



EXECUTIVE BOARD

Eighty-seventh Session

PROVISIONAL SUMMARY RECORD OF THE FIFTH MEETING

WHO Headquarters, Geneva
Wednesday, 16 January 1991, at 9h30

CHAIRMAN: Mr R. SRINIVASAN

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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.

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The final text will appear subsequently in Executive Board, Eighty-seventh session: Summary Records (document EB87/1991/REC/2).

FIFTH MEETING

Wednesday, 16 January 1991, at 09h30

Chairman: Mr R. SRINIVASAN

1. APPOINTMENT OF A RAPPORTEUR

The CHAIRMAN announced that Dr Sadrizadeh, who had been elected Rapporteur at the eighty-sixth session of the Board, was unable to attend the current session. He therefore proposed that Dr Shamlaye should be elected to that office.

Decision: Dr C. Shamlaye was elected Rapporteur.

2. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1992-1993: Item 5 of the Agenda (Document PB/92-93) (continued)

IMPLEMENTATION OF RESOLUTIONS (Progress reports by the Director-General): Item 6 of the Agenda (Documents EB87/8, EB87/9, EB87/9 Add.1, EB87/10, EB87/11, EB87/12, EB87/13 and EB87/INF.DOC./8) (continued)

REPORTS OF THE REGIONAL DIRECTORS ON SIGNIFICANT REGIONAL DEVELOPMENTS, INCLUDING REGIONAL COMMITTEE MATTERS: Item 7 of the Agenda (Documents EB87/14, EB87/15, EB87/16, EB87/17, EB87/18 and EB87/19) (continued)

PROGRAMME REVIEW: Item 5.2 of the Agenda (Documents EB87/3, EB87/4, EB87/5, EB87/6 and EB87/INF.DOC./4) (continued)

HEALTH SCIENCE AND TECHNOLOGY - DISEASE PREVENTION AND CONTROL (Appropriation Section 4) (continued)

Disease prevention and control (Programme 13) (Documents PB/92-93, pages B-179 to B-286, and EB87/13) (continued)

Programmes 13.1 to 13.4: Immunization; Disease vector control; Malaria; and Parasitic diseases (continued)

Professor RANSOME-KUTI commended the activities undertaken within the framework of the Expanded Programme on Immunization, which were providing both direct and indirect benefits in developing countries, and noted that, as the end of 1990 had approached, many countries had stepped up their efforts to achieve the 80% coverage that was targeted for that date. It was clear, however, that the benefits derived from the programme must be secured by the necessary technological support. Few countries could continue to maintain high immunization coverage by means of campaigns, but the lack of an adequately established primary health care infrastructure in many countries would hamper their ability to do so by other means. He was pleased to note, therefore, that in the coming five years, greater emphasis would be placed by many organizations in the United Nations system on the establishment of primary health care systems. He also noted that it was

intended to evaluate the effectiveness of immunization by the sentinel surveillance system and hoped that method was to be merely temporary as it was no substitute for measurement of actual immunization coverage.

He applauded both the development of new vaccines, which would increase the effectiveness of immunization programmes, and the move to include hepatitis vaccine in those programmes. In Nigeria, yellow fever vaccine was also being included, as the disease was assuming considerable importance there and protection could be ensured for ten years by a single dose of vaccine.

His country was grateful for the donation, by the manufacturer, of ivermectin for the control of onchocerciasis; the health authorities were developing programmes for delivering the drug to the population. His country was also grateful to Global 2000 for its initiative in guinea-worm control, and he was hopeful that the disease could be eliminated from Nigeria by 1995.

Referring to section IX of document EB87/6, on participation of scientists from developing countries in the development of new vaccines, he doubted whether the action described therein would in itself achieve the aim of providing developing countries with the capability to produce their own vaccines. More than collaboration and participation in research was required in order to transfer technology to developing countries; new and effective ways of establishing vaccine-production institutes were needed. Those must include on-the-job training in the situation in which scientists would actually be expected to function later. There was little use simply in training scientists in developed countries, and then expecting them to function in the same way in developing countries, where the infrastructure was usually inadequate.

Dr TIN U, referring to Sir Donald Acheson's comments on maintaining sustainability of immunization programmes, said that two factors were involved: the cold-chain mechanism on the one hand, and good logistics and a well-integrated primary health care structure on the other. His own country, Myanmar, had, with UNICEF support, obtained an annual US\$ 1 million budget for vaccines and the cold chain, polio vaccine being supplied by the Save the Children Fund. However, UNICEF could not guarantee further support beyond 1992. He therefore asked what was to happen in countries such as his own, where the Government had insufficient foreign exchange to buy vaccines.

Dr LIEBESWAR referred to the proposed budgetary allocations for the development of drugs and vaccines for the control of infectious diseases, including AIDS and malaria, and for the development of effective pesticides with a low environmental risk. Although such activities had long received the support of WHO, he recommended that the policy should be reconsidered. WHO's support of such research and development was often said to be necessary because drug manufacturers were not attracted to the development of drugs intended primarily for use in poor regions. He would point out, however, that reports of authorization by health authorities to carry out clinical trials of new drugs, including drugs against AIDS and malaria, had a marked effect on the share prices of the pharmaceutical companies concerned. WHO should gradually move away from supporting the development of new drugs, for three reasons. Firstly, WHO should leave it to the pharmaceutical industry to develop new drugs as the market forces usually provided sufficiently strong incentive for research, especially on drugs likely to be bought by large numbers of people in affluent countries (as was clearly the case with drugs for the control of AIDS and malaria). Secondly, WHO should avoid becoming entangled in a conflict of interests. The Organization was clearly on the side of the consumer and should primarily help to guarantee safe drugs and strict adherence to ethical guidelines for the conduct of clinical trials and should therefore be equally impartial towards all pharmaceutical companies. Thirdly, it was very difficult to assess whether the expenditure on new products developed with WHO support was equitably reimbursed to all Member States in the form of more favourable prices.

Mr CAO Yonglin, referring to Programme 13.1 (Immunization), drew attention to the importance of carrying out immunization activities in close consent with the other organizations concerned, such as UNICEF and UNFPA; that was especially pertinent to joint action resulting from the 1990 World Summit for Children. Paragraph 38 of section 13.1 of document PB/92-93 indicated a decrease in budgetary allocations for immunization in almost all regions as additional support was expected from outside donors; he feared serious problems if such support did not materialize. Although it was desirable for national allocations to be increased, many countries were facing serious economic problems and might have difficulty in doing so. As many of them lacked experience in fund-raising he hoped that WHO would be able to assist them in holding multilateral and bilateral meetings with potential donors. Finally, he stressed the importance of EPI reviews as key tools in measuring progress towards immunization targets. In China, a review had been carried out in 1990 by WHO and UNICEF. In March 1991 an 85% coverage review was to be carried out; the active participation of WHO would be very helpful.

Referring to Programme 13.2 (Disease vector control), he expressed concern at the considerable reduction in the budgetary allocations and feared that it would mean that some parts of the programme could not be implemented.

For Programme 13.3 (Malaria), on the other hand, he was pleased to note the increased allocation, particularly for global and interregional activities. However, much remained to be done to improve malaria control at national level by the implementation of recent resolutions of the World Health Assembly. He hoped that other organizations in the United Nations system would also provide support for antimalaria activities in countries with a high prevalence of the disease.

Concerning Programme 13.4 (Parasitic diseases), he considered the proposed 1992-1993 allocations to be in line with the targets for 1995. He hoped, however, that it would be possible to give greater priority to schistosomiasis of the lungs and liver. The prevalence of schistosomiasis was a matter of serious concern to many countries, which required assistance in training health personnel and in developing effective prevention.

Dr MARGAN said that at every meeting of the Board and the Health Assembly, national health authorities described malaria as a major problem that should be given priority attention. However, he was not sure how such statements should be taken. Since the adoption of the malaria control strategy in 1978 by the Thirty-first World Health Assembly, budget proposals and periodic reports had repeatedly stressed the need for an epidemiological approach to malaria control and the need to integrate malaria activities into primary health care. Appeals had been made for more staff to be trained for malaria control and for further research into the disease. While those activities were important, the fact remained that for no other disease had so many thousands of health workers already been trained. What had happened to them, and how were they now being utilized? The need to integrate antimalaria activities into the general health care structure had been insisted on for the past thirty years without leading to much success in control; it would be interesting to know the reasons for that failure.

The statement in the proposed programme budget that in Africa 40% of all child hospital admissions and up to 25% of deaths in infancy and childhood were due to malaria led to the question whether WHO was protecting children in Africa against measles, pertussis and diphtheria through immunization campaigns, only to let them die later from malaria. While it was true that in terms of control malaria was in many respects not comparable to other communicable diseases, national health services should be doing more at least to reduce the death rate.

He was encouraged to note that a global conference on malaria was planned for early in 1992. However, there was no provision for it in the proposed programme budget. Was it to be financed from "Other sources"? In the current tense world situation, prospects for mobilizing further contributions from such sources, whether for such a conference or for other activities in support of national malaria control programmes, might not be very favourable.

Dr CABA-MARTIN said the fact that three million people in the world were continuing to die from diseases preventable through immunization was an indication of the importance of the Expanded Programme on Immunization. It would seem from the documentation that the best strategy would be to increase coverage to 95%, and maintain it at that level until the diseases were eliminated. The first objective should be to ensure the availability of effective vaccines to treat all children and adults covered by the programme. The second objective should be to reduce morbidity from other diseases preventable through immunization, such as rubella and mumps. A crucial factor for the Programme's success was the availability of properly trained managers, both at local and national level, but, in practice, programme managers often lacked proper training. Every effort should therefore be made to train health manpower for immunization programmes at all levels.

Attention should also be given to improving the cold chain, in regard to both distribution and storage, with the aim of eventually supplying the whole system with refrigerated transportation, portable refrigerators, temperature monitors, and proper thermometers and refrigerators in stores and immunization centres.

Two indicators should be used to evaluate the programme: immunization coverage and morbidity rates of the target diseases.

In some countries, neonatal tetanus was not notified separately from other forms of tetanus, and for that reason there was a lack of data on its real incidence. If such an outdated disease was to be eradicated, a twofold strategy must be adopted: separate notification of neonatal tetanus on individual forms, and an increase in antitetanus immunization for pregnant women and women of child-bearing age.

Where malaria was concerned, he noted a certain lack of balance between the allocations to the programmes for the control of tropical diseases and for tropical disease research, in that all extrabudgetary funds were allocated to the latter. He urged the Organization to make an effort to allocate extrabudgetary resources also for control. In his view, the extra allocation for malaria that resulted from the Director-General's 2% reduction in some other global and interregional programmes should be incorporated directly into regional programmes.

In conclusion, he asked whether it had been definitely decided to hold a world conference on malaria, whether a date and place had been fixed, and whether budgetary provision had been made.

Professor GIRARD welcomed the progress that had been made in the past year in the fields of immunization and what was coming to be known as vaccinology. That work strengthened the Organization's own efforts, and it was right for WHO to involve itself in it to the fullest extent possible. There were few other areas that so well combined technological progress, medical efficacy and public health importance to generate a force for human and social betterment that could redound to WHO's credit. Eradication of disease could only be achieved through immunization, and he was glad that the Organization was playing a dominant role in what was undoubtedly a lead area - possibly the lead area - in health work.

Regarding malaria, he welcomed the steps taken in 1990 and the plans for future meetings. Efforts should be made by all interested countries to contribute as fully as possible to those meetings. In particular, government departments outside the health field should be asked to play a part, since malaria was a good example of a disease that required other than purely medical skills for its control.

THE CHAIRMAN, speaking in his personal capacity, said it was time for an objective reevaluation of the quality and effectiveness of the training programmes supported by WHO. In his experience, such programmes tended to become somewhat mechanistic and to impart knowledge inapplicable in real life. At the same time, they often proved more attractive than the more routine but useful courses offered by existing training institutions responsible for the regular training load in a country. That had led to distortions both in the types of personnel attracted to training and in the resources committed to it. One reason for those distortions was that traditional programmes were based on a disease-oriented technology and imparted corresponding skills, whereas in a real-life situation a variety of skills was needed to meet widely differing circumstances. Training programmes should be modified to take account of the limitations of the primary health care systems actually existing in countries. He would suggest that

WHO should undertake an evaluation of the quality of training programmes in a few sample cases: the study should be carried out by independent experts with a wider view of training than as mere communication of medical knowledge.

Where immunization was concerned, India had the largest target population of any country except China. It was relatively easy to reach a target of 40-60%, but there was a logarithmic increase in difficulties encountered when trying to cover 60-70% of the target group. At that point the managerial tasks involved became increasingly complex and sustainability a major problem. Coverage of the 15-20 million babies born every year - over a 9-12 month schedule on a regular basis and often in extreme climatic conditions - was excessively difficult. He suggested that WHO should investigate how adjustments could be made, so that defects in delivery systems which were not of a high order of efficiency and did not attract much financial support would not have an adverse effect on coverage. For example, could the need for the cold chain be reduced by 50%, and could there be more reliance on oral vaccines and less on parenteral vaccines? In India, it was unfortunately likely that the current situation, in which a poorly-informed delivery system was responsible for the coverage of an equally poorly informed population, would persist for perhaps another two decades. Immunization efforts should not lead to a situation in which sustainability was impossible, or recrudescence of a disease could not be handled, because demands had been made on the system that were far beyond what it was capable of.

While commending the overall support given to immunization by WHO, he urged that in considering that the figures for both extrabudgetary and budgetary resources shown on page B-184 of the programme budget, the Board should take into account not only the amounts to be expended, but also the considerations he had referred to.

He fully agreed with the statement in paragraph 5 on page B-185 of the programme budget that vector control was still largely dependent on pesticides. The application of pesticides over large areas, where environmental hazards would come to light only after a considerable time, introduced another dimension to the problem, which should be given careful consideration. He welcomed the statement in paragraph 22 on page B-186 that vector studies had been integrated into specific disease control programmes. There had been a large-scale reemergence of Japanese encephalitis and dengue fever in his country, and such an integrated study would be valuable to show what could be done in the various countries, within the limits of their resources.

There was no doubt that malaria needed special attention. Migrations of populations over wide areas, the creation of large bodies of water, and the tendency for people to move to the cities, where they were met with highly inadequate social services, would tend to make it even more widespread in years to come. It constituted a classic example of a disease that called for a combined social and medical approach. India had experienced a recrudescence of falciparum malaria, while at the same time the number of malaria experts had decreased, leaving its programme inadequately staffed.

He urged that any regional technical assessments made on the disease should not be too narrow in scope. An important issue was how a horizontal health care system could continue to devote day to day, routine attention to a disease that was likely to prevail well into the twenty-first century. Integration of malaria control into primary health care systems had not been a great success wherever it had been attempted. Regional symposia should address the managerial issues involved, and should investigate control techniques that did not require skilled health personnel but could be applied by the community. Any global or regional solution that did not take account of failures experienced in actual country situations ran the risk of not producing concrete results; for that reason, case studies of the experiences of specific countries were urgently needed.

Turning to other parasitic diseases, he said that there had unfortunately been a large-scale recrudescence of leishmaniasis in India, which again illustrated the failure of a normal, routinely functioning health care system to cope with responsibilities other than treatment. The health care structure should not be expected to undertake what could equally well be tackled by community action. Here, too, WHO should support any attempts being made by countries to deal with the problem by alternative strategies that were broader in scope than purely technical strategies.

He pointed out that the second-choice drug for leishmaniasis was 10-15 times more expensive than the first-choice drug. Unfortunately, resistance to the drug of first choice had been reached so early that India's programme had rapidly been disorganized by

an overwhelming demand for the second-choice drug. Some reduction in the prices of such drugs was essential if the programme was to continue; in view of the very large numbers at risk, it would be regrettable if WHO were to leave those prices to be determined entirely by market forces.

Some of the issues he had raised might not be directly related to the programme budget under discussion, but he had no doubt that they would ultimately determine the pattern of the Ninth General Programme of Work, and would thus be relevant to much of what WHO sought to achieve within the framework of the new health paradigm.

Dr KIM-FARLEY (Expanded Programme on Immunization) thanked members of the Board for their valuable comments and suggestions.

Concerning the sustainability of the Expanded Programme on Immunization (EPI), he attributed much of its success to support from an international coalition consisting of Member States, WHO, UNICEF and other organizations of the United Nations system, bilateral development agencies and nongovernmental organizations. In the 1990s that coalition would have to be sustained, especially in the least developed countries, if hard-won gains were to be maintained and if the target of 90% immunization coverage by the year 2000 was to be achieved. His discussions with the donor community, especially following the recent World Summit for Children, had given him grounds for optimism that support for EPI would not only be sustained, but increased. The challenges facing EPI - namely, the eradication of poliomyelitis, the elimination of neonatal tetanus, and the dramatic reduction in measles - had sparked a renewed commitment from the programme's partners to focus their efforts on the impact of immunization on the target diseases.

The consequences of not sustaining the programme would be catastrophic. Not only would there be resurgence of the diseases, but there might also be alterations in distribution patterns, so that, for example, measles and polio would affect older age groups, possibly resulting in higher fatality rates and higher rates of paralysis, respectively.

In reply to the question on advances in improved tetanus toxoid, he drew attention to the progress report on research and development in the field of vaccines (document EB87/6), which summarized efforts by the WHO programme for vaccine development to develop new and improved vaccines. Those efforts included work on a one-shot, controlled-release tetanus toxoid vaccine, integrated into injectable microcapsules. Ultimately, the microencapsulation technique might also be used for oral administration. Work in that area had recently been stimulated by the launching of the Children's Vaccine Initiative, a major acceleration of the development of essential vaccines for children before the end of the century. As the Chairman had noted, heat-stable and oral vaccines would also help in programme sustainability.

Regarding the questions of neonatal tetanus and the low coverage with tetanus toxoid of pregnant women and women of child-bearing age, it should be noted that, since the statistics did not take into account doses given prior to the most recent pregnancy, the actual level of protection against neonatal tetanus was higher. None the less, even when levels of tetanus toxoid were measured through coverage surveys that took prior doses into account, it was still found that tetanus toxoid coverage lagged behind that of the infant vaccines. One of the reasons behind the neonatal tetanus elimination initiative had been to bring that problem to light and aggressively tackle a disease that killed some 770 000 children each year. However, as Professor Borgoño had clearly stated, to achieve the ultimate goal of neonatal tetanus elimination it would be necessary to use the dual strategy of not only administering tetanus toxoid but ensuring clean deliveries as well.

The question posed by Dr Cabral on using EPI as an entry point for other primary health care interventions was extremely important and EPI had done that in many ways: through development of effective training materials in cooperation with other programmes and by developing indicators to monitor programme progress and evaluation methodologies that included other primary health care areas. EPI had been working closely with the Maternal and Child Health and Family Planning (MCH) programme in the neonatal tetanus elimination initiative and had recently been able to identify extrabudgetary funds to support professional staff in EPI and in MCH, thus strengthening activities in that initiative. It had been working together with the Nutrition unit to determine ways to

best use the contacts for immunization to deliver vitamin A and iodine supplementation where needed - recognizing that supplementation, a short-term intervention option, should be part of a broadly-based programme for the long-term improvement of nutrition.

The question on introduction of new vaccines into EPI was a major challenge for the decade. Hepatitis B was a prime example. The Global Advisory Group had noted that there was no technical impediment to its introduction, yet its cost still kept it out of the reach of many countries' immunization programmes. EPI was working closely with its partners to increase donor support and to help reduce costs through competitive bidding mechanisms and through transfer of technology, where appropriate. It considered the problem an urgent one, and one of high priority with implications for all new vaccines. It would be a great tragedy if new or improved vaccines were developed but, because of their cost, could not be used in the countries that needed them most.

Professor Ransome-Kuti had raised the question of disease surveillance and monitoring of immunization coverage. Monitoring capacities in both those areas needed to be strengthened. There was need also to disaggregate immunization coverage and no longer be satisfied by national averages, but to look behind the averages to see what was the immunization coverage state at provincial, district and community levels.

Disease surveillance systems must also be strengthened to monitor progress towards the disease eradication, elimination and reduction initiatives and to help direct the programme to the areas of greatest need. Sentinel surveillance was only a start towards a more comprehensive disease surveillance system.

Mr Cao Yonglin had raised the question of WHO assistance to countries in raising donor funds. EPI realized that that was an extremely important area and was developing a global document on EPI for the 1990s and its funding implications which might prove helpful in attracting donor funds when suitably adapted at regional and country levels. The importance of forming or strengthening interagency coordinating committees in countries to review EPI plans and to look at funding requirements, as well as to consider which donors could assist in which areas, could not be overemphasized.

Dr NAJERA-MORRONGO (Division of Control of Tropical Diseases) thanked the members of the Board for their thoughtful comments. He reassured Dr Cao Yonglin and the Chairman that, as had been explained to the Board the previous year, the reduction of funds for the programme of vector control at global level had been mainly due to the redistribution of programmes and the assignment to environmental health of the programme activities on toxicology of pesticides, safe use of pesticides and general environmental management for disease control. It was expected that those activities, which had formerly come under the programme of vector control, would become clearer and more effective in the context of chemical protection and general environmental management; so the reduction in the budget was more apparent than real. Some savings had been ensured by the reduction of the administrative support from three divisions to one single division.

Professor Borgoño had asked what could be expected of the improvements in the strategy of malaria control and when technical difficulties might be overcome and a start made on a sustainable control. He agreed with the comments by the Chairman and others on the need to move towards an integrated approach to the control of malaria and other vector-borne diseases. The emphasis of the new strategy was on according priority to the management of the disease and the selective application of vector control whenever it could be done in an effective and sustainable manner. Experience showed that short-term reductions could be easily obtained with available technology but that long-term sustainable improvement was dependent on the integration and improved capability for disease management to be achieved not only by transferring that responsibility to the general health services, but also by the sustainable financing of the necessary activities. Malaria was currently increasing beyond control in the areas of the frontiers of development, of civil disturbance and war. Moreover, the specific effects of urbanization combined the reduction of transmission and an epidemiological change from holoendemicity to disturbed endemicity, sometimes with limited protection for some time, leading to what had been characterized by Dr Monekosso, Regional Director for Africa, and Professor Ransome-Kuti as an increase in severe and cerebral malaria in adolescents.

In further reply to the Chairman he said that the planning of the malaria summit and pre-summit meetings was aimed at addressing the managerial and, more specifically, the socioeconomic aspects of the problem and that of sustainability in the different

ecological niches in which malaria presented itself. The new development of the strategy aimed at the understanding of the diversity and the identification of the major prototypes of malaria and the main paradigms for its control.

Dr Cabral and Professor Borgoño had asked about the links with maternal and child health and what attention was being given to the main problems of malaria in new-born babies, malaria in pregnancy, the very serious influence of malaria in anaemia and the impact that the treatment of anaemia might have on the transmission of human immunodeficiency virus (HIV). Those aspects had been crucial to the understanding and management of the malarial problem and the collaboration with the Division of Family Health, and particularly with the programme of maternal and child health, had been continuous within the previous Malaria Action Programme and the present Division of Control of Tropical Diseases. Not only had the question of incorporation of the proper diagnosis and treatment of malaria affecting new-borns and the protection of pregnant women with chemoprophylaxis been dealt with, but also the programme on women, health and development was addressing the role of women as the main group at risk of malaria during pregnancy but also as the major health providers at the periphery and at home. There was also close collaboration with the Special Programme for Research and Training in Tropical Diseases, particularly in field research on malaria, aimed at understanding, because of the difficulties of achieving continuous chemoprophylaxis, alternative mechanisms for protection during pregnancy - not only by a better selection of drugs but also by other mechanisms - and evaluating the effectiveness of periodic treatments on contact with maternal and child services compared with the management of disease manifestations.

On the role of WHO in the development of new drugs for malaria, he said that question should also be addressed when the Special Programme for Research and Training in Tropical Diseases was discussed, but he assured Dr Liebeswar that his recommendations represented the main approach to the problem. WHO was not dependent on individual industries but on the collaboration of the industry as a whole, the mobilization of all interest in the development of drugs and their evaluation, and the development of guidelines for the proper conduct of clinical trials. Price reductions for praziquantel, ivermectin, mefloquine and current negotiations on ornithine were good examples of the results of following the relevant recommendations.

In reply to Dr Margan, he said that in the 1950s and 1960s great efforts had been devoted to malaria training, but during the 1970s and early 1980s there had been a decline in interest and a continuous decrease in the number of technical staff in the programmes. Programmes were now paying particular attention to the need to reconstruct those cadres, and WHO had been very active in the coordination of international training courses and the development of national training programmes with the assistance of some governments and institutions, particularly in Italy, France and Belgium, the USSR, Thailand, Brazil, Venezuela and other countries.

Dr DE RAADT (Division of Control of Tropical Diseases) thanked Board members for their valuable comments and continued support. He informed the Board that the Division had organized a meeting for interested members the following week to brief them on the "malaria summit" and receive further suggestions. From the technical and administrative points of view, progress was very satisfactory. However, in order to ensure full global involvement in the preparation of the whole concept of a world strategy and of a declaration of commitment and involvement of Member States, it was necessary for all the regions to be involved in the preparation of the summit. Thus, three pre-summit meetings were planned, one in Africa, one in Asia and one in the Americas. The first, as the Regional Director for Africa had already announced, would take place in October 1991, in Brazzaville, the second one would take place in February 1992, in India, and the third in April 1992.

So far, the planning of the malaria summit had taken place in consultation with a group composed of senior health officials from various parts of the world, and including the WHO regional advisers. A relatively modest budget of US\$ 3 million for the four international meetings had been prepared. The Netherlands had offered to host the summit, India and the Regional Office for Africa in Brazzaville would each host a pre-summit meeting. Other regional offices had offered to contribute to the organization of the summit, and the Director-General had authorized a transfer of funds from other programmes in order to make it possible to carry out some of the initial activities. The donor community had shown interest; firm commitments were needed in the next few months.

In reply to Dr Novello and Dr Mahdi, who had asked about competition for funds between the summit and malaria control, he said that to a certain extent that was unavoidable, but in parallel with preparations for the summit, an initiative was under way in cooperation with the World Bank and UNDP which would help WHO in establishing a consortium for donations to a long-term programme on control of tropical diseases. Malaria control would be the main target and there would be an integrated approach to malaria control in the general health services together with control of other tropical diseases. The forthcoming meeting for Board members would provide more details.

Dr Ransome-Kuti and others had referred to dracunculiasis control at country level and Dr Novello had spoken of the global level. Dracunculiasis fell under programme 13.2, Disease vector control, as well as under 13.4, Parasitic diseases, in the programme budget. Since the two programmes had become part of the Division of Control of Tropical Diseases, by the reallocation of funds and resources the control programme had gained impetus, and it had become possible to make one professional member of staff available full-time for the control of dracunculiasis. That had speeded up the issue of the document on the criteria for certification. The current budget was not greatly affected, because the certification activities would mainly develop after the year 1993. The question of adequacy of direct voluntary contributions to country programmes had been raised. Dracunculiasis control was a popular programme and likely to attract adequate funds; US\$ 65 million were projected for the operational costs of control and eradication, and it was reasonable to expect that in the next five to ten years that money would become available, although the present political and economic climate raised some doubts. As for WHO's resources, UNDP had provided support, as had a few individual donors. The text on page B-194 of document PB/92-93 might seem somewhat too optimistic, but the Secretariat was still confident that the challenge could be met, particularly in view of the strong emphasis placed on it by the Regional Committee and the Regional Office for Africa, and the continued participation of UNICEF.

A 60% reduction in schistosomiasis by 1995 was feasible; setting a higher target would be unrealistic. Feasibility depended not only on the availability of funds, but also on manpower, capacity and the time factor. The Schistosomiasis unit had therefore placed emphasis on developing new training tools. Substantial bilateral funding was available for country support. WHO was involved in most of those programmes, helping in the preparation of plans, coordination and the monitoring of progress. A schistosomiasis data base was available to help countries to run their programmes and rank their priorities.

Leishmaniasis required a multidisciplinary approach and the intersectoral coordination which was so difficult to establish at national level in many countries. High priority was being accorded to the development of drugs for leishmaniasis in the Special Programme for Research and Training in Tropical Diseases, but abuse and inappropriate application of drugs was one of the main reasons for drug resistance to the disease. The recent report of the Expert Committee on the Control of the Leishmaniasis¹ included guidelines for control which might help in overcoming such problems. The possibilities for intercountry coordination were being investigated, particularly in Asia, and the introduction of new diagnostic tools was envisaged in Bangladesh, India and Nepal.

Dr GUERRA DE MACEDO (Regional Director for the Americas) stressed the importance of interagency cooperation and of the commitment and efforts of countries and governments to attain the objectives of the Expanded Programme on Immunization (EPI). Over the past five years, in the Region of the Americas, five organizations (WHO/PAHO, UNICEF, Rotary International, USAID and IDB) had worked together on a common programme, thus multiplying their efforts. Not only had activities been carried out at regional level, but national interagency groups had been active in each country. A total of US\$ 630 million had been spent on the intensification and promotion of EPI, especially for the eradication of poliomyelitis. Of that, a staggering total of US\$ 520 million, or 83%, had been provided by the countries themselves. Calling for such a level of contributions from countries at the beginning of the Programme would have been said to be utopian. All that was needed to produce the hoped-for results was organization and management support.

¹ WHO Technical Report Series No. 793, 1990.

In addition to the goal of eradicating poliomyelitis, goals had already been set in the Region for the eradication of urban rabies, neonatal tetanus and foot-and-mouth disease; in addition, a target had been set of eliminating measles in the English-speaking Caribbean countries and in Cuba. Following a resolution adopted by the Regional Committee, feasibility studies would be carried out on the eradication at regional level of measles, onchocerciasis, non-venereal treponematosi, Chagas disease, leprosy, and vitamin A and iodine deficiency diseases. The setting of targets for the eradication of specific diseases had effects that went well beyond addressing the problems posed by those diseases; resources and services were mobilized, surveillance systems and diagnosis procedures were developed, staff were trained and the organization of primary health care in general was improved.

Because of the need to develop new vaccines to meet the specific requirements of the Region, a feasibility study had been carried out on the setting-up of a regional system for vaccine development. The study had concluded that it would be feasible initially to develop three vaccines (for typhoid fever, streptococcal pneumonia, and meningitis, particularly meningitis B) with the likelihood of adding a fourth vaccine for dengue fever. There would be two regional centres, in Mexico and Brazil, supported by at least eight national affiliated laboratories and 16 epidemiological study centres distributed throughout the Region. It was hoped that the regional programme would be an integral part of WHO vaccine development work and provide opportunities for epidemiological field studies and clinical trials of other vaccines.

Dr KO KO (Regional Director for South-East Asia) said that the incidence of malaria in the South-East Asia Region was the highest in the world. Some 10 years earlier, there had been between eight and 10 million reported cases of malaria cases per year in the Region; the current registered incidence was between two and three million cases per year. Assuming the level of under-reporting remained constant, that reduction was an excellent achievement. But the success in reducing the number of cases was being threatened by some other developments: the resistance of mosquitos to insecticides, drug resistance in malaria parasites, non-availability of effective biological and environmental control measures, the lack of an effective malaria strategy, and the declining interest of donors and governments.

Mosquito resistance to insecticides had been seen throughout the Region, in particular in central India. Resistance to newer insecticides was increasing, and in some areas no insecticides were effective. Although trials had been made of various types of bio-engineering controls, a solution seemed to be very far away. Unless effective action were taken rapidly, there might well be a large-scale outbreak of malaria in the near future. Guidelines had been formulated in 1978 to provide an epidemiological basis for malaria control, but as yet no effective global strategy had been available.

Work was already under way to prepare the technical content of the regional meeting, to cover such areas as management and primary health care, as well as public health, epidemiology, clinical management, entomology, etc. Countries were starting to collect information and make case studies, epidemiological assessments and programme reviews. By 1992, the countries would be able to make definitive statements on the situation and the problems they faced. The summit meeting on malaria would definitely prove cost-effective if it led to the development of an effective global strategy on malaria. Furthermore, it would focus the interest of donors and of governments on the malaria problem. Several agencies had dropped their malaria activities, and governments often, if given the choice, directed resources to other health activities or other sectors than health.

The South-East Asia Region was fortunate in that the countries of the Region tended to implement expanded programmes on immunization as part of integrated health services; for example, EPI targets had been achieved in many countries even without the establishment of an EPI unit, work being done by the maternal and child health programme. Following the achievement of smallpox eradication, there had been a tendency for health managers to think in terms of eradication programmes. That could be detrimental to sustainability, if programmes were not planned properly. It was important to examine carefully the epidemiological situation and available health development systems, effective technological tools and financial and material resources, etc., in order to ensure the success and sustainability of the selective programmes, rather than to set up a score or more of eradication programmes and fail to achieve and sustain eradication.

Dr MONEKOSSO (Regional Director for Africa), referring to the programme budget for the African Region, noted that the figures were essentially aggregates for particular programme areas and did not indicate priorities; countries had decided to allocate WHO funds to particular areas, in the knowledge that more funds were often available from donors (usually bilateral donors) for work in other areas. Where programmes were financed by other donors, WHO was nevertheless usually involved in the implementation of activities. At the session of the Regional Committee in September 1990 the attention of Member countries had been drawn to the fact that the WHO budget document should be consistent with the Organization's priorities. The countries concerned had agreed to take a further look at the budget proposals so that some internal adjustments could be made to the published figures; it was hoped that those changes could be reported to the Board. Some inconsistencies between priorities and budget arose because countries might draw up their budget proposals on the basis of their own priorities, unaware of other priorities subsequently set by the Organization at regional or international level. Meetings of donors and those concerned in the health sector had been held at country level in order to establish country priorities, and it was hoped that a report would be presented to a future meeting of the Board giving profiles of particular countries and showing the role played by the WHO budgetary provisions, as well as those of other agencies involved, in ensuring that priorities were respected. It was up to WHO to urge countries to give consideration to additional priorities recognized by the Organization or by donor agencies.

Major initiatives had been taken in the African Region, with strong support from the international community, to eradicate neonatal tetanus and poliomyelitis. Under the EPI umbrella, staff were working on those particular problems, and there had been an active poliomyelitis eradication campaign.

Concerning dracunculiasis, an epidemiologist included in the intercountry team in Bamako was assisting in following up field studies and work under way in the affected countries. There had been support from private industry, and UNICEF was actively involved with WHO in the survey work. A sum of US\$ 50 000 from the Regional Director's component of the Director-General's and Regional Directors' Development Programme had been allocated to regional activities in dracunculiasis control. The Carter Center offered a major hope for the eradication of dracunculiasis; former President Carter of the United States of America had participated personally in the activities and had succeeded in helping to mobilize political support at the highest levels for the elimination of the "forgotten disease of forgotten people". Indeed, it would be possible to eradicate dracunculiasis from the African Region by 1995.

The allocation for EPI had been reduced because only 17 out of 44 countries had included EPI in their WHO budgets. It should be borne in mind that a large amount of extrabudgetary funds was still available, about 70% of the vaccines used in the African Region being donated by external suppliers. Some countries in the Region were actually using 5% of their regular health budgets for strengthening the district infrastructure in order to ensure sustainability. Those amounts did not appear as EPI expenditure. The acceleration of immunization which had started in the African Region in 1986 had had a favourable impact, and it was hoped that fewer countries would depend on special campaigns to sustain the efforts made thus far. Changes were also occurring in the allocation of national resources for immunization. He had the impression that international generosity in that area encouraged countries to spend money on high technology that could have been used to buy vaccines. There were countries which could afford to buy vaccines but which were receiving them free of charge.

The initial efforts to eradicate malaria had led to the "eradication of malariologists". He was not sure that they needed to be revived, since much of the action that had to be taken was covered by other programmes which could mostly be carried out at the local level. The campaign against malaria provided an opportunity for effective community participation and for the involvement of other sectors. Attempts to arrange that from the centre were fraught with difficulties and were extremely expensive. Those considerations formed the backbone of the strategic contribution which the African Region would be making to the summit conference on malaria to be held in 1993.

The CHAIRMAN, speaking in his personal capacity, expressed his pleasure with the emphasis placed on community action to combat malaria and the hope that conferences on malaria would focus on that aspect, among others.

Professor RANSOME-KUTI noted that schistosomiasis had received very little attention, although it was endemic in 76 Member States, with 600 million people at risk and 200 million actually infected. Now that the burden of disease could be so considerably reduced, he wondered why many Member States were relatively inactive. He had been informed that the reason was that the single-dose drug praziquantel was too expensive. If that were so, such a situation should not be allowed to continue much longer. Could not WHO consult the manufacturers and ask them to reduce the price of the drug? The volume of drugs needed to treat 200 million infected persons ought to be large enough to bring the price down to some extent. In Nigeria alone, for instance, some 20 million people were infected.

The CHAIRMAN observed that in the case of a fairly large demand for a drug of proven efficacy used to treat an eradicable disease, the marginal costs of production should, in the long run, diminish, leading to lower prices. That was a normal law of economics in the pharmaceuticals industry, except in cases of monopoly. Consequently, some steady watch ought to be kept, at least in respect of treatment for diseases that affected very large numbers of people. He requested information on WHO's preparedness to deal with such situations.

Dr MOTT (Schistosomiasis Control) explained that WHO had been involved in the early clinical development of praziquantel by coordinating the phase IIB and phase III trials for the treatment of schistosomiasis. Implementation of schistosomiasis control programmes in the 76 endemic countries was at an important crossroads. The current cost of praziquantel represented 50%-90% of the budget for control. The Division of Control of Tropical Diseases had initiated informal contacts with the WHO units concerned and interested parties outside WHO to set out a plan to negotiate an acceptable price reduction. He hoped to be able to report to the Board at its next session on the specific steps to achieve that objective.

The CHAIRMAN requested information on the measures taken to make drugs available at prices that diminished over a period of time, and suggested that it should be presented as a document.

Programmes 13.6 to 13.8: Diarrhoeal diseases; Acute respiratory infections; and Tuberculosis (Document PB/92-93, pages B-206 to B-219)

Professor BORGONO asked whether there were any reliable indicators showing the extent to which morbidity and mortality due to diarrhoeal diseases had diminished. It was not enough to know that the distribution of oral rehydration salts had increased; it was also necessary to have information on the use of the salts and their effects. Furthermore, it would be interesting to know whether the disease control and research components of the diarrhoeal disease programme were combined; it was his understanding that funds for research had diminished and that the number of projects being financed had been less in 1990 than in 1989 or 1988. Confirmation of that point would be appreciated. Some information on the use of rice products for rehydration therapy, particularly in infants under one year of age, would also be welcome.

The programme on acute respiratory infections was an important one. Many people believed that much more research was needed before it could be expanded, but enough knowledge was currently available to make it possible to reduce mortality substantially and to have a considerable impact on child mortality, especially in the developing countries. The programme was attracting extrabudgetary support, and the current figure of US\$ 8 552 300 in voluntary contributions would probably be exceeded, making it possible to expand the programme to combat the bacterial infections which caused so many deaths in the developing countries. The programme was also one in which technology could be substantially applied or adapted to enable the community, especially mothers and those

responsible for looking after children, to assess the symptoms important for timely diagnosis at the primary level so that the patient could, if necessary, be referred to the secondary level.

Nowadays tuberculosis was a preventable disease and was wholly curable if diagnosed in time. Nevertheless, the figures given in document EB87/4 indicated that 1700 million people in the world were infected, most of them in the developing countries, and that every year three million died of tuberculosis. That disease killed more people in the world than any other. Efforts should therefore be made to raise more extrabudgetary funding for the tuberculosis programme, with the likelihood of fairly prompt results.

The meeting rose at 12h30

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