1968 - BRAZIL - (APRIL) REG. ADVISORS MTG.

SPX

Mr. Prosek.

On behalf of WHO and other participants - appreciation for warm welcome and most gracious offer of facilities for this meeting.

Most appropriate for this meeting to be held here for aside from most elegant facilities, we are meeting almost literally in the shadow of the great and storied Fundação Oswaldo Cruz which if any place could claim distinction as the cradle of the concept "eradication" this institute certainly is deserving. Our hosts, we know, will expand upon this further.

Welcome to Nikiforovskaya, Millar, Wilson - special consultants who

We are meeting in the only country in the Americas now known to be endemic for smallpox.

Eradication has progressed in this hemisphere a very long way indeed. Only Brazil remains as a threat to its neighbors but, as you will learn, plans have been laid and a program set in motion which, with luck - and a bit of sweat - should result in Brazil joining the privileged status of its neighbors.

A year ago we first met ~~the program~~ in Alexandria - the program was 4 months old. A year ~~later, still not we met again~~ ago, programs were just beginning in a number of countries of West Africa; ~~and~~ in Brazil, pilot programs and planning were only beginning; the IRE_M_R_, plans of operation were just being written and in SEARO, programs in Afghanistan and Nepal were barely operative - in India, a disastrous program was foundering badly.

A year later - we find activities underway throughout the Americas; in the 19 country bloc of West Africa, almost 30 million of 115 million inhabitants have been vaccinated; programs are now underway or about to begin in much of East Africa, Sudan, Somalia, Pakistan and Indonesia. The program in Afghanistan has been given new life and the painfully slow process of rebuilding the Indian program has begun.

Thanks in major part to contributions of f.d. vaccine from USSR as well as other countries and bilateral support (from France) to West Africa, the use of liquid vaccine is receding at a fantastic pace. e.g. 1½ yrs ago, little ~~virtually no~~ f.d. vaccine was used in Africa - today virtually no liquid vaccine is in use. The quality of vaccine has markedly improved in many laboratories - new Burma & India Kenya Indonesia Brazil

During this past year - the bifurcated needle has been tested in multiple puncture vaccination and is now rapidly replacing the conventional techniques. We had learned considerable about the epidemiology of smallpox which importantly influences our strategy & outlook.

During the past year, the Handbook which we worked on so diligently a year ago has now been widely distributed – 2nd printing; Scientific Group – incl – printed report next month; vaccine producers Seminar just concluded and methodology to be available within months; a ~~diagnostic~~ establishing laboratory manual will ~~complete~~ along towards completion.

Eventful year – productive year. I believe we can take some justifiable pride in the accomplishments. I regret to say, however, that this has probably been the easiest year of the program – the honeymoon, if you will – with many hopes and comparatively few recognized problems.

The problems are now becoming apparent – the hopes are not reality, by any means. It will take a greater effort from us in this coming year ~~and~~ than in the year past. ~~We have a goa~~ Unlike so many programs, we have a very clearly defined goal and a very clearly defined time in which to reach that goal. Sir Wm. Refshauge, D-G Australia, seconded by others, stated the case rather clearly at the ~~Exec.~~ Exec. Bd. in Jan. when he observed that for the prestige and further growth of the W-H-O, this program cannot fail – One eradication program was declared and is clearly not to prosper within, I suspect, my lifetime; a second program has been embarked upon by unanimous decision of the Assembly. A second failure in meeting expectations could be disastrous.

It is fitting that we meet in Brazil for ~~curiously~~ I suspect that this is the most important ~~problem~~ program of all. It is the home of our D-G who has and does worry incessantly regarding the program here ~~and~~, its progress and probable success. However much we have endeavored to reassure him, he is certain that the Indians in the Amazon represent the insuperable obstacle which spell doom to the program – they cannot be found, let alone vaccinated. To persuade him that smallpox eradicating, as he persist, ~~is not~~ malaria eradication, that ~~its the disease~~ the logistics, the strategy, etc. are totally different – that Indians in the Amazon are of essentially no consequence – has proved futile. He must be shown. We say to our Brazilian colleagues that we shall do all possible to support you.

We look forward to our brief stay in Brazil and thank you Mr. Peccy for your most cordial hospitality.

1. 1967 – SE was launched with a 10 yr. target date – SE representing 1 of 2 programs of ord. WHO involved with. At the instigation of the U.S. delegation, it was the WHA formed it, a principle program of WHO – toned down from the principle program.

2. Why? Smallpox in perspective – now sometimes thought of as a "lesser" problem – tetanus, cholera, typhoid

Today Most lethal disease known to man – capable of infecting everyone → 40% mortality in unvaccinated

Before vaccin – variolation.

No respecter of climate

No subclinical infection (polio, tuberculosis)

Today – it is not as major a problem as many other diseases –

World-wide 115 000 cases reported 1967 – Actual total – perhaps a million – deaths ~ 200 000

Today – only 29 endemic countries

Almost a paradox – why?

Throughout the world – vaccination is practised. No country can afford not to.

U.S. – 16×10^6 vacc. – cost overall $\$20 \times 10^6$/yr.

The response evoked by a single case of smallpox today is wholly commensurate with the respect that the disease is held.

1967 – Germany – 1 case – 107 people isolated

1965 – Washington 1 suspect case – 1000 people under surv.; a special ward opened; about 20 000 specially vaccinated (do we do this ē malaria, thr. polio)

Not forgot Int'l travel – cholera vac. needed some areas; y.f. in others. Smallpox is needed in all.

3. Prospects for erad. – long recognized as the single disease known to man as being most susceptible to eradication.

Man to man – no insect vectors, no animal reservoir

Once infected – permanent immunity – not like malaria.

Rash + lesions obvious – detection simple

Vaccination highly effective >80% @ 10 or yrs.

Technique – vacc. of sufficient no. of pop. – disease dies out – (2–3 years not everyone. Critical mass of population necessary to keep the disease going.

4. Today – recognize 29 endemic countries in 4 principle regions

a. Brazil

b. 23 African countries

c. Asia – Afghan. – India – Nepal – Pakistan complex

d. Indonesia.

Strategy – attack disease in these countries – augment present activities

strengthen programs in adjacent countries to restrict extension

Objective – smallpox free – India + Pak now 3% – sp. areas 5–10%

5. Progress - end 1st year

5 years program S. America. -

Brazil - WHO 10^6 # vaccination - 1967

38×10^6 " - 1968

35×10^6 " - 1969

Africa -

U.S. Assistance to 19 countries W + Cent. Africa - WHO providing petrol in half of them.

in 14 mos., ~~38~~ ~~20~~ of 115 millin vaccinated. Incidence already appears to be falling sharply.

WHO programs beginning or started in Congo (K), Rwanda, Burundi, Uganda, Kenya, Tanzania, Somalia, Sudan, Zambia

Asia - WHO Progs. operative in E. Pak, Nepal and Afghanistan.

~~Hopefully~~ Beginning shortly in Indonesia + W. Pak.

At present - feel we are on target.

3 ~~lobes~~ developments / major significance.

1) F.D. vaccine - ~~stability~~ begun in major way +

Production begun a bit over 10 yrs. ago. ~~Activity~~ support & labs. + WHO (consultation + training + establishment / vaccine testing service, quantity + qual of vaccine improving markedly

(Uganda - liquid vaccine - 7×10^6 vac. mechanics; speed; success of tubes)

2) Jet guns - U.S. developed. + tested - / used in Brazil + W. Africa successfully.

Hope to be able to extend them use more widely

3) Bifurcated needles - U.S. developed - exhibit + dinners.

Most encouraged by 1st 14 mos. but there are problems identifiable.

1) Countries

a) Congo (K.)

b) Ethiopia

c) Indonesia

d) India

} Costs / program. If take resources already devoted to smallpox control, add some equipment + vaccine - must can do job. Once job is done - a real saving in resources. 5-10% vaccination.

2) Vaccine for jet injection -

sterility, container - U.S. + Canada.

3) Vaccine generally - Why not produce

Soviet Union - 125×10^6 doses/yr. bilateral + 25×10^6 multilateral. + a number of other countries (Netherlands, Switzerland, Norway, Yemen, Hungary, UAR, Algiers, Thailand, Philippines, etc)

1966	1967	1968
3	13	56