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EXECUTIVE BOARD

Eighty-ninth Session

PROVISIONAL SUMMARY RECORD OF THE EIGHTH MEETING

WHO Headquarters, Geneva
Thursday, 23 January 1992, at 14h30

Chairman: Professor O. RANSOME-KUTI

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EIGHTH MEETING

Thursday, 23 January 1992, at 15h15

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The meeting was held in private from 14h30 to 15h00 and resumed in public at 15h15.

1. **APPOINTMENT OF THE REGIONAL DIRECTOR FOR THE EASTERN MEDITERRANEAN:** Item 5 of the Agenda (Document EB89/9)

Dr YOOSUF (Rapporteur) read out the following resolution adopted by the Board in private session:[1]

The Executive Board,
Considering the provisions of Article 52 of the WHO Constitution and Staff Regulation 4.5; and
Considering the nomination and recommendation made by the Regional Committee for the Eastern Mediterranean at its thirty-eighth session;

1. REAPPOINTS Dr Hussein A. Gezairy as Regional Director for the Eastern Mediterranean as from 1 October 1992; and

2. AUTHORIZES the Director-General to issue Dr Hussein A. Gezairy a contract for a period of five years from 1 October 1992, subject tc the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN, joined by the other members of the Board, congratulated Dr Gezairy and wished him continuing success in all his endeavours in the Eastern Mediterranean Region.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean) thanked the members of the Executive Board for the trust that they had once again placed in him and for the confidence expressed by the Regional Committee at its thirty-eighth session. He considered his reappointment an expression of the conviction that the work of WHO and the Regional Office had been useful, and of faith in the cooperation between the Regional Office and headquarters. The credit for that went to his assistants at the Regional Office, without whose unceasing labours he would not have been able to accept the reappointment. Countries had an opportunity to refuse reappointment if they did not approve of the work being done; the relationship was based on trust and should continue in that manner.

2. **IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL):** Item 8 of the Agenda (Documents EB89/20, EB89/21, EB89/22 and EB89/22 Add.1, EB89/19; EB89/INF.DOC./8 and EB89/INF.DOC./9) (continued)

Strengthening technical and economic support to countries facing economic constraints (including least developed countries (resolutions WHA43.17 and WHA44.24); (Document EB89/20) (continued)

Dr SHAMLAYE endorsed Dr Yoosuf's earlier appeal for special attention to small island states because of their specific problems and needs, in particular in relation to manpower. WHO might help in the re-evaluation of some of the traditional yardsticks for assessing countries; for example, population size. It was sometimes thought that the bigger the population the greater the concerns, but a small and scattered population might be grappling with serious problems. Another commonly used indicator, per capita GNP, could be misleading in a small-scale economy, as the Director-General himself had indicated.

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[1] Resolution EB89.R1.

Dr MASON stressed that one of WHO's major responsibilities was to do everything in its power to narrow the gap between what would be optimal health for all and those nations that were furthest from it. He asked whether WHO was setting priorities and directing its technical and financial resources adequately towards the least developed countries and appropriately coordinating those resources, not just from a particular programme but from all WHO programmes, as well as securing coordination with other United Nations agencies and NGOs. A dollar spent on the least developed countries might well bring the greatest return on investment in quality of life and health.

Dr KAYAMUPIRA was firmly in favour of strengthening support to the least developed countries; his own country was classified in that group and was facing great economic difficulties owing principally to the loss in recent years of income from exports, the decrease in tax revenues because taxpayers were becoming increasingly impoverished, and the increase in population, not forgetting the bad management of the scanty resources available. All those factors had worsened the already precarious health situation; the health services could no longer meet the needs of the population, especially those most vulnerable: women and children. Health personnel had become scarcer and less motivated. Even so-called essential drugs were scarce and reserved for the most well-off; health services themselves had very little credibility in the eyes of the population and were therefore shunned. It came as no surprise, therefore, that the evaluation considered by the Board under the previous agenda item showed that the gap had grown between the minimum acceptable health level and the current situation. The strengthening of support to least developed countries in an attempt to close the gaps observed during the ten years since the adoption of the Declaration of Alma-Ata would consolidate the foundations of primary health care, and reflect international equity and solidarity between all peoples in pursuit of a minimum level of health. Two years after the launching of the initiative of intensified WHO cooperation, the programme had not yet covered even half of the least developed countries. At that rate one might well ask when all of them would be covered, with only ten years to go until the health-for-all deadline of the year 2000. In the absence of increased support by WHO for the 20-25% of Member States that were most disadvantaged, several donors were providing funds, but technical support was often lacking to derive maximum profit from the resources placed at the disposal of their populations, because the donors, usually multilateral organizations and especially the World Bank, which were now intervening within the framework of structural adjustment, did not possess the skills required to implement the necessary actions. WHO country offices should therefore be strengthened, particularly in human resources, so that the managerial and technical capacity necessary for the functioning of the main components of primary health care might be established at the national level.

Dr KHAIRY praised the intensified WHO cooperation initiative and its authors, but cautioned that the issue might remain abstract if certain points were not taken into consideration. Obviously each country had its own health policy and strategy, carefully formulated in keeping with its priorities. A donor institution or country might not accept the priorities set by the beneficiary: the task of evaluating strategy would then become more complicated. Many countries possessed a large number of highly qualified planning and programming staff, but their work might remain theoretical for want of funds. He commended the statement by Dr Mason on WHO's responsibilities; but it might have gone further, and pointed out that countries, too, should perhaps be mobilized in the effort to alleviate the suffering of the so-called poor countries. Where poverty was concerned, some countries set principles and ethics before material considerations; but money was of course important. In keeping with its mandate, WHO should prepare a recommendation to set up a fund to be financed by WHO as the supervising body, and by other organizations and donor countries. Moneys collected would augment those originally allocated by WHO, whose own financial resources were limited. The fund would support a programme administered by WHO and its regional offices, that would ultimately fill the gap mentioned by Dr Mason between the least developed countries whose health situation was deteriorating and those countries which God had endowed with wealth. All members of the human family would thus be satisfied.

Dr KAWAGUCHI (Director, Planning, Coordination and Cooperation) recalled that the intensified WHO cooperation initiative (IWC) had been launched by the Organization in 1989 in recognition of the changing world health situation and in the effort to find out how WHO could best respond. Therefore, the strengthening of technical and economic support to countries facing economic constraints, including least developed countries, involves in effect all WHO's resources, together with those of committed Member States and the participation of donor partners: Dr George-Guiton had eloquently covered the important elements of the initiative. He thanked the Government of France as well as other partners, in particular Finland, Italy, Japan and other multilateral and bilateral donors, for their powerful backing with both financial and technical

resources. That pragmatic, concerted approach had enhanced WHO's leadership role in health development in the eyes of the world community. The IWC strategy drew fully upon WHO's clearly defined constitutional leadership role as the directing and coordinating authority on international health work. Furthermore it fulfilled the Organization's main function of helping countries to overcome their health problems in the process of national health development. Partnership with multi- and bilateral donors had already taken place. In the IWC process of identifying countries most in need, priorities were set and proper resources were made available at the initial stage.

In reply to the question raised by Mr Varder, he said that Member States themselves were convinced that the health for all strategy had in fact been strengthened by such a holistic, comprehensive and participatory approach.

Concerning the capacity to implement the initiative, he acknowledged that more human resources would have to be mobilized. The Office of International Cooperation was playing a key role in facilitating the coordination of all activities with headquarters and regional offices technical staff, as well as with staff in WHO's country offices. There would certainly be need for additional staff if the process was to be accelerated, and a number of internal mechanisms had been set up for that purpose within WHO, notably the Inter-programme Task Force on IWC. In fact, all WHO staff constituted potential resources, which could be used to contribute to the health development of countries in need.

He was likewise fully aware of the need to strengthen the capacity of country offices, referred to by several Board Members. In that connection, some degree of redeployment of staff at regional office level might be considered. In addition, in a number of countries already covered by the initiative, technical and managerial staff had been attached to the office of the WHO representative on a secondment basis.

As pointed out by Mr Varder, the question of staff redeployment should be looked into very carefully, and carried out in a properly regulated manner. Concerning staff composition, he pointed out that the number of professional staff and long-term assigned staff with an economic background had increased rapidly over the past three years. WHO now had a team of economists, working together with other professionals.

Since IWC had received such strong support, it would seem natural that it should be taken into consideration in the process of elaborating the Ninth General Programme of Work, and in consequence by the working group of the Executive Board which was to be convened to study WHO's leadership role. In that connection, the budgetary implications of the initiative could also be considered even before 1994-95, as suggested by Dr George-Guiton.

He agreed with Dr Margan that the countries themselves should have the capacity to coordinate aid received from donors so as to ensure that health was an essential component of their national socioeconomic development; WHO's policy was of course to assist in that process. In fact, in several countries, national and international groups had already been identified as able to assist in the formulation of national health policies.

He also agreed with Dr Sarr that WHO should respond swiftly to requests from the most needy countries. Such a response would require that the countries concerned were firmly committed to reforming their own systems, and to making the identifying of priority areas for action, resource allocation, and macro-economic analysis part of that reform. In fact, efforts had been made to respond swiftly to most requests, in the belief that it was important to demonstrate WHO's willingness to assist as well as its visibility.

As Dr Mason and others had pointed out, it was also important to bridge the gap between the haves and the have-nots, and the new initiative, by intensifying cooperation with many of the least-developed countries, could help in a practical way to bridge that gap.

The number of donor partners in the intensified WHO cooperation initiative was increasing, and that participation was most welcome. An evaluation of the initiative had already been carried out internally within the Organization and he hoped that the findings would be published in the near future.

Dr MONEKOSSO (Regional Director for Africa) offered additional information in reply to the important questions raised by Mr Varder, since many of the countries listed in the annex to the report (document EB89/20) were situated in Africa.

In the early stages, many countries had equated the intensified WHO cooperation initiative with the arrival of more money to support their programmes, and that had been a cause of some misunderstandings. He was glad to say that the issue had now been clarified. While countries had accepted the global strategy of health for all through primary health care in a general sense, no specific health policies deriving from that strategy had ever been defined. Under the new initiative, renewed efforts were being made to define such policies on the basis of studies of health economics and health financing in the countries concerned.

The initiative had also made possible a better understanding of what the Director-General had described as the "country-focussed approach" as opposed to the "programme approach". Concentration on specific programme areas often made it difficult to see the issues in a particular country in an overall rather than

fragmented manner, and the new initiative was making a very important contribution in that respect. There was thus a two dimensional thrust, comprising on the one hand, activities that were programmatic, and on the other, activities that were national or subnational. Often, work was being carried out, with support from donors, in only one or two districts of a particular country, as part of the country-focussed approach.

There had been a serious problem of country staff in the region. Efforts had been made, within the limits of available resources, to recruit national staff on special contracts under which they worked in association with the office of the WHO representative, and those country teams had in fact been extremely useful in helping to solve the region's problems. In addition to the classical disciplines, such as nursing, other disciplines as epidemiology, statistics, economics and sociology were represented on the country teams, which were coordinated by the Regional Office.

Because the financing of health care was a major problem for all countries in the Region, health ministers had come to realize that the cost of health care in one country, however poor, could not be met by another country. The Region was developing what it termed a health care financing programme, under which WHO, countries and the donor community would work together to establish a social dialogue, so that who paid what, for what, and under what circumstances, could be clarified. In the long run, however, the alpha and omega of the new initiative would be policy-making as a continuous activity. A further innovation under the intensified cooperation scheme was the use of country teams from one nation to help in another, under what might be described as a form of TCDC, and that development was a particularly useful one.

One member had alluded to the possibility of conflict between donor priorities and government priorities. But experience had also shown that government priorities were not always identical with those determined by a country's health officials. What was essential was to reach agreement: the new initiative was based on partnership between the donor community on the one hand and governments on the other, and both partners should share in a common effort to solve the health problems of particular countries in need.

The Board noted the Director-General's report on strengthening technical and economic support to countries facing economic constraints, including least developed countries.

Technical Cooperation Among Developing Countries in Support of Health for All: Implementation of resolution WHA43.9 (Document EB89/21)

Dr MARGAN said the report would be a great source of satisfaction to all who had long worked to improve TCDC philosophy and to implement TCDC programmes, often in the face of what had seemed to be insurmountable obstacles. He fully supported the report's recommendations. It was clear from the report that TCDC was now indispensable to the formulation of national health policies and the establishment of priority programmes. Policy-makers would need to use the Medium-term Programme on TCDC for health for all to the full if they wished to derive the maximum benefit from cooperation with other countries, formulate rational and efficient policies, and make the best possible use of their internal resources. The first and second Medium-term Programmes had served as a useful basis for decisions at many conferences of health ministers, international organizations and experts in the developing countries. Progress in the implementation of resolution WHA43.9 was being followed with great interest, and expectations of what could be achieved by it were high. Stronger action by developed and developing countries alike were urgently needed if the obligations assumed under the operative part of the resolution were to be fulfilled.

The contribution of WHO regional offices was significant because of their permanent collaboration with countries interested in TCDC and with national institutions such as the Zagreb Centre for International Technical Cooperation, which was particularly active in the preparation of medium-term programmes on TCDC and in methodology for data collection relating thereto.

He fully endorsed all the recommendations in document EB89/21 and proposed an additional recommendation, namely that, in the light of the serious economic difficulties which would face developing countries in the coming decade, it would be in their interest to establish, with the use of TCDC mechanisms, an international strategy on debt conversion as an important potential source of health financing.

Parallel to that, a resolution or international convention might be prepared for adoption by the World Health Assembly and subsequent endorsement by the United Nations General Assembly, whereby Member States would agree to establish compulsory primary health care for all from the year 2000 onwards, to be financed by a percentage of their own debt, with the agreement of the creditor, and obtained through the mechanism of debt conversion.

Mr CARTER welcomed document EB89/21 as a comprehensive presentation of ideas particularly appropriate for small countries. The Caribbean subregion, to which several references were made in the document had achieved particularly successful results through TCDC. In 1986, the ministers responsible for health in the Caribbean had identified the six priority areas for cooperation listed in the document. In 1988, AIDS had been added to that list.

The TCDC mechanism gave small Caribbean countries an opportunity to benefit from expertise, e.g., in AIDS and drug procurement, within their own subregion. Thus it had succeeded in lowering the cost of drugs in hospitals in the eastern Caribbean, and similar programmes had been successful elsewhere; thus solutions to problems that had arisen, for instance, in Barbados had been found in the Bahamas. Links had also been established between programmes in the Bahamas and Guyana, and between Jamaica, where health education and advertising programmes had been devised, and St Vincent, where those programmes had been applied. Such exchanges enabled small countries to have access to essential outside expertise. It was therefore important for WHO to record the success of such programmes, to transfer them to other regions, and to give general support to the concept of TCDC.

Mr AL-SAKKAF said that the report highlighted TCDC as one of the most effective ways in which WHO could achieve primary health care for all. Despite the many positive aspects reflected in the report, TCDC was sometimes only a slogan and had achieved widely varying results depending on the country, perhaps because of the lack of any real understanding of its importance or of a major programme to fund and administer that type of cooperation. TCDC called for combined efforts which should rise above political interests and ideas. He hoped that it would become a part of WHO's major programmes, rather than an isolated element.

Dr LU Rushan said that the report provided a great deal of information on the use of TCDC in regional health-for-all strategies and in the implementation and refinement of health programmes. Use had been made of TCDC in all WHO's activities as a mechanism for the implementation of programmes, and such use had increased continuously since the 1978 Buenos Aires Conference. A global strategy for TCDC should be devised on the basis of past experience. He supported the Director-General's recommendation that TCDC should be used more widely so as to achieve the objective of health for all by the year 2000.

Dr YOOSUF welcomed the use of TCDC in support of health for all and primary health care. Countries in South-East Asia were using TCDC in many areas. In June 1991, at a Regional conference on health planning in South-East Asia, a Regional Plan of Action for the development of management capacities in support of health for all, on national and regional bases, had been formulated. TCDC had been clearly identified as a valuable and cost-effective mechanism in achieving the stated objectives. Machinery had been set up for the exchange of information and experience on health planning and management, including the establishment of a regional data base; for the exchange of research and experts in health planning and management; and for the exchange of training materials and students and academics. It had also been agreed that a series of research and development studies should be conducted by various countries and that information on research findings should be exchanged.

One problem, reflected in the report, was the shortage of in-country managerial capacity within the TCDC programmes; that indicated a general need for effective programme management. He supported the proposed recommendation that the use of TCDC in national health programme implementation should be increased, and associated himself with the views expressed by previous speakers concerning both the development of national capacity for coordinating donor aid, and the problems of small countries.

Dr KAWAGUCHI (Director, Planning, Coordination and Cooperation), referring to Dr Margan's proposed additional recommendation, considered that the use of debt conversion for future TCDC activities was interesting and should be carefully reviewed by countries themselves.

The Board noted the Director-General's report on improving technical cooperation among developing countries.

Cholera (resolution WHA44.6; Documents EB89/22 and EB89/22 Add.1)

Mr de RIVERO, representative of Peru, speaking at the invitation of the Chairman said that he had been requested to inform the Director-General and members of the Board concerning the national plan drawn

up by the Peruvian Government for minimum action for prevention of a fresh outbreak of cholera. The plan, which had been drafted by the National Multisectoral Commission for Cholera Control, was adapted to the biological and social nature of the disease in the country, with the general aim of preventing further epidemics.

The objectives of the plan were as follows: new investments in health development, particularly in drinking-water supply and excreta disposal; improved solid waste disposal; better food hygiene; and the promotion of domestic hygiene. The strategies to achieve those objectives included: multisectoral and multidisciplinary coordination in mobilizing resources for environmental health; the obtaining of technical cooperation and financing for planning and implementing environmental health projects; the use of local resources through the application of appropriate technologies with the active participation of the community; the strengthening of institutions and the development of human resources in environmental health; health education programmes; compliance with existing legal provisions and proposals for new legislation, if required; and introduction of an epidemiological strategy for environmental and human surveillance. Each proposal was already being reflected in specific projects, and implementation of the plan should be completed in 1992.

Other related activities carried out by the Government included the launching of an intensive information campaign, the distribution of chlorine tablets and water containers, the provision of drugs and basic equipment to hospitals and medical centres, and the implementation of an emergency plan to improve the health services and infrastructure of Lima.

Resolution WHA44.6 was a good example of how a specialized agency of the United Nations could help Member States to improve the health care and promote the socioeconomic development of their populations. Operative paragraphs 3 and 5 of that resolution, on the priority to be given to requests for loans and financial support by countries at risk, and the removal of unjustified trade restrictions, respectively, should be urgently implemented. In the previous year, Peru had suffered losses of nearly US$ 400 million from restrictions imposed without any justification on Peruvian exports on account of cholera, in addition to the sharp decline in earnings from tourism. Government health expenditure on cholera control had been well in excess of US$ 20 million. In order to implement the national plan for minimum action to prevent a further outbreak of cholera, Peru required the continued invaluable cooperation of WHO, as well as cooperation with Member States of the Organization and international financial institutions.

Dr PAZ ZAMORA expressed gratitude on behalf of his country, which bordered on Peru, for WHO's assistance to the countries of the Region affected by cholera. As reflected in the report, concerted action had the strongest impact. During the emergency phase following the outbreak in Peru, the unprecedented efforts made by the Bolivian health services had resulted in greater public awareness but had also brought to light huge deficiencies in terms of basic sanitation. A national commission for cholera control had been set up and a large-scale control and epidemiological surveillance mechanism had been established, including a diarrhoeal diseases control programme. Reference laboratories had been strengthened, as had the preparedness of hospital systems and health education activities.

Joint activities along the border with both Brazil and Peru had been of vital importance in controlling the epidemic. His country had also launched a major water-for-all programme in an endeavour to centralize and control water supplies.

Dr KOMBA KONO said that, in the light of the data on the number of cholera cases and resulting deaths, the seasonal nature of the disease and the predominant causes in the developing countries over the previous ten years, the focus should now be on preventive strategies rather than on "fire-fighting". During the 1986 outbreak of cholera in his country, health workers had been trained only in treatment of the disease. WHO and national teams should now redirect their strategies towards early warning and prevention.

Dr BUNNI said that a major difficulty in dealing with cholera was that the disease was transmitted through the water supply, which was not the responsibility solely of the health authorities. Cooperation with other ministries was satisfactory when an epidemic broke out, but tended to lapse after the emergency had passed.

The relationship between the diarrhoeal diseases control programme and the cholera control programme was unclear to him; were they separate programmes or part of the same programme? What was WHO's position with regard to notification of the disease? Were cholera epidemics and endemic cholera subject to the same notification requirements? He welcomed the work being done on the development of oral cholera vaccines. Finally, he agreed that cooperation among neighbouring countries was essential in halting the spread of disease.

Professor BORGONO said that up-to-date information must be available for inclusion in the report to be submitted to the Health Assembly; in paragraph 2 of the report now before the Board, Brazil was said to have relatively few cases of cholera, but that was no longer true.

One of the critical problems facing Latin America was the lack of adequate laboratory equipment; such equipment was vital to diagnosis, especially at the outbreak of an epidemic and in epidemiological surveillance. The latter required a continent-wide approach and the monitoring not only of morbidity and mortality but also of the environment, which could yield vital information on the presence of the pathogen in food and water.

The number of deaths from a curable disease was unacceptably high and could be greatly reduced if swifter action were taken and diagnosis, treatment and care were readily accessible.

What research was being conducted on new vaccines? There appeared to be some gaps in the information available and there was some duplication of research in a number of countries.

Credit was due to the Organization for its response to the cholera epidemic in the Region of the Americas, which had, moreover, enabled substantial resources to be mobilized.

Dr GRILLO congratulated WHO and the countries of the Region affected by cholera on the measures they had taken to control the disease. Although cholera was not present in his country, the necessary steps had been taken and the relevant services strengthened both along the borders and in hospitals. Particular attention had been given to places with poor sanitation or unsafe water supplies.

Dr VIOLAKI-PARASKEVA congratulated the Organization on the part it had played in helping countries to control cholera outbreaks. It was imperative to strengthen epidemiological surveillance in areas not yet affected by the disease. Furthermore, as she knew from personal experience, some countries were still requiring visitors to provide proof of immunization with traditional injectable cholera vaccine, which WHO no longer recommended, and were still applying out-dated international health regulations.

Had there been any further developments with regard to vaccines since paragraph 39 of the report had been written?

Dr CARVALHO said that, coming as he did from a country where the infrastructure was weak, as it was throughout sub-Saharan Africa, he viewed cholera with considerable concern. The continent had already been gravely affected by the disease, and countries as yet untouched were also at risk. He wondered, in fact, which cost more - AIDS or cholera. It was vital, therefore, that a country should choose the right control strategy. A community approach was necessary; cholera control should be in the hands of community workers and nurses, who needed to be trained for the task. It should also form part of diarrhoeal disease control. In his country, for example, the existence of a diarrhoeal disease monitoring system had enabled community health workers and nurses to detect the initial cases of cholera. Accurate diagnosis was difficult, however, since laboratory support was lacking. The country was also unable to undertake environmental monitoring despite the assistance provided by WHO, France and Portugal. However, an intercountry monitoring system had been established in the Region; such cooperation should be intensified, given the number of deaths. The control of diarrhoeal diseases, including cholera, called for substantial investment.

Dr GEORGE-GUITON (alternate to Professor Girard) praised WHO's swift and effective response to the outbreak of cholera, a disease that health services were often initially unable to contain since the cause lay in other sectors such as water supply and sanitation. However, direct person-to-person transmission was also possible and should not be forgotten in health education efforts. The mortality from the disease, particularly in Africa, was unacceptable since a simple cure was readily available. The references made in the course of the debate to the links between the diarrhoeal diseases, cholera and other WHO programmes were a further indication of the need for programme integration which she had emphasized throughout the present session.

Dr GUERRA DE MACEDO (Regional Director for the Americas) said he did not fully share Professor Borgoño's view that the mortality rate from cholera in the Americas was excessive since the overall case fatality rate in the epidemic had been 1%, the lowest in the history of the disease. He accepted that cholera was a disease that should not kill at all, but considering that those at risk had been the poor and the undernourished living in appalling conditions and exposed to all manner of infections it was a miracle the death rate had not been higher.

In addition to the impact of the cholera epidemic on the health and socioeconomic situation, it had had a number of positive aspects, which it was worth bearing in mind. Firstly, the outbreak had jolted national leaders into realizing how little attention had been paid to health for far too long as part of the social debt to the people that had accumulated. Thanks to cholera, health had become an obligatory topic in the political

agenda and at all major political meetings in the Region, including summits. As a result, living conditions and human life itself were no longer the subject of abstract theorizing but had become a reality for national leaders. Cholera had come as a shock to the social and political leadership in the Region.

Secondly, the cholera epidemic had given tremendous impetus to the mobilization of national resources, health workers in particular. It was worth recalling that, at the peak of the epidemic in Peru, health workers had been on strike for five months in succession. Nevertheless, in a display of extraordinary solidarity, and at times working unpaid, health workers collectively went on working to cope with the outbreak. The community too was mobilized, thousands of volunteer workers forming the backbone of the initial workforce notifying and recording cases of disease. That harnessing of community forces was something that should remain even after the emergency was over.

Thirdly, the epidemic had succeeded in persuading many people to change age-long practices in handling food and water and other hygienic practices that had resisted earlier health education efforts. As a result, there had been up to a 50% drop in the incidence of diarrhoea in countries of the Region during 1991.

Fourthly, the epidemic had proved the worth of the surveillance system that had been set up, principally under the Expanded Programme on Immunization, throughout Latin America and the Caribbean. At present, 20 000 notification units were in operation and had been used for cholera surveillance. The system had been further improved by strengthening the laboratory and diagnostic systems to which Professor Borgoño had referred. Progress had also been made in environmental surveillance.

However, the effect of the social and moral shock occasioned by the cholera epidemic must not be allowed to fade away, nor the death of the poor, and especially of poor children, be regarded with apathy. Nobody was responsible or accountable for the death of a child because a vaccine was not applied or oral rehydration was not made available. The suffering and death of the poor and the weak were accepted as normal; it was very likely that cholera, after becoming endemic, would be accepted as one more of those "normal" problems, one more type of diarrhoea. It was necessary to act now to take advantage of the momentum. He took the present opportunity to inform the Board and through them the Member States of the Organization that major investment plans were in the pipeline for environmental and health infrastructure development programmes to pay back the social debt to the disadvantaged that had accumulated over so many years in the region. Cholera had provided that opportunity.

Finally, the Region was on the point of preparing final protocols for testing two promising candidate oral vaccines in the epidemiological conditions prevailing in Latin America.

The CHAIRMAN, speaking in his personal capacity, joined previous speakers in praising WHO's support to Member States during the cholera outbreak. He was particularly appreciative of what had been done in Nigeria. Like Dr Komba-Kono, he felt that greater efforts should be made to prevent any future outbreaks in the African Region of what was an easily preventable and curable disease. The action taken to cope with the epidemic in the Americas would be an encouragement to that effort.

Dr TULLOCH (Diarrhoeal and Acute Respiratory Disease Control), replying to questions, said that cholera was part of the diarrhoeal diseases programme. It was, however, not solely the concern of that programme but also had links to the WHO programmes dealing with water supply and sanitation, health education, surveillance systems, including laboratory support, food safety programmes, and others. In addition to the immediate responsibility for cholera control, the diarrhoeal diseases programme was the coordinator of the Global Task Force.

Under the International Health Regulations, cholera was one of three reportable diseases. Any new outbreak of cholera must be reported immediately, and weekly reports were required on numbers of cases and deaths and the control measures taken. No distinction was made in the Regulations between endemic and epidemic cholera, since it would, in fact, be difficult to make such a distinction in many cases. However, the quality of cholera reporting was very variable; some countries regularly reported cholera and others never did so, although they were known to have cholera. Questions that the Task Force had addressed but not necessarily resolved had been the extent to which the Organization should urge countries to report and whether any action should be taken against countries that failed to do so. The reasons for failure to report had been mentioned; although WHO could take measures to minimize them it could not eliminate them. No action was in fact being taken at present against countries that failed to report cases of cholera.

In cholera vaccine research, as Dr Guerra de Macedo had pointed out, two oral vaccines were on the point of trial in Latin America. Phase II trials of a whole-cell B subunit vaccine given in two or three doses would probably be conducted in four countries, to be followed by efficacy trials, possibly in two countries. Phase II studies were expected in three countries of Latin America with another oral vaccine which, being a single-dose vaccine, offered a number of operational advantages.

No new information had become available since the report was written, and issues concerning cost, the possible need for multiple doses and level of efficacy remained. Ultimately, the choice would turn on the cost effectiveness of the various options available. An answer could be given only after the completion of the current trials.

The Board noted the Director-General's report on cholera.

The meeting rose at 17h35.

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