

✓ MOC/CTD/97.3

DIVISION OF CONTROL OF TROPICAL DISEASES

**REPORT OF THE  
MEETING OF  
COLLABORATING PARTNERS**

**17-18 JUNE 1996**



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**DIVISION OF CONTROL OF  
TROPICAL DISEASES  
(CTD)**

**REPORT OF THE MEETING  
OF COLLABORATORS  
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## **INTRODUCTION**

The Division of Control of Tropical Disease's Meeting of Collaborating Partners (MOC) took place in Geneva on 17-18 June, 1996. The agenda and a list of participants are provided at the end of this document. During the meeting a number of presentations were made to inform the participants about global progress, some obstacles and opportunities, and more detailed consideration of three national programmes (Bolivia, Ethiopia and India).

The meeting was opened by Dr Ralph Henderson, ADG who welcomed all the participants to Geneva and thanked them for their valuable time. He continued by giving some background to the Division of Control of Tropical Diseases (CTD), explaining how the programme came into being in 1990 through the amalgamation of the Malaria Action Programme, Parasitic Diseases Programme and the Division of Vector Biology and Control and Leprosy Control Programme. The decision to bring these programmes into a single technically strong division was taken with the intention of streamlining the work of the Organization through an integrated approach to disease control.

Furthermore, he explained that CTD is not a traditional donor supported WHO programme and that attending participants had been invited to seek a way forward to establish a true collaborative partnership. As mentioned in the 1996 World Health Report, the Organization is devoted to fighting disease and fostering development. The report indicates that we stand on the brink of a global crises in infectious diseases, that no country is safe from them, and that no country can afford to ignore their threat. Global change will only be brought about by working together.

Inequalities in health status continue to widen by social class and development status within many countries, leaving a large proportion of the population at risk to ill health. Malaria, above all the tropical diseases, thrives best among populations living in impoverished conditions with poor access to health.

Through the past year the Division has developed or revised strategies for all the mandated diseases, the tools have been made available and the way forward is clear for careful implementation. However, this cannot be undertaken alone with the 100 or so Member States where these diseases are endemic. A well orchestrated, dynamic effort is required involving collaborating partners who share the same commitment to reduce the global burden of disease suffering and death.

The Chairman for this meeting was Professor A. Degrémont of the Swiss Institute of Tropical Medicine and the Rapporteur was Dr A. Deyal from PAHO.

## **OBJECTIVES**

The meeting was convened to discuss the progress that has been made and the needs which are still outstanding. It focused primarily on providing information about the Division's activities, priorities, financial and technical resources available, as well as the current CTD control and eradication programmes and the plan of activities for the biennium. Discussion was invited on strengthening existing collaborative mechanisms, identifying new areas for partnership and mobilizing additional resources for implementation of control programmes in the field. Although not a formal management or policy-making body, it was intended that the deliberations together would influence the future direction of the programme.

## **BACKGROUND**

Within WHO Headquarters, CTD is one of the very few regular budget programmes that has opted to bring together its main collaborators on a regular basis. In so doing, it is hoped to create an open forum where issues can be freely discussed in order to move towards a more coordinated approach to reduce the global burden which these diseases impose. The first of these meetings was in September 1993 and was designed to follow up the 1992 Ministerial Conference on Malaria. That Meeting of Interested Parties, as it was called, was then extended to address the other tropical diseases in the second meeting, which was held in September 1994. For the Director of the Division, Dr Kazem Behbehani, it was the first opportunity to bring together the main CTD partners and share with them his vision for the future.

Fundamental changes have been made since the last meeting in 1994. Leprosy control, which was one of the mandated diseases, became a separate Action Programme for Elimination. In addition, The Director General transferred the responsibility for the control of intestinal parasites to CTD for better delivery of health care at the grass roots level. A few weeks prior to the meeting, the 49th World Health Assembly<sup>1</sup> expressed its concern at the seriousness of the global malaria situation and stated that its control is a major global priority, especially for Africa, for which adequate resources should be allocated. ECOSOC and the United Nations General Assembly voiced similar concerns in 1994 and 1995.

## **WHO PROGRAMME FOR CONTROL OF TROPICAL DISEASES**

Apart from causing many millions of deaths, infectious diseases, especially the tropical diseases, reduce the quality of life of millions of people, reduce land availability for cultivation and human habitation, damage productivity, divert scarce household resources and even inhibit the growth and educatability of children - the future of these affected countries.

The cost of these diseases in developing countries is difficult to assess. However, from case studies the cost of an average case of malaria in sub-Saharan Africa has been calculated as equivalent to about 12 days of productive output. The total cost for the area in 1995 was projected at over US\$1.6 billion or 1% Gross Domestic Product. Studies from various countries revealed that an average cost of a malaria case is US\$11.8 and that those affected are unable to work for 22% of the time during the course of a year. It is also estimated that on average 5.3 school days are lost every time a school age child suffers from malaria. Furthermore, in Nigeria the losses for rice production have been calculated as about 12% of person-days as a result of guinea worm infections.

On the positive side, the WHO Onchocerciasis Control Programme, launched in 1974 in West Africa, has added more than 1.7 million additional years of productive labour and made available an additional 25 million hectares of land for agricultural production. This could feed 17 million more people per year.

The CTD mission is to provide support to country activities through the Regional Offices, to promote, advocate and coordinate tropical diseases control with the aim of improving the health status of individual communities and populations, and to contribute to social and economic development. In order to accomplish these tasks, CTD is helping countries to develop plans of action and to implement them. However, the Division needs to review these activities and coordinate donor contributions. The Division recognizes and appreciates the bilateral contributions to national tropical disease control programmes by many governments and agencies.

Great emphasis is placed on human resources development and national capacity building. CTD has embarked upon a global needs assessment, is producing new materials, including computer assisted learning programmes, and updating existing ones.

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<sup>1</sup> In resolution WHA 49.11

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This is only possible by financial and in-kind contributions from collaborators such as the governments of Australia, Denmark, Italy, The Netherlands and the United Kingdom, institutions such as the Danish Bilharziasis Laboratory, the Italian Institute of Public Health, the University of Rome, the Malaria Consortium and the Liverpool School of Tropical Medicine, as well as private donors in Kuwait and industrial partners such as Bayer AG, SmithKline Beecham and other members of the MANTEAU consortium.

CTD has also paid attention to developing human resources within the Division by providing all staff with up-to-date computer equipment and training courses on the use of essential software, including Geographical Information Systems (GIS). To recycle equipment no longer required at headquarters, control programmes in the field have benefited from computers and computer accessories.

Professional staff have participated in management training courses and the Division has opted for the new WHO staff performance appraisal system. Both professional and general service staff have undergone a series of training sessions on this new system and are now entering into the implementation phase.

CTD is increasingly collaborating with other Divisions within the Organization, especially TDR, CHD<sup>2</sup>, SSC<sup>3</sup> and EHA<sup>4</sup> and are using Expert Committees, study groups and scientific groups to develop control strategies and technical guidelines.

During the annual joint retreat with TDR this year, the areas of applied field research essential to direct improvement of the control activities at the country level were defined. The Division continues to collaborate with the Sick Child Initiative which is now the responsibility of CHD. Collaboration has been strengthened with the United Nations System and confirmation has been received that UNICEF wishes to work with the Division in malaria control.

Renewed activities with the World Bank resulted in a joint meeting at the end of 1995 to address the operational problems of malaria control. One of the recommendations was to set up a Malaria network on the Internet to establish a forum for exchange of information on the malaria problem globally. The collaboration with the Bank extends also to providing technical expertise to Bank supported programmes such as in Madagascar.

In addition, a new partnership with the European Commission was established to develop malaria control projects for Cambodia, Laos and Viet Nam. CTD together with the Western Pacific Region of WHO, continues to provide expertise to the European Commission and the three countries involved in this important undertaking.

Close collaboration has continued with UNHCR and the Division has responded to emergency problems in refugee camps and has assisted the ICRC in the prevention of typhus among prisoners in Burundi.

As the problem of tropical diseases is a global one, CTD is continually looking for opportunities for new partnerships, including non-governmental organizations (NGOs), industry, private enterprises and other groups who have a rapport with communities in endemic areas and who are working with community health workers.

This support to communities can take many forms and already such collaborators are offering to bore wells for drinking water, provide impregnated mosquito nets and to contribute to other much needed elements for the implementation of control strategies. In fact CTD is taking every opportunity to ensure that objectives are achieved by increasing contacts with its partners so that as many planned activities as possible are implemented. A very recent example is the interest shown by Rotary International to extend their global network to fight malaria.

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<sup>2</sup> Division of Child Health and Development

<sup>3</sup> Division of Strategic Support to Countries in greatest need, which was previously ICO

<sup>4</sup> Division of Emergency and Humanitarian Action

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Most of the available control tools used in the field today are very old. An increasing problem is resistance of the parasites and the vectors to drugs and insecticides, which necessitates urgent and continuous development of new means of control. Control strategies have been developed or revised for all the diseases that come under CTD's mandate.

### ***Malaria***

The attitude towards malaria control is changing in the political arenas of the United Nations, World Health Assembly, the World Bank and the European Commission to mention just a few. There is renewed interest in working with WHO as the lead agency in this field and, as mentioned earlier, the Division is fostering closer ties within and outside the UN system.

Funding for malaria has been slightly increased thanks to the governments of Greece, Italy, Japan, Lebanon, the Netherlands, Spain, Sweden and the United Kingdom and the World Bank. The funding situation, however, is by no means satisfactory. The resources available, especially for Africa, are inadequate compared with the size of the problem.

Over 90% of all malaria cases in the world occur in Africa and we need to intensify activities at the country level, to try to make some impact on the burden it causes. These endemic countries rely on WHO for their strategy development, technical guidance and training.

Despite all the improvements seen in recent years, there is great concern about the malaria problem in the world, especially in Africa. To improve our response, the Division is in the process of restructuring the malaria programme. The global malaria situation will be re-evaluated, to bring to the attention of the donor community important gaps which need to be filled to make a significant impact in reducing this disease.

### ***African Sleeping Sickness***

The Division has been very much concerned with the recent increase in the number of patients suffering from sleeping sickness especially in Angola and Zaire. The problem is compounded by the lack, or breakdown, of the surveillance system. Fortunately there has been renewed interest by the French and Belgian governments to support the programme which already benefits from contributions from AGFUND, and by Rhone Poulenc Rorer which contributes by providing the specific drug pentamidine to the Programme.

### ***Lymphatic Filariasis***

Affordable tools are now available to tackle this disease which affects over 120 million people in 76 countries. In fact this disease is now targeted for elimination as a public health problem. Coordinated efforts will be necessary to implement the control/elimination strategy, and Merck and Company Inc. has agreed to provide Ivermectin (Mectizan®) free as one of the essential drugs to be used.

### ***Leishmaniasis***

The emergence of *Leishmania*/HIV co-infections calls for urgent action to bring this disease under control and we are supporting national control programmes and helping to contain the upsurge of severe and deadly epidemics. Support has been received in this endeavour from the Governments of Belgium, France, Spain, Switzerland, the United Kingdom and from The London School of Hygiene and Tropical Medicine and private donors in Kuwait.

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Drs Desjeux (CTD) and Majori (Institute of Health, Italy) made presentations on the increasing incidence of *Leishmania*/HIV co-infections due to the spread of the AIDS pandemic in suburban and rural areas of the world. Simultaneously it is estimated that 500,000 new clinical cases of visceral leishmaniasis (VL) occur annually, and 200 million people live in endemic areas. VL is endemic in 62 countries around the world and is spreading in several new areas owing to epidemiological changes, such as urbanization in Brazil, and/or to mass migration as in the Indian continent.

*Leishmania*/HIV is considered as an "emerging disease" especially in Southern Europe where 25% of 70% of adult VL cases are related to HIV infection and 1.5% to 9% of AIDS cases suffer from newly acquired or reactivated VL. In May 1995, the total number of *Leishmania*/HIV co-infections in the Mediterranean area was estimated at more than 1,000 cases, indicating a sharp increase. Most co-infections reported in the New World are from Brazil. In eastern Africa *Leishmania*/HIV co-infections reported were from Ethiopia, Kenya, Malawi and Sudan. In Asia, the first cases of *Leishmania*/HIV co-infections were recently reported from India and it is anticipated that this problem will augment.

### **Guinea Worm Disease**

This disease is targeted for elimination and we are grateful to the donor agencies who are fully supporting the eradication programme, especially in the remaining 18 endemic countries. In 1986 there were an estimated 3.5 million cases globally; by 1995 this number had been reduced to less than 130,000, and 5 countries had less than 100 cases!

The success of this eradication programme is due to its implementation by affected communities, in the most remote areas of the world, as well as to strong collaboration between agencies of the UN system, such as, UNICEF, UNDP and the World Bank. Contributions have been received from various bilateral donors and the OPEC fund. In addition nongovernmental organizations such as Global 2000 and private industry including Du Pont, Precision Fabrics Group and American Cyanamid, are supporting the programme.

Dr Hervé Périès, from ITECH, Ouagadougou, Burkina Faso presented the global situation of the eradication programme and discussed programme developments in western and central Africa. Since the implementation of surveillance and control activities i.e. provision of clean drinking water, filtration of water, active recording and isolation of guinea worm cases and chemical treatment of infected waters, results in Cameroon, Senegal, Chad, Ghana, Nigeria, Uganda and Togo have been spectacular.

It was emphasized that community participation was vital in the implementation of control activities, however some areas most at risk were inaccessible to health care teams and lack provision of clean water. Furthermore these regions are inhabited by nomadic peoples who have not been exposed to guinea worm education and information. These factors inhibit active surveillance and slow down the process for eradication. Taking this into consideration, control strategies have been adapted to specific zones, many providing treatment for guinea worm within an integrated health care programme, linked to polio, malaria, leprosy, parasitic infections, diarrhoeal diseases, and respiratory infections. In this way the cost of surveillance is shared, wider exposure is achieved, and the eradication process is continued throughout the certification phase in endemic and non-endemic areas.

UNICEF is one of the very strong partners in the Guinea Worm disease eradication effort. The Joint WHO/UNICEF Health Mapping technology is crucial in this programme and it will continue to promote Geographical Information Systems. This management and decision-making tool is now being offered by CTD to other programmes.

### ***Dengue and Dengue Haemorrhagic Fever***

This is the only viral disease within CTD's mandate and this Division is responsible for the development and implementation of the prevention and control strategy, which is based on selective integrated vector control, with community participation. Training is an important element in this strategy for which training materials are being developed and workshops conducted. Support has been received from AusAID and USAID.

### ***Schistosomiasis and Intestinal Parasites***

This programme is aimed at reducing the number of infections caused by Schistosomiasis, foodborne trematodes and intestinal parasites. It is anticipated that by the year 2001 there will be fewer than 60 million schistosomal infections and fewer than 30 million foodborne trematode infections in the world. Valuable support has been received from Ciba Geigy, the German Pharma Health Fund, Italian Government, The Rockefeller Foundation, the Edna McConnell Clark Foundation, USAID, UNDP and the World Bank.

### **WHOPES**

The WHO Pesticide Evaluation Scheme (WHOPES) is the only international programme which promotes the development and evaluation of new pesticide products and formulations, and pesticide application equipment for use in public health.

The Division is working in very close collaboration not only with other programmes within WHO but also with national disease control programmes, international organizations, industry, and the pesticide manufacturers association.

Notwithstanding the programmatic changes that have now been made, the effectiveness of WHOPES was compromised for a number of years. As staff performance is a top priority for this Division, CTD is now in the process of finalizing the recruitment of a new staff member for this important position.

### ***Chagas Disease***

This disease has been targeted for elimination from Latin America before the year 2010 by interrupting vector transmission and by the systematic screening of blood donations. CTD provides technical advice to three initiatives (Southern Cone, Andean and Central American) which have been launched to eliminate this disease.

Dr J. Torres-Goita from the Ministry of Health, Bolivia addressed the meeting and presented the recent success brought about by community participation in disease control. Important progress in house desinsection has been made in this country and improvement was reported for the first time since 1992. It is planned to cover 32% of the endemic area in 1996-97 which is an enormous effort in view of the scarcity of resources. The activities have been centred as a first priority in highly endemic areas of Potosi, Tarija, Chuquisaca, Santacruz and La Paz: 26,000 houses were sprayed (60% of the goal for 1995) and 26,000 houses were improved (82% of the 1995 goal). Popular participation is the key element in the improvement of integrated disease control in this country.

### ***Capacity building***

Capacity building is the development of the national competence to control tropical diseases through training and retraining of personnel, the development and implementation of appropriate recruitment and career policies, the provision of facilities and resources and the development of information, communication and supply systems. The lack of human resources development for the control of tropical diseases was clearly identified during the meeting.

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There is not only a shortage of trained people for control, but often those who have been well trained, take up other activities where there are better opportunities and facilities. In the absence of financial incentives for health personnel, it is necessary to improve job satisfaction. Capacity building can contribute to that especially training as a continuous process together with improvement of work facilities. CTD has made an effort to operationalize capacity building globally by initiating a process of needs assessment at country level.

To date 43 Member States have responded. This will form a solid basis upon which to develop national training programmes, associated infrastructure development and to plan CTD's capacity building activities. The major priority areas identified by the countries are clinical and laboratory diagnosis, diseases management, vector control, communications, and planning, management and evaluation. Some countries have also identified infrastructure development needs.

CTD's role is to support countries in the needs assessment process and to develop realistic training programmes, to develop training materials in different formats based upon the identified needs, quality assurance, evaluation of training activities and resource mobilization. Training materials also need to be adapted for regional differences and to take into account cultural and language requirements.

## **STRATEGIC ISSUES**

The Division is increasingly exploring possibilities and opportunities for a comprehensive package approach, in the context of primary health care, to provide a more cost-effective delivery of control measures at the country level. The Division has recently embarked upon an inter-divisional, multi-disease approach to control in Eritrea. This and other projects, such as the ongoing collaboration with the Sick Child Initiative, are learning experiences showing how best to work and what needs must be adjusted.

A second approach, is the provision of two or more tropical disease interventions as an integrated package in the field. In order to achieve this on a much wider scale than in the past, the Division has assigned the responsibility to coordinate control activities in a number of countries to a few professional staff. This will provide a more cost effective delivery of services to the country. Success and constraints of this approach will be monitored and reported at the next meeting.

The structure of the Division is currently under review. At present, due to a shortage of resources, some activities have been assigned one staff member per disease, which represents a semi-vertical approach. In order to enhance the coverage of the services to Member States, in a more coordinated fashion, a feasibility study is being undertaken to regroup several activities together. This reorganization, based upon a comprehensive review conducted in 1995 by the WHO Office of Staff and Management Development, will take place shortly. At the same time activities will be evaluated in accordance with the Division's established work plans. Another essential change is to create a technical consultation process and to achieve this a Technical Advisory Group has been proposed.

The control of tropical diseases is often hampered by setbacks at the country level. Malaria especially, is a resurgent disease, if the control pressure is not sustained. These programmes are among the first to break down in times of political and social disturbances. There are many examples in the world today, specifically in Africa but not confined to that continent. An example in Europe is that of rapidly spreading malaria in Azerbaijan. In 1960 malaria was practically eradicated. Now malaria has spread to nearly two thirds of the country mainly because of the recent influx into the south of large numbers of displaced persons. A viable global programme is required but there must be enough flexibility in the system to respond immediately to these sudden situations.

The Division has built a foundation upon which to fight tropical diseases, those which are among the least-well supported, affecting millions of marginalized and deprived people. In order to improve the health of those who look to us for aid, closer collaboration is required to bring these threatening diseases under control.

## **BUDGET OVERVIEW**

To date the resources available to the Division are not sufficient to complete the planned activities. In an effort to make more cost-effective use of the limited resources, the Division is merging staff activities to provide support to integrated control at the country level. Increasingly, collaborating centres are carrying out activities jointly or on behalf of the Division. In order to achieve this, copies of a detailed plan of activities covering all aspects of the programme have been sent to more than 40 CTD Collaborating Centres and to all WHO Country Representatives so that they may identify areas where they could contribute to the achievement of joint objectives. Responses from centres and WHO Representatives have been received. Furthermore, a revision is being undertaken of panels of experts with a view to increasing the use of their expertise as, and when, needed.

In response to the recommendations made at the previous meeting, a new financial monitoring system linked to the work plans has been developed. For the 1996-97 biennium, CTD has invested considerable efforts in planning its global, regional and country activities for controlling tropical diseases. The resulting detailed plan of activities is presented in a separate document. A spirit of partnership governed this exercise and the participation of all concerned, both inside WHO and outside of the Organization, was sought with a common goal of strengthening countries capabilities in their efforts to reduce the number of people suffering from tropical diseases and preventing new infections. It is hoped that this plan will facilitate the coordination of the Programme's activities at regional and country level. It is also hoped that this plan of activities will enable a greater involvement of WHO Collaborating Centres throughout the world, thus ensuring a better use of the resources available in countries and a more cost-effective implementation of control activities. The plan provides a basis for the development, with the donor community, of a constructive and fruitful partnership.

The 1996-97 proposed budget was established on the basis of the CTD plan of activities. To carry out the activities described in the plan US\$ 29,717,846 would be necessary.

In January 1995 the Executive Board recommended to the Director General of WHO to shift resources from low-priority to high-priority programmes. This was endorsed by the World Health Assembly of the same year (WHA 48). In this context, CTD was granted an additional US\$ 1,000,000 for malaria control and dracunculiasis eradication, bringing the regular budget for activities for this biennium to US\$ 4,516,684. However, due to reductions in the overall 1996-97 WHO budget, the share of the regular budget for activities in CTD dropped down to US\$ 1,716,340 corresponding to a reduction of 62%. This will have important consequences and will put the implementation of the full programme of work in jeopardy.

Extrabudgetary funds including voluntary contributions made or pledged to WHO in support to CTD activities as of 31 December 1995 amount to US\$ 3,052,208. Despite these extrabudgetary funds which will be used to carry out activities in the field, there remains a shortfall of US\$ 16,632,350. Additional extrabudgetary funds will need to be secured if the planned control activities are to be carried out with a reasonable chance of reaching the targets.

## CONCLUSIONS

1. The tropical diseases as a group impede social and economic development and impose an unacceptable burden of mortality and morbidity, especially in Africa. Unless the death and suffering they cause can be reduced, the future prospects of families, communities and whole nations will be severely compromised.
2. WHO has given high priority to the prevention, control and, where feasible, eradication of tropical diseases. This priority has been reinforced by recent resolutions passed by the World Health Assembly. The meeting was surprised to learn that, despite this stated priority, the regular budget allotment to CTD had been drastically cut, especially support to the malaria control programme. Concern was expressed that the work of CTD could be seriously undermined if this situation was allowed to continue. It is to be hoped that WHO allocates the funds that have been promised, and that extrabudgetary funding increases to maintain the momentum that the programme has gathered in recent years.
3. CTD priority setting for its activities was greatly appreciated by the meeting, especially in the manner in which priority one activities have been implemented at a time of budgetary shortfalls.
4. The global control and eradication strategies developed by CTD provide a sound basis for national disease control programme planning. It is recognized, however, that these strategies need to be implemented with sufficient flexibility to permit the responsible programme managers to find the best way to integrate control methods within the national public health system. CTD is encouraged to explore and develop a comprehensive "packaging" approach which facilitates adaptation of disease control strategies to the different needs of central, district and community levels, with particular attention given to the importance of community participation in this process. It is critical that the shortfall identified for CTD country-support activities be overcome to allow this new initiative to continue on a strong footing.
5. Human resources development and national capacity building are recognized as the keys to successful achievement of the objectives and goals agreed upon. CTD should continue to refine its methods for assessing training and capacity building requirements on a country by country basis. The shortfall of funds identified needs to be urgently addressed. Collaborating institutions and agencies are invited to increase their support in this area, especially at country level.
6. The participation of representatives from the private sector in this meeting was much appreciated. The recent progress that has been made in strengthening industry collaboration in the WHO Pesticide Evaluation Scheme (WHOPES) provided very real evidence of the benefits to be achieved. CTD is encouraged to continue this line of development, and to explore other innovative ways of involving the private sector in its programme.
7. The purpose of MOC 1996 was to share up-to-date information concerning control strategies, progress and the outlook for the future for the diseases for which CTD is responsible. The sense of the meeting was that this was a more constructive exercise than previous ones. The documentation provided during the meeting, which described technical progress as well as the financial status of the programme, was much appreciated. Nevertheless, there still remained the difficulty of finding the right balance between technical presentations and those that concentrated on programme progress, constraints, needs and future directions. Also, the role of the voluntary contributions and their carryover from one biennium to the next needed to be more clearly described in the financial report.

It was agreed that, in the future, separate consideration would be given to the technical issues by a Technical Advisory Group (TAG), which would precede that of the meeting of collaborators (MOC), whose focus would be on programme development issues. Both meetings should be organized to take place close enough to meetings of TDR and other WHO collaborating programmes to facilitate the widest participation of the most appropriate agencies and individuals.

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## AGENDA

### Monday 17 June

13.00 hrs	Opening	Dr R.H. Henderson
13.10 hrs	Strategic Issues in tropical diseases control	Dr K. Behbehani
13.40 hrs	Malaria Introduction	Dr A. Kondrachine
	Resistance to antimalarial drugs in Africa	Dr O. Walker
	Community based malaria control in Ethiopia	Mr T. Adhanom
	Opportunities for the future of malaria control	Dr B. Liese
14.40 hrs	Discussion	
15.10 hrs	African Trypanosomiasis Introduction	Mr P. Cattand
	African Trypanosomiasis	Dr M. Ekwanzala
15.40 hrs	Dracunculiasis Introduction	Dr P. Ranque
	Dracunculiasis Eradication	Dr H. Périès
16.00 hrs	Break	
16.20 hrs	Lymphatic Filariasis Introduction	Dr E. Ottesen
	Lymphatic Filariasis control - New approaches in India	Dr G. Biswas
16.40 hrs	The Leishmaniases Introduction	Dr P. Desjeux
	The Leishmaniases and Leishmania/HIV co-infection - an increasing threat	Dr G. Majori
17.00 hrs	Discussion	
17.30 hrs	Close	

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## AGENDA

### Tuesday 18 June

09.00 hrs	Human Resources Development Introduction	Dr P. Beales
	Human Resources Development for the control of tropical diseases	Prof. T. Chongsuphachaisiddhi
09.30 hrs	Effectiveness of population participation in control of tropical diseases. Examples of Malaria and Chagas Disease control in Bolivia	Dr J. Torres-Goitia
09.50 hrs	Health mapping for surveillance & management of tropical diseases	Mr J.-P. Meert
10.10 hrs	Budgetary Uncertainties	Dr M. Karam
10.40 hrs	Break	
11.00 hrs	Discussion	
11.30 hrs	GIFAP, The Function and Collaboration with WHO	Dr G.H. Hesse
12.15 hrs	Collaboration with our partners in health	Dr N.O. Christensen Dr I. Périn
12.30 hrs	Lunch	
13.00	Demonstration of the Malaria Network, CTD Home Page - World Wide Web, Plan of Activities, Country Profile	
14.00 hrs	Discussion on the outlook for tropical disease control	
16.00 hrs	Break	
16.30 hrs	Discussions and recommendations (continued).	
17.30 hrs	Summing up	
17.40 hrs	Closure of the Meeting	

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## LIST OF PARTICIPANTS

<b>Australia</b> Mr Angus McDonald	The Permanent Mission of Australia to the United Nations Office at Geneva
<b>Arab States (League of)</b> Dr O. El Hajjé Mr. Talal Shubailat Mr Samer Sef Elyazal	Permanent Mission of the League of Arab States to the United Nations Office Permanent Mission of the League of Arab States to the United Nations Office Permanent Mission of the League of Arab States to the United Nations Office
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<b>Brunei and Darussalam</b> Mr Hamid Mahd Jaaafar	Mission of Brunei and Darussalam to the United Nations Office at Geneva
<b>Canada</b> Ms Alex Volkoff  Dr Jean Lariviere Mrs Danielle Testelin	Director Gen. Multilateral Technical Cooperation Division, Canadian Int. Development Agency International, Affairs Directorate, Ministry Health and Welfare Snr Prog. Officer, Multilateral Technical Cooperation Division, Canadian Int. Development Agency
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<b>CIBA-GEIGY</b> Dr Catherine Royce  Dr Yvonne Severne	Foundation for Cooperation with Developing Countries, CIBA-GEIGY, Basle, Switzerland Head, Regulatory Group Oncology/Infectious Diseases, Central Drug Regulatory Affairs, CIBA-GEIGY, Basle, Switzerland
<b>European Commission</b> Dr Marc De Bruycker	European Commission, Brussels, Belgium
<b>France</b> Docteur Pierre Eozenou Docteur C. Guilhou  Docteur J.-G. Moreau	Ministère de la Coopération française et du Développement, Paris Direction des Nations Unies et des Organisations Internationales, Ministère des Affaires Etrangères, Paris Division des Relations Internationales, Mission OMS, Ministère des Affaires Sociales de la Santé et de la Ville, Paris
<b>German Pharma Health Fund</b> Dr Joachim Ernst	Member of the Board, German Pharma Health Fund, c/o Bayer AG, Germany
<b>GMBH</b> Dr Rolf Korte	Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GMBH, Germany
<b>IFPMA</b> Dr O. Morin	International Federation of Pharmaceutical Manufacturers Associations (IFPMA), Switzerland

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**IFPMA (continued)**

Ms Margaret Cone                      International Federation of Pharmaceutical Manufacturers Associations (IFPMA),  
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**Italy**

Docteur G. Schiavoni                  Mission Permanente de l'Italie auprès de l'Office des Nations Unies à Genève et des  
Institutions spécialisées ayant leur siège en Suisse  
Dr Marta di Gennaro                  Ministry of Health, International Relations Office, Rome  
Mr Eduardo Missoni,                  Health Expert, Central Technical Unit, Directorate General for Development  
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**Institut d'Hygiène et de Médecine tropicale**

Professeur C. Ferreira                Institut d'Hygiène et de Médecine tropicale, Lisbon, Portugal

**Institut Suisse de Médecine Tropicale**

Prof. Antoine Degrémont            Director, Institut Suisse de Médecine Tropicale, Bâle, Switzerland

**Kardinska Institute, Sweden**

Dr Anders Bjorkman                  Ass. Professor, Stockholm, Kardinska Institute, Sweden

**Lebanon**

Mr Ghassan Moallem                Mission of Lebanon to the UN & other specialised agencies in Geneva

**Luxembourg**

Mme D. Hansen-Koenig              Directeur General de la Santé, Ministère de la Santé, Luxembourg  
M. Alain Weber                      Mission permanente du Grand-Duché de Luxembourg auprès de l'Office des Nations  
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**National Institute of Communicable Diseases**

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**Netherlands**

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Mr A.P. Uijterlinde                  Deputy Head, UN Aid Section, Multilateral Development Cooperation and  
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**OCCGE**

Professeur A.G Rahli                Secrétaire général, Organisation du Coordination et Cooperation pour la Lutte contre  
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**OCEAC**

Docteur Auguste Manene            Secrétaire Général, Organisation de Coordination pour la Lutte contre les  
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**ORSTOM, France**

Docteur B. Philippon                Département Santé ORSTOM, Paris

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Dr David Smith                      Acting Director, Liverpool School of Tropical Medicine  
Ms Jenny Hill                        Malaria Consortium Head, London School of Hygiene and Tropical Medicine  
Dr Harrison Spencer                Dean, London School of Hygiene and Tropical Medicine, London

**SmithKline Beecham Pharmaceuticals**

Dr Manouchehr Yazhari            Community Treatment International, SmithKline Beecham Pharmaceuticals  
Dr John Horton                      Head of Tropical Therapeutics SmithKline Beecham Pharmaceuticals

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**Switzerland**

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Monsieur J.F. Giovannini

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Direction de la Copération au Développement et de l'Aide Humanitaire(DDA),  
Berne

**UNESCO**

Monsieur Henri Lopes  
Monsieur P.L. Malhotra

Assistant Director General, UNESCO, Paris  
Officer-in-Charge, UNESCO Liaison Office at Geneva

**United Kingdom**

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Mr T. Simmons  
Ms Helen Frary

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Mission of the UK. to the UN Office & other International Organizations at Geneva

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Health Attaché, US Mission to the U.N. Office & other Int. Organizations at Geneva

**World Bank**

Dr David de Ferranti  
Dr Bernhard Liese  
Mr Tom Merrick  
Ms Mathur Dipika

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Director, Health Services Department, The World Bank, N.W. Washington D.C.  
Human Development Department, The World Bank, N.W. Washington D.C.  
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## WHO REGIONAL OFFICES

Dr A.E. Afari	AFRO
Dr A.Deyal	PAHO
Dr N.I. Neouimine	EMRO

## SPEAKERS

Mr T.Adhanom	Tigray Health Bureau, Ethiopia
Dr G. Biswas	National Institute of Communicable Diseases, New Delhi, India
Prof. T. Chongsuphachaisiddhi	Mahidol University, Bangkok, Thailand
Dr N.O. Christensen	Danish Bilharziasis Laboratory, Denmark
Dr M. Ekwanzala	Central Trypanosomiasis Office, Kinshasa, Zaire
Dr G..H. Hesse	Bayer AGM, Germany
Dr B. Liese	World Bank, USA
Dr G. Majori	Instituto Superiore di Sanita, Italy
Dr H. Périès	UNICEF, Abidjan, Cote d'Ivoire
Dr I. Périn	European Commission, Brussels, Belgium
Dr J. Torres-Goita	Ministry of Health, Bolivia
Dr O. Walker	AFRO Brazzaville, Congo

## CTD STAFF

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Ms A. Chadarevian	Ms K. O'Neill
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Dr P. Desjeux	Dr C.P. Ramachandran
Dr P. Herath	Dr P. Ranque
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Miss T.R. Jorgensen	Dr F. Rio
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Dr A. B. Knudsen	Dr A. Seim
Dr A. Kondrachine	Dr A. Teklehaimanot
Dr R. Kouznetsov	Dr P. Trigg
Dr S. Litsios	Dr M. Zaim
Mrs V. Mattei	