



EXECUTIVE BOARD

Seventy-first Session

PROVISIONAL SUMMARY RECORD OF THE SIXTEENTH MEETING

WHO Headquarters, Geneva  
Friday, 21 January 1983, at 9h00

CHAIRMAN: Mr M. M. HUSSAIN  
later: Dr Maureen M. LAW



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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, Seventy-first session: Summary records (document EB71/1983/REC/2).

SIXTEENTH MEETING

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PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1984-1985: Item 7 of the Agenda (Resolutions WHA33.27, para. 4(1), WHA33.24, para. 3, EB68.R2 and EB71.R3; Document PB/84-85) (continued)

REPORTS OF THE REGIONAL DIRECTORS ON REGIONAL COMMITTEE MATTERS REQUIRING THE PARTICULAR ATTENTION OF THE BOARD: Item 8 of the Agenda (Documents EB71/9, EB71/10, EB71/11, EB71/12 and EB71/14) (continued)

PROGRAMME REVIEW: Item 7.2 of the Agenda (Resolution WHA35.25, para. 5(3); Documents EB71/6, EB71/7 and EB71/40) (continued)

HEALTH SCIENCE AND TECHNOLOGY - DISEASE PREVENTION AND CONTROL (Appropriation Section 4; Document PB/84-85, pages 219-297) (continued)

Disease prevention and control (programme 13) (continued)

Parasitic diseases (programme 13.4)

Dr BRAGA noted with approval that, formerly the subject of a subdivision of the Parasitic Diseases Programme in the Secretariat, Malaria had now been accorded separate status. In view of the importance of that disease, the administrative adjustment was fully justified.

Tropical disease research (programme 13.5) (Document EB71/6)

Dr OLDFIELD, on behalf of the Programme Committee, introduced its report on the Special Programme for Research and Training in Tropical Diseases (TDR), which included its findings on the report of the External Review Committee established to review the first five years of the Special Programme's operations. The two reports were contained in document EB71/6 and its annex.

The Programme Committee of the Executive Board had decided to evaluate TDR for a number of reasons: TDR had recently completed its first five years of scientific and technical operations; it had recently undergone a quinquennial review by the External Review Committee he had referred to; and, in terms of the number of projects involved and the size of its budget, it was WHO's largest research programme, with several built-in mechanisms for formal evaluation. The report of the External Review Committee, however, had not considered the scientific activities or progress of TDR and therefore a summary of the scientific and technical activities and their progress had been presented to the Programme Committee by Dr A. O. Lucas, Director, TDR, during the meeting of the Committee in October 1982.

The report of the Programme Committee before the Board was quite short and should be considered in the context of the report of the External Review Committee. In summary, the latter body had found the Programme to be well launched, strongly led, and an important contribution to the worldwide efforts against the six diseases that were its targets. In the Review Committee's judgement, the need for the Programme remained urgent, the objectives were appropriate and the balance among Programme elements reasonable. The basic organization of the Programme - the system of steering committees, the Scientific and Technical Advisory Committee, the Joint Coordinating Board and the secretariat, all linked to the World Health Organization - were, in the opinion of the Review Committee, sound. It had resulted in mobilizing people around the world and was achieving high quality decisions and choices of scientific work. Thus the Review Committee's report was basically positive: the Programme was considered to be important to the world and to be managed in a manner in which WHO could have confidence.

The Review Committee had made a number of recommendations for administrative, structural and procedural changes which, in the Programme Committee's view, would strengthen the Programme.

The Review Committee had expressed concern about the Programme's financing. Contributions had been levelling off in current dollars and declining in constant dollars at a time when the scientific opportunities called for a steady rise in funds. Moreover, there would soon be large needs for funds for field trials - for example, where the leprosy vaccine was concerned. The Programme Committee had agreed that if the Programme was to have the impact desired - which was scientifically feasible - the real resources available to it should be rising gradually but steadily and not, as at present, steadily declining.

Should the Board accept the report of the Programme Committee, members might wish to adopt a resolution. In that case, a draft resolution could be made available for its scrutiny.

Dr BRAGA said that the tropical diseases programme was one of WHO's most important programmes, and that it commanded his personal enthusiasm. With the exception of African trypanosomiasis, the diseases covered were prevalent in his country, which needed the Organization's help in facing the problems they caused. Brazil was currently undergoing an interesting development process involving population movements from the more developed south towards the north-east of the country, the Amazon region, and the regions bordering on Colombia, Peru and Bolivia. At the same time, health problems had increased, particularly where malaria was concerned, since the migrants came from regions where the scourge of malaria was unknown and had acquired no immunity. Thus, study of malaria problems was particularly important. Progress was also being made in combating Chagas' disease. The problem of schistosomiasis, which was linked to socioeconomic conditions, would probably not be solved until those conditions had been improved.

He stressed the need to support the programme, only regretting that its budget could not be larger.

Professor ISAKOV fully endorsed the report of the Programme Committee. The TDR programme was worthy of support, and should be strengthened. He stressed in particular the importance of scientific research for the control of the diseases in question. The programme should be practically-oriented to enable countries, especially developing ones, to apply the results of such research.

Dr HASAN (alternate to Dr Jogezeai) was deeply appreciative of the work of TDR, which had been of assistance to many countries.

He inquired whether the work of the Joint Coordinating Board, which had been reported to be functioning well, had been affected by the vacancy in its membership which he assumed to exist as a result of the difficulties experienced by the Eastern Mediterranean Region. As the Regional Committee for the Eastern Mediterranean had not met for two or three years, he wondered whether, in its absence, it would be possible for the seat to be filled on the recommendation of the Regional Director.

Dr ORADEAN said that the External Review Committee's evaluation of the work of TDR was a technical document of great importance, which not only facilitated assessment of the progress made but also indicated clearly the future tasks of the programme, as the Programme Committee had pointed out.

Programme 13.5 was a model of presentation, with action tailored to fit the problems and technical solutions matching the outstanding scientific capacity available, namely, 13 000 scientists, 6000 of them in tropical developing countries. The Director-General, the Secretariat and all connected with that work were to be congratulated.

Dr XU Shouren said that the objectives of the TDR programme were correctly focused and well-suited to the needs of the developing countries. It had a good management system, an excellent international cooperation network and a strong force of international scientific research workers, and had secured widespread international support. Thus, conditions were favourable for the achievement of the 1984/1985 targets.

However, control of the six tropical diseases still faced great difficulties. Stress should therefore be placed on correct policies and a better use of international cooperation and the international force of research workers. Above all, work in the field should be strengthened, with particular reference to research.

Dr ABDULLA observed that schistosomiasis also affected regions contiguous with those where it was endemic and, probably as a result of increased travel and transport, was spreading. Infected persons were moving about the world, possibly carrying the disease to regions never previously affected. Research had shown that some of the molluscs in previously clear areas were capable of harbouring the disease.

He therefore wondered whether, as traditional research methods had not yielded great results, it might not be more profitable to stress the social health aspects of the problem. In other words, was a real attempt being made to educate farmers and peasants in remote areas in measures that would interrupt the cycle of the disease?

Dr NAKAJIMA (Regional Director for the Western Pacific) said that one of the major implications of TDR at the regional and country level was applied field research, but the basic biomedical research activities of the programme were also centrally coordinated. There was only one scientific working group on applied field research, which was concerned with malaria. The TDR Scientific and Technical Advisory Committee (STAC) had recognized the difficulties of doing field research by TDR in the affected countries. He would therefore suggest that the responsibility for promoting and coordinating applied field research be entrusted to the regional offices. Field research was more closely related to control programmes than to basic research, and much more akin to field project activities in its concept and operations. Another major WHO programme - the Diarrhoeal Diseases Control programme - had already adopted an operational system involving the centralized coordination of fundamental and basic research and decentralized management of applied field research, and that system had been found to be very effective in balancing the roles of headquarters and the regional offices in research promotion related to diarrhoeal diseases. It was therefore hoped that TDR would gradually shift the responsibility for field research in relation to the control of the six diseases to the regional offices.

In that connexion, he drew attention to his Region's concern about the statement in the External Review Committee's report (EB71/6, Annex, page 6, third paragraph) which suggested that the present system of TDR budgeting for regional staff in five of WHO's regional offices was perhaps not a good use of scarce administrative resources and that the responsibilities of TDR-supported regional staff could be carried out by WHO's regular budget staff in the regional offices. However, if applied field research was to be carried out in the region, in order to achieve effective coordination he hoped that the regional office would continue to receive support from global TDR funds for financing the regional TDR staff.

Dr NOGUER (alternate to Dr Fuejo) agreed with Dr Xu Shouren that the programme should focus on the most promising areas and not dissipate its efforts. It should also identify research areas which were likely to lead to the solution of control problems and determine the type of field investigations which should form part of the activities of the Special Programme for Research and Training in Tropical Diseases.

He shared Dr Oldfield's concern about the progressive reduction of the funds available for the programme, which members of the Board obviously considered very important, and welcomed that speaker's suggestion that the Board might adopt a resolution on the subject.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean), after thanking the Board for the tribute which it had paid to the late Dr Taba, said that unfortunately it had once again not been possible to hold a meeting of the Regional Committee or to hold formal consultations with Member States regarding the proposed programme budget for the financial period 1984-1985. Despite the shortcomings arising out of that situation, a certain degree of consultation had been carried out through visits, correspondence and contacts with programme coordinators in various countries. The country programmes had been drawn up in such a way as to take into consideration the programmes of the region as a whole, with due allowance for the need to avoid duplication. The increases in the proposed budget appropriations for the Region did not exceed 2%. They had all been allocated to country programmes in the six least developed countries of the Region. It was proposed that provision should be made for four additional posts.

Dr LUCAS (Director, Special Programme for Research and Training in Tropical Diseases) noted that some questions had been asked regarding the manner in which tropical disease research activities were related to those of the associated control programmes. Apart from a small core staff involved in specific administrative procedures, other tropical disease research staff were lodged in relevant technical divisions and regional offices. There were, for instance, two staff members in the Leprosy unit, working under the guidance of the chief of that unit, who was the secretary of the Tropical Disease Research Scientific Working Groups on Immunology and Chemotherapy of Leprosy. That example emphasized the great advantage which the programme derived from appropriate coordination and from ensuring that research activities dealt with practical issues relating to control.

The Board might be interested to learn about the measures which the Special Programme had used to ensure that any discoveries could be rapidly brought into practical application. The first link was provided by the reports of expert committees, study groups and other bodies. The Sixth Report of the WHO Expert Committee on Vector Biology and Control contained several references to the work of the Special Programme, especially in relation to B. thuringiensis, which had now been applied in the field. The most recent information available from the Special Programme had been provided to that Committee for transmission to Member States. In the report of the WHO Study Group on Chemotherapy of Leprosy for Control Programmes, there were several references to the work of the Special Programme and to results obtained from multiple drug treatment in the face of the increasing problem of dapsone resistance.

The second link was provided by other publications. The Special Programme, for example, had issued a publication on drug resistant malaria. That publication had resulted from a meeting jointly sponsored by the Regional Offices for South-East Asia and the Western Pacific and by the Special Programme, bringing together scientists collaborating with the regional offices and the TDR programme on monitoring the problem of drug resistance. The findings of that group and their recommendations had been put together in the form of a publication for distribution to scientists and malaria control programmes.

The third link was provided by seminars and workshops. An example of such seminars was the Leishmaniasis Travelling Seminar held in the USSR to study the work being done on that subject, particularly in the field.

With regard to the application of new techniques, B. thuringiensis was being used in the area of the Onchocerciasis Control Programme, with 15-20% of that area being sprayed. It was hoped that in that way the usefulness of the tool would be evaluated and extended. Information on field research - for example, with regard to African sleeping sickness - was transmitted to Member States. The Regional Committee for Africa had recently adopted a resolution on the availability of test kits and new methods.

Several questions had been asked on how priorities were selected. The work on malaria illustrated how the Special Programme was dealing with that kind of problem. There were three main working groups. The first was the Scientific Working Group on Applied Field Research, which dealt with epidemiology and practical measures for control. The second was the Scientific Working Group on Immunology of Malaria, which incorporated scientists working in biomedical research on immunology; substantial progress had been made in developing a vaccine against malaria, although a great deal of work still needed to be done before it was known if a useful vaccine would result. The third was the Scientific Working Group on Chemotherapy of Malaria, which worked in collaboration with industry and other agencies. It was hoped that mefloquine, which had been discovered outside the Special Programme some years previously but which was not yet in use, would soon be widely available. Work was also being carried out with colleagues in the People's Republic of China on the antimalarial drugs derived from the traditional remedy Qinghaosu.

With regard to the questions raised by the Regional Director for the Western Pacific, the Special Programme was grateful for the valuable collaboration with regional offices in respect of the work done by the Regional Advisory Committees on Medical Research in identifying priorities. The Regional Centre for Tropical Disease Research in Kuala Lumpur, jointly funded by the Regional Office for the Western Pacific and the Special Programme, was one specific example of such collaboration. Dr Nakajima's suggestion regarding administrative responsibility for field research needed to be studied. An important start had been made in that direction with the establishment, at the regional level, of a Scientific Working Group on Schistosoma japonicum. The Regional Director for the Western Pacific might wish to provide the Board with further information on the present status of that activity.

Questions had been raised with regard to the programme budget. The figures shown in the budget document represented initial projections. The definitive budget for the 1984-1985 biennium was being prepared. It would be submitted in March 1983 to the Special Programme's Scientific and Technical Advisory Committee, which would make recommendations to the Joint Coordinating Board in June 1983.

Reference had been made to the fact that the Special Programme would require additional financial resources in the near future. There were several reasons for that, including the need to test out some of the new developments in the Special Programme. In 1983, a leprosy vaccine developed by the Special Programme would be put into man for the first time. Decisions would be taken as to whether it should be more widely tested. Starting a leprosy vaccine trial was a long-term commitment and priorities could not be changed on an annual basis; it might be necessary to continue observations for 8-10 years. New antimalarial drugs were likely to become available soon, and would also need large-scale testing. Apart from B. thuringiensis, other biological agents for vector control would require further work. Those new activities would be accommodated to the fullest extent possible within the present level of resources, but a decision would have to be taken as to whether the new drugs and vaccines should be left on the shelf or whether they should be tried out in the field.

Dr DAVIS (Director, Parasitic Diseases Programme) recalled that Dr Abdulla had asked a question about the importance of health education in the prevention of schistosomiasis, and that he and Dr Braga had also referred to the spreading of schistosomiasis by migrant labour. There had been a very marked change in the control of schistosomiasis as a parasitic disease during the past three or four years, and it could now be dealt with by controlling the morbidity through the use of the highly effective anti-schistosomal drugs developed over the past five to ten years. Health education, aimed both at school-age groups and at farmers, had certainly to be continued as a long-term policy. Unfortunately the resources devoted to health education in most of the endemic areas were small in proportion to the actual needs. Important as it was, health education should only be included in conjunction with chemotherapy, for those sections of the population for whom it was required.

The DIRECTOR-GENERAL, commenting on the fund-raising and resource allocation aspects, emphasized the difficulties involved in achieving a proper balance between the Organization's various activities in its programme budget. Tropical disease research had, he hoped, been integrated in WHO's policy framework in a balanced fashion, as was probably evident from Dr Lucas's statement. It was, however, quite clear that further funding would be needed. He had just received a letter from the President of the World Bank, who had expressed his strong support for the Special Programme for Research and Training in Tropical Diseases and had offered to embark upon a joint WHO/UNDP/IBRD effort to mobilize additional funds for it. As Director-General of WHO, he would, of course, lend his full support to such a fund-raising drive.

The problem of having to decide how funds should be allocated as between different programmes was a recurring one. Was the Organization's main priority the Special Programme for Research and Training in Tropical Diseases? Or was it the Special Programme for Research, Development and Research Training in Human Reproduction, or the Expanded Programme on Immunization, or the Diarrhoeal Diseases Programme, or the Health System Development Programme? One of the main considerations to be borne in mind in answering such questions was what kind of activity WHO could engage in most effectively. Given that premise, it was his view that high priority had to be given to health system development and related health systems research and to managerial processes and related managerial information systems, since all those activities were closely linked to national health strategies. Very often, therefore, WHO's role was not so much to provide resources, either from within its own regular budget or from special programmes executed by the Organization and financed mainly by extrabudgetary funds, as to ensure that an increasing volume of bilateral and multilateral resources was made available for the implementation of national strategies.

#### Diarrhoeal diseases (programme 13.6)

Dr BORGONO said that it was often overlooked that the excellent programme on diarrhoeal diseases was designed to do more than reduce mortality and morbidity, although that was obviously the most important goal. Its other objectives should always be borne in mind,

especially when assistance from international institutions or through bilateral arrangements was being considered. Where mortality and morbidity were concerned, it was important to produce reliable figures showing what had been achieved. Oral rehydration was effective and easy to apply at all levels, but its success should be authoritatively demonstrated by statistics, especially in relation to the reduction in mortality.

Manpower training was as important a component of the diarrhoeal diseases programme, as it was of the Expanded Programme on Immunization. The efforts being made to combine certain aspects of both programmes in training courses were highly satisfactory and should be continued, subject to the obvious limitations of such an approach.

If the diarrhoeal diseases programme was to progress in the Region of the Americas, it was important that the post which was vacant in one country should be filled soon, by March 1983 at the latest.

He considered that the Board should be provided with more ample information concerning the different elements of the programme, and not merely with an analysis of budgetary figures. Moreover, whenever the Director-General rejected a proposal because he considered it inappropriate, the Board might be provided with substantive details.

Dr XU Shouren said that although the diarrhoeal diseases programme was relatively new, it had proved to be most dynamic. He was pleased to note that there was to be a relatively large increase in the amount budgeted for the programme in 1984-1985. Although the primary aim was to reduce mortality and morbidity, he was inclined to believe that treatment had been overemphasized at the expense of prevention, as the Director-General himself had pointed out. Like Dr Borgoño, he considered that manpower training was an important component of the programme, and that it should be strengthened, together with epidemiological research and surveillance of the causes of diarrhoeal diseases.

Dr FAICH noted with appreciation that the programme statement was concise and readily understandable. The targets were well defined. He agreed with Dr Borgoño regarding the need to document the reduction in mortality more adequately, although he realized that such a task would not be easy. The programme had the almost incredibly ambitious goal of reducing deaths from diarrhoeal diseases by one and a half million per annum; even if that were achieved, however, the mortality rate at the end of the coming biennium would still be 3.1 million deaths per annum.

In the programme statement a rather clear distinction was drawn between two separate but interrelated elements - disease control, and research. Within the latter, particular emphasis was laid on operational research, with a well defined basic research programme agenda relating to the various sub-areas. He approved that distinction.

All in all, the programme was highly commendable. Moreover, it was heartening to note that while the budget appropriation was to increase in all regions and in virtually all categories programme management and support costs were to remain relatively low, at 6.47%.

Dr BRAGA agreed with the comments made by Dr Borgoño. The diarrhoeal diseases programme was of paramount importance within the framework of WHO's action programmes; he considered that it was being implemented in a very satisfactory manner.

It was generally recognized that the health of mother and child deserved special attention. In Brazil, children, adolescents and women of childbearing age accounted for no less than 70% of the population. Any improvement in the quality of their lives and health would depend on intersectoral activity in the fields of education, housing, basic sanitation, and appropriate technology, with due regard for other specific factors related to living conditions. However, the problem of infantile diarrhoea was fundamental, and the formula for oral rehydration salts pioneered by WHO and UNICEF had proved to be a most valuable therapeutic tool. Since the salts were supposedly easy to manufacture, it was important that they should be produced and distributed by reliable enterprises in order to ensure that the quality of the formula and of the packaging was adequate and that distribution was subject to appropriate controls. In that respect, governments had a responsibility similar to that which they bore in the case of poliomyelitis and measles vaccines.

It would be recalled that during the Second World War, antimalarial drugs such as atabrine had been introduced which were widely rumoured to produce an adverse effect on sexual potency; they had not, therefore, been readily accepted. The oral rehydration fluid was a simple mixture of sodium and glucose, but if persons, desirous only of making a quick profit, failed to prepare it properly, it would be ineffective, its reputation would suffer in the eyes of the population, and, like atabrine, it would not be accepted. It was consequently essential to deny the right to manufacture oral rehydration fluid to unscrupulous persons whose only interest was financial. Governments should retain the right to supervise production, especially in countries which had not yet reached a high level of social and economic development, so as to make full use of ORF as a weapon in the fight against infantile diarrhoeal disease within the framework of primary health care.

Dr TALIB observed that diarrhoeal disease was a very serious problem in the developing areas of the world. Although children were the most susceptible, it affected all age-groups. Its continued existence in developing areas was regrettable, since its causes, and reliable methods of treatment were well-established. It was, perhaps, a disease which flourished against a background of ignorance and adverse social and economic conditions. In addition to the measures listed in the programme, attention should therefore be paid to environmental aspects such as proper sanitation and to the effective dissemination of health information.

Dr NOGUER (alternate to Dr Fuejo) said that the diarrhoeal diseases control programme was experiencing operational difficulties which were common to many other programmes. Oral rehydration salts had to be continually available, in terms both of time and of space. Recalling that a new epidemiological approach had been introduced a few years ago in relation to malaria - another disease with a high mortality risk - which placed particular importance on the distribution of essential drugs, he suggested that programmes of a similar nature should be jointly planned or linked together for joint implementation, especially in areas where the main problem was of a logistic nature, involving availability. Paragraph 2 of the programme statement said that at least 2000 national management and supervisory staff were expected to have attended courses developed and coordinated by WHO by the end of the period covered by the programme. Those personnel could - he suggested - play a part in the distribution of chloroquine or slow-acting sulfonamide drugs.

More generally, he believed that the Organization should give a lead, to enable countries to find joint solutions to their various fundamental problems in rural areas, where similar operational difficulties were being encountered with different diseases.

Problems of the same nature arose where evaluation systems were concerned. In areas which he knew well, tropical rural areas, evaluation of diarrhoeal diseases control and antimalarial control programmes - and that applied to schistosomiasis also - could be carried out on a joint basis. Such joint evaluation could also be based on indirect data such as hospital admission figures or attendance figures at dispensaries or health centres, or on ad hoc mortality surveys of different areas.

Professor ISAKOV concurred with previous speakers that the main attention in diarrhoeal diseases control should be centred on prevention and on the training of health personnel. Although the reference to research in paragraph 13 of the programme statement could obviously not go into ~~too great detail~~, he believed that there were three very important lines of investigation which should be pursued in implementation of the programme: prophylactic measures against diarrhoeal disease at a young age when the mortality rate was extremely high; research on the changing etiological structure of diarrhoeal diseases and - in that connexion - on the spread of drug-resistant strains of pathogens, together with the exchange of relevant information and experience; and the preventive aspect of health education, which could be particularly effective in countries where the mortality due to diarrhoeal disease was still high.

Dr LAGET (alternate to Professor Roux), welcoming the increased funds allocated to research in the diarrhoeal diseases control programme in the 1984-1985 biennium, pointed out that it would be useful to know the breakdown between basic and operational research, since in the final instance operational research depended on sound basic biomedical research. Oral rehydration, for example, merely involved a proper understanding of the physiopathology of



diarrhoea, but it had to be remembered that the programme had also included a certain amount of basic research on the medicines and vaccines required. It was important to strike the right balance.

Dr MERSON (Diarrhoeal Diseases Control Programme), replying to Dr Borgoño, Dr Xu Shouren and Dr Talib, said that the question of the balance between reducing the mortality and morbidity rates had been constantly borne in mind and discussed by the Programme's Technical Advisory Groups. As pointed out by Dr Faich, about five million deaths occurred annually in the under-five year age-group due to diarrhoeal diseases. Oral rehydration therapy could have a significant impact in reducing that high mortality rate and considerable priority had therefore been given during the decade to implementation of that technique. He was fully aware at the same time of the need to reduce morbidity, especially since diarrhoeal mortality was not a major problem in some countries. An intensive review of all known morbidity strategies was being carried out during the current year and the results should indicate which strategies would produce the greatest impact on morbidity reduction. In addition, the research programme was oriented towards strategies to reduce morbidity, a promising example of which was the field testing of a new oral typhoid vaccine in Chile.

Dr Faich and Dr Borgoño had asked how it was intended to measure the impact of oral rehydration and other programme strategies on mortality figures. Probably the best solution to that challenging problem was to build into national diarrhoeal diseases control programmes a mechanism for obtaining the required impact information by routine and sentinel surveillance systems and special surveys. In addition, cluster sample surveys had been undertaken in 10 countries to define the extent of diarrhoea morbidity and mortality and more would be undertaken in other countries in 1983. Comprehensive national programme reviews were also being carried out to examine more closely both operational and impact indicators. Results of such activities should bring out both the achievements and the constraints of national diarrhoeal diseases control programmes.

Dr Borgoño and Dr Noguera had stressed the importance of combining diarrhoeal diseases control with other primary health care activities. The Programme's training course in supervisory skills, which was being field tested in Burma at the present time, included not only material on diarrhoeal diseases but also on malaria, the Expanded Programme on Immunization (EPI) and other primary health care interventions. Information on EPI coverage and possibly also on the incidence of acute respiratory infections could be obtained from the programme's morbidity and mortality surveys already mentioned. Close links were also being maintained with the new joint nutrition support programme.

Replying to Dr Braga, he said that specifications had been drawn up in conjunction with UNICEF for oral rehydration salts (ORS) production, to ensure that quality in the developing countries - where obviously ORS should be produced to the extent possible - complied with all the relevant requirements and standards of national governments.

The Programme staff was aware of the importance of the right balance between basic biomedical and operational research, a point raised by Dr Laget. Other organizations, such as UNICEF, were also engaged in the promotion of operational research on diarrhoeal diseases. The current programme budget included 35%-45% funds allocated to operational research and the remainder to biomedical research. It was felt that operational research should be linked to national control programmes, and that the scope of research would expand with those national programmes, in order to cater for their needs.

The DIRECTOR-GENERAL said that diarrhoeal diseases control was very closely linked with the extremely important chapter 11 of the proposed programme budget on the promotion of environmental health, and in particular water and sanitation, a subject on which the Board had maintained silence. In diarrhoeal diseases control attention tended to be concentrated in the main on the infant mortality rate, or if not, on the morbidity rate. Stimulated by the comments of Dr Abdulla, Dr Xu Shouren and others, he wished to suggest that perhaps more attention should be paid to the wellbeing and to the state of health of sufferers from diarrhoeal diseases rather than to the traditional disease indicators, the mortality and morbidity rates. If the incidence of infantile diarrhoea could be reduced, children would arrive at school in a very much better state of health. People in rural communities were not so much concerned with infant mortality - which they tended to take for granted - as with the

desire to see their children healthy and able to be educated and become productive members of society. A programme like diarrhoeal diseases control could certainly be considered in parallel with other elements such as malaria, but he preferred to regard it as a stepping-stone towards prevention, and that was where the link with environmental health came in, more specifically with water and sanitation.

There was a tendency in Member States not to be sufficiently serious about water and sanitation, a tendency which was clearly reflected in their rather half-hearted attitude to the Water Decade. Equally unfortunate was the failure to bring home to the population the miracles which could be performed by a proper understanding of water and sanitation. He could give the Board examples of communities which had in fact achieved miracles in just that way. The importance of water and sanitation should therefore not be overlooked; it was a field which should not be, but had been starved of investment. The first on the list of essential elements of primary health care as defined at the Alma-Ata Conference had been to educate people to understand their responsibilities concerning their health; that applied not only at the grassroots but at the policy-making level as well. Health education too, the importance of which was universally acknowledged, had always been poorly practised and funded. The Organization was grappling with a radically new approach to health education, but at the same time Member States had to rouse themselves both to invest in health education on a different scale and to abandon any bureaucratic or technocratic approaches which were quite inappropriate to imparting health education.

A down-to-earth approach to health education would, for example, eliminate any misunderstandings on self-medication, a subject which had been discussed at the present session of the Board, because the best form of self-medication could be said to be boiling your own water, if clean water was not available. Even in illiterate communities it was perfectly possible to make people understand within a reasonably short space of time why it was necessary to boil water, but that was an idea which had apparently gone out of fashion. Another highly desirable form of self-medication, to go with clean water, was proper and balanced nutrition, both aspects being a great improvement on the meaning attached to "self-medication" in the "Western" sense. Health services had not made a sufficient effort to get across to the population the reasons for making proper use of sanitation facilities. That was another example of failure of health education. All those aspects were linked in one way or another with the diarrhoeal disease control programme, but it was important to remember that the overriding priority was always the wellbeing of the child.

Dr LAGET (alternate to Professor Roux) said that he had the feeling that his question in regard to basic and operational research had been understood in the opposite sense to what he had intended, since the reply had emphasized the operational research being carried out by UNICEF and indeed by WHO. His intention, on the contrary, had been to underscore the importance of basic research.

#### Acute respiratory infections (programme 13.7)

Dr ORADEAN emphasized the importance of the programme in view of the high mortality rates in infants and children due to viral and bacterial diseases of the respiratory tract. Rapid diagnosis was difficult and the range of possible treatments very wide. It was essential that regional and national seminars should be organized by WHO to standardize methods of dealing with acute respiratory diseases. The proceedings of those seminars could also be useful to the advisory groups to be convened during the biennium to monitor progress.

Dr MAKUTO had been pleased to see that the programme had been included in the chapter on disease prevention and control. It was clear that a move had been made toward tackling the problems of child health in developing countries to which Dr Cabral had alluded earlier, but he wondered why no funds had been allocated under the programme to the African Region and to the Region of the Americas for either 1982-1983 or 1984-1985. The programme was in fact of paramount importance at least in the African Region and it was essential to marshal resources and initiate activities as soon as possible.

Dr BORGONO said that progress in the development of methods of rapid diagnosis had been greater in virology than in bacteriology. The programme might well serve as a pilot study in regard to the methods of research employed, in order to make best use of the results obtained. At the same time, the epidemiological surveillance of infections of the respiratory tract presented a challenge, greater for example than that of poliomyelitis because of the multiple etiology of respiratory infections. Special epidemiological surveillance systems were required to assess the magnitude of the problem and to gauge the impact of the measures taken.

In reply to the comment by the Director-General he said that the silence of the Board on environmental health should not be interpreted as a failure to understand the importance of the problem. Anything that contributed to the wellbeing of a human being certainly merited consideration. In approving the budget, the Board were after all giving their support to all the elements in it and the subject would certainly be raised and discussed at the Health Assembly.

Dr QUENUM (Regional Director for Africa), in reply to Dr Makuto, said that morbidity and mortality from acute respiratory infections (ARI) was indeed a subject to which the Regional Office for Africa was giving attention. Both the medium-term programme for 1984-1989 and the activities for the biennium 1984-1985 included investigation of the principal etiologies of ARI in children under five years of age, the preparation of handbooks to assist community health workers in the diagnosis, treatment and referral of ARI in under-fives and training community health workers in appropriate methods for the control of ARI. Such activities had an impact on many areas of concern to WHO and were in fact being carried out as part of the programmes for health situation and trend assessment, organization of health systems based on primary health care, health manpower development and environmental health. That was the reason no funds had been specifically allocated to ARI at country or inter-country level in the Region, but it did not mean that no activities in the field were being contemplated.

Dr ACUÑA (Regional Director for the Americas) said that funds for ARI activities in the American Region came solely from PAHO, whose governing bodies had adopted a control strategy for ARI aimed at prevention, especially among children under five years of age. Epidemiological and operational studies had been envisaged to provide data on which to base that strategy; many countries of the Region had already embarked on such studies. In addition, the Regional Office had sponsored a number of meetings on the topic, organized a course for virologists on the identification of respiratory viruses and convened a meeting of experts from various countries to prepare a protocol for research on the etiology, management and clinical course of pneumonia in children using the health services. Advice had been provided to countries at their request, and documentation on the epidemiological surveillance of ARI prepared. A meeting of regional experts had also been held. International courses for programme managers had been held in a number of countries on the epidemiology and control of tuberculosis and had included material on ARI. It was important to note, however, that ARI were replacing diarrhoeal diseases as a major cause of morbidity and mortality in the Region.

Dr NOGUER (alternate to Dr Fuejo), wishing to clarify his earlier comments, said he had observed that in Africa 90% of hospital patients had been admitted for treatment of infantile diarrhoeal disease, ARI or malaria. That was the reason for his conviction that ARI was one of a group of diseases that should have a common control strategy for priority action, after which attention could be given to less urgent problems. He would go further than the Director-General's recommendation of operational integration; the control of certain diseases and the reduction of mortality from them should be the spearhead of efforts to develop primary health care. That done, prevention and public awareness would follow as a matter of course. He disliked the term "health education"; something wider, more politically mobilized to create awareness at all points was, in his view, a crucial component in the introduction of primary health care infrastructures and services.

Dr BRAGA was gratified to see, on page 255, that the funds available for global and interregional activities on ARI, in other words headquarters activity on the subject, were to be increased in 1984-1985; he was pleased, too, to hear what was being done in the same field in the Americas with funds provided by the PAHO budget. However, he noted that the allocation for the programme in the Western Pacific was much higher than for the other regions and asked what the reason for that disproportion might be.

Dr NAKAJIMA (Regional Director for the Western Pacific) said the reason was an historical one. The Western Pacific had been the first region to initiate an ARI programme, principally because acute respiratory diseases were a major direct cause of infant mortality in many countries of the Region. An ARI research centre had been established in Papua New Guinea. It carried out both field research and biological and medical research and its activities were now being extended to other countries in the Region. Most of the funds for the regional ARI programme still came from the regular budget but support was now also coming from extrabudgetary sources - a trend that was increasing as time went on.

Dr PIO (Tuberculosis and Respiratory Infections), making a general comment as no specific questions had been raised, said that it would be unfair to affirm that the ARI programme was of recent origin. The WHO programme on surveillance of viral respiratory infections and the development of rapid techniques for the diagnosis of respiratory viruses was a long-standing one. What was new was the expansion of that programme into a comprehensive approach embracing both bacterial and viral etiological agents and aimed in the long term at preventing mortality and morbidity, especially among children in the developing countries. That emphasis on control had been advocated in the past, amid general scepticism, by a few voices crying in the wilderness. The situation had now changed, however, and a number of research projects had been started in three regions and were at the planning stage in two others. The indications were that the interest in initiating ARI activities was growing rapidly in many countries. WHO had made a determined effort to overcome the intellectual constraints that had been prevalent some years ago. Those constraints were now much reduced and he was sure that budgetary constraints would also gradually be overcome.

#### Tuberculosis (programme 13.8) (Document EB71/7)

Professor MALEEV, on behalf of the Programme Committee, introduced its report entitled "Tuberculosis control in the world - situation analysis", which was contained in document EB71/7.

The Programme Committee, in its report, made a careful analysis of tuberculosis control in the world on the basis of the Director-General's survey of the situation, which was attached as an annex to it, gave an objective summary of the report of a recent WHO/IUAT Study Group and described the results of the extensive investigations that had been carried out by the regional offices at country level. The Committee had greatly appreciated the clear and concise presentation of the material in the Director-General's report on the subject and fully agreed with the realistic control policy it proposed. The Committee stressed several points in its report and he proposed to expand somewhat on the subject of its first paragraph in order to put those various points in perspective.

The situation analysis had been prepared in response to resolution WHA33.26, which expressed the Health Assembly's concern that tuberculosis remained one of the most important health problems in developing countries despite the fact that a simple control technology had been available for many years. The situation analysis showed that still to be true; however, it should not necessarily be assumed that there was a causal relationship between the two facts. It should not be forgotten that the primary aim of the original tuberculosis programme had been the alleviation of suffering and was thus different from other disease programmes, such as malaria or smallpox, where the aim was eradication. The decline in tuberculosis in the developed countries could to some extent be attributed to improvements in socioeconomic conditions, but the epidemiology and pathology of the disease might well be different in developing countries, mainly in the tropics. Moreover, a real small decline in tuberculosis was difficult to demonstrate with the surveillance techniques currently available.

Failure to observe a substantial decline in tuberculosis was therefore not necessarily an indication that the tuberculosis programme had failed in so far as its social objective was concerned. Nevertheless, more could have been achieved if the existing health infrastructure had been fully exploited in the delivery of tuberculosis control technology.

The Committee therefore strongly recommended the further and full integration of tuberculosis control into the existing health delivery systems based on primary health care. However, many millions of people still lived outside the reach of such systems. The only way to arrive at tuberculosis control for all was to make rapid progress in implementing the Organization's main strategy of health for all by the year 2000 through primary health care.

Even though effective tuberculosis control would gradually reduce the problem, the disease could not be eliminated in a few years. The diagnosis and treatment of patients who sought help to alleviate symptoms was, however, within the possibilities of all health care services, and vaccination could be made available for all children. The objective of WHO's programme was therefore to generate a determined process of utilizing the health infrastructure and the primary health care system efficiently and whilst doing so to strengthen its harmonious development. Those responsible for the organization and development of the health infrastructure and experts in tuberculosis would have to determine together which tuberculosis control measures were to be included in the general programme and how the whole country was to be covered progressively.

An efficient approach would require great efforts to be applied immediately in both basic and health systems research. The application of modern immunological and other biological techniques in tuberculosis had so far been very limited, but scientific interest in the area was rapidly expanding and if pursued consistently would no doubt lead to important progress in tuberculosis control in the near future.

Epidemiology was another priority area in research. An appropriate method was needed to measure the problem and its evolution in developing countries and to determine the mechanism of the transmission of infection and of the progression from infection to disease.

Finally, the delivery of health technology should now be considered as a subject for sociological research; the human factors influencing the application of tuberculosis control within primary health care programmes as well as community participation in control programmes should be explored forthwith. In addition to that, better education of the public was needed to ensure the necessary community participation in the control programme, which the Committee felt might have been somewhat neglected in the past.

Dr ROUILLON (International Union against Tuberculosis), speaking at the invitation of the Chairman, said that the Union greatly appreciated the comprehensive report now before the Board, the remarks that had introduced it and the interest shown by the Board in tuberculosis.

However, she would, with respect, like to draw the Board's attention to the advisability of some modification, small in terms of words but substantive in meaning, that might increase the pertinence of the recommendations made.

First, the pool of experts should be national as well as international. The international pool of experts could support and complement the national one, but the Union felt that one or two national experts should be retained, both in developed countries where the younger generation of physicians had little experience of tuberculosis and there had been cases that had not been diagnosed until autopsy, and in the developing countries, which were gradually becoming the reservoirs of expertise on tuberculosis.

Secondly, WHO resolutions made reference to health infrastructures based on primary health care. The Union had for 20 years urged the integration of tuberculosis into the health system as a whole and favoured primary health care as a unique opportunity to extend early diagnosis, treatment and follow-up to the periphery. It felt, however, that the words "effective and efficient" should be added when primary health care was mentioned. It could perhaps be part of sociological and operational research to ensure, by various methods, that primary health care had those qualities.

Thirdly, the Union found it significant that the Board wished to expand research on tuberculosis. It was true that health care delivery, and social and human factors, ought to be explored in more detail, but the Union would also like to see fundamental research, which

in immunology, for example, was closely linked to the development of control techniques, specifically mentioned in the recommendations.

Fourthly, the report was correct in pointing out that the Union's report made little mention of health education. The Union felt that out-of-date methods were increasingly used in health education and that there should be some investigation of that point. Furthermore, health education at national level was often disseminated by the mass media and there the advice of the national tuberculosis expert would be useful to national authorities.

Fifthly, none of the recommendations made mention of BCG vaccine. The Union felt that countries had been shocked and perturbed by the result of the survey carried out in India and it would perhaps be wise to mention in the recommendations the importance of BCG in the Expanded Programme on Immunization. That would merely highlight one of the social objectives of the programme since, although BCG was not very effective from the epidemiological point of view, it was invaluable from the clinical standpoint for the prevention of severe and fatal forms of tuberculosis in children.

She thanked the Board for its attention and for giving the Union and its members the opportunity of continuing to cooperate with WHO while still allowing the Union to play its role as a pathfinder and critic to stimulate ideas, research and progress.

Dr DE LIMA was convinced that there would be no satisfactory change in prevalence of tuberculosis throughout the world until socioeconomic conditions, particularly those related to food and housing, were changed. With regard to prevention, and more particularly immunization, he was sure that in many developing countries vaccines did not retain their potency in use because of deficiencies in the conditions of storage. If any further details were available on the efficacy of BCG vaccination he would like to have them. Again, the use of rifampicin in other diseases than tuberculosis was linked to the growing abuse of antibiotics, which led to the development of pathogen resistance and side effects in patients. To meet that situation might it not be advisable to establish codes of practice for the use of antibiotics in health establishments?

Dr ORADEAN welcomed the situation analysis of tuberculosis control, which reflected a very active period in which the tactical and strategic lines of such control had been laid down and in which it had become the spearhead of many programmes. She particularly appreciated the determination to tackle the problem in developing countries in which there had been little, if any, fall in the number of cases of the disease, by strengthening tuberculosis control programmes as a primary health care component rather than by the use of highly specialized services whose development tended to diverge from that of the overall health structure. Those were aspects that the Programme Committee of the Executive Board had undoubtedly sought to stress in its emphasis on the need for close cooperation between the national authorities responsible for health infrastructure organization and those dealing specifically with tuberculosis control activities. She supported the emphasis on the importance of research into health systems, immunology and the most effective treatment accessible to the developing countries. Information and education, with emphasis on early detection of respiratory symptoms and the monitoring of high-risk groups, particularly those in contact with existing patients, were also essential components of tuberculosis control programmes. In addition to managerial problems, there were also shortcomings in epidemiological orientation.

The report of the Director-General stressed the wide variety of approaches that had been followed in various countries. Much remained to be done to ensure that the tuberculosis control strategy was better known and the results better evaluated as to their effectiveness, efficiency and cost/benefit ratio. She hoped that further discussions would be held on the problem, bearing in mind that, despite an increase of approximately US\$ 600 000 in regular budget resources, there was a fall of \$ 1.2 million in total expenditure on tuberculosis control.

She supported in principle the draft resolution proposed by the Programme Committee, but would like to see it amended as suggested by the representative of the International Union against Tuberculosis.

Professor ISAKOV observed that tuberculosis control was one of the most important health problems in most countries, and particularly in developing countries, as noted by the Thirty-

third World Health Assembly. Despite the preventive measures taken throughout the world, a million new cases, with 200 000 deaths, were registered annually. Drawing particular attention to the importance of social measures and progressive development, he said that his own country had succeeded in controlling the disease in a comparatively short period. Work on the problem was being actively pursued in most countries and in the Organization, and the practical steps taken in recent years were reflected in the report of the Director-General for 1980-1981. The Seventh General Programme of Work leading up to 1989 provided for an annual reduction in the tuberculosis morbidity level in the lower age-groups and for a lowering of the risk level by more than 2%. The Director-General should draw the attention of the Thirty-sixth World Health Assembly to the seriousness of the problem in many countries. Great attention must be paid to primary and secondary prevention and to specialized services in primary and secondary health care. The attitude of the population towards the measures taken in primary health care was extremely important.

He fully supported the draft resolution under consideration.

Dr HASAN (alternate to Dr Jozegai) said that socioeconomic conditions were highly relevant to the problem of tuberculosis. Unless improvements in such areas as nutrition, education and housing were brought about, the problem would remain for many developing countries. He noted that activities included field studies on new treatment regimens and global surveillance. For many developing countries in which the disease continued to pose a problem it was necessary to seek less expensive and shorter treatment regimens. Special surveillance was required in countries from which WHO technical guidance had been withdrawn because national staff had taken over, since many were carrying out integrated programmes and there was a danger that the tuberculosis control programmes might be overlooked. Although surveillance at the country level by national health authorities was of the utmost importance, there was an equal need for WHO surveillance to draw the attention of countries to the problem from time to time.

The tuberculosis problem should be kept in mind in respect of the areas of the world in which WHO was cooperating with governments and UNHCR.

Dr CABRAL, drawing attention to pages 257 and 258 of the proposed programme budget, stressed the importance of the link between tuberculosis control programmes and primary health care. In a country such as his, the kind of conditions to which previous speakers had drawn attention were unlikely to be improved in a short period of years, but efforts must nevertheless continue. The situation analysis (document EB71/7) and the programme statement in the proposed programme budget were pertinent to the experience of his country, which had formulated a strategy for tuberculosis control. In its struggle against the disease, the country had made some mistakes and some useful efforts. He had been impressed with the identification of certain particular problems in the programme statement. The first was the need to train personnel, mainly doctors, who were the least well equipped to deal with the problem and the ones most resistant to discipline in terms of therapeutics, for example. His country had decided that rifampicin would not be made available to any health care centre unless there was a patient receiving second-line treatment there.

A further problem was the connexion between tuberculosis control and delivery of health services in primary health care, to which reference was made in paragraph 3 of the programme statement. His country had found that the impact and efficacy of tuberculosis control was one of the most accurate indicators of the relationship between a health unit and the population it had to serve. When a particular health centre had a good measure of control of the tuberculosis patients diagnosed there, the relationship of its staff with the patients would be found to be excellent, since patients would not otherwise be prepared to travel long distances for treatment. His country had decided on certain guidelines for the evaluation of health units, and the rate of control of patients was one of the main points. When expert committees considered the problem, they should take account of the difficulties of achieving broad coverage because of the lack of infrastructure and managerial support and because of the long distances involved. Efforts were being made to restrict coverage to areas in which there was a good guarantee of interaction between the health unit and its patients and to apply it to some controllable population groups, such as factory workers. Coverage of such population groups or geographical areas at least produced some results. That was good for the morale of the personnel concerned, avoided wastage of resources and brought credit to the programme.

He wondered why the Programme Committee - bearing in mind its concern about information and education of the public - had omitted from the recommended draft resolution the reference that had appeared in a similar draft resolution to collaboration with the Division of Health Manpower Development.

Secondly, he recalled that, when the report of a joint study group of the International Union against Tuberculosis and WHO had been under consideration on an earlier occasion, it had been proposed that a special fund should be established for the large-scale purchase of essential drugs for tuberculosis control. Reference was also made in paragraph 8 of the programme statement to assistance to the least developed and other developing countries that experienced particular difficulties in implementing tuberculosis control. There was no mention of such assistance in the draft resolution.

He supported the amendments proposed by the representative of the International Union against Tuberculosis.

The CHAIRMAN said that she could recall no specific reason for the Programme Committee's omission of the points to which Dr Cabral had referred: the omission had no doubt been unintentional.

Dr BORGONO said that the report under consideration was outstanding. Tuberculosis could be cured when diagnosed early enough, and the tools available were excellent. Although a poor country, his country had made great progress in integrating tuberculosis control into primary health care and in financing chemotherapy on a country level. The tools available had to be used as effectively as possible.

He hoped the funds available to the Director-General would make it possible to give further support to the tuberculosis control programme. No decision should be taken regarding the problem of alcoholism until it was clear how many other programmes required additional funds.

He wished to propose some amendments to the draft resolution in document EB71/7 which were closely connected with the statement of the representative of the International Union against Tuberculosis. In keeping with the Expanded Programme on Immunization, the field trial in India, the report of the Study Group, and the report on BCG vaccination and policy, some reference should be made in the draft resolution to BCG. He proposed that the following words should be added at the end of operative paragraph 8(1) of the draft resolution:

"and to ensure that specialists in tuberculosis control remain available to the national and international community".

He further proposed that operative paragraph 8(3) should be amended to read:

"(3) to promote technological research, particularly in the fields of epidemiology, immunology and sociology, designed to provide new and more effective preventive and diagnostic measures."

He would be pleased to join the Secretariat and the representative of the International Union against Cancer in producing a revised draft resolution for submission to the Board.

The meeting rose at 12h30.

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