditions, as had been the case in Malta. While infectious diseases had been brought under control in his country and poliomyelitis and diphtheria had disappeared, chronic noncommunicable diseases, and diabetes in particular, were giving rise to concern, calling for urgent action which was constituting a heavy drain on the resources of a small country. Such diseases could be expected to create tremendous problems in the developing countries well before the year 2000 unless appropriate plans of action were put into effect.

His country had also a particular interest in other noncommunicable disease prevention and control activities (programme 13.17). The fallacy associating diabetes with affluent societies had been continued for far too long, the findings of the expert committee had shown that diabetes mellitus was a universal health problem in human societies at all stages of development, affecting at least 30 million people throughout the world. Rates tended to be moderate to high in urban areas particularly of Africa, Asia and Latin America and varied a great deal in Oceania. Prevalence studies carried out in a number of developing countries, including Malta, showed a rate of 7% or over. The cost of diabetes in human lives and disability through attendant complications was considerable.

In chronic noncommunicable diseases, perhaps more than in any other field, the total integrated approach - involving promotion of primary health care, health education, healthy lifestyles, balanced nutritional policy and physical activity - was highly exemplified and most likely to yield positive results. His delegation therefore fully supported recommendations for additional funding, particularly in relation to diabetes, with its close relation to heart and vascular diseases. Malta wished to be included as a co-sponsor of the proposed resolution on the prevention and control of cardiovascular diseases.

Dr TOSKA (Albania) said that in his country tuberculosis was widespread. Following liberation, one of the major thrusts of the health services had been tuberculosis control. A series of economic, social and health measures had been introduced to improve the socio-economic conditions of the population, and a number of organizational, prophylactic and therapeutic measures had been introduced to combat tuberculosis. Tuberculosis clinics had been established with sufficient means and manpower to serve all areas and to undertake detection, chemotherapy and obligatory vaccination, which had commenced in 1952. A number of other health institutions in towns and villages were also involved, in close cooperation with the clinics, in detection of cases, to ensure follow-up of treatment and to undertake prophylactic and health education measures.

The efforts undertaken from 1952 to 1960 had prevented the further spread of the disease, and since then there had been a gradual decline with an annual decrease in incidence of 10%-12%. In recent years there had been a significant diminution in the number of cases of serious forms of tuberculosis and in tuberculosis in children, and the annual risk of infection was now no higher than 0.3%. In 1982 incidence of tuberculosis had been 33 per 100 000 of the population. It was hoped to reduce incidence to 16 per 100 000 by 1990 and to eradicate the disease by the year 2000, using both radiological and bacteriological methods. It was felt that the target could be realized, since the measures being undertaken had a sound intersectoral base.

Current procedures involved the selective detection of specific foci of tuberculosis in exposed population groups, of cases with residual infection, and amongst students. BCG vaccination was obligatory and lyophilized BCG vaccine was being produced locally. Although the number of hospital beds reserved for tuberculosis cases had been reduced by 50%-60% because of the decline of the disease, on detection each case underwent obligatory hospitalization with intensive treatment for a period of about three months. After that, follow-up treatment and observation was undertaken by the clinics. Hospital and outpatient treatment of tuberculosis was free of charge.

It was recognized that there was a reservoir of endogenous tuberculosis so that, in view of the objectives, there would be no relaxation of the efforts to control the disease. Particular emphasis would be given to improving early diagnosis and treatment.

His delegation supported the draft resolution on the control of tuberculosis recommended by the Executive Board for adoption by the Health Assembly and endorsed the action recommended by the Board for the elimination of the disease.

Dr SIDHU (India) commended the excellent documentation provided. In India malaria had been a major public health problem in the early 1950s. The number of cases recorded had

been reduced from 75 million to 100 000 by 1965. At the same time mortality had been reduced from 0.8 million to almost nil. Owing to various factors throughout the South-East Asia Region the incidence of malaria had started rising again from 1966 onwards, reaching the high level of nearly 6.5 million cases by 1976.

On the basis of the recommendations of the Consultative Committee of experts and the second in-depth evaluation committee, the Government of India had drawn up a modified plan for the national malaria eradication programme in 1976, which had been implemented from April 1977. The objective of that modified plan was the prevention and control of morbidity and mortality and reduction in incidence of malaria. Areas were stratified on the basis of incidence, and selective spraying was undertaken in areas with an annual parasitic index of two or more with appropriate insecticides. Fortnightly active case detection was undertaken and treatment given to microscopically-confirmed positive cases. As a result of such action, incidence had been reduced by 66% to 2.2 million cases by 1981.

The programme now faced technical problems of vector resistance, and Plasmodium falciparum resistance to chloroquine in some areas, as well as the increasing cost of operation and materials. The debilitating effects of the disease on production and productivity were well known, and it was therefore vital to reinforce eradication efforts. He appealed to WHO and to the developed countries to support work on the antimalaria vaccine, which was of great interest to the developing countries.

The incidence of acute diarrhoeal diseases in India was estimated at 500 per thousand in infants and 200 per thousand in pre-school children; 1.5 million children under five years died annually. The major cause of death in all cases was dehydration, with mortality as high as 60%-70% in untreated serious cases. The Government of India had launched a national diarrhoeal diseases programme in 1982. The main approach was the distribution of packets of oral rehydration salts via a massive network of primary health care personnel, health guides and other auxiliary health workers, and health education by means of demonstrations in villages.

Tuberculosis remained a serious public health problem in India with an estimated 10 million cases of radiologically-confirmed active tuberculosis, 25% of those being sputum positive. The disease was prevalent in both rural and urban areas. The tuberculosis programme was included in the twenty-point development programme launched by the Prime Minister as a national charter of action. Case detection and treatment was the main approach, with specified targets for each year. In 1982 and 1983 the targets had been met, with the detection of some 1.5 million cases. Domiciliary treatment was undertaken through primary health care and by the network of district tuberculosis centres and clinics.

India attached great importance to the expanded programme on immunization, which had been introduced in 1978 with the objective of achieving 85%-100% coverage of pregnant women against neonatal tetanus and eligible children with all immunizations except poliomyelitis by 1990, and with achieving self-sufficiency in the production of vaccines. WHO assistance was being provided in the following areas: promotion of integrated immunization services; expansion of coverage; development of the cold-chain; organization of surveillance systems; addition of new vaccines where epidemiologically necessary; coordination of production, quality control and supply of vaccines; training of health personnel; and the preparation of relevant health education materials. Sample surveys to collect baseline data on poliomyelitis and neonatal tetanus had been undertaken, since those two diseases were considered to be more serious than had been indicated by routine reporting. Poliomyelitis immunization was now a massive programme with coverage of some 2.5 million in 1981, 5 million in 1982 and 7 million in 1983. It was hoped that all vulnerable groups would be covered by 1990.

Despite all the efforts undertaken no real impact had been made in the programme areas under discussion and somewhere a child was dying every two seconds from hunger, malnutrition or a parasitic infection. Urgent action rather than long-winded debate was required.

Apart from the constraints arising from socioeconomic factors, the main problems faced in the control and eradication of communicable diseases were the growing resistance to chemotherapy and vector resistance to pesticides and the explosion in costs that that engendered.

The tropical disease research programme was providing relevant support to national efforts, and he commended those responsible in WHO. Control programmes should be based on sound evaluation, with specific objectives appropriate to local situations, and would therefore require greater technical and managerial support. Headquarters and the regional offices should urgently review the situation by country and should focus attention on the

development and application of appropriate technology so that delivery systems relevant to the needs and capacities of countries could be established.

WHO should also provide timely warning of emerging problems. Worldwide travel and trade in human and animal foods were contributing to the spread of disease. Greater attention should therefore be paid to the enforcement of biosafety procedures, to the exchange of relevant information and to the establishment of an efficient intercountry and interregional epidemiological surveillance system, through a network of advanced warning centres. Such activities would require much more collaboration than was currently undertaken.

The control of communicable diseases would be achieved through effective technical cooperation among countries, with organized efforts to improve national self-reliance through coordination of research efforts, training of manpower, surveillance and vector control measures. He hoped that during 1984-1985 WHO would give due regard to the necessary collaborative approach, reorienting its programmes to that end. It was no longer relevant for individual countries to try to resolve problems of communicable diseases independently. Countries would have to assist one another, with WHO's help, to ensure maximum utilization of technical and financial resources.

He supported the proposed budget allocations to the appropriation section under discussion and hoped that there would be no attempt to seek any reductions; if anything, there should be further increases.

Dr NYAYWA (Zambia) said that activities in his country for immunization (programme 13.1) were running according to schedule. Overall coverage was some 55%, with BCG coverage of 78% and measles coverage of 66%. He expressed his gratitude for the assistance provided by WHO and UNICEF in the training of senior and medium-level staff and peripheral workers. Some 2000 of the latter had been trained thus far. The major constraint was the cold-chain, but he hoped that the situation would be improved with the aid of a two-year SIDA/UNICEF/WHO programme starting in 1983. Zambia welcomed WHO's objective of promoting regional self-reliance in production and quality control of vaccines, and wished to collaborate in that work.

Malaria was increasing in Zambia as in other developing countries, and an urgent practical solution was required. Factors responsible for the increase included the worsening economic and foreign exchange situation and the increasing costs of drugs and pesticides, which had led to cuts in preventive, prophylactic and therapeutic activities.

Many developing countries were giving priority to development projects such as irrigation schemes and the building of dams. WHO should cooperate closely with the agencies involved in such projects, for example UNDP and the World Bank, to ensure the inclusion of programmes to prevent malaria and schistosomiasis. Unless that was done the morbidity target for malaria of less than 1% by 1989 was unlikely to be reached.

He wondered whether it would be possible for WHO to set up a scheme, similar to that operated by UNICEF for the purchase of vaccines for the Expanded Programme on Immunization, for the purchase of antimalaria drugs and pesticides on a "reimbursable procurement" basis. The scheme had proved of great benefit in the development of the Expanded Programme, especially to countries such as his own which had foreign exchange difficulties.

He supported programme 13.4, parasitic diseases, and the plan of action outlined. It would require close cooperation between water and sanitation authorities and the health sector.

In relation to tropical disease research (programme 13.5), his Government was collaborating closely with WHO and with the WHO collaborating centre in Zambia. He was pleased to note the emphasis given in the programme to institution-strengthening.

Control of diarrhoeal diseases (programme 13.6) was most important, and he supported the plan of action proposed. His country wished to collaborate with WHO on that programme.

He fully supported programme 13.7 on acute respiratory infections. He expressed his country's gratitude to WHO for assistance received in tuberculosis control. In view of the continued increase in tuberculosis, the increase in the budget allocation for the African Region from US$ 62 300 in 1982-1983 to US$ 181 000 in 1984-1985 was probably insufficient.

He supported the objectives and plan of action against leprosy (programme 13.9). In Zambia, tuberculosis and leprosy control activities were being integrated in primary health care.

Zambia was working with Botswana, Lesotho, Malawi, Mozambique, Swaziland, Zimbabwe and the United Republic of Tanzania in activities against the Zoonoses (programme 13.10). He supported the programme together with those on blindness (programme 13.14) and cardiovascular diseases (programme 13.16); cardiovascular diseases were on the increase in Zambia.

The meeting rose at 11h20.

= = =