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PROVISIONAL SUMMARY RECORD OF THE NINTH MEETING
Palais des Nations, Geneva
Tuesday, 10 May 1994, at 14h30
Chairman: Mr D. VAN DAELE (Belgium)
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A47/A/SR/9
NiNTH MEETING
Tuesday, 10 May 1994, at 14h30
Chairman: Mr D. VAN DAELE (Belgium)
IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL):
Item 19 0f the Agenda (continued)
Eradication of dracunculiasis (Resolution WHA44.5; Document A47 / 10)
Professor MBEDE (representative of the Executive Board), introducing the item, said that the Executive Board had noted with satisfaction the Director-Generafs progress report (document A47/ 10) on the eradication of dractmculiasis, commonly referred to as guinea-worm disease. It had noted that eradication activities had been intensified following the adoption of resolution WHA44.5, including the application of criteria and procedures for certifying eradication. As eradication of the disease was now very close in Asia, programme activities were being focused on Africa south of the Sahara. Recent data indicated that the total annual world incidence had fallen below 2 million cases. The target of eradication by 1995 was technically feasible, provided that activities were intensified and additional resources made available.

Despite its satisfaction with the progress made in eradicating the disease, the Board had put on record its concern about the need to intensify activities to meet the programmes targets. The future steps outlined in the Director-GeneraPs report needed to be implemented rapidly, and the Committee might wish to comment on the need for further mobilization of resources for the programme.

Dr SOMBIE (Burkina F aso) said that his country was making every effort in information, education, communication and the use of filters to eradicate guinea-worm disease. The fundamental problem faced by many developing countries was the lack of safe drinking-water. In Burkina Faso, priority in the water supply programme was being given to rural areas in which dracunculiasis was endemic. In that connection the Government appealed urgently to the international community for additional financing for its water programme, which was essential in eradicating the disease.

Dr CICOGNA (Italy) said that in spite of the results achieved, much effort was still needed to reach the goal of complete interruption of transmission by the end of 1995. The transmission cycle could be broken by simple and relatively inexpensive measures, much of the requisite action being part of the health-for-all strategy: community participation, intersectoral cooperation, training of health workers, health education, and feasible cost-effective measures. So far, the response from endemic countries and donors had been positive and productive. More was needed, however, from them and from WHO in terms of political commitment, financial resources and technical and operational commitment. Dracunculus medinensis needed man to survive; man did not need the parasite.

Dr DAVIS (United States of America) commended WHO and its partners on the significant progress made towards the goal of eradicating dracunculiasis since the 1991 report. Nevertheless, as it moved closer to its target, WHO needed to begin the process of certification of dracunculiasis eradication. As resolution WHA44.5 had urged the Director-General to initiate country-by-country certification of elimination immediately in order that the process might be completed in the 1990s, the United States delegation sought information on the planning for certification, on the action taken to date, the amounts budgeted, and whether the Director-General planned to establish a Commission for Certification of Dracunculiasis

Eradication and, if so, when. It also sought information about the state of resources and actions necessary to achieve eradication by the 1995 target date.

Dr NOVELLO (United Nations Children,s Fund) said that the Director-Generalls report carried a strong message of hope and commitment to achieving the goal of complete eradication of guinea-worrn transmission in all affected villages by 1995. The dramatic progress achieved since 1991 demonstrated the possibility of reaching that mid-decade target in most countries with sustained political support, widescale social mobilization and adequate resources. Established programmes in the countries with the highest endemicity were reducing the number of new cases by about 50% each year. Dracunculiasis eradication should not, however, be seen as an end in itself but as a means of strengthening other aspects of primary health care in order to provide sustainable follow-up benefits to the endemic communities. Those benefits included regional and community-based surveillance systems, networks of village health workers, supervision systems, increased health education capacity and links with other sectors.

Any relaxation of efforts as the target neared carried the risk of resurgence of the disease in areas from which it had been eliminated. Therefore, in a collaborative effort of the United Nations system, bilateral development organizations and nongovernmental organizations, the level of surveillance, financing and technical support had to be sustained and increased until the last foci of the disease had been eradicated. All UNICEF field offices in endemic countries were ready to assist the national programmes in four key areas: the epidemiological mapping of all infected areas using geographical information systems; the rapid institution of control measures in all endemic villages before the end of 1994; social mobilization to turn the dracunculiasis eradication programme into a movement promoting responsibility and accountability of national and local authorities and behavioural changes with regard to drinking-water; and, finally, the provision of low-cost water supply systems in the small and remote villages in which the parasite remained endemic.

Professor MBEDE (representative of the Executive Board) said that the progress made in eradicating dracunculiasis showed that in some African countries, particularly Cameroon, eradication was possible with the collaboration and coordination of efforts between the various sectors involved, and between the various partners for development. Thanks were due to those who worked in Africa to control the disease, especially UNICEF, UNDP and the "Global 2000" project. Eradication of the disease was technically possible and was within reach in some countries. Success could even be achieved in countries where eradication appeared remote, provided that the necessary resources continued to be mobilized.

Dr HENDERSON (Assistant Director-General) said that WHO much appreciated the comments made which had so eloquently summarized the situation. WHO was committed to and confident of achieving total success, with the continued support of all parties.

Dr de RAADT (Division of Control of Tropical Diseases) confirmed that resources were limited and that everything possible had been done to make use of all identifiable reserves in the regular budget, including transferring them from one programme to another in order to strengthen the dracunculiasis eradication programme. WHO,s budget for dracunculiasis (regular budget and extrabudgetary funds combined) was currently of the order of US$ 1.3 million per year, and was about to be augmented by the equivalent of half a professional staff member. The greatest support in kind both in the field and at

headquarters had come from UNICEF, which had seconded two staff members to the team in Geneva,
who were in the process of identifying all the dracunculiasis-endemic villages, an essential step in the
certification process. UNDP, OPEC and the "Globa12000"project also provided valuable support. Given
that everything possible had been done within the budget of the Division of Control of Tropical Diseases,
he endorsed the call by the delegate of Italy for more donor funds.
Dr RANQUE (Division of Control of Tropical Diseases) said that 69 countries would require certification, 30 of which would require visits by an international certification team. Each team would cost
some US$ 45 000 and, according to the timetable, 15 countries would have to be visited during the biennium
1994-1995. Thanks were due in particular to UNICEF whose contribution amounted to some US$ 555 000
for that biennium, largely devoted to epidemiological mapping, which would be of great use in certification
and pave the way for other health measures, bearing in mind the follow-up work that would be necessary.
Some US$ 1 275 000 remained to be found to ensure that the headquarters team was fully operational in
1994-1995 and to permit recruitment of the certification teams that would visit the countries concerned.

Elimination of leprosy as a public health problem (Resolution WHA44.9; Document A47/11)

Professor MBEDE (representative of the Executive Board), introducing the item, said that the Board was satisfied with the progress made in reducing the global prevalence of leprosy through the use of multidrug therapy (MDT) but had noted the challenge that still lay ahead in bringing that therapy to patients difficult to reach.

Compared with 1990, the total number of cases at the end of 1993 had been reduced by some 55% from 3.7 million to 1.7 million, with the South-East Asia Region continuing to account for some 69% of the total. Implementation of MDT and case-finding had continued to make steady progress, resulting in a cumulative MDT coverage of 89.3% by the end of 1993. The cumulative number of cases cured through MDT since 1985 was 5.6 million.

The indications were that the goal set by resolution WHA44.9 on eliminating leprosy as a public health problem, with a prevalence below 1 case per 10 000 population, could be attained provided that the implementation of MDT was further intensified in order to reach the uncovered populations.

Dr MAHATHEVAN (Malaysia), commending the Director-General on his progress report, said that Malaysia had integrated its existing vertical leprosy control programme from the beginning of 1995, following a successful pilot study. Monotherapy had been discontinued in favour of MDT in 1989. The introduction of blister packs for the medication had improved convenience and compliance with treatment, and early case detection and prompt defaulter tracing had been introduced. Decentralization had taken place through the extensive training of all health workers and community participation was being organized through the village health promoters and volunteers from the Malaysian Leprosy Association. Those strategies had been implemented with a view to eliminating leprosy in Malaysia by the year 2000.

Dr MACHADO (Brazil) said that in order to achieve the target of reducing the prevalence of leprosy to less than 1 case per 10 000, Brazil had two years previously set up a national leprosy control and elimination programme which was already showing good results. Recent epidemiological data indicated that the prevalence had fallen to 14 per 10 000 inhabitants, and that 6 of BraziPs 27 states were on the way to achieving the national target. Four national reference centres had been appointed to support the programme, and budgetary resources had been earmarked on a priority basis. The Ministry of Health supported the goal of eliminating leprosy as a public health problem by the year 2000 and was consequently preparing an elimination plan for Brazil for the period 1995 - 2000 to ensure that goal was achieved.

Dr DAI Zhicheng (China) said that the global campaign for the elimination of leprosy had produced good results, although it would still be difficult to achieve the goal on schedule. Leprosy was now mainly prevalent in developing countries, particularly in consequence of insufficient government funding. WHO should provide guidelines on prevention and control and coordinate the rational use of world resources.

MDT and early detection, as well as training of grass-roots workers, did not receive sufficient emphasis and should be integrated into the programme as strategic priorities.

Dr CICOGNA (Italy) noted with satisfaction that the elimination of leprosy as a public health hazard was well under way, thanks to WHOls support and to increased political commitment by the endemic

countries and by nongovernmental organizations. However, his delegation was concerned about the difficulties of increasing MDT coverage, in view of the fact that the lower prevalence of the disease made case-finding activities more difficult and expensive. It was important not to adopt an attitude of relaxed optimism, but on the contrary to intensify the effort, which must include community- based rehabilitation.

Dr ADAMS (Australia) said that his country had been extremely concerned to learn of an alarming incidence of phocomelia in Brazil affecting infants whose mothers had received thalidomide for the management of reactions to leprosy treatment. Australia had immediately changed its policy, to the effect that thalidomide should only be used in the management of severe life-threatening reactions. It urged WHO to adopt a similar policy, ensuring in particular that thalidomide was not given to women of child-bearing age.

Dr MAREI (Egypt) said that Egypt was committed to eliminating leprosy by the year 2000. Since 1985, there had been 100% MDT coverage. A plan had been adopted for early detection and for training skilled health workers. Surveys had been carried out in villages and free health care provided.

Professor ORDONEZ CANCELLER (Cuba) said that his country had made considerable progress in the elimination of leprosy, the prevalence of which in 1993, was down to 0.79 per 10 000 population. More than 95% of patients received MDT regularly. Serological studies had been carried out in order to make an epidemiological evaluation with a view to early detection. Cuba had been using new technology which it would be willing to share with interested countries. It had attained its objective of eliminating leprosy as a public health problem, and hoped to stop its transmission by the next century.

Mr AL-JABER (Qatar) said that there were no cases of leprosy among nationals in his country. The only cases were imported ones, and a policy had been adopted to test all workers arriving from abroad; treatment was provided where required.

Dr DOFARA (Central African Republic) said that his was one of the countries in which the prevalence of leprosy exceeded 5 cases per 10 000 inhabitants. It had difficulty in obtaining medical supplies, and public health services had been undermined by the devaluation of the CFA franc. He appealed to WHO and nongovernmental organizations to assist the African countries in which there was a high incidence of leprosy, not omitting assistance with the social rehabilitation of former patients. He expressed particular gratitude to the Raoul Follerean Foundation for its help.

Dr MUKHERJEE (India) said that one quarter of all registered leprosy sufferers were to be found in India. There had been a successive increase in the number of reported cases in each decade as a result of better detection, greater awareness and voluntary reporting. The elimination of leprosy constituted a public health problem, although it was hoped that the disease would be almost eradicated by the year 2000 with the help of MDT, i.e. the goal would be achieved of less than 1 case per 10 000 population. Long-term strategies were required, accompanied by constant monitoring and MDT therapy, also including the treatment of chronic ulcers and other disabilities. Indials leprosy eradication programme was one of the worlds most successful public health programmes at the present time.

Dr AZMOODEH (Islamic Republic of Iran) said that in 1993, only 140 leprosy cases had been detected in his country; they had been treated with MDT. There were now approximately 2900 cases under treatment: the overall figure for the Islamic Republic of Iran was 0.4% per 10 000 population.

Dr KHOJA (Saudi Arabia) said that his country had adopted the target of reducing the number of cases to 1 per 10 000 inhabitants. In 1993, there had been 124 cases, ascertained by an early-detection programme, which went hand in hand with increased surveillance and the provision of MDT to all sufferers.

There were three essentials for a successful anti-leprosy campaign. First, the disease had to be perceived as an important public health problem, for the elimination of which all patients must receive MDT.

Secondly, early detection and treatment were of vital importance, and for that purpose a change of social attitude was crucial to overcome the social stigma that made people unwilling to admit that they were infected until deformities had become apparent. Thirdly, positive collaboration between the countries of a region should be assured by the adoption of regional plans; those were of importance to Saudi Arabia

as a labour-importing country.

Dr ASHLEY-DEJO (Nigeria) said that Nigeria had launched a leprosy and tuberculosis control programme in 1988. Since then, the number of registered leprosy cases had been reduced to some 30 000. The prevalence had been reduced from 7.4% per 10 000 in 1991 to 3.2 per 10 000 currently at the present time. The programme was organized on a decentralized basis by state and district, with committees at every level and with the help of various nongovernmental organizations, for which he was extremely grateful.

Nigeria had established its own leprosy training centre. He was happy to be able to report good results obtained with the anti-leprosy activities, which had been integrated into the primary health care system, but the tuberculosis control component of the joint programme was doing less well.

Dr VIOIAKI-PARASKEVA (Greece) said that the elimination of leprosy still required vigorous efforts, including the training of managers in leprosy control at country level. Referring to paragraph 12 of document A47/11, she asked for details of the programme for the rehabilitation of patients as part of community-based efforts. She also inquired what progress had been made in developing a leprosy vaccine.

It was important to stress the political commitment to eliminate leprosy, as well as the importance of public health education, in order to avoid discrimination against leprosy sufferers.

Dr KAMARA (Sierra Leone) endorsed the Italian delegations insistence that there should be no relaxation of efforts to achieve the goal of eliminating tuberculosis by the year 2000. In his country, the combined leprosy and tuberculosis control programme had helped reduce the incidence of leprosy very considerably over the past three years. He particularly thanked the German Leprosy Relief Association for funding the Programme, and looked forward to the prospect of seeing leprosy completely eliminated in Sierra Leone within the next few years.

Professor LANGUILLON (Order of Malta), speaking at the invitation of the CHAIRMAN, recalled that the Sovereign Order of Malta had unstintingly cared for lepers since its creation in the twelfth century; the French Hospitallers Oeuvres in particular continued that tradition. The elimination of leprosy was based on a thorough case-detection and regular multidrug therapy in accordance with the WHO protocol.

The Order had observed, however, that in many countries case-finding and contact surveillance were no longer carried out. In certain countries multidrug therapy did not even cover half of the patients.

Management of the leprosy problem was not confined to curing the infection. It was important also to address the associated physical disabilities and moral stigmata which were insufficiently dealt with by the medical and social services, thus impeding the proper social rehabilitation of the former patient. The Orderls many years of experience with leprosy tempered its optimism. Leprosy would still be a public health problem in the year 2000, particularly where prevention of disabilities and of social rehabilitation were concerned. The handicapped should not be socially excluded, and efforts would have to be continued through the first two decades of the twenty-first century.

Dr YUASA (International Leprosy Association), speaking at the invitation of the CHAIRMAN, remarked that he represented both the ILA (International Leprosy Association) and the ILU (International Leprosy Union). On behalf of both, he congratulated the health authorities in the leprosy-endemic countries and the Leprosy unit of WHO for the remarkable achievements to date through the global application of MDT. The leprosy picture had changed dramatically for the better over the past 10 years, but the attainment of the elimination goal was not yet assured, with about 5 million patients still to be treated with MDT before the year 2000, unless efforts were redoubled. The ILU and the majority of the individual members of ILA were solidly behind the elimination programme, and working towards the target of reducing the prevalence rate to less than 1 per 10 000 in every leprosy-endemic country by the year 2000.

Both the ILA and ILU were looking beyond the goal of elimination towards more permanent solutions for all leprosy-related problems. Those included not only the provision of early detection and effective treatment leading to a complete cure of the disease, as well as the prevention of deformities and disabilities for each new case which was bound to appear for a considerable period beyond

the year 2000,
but also ensuring that necessary care was available to those already suffering from physical or social
disabilities, whose numbers were estimated to be more than 2 million. Solutions to those problems
depended on the principle of total integration with the health care and social welfare systems of each
country. In the past the mistake had been made of handling leprosy separately; that had contributed to its
segregation both in concept and practice with negative physical and social results.
Despite those long-term concerns, the foremost immediate priority was the successful implementation
of the elimination programme, which was nothing more than bringing effective chemotherapy to the greatest
number of patients as quickly as possible. He therefore reiterated the pledge that members of the two
organizations he represented would collaborate fully with the health authorities of leprosy-endemic
countries, the Leprosy unit of WHO and national and international nongovernmental organizations towards
the successful implementation of the programme.

Dr MACHADO (Brazil), referring to the statement by the delegate from Australia, said that there were no cases of Brazilian children born with deformities caused by thalidomide taken by the mother in the course of leprosy therapy. The treatment of leprosy among women of child-bearing age was always subject to strict medical supervision. Cases of Brazilian children born with deformities owing to the use of thalidomide by mothers were a thing of the past, when the drug was used without adequate knowledge of the side-effects.

Dr NOORDEEN (Division of Control of Tropical Diseases) thanked the participants for their suggestions and comments. Regarding the need to intensify efforts in order to attain the target of reducing leprosy to the level of 1 per 10 000 people, he was confident that that could be achieved provided efforts were stepped-up over the next few years. Today MDT (multidrug therapy) and case-detection were working well in curing leprosy and detecting hitherto undiscovered patients. In most parts of the world the epidemiological situation was favourable, and there was also a strong political commitment in most major leprosy-endemic countries. In addition, the donor community, including international nongovernmental organizations, considered investment in leprosy control worthwhile. While it was wrong to be complacent, he did expect the target elimination level to be attained at least at national level by the year 2000.

On the question of disabilities he pointed out that, although leprosy was often associated with physical deformities, they were not invariable; MDT could do very little for patients already deformed in consequence of late diagnosis and irreparable nerve damage; such patients often required surgical or other interventions. However, MDT, through early detection was contributing to the prevention of deformities occurring later, and one estimate had indicated that over the past 10 years as many as 500 000 deformities had been prevented by MDT. The leprosy programme recommended that disability prevention and management should be incorporated within the MDT programme at an early stage. WHOhad therefore recently published a manual for field workers on disability prevention in leprosy, and another publication on leprosy surgery for district hospitals was in preparation.

On the question of thalidomide, the drug was highly effective against erythema nodosum leprosum, one of the common complications of leprosy, and the WHO Study Group on Chemotherapy of Leprosy which met in November 1993 had recommended that thalidomide should be available at leprosy referral centres, but should never given to women of child-bearing age. It should only be administered under the close supervision of referral centres; where close supervision could not be ensured, thalidomide should not be used.

Concerning anti-leprosy vaccine, he said three trials were being carried out under the auspices of the Special Programme for Research and Training in Tropical Diseases in India, Malawi and Venezuela. Preliminary results from Venezuela indicated that the vaccine combination BCG with killed Mycobacterium leprae was not more effective than BCG itself. Results from Malawi were expected by the end of 1995 and from India in about five years time. .

Regarding the supply of drugs, no leprosy programme should suffer from lack of drugs if the appropriate approaches were made; a number of donor agencies were willing to provide drugs for leprosy treatment.

Tuberculosis programme (Resolution WHA46.36; Document A47/12)

Professor CALDEIRA DA SILVA (representative of the Executive Board), introducing the item, said that the Board had considered a progress report by the Director-General (now revised as document A47/ 12) outlining a number of constraints on tuberculosis control: firstly, if urgent and effective action was not taken, the last decade of the twentieth century would see 30 million deaths and ahnost 90 million new tuberculosis cases; secondly, multidrug resistant strains of the tuberculosis bacillus were becoming more prevalent, primarily because many countries were using inappropriate treatment techniques; thirdly, co-infection with HIV and tuberculosis was rapidly increasing, from about 4% in 1990 to an expected 14% by the year 2000; lastly, many countries had not yet been able to adopt WHOts new tuberculosis control strategy.

On the other hand the Board had noted progress made within the programme on a number of items, including enhancement of support for the programmes work by WHO,s declaration of a global tuberculosis emergency; increased global training activities resulting in more countries adopting WHOls control strategy;

and technical assistance being provided to countries in every region, in some instances, in cooperation with the World Bank.

The Board had approved the Director-Generalls decision to establish, in accordance with resolution WHA29.31, a Special Account for Tuberculosis within the Voluntary Fund for Health Promotion. That would give the programme higher priority and present its accounts more clearly within WHO is overall accounts. It would also draw attention to the status and activities of the programme and the need for increased external funding. WHO should continue to play a key role in mobilizing funds for tuberculosis control activities at the global and country levels.

The Board had expressed concern over the worsening situation regarding HIV-associated tuberculosis, and called for continuing coordination between the tuberculosis programme and the Global Programme on AIDS.

The Board had also called on Member States to give more attention to short-course chemotherapy as being a most cost-effective treatment, and to support the development of rapid and early diagnosis methods using new technologies.

Dr MUKHERJEE (India) commended the report and stated that India was seeking to attain the target of tuberculosis control by the year 2000. The disease, however, continued to be a major public health problem in India, with an estimated 40% of the population infected. Surveys indicated that nearly 1.5% of the population suffered from pulmonary tuberculosis, with 0.4% positive cases; that meant 12-13 million out of a total population of 881 million had pulmonary tuberculosis, with about 3 million positive cases.

In India, moreover, 56% of AIDS cases studied had tuberculosis, a much higher percentage than that reported globally.

In 1992 a progress review, conducted with the help of national and international experts, had resulted in the formulation of a revised strategy for the national tuberculosis programme. Aims of the strategy included detecting 1500 positive cases per million population per year and instituting chemotherapy, which would be directly supervised during the intensive phase; other features were regular monitoring of treatment, maintenance of uninterrupted drug supply, and enhancing of community awareness. External funds were being sought to support the programme.

He hoped that with the introduction of effective short-course chemotherapy and the implementation of the new strategy, it would be possible for India to achieve its goal by the year 2000.

Mr WHITE (Canada) expressed his delegation’s support for the new WHO tuberculosis control strategy which had successfully attracted global attention to a major threat to human health. He noted that the World Bank,s World development report 1993: Investing in health identified tuberculosis control as one of the most effective health interventions. The Canadian delegation believed in encouraging, supporting and promoting well-organized comprehensive control programmes at the country level, and welcomed a programme developed by the United Republic of Tanzania, which was a model that could be adapted to benefit other Member States.

Canada wished to reiterate the concern it had expressed at an earlier meeting about the inappropriate and excessive use of antimicrobial drugs that led to problems of resistance. If effective control measures, including the rational use of drugs, were not implemented, the new tuberculosis strains that were resistant to the best treatment agents could lead to a global catastrophe. Such drug resistance was also seen among

the causative organisms of other diseases and must be addressed immediately by all Member States.

Mrs BALOSANG (Botswana) welcomed the establishment of a Special Account for Tuberculosis within the Voluntary Fund for Health Promotion in view of the serious rise in the prevalence of tuberculosis throughout the world. As the representative of the Executive Board had said, establishment of the account would demonstrate the higher priority given to tuberculosis control activities by WHO and would distinguish the accounts of the tuberculosis programme within the overall budget of WHO. Her delegation had previously expressed its satisfaction at the renewed activity of that programme in support, operational research and other areas.

As in other countries, the number of notified cases of tuberculosis had increased in Botswana within the past three years, following several years of declining numbers. The increase was attributable to increasing rates of infection with HIV. She hoped that WHO would help Botswana to strengthen its

national programme. against tuberculosis and maintain it at a high level of operational efficiency. In view of the interaction between tuberculosis and AIDS, new ways should be found for the early diagnosis and treatment of tuberculosis. She expressed her support for the WHO tuberculosis programme.

Dr ADAMS (Australia) said that tuberculosis should receive high priority among the programmes of WHO, in view of its alarming increase throughout the world. As it was becoming increasingly difficult to raise extrabudgetary funds, WHO should review its priorities and consider attributing more of the regular budget to tuberculosis.

Dr MIRCHEVA (Bulgaria) said that while WHO tended to focus on areas of the world where the prevalence of tuberculosis was very high, and especially on developing countries in which the number of HIV-seropositive people who contracted tuberculosis was increasing, in the present period of political, economic and social change, it should also take direct action to control tuberculosis in the countries of central and eastern Europe.

The lowest tuberculosis prevalence in Bulgaria, 25.1 cases per 100 000 population had been recorded in 1990; subsequently, the rate had increased steadily; the rate of positive sputum smears was also increasing, creating a particular risk for children. The deterioration was due mainly to social conditions, including declining living standard, rising unemployment, large numbers of alcoholics and diabetics, and an aging population. The number of HIV-seropositive persons was comparatively low and did not appear to be related to the increase in tuberculosis.

The priorities were to preserve the network of dispensaries, which were having financial difficulties; to increase the numbers of qualified physicians; to supply up-to-date equipment to specialized laboratories, including X-ray facilities and analytical apparatus; to modernize the diagnosis of tuberculosis; to promote research on immunoprophylaxis, diagnostics and treatment; and to improve the general populationts knowledge about the disease.

She supported the decision to open a Special Account for Tuberculosis within the Voluntary Fund for Health Promotion.

Dr DAVIS (United States of America) commended the report and WHOls programmatic approach to tuberculosis control. However, BCG was not dealt with in the report and he wondered whether it was considered an important preventive measure and what WHO recommended to national tuberculosis programmes concerning collaboration with national expanded programmes on immunization. He asked further whether WHO was collaborating with the International Union Against Tuberculosis and Lung Disease, which was a major supporter of tuberculosis control programmes.

He shared the concern of other delegates that insufficient funds had been allocated from the regular budget for the tuberculosis programme. Although the establishment of a special account within the Voluntary Fund for Health Promotion was commendable, the programme could not rely entirely on voluntary funds, and he urged the Director-General to reallocate funds from the regular budget to the tuberculosis programme.

Dr EMIROGLU (Turkey) considered tuberculosis to be one of the priorities of the Forty-seventh World Health Assembly. It would remain important in both developing and developed countries because of co-infection with HIV. A vertical national programme to control tuberculosis intervention had been established in Turkey in the 1960s; it had been successful in reducing incidence and prev

alence but the
disease remained a problem because its control had not been integrated into primary healt
h care owing to
inadequate case detection and treatment and other factors. The key strategies of the curr
ent national
control programme were integration into primary health care; implementation and monitorin
g of standard
short-course chemotherapy; strengthening of the surveillance and reporting system; and pu
blic education
and training of health personnel.
She agreed with the establishment of the proposal to establish a Special Account for Tube
rculosis,
as that would give the WHO programme higher priority. Political will was also important i
f the global
targets were to be attained.

Dr CICOGNA (Italy) said that the continuing spread of tuberculosis was a matter of grave concern.
As had been emphasized at a recent conference in the Netherlands, supported by WHO, tuberculosis was by no means eliminated in developed countries and was a veritable scourge in developing countries, where it killed more adults annually than AIDS, malaria and other infectious diseases combined. Its control, however, was very cost-effective, as the World Bank pointed out in its World development report 1993: Investment in health He supported WHO'S declaration in 1993 of a global emergency with respect to tuberculosis and noted that the tuberculosis programme was given high priority in the Ninth General Programme of Work.
Dr SIDHOM (Tunisia) noted that the renewed attention to tuberculosis came somewhat late, as AIDS had already spread before the WHO tuberculosis programme was reinforced. The strategy should be adapted to the needs of the health sector in each country. Education and training of health workers should accompany chemotherapy, which, he noted from document A47 / 12, was used in only 36% of countries. Regional committees should strengthen their programmes in that respect. Several developing countries did not have a supply of the appropriate drugs; the disease had therefore spread and become resistant to chemotherapy. There had been a lack of vigilance in many countries but the problem of AIDS might increase awareness of tuberculosis. He supported the suggestions made in the report with regard to control activities as well as the establishment of a Special Fund for Tuberculosis.
Dr AZMOUDEH (Islamic Republic of Iran) said that the tuberculosis programme in his country was integrated within primary health care. A surveillance system had been in place since 1990. There had, however, been a continuous increase in the number of cases, from 12 per 100 000 population in 1990 to 36 per 100 000 in 1993. The treatment strategy was based on short-course chemotherapy, and all drugs were distributed free of charge within the primary health care system. Almost 100% of children under the age of 1 year were vaccinated with BCG. The weak point of the programme was that only 7 cases per 100 000 had been found to be sputum-positive. HIV seropositivity rates were very low in the Islamic Republic of Iran, where the increase in tuberculosis was not associated with AIDS. Additional funds had been allocated to promote the national programme.
Dr VIOLAKI-PARASKEVA (Greece) said that the report on WHOis tuberculosis programme made it quite clear that the disease was a major challenge to public health. It was important that tuberculosis control should be incorporated into the primary health care structure. She noted that paragraph 9 of the report stated that morbidity and mortality from tuberculosis among young women were at last being recognized, which was of interest to all people concerned with women's health. The mention in paragraph 32 of the development of new drugs gave hope to developing countries that they might be able to improve control. WHO should continue to promote information and education activities and to train physicians and other health professionals, some of whom might be unaware of the problem of tuberculosis in developing countries. She noted that BCG vaccine provided some protection for young children but asked how adults could be protected. Close collaboration with the Global Programme on AIDS was essential.
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Mr LYKOV (Russian Federation) emphasized that tuberculosis was a problem not only in its own

right but also in combination with HIV infection. The forecasts reported in document A47 / 12 were convincing and alarming, and the efforts of WHO to draw international attention to the problem of tuberculosis were essential. He supported the decision to establish a Special Account for Tuberculosis control within the Voluntary Fund for Health Promotion.

The number of cases of tuberculosis in the Russian Federation had increased by 15% during the preceding two years, and the number of deaths from the disease had also increased. A federal programme had been started to control the disease, with the cooperation of many government and social bodies, at local, state and federal levels. As the Russian Federation had much experience in controlling tuberculosis, he was confident that the current problem of infection with tuberculosis would be overcome.

Dr KARAGULOVA (Kazakhstan) said that the report in document A47/ 12 was of great interest and supported the establishment of a Special Account for Tuberculosis. She regretted that Kazakhstan had not been included in the list given in paragraph 11 of States of the former USSR in which there was a high risk

that the tuberculosis situation would further deteriorate. The problem of tuberculosis in Kazakhstan was serious and was worsening, in both urban and rural areas; it was considered to be of high priority for action.

The situation was deteriorating as a result of the current socioeconomic situation, which meant that inadequate resources were available to operate effective programmes.

Training courses and workshops were the best means of ensuring that WHO'S policy and strategy with regard to tuberculosis were disseminated and implemented at the national level. She hoped that various activities, including training, would be intensified in the region and urged the strengthening of regionally coordinated activities in the Central Asian republics of Kazakhstan, Kyrgyzstan, Tajikstan, Turkmenistan and Uzbekistan.

Mr THORPE (United Kingdom of Great Britain and Northern Ireland) said that the report highlighted a disease that should be accorded the highest priority. He welcomed the emphasis of the tuberculosis programme on training, operational research and publicity, which had contributed to international recognition of the disease. Funds could be raised from outside the United Nations system, as donors from all nations would soon appreciate the cost-effectiveness of tuberculosis control programmes.

Mr OSAWA (Japan) said that the report indicated clearly the nature and magnitude of the global tuberculosis epidemic, the cost-effectiveness of its control, and the consequences of past neglect in both rich and poor countries. The information and education activities of the tuberculosis programme had confirmed WHOls leadership with respect to the problem, but as apathy and neglect of the disease still existed in some parts of the world those activities should be continued. Noting that the report indicated that the proportion of cases of tuberculosis associated with AIDS would increase to 14% by the year 2000, he asked whether collaboration with the global programme on AIDS existed or was foreseen. He noted that the tuberculosis programme had appropriately been given higher priority in the programme budget for 1994-1995 than previously, as it appeared as a separate entity, in the same way as programmes such as those on AIDS and other sexually transmitted diseases and on vaccination and immunization.

Dr TIERNEY (Ireland) commended the report and the strategy contained within it. It was important that the major health problem of tuberculosis continued to be recognized and confronted. The recrudescence of the disease, its association with HIV/AIDS and the development of drug-resistant strains of the bacillus added a new sense of urgency.

While tuberculosis was not a major cause of mortality and morbidity in Ireland, the country was nonetheless reviewing its existing policies and strategies, particularly the role of BCG in disease prevention.

The Department of Foreign Affairs and the Department of Health were committed to providing assistance to countries with a high incidence of tuberculosis and were working with the WHO programme toward that end.

Ireland endorsed the suggestion that additional funding for the programme should be sought by re-allocation of resources.

Mr FREIJ (Sweden), welcoming the informative and concise report, said that development of the tuberculosis programme as a combined action and research programme was to be applauded. A special initiative on tuberculosis would be most timely and merited substantial and continued support from the

regular budget and from the donor community.
Since no disease-specific programme could work in isolation, the initiatives taken for co operation with other programmes within WHO were welcomed. Further information on such essential cooperation and coordination with the health systems research and development programme, the Action Programme on Essential Drugs and the Global Programme on AIDS would be appreciated. Additional information would also be welcome on strategies for the integration of tuberculosis control in primary heath care and on how the gender perspective was included in tuberculosis control activities and operational research.
Ms MIDDELHOFF (Netherlands) said that the Netherlands supported the tuberculosis programme and commended the progress achieved in tuberculosis control, in particular the support given to national programmes. The social aspects of the tuberculosis problem were very important; non-medical issues should also be addressed. The experience gained in various AIDS-control programmes would be useful in

that context. It was also important to ensure cooperation between tuberculosis and AIDS programmes at country level. Further, the strengthening of primary health care services was an essential precondition for sustainable control of tuberculosis.

Dr SHONGWE (Swaziland), welcoming the report, said that tuberculosis was a major public health problem in Swaziland, with prevalence now at an alarming level. The health services were currently overburdened in trying to cope with the disease, a situation exacerbated by the AIDS epidemic. There was a high default rate among tuberculosis patients, which meant that treatment was inadequate and might well lead to drug resistance. The Ministry of Health was committed to WHO policy on the treatment of tuberculosis and appealed to the Organization for technical support to enable the national tuberculosis programme to be further strengthened. Swaziland knew it would have to increase its efforts to combat the disease and to that end was giving high priority to the training of physicians in the diagnosis and treatment of tuberculosis as well as to the strengthening of support services, in particular laboratory and X-ray serv1ces.

Within countries, particular attention needed to be paid to disease surveillance especially at community level. Countries also needed to strengthen their programmes and seek assistance from their neighbours. Swaziland itself was hoping to receive support from other countries in southern Africa as well as assistance from WHO.

Swaziland endorsed the establishment of a Special Account for Tuberculosis.

Professor KOREWICKI (Poland), welcoming the report, said that Poland belonged to a part of the world where the tuberculosis situation had recently been deteriorating, but it was making every effort to cope with the problem. In addition, since its national tuberculosis institute had been designated as a WHO Collaborating Centre for Tuberculosis, Poland hoped to be able to contribute to the strengthening of programme activities in other countries of central and eastern Europe and in the former USSR. In June 1994, a first meeting of programme managers from those countries would be held in Warsaw, organized jointly by the Collaborating Centre and by the WHO tuberculosis programme. The meeting would review the current epidemiology of tuberculosis in the area. In addition the problems faced by programme managers in implementing control activities in their countries would be discussed and analysed and a plan drawn up establishing priorities for action to strengthen national tuberculosis programmes to enable them fully to implement the WHO tuberculosis policy set out in paragraph 12 of the report.

Professor DAI Zhicheng (China), commending the report, said that there was now a need for a global strategy in the control of tuberculosis, otherwise it was unlikely that the programme goal for the year 2000 would be realized. The tasks ahead were arduous. Since high incidences of tuberculosis morbidity and mortality generally occurred in the developing countries, WHO should focus its support and assistance for tuberculosis control on them. Furthermore, it should make tuberculosis control a priority. Budget allocation, technical assistance and training should be adjusted in the light of programme targets.

Dr MELKAS (Finland) welcomed the report, which made plain the health burden of tuberculosis and demonstrated the cost-effectiveness of well-managed control strategies. Support to management of national tuberculosis programmes, as an integral part of existing health structures, was a key act

ivity for WHO.
Persons who had left their own surroundings were an important group at risk from tubercul
osis. In
many countries, the incidence of the disease was much higher among immigrants than among
the native
population. In some, as many as half of all new cases occurred among the immigrant popula
tion. Long-
term control programmes and good case management were more difficult to implement among m
igrating
people, while at the same time their living conditions often increased their exposure to
infection. Special
consideration should therefore be given to the problem in national tuberculosis control p
rogrammes.
Dr KORTE (Germany), commending the report, said that tuberculosis was a health problem th
at was
continuing to receive insufficient attention and support. WHO should therefore be encoura
ged to
strengthen its programme, not merely to respond to epidemiological developments but to fo
restall them in
what would otherwise be an approaching global emergency. It was timely that WHO should ta
ke a forceful
role in developing awareness of the problem and promoting low-cost chemotherapy. Germany
endorsed

the Organization's tuberculosis programme and had supported its activities in 1993 and 19 94, but considered
that a change in budget priorities within WHO was also needed. Germany would, in addition , continue to
provide bilateral support for tuberculosis control to countries at their request as part of its technical
cooperation programme. That channel was still being underused. It was hoped that his coun tryls close
collaboration with WHO could be further expanded to combat the global threat of tuberculo sis.
Dr KHOJA (Saudi Arabia), welcoming the report, said that in Saudi Arabia tuberculosis pri ncipally
affected migrant workers coming in from other countries. It was thus important to coordin ate efforts within
the region in order to combat and prevent tuberculosis. There had been a marked decrease in tuberculosis
in Saudi Arabia during the past three years as a result of special programmes for the ear ly detection and
treatment of cases among incoming workers.
In its efforts to combat tuberculosis, the Organization should encourage countries to avo id treatment
practices that would foster drug resistance. Further, it should promote research to seek new and more
potent drugs with fewer side-effects and requiring less follow-up of patients. Such drugs would be
particularly useful in developing countries. Lastly , it would be very useful for the Org anization to publish
a periodical devoted to tuberculosis Which would provide information on changes in the in cidence and
spread of the disease, the geographical distribution of drug resistance, new methods for combating the
disease throughout the world, experience gained in various countries and recommendations on training.
He endorsed the view that the Organization should review its position on BCG and include immunization of all the worlds children with the vaccine within the Expanded Programme on Immunization.
He agreed with the delegate of Italy that tuberculosis control was cost-effective. A usef ul measure would
be the adoption of an international day, on the lines of International AIDS Day, to highl ight the need to
control tuberculosis.
Dr MAHATI-IEVAN (Malaysia), welcoming the report, expressed appreciation of the new WHO policy of global targets for tuberculosis. Malaysia adhered closely to the strategies add ressed in the
document and hoped to eradicate tuberculosis in the near future. Appropriate priority, in terms of financial
resources and manpower, was being given by the Ministry of Health to the national tubercu losis programme.
Through such measures, it was hoped to increase case finding and raise the treatment comp letion rate to
85% in the near future. The national tuberculosis control programme was an integral part of the primary
health care programme; technical leadership was provided by a central unit. Close collabo ration was
maintained with nongovernmental organizations through the Malaysian Association for the P revention of
Tuberculosis, which was affiliated to the International Union against Tuberculosis and Lu ng Disease.
Training of doctors and paramedical staff was being given close attention and strengthene d from time to
time. However, current constraints included an increasing number of HIV infections and an increasing
incidence of tuberculosis, particularly among the immigrant population and migrant worker s.
Malaysia endorsed the establishment of a Special Account for Tuberculosis.
Dr MOURA FE (Brazil), commending the report, said that currently about 8 million new case s of
tuberculosis occurred annually throughout the world with 2.7 million deaths, 90% of them in the developing
countries. Although tuberculosis had re-emerged in the industrialized countries of Europe

and North
America in the past few years, the majority of cases were still occurring in developing countries, which had
led WHO to declare the disease a worldwide priority. Although historically tuberculosis had generally
struck persons affected by other disease or living in adverse circumstances, the HIV/AIDS pandemic had
brought a new element into the pattern of mycobacterial infection. The burden of the increasing poverty
of the world population and the spread of HIV infection had led to an increase in the number of people
with tuberculosis.
Tuberculosis was still a major public health problem in Brazil. During the past decade, reported new
cases ranged from 80 000 to 90 000 a year. Although incidence had declined slightly in the period 1980-
1992, the number of cases remained frighteningly high. Mortality from tuberculosis had decreased
significantly following the introduction of chemotherapy but still remained high in all parts of the country,
the figure for 1989 being 3.8 per 100 000. HIV/AIDS did not affect the Brazilian population uniformly but
had progressed most rapidly in the poorest communities, which lacked access to information and health
facilities. Such communities also had a high prevalence of tuberculosis. The association between the two

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diseases posed a challenge to the health authorities, tuberculosis being the third most common illness seen in AIDS patients, and was a serious threat to control programmes throughout the country. It placed an additional burden on an already overstretched health service. There was an urgent need for the tuberculosis and AIDS programmes within WHO to join together to tackle the problem.

The meeting rose at 17h35