

53749

Distr.: Limited
CDR/MIP/94.13
Original: English

Division of Diarrhoeal and Acute Respiratory Disease Control

REPORT OF THE FOURTEENTH MEETING OF INTERESTED PARTIES

Geneva, 30 June-1 July 1994



World Health Organization

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SUMMARY AND CONCLUSIONS

The fourteenth Meeting of Interested Parties (MIP) of the Programmes for the Control of Acute Respiratory Infections (ARI) and Diarrhoeal Disease Control (CDD) accepted the report of its thirteenth meeting and noted the action taken at its request.

With regard to the External Review of the two Programmes, the Meeting:

1. Essentially endorsed the very positive assessment of the technical and programme achievements of the Division of Diarrhoeal and Acute Respiratory Disease Control (CDR) by the External Review Group.
2. Suggested that recommendations 1, 2 and 3 (lines 3 and 4) were non-actionable by CDR but required review and potential action by the WHO Director-General (see Annex 1 of the External Review Report: Recommendations of the External Review).

Suggested that recommendations 1 and 14 were non-actionable by CDR but required potential action by the contributors to the Programmes.

3. Noted that the recommendations and findings of the report needed follow-up by CDR, donors, recipient countries, WHO and others, and suggested a further informal meeting to consider responses and follow-up by these groups.
4. Proposed that CDR review the external review report recommendations and findings and formulate a response for the Meeting participants, indicating plans of action and resource implications.

Suggested that CDR communicate their response in writing to the Meeting participants by 15 August and invite comments to be submitted to CDR for discussion at an informal open meeting on 30 August 1994.

Proposed that CDR report to the MIP on progress regarding follow-up of external review recommendations at the 1995 meeting.

With regard to both Programmes the Meeting:

1. Reviewed and discussed the progress and plans of the Programmes as well as the report of the ninth meeting of the ARI Technical Advisory Group (TAG) and the fifteenth meeting of the CDD TAG.
2. Reaffirmed its support for the main approaches of the ARI and CDD Programmes and again stressed the importance of ARI and CDD activities at all levels of an integrated primary health care system.
3. Congratulated the Secretariat on the considerable progress and achievements over the last year and on the continued high quality of the documentation, in particular the Programme Reports for the 1992-1993 biennium.
4. Welcomed the Programmes' exploration of bilateral and multi-bilateral funding arrangements to support country-level activities and undertook to facilitate contact with relevant donor agency authorities in countries and in their headquarters offices.
5. Reiterated the importance of developing and implementing preventive interventions and welcomed the Programmes' activities in nutrition, particularly breastfeeding, indoor air pollution, vaccine research and the review of potential preventive interventions for ARI control.

6. Welcomed the Programmes' effort to develop methods to improve the monitoring of the quality of health-worker performance.
7. Requested that, for future meetings, revised budgets be provided in advance, at the same time as other documents.

With regard to the development of the **integrated approach to management of childhood illness**, the Meeting:

1. Welcomed the progress report on this activity and endorsed the approach being taken.
2. While recognizing the demand from countries for integrated approaches, urged that activities be introduced in a progressive manner, so as not to disrupt ongoing ARI and CDD programmes, and be carefully evaluated.
3. Commended CDR's role in setting up an informal working group at WHO Headquarters to coordinate the input of a number of programmes, as well as the level of collaboration achieved.
4. Urged that preventive interventions focused on the major killers of children also be given appropriate attention by WHO.

With regard to the **ARI Programme**, the Meeting:

1. Urged the Programme to disseminate research findings as well as the scientific basis for its case management approach to help ensure their wider acceptance, particularly with senior health professionals.
2. Appreciated the Programme's work in relation to the behavioural aspects of ARI control, including the use of focused ethnographic studies.
3. Welcomed the Programme's efforts to intensify the assistance to African countries in particular, and again urged that these continue.
4. Accepted the revised budget for 1994-1995, and noted with satisfaction pledges which should permit the Programme to overcome its current shortfall in funding.

With regard to the **CDD Programme**, the Meeting:

1. Welcomed the report on the study of impact of the Programme's activities in Brazil and urged continued efforts to measure programme impact in other countries.
2. Again urged the Programme to increase its activities in Africa and noted the considerable efforts still required to develop sustainable national control programmes in that region.
3. Accepted the revised budget for 1994-1995 and expressed concern at the serious financial circumstances currently facing the Programme. Existing donors were urged at least to continue their support at current levels wherever possible and to pay their contributions as early as possible. The Meeting appreciated the approach taken by the Programme in planning to present a realistic rather than over-optimistic budget for 1996-1997, but requested that consideration also be given to presenting a contingency budget showing what could be implemented if additional resources were obtained.

* * *

1. INTRODUCTION

Representatives of 31 governments and 13 agencies attended the fourteenth MIP convened by CDR on 30 June-1 July 1994 at WHO Headquarters in Geneva to consider:

- (a) the final report of the External Review¹ of the two Programmes;
- (b) the progress and plans of the ARI Programme, including the report of the ninth Meeting of its TAG;
- (c) a progress report on the integrated management of childhood illness;
- (d) the progress and plans of the CDD Programme, including the report of the fifteenth Meeting of its TAG and Programme activities relating to cholera control; and
- (e) for both Programmes, the financial report for the 1992-1993 biennium and the financial status and revised budgets for 1994-1995.

The participants in the meeting are listed in Annex 1.

2. OPENING OF THE MEETING

Dr R. Henderson, Assistant Director-General, opened the meeting by pointing out that, in a complex and changing environment, setting health priorities is becoming increasingly important, but also more difficult. However, if there is concern for the future then the health of today's children, especially those in the less-empowered developing world, cannot be neglected. In dealing with the two main causes of morbidity and death in children, the CDD and ARI Programmes play a key role in carrying forward the "child survival movement".

Both these Programmes have developed sound technical and managerial tools for the successful delivery of basic health services to control diarrhoeal diseases and acute respiratory infections. The use of the Programmes' guidelines for planning, training, communication and evaluation is highly recommended. They are also among the programmes in WHO that have successfully established the bridge between research and programme implementation and used this to ensure the relevance of developmental activities.

In addition to their disease-specific activities these two Programmes, which come together as CDR, are coordinating at WHO headquarters a broader effort to develop an integrated approach to the major causes of childhood mortality. This involves 10 programmes in WHO, in collaboration with UNICEF, and has provided a model of inter-divisional collaboration which could well be applied to more areas of the organization's work.

Dr Henderson thanked the External Review Group, represented at the MIP by its Chairperson Dr D. Ashley, for its efforts during the preceding months in carrying out its independent evaluation of the CDD and ARI Programmes and hoped that the MIP would consider the Review to have adequately met its objectives.

Dr Henderson was pleased to announce that the projected contribution to CDD and ARI from the WHO Regular Budget for 1994-1995 is 15% higher than for the last biennium, confirming WHO's continued commitment to these two Programmes. However, the scale of work required to respond adequately to countries' needs far exceeds the availability of Regular Budget funding. He and the Programmes appreciated the vital role their donors played in providing extrabudgetary resources and hoped that, despite the enormous and pressing challenges to health care and general global stability, the children of the developing world would continue to receive the attention they deserve.

¹ It was agreed by the three agencies which make up the Management Review Committee that the CDD/ARI External Review could exceptionally replace its fourteenth Meeting.

The Meeting elected as Chairperson Dr B. Liese, Director, Health Services Department, World Bank, Washington, D.C., USA.

3. ADOPTION OF THE AGENDA

The participants adopted the draft agenda, with amendments to the order of topics to be discussed (see Annex 2). It was agreed that the report of the External Review Group be the first item tabled for discussion.

4. MATTERS RELATING TO THE REPORT OF THE THIRTEENTH MEETING OF INTERESTED PARTIES

The MIP endorsed the report of its thirteenth meeting.²

5. REPORT OF THE EXTERNAL REVIEW OF THE PROGRAMMES FOR THE CONTROL OF DIARRHOEAL DISEASES AND ACUTE RESPIRATORY INFECTIONS

Dr Deanna Ashley, Chairperson of the External Review Group, made a detailed presentation of the objectives, methodology, findings and recommendations of the Review.

The Review Group consisted of:

- Dr Deanna Ashley, MCH and Family Planning, Ministry of Health, Kingston, Jamaica
- Dr John Bennett, Task Force for Child Survival and Development, Carter Center, Atlanta, USA
- Dr Sadia Chowdhury, Women's Health and Development Program, Bangladesh Rural Advancement Committee, Dhaka, Bangladesh
- Dr Adetokunbo Lucas, Department of Population and International Health, Harvard School of Public Health, Boston, USA
- Dr Paul Nchoji Nkwi, Department of Anthropology, University of Yaoundé, Cameroon
- Dr Giovanni de Virgilio, Istituto Superiore di Sanità, Rome, Italy

The Group made formal visits to five countries — namely Brazil, Guatemala, Pakistan, Philippines and Zambia — and took advantage of group members' presence in four other countries to also enquire about the Programmes. Interviews were held with staff of bilateral collaboration agencies that also provide financial support to the Programmes, with staff from a number of WHO programmes at headquarters and in the regional offices, and with representatives from other collaborating institutions.

Dr Ashley traced briefly the evolution of the two Programmes which has culminated in their global research and development activities now being coordinated by three internal working groups while support to national programmes is provided both separately and, progressively, in an integrated manner.

The Division's initiative in coordinating the development of an integrated approach to the management of the sick child has led to greater collaboration with other programmes within WHO. Collaboration with UNICEF and other partners in programme implementation and research and development is generally good and productive.

Dr Ashley reviewed the progress of the Programmes towards their targets, as summarized in their annual reports. At country level the review had taken a particular interest in the level of priority given by the government to the Programmes, concluding that they had been successful, inevitably to a varying degree, in attracting attention and support. The review expressed concern about the sustainability of the achievements that had been made to date. It also addressed the issue of finding a balance between the need for integrated approaches and the need not to lose the focus that had characterized, and partially explained, the relative success of the Programmes.

² Document CDR/MIP/93.10.

The Review recognized the difficulties of measuring changes in childhood mortality and in particular of attributing them to particular programmes. It nevertheless concluded that it was reasonable to assume that the CDD Programme, at least, had contributed to the global fall in childhood mortality.

It was considered that the Programmes' potential impact had been limited by a number of systemic factors, including high staff turnover in the health services and insufficient intersectoral collaboration such as with the private sector and nongovernmental organizations (NGOs).

In the review of research activities, it was noted that there had been a decrease in basic research over the life of the CDD Programme with an increase in operational research. It was felt that behavioural research, relatively strong in the ARI Programme and weaker in the CDD Programme, should be encouraged. Currently, about 25% of the Programmes' resources go to research. The review commented that research findings had been well used in global policy and guideline development, but direct application at country level had been less apparent. Related to this finding was the need to strengthen research competence at national level; in this regard the Review welcomed the Programmes' use of proposal development workshops.

In its appraisal of programme management, the Review commended the staff of the two Programmes, noting that a considerable amount of work is achieved by a limited number of staff. It considered that the Programmes' financial resources are well managed. The Review felt that separate Technical Advisory Groups were an unnecessary expense and recommended their merging. It commented that the role of the Meeting of Interested Parties may need to be better defined.

Dr Ashley completed her presentation by presenting in abbreviated form the 18 recommendations of the Review (see Box on page 8).

Following Dr Ashley's presentation, a number of comments were made by meeting participants and where appropriate Dr Ashley provided clarification. The following were some of the issues most discussed:

- Selection of countries for the Review had unavoidably been biased in favour of countries where there was something to evaluate, i.e. a functioning CDD or ARI programme, and where there was a focal point able to organize the country visit. In view of time and logistical constraints, only a small number of countries could be visited.
- The Review Team believed that it was reasonable to conclude that the CDD Programme had contributed to reductions in mortality rates observed in many countries. It urged the Programmes to continue their efforts to measure impact on mortality and, as appropriate, morbidity.
- It was felt that the role of the MIP could be clarified by the MIP participants themselves but that this need not imply a more formal mechanism than the current one.
- Although there was wide agreement that more should be done by the Programmes in the area of disease prevention, it was recognized that the previous External Review of the CDD Programme had made a similar recommendation but this had not been followed with an increase in resources. The Programmes could not be expected to broaden their scope without increased funding as had been recommended by the External Review Team.
- It was concluded that time did not permit an adequate discussion of all of the Review's findings nor of the Programmes' proposed response to them. It was agreed that a follow-up meeting would be held with parties interested to attend on 30 August 1994. The Secretariat was to provide participants at the meeting with a response to the Review's findings and recommendations by 15 August.

RECOMMENDATIONS

1. (a) Donor funding to CDR should be increased.
(b) WHO should increase core funding to CDR.
2. WHO should clarify its organizational structures and responsibilities for programmes related to child health.
3. WHO should provide a clear mandate for the Sick Child Initiative (SCI).
4. SCI should be pursued, following careful field-testing, without undermining the effectiveness of the ongoing CDD/ARI activities.
5. (a) WHO should push for the incorporation of diagnostic and treatment guidelines into medical and other teaching institutions.
(b) The science behind interventions should be published and promoted in international fora.
6. CDR should expand the base of collaboration with academic institutions in all programme areas.
7. CDR should strengthen and extend collaboration with UNICEF and other agencies.
8. CDR should increase its focus on behavioural and focused ethnographic studies to resolve generic communication problems between health workers and mothers.
9. Evaluation of programmes should move towards the use of disease outcome indicators and surveillance systems.
10. Prevention-related research should be increased.
11. Countries' plans should be integrated to ensure sustainable programmes within the context of their national primary health care strategy.
12. A single multi-disciplinary TAG for CDR should be formed to provide the technical direction and assistance to CDD, ARI and SCI.
13. CDR should review its research strategy to ensure incorporation of ideas from a wider network of scientists.
14. Donors should be encouraged to provide multi-year support to CDR.
15. (a) The Division should strengthen surveillance and monitoring of pathogens and their resistance to antimicrobials globally.
(b) Research on alternative treatments should be pursued.
16. Proposal development workshops and multi-centre trials should be encouraged.
17. CDR should increase the involvement of WHO regional officers in the identification of research scientists, institutions and activities.
18. WHO country representatives should work with national scientists to identify research and capacity strengthening activities.

Dr Tulloch was requested by the Chairperson to comment on the External Review findings and the discussion. He thanked the External Review Group for its efforts and for the predominantly positive assessment of the Programmes. The Review had been a truly independent one, with the Secretariat collaborating as fully as possible on request. It was for the MIP to decide what follow-up was needed. The Secretariat welcomed the opportunity to review and respond to the Review's findings before a follow-up meeting.

He confirmed that most of the data presented in the External Review Group's report was derived from the Programmes and pointed out that it was unrealistic to expect that a small external group could in a limited period validate information generated by the Programmes throughout the year, using a number of different evaluation instruments. The Programmes critically analysed the data received and did not selectively present the positive findings as was evident from the low reported rates for some of the key indicators.

Concerning the need for further definition of the role of the MIP, Dr Tulloch pointed out that this was not a body comprised of formal members but simply a mechanism of sharing, annually, the Programmes' progress, plans and financial status. The Secretariat had over the years been responsive to the Meeting's comments on the Programmes' directions and priorities and it seemed unlikely that this would be improved by formalizing the Meeting's structure or mandate.

CDR's role in coordinating the integrated management of the sick child was placing a burden on the Division's resources. It was not realistic to think that the Division could maintain a comprehensive research and implementation agenda in all aspects of disease prevention, particularly as other WHO programmes were charged with many aspects of such prevention.

Dr Tulloch concluded his remarks by recalling that some of the External Review Group's recommendations were directed not to the Programmes themselves but to others, including donor agencies. The Programmes would do their best to respond appropriately to the recommendations and it was hoped others would do likewise.

6 PROGRAMME FOR THE CONTROL OF ACUTE RESPIRATORY INFECTIONS

6.1 Summary overview — progress and plans

Dr J. Tulloch, Director, CDR, reviewed the progress of the ARI Programme, referring to the Sixth Programme Report 1992-1993³ and opening his presentation with a report on research activities.

Thirty-five new research projects were funded in 1992-1993 and support for 20 others continued. These projects were in 22 countries and evenly distributed between case management, behavioural, health systems and disease prevention research.

An important achievement was the completion of the multicentre study, started in 1990, on clinical signs and etiological agents of pneumonia, sepsis and meningitis in young infants. Over 8400 infants were triaged and 2400 received full clinical, laboratory and X-ray investigation, providing the richest data set yet available on this topic. Results of preliminary analysis showed a significantly higher case fatality rate associated with hypoxaemia and showed the important role of *Streptococcus pneumoniae*, Group A streptococci and *Streptococcus aureus* as causative organisms. Further detailed analysis is ongoing.

Other studies reaching completion dealt with: comparison of cotrimoxazole and amoxycillin in the treatment of pneumonia, the pharmacokinetics of cotrimoxazole and chloramphenicol, alternative antibiotic regimes, optimal methods for delivery of oxygen, risk factors for relapse following pneumonia treatment and the diagnosis of pneumonia in malnourished children.

In field-testing its manual on surveillance of antimicrobial resistance in three countries, the Programme had identified many practical problems which were now being addressed, including the need to simplify, where possible, laboratory procedures.

Research in relation to behaviour and communication had centred on validation of the use of the focused ethnographic study protocol developed by the Programme and on how to complement its findings in an individual country through use of a simpler adaptation protocol for other geographic areas.

³ Document WHO/ARI/94.33.

The review of potential preventive interventions was completed in 1993. A pneumococcal conjugate vaccine and reduction of indoor air pollution were found to be the interventions offering the most potential benefit in reducing acute lower respiratory tract infection, by 18% and 13-20%, respectively. These findings compared with a mortality reduction by case management, as estimated in a meta-analysis of 9 studies, of 50%. Preparations for trials of a pneumococcal vaccine and of interventions to reduce indoor air pollution are being supported by the Programme. A *Haemophilus influenzae* vaccine trial was also started and plans developed for trials of vitamin A supplementation given with the routine immunizations of early infancy.

In the area of appropriate technology, information sheets on the respiration rate timers, oxygen concentrators and foot pump/nebulizer sets tested by the Programme were included in the widely distributed *Product Information Sheets* of the WHO/UNICEF Technical Series. Three new technical guidelines were issued on oxygen therapy, the use of bronchodilators and the management of fever in children with an ARI.

In programme implementation emphasis continued to be given to training, particularly using the short-course on case management of ARI. This course adds to those on programme management, supervisory skills and case management by community health workers. A strategy to accelerate training was developed in 1993. Among the many training-related activities conducted in 1993, two workshops were held to train consultants to support training activities in the African Region, and thirteen countries in Latin America introduced ARI training materials into medical school teaching. ARI communication activities involved use of the focused ethnographic study in 5 countries in 1993 bringing the total to 19. Associated intercountry workshops were held in Africa and Latin America.

For the first time the Programme was able to present data from a number of household surveys of careseeking and treatment related to ARI. These were conducted in 6 countries and although this was inadequate to determine global status, they provided important information to guide national programmes. Use of antibiotics for children not needing them was reported in 15-55% of cases but use of harmful drugs was quite low. Results from 6 health facility surveys of treatment practices showed encouraging rates of practice of respiratory rate counting and observing for chest indrawing, but further improvement was needed in all surveyed countries; between 16 and 69% of pneumonia cases observed in the surveys were adequately treated. A health facility survey conducted in Pakistan showed very marked differences in practice between untrained health workers and those trained using the WHO training approach.

At the end of 1993, 77 countries had operational programmes including 57 of the target countries, i.e. those with an infant mortality rate of 40 per thousand or greater. A further 14 countries had plans of operations. During 1992-1993 the Programme intensified its collaboration with non-governmental organizations (NGOs), holding meetings with a number of those working in Africa and briefings with large North American and European NGOs.

The Programme had continued to benefit from the support of Associated Professional Officers, currently placed in 9 countries. Collaboration with UNICEF, the World Bank, a number of bilateral agencies and numerous research institutions was once again critical to the Programme's global progress.

6.2 Report of the ninth meeting of the Technical Advisory Group

Professor A. Muller, Chairperson of the Technical Advisory Group of the ARI Programme reported on its ninth meeting, held on 18-20 April 1994 at WHO Headquarters in Geneva. Drawing on the report of that meeting⁴, he highlighted some of the TAG's conclusions, including the following:

- The TAG was satisfied with the general progress of the Programme and appreciated efforts to increase cooperation with countries in the African Region. It fully supported the initiative to develop an integrated approach to the management of childhood illness but encouraged the

⁴ Document WHO/ARI/94.35.

Programme to ensure that this facilitate rather than impede efforts to control ARI mortality and morbidity.

- The TAG urged the Programme to develop approaches to the private sector, including the development of training courses and medical education materials and work with professional associations. The Group commended the high quality of training materials but emphasized the need for monitoring and supervision, using locally appropriate methods.
- While welcoming the completion and use of the focused ethnographic study protocol, the TAG emphasized the need for guidelines on programme use of the data derived from the studies. The Programme's technical review series and the continued high quality of *ARI News* were appreciated.
- Continuous supply of drugs being a prerequisite to successful programme implementation, the TAG had reiterated the need to work closely with the Action Programme on Essential Drugs. It added its voice to the growing concern about bacterial drug resistance and urged the Programme to continue its efforts to establish effective monitoring approaches.
- The TAG supported the research directions taken by the Programme, the reorganization of research and development activities into three working groups and the coordinating role in research in relation to the integrated management of the sick child.
- The TAG specifically endorsed the research agendas in relation to case management research, behavioural research and suggested areas requiring particular attention. With respect to prevention of ARI, the TAG felt that the outcome of the preventive interventions review supported a continued emphasis on improving case management and use of existing vaccines. It welcomed the initiation of the *H. influenzae* type b vaccine trial and encouraged the Programme's continued involvement in developing trials of *S. pneumoniae* conjugate vaccines and associated studies. It further supported the planned intervention study of the impact of controlling indoor air pollution and the Programme's safety and efficacy of vitamin A delivered with immunization in infancy.
- The TAG noted with satisfaction the increased funding provided to the African Region and approved the revised 1994-1995 budget while noting that it remained modest relative to the extent of the ARI problem.
- Finally, the TAG commented extensively on the first draft of the report of the External Review of the CDD and ARI Programmes.

* * *

In the ensuing discussion on the above two items, several participants requested additional information or clarification on certain matters. The Secretariat provided the following information:

- The levels of health workers authorized to use antibiotics to treat pneumonia vary from country to country, with a number of countries still resisting their use by community health workers. Decisions of this type are part of the discussions with countries to define a national policy on ARI case management.
- A review paper on cough and cold medicines is still in preparation. Clear guidance on the use of all such medicines is not as straightforward as, for example, that on antidiarrhoeals since some, although not having an effect on the course of illness, are soothing and apparently harmless.
- The development of materials to improve the teaching in medical schools on ARI will be undertaken following completion of materials on inpatient management of severe pneumonia and other associated conditions. Materials have not yet been developed for pharmacy training schools but the CDD Programme approach to existing pharmacists is being extended to cover treatment of ARI. Dealing with doctors-in-training and pharmacists is part of the important

issue of addressing treatment practices in the private sector. It is not clear what other affordable but effective measures can be taken with this group of frequently consulted health care providers.

- Training activities have not yet been sufficiently focused on the highest priority areas. The reason for fewer programme management training courses in the African Region is that this type of training has not yet extended to the provincial level there as it has in the other regions.
- In 1988, 88 countries were defined as priority countries because their infant mortality rate was greater than 40 per thousand. The Programme is focusing, however, on a smaller number of countries selected because of the magnitude of ARI mortality and the likelihood of mounting successful control efforts. This is difficult as these two factors do not always coincide.
- As requested in earlier meetings and by the TAG, a special effort has been made to increase programme activity in the African Region. There is now a regional adviser, two subregional medical officers and medical officers or associate professional officers in ten countries. Subregional and country staff also work on CDD.
- The programme involvement in emergency situations is limited, except indirectly through the training of NGOs.
- The household survey method being developed in conjunction with the CDD Programme is based on more than 10 years of experience and refinement of methodology. While recognizing that it is difficult to obtain reliable information from households, the Programmes are confident that the instrument is as good as is possible in this regard.
- Resistance of pneumonia-causing bacteria to recommended antibiotics is an increasing problem and constant threat. The Programme has field-tested a manual on the monitoring of antibiotic resistance and uncovered the need for simpler methods for translating samples and isolating organisms. These are being explored but cost is a limiting factor with some of the newer methods. Systematic surveillance could prove to be very expensive and the Programme is seeking to collaborate with others developing similar systems.
- The Programme's documents are mostly targeted to developing countries because this is where bacterial pneumonia is most prevalent and where the WHO treatment approach is most likely to have an impact. The Programme would welcome collaboration with bilaterally funded health projects to translate materials into local languages. More local input into *ARI News* would also be welcome.
- Dr Henderson responded to several questions concerning vaccines. He pointed out that use of the newer acellular pertussis vaccine would double the costs of DPT without necessarily increasing efficacy or overall safety. He also endorsed CDR's decision to support trials of vitamin A supplementation given along with vaccination in the first months of life and mentioned that maternal supplementation may ultimately prove to be a better route.
- Dr Muller explained that the TAG viewed research capacity strengthening as an important by-product of support to high quality research on priority topics. Given the Programme's limited research budget, it could not be given primary importance. He also explained that the report of the last meeting of the TAG did not lay out priorities as it was felt that the Programme was on the right track in this regard. He reaffirmed the TAG view that research should focus on topics of most relevance to programme implementation. While research on preventive interventions is important, for example indoor air pollution, it is also expensive and must be done in collaboration with other partners.
- Dr Muller commented that the Programme's case management guidelines should lead to more focused antibiotic use and thus slow down rather than accelerate the emergence of resistant organisms.

- Finally, the TAG felt that the progress of the ARI Programme was partly attributable to its focus and that this should be borne in mind when activities are integrated, as in the management of the sick child.

6.3 Financial report for the 1992-1993 biennium

Mr R.C. Hogan, Programme Management Officer, introduced this item and drew attention to the following points:

There had been encouraging growth in the level of contributions to the Programme during 1992-1993 as compared with previous periods, showing an increase of US\$ 5.9 million or 73% over 1990-1991. The number of contributors had also increased from 13 to 17.

During the biennium, 85% of the Programme's estimated obligations were actually obligated, representing a 40% increase over 1990-1991; while sufficient funds to support the entire budget were eventually received, a large portion of them were received late in the biennium.

At the global and interregional levels, actual obligations under "health services" were very similar to estimates and showed an increase of 25% over 1990-1991. Although obligations at the regional and country levels increased 37% compared with the previous biennium, they were still 22% lower than planned, owing to the somewhat slow pace of implementation at country level.

Obligations under "research", including contracts, doubled in two years but were still slightly more than 20% less than planned due to the slow development of some studies.

Obligations were slightly higher than anticipated for "programme management and support" because actual costs of staff salaries were greater than average costs used in budgeting.

A carryover of US\$ 3.9 million was available to the Programme to begin the 1994-1995 biennium, thus allowing uninterrupted continuity of activities. However, a 20% carryover is considered sufficient and a smaller percentage is expected by the end of the current biennium.

6.4 Financial status and revised budget for 1994-1995

Mr Hogan presented the financial status and revised budget for 1994-1995.

The proposed 1994-1995 budget had been approved during the 1993 meetings of the TAG, Management Review Committee (MRC) and MIP, and the budgetary expectations presented then are still considered by the Programme to be realistic. Therefore the revised budget total remained essentially the same as the original estimate.

Revisions included increases in the amounts for salaries at global, regional and country levels. The size of the present ARI staff remained smaller than any other priority programme in WHO. Thus salary increases represented a small increase in ARI staff as well as a more equitable sharing of the costs of CDR staff who contribute to ARI.

In the regions, increases in operations also reflected the equal sharing of costs between CDD and ARI of all eight country posts. Although obligations for planning, training and evaluation are 50% greater as compared with 1992-1993, these are 15% less than the original budget of these categories.

Once obligation patterns and financial possibilities are clearer, a final budget revision for 1994-1995 will be made at the end of 1994. So far the Programme has been on schedule, having obligated one quarter of its budget during the first quarter of the biennium.

Thirteen of the 17 contributors for 1992-1993 have also made funds available for the current biennium, and one new contributor has added its financial support to the Programme. Projections show that the

Programme should make up the current shortfall of US\$ 3.9 million, but could not assure an adequate carryover, in which case there would be a reduction in the revised budget at the end of 1994. Based on past experience with the CDD Programme it is estimated that the ARI Programme would probably not be able to obligate funds much beyond the level of contributions received during the last biennium.

Due to uncertainties of the funding situation, it was decided that no presentation of a 1996-1997 preliminary budget would be made at this time. A budget at the same level as that for 1994-1995 would therefore be assumed unless further budgetary information became available.

* * *

In the ensuing discussion of the above two items it was agreed that, for future meetings, revised budgets would be provided to participants in advance, at the same time as other documents. Past practice had been to present budget information, other than that documented in the Programme Report, at the time of the meeting.

The Meeting accepted the revised budget for 1994-1995, and was pleased to note that pledges made to date should permit the Programme to overcome its current shortfall in funding.

7. Integrated management of childhood illness

Dr S. Gove, Chairperson of the CDR Working Group on case management outside the home and national programme management, presented a summary of progress up to the time of the meeting on the development of an integrated approach to the management of childhood illness.

This initiative, also known as integrated management of the sick child, was started by WHO in collaboration with UNICEF in 1992. Ten programmes within WHO collaborate under CDR's coordination.

Dr Gove explained that the initiative is focused on the five main killers of children after the immediate postnatal period: acute respiratory infections, diarrhoeal diseases, measles, malaria and malnutrition. Together, these conditions accounted for 7 out of 10 of the estimated 12.3 million deaths in children less than five years old that occurred in 1993.

The fact that these are the main causes of death would not on its own justify an integrated approach to their control. More important, in this regard, is that they often occur together and that their clinical features often overlap. A child with cough and fast breathing, for example, may have pneumonia, malaria or anaemia. A child who is abnormally sleepy or difficult to wake may have cerebral malaria, meningitis, severe dehydration or severe hypoxic pneumonia. Measles may be complicated by diarrhoea, pneumonia or an ear infections, and malnutrition can accompany and confuse the diagnosis of most severe illnesses. For these reasons, an integrated approach to the sick child is essential.

Dr Gove listed the collaborating partners in the project, both within WHO and outside, and mentioned a series of six consultations that were held to discuss different aspects of the research and development activities. The most important developmental activity was the training course for first level health facility workers. Case management guidelines that form the basis of this course were defined, using an approach similar to that for diarrhoea and acute respiratory infections. They were summarized on four charts. Training modules and other teaching materials are being developed around the technical guidelines. A guide for adapting the guidelines and the materials to local conditions is also being prepared. This will cover, for example, feeding advice appropriate to the setting and choice of antimicrobials, taking into account local sensitivity patterns.

In addition to the training course for first level health facility workers, four other sets of materials are under development. These are:

- training materials on inpatient case management,
- an inservice training course on drug management,
- guidelines for monitoring and improving health worker performance, and
- a guide to the development of interventions to change family behaviour in relation to childhood illness.

Preliminary evaluation of the assessment and classification part of the materials was carried out in the Gambia and Kenya. The vast majority of presenting symptoms were covered by the charts and the disease detection process functioned acceptably, except for malaria and anaemia. The guidelines were refined on the basis of research findings and a pretest of the training course was in preparation. Further research priorities were defined.

It is expected that the first level health facility training course will be available for use in mid-1995.

In the ensuing discussion, the following points and clarifications were made:

- At the current time there is no WHO organizational or budgetary entity formally associated with the integrated management of the sick child. Funding support could be provided to CDR or, for some research activities, to the Special Programme for Research and Training in Tropical Diseases (TDR), or to other involved WHO programmes. CDR has to date borne most of the developmental costs and would expect to bear most of the expense of implementation. No regular budget funds had yet been allocated to this initiative.
- The sick child initiative did include certain preventive measures in the context of case management and follow-up. Some aspects of prevention for the same diseases were also already covered by other WHO programmes. It may, however, be appropriate to develop a complementary set of interventions focusing on prevention of these diseases, perhaps through community and household interventions. This was beyond the scope of CDR's current resources. As has often been mentioned, the relative success of the CDD and ARI Programmes is partly attributable to their focus. The sick child initiative should not become so diffuse as to lose its primary focus on improving case management.
- It is important to maintain support to CDD and ARI activities while making the transition to the integrated approach. It was not possible to foresee how the sick child activities would be coordinated and would evolve in all countries. CDR would work with countries and collaborating partners to adapt the generic materials and define the best ways to use them in each country's context. The scientific base of the initiative will be constantly improved through ongoing focused research.
- Incorporation of integrated management of the sick child into bilaterally funded health projects would be most welcome. CDR would be interested in all proposals for providing technical input into such projects.
- It is recognized that in a number of countries integrated child health care is already being promoted and that, at the level of the health worker, care is necessarily integrated. The new approach will, however, systematize the process of health worker/sick child interaction and allow greater efficiency in support to service delivery, including training, monitoring and evaluation.

8. PROGRAMME FOR THE CONTROL OF DIARRHOEAL DISEASES

8.1 Summary overview — progress and plans

Dr J. Tulloch, Director, CDR, reviewed the progress of the CDD Programme, referring to the Ninth Programme Report 1992-1993⁵ and opening his presentation with a report on research activities.

During 1992, 18 new projects were funded and in 1993 a further 16. Of these 34 studies, 12 concerned infant feeding and 12 aspects of case management delivery and rational drug use. Decisions to fund these studies and their design were based on the opinions of 85 external advisers representing 14 areas of expertise. In addition, expert advice was sought through two consultations: one convened jointly with Community Water Supply and Sanitation (CWS) on hygiene behaviour in the community, and the other with Nutrition (NUT) on improved complementary feeding.

One of the most extensive research activities of the Programme has been the search, over more than 10 years, for improved oral rehydration salts (ORS). Rice-based ORS has shown the most promise of significant benefit. A meta-analysis of nine studies of rice-based ORS, however, showed it to have no advantage over standard glucose ORS with early feeding in children with non-cholera diarrhoea. Rice-based ORS appears to have some advantage in cholera cases and its use for such cases should be encouraged where convenient.

As the studies of improved ORS have consistently indicated the importance of the total osmolarity of the solution, a four-country study of a low osmolarity ORS was initiated and yielded very encouraging results. A similar study in adult cholera cases is under way. In June 1993 a six-centre study of an algorithm for the treatment of persistent diarrhoea was completed. Despite the severe nature of the 485 cases treated in the studies, the algorithm's success rate was 88%.

A series of four studies is examining the determinant sources and costs of drug use and testing interventions to change inappropriate practices. In addition, successful deregistration of antidiarrhoeals in Pakistan is being evaluated. In other studies, pivmecillinam was shown to be an effective treatment for shigellosis and cotrimoxazole was found not to be of benefit in persistent diarrhoea. Determinants of continued use of ORS are under study as is the risk that increased fluid intake during diarrhoea displaces food intake.

A meta-analysis of 29 studies of the effects of milk feeds during diarrhoea concluded that there was no evidence to support the recommendation to dilute such feeds. Research on breastfeeding has also been given considerable attention. In Brazil a study showed that lactation management training improved health worker compliance with practices supportive of breastfeeding leading to an increase in its duration among the population served. Forty-three per cent of mothers attending lactation support clinics were still breastfeeding their child at four months of age compared with 18% of those who did not attend the clinics. Similar results were found in a study in Pakistan.

A study in Jamaica demonstrated that energy density of complementary feeds is more important than feeding frequency in ensuring total energy intake. It was shown that energy-rich porridge thinned with amylase reduced feeding time but did not increase energy intake compared with a thick porridge. Both were clearly superior to a thin less energy-rich porridge.

Two studies of vitamin A supplementation showed an impact on diarrhoea prevalence and severity. Four-monthly supplementation in home visits in a study in Brazil produced a 23% decrease in severe diarrhoea; the effect diminished steadily to disappear after four months.

Although vaccine development has become primarily the responsibility of the WHO Global Programme on Vaccines and Immunization, the CDD Programme continued to conduct field trials of candidate vaccines. In Venezuela a rhesus rotavirus tetravalent vaccine continues to be tested. Trials of two oral cholera vaccines are being supported by the Programme in Peru and Indonesia. The search for a cholera vaccine was made more complex by the emergence of a new cholera-causing organism, *Vibrio cholerae* O139.

⁵ Document WHO/ARI/94.46.

In support to national programme implementation, replanning followed programme reviews in 12 countries. Five countries in Central Asia developed plans for the first time and five regional review and planning meetings were held. Collaboration with NGOs increased, one example being collaboration with the International Federation of Red Cross and Red Crescent Societies in the former Soviet Union. This necessitated the translation of many programme documents into Russian.

In 1992-1993 the range of training materials available from the Programme was expanded with the addition of two sets of materials for improving teaching in medical schools and other professional training schools. A distance learning course on clinical skills and a guide for improving treatment practices of pharmacists and drug sellers were also completed. Training modules on advising mothers were also made available, as was a complete set of materials on breastfeeding counselling. All of these materials are to be incorporated into training plans.

In 1992-1993 over 1000 diarrhoea case management training courses were reported to WHO compared with 280 in the previous biennium. These include 72 national and eight intercountry training of trainers courses. Thirty-nine programme management courses were also held in the most recent biennium. By the end of 1993, 84 medical schools had been covered by the effort to improve teaching on diarrhoea to medical students.

Support to countries in the production of ORS continued, including increased collaboration with the private sector and guidance on how to keep production costs and sales prices low. Total developing country ORS production remained relatively stable. However, there are large regional differences in the degree of self sufficiency of countries. UNICEF continues to provide 75% of the ORS used on the African continent compared with around 1% in South-East Asia.

In the area of communication the guide on advising mothers is now being incorporated in clinical training in most countries. The method has been applied in eight countries and a group of consultants trained. A guide on the effective use of radio was developed and field-tested. In most countries communication activities are conducted in collaboration with UNICEF.

The CDD Programme continued to coordinate the activities of the Global Task Force on Cholera Control. Although the highest number of countries ever reported cholera, in total 78, the number of cases and deaths were less than in 1993. Major epidemics of dysentery in Southern Africa produced additional challenges and the Task Force broadened its scope to cover all epidemic diarrhoeal diseases.

In 1992-1993 a large number of countries applied the Programme's evaluation tools; 24 household surveys were conducted, as were 13 health facility surveys and 12 focused programme reviews. In the latter the problem areas most commonly identified in the first phase of the activity, to be analysed further in the second, were: training, supervision, communication and programme management.

Seventy-six household surveys in 36 countries from 1990 to 1993 showed that 57% of diarrhoea episodes in children less than five years were treated with ORS or a recommended home fluid. While in 32% of cases fluid intake was increased and in 69% feeding continued, only in 21% were both of these aspects of home case management applied. Six more recent surveys using a revised method showed somewhat more optimistic results with one-third of cases receiving increased fluids and continued feeding.

Health facility surveys conducted in 23 countries had shown very variable results but with unacceptably low median values. Part of the reason for these is the very stringent criteria applied by the survey in assessing health workers' performance.

Although access to ORS continued to increase, 25% of the developing world's children still do not have access to this inexpensive life-saving remedy. With regard to the Programmes' training coverage targets, good progress continued to be made and the 40% levels set for 1995 for training in case management and supervisory skills may be achievable. Some of the other targets appeared less attainable.

A programme impact evaluation conducted in the north-eastern states of Brazil had produced persuasive evidence of a significant impact on mortality. A similar study is underway in the Philippines.

Dr Tulloch completed his presentation by pointing out that the Programme's continued progress was dependent on the joint efforts of a wide range of collaborative partners. In working with ministries of health, the Programme counted on the support of UNICEF and other international and bilateral agencies. In the research and development activities, numerous individuals and institutions in both developed and developing countries continued to collaborate actively with the Programme.

8.2 Report of the 15th Meeting of the Technical Advisory Group

Professor S. Lie, Chairperson of the TAG, reported on its fifteenth meeting⁶ held on 20-23 April 1994 at WHO Headquarters in Geneva.

The TAG commented particularly on the high quality of the 1992-1993 Programme Report and endorsed the directions of the Programme outlined therein. It felt that the Programme had evolved in response to experience and research, and its current content and organizational structure were appropriate.

Professor Lie chose to highlight the following aspects of the TAG's conclusions:

- The TAG endorsed the concept of the **integrated management of childhood illness** and commended the Division on the coordinating role it was playing in the initiative. The TAG reviewed in some detail the progress to date and was satisfied that guidelines were being soundly built on available research findings.
- The **impact assessment of the CDD Programme** in north-eastern Brazil was welcomed by the TAG and the Programme was urged to conduct similar studies in other countries.
- Another activity particularly welcomed by the TAG was the development of **methods for monitoring health worker performance**. However, it expressed concern that the feasibility of such methods be adequately assessed before being widely promoted.
- Finally, Professor Lie reported that the Group appreciated the **review of findings of focused programme reviews**. The Chairperson of the TAG had himself participated in such a review and found the process to be well designed and useful.
- After reviewing the Programme's financial matters, the TAG expressed considerable concern that funding had decreased from 1990 to 1993. It noted and supported the action taken by the Programme in 1993 faced with diminished resources. It approved the 1994-1995 budget and expressed the view that the Programme offered an exceptional opportunity to donors to contribute to reducing childhood morbidity and mortality.

* * *

In the ensuing discussion on the above two items, several participants requested additional information or clarification on certain matters. The Secretariat provided the following information:

- Although case management of diarrhoea has changed considerably over the lifetime of the CDD Programme, this was not felt to be a reason to focus now on preventive strategies. Moving now into other areas would likely result in the loss of gains made to date.
- The Programme's research, development and implementation activities on the prevention of diarrhoea are now focused very largely on improving infant and young child nutrition, in particular on the promotion, protection and support of breastfeeding. Other programmes within WHO are responsible for other aspects of prevention such as water and sanitation and food safety. In the area of vaccines, the Programme's activities are limited to completing ongoing trials in relation to rotavirus and cholera vaccines.

⁶ Document WHO/CDD/94.47.

- As observed by some of the meeting participants, the Programme agreed that its current targets would not all be met with current levels of activity. Even in countries where progress had been encouraging, continued support was needed to maintain interest and ensure continued activity.
- The levels of different key indicators varied greatly, being as low as 11% for maternal knowledge of the three rules of home care for diarrhoea. The Programme believes that the currently used evaluation tools provide reliable estimates. However, the criteria applied for satisfactory performance, particularly for health facility workers, are very stringent. Results of surveys were used not only to measure levels of programme achievement but to redirect programme activities such as training.
- In the area of vitamin A deficiency, supplementation in infants and children older than six months can significantly reduce diarrhoea severity and mortality. The Programme is conducting a multicentre study of vitamin A supplementation linked to immunization in the first months of life.
- The problem of resistance of shigella organisms to commonly available antibiotics posed significant problems for making treatment recommendations. Although concern about the safety of quinolones in children had previously prevented their evaluation, it had recently been decided to study ciprofloxacin for this purpose, bearing in mind that a short course (i.e., low total dose) treatment may be effective and that nalidixic acid is already widely used with few reported side effects.

8.3 Financial report for the 1992-1993 biennium

Mr R.C. Hogan, Programme Management Officer, introduced this item and drew attention to the following points:

The CDD Programme's funding trend had changed in 1992-1993. From past levels of either increased or at least sustained support, funding had decreased by US\$ 1.7 million, or 8.5%. Although the Programme gained two new contributions, others declined thus counteracting any advantage. Consequently, in addition to the 12.4% reduction discussed at last year's MIP, actual obligations for 1992-1993 were cut a further US\$ 0.5 million, or 2.5%. Cost reductions characterized the Programme throughout 1993, often in the area of planned activities. The total amount obligated was US\$ 21.7 million or 4% more than in 1990-1991.

All posts in the "services" component (nine professional and six support) at both the global and interregional levels were filled during the biennium, thus explaining the significant increase in salary obligations over the 1990-1991 biennium, which had been characterized by frequent staffing gaps. There had also been an increase in cholera control expenditure, funds being provided by the Director-General's Development Fund.

Although most countries now have national plans of operation, less than anticipated was obligated for planning; modification of plans has not yet become a major activity. The largest single budget category for "services" is support for operational activities, including WHO regional and country staff. Training activities absorbed significantly less funds than anticipated and, although coverage had increased, it was not as rapid and far-reaching as the Programme had hoped.

Two-thirds of the "services" obligations continued to be made at the regional and country levels, as were nearly one-half of the CDD Programme's total obligations.

Two posts — one professional and one support staff — have been eliminated in the "research" component. Overall, less than anticipated was spent on the four research areas, but a greater proportion of the budget was spent, as planned, on implementation research. The increase in the area of immunology, microbiology and vaccine development reflects a one-time purchase of vaccine for a trial, for which special funds were contributed.

Programme management and support costs reflect an increase in permanent and short-term staff.

In spite of efforts to economize during 1993, planned and ongoing activities could not easily be stopped. This necessitated the use of part of the biennial carryover to make up the difference between contributions and obligations. The carryover was already less than half the amount the Programme has usually had available in the past. Thus in the new biennium, the Programme has been closely monitoring global expenditures as well as allocating less than usual to the regional offices during the first half of the year.

8.4 Financial status and revised budget for 1994-1995

Mr Hogan presented the financial status and revised budget for 1994-1995.

In 1993, the TAG, MRC and MIP endorsed the 1994-1995 budget at a level of US\$ 26.8 million. However, due to inadequate sources of funding this amount had to be revised to a level of US\$ 17.8 million — a 33% reduction of the original budget. The Programme did not expect to obtain resources to increase this level.

Decreases across the budget are proportionately greater for programme implementation than for research, with the assumption that other agencies may support country level activities, whereas such agencies may be less likely to support high quality research and development work outside WHO. Decreases also reflect the loss for the Programme of four professional and two support staff post at headquarters. Reductions at regional and country levels have also been necessary. It is hoped that the eight country level posts will be retained — all to be joint ARI/CDD posts. Major cuts have been made in training activities and there is little evidence that other funding sources will compensate for this drop in WHO support.

So far, the Programme's obligations were on schedule — approximately one-fourth of the way through the biennium, 25% of the budget had been obligated. A final budget revision for the biennium will be made at the end of 1994, taking into account obligation patterns and actual contributions.

In addition to special funds for activities on cholera and in the "Newly Independent States", the CDD Programme had received pledges and contributions from 14 of its 20 donors currently listed. This leaves a shortfall of US\$ 5.6 million, excluding the need for a carryover for 1996-1997. Factors indicate that the Programme may receive US\$ 2 million less in extrabudgetary funding during the present biennium as compared with 1992-1993. It is very likely then that further reductions will be required for the final budget revision.

The Programme felt it unrealistic at this point to attempt any financial projections for 1996-1997. Assuming funding stability at best, a formal proposal at about the same level as the next revised budget will be prepared in 1995.

Even though the CDD Programme addressed one of the major causes of mortality and morbidity in children, had developed and demonstrated the effectiveness of technical and managerial tools which could deal with the problem, and had been consistently recognized as managing itself in an effective and efficient manner, it could not obtain the support required to expand or even maintain its activities.

* * *

In the ensuing discussion of the above two items, the revised budget for 1994-1995 was accepted. The participants expressed concern at the serious financial circumstances currently facing the Programme. Current donors were requested to try and maintain their present levels of support wherever possible. They were also requested to pay their contributions as early as possible. The Meeting commended the Programme's cautious approach in planning to present a realistic budget for 1996-1997, but requested that it also show in a contingency budget what could be implemented, given the availability of additional resources.

Dr Tulloch thanked the contributors to both the ARI and CDD Programmes for their continued support during this difficult period and for the pledges made for the current and coming biennia. He reiterated the Programmes' interest in working more closely with bilaterally funded health projects in countries and requested the representatives of donor countries to facilitate this in whichever manner possible.

9. Time and place of next meeting

Following the decision taken by the seventeenth Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases to accept the invitation of the Government of Luxembourg to hold their eighteenth session in that country, it was agreed that the 15th Meeting of Interested Parties would also take place in Luxembourg, on Thursday 6 and Friday 7 July 1995.

10. Other business

There was no other business to report.

Annex 1

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Annex 2

AGENDA

1. Opening of the meeting
2. Election of the Chairperson
3. Adoption of the agenda
4. Matters relating to the report of the thirteenth Meeting of Interested Parties
5. Report of the External Review of the Programmes for the Control of Diarrhoeal Diseases and Acute Respiratory Infections
6. Programme for the Control of Acute Respiratory Infections
 - 6.1 Summary overview - Progress and plans
 - 6.2 Report of the ninth Meeting of the Technical Advisory Group
 - 6.3 Financial report for the 1992-1993 biennium
 - 6.4 Financial status and revised budget for 1994-1995
7. Integrated management of childhood illness — a progress report
8. Programme for the Control of Diarrhoeal Diseases
 - 8.1 Summary overview — Progress and plans
 - 8.2 Report of the fifteenth Meeting of the Technical Advisory Group
 - 8.3 Financial report for the 1992-1993 biennium
 - 8.4 Financial status and revised budget for 1994-1995
9. Time and place of next meeting
10. Other business
11. Closure
