OFFICIAL RECORDS
OF THE
WORLD HEALTH ORGANIZATION
No. 202

TWENTY-FIFTH WORLD HEALTH ASSEMBLY

GENEVA, 9-26 MAY 1972

PART II

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WORLD HEALTH ORGANIZATION
GENEVA
1972

MEMBERSHIP OF THE HEALTH ASSEMBLY

LIST OF DELEGATES AND OTHER PARTICIPANTS

DELEGATIONS OF MEMBER STATES

AFGHANISTAN

Delegates:
Professor A. M. KHOSHBEEN, Deputy Minister of Public Health (Chief Delegate)
Dr G. R. ROASHAN, President, Child Health Institute

ALBANIA

Delegates:
Dr Vera NGJELA (POJANI), Deputy Minister of Health (Chief Delegate)
Professor S. ÇIÇO, Faculty of Medicine, University of Tirana

ALGERIA

Delegates:
Professor O. BOUDJELLAB, Minister of Public Health (Chief Delegate)
Dr A. BENADOUDA, Directeur de l'Action sanitaire, Ministry of Public Health
Dr B. HADJ-LAKEHAL, Chief Medical Officer, Nutrition Section, Ministry of Public Health

Alternates:
Mr A. BOUDEHRI, Secrétaire d'Ambassade, Permanent Mission of the Democratic and Popular Republic of Algeria to the United Nations Office at Geneva and to the Specialized Agencies in Switzerland and Austria
Mr O. BENZITOUNI, Attaché d'Ambassade, Permanent Mission of the Democratic and Popular Republic of Algeria to the United Nations Office at Geneva and to the Specialized Agencies in Switzerland and Austria

ARGENTINA

Delegates:
Professor M. M. J. BREA, Under-Secretary of State for Public Health (Chief Delegate)
Dr V. V. OLGUÍN, Director, International Health Relations, Under-Secretariat of State for Public Health

Advisers:
Professor H. RODRÍGUEZ CASTELLS, Director of Promotion and Protection of Health, Under-Secretariat of State for Public Health
Mr R. A. RAMAYÓN, First Secretary, Permanent Mission of the Republic of Argentina to the United Nations Office and the other International Organizations at Geneva

AUSTRALIA

Delegates:
Sir William REFSHAUGE, Commonwealth Director-General of Health, Department of Health (Chief Delegate)
Dr J. S. BOXALL, Director of International Health, Commonwealth Department of Health
Mr G. BILNEY, First Secretary, Permanent Mission of Australia to the United Nations Office and other International Organizations at Geneva

Alternates:
Dr J. O. TUVI, Assistant Director, Maternal and Child Health, Department of Health, Papua New Guinea
Dr P. HALLETT, Assistant Chief Medical Officer, Australia House, London
Dr L. B. JOHNSON, Medical Director, Australian Embassy in Greece

AUSTRIA

Delegates:
Dr Ingrid LEODOLTER, Federal Minister for Health and Environmental Protection (Chief Delegate)
Dr A. KRASSNIGG, Director-General of Public Health (Deputy Chief Delegate)
Dr J. DAIMER, Director, Federal Ministry for Health and Environmental Protection

Alternates:
Dr R. HAVLASEK, Director, Federal Ministry for Health and Environmental Protection
Dr jur. F. CESKA, Counsellor, Deputy Permanent Representative of Austria to the United Nations Office and the Specialized Agencies at Geneva

BAHRAIN

Delegates:
Dr A. FAKHRO, Minister of Health (Chief Delegate)
Mr J. ZABAR, Superintendent of Administrative Affairs, Ministry of Health

BANGLADESH[1]

Delegates:
Dr T. HOSSAIN, Secretary, Ministry of Health and Family Planning (Chief Delegate)
Mr W. RAHMAN, Ministry of Foreign Affairs

BARBADOS

Delegates:
Mr G. G. FERGUSSON, Minister of Health and Welfare (Chief Delegate)
Mr A. S. HOWELL, Permanent Secretary, Ministry of Health and Welfare
Dr A. V. WELLS, Chief Medical Officer, Ministry of Health and Welfare

BELGIUM

Delegates:
Professor S. HALTER, Secretary-General, Ministry of Public Health and Family Welfare (Chief Delegate)
Dr jur. J. DE CONINCK, First Counsellor; Chief, International Relations Section, Ministry of Public Health and Family Welfare (Deputy Chief Delegate)
Dr M. KIVITS, Chief Physician; Director, Cooperation for Development Office

Alternate:
Mr J. P. VAN BELLINGHEN, Ambassador, Permanent Representative of Belgium to the United Nations Office and the Specialized Agencies at Geneva

Advisers:
Count L. CORNET D'ELZIUS DU CHENOY, Deputy Permanent Representative of Belgium to the United Nations Office and the Specialized Agencies at Geneva
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Mr J. P. DELBUSHAYE, Executive Secretary, Ministry of Foreign Affairs and Trade
Dr F. BOSQUET, Director-General in the Ministry of Public Health and Family Welfare
Dr P. DE SCHOUWER, Director-General in the Ministry of Public Health and Family Welfare
Dr A. DE WEVER, Director-General in the Ministry of Public Health and Family Welfare
Professor K. VUYLSTEEK, Section of Hygiene and Social Medicine, University of Ghent
Professor M. GRAFFAR, Director, School of Public Health, Free University of Brussels
Professor M. F. LECHAT, School of Public Health, Catholic University of Louvain
Professor J. M. PETIT, Director-General, Institut provincial Ernest Malvoz, Liège
Professor P. G. JANSSENS, Director, Prince Leopold Institute of Tropical Medicine, Antwerp
Professor E. SAND, School of Public Health, Free University of Brussels

BOLIVIA

Delegates:
Dr C. VALVERDE BARBERY, Minister of Social Welfare and Public Health (Chief Delegate)
Dr G. DE ACHÁ, Counsellor, Deputy Permanent Representative of the Republic of Bolivia to the United Nations Office and other International Organizations at Geneva
Mrs W. BANZER, Third Secretary, Permanent Mission of the Republic of Bolivia to the United Nations Office and other International Organizations at Geneva

BRAZIL

Delegates:
Professor F. de P. DA ROCHA LAGÔA, Minister of Health (Chief Delegate)
Professor R. VIEIRA DA CUNHA, Secretary-General, Ministry of Health
Dr J. FONSECA DA CUNHA, Secretary for Public Health and Chef de cabinet of the Minister, Ministry of Health

Alternates:
Dr V. PINTO MUSA, Director, Division of Rural Superintendance, Ministry of Health
Mr F. CUMPLIDO, Jr, Minister, Permanent Mission of Brazil to the United Nations Office and other international Organizations at Geneva
Mr O. BANDEIRA DA SILVA CASCAES, Sous-chef de cabinet of the Minister, Ministry of Health
Mr A. AMARAL DE SAMPAIO, First Secretary, Permanent Mission of Brazil to the United Nations Office and other International Organizations at Geneva
Mr J. A. DA ROCHA LAGÔA, Member of the Minister's Secretariat, Ministry of Health

Adviser:
Mr R. DE SALVO COIMBRA, Second Secretary, Ministry of External Relations

[1] Admitted to membership by the Twenty-fifth World Health Assembly on 19 May 1972 (resolution WHA25.20).

BULGARIA

Delegates:
- Dr A. TODOROV, Minister of Public Health (Chief Delegate)
- Dr D. ARNAUDOV, Director, Department of International Relations, Ministry of Public Health
- Mr T. PETROV, Ambassador, Permanent Representative of the People's Republic of Bulgaria to the United Nations Office and other International Organizations at Geneva

Alternate:
- Mr S. CVETKOV, First Secretary, Permanent Representation of the People's Republic of Bulgaria to the United Nations Office and other International Organizations at Geneva

Adviser:
- Dr P. PETKOV, Chief, Department of Public Health Planning, Ministry of Public Health

BURMA

Delegates:
- Dr THEIN AUNG, Deputy Minister of Health (Chief Delegate)
- Dr AUNG THEIN, Director, Department of Health, Ministry of Health

BURUNDI

Delegates:
- Dr F. BUYOYA, Director-General of Public Health (Chief Delegate)
- Mr P. RUTAKE, Director of the Minister's Secretariat, Ministry of Public Health
- Mr I. MAGEREGERE, Director, Department of Hygiene and Laboratories

CAMEROON

Delegates:
- Mr P. FOKAM-KAMGA, Minister of Public Health and Population (Chief Delegate)
- Mr P. BEB A DON, Ambassador of Cameroon in the Federal Republic of Germany
- Dr E. ELOM NTOUZOO, Technical Adviser, Ministry of Public Health and Population

Alternates:
- Professor G. MONEKOSSO, Director, University Centre for Health Sciences, Yaoundé
- Dr T. C. NCHINDA, Delegate of the Minister of Public Health to West Cameroon

CANADA

Delegates:
- Dr M. LECLAIR, Deputy Minister of Health, Department of National Health and Welfare (Chief Delegate)
- Mr G. IGNATIEFF, Ambassador, Permanent Representative of Canada to the United Nations Office and other International Organizations at Geneva (Deputy Chief Delegate)
- Dr B. D. B. LAYTON, Principal Medical Officer, International Health, Department of National Health and Welfare

Alternates:
- Dr R. A. CHAPMAN, Special Adviser to the Deputy Minister of Health[1]
- Mr A. OUELLET, Parliamentary Secretary to the Minister of National Health and Welfare
- Dr S. HAIDASZ, Member of Parliament
- Mr L. FRANCIS, Member of Parliament
- Dr D. SCOTT MACNUTT, Minister of Public Health, Province of Nova Scotia
- Mr R. E. GUAY, Assistant Deputy Minister, Ministry of Social Affairs, Quebec
- Dr D. CANT, Deputy Minister of Health, Province of Newfoundland
- Dr S. L. SKOLL, Deputy Minister of Health, Province of Saskatchewan
- Mr J. A. ROY, Director, Environmental Hygiene, Department of Municipal Affairs, Quebec
- Mr T. BOUDREAU, Head, Department of Behavioural Sciences, University of Sherbrooke

Advisers:
- Mr P. A. LAPOINTE, Counsellor, Permanent Mission of Canada to the United Nations Office and other International Organizations at Geneva
- Mr R. D. AUGER, Second Secretary, Permanent Mission of Canada to the United Nations Office and other International Organizations at Geneva
- Mr R. ROBILLARD, International Programmes Division, Department of Finance

CENTRAL AFRICAN REPUBLIC

Delegates:
- Mr A.-D. MAGALÉ, Minister of Public Health and Social Affairs (Chief Delegate)
- Dr J. GODY

[1] Chief Delegate from 19 May.

CEYLON[1]

Delegates:
- Mr W. P. G. ARIYADASA, Minister of Health (Chief Delegate)
- Mr A. PATHMARAJAH, Permanent Representative of Ceylon to the United Nations Office and other International Organizations at Geneva
- Dr F. A. WICKREMASINGHE, Deputy Director, Public Health Services

Alternates:
- Mr J. R. SAMARANAYAKE, First Secretary, Permanent Mission of Ceylon to the United Nations Office and other International Organizations at Geneva
- Mr A. C. GOONASEKERA, Third Secretary, Permanent Mission of Ceylon to the United Nations Office and other International Organizations at Geneva

CHAD

Delegates:
- Dr J. BAROUM, Minister of Public Health and Social Affairs (Chief Delegate)
- Dr O. BONO, Director of Public Health, Ministry of Public Health and Social Affairs
- Dr J. COULM, Director, Major Endemic Diseases Service

Alternate:
- Mr J. ABDULAHAD, Permanent Representative of the Republic of Chad to the United Nations Office and other International Organizations at Geneva

CHILE

Delegates:
- Dr B. JURICIC, Chief, Office of International Affairs, Ministry of Public Health (Chief Delegate)
- Mr A. ALBERTI, Minister Counsellor, Permanent Mission of Chile to the United Nations Office and other International Organizations at Geneva (Deputy Chief Delegate)
- Mr R. SERRANO GÓMEZ, Commercial Attaché, Permanent Mission of Chile to the United Nations Office and other International Organizations at Geneva

Adviser:
- Mr J. M. OVALLE, Third Secretary, Permanent Mission of Chile to the United Nations Office and other International Organizations at Geneva

[1] Ceylon became Sri Lanka on 22 May 1972.

COLOMBIA

Delegates:
- Dr D. GARCÉS, Ambassador, Permanent Representative of Colombia to the United Nations Office and the Specialized Agencies at Geneva (Chief Delegate)
- Dr G. RESTREPO CHAVARRIAGA, Vice-Minister of Public Health (Deputy Chief Delegate)
- Dr A. GARCÍA BURGOS, Ambassador of Colombia in Switzerland

Alternates:
- Mr P. MORILLO, Director, National Institute of Special Health Programmes (INPES)
- Mr N. GÓMEZ, Counsellor, Deputy Permanent Representative of Colombia to the United Nations Office and the Specialized Agencies at Geneva

CONGO

Delegates:
- Mr D. ITOUA, Minister of Public Health and Social Affairs (Chief Delegate)
- Dr R. POUATY, Secretary-General for Public Health and Social Affairs
- Dr D. MAKOUNDOU, Chief, Epidemiology and Major Endemic Diseases Section, Ministry of Public Health and Social Affairs

COSTA RICA

Delegates:
- Dr R. JIMÉNEZ MONGE, Director, Department of Epidemiology, Ministry of Public Health (Chief Delegate)
- Mr C. DI MOTTOLA BALESTRA, Ambassador, Permanent Representative of the Republic of Costa Rica to the United Nations Office and other International Organizations at Geneva
- Mr M. A. MENA, First Secretary, Permanent Mission of the Republic of Costa Rica to the United Nations Office and other International Organizations at Geneva

Alternate:
- Mr M. CARRERAS MARTI, Consul-General of Costa Rica at Geneva

CUBA

Delegates:
- Dr J. ALDEREGUÍA, Vice-Minister of Hygiene and Epidemiology, Ministry of Public Health (Chief Delegate)
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- Dr Dora GALEGO, Assistant Director of International Relations, Ministry of Public Health

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CYPRUS

Delegates:
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Dr V. P. VASSILOPOULOS, Director-General, Ministry of Health
Mr M. SHERIFIS, Permanent Representative of the Republic of Cyprus to the United Nations Office and the Specialized Agencies at Geneva

CZECHOSLOVAKIA

Delegates:
Professor J. PROKOPEC, Minister of Health of the Czech Socialist Republic (Chief Delegate)
Dr Eliška KLIVAROVÁ, Director, Foreign Relations Department, Ministry of Health of the Czech Socialist Republic
Mr J. ŠTAHL, First Secretary, Permanent Mission of the Czechoslovak Socialist Republic to the United Nations Office and other International Orgánizations at Geneva

Alternates:
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Dr Anna SOBOTKOVÁ, Federal Ministry of Foreign Affairs

DAHOMEY

Delegates:
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Dr J. HOUNSOU, Technical Adviser, Ministry of Health and Social Affairs

DENMARK

Delegates:
Mr E. JENSEN, Minister for the Interior (Chief Delegate)
Dr Esther AMMUNDSEN, Director-General, National Health Service (Deputy Chief Delegate)
Mr F. NIELSEN, Head of Department, Ministry of the Interior

Alternate:
Dr A. MAHNEKE, National Health Board

Advisers:
Mr O. FORSTING, Head of Section, Ministry of the Interior
Mr M. WEINCKE, Head of Department, National Health Board
Dr J. WORM-PETERSEN, Chief Physician
Dr E. HOLST, Associate Professor, Institute of Social Medicine
Mr J. ESPER LARSEN, Counsellor of Embassy, Permanent Mission of Denmark to the United Nations Office and other International Organizations at Geneva

DOMINICAN REPUBLIC

Delegates:
Dr H. PEREYRA ARIZA, Secretary of State for Public Health and Social Welfare (Chief Delegate)
Dr F. HERRERA-ROA, Ambassador, Permanent Representative of the Dominican Republic to the United Nations Office and other International Organizations at Geneva
Mr E. PAIEWONSKY, Second Secretary, Permanent Delegation of the Dominican Republic to the United Nations Office and other International Organizations at Geneva

ECUADOR

Delegates:
Dr C. GUARDERAS RECALDE, Under-Secretary of State for Public Health (Chief Delegate)
Dr H. JATÍVA, Deputy Permanent Representative of Ecuador to the United Nations Office at Geneva
Dr O. EGAS CEVALLOS, Chief, Department of Planning, Ministry of Public Health

EGYPT

Delegates:
Professor M. M. MAHFOUZ, Minister of Public Health (Chief Delegate)
Dr F. R. HASSAN, Under-Secretary of State, Ministry of Public Health (Deputy Chief Delegate)
Dr A. G. KHALLAF, Director, International Health Relations, Ministry of Public Health

Alternates:
Dr M. S. ZAKI, Under-Secretary of State, Ministry of Public Health
Mr A. R. EL REEDY, Counsellor, Permanent Mission of the Arab Republic of Egypt to the United Nations Office and the Specialized Agencies at Geneva
Dr R. A. GOMÀA, Secretary-General, Supreme Council for Health Services
Dr A. M. M. ALY, Assistant Director, International Health Relations, Ministry of Public Health

EL SALVADOR

Delegate:
Dr A. AGUILAR RIVAS, Director, Department of Planning and Coordination, Ministry of Public Health and Social Welfare

ETHIOPIA

Delegates:
Mr K. ABEBE, Minister of Public Health (Chief Delegate)
Dr A. TEKLE, Director, Central Laboratory and Research Institute
Mr M. O. SIFAF, Director-General, Ministry of Public Health

FEDERAL REPUBLIC OF GERMANY

Delegates:
Mrs K. STROBEL, Federal Minister for Youth, Family Affairs and Health (Chief Delegate)
Professor L. VON MANGER-KOENIG, Secretary of State, Federal Ministry for Youth, Family Affairs and Health (Deputy Chief Delegate)[1]
Dr jur. S. SCHNIPPENKOETTER, Ambassador, Permanent Observer of the Federal Republic of Germany to the United Nations Office and Permanent Delegate to other International Organizations at Geneva (Deputy Chief Delegate)[2]

Alternates:
Dr B. E. ZOLLER, Head, International Relations Section, Federal Ministry for Youth, Family Affairs and Health[3]
Baron O. VON STEMPEL, Minister, Deputy Permanent Observer of the Federal Republic of Germany to the United Nations Office and Deputy Permanent Delegate to the other International Organizations at Geneva[4]
Dr W. SCHUMACHER, Head, Communicable Diseases and Epidemiology Section, Federal Ministry for Youth, Family Affairs and Health
Dr Elisabeth FUNKE, Head, Public Health Care Section, Ministry of Labour, Health and Social Affairs of North Rhine-Westphalia

Advisers:
Mr W. GOERKE, Head, Environment Sanitation Section, Federal Ministry of the Interior
Mr H. P. MOLLENHAUER, Head, Food Control and Environmental Health Section, Federal Ministry for Youth, Family Affairs and Health
Dr H. KARL, Counsellor, Ministry for Social Affairs of Hesse
Dr Gisela RHEKER, Minister Counsellor, Office of the Permanent Observer of the Federal Republic of Germany to the United Nations Office and Permanent Delegate to other International Organizations at Geneva
Dr jur. H. SCHIRMER, Counsellor, Office of the Permanent Observer of the Federal Republic of Germany to the United Nations Office and Permanent Delegate to other International Organizations at Geneva
Dr jur. E. SCHOBER, First Secretary, Office of the Permanent Observer of the Federal Republic of Germany to the United Nations Office and Permanent Delegate to other International Organizations at Geneva
Mr T. WALLAU, First Secretary, Office of the Permanent Observer of the Federal Republic of Germany to the United Nations Office and Permanent Delegate to other International Organizations at Geneva
Mr H. A. SCHRAEPLER, First Secretary, Federal Ministry for Foreign Affairs

FIJI

Delegate:
Dr D. SINGH, Secretary for Health

FINLAND

Delegates:
Dr O. KAIPAINEN, Minister of Social Affairs and Health (Chief Delegate)
Professor L. NORO, Director-General, National Board of Health (Deputy Chief Delegate)
Dr M. PARMALA, Head, International Relations Section, National Board of Health

Alternates
Mr M. KAHILUOTO, Assistant Director, Ministry for Foreign Affairs
Mr M. HÄKKÄNEN, Chief of Section, Ministry for Foreign Affairs

Advisers:
Miss V. KIVISTÖ, Head of Section, Ministry of Social Affairs and Health
Mr V. OLLIKAINEN, Attaché, Permanent Mission of Finland to the United Nations Office and other International Organizations at Geneva

FRANCE

Delegates:
Professor E. J. AUJALEU, Honorary Director-General, National Institute of Health and Medical Research (Chief Delegate)

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[1] Chief Delegate from 12 May.

[2] Chief Delegate from 16 May.

[3] Delegate from 12 May.

[4] Delegate from 16 May.

Mr J. FERNAND-LAURENT, Ambassador, Permanent Representative of France to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Dr J. P. CHARBONNEAU, Director-General of Health

Alternates:
Dr L. P. AUJOULAT, former Minister; Inspector-General of Health
Dr J.-S. CAYLA, Director, National School of Public Health
Dr P. FAVREAU, Inspector-General of Health
Professor R. SENAULT, Faculty of Medicine, Nancy

Advisers:
Miss J. BALENCIE, Assistant Secretary, Ministry of Foreign Affairs
Mr R. FAURIS, First Secretary, Permanent Mission of France to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Mr G. FROMENT, Chief, International Relations Division, Ministry of Public Health and Social Security
Dr H. P. JOURNIAC, Chief, Division of Public Health and Social Affairs, Secretariat of State for Foreign Affairs
Dr J. MEILLON, Chief Medical Inspector, International Relations Division, Ministry of Public Health and Social Security
Professor G. OLIVE, Scientific Adviser, National Institute of Health and Medical Research
Mr F. NICAISE, Pharmacien-Inspecteur régional, Ministry of Public Health and Social Security
Dr M. TRAZZINI, Technical Adviser, Directorate-General of Health, Ministry of Public Health and Social Welfare

GABON

Delegates:
Mr S. MINKO, Minister of Public Health and Population (Chief Delegate)
Dr J. B. BIYOGHE, Deputy Chief of Surgical Services, Libreville Hospital Centre
Mr M. G. NDIMAL, First Counsellor, Permanent Mission of the Republic of Gabon to the United Nations Office and other International Organizations at Geneva

GAMBIA

Delegates:
Mr I. M. GARBA-JAHUMPA, Minister of Health and Labour (Chief Delegate)
Dr P. J. N'DOW, Chief Medical Officer, Ministry of Health and Labour

GHANA

Delegates:
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Dr M. A. BADDOO, Deputy Director of Medical Services, Ministry of Health (Deputy Chief Delegate)
Dr N. F. HAMMOND-QUAYE, Senior Medical Officer for Planning, Ministry of Health

Alternate:
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Adviser:
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GREECE

Delegates:
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Professor A. KANELLAKIS, Athens School of Hygiene
Mr G. HELMIS, Secrétaire d'Ambassade, Permanent Mission of Greece to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

GUATEMALA

Delegates:
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Mr E. PERALTA DUARTE, Minister Counsellor, Permanent Representation of Guatemala to the United Nations Office and the Specialized Agencies at Geneva[1]
Dr R. ZECEÑA FLORES, Consul of Guatemala in Hamburg

Alternate:
Mrs C. GARCÍA DE PERALTA

GUINEA

Delegates:
Dr K. CAMARA, Secretary of State for Public Health (Chief Delegate)
Mr S. KEITA, Ambassador of the Republic of Guinea in Western Europe
Dr A. BANGOURA-ALÉCAUT, Director, Major Endemic Diseases Service

HAITI

Delegates:
Dr A. THÉARD, Secretary of State for Public Health and Population (Chief Delegate)
Dr C. DAMBREVILLE, Director, Division of Public Hygiene, Department of Public Health and Population

[1] Chief Delegate from 20 May.

HONDURAS

Delegates:
- Dr C. A. PINEDA, Minister of Public Health and Social Welfare (Chief Delegate)
- Mr M. CARÍAS, Ambassador, Permanent Representative of the Republic of Honduras to the United Nations Office at Geneva and the International Organizations in Switzerland

HUNGARY

Delegates:
- Professor L. FARÁDI, First Deputy Minister of Health (Chief Delegate)
- Dr D. FELKAI, Head, Department of External Relations, Ministry of Health
- Dr L. SÁNDOR, Deputy Head, Department of External Relations, Ministry of Health

Alternates:
- Professor J. TIGYI, Pro-Rector, University of Medical Sciences, Pécs
- Mr J. VARGA-PERKE, Counsellor, Ministry of Foreign Affairs
- Dr K. ÁGOSTON, First Secretary, Permanent Mission of the Hungarian People's Republic to the United Nations Office and the other International Organizations at Geneva

ICELAND

Delegates:
- Dr P. SIGURDSSON, Secretary-General, Ministry of Health (Chief Delegate)
- Dr S. SIGURDSSON, Chief Medical Officer

INDIA

Delegates:
- Mr U. S. DIKSHIT, Minister for Health and Family Planning (Chief Delegate)
- Mr K. K. DASS, Secretary, Ministry of Health and Family Planning[1]
- Dr P. K. BANERJEE, Ambassador, Permanent Representative of India to the United Nations Office and other International Organizations at Geneva

Alternates:
- Dr J. B. SHRIVASTAV, Director-General of Health Services
- Dr S. K. SENGUPTA, Director, Central Bureau of Health Intelligence
- Mr P. M. S. MALIK, First Secretary, Permanent Mission of India to the United Nations Office and other International Organizations at Geneva

[1] Chief Delegate from 12 May.

INDONESIA

Delegates:
- Professor G. A. SIWABESSY, Minister of Health (Chief Delegate)
- Professor Julie SULIANTI SAROSO, Director-General of Communicable Disease Control, Department of Health (Deputy Chief Delegate)[2]
- Dr P. P. SUMBUNG, Director, Bureau for Special Affairs, Department of Health

Alternate:
- Dr W. BAHRAWI, Director, Provincial Health Service of East Java[3]

Adviser:
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IRAN

Delegates:
- Dr M. SHAGHOLI, Minister of Health (Chief Delegate)
- Dr A. DIBA, Ambassador; Health Adviser on WHO Affairs, Permanent Mission of Iran to the United Nations Office and the Specialized Agencies at Geneva
- Dr G. SOOPIKIAN, Director-General of Planning and Programmes, Ministry of Health

Advisers:
- Dr M. ROUHANI, Director-General, Medical and Health Services, National Iranian Oil Company
- Mr M. B. NAMAZI, Director, Division of Health and Social Welfare, Plan Organization
- Dr I. TABIBZADEH, Director-General, Malaria Eradication Organization, Ministry of Health
- Dr A. NADERI, Director-General for Pharmaceutical Affairs, Ministry of Health
- Mr A. N. AMIRAHMADI, Director, International Health Relations Department, Ministry of Health
- Dr E. DJAHANNEMA, Counsellor, Permanent Mission of Iran to the United Nations Office and the Specialized Agencies at Geneva

IRAQ

Delegates:
- Dr I. MUSTAFA, Minister of Health (Chief Delegate)
- Dr A. W. AL-MUFTI, Director-General of Scientific Affairs, Ministry of Health
- Dr M. IBRAHIM, Director, International Health, Ministry of Health

[2] Chief Delegate from 17 May.

[3] Delegate from 17 May.

Advisers:
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Mr S. DAOUD, Third Secretary, Permanent Mission of the Republic of Iraq to the United Nations Office at Geneva

IRELAND

Delegates:
Dr J. C. JOYCE, Chief Medical Officer, Department of Health (Chief Delegate)
Mr D. WHELAN, Principal Officer, Department of Health

ISRAEL

Delegates:
Mr V. SHEMTOV, Minister of Health (Chief Delegate)
Mr A. A. ZOUBI, Deputy Minister of Health (Deputy Chief Delegate)
Dr A. HARELL, Director-General, Municipal Governmental Medical Centre, Tel Aviv-Jaffa

Alternates:
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Dr D. PRIDAN, Chief Medical Officer, Judea and Samaria

Advisers:
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Mr E. DOWEK, Assistant Director, Division for Africa and Madagascar, Ministry of Foreign Affairs
Mr M. MELAMED, First Secretary, Permanent Mission of Israel to the United Nations Office and the International Organizations at Geneva

ITALY

Delegates:
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Professor R. VANNUGLI, Director, Office of International Relations, Ministry of Health (Deputy Chief Delegate)
Mr S. D'ANDREA, Minister Counsellor, Deputy Permanent Representative of Italy to the United Nations Office and to other International Organizations at Geneva

Alternates:
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Mr E. DI MATTEI, First Secretary, Permanent Mission of Italy to the United Nations Office and to other International Organizations at Geneva
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Professor G. A. CANAPERIA, Ministry of Health
Professor A. CORRADETTI, Director, Laboratory of Parasitology, Istituto Superiore di Sanità, Rome
Professor L. GIANNICO, Ministry of Health
Professor B. PACCAGNELLA, Director, Institute of Hygiene, University of Ferrara
Professor F. PETRILLI, Ministry of Health
Professor G. PENSO, Adviser, Ministry of Health
Professor F. POCCHIARI, Director, Istituto Superiore di Sanità, Rome
Dr G. SPALATIN, Inspector-General of Health, Ministry of Health

IVORY COAST

Delegates:
Professor H. AYÉ, Minister of Public Health and Population (Chief Delegate)
Mr B. NIOUPIN, Ambassador, Permanent Representative of the Republic of the Ivory Coast to the United Nations Office at Geneva and the Specialized Agencies at Geneva and Vienna
Dr I. DJOMAND-DIPLO, Directeur de la Médecine hospitalière

Alternate:
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JAMAICA

Delegates:
Dr Mavis G. GILMOUR, Parliamentary Secretary, Ministry of Health and Environmental Control (Chief Delegate)
Dr W. J.-S. WILSON, Chief Medical Officer, Ministry of Health and Environmental Control

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JAPAN

Delegates:
Dr K. TSUKAMOTO, President, National Cancer Centre, Ministry of Health and Welfare (Chief Delegate)

Mr H. KAYA, Counsellor, Permanent Mission of Japan to the United Nations Office and other International Organizations at Geneva
Mr M. TSUNASHIMA, Counsellor and Chief Liaison Officer, International Affairs, Minister's Secretariat, Ministry of Health and Welfare

Alternates:
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Mr K. TERADA, Specialized Agencies Division, United Nations Bureau, Ministry of Foreign Affairs

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Mr Y. KAWASHIMA, Second Secretary, Permanent Mission of Japan to the United Nations Office and other International Organizations at Geneva

JORDAN

Delegates:
Dr M. AL-BASHIR, Minister of Health (Chief Delegate)
Dr A. NABULSI, Under-Secretary of State, Ministry of Health (Deputy Chief Delegate)
Dr I. HIJAZI, Director of Curative Medicine

KENYA

Delegates:
Mr I. OMOLO OKERO, Minister for Health (Chief Delegate)
Dr J. M. GEKONYO, Deputy Director of Medical Services, Ministry of Health (Deputy Chief Delegate)
Mr J. W. OWUOR, Deputy Secretary, Ministry of Health

Alternate:
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KHMER REPUBLIC

Delegates:
Professor SO SATTA, Faculty of Medicine of Phnom Penh (Chief Delegate)
Dr PRUOCH VANN, Deputy Director-General of Health, Ministry of Public Health
Dr SUON BOPHEAK, Chief, External Relations Bureau, Ministry of Public Health

KUWAIT

Delegates:
Dr A.-R. M. AL-ADWANI, Minister of Public Health (Chief Delegate)
Dr A. M. AL-REAFAI, Director of Curative Services, Ministry of Health
Dr A. R. AL-AWADI, Director, Preventive Services, Ministry of Health

LAOS

Delegates:
Dr K. ABHAY, Secretary of State for Public Health (Chief Delegate)
Dr P. PHOUTTHASAK, Director-General, Ministry of Public Health

LEBANON

Delegate:
Dr J. ANOUTI, Director-General, Ministry of Public Health

LESOTHO

Delegates:
Mr C. D. MOLAPO, Minister of Health, Social Welfare and Education (Chief Delegate)
Dr J. L. MOLAPO, Director of Health Services, Ministry of Health, Social Welfare and Education (Deputy Chief Delegate)
Dr M. C. MOKETE, Medical Officer

LIBERIA

Delegates:
Mrs M. PADMORE, Minister of Health and Social Welfare (Chief Delegate)
Mr H. Q. TAYLOR, Assistant Minister of Health
Dr H. N. COOPER, Chief Medical Officer, J. F. Kennedy Medical Centre

LIBYAN ARAB REPUBLIC

Delegates:
Dr E. A. SASY, Director-General of Preventive Medicine, Ministry of Health (Chief Delegate)
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LUXEMBOURG

Delegates:
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MADAGASCAR

Delegates:
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MALAWI

Delegates:
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MALAYSIA

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[1] Chief Delegate from 19 May.

[2] Delegate from 19 May.

MALI

Delegates:
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MALTA

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MAURITANIA

Delegates:
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MAURITIUS

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MEXICO

Delegates:
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Dr H. R. ACUÑA-MONTEVERDE, Director-General, International Affairs, Secretariat for Health and Welfare
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MONACO

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Mr J.-Ch. MARQUET, Legal Adviser, Office of H.S.H. the Prince of Monaco
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MONGOLIA

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MOROCCO

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NEPAL

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NETHERLANDS

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Mr W. C. REIJ, Director-General for Environmental Hygiene, Ministry of Public Health and Environmental Hygiene
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NEW ZEALAND

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NICARAGUA

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NIGER

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NIGERIA

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OMAN

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PAKISTAN

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Delegates:
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PEOPLE'S DEMOCRATIC REPUBLIC OF YEMEN

Delegates:
Dr A. MAISARI, Assistant Director of Health Services, Ministry of Health (Chief Delegate)
Mr M. A. AULAQI, Minister Plenipotentiary, Ministry of Foreign Affairs

PERU

Delegates:
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PHILIPPINES

Delegates:
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POLAND

Delegates:
Professor M. SLIWINSKI, Minister of Health and Social Welfare (Chief Delegate)
Professor W. RUDOWSKI, Chairman, Scientific Council of the Minister of Health and Social Welfare
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PORTUGAL

Delegates:
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Professor G. JANZ, National School of Public Health and Tropical Medicine

QATAR

Delegates:
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REPUBLIC OF KOREA

Delegates:
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ROMANIA

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RWANDA

Delegates:
Mr A. SEBATWARE, Minister of the Interior and of Justice (Chief Delegate)
Dr M. GASHAKAMBA, Deputy Director, Kigali Hospital Centre

SAUDI ARABIA

Delegates:
Mr J. HEJAILAN, Minister of Health (Chief Delegate)
Dr A. S. TABBAA, Director-General, International Health, Ministry of Health (Deputy Chief Delegate)
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SENEGAL

Delegates:
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Dr M. N'DIAYE, Chairman, Commission of the National Assembly on Health and Social Affairs

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Mr J. P. CRESPIN, Counsellor, Permanent Mission of the Republic of Senegal to the United Nations Office and the Specialized Agencies at Geneva

[1] Chief Delegate from 17 May.

[2] Delegate from 17 May.

SIERRA LEONE

Delegates:
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SINGAPORE

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SOMALIA

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SPAIN

Delegates:
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SUDAN

Delegates:
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SWEDEN

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SWITZERLAND

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SYRIAN ARAB REPUBLIC

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TOGO

Delegates:
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- Dr P. MIKEM, Director, Medical Welfare Division and Basic Health Services
- Dr P. KARSA, Chief Physician, Tabligbo Health Subdivision

TRINIDAD AND TOBAGO

Delegates:
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TUNISIA

Delegates:
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TURKEY

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UGANDA

Delegates:
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Alternate:
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UNION OF SOVIET SOCIALIST REPUBLICS

Delegates:
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[2] Delegate from 18 May.

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UNITED ARAB EMIRATES

Delegates:

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Mr M. KHAMIS

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Mr A. AL-FARDAN

UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND

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UNITED REPUBLIC OF TANZANIA

Delegates:

Mr A. H. MWINYI, Minister of Health (Chief Delegate)

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UNITED STATES OF AMERICA

Delegates:

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Mr F. T. BOW, Member of Congress from the State of Ohio

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Dr I. A. MITCHELL, Special Assistant to the Assistant Secretary for Health and Scientific Affairs, Department of Health, Education and Welfare

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[2] Deputy Chief Delegate from 13 May.

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UPPER VOLTA

Delegates:
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Alternate:
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URUGUAY

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VENEZUELA

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Mr L. FERNÁNDEZ, Second Secretary, Permanent Mission of Venezuela to the United Nations Office and other International Organizations at Geneva

VIET-NAM

Delegates:
Dr TRUONG MINH CAC, Director-General of Health, Ministry of Health (Chief Delegate)
Dr NGUYEN DANG QUE, Director of Public Health
Mr CHAU VAN MUOI, Private Secretary to the Minister of Health

Advisers:
Mr PHAM VAN TRINH, Second Secretary, Office of the Permanent Observer of the Republic of Viet-Nam to the United Nations Office and Permanent Delegation to the other International Organizations at Geneva
Miss NGUYEN LE DUNG, Third Secretary, Office of the Permanent Observer of the Republic of Viet-Nam to the United Nations Office and Permanent Delegation to the other International Organizations at Geneva

WESTERN SAMOA

Delegates:
Dr J. C. THIEME, Director of Health, Health Department (Chief Delegate)
Mr A. W. DAWSON, Second Secretary, Permanent Mission of New Zealand to the United Nations Office at Geneva

YEMEN

Delegates:
Dr M. K. AGHBARI, Minister of Health (Chief Delegate)
Dr A. TARCICI, Ambassador, Permanent Representative of the Yemen Arab Republic to the United Nations Office at Geneva and the Specialized Agencies in Europe
Dr A. W. ATEEK, Director of Curative Medicine, Ministry of Health

YUGOSLAVIA

Delegates:
Mr V. DRAGAŠEVIĆ, Federal Secretary for Labour and Social Policy (Chief Delegate)
Dr D. JAKOVLJEVIĆ, President, Yugoslav Commission for Cooperation with International Health Organizations (Deputy Chief Delegate)[1]
Mr L. JEREMIĆ, Minister Plenipotentiary, Federal Secretariat for Foreign Affairs

Alternate:
Dr B. SKUPNJAK, Under-Secretary, Secretariat for Public Health and Social Welfare, Federal Republic of Croatia[2]

[1] Chief Delegate from 16 May.

[2] Delegate from 16 May.

Adviser:
Mr T. BOJADZIEVSKI, Second Secretary, Permanent Mission of the Socialist Federal Republic of Yugoslavia to the United Nations Office and International Organizations at Geneva

ZAIRE

Delegates:
Dr P. KALONDA LOMEMA, Minister of Public Health (Chief Delegate)
Dr S. MATUNDU-NZITA, Director, Kinshasa Health Services
Dr R. LEKIE, Director, National Smallpox Eradication Campaign

Advisers:
Mr E. DIMBAMBU MANUENU, Secretary to the Minister of Public Health
Dr Y. YOKO, Chargé d'Affaires and First Counsellor, Permanent Mission of the Republic of Zaire to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Mrs A. NKUBA-MPOZI, Attaché d'Ambassade, Permanent Mission of the Republic of Zaire to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

ZAMBIA

Delegates:
Mr A. B. CHIKWANDA, Minister of Health (Chief Delegate)
Dr M. NALUMANGO, Permanent Secretary for Health; Director of Medical Services, Ministry of Health
Dr C. O. AKERELE, Assistant Director of Medical Services, Ministry of Health

OBSERVERS OF NON-MEMBER STATES

HOLY SEE

Monsignor S. LUONI, Permanent Observer of the Holy See to the United Nations Office and the Specialized Agencies at Geneva
Dr P. CALPINI
Dr G. NICOLAS
Rev. Father P. BOLECH

SAN MARINO

Mr G. FILIPINETTI, Minister Plenipotentiary, Permanent Observer of the Republic of San Marino to the United Nations Office and other International Organizations at Geneva
Mr J.-Ch. MUNGER, Chancellor, Office of the Permanent Observer of the Republic of San Marino to the United Nations Office and other International Organizations at Geneva

OBSERVERS INVITED UNDER RULE 3 OF THE RULES OF PROCEDURE OF THE ASSEMBLY

GERMAN DEMOCRATIC REPUBLIC
(up to and including 19 May 1972)

Professor L. MECKLINGER, Minister of Health
Dr K.-H. LEBENTRAU, Head, Department of International Relations, Ministry of Health
Mrs H. KIERMEIER, Deputy Head of Department, Ministry of Foreign Affairs
Professor K.-H. RENKER, Director, Institute of Hygiene, Martin-Luther University of Halle
Dr S. ZACHMANN, Minister Plenipotentiary
Dr H.-G. KUPFERSCHMIDT

OBSERVERS

ORDER OF MALTA

Mr A. KOCH, Ambassador, Permanent Delegate of the Sovereign Order of Malta to the International Organizations at Geneva
Count E. DECAZES, Minister Plenipotentiary, Deputy Delegate of the Sovereign Order of Malta to the International Organizations at Geneva
Dr M. GILBERT, Secretary-General, International Committee of the Sovereign Order of Malta for Aid to Leprosy Victims

solidarity which ought to animate every human being. And WHO is the place where all those are assembled who are bringing their skill and organizing ability, together with their devotion and their spirit of sacrifice, to the bedside of their sick and ailing fellows.

The Government and people of Switzerland wish every success to the work of an Assembly inspired by such an ideal.

4. ADDRESS BY THE PRESIDENT OF THE TWENTY-FOURTH WORLD HEALTH ASSEMBLY

The PRESIDENT: Once again we are gathered together in this great Assembly to review the health problems which beset the world and to plan the way forward to that ideal situation envisaged in the World Health Organization's definition of health.

Our studies and our decisions will be based on the treasure of knowledge and experience we have accumulated, sharpened by our analysis of the progress as well as by the setbacks of last year. Our efforts have no doubt produced inspiring results in bringing some health problems nearer control. At the same time we have gathered new evidence that some of the problems which have been the cause of our concern for many years will continue to challenge human skills and dedication for some time yet. In still other areas, new challenges have emerged. Health is not a discipline in which one can look forward to a diminution of the areas of challenge. Human expectations are such that the target levels for health will move constantly forward to new frontiers, so that health agencies, whether national, regional or international, face a continuing prospect of new tasks being added to their workloads.

Since the earliest times, mankind has been seeking the touchstone of continuous good health, first as individuals, then within a small community, and later within a State. It is only in the twentieth century - particularly in the last 25 years - that, by a concerted effort by all nations working together in one direction, results have been achieved sufficient to offer real hopes that good health - not only of the body, but of the mind - is not a vision but something within our reach. The World Health Organization is the logical and indispensable instrument for delivering and organizing such concerted efforts.

I believe this Organization has already justified its existence by the work it has sponsored towards the eradication or control of such diseases as smallpox, cholera, plague, trachoma, yaws and tuberculosis. Indeed, in spite of some temporary setbacks, the record of the smallpox campaign alone should pass into history as one of the World Health Organization's greatest achievements. You will recall that in 1967, after the replanning of its strategy against smallpox, WHO launched the final drive against smallpox with the target of complete eradication in 10 years. Half of those 10 years have now elapsed, and it does seem that, if the dramatic progress of the first five years is any guide, there are good prospects that the end of the second five years will see the final disappearance of smallpox throughout the world. If, as we all hope, this target can be achieved, it will be the first time in history that a once common disease has been totally eradicated. There can, of course, be no complacency about an ultimate victory over smallpox and we must be constantly on guard against its sudden and unpredictable appearances. Recent events have surely demonstrated this, while evidencing at the same time the efficiency of the methods developed and the public confidence enjoyed by WHO.

Another of the great global problems - namely, malnutrition - was a subject of growing concern to the Organization. The Executive Board, at its forty-ninth session, expressed deep concern at the gravity and complexity of the problems of malnutrition, and has recommended that the Organization strengthen its activities in nutrition, stressing particularly the importance of manpower training and institutional development.

The importance of manpower training, of course, applies in many fields of national health endeavour other than nutrition. It has emerged, I think, as a matter for particular priority and as one which offers an assured return in terms of health problem solving. Our manpower resources have not only to be enlarged, we have also learned that they need to be trained in new ways to meet newly recognized requirements.

In our struggle with the diseases of deficiency and infection, public health methods have indeed achieved notable success. Part of the secret of that success has been that the technological age was well equipped to partner public health methods in attacks on deficiency and infectious diseases.

Even where the hazards were partly the creation of industrialization, as in the growth of large cities, science and technology had the tools to remedy their own defects. They were just as efficient in providing water supplies and sewerage systems as in building and operating factories and railways. But I sometimes wonder if the technological viewpoint, in the way

posts and in field work in public health. In the same year, he entered his country's Ministry of Health - now the Department of Health and Social Security. He was appointed Deputy Chief Medical Officer in 1950 and, since 1960, has been Chief Medical Officer of the Department of Health and Social Security, the Department of Education and Science, and the Home Office of Great Britain.

These are the bare outlines of a career marked by honours and distinctions too numerous for me to mention. Sir George was elected a Fellow of the Royal College of Physicians, London, in 1947, and of the Royal College of Obstetricians and Gynaecologists in 1966. He was Honorary Physician to the Queen from 1953 to 1956. He was created Knight Commander of the Bath in 1962 and promoted to Grand Cross in 1971. He holds honorary degrees in law from Manchester, Hull, and Newcastle Universities and is an honorary fellow of numerous societies, including the American Public Health Association and the American Hospital Association.

While Sir George has spent almost his entire professional life in the service of the same government department, his activities have, in fact, been widely varied and extend to many facets of that complex of concepts which we epitomize in the word "health".

He was, for example, one of a group which undertook regional surveys of all hospitals in the United Kingdom in the years 1942 to 1944. In the latter year, the National Health Service in the United Kingdom was in its early planning stages, and in these beginnings Sir George played a notable part, as he did later in the operation of the new Health Service after it came into being in 1948. It was my personal pleasure to meet Sir George - then Dr Godber - just one year later when I visited the United Kingdom to study the newly founded National Health Service.

At that time and subsequently Sir George's imagination and vigour contributed in no small measure to the practical administration and the achievements of his country's health service, with its many innovatory features in both prevention and cure. His concern with, and insight into, the organization and delivery of health services are reflected in his many publications. To illustrate further his diversity of interests, Sir George's name is also associated with campaigns against diphtheria, tuberculosis, poliomyelitis and venereal diseases.

In addition to the national, there is also the international Sir George whom we have learned to appreciate and respect increasingly over the years. Sir George has been the leader of the United Kingdom delegation at the World Health Assembly since 1961, and for much of that time he has also been a member of the Executive Board as well as of the Expert Advisory Panel on Public Health Administration.

To WHO Sir George has brought inexhaustible knowledge and many-sided experience of public health, with the sound judgement of a senior administrator. Many of us also know with what determination he has pursued internationally a cause he has long since made his own on the national level, and here I refer to his concern with the dangers of tobacco smoking. The fact that those present at this Assembly as well as at the other bodies of WHO no longer smoke in meeting rooms is due in large measure to the work of Sir George, and I think it is fair to say that he has done more than any other man to alert world opinion to the hazards of smoking.

In his many spheres of interest, his actions have been marked by wisdom and moderation, with a deep-rooted devotion to the cause of health. With Sir George Godber's name, the list of Léon Bernard prize-winners is enriched by an impressive personality, and it is with great pleasure and personal pride that I now present him with the Léon Bernard Foundation Medal and Prize.

Amid applause, the President handed the Léon Bernard Foundation Medal and Prize to Sir George Godber.

Sir George GODBER: Mr President, friends and colleagues at this World Health Assembly, it is difficult for me to express to you the depth of my gratitude for the honour you have done me. I am too much of a realist to believe all the kind things you, Mr President, have just said, but I am grateful for your generosity. The award of the Léon Bernard Prize is a personal distinction which I can only accept with humility in the knowledge that I have done far less to earn it than those who have gone before me. I will not go through the roll of their names because Professor Aujaleu, who knew them better than I, spoke of them last year. It has been my good fortune to have known them all and I will do no more than refer to the last three recipients, Dr Karl Evang, Dr Mudaliar and Professor Aujaleu himself. At the World Health Assembly and on many other occasions they have been the friends and colleagues from whom I have learned most and whom I am most honoured to follow.

This prize is awarded for contributions to social medicine, but it is clear that the Committee of the Foundation has consistently interpreted this remit as meaning social medicine in a world context. Thus, the previous recipients of this award down the years have, almost

without exception, been men distinguished for their contributions to the work of the World Health Organization. I must confess that I first took part in WHO activities with less than a proper appreciation of their value. Twenty-one years ago and again 16 years ago I was the fortunate recipient of travelling fellowships which first made me realize how little one knows of medicine and its organizations if one only knows the pattern of one's own country. There were other occasions also before I came to my first Assembly in New Delhi in 1961 with a greatly enhanced respect for the contribution which this Organization can make to the improvement of health services, not only in the developing countries but also in those with the most sophisticated facilities and organization already. I make this point because there are far too many people in countries with developed health services who think that WHO has nothing to offer them. Nothing could be further from the truth. And I will return to that later.

Once one is fully involved with the work of the Assembly and the Executive Board, the crucial role of WHO in promoting the health of that great mass of the world's people still desperately short of the means of achieving it becomes apparent. One learns at once that such an organization as this has not, and perhaps never will have, the resources required to make good what so many developing countries lack. The Director-General and his staff face the most exacting examination in the art of the possible that could be set. No government, to my knowledge, places as much store upon the need for health resources as do we here, whose primary concern they are, but nonetheless this Organization can do, and has done, remarkable things to help those struggling in the face of great obstacles to make progress in the health field.

Communicable diseases are still the major health preoccupation for the greater part of the world's population. Some of us have been fortunate in the extent to which we have been able to bring our own communicable disease problems under control, but we have had the advantage of more than a century of effort that our forebears have put into the provision of a sanitary foundation upon which community health could be built. The health of the world cannot be secured without this foundation. Yet, great cities of Africa and Asia have not had that fortunate heritage and face such obstacles to making good their deficiencies as we have not faced in this century, and their resources are less. The world is beginning to show consciousness of its duty to assist in such development, but so far the contribution has been pitifully small. We all know well that the lethal consequences of too few calories and of too little sanitation will not be prevented by vitamin concentrates and vaccines, even if we could provide them.

Just as the control of certain communicable diseases must be built on a sanitary foundation, so the conquest of others must rest on an infrastructure of health services. I venture to prophesy that the verdict of history will vindicate WHO's insistence on that as a prime requirement. The world needs vast numbers of trained men and women to serve in the health professions. The guidance of WHO has been of immeasurable value in stimulating and developing the necessary programmes, particularly, it seems to me, against the background of the special problem of Africa.

In many ways the most striking success of the Organization has been in smallpox eradication. That programme is not yet complete but the campaign has advanced at a pace and over a wide front such as few of us would have thought possible five years ago. We may truly be moving toward the elimination of a disease as old, perhaps, as man himself which in its time has ravaged every land and whose annual toll was certainly not fully known and must have been measured in millions. Without this Organization, and especially without the trust which is reposed in it by all countries, such a worldwide intercountry programme could not have been attempted, much less have succeeded.

WHO has existed now for almost a quarter of a century. It has moved forward on a scale which I doubt whether even its founding fathers foresaw. It has acquired a worldwide respect which in our own countries many of us must envy, since national administrations seldom enjoy such recognition even if they deserve it. In a way it has managed to ride above the ordinary man's reaction against his own bureaucracy. It is already a very large organization with a highly expert Secretariat capable of responding to the calls made upon it in a way which is a credit to the two Directors-General who have built it up. It must avoid the temptation to overreach itself, as might very well happen if it tried to handle directly each and every scientific and social issue, no matter how complex, that may arise to threaten or appear to threaten the health of mankind. Possibly a way has been found in the International Agency for Research on Cancer, scientifically autonomous although in intimate relationship with WHO itself.

2. SMALLPOX ERADICATION Agenda, 2.5

The CHAIRMAN invited Dr Ehrlich to report on the Executive Board's discussions.

Dr EHRLICH, representative of the Executive Board, said that during its review of the proposed programme and budget estimates for 1973 the Board had considered a report by the Director-General on the smallpox eradication programme (Official Records No. 199, Appendix 12), which showed that substantial progress had been achieved in national programmes during 1971; the report stressed the need for continued active vigilance to ensure the success of the programme. Special attention had been given to the seven recommendations of the Expert Committee on Smallpox Eradication which had met in November 1971 (listed on page 104 of Official Records No. 199). The Board had expressed its satisfaction with the progress achieved, and the Director-General had pointed out that the success of the smallpox eradication campaign was due to the generous contributions received from the participating countries, and to the efforts of the smallpox-endemic countries themselves, which were in fact bearing the major burden of the cost.

In consequence of a recent outbreak of smallpox, the Director-General had brought his report up to date by means of a further report to the Health Assembly, which was contained in document A25/9.

Dr BERNARD, Assistant Director-General, said that the report gave an account of recent developments and problems encountered, suggesting solutions based on the conclusions of the Expert Committee[1] to which Dr Ehrlich had referred.

Two lessons could be learnt from recent experience. First, there were grounds for optimism in that smallpox eradication was technically and operationally possible, provided a potent and stable vaccine was used and that vaccination techniques were adequate. Such a vaccine was available in the lyophilized vaccine that was now in general use in smallpox eradication programmes and which was produced in many countries. The bifurcated needle was proving a very satisfactory innovation in vaccination technique. From an operational point of view, the experience of the past five years had clearly shown that, even if coverage was good, systematic vaccination was not always enough: it had to be accompanied by organized

[1] Report published as Wld Hlth Org. techn. Rep. Ser., 1972, No. 493.

epidemiological surveillance, consisting of a system of control at various levels by qualified personnel who would thoroughly investigate the source and the contacts of every case. Only in that way could an outbreak be contained and isolation measures and vaccination have maximum impact.

Remarkable progress had been made. The 20 countries of Central and Western Africa where eradication had been undertaken in 1967 had reported no cases since the spring of 1970, although surveillance had been constant and active. In Latin America, including Brazil where the disease had so recently been endemic, no cases had been reported in the past year - a result achieved by epidemiological surveillance and systematic vaccination. The Americas therefore were currently free from infection; at the 1971 meeting of the WHO Regional Committee for the Americas/Directing Council of PAHO, the news had been received with legitimate satisfaction, but Member States had at the same time stressed the need for active surveillance to prevent any recurrence of endemicity.

The situation had its less positive aspects which called for prudence. The disease was still endemic in certain countries of Africa and Asia and had reappeared in the Eastern Mediterranean and in Europe. There had been an outbreak in Yugoslavia and one recorded case in the Federal Republic of Germany. Before that, Yugoslavia had been smallpox-free for 42 years. The first cases had occurred in February 1972 but, as was usual in such circumstances, they had not been immediately identified. When the diagnosis of smallpox was confirmed in early March the health authorities had promptly started an epidemiological survey, in close collaboration with WHO, which had been immediately notified. The outbreak had been controlled in less than a month.

That example showed that as long as there was smallpox anywhere in the world, there would be a risk to smallpox-free countries. It also showed that outbreaks could be controlled by prompt and systematic action. Those considerations should stimulate further efforts; such efforts would, for the most part, have to be made by Member States, but WHO was ready to assist with all the means at its disposal. The Organization had specialists with practical field experience who could help in developing and implementing national plans. Such plans should essentially comprise arrangements for the rapid, exact and complete reporting of cases; the establishment of a national system of epidemiological surveillance for case-finding and investigation of sources and lines of transmission; and routine vaccination, especially for high-risk population groups, with specific immunization in and around foci. Rapid reporting was particularly important at national and international levels to permit coordination of action and create a climate of confidence. Neighbouring countries should coordinate their planning and action; WHO was willing to take part in that coordination at any time.

Special mention should be made of the spirit of solidarity shown by the countries donating large quantities of stable and effective vaccine, either through bilateral assistance or by contributions to the Voluntary Fund for Health Promotion. Between January and May 1972, over 60 million doses of vaccine had been received and distributed. The large support given to the programme throughout the world added to the conviction that if there was the will to deploy the necessary resources, and with the effective methods now available, smallpox eradication could be achieved.

Sir George GODBER (United Kingdom of Great Britain and Northern Ireland) said that the fact that the goal was so near increased the importance of carrying out surveillance wherever eradication had been achieved, until such time as it was certain that eradication was worldwide. All the smallpox-free countries were indebted to those countries where the disease had been endemic and was now being eradicated; their efforts were protecting all the others.

Experience in Yugoslavia had shown that an outbreak could be quickly controlled. If the disease did not reappear there, worldwide eradication would seem to be not far distant.

The United Kingdom, the United States of America and Canada had recently ceased to recommend routine vaccination in infancy. However, there had been no systematic vaccination of infants for the past 60 years in the United Kingdom; only about 40% of infants were vaccinated in the first two years of life. It had therefore been decided to rely on prompt detection of imported cases and quick action around them. In such a situation arrangements for action at a moment's notice must be carefully prepared. In the United Kingdom all the physicians in an area where a case of smallpox was diagnosed, or suspected, would be provided with a recorded talk accompanied by coloured slides to help them in diagnosis of the disease. He knew that WHO had similar aids that were useful in control work. The countries at present free from smallpox had an obligation not only to keep up their own surveillance but also to

ensure that travellers were vaccinated before going to areas where eradication was not complete - for he hoped that no one would imagine that vaccination could be abandoned as long as there was smallpox anywhere in the world.

The continued success of the campaign would depend increasingly on rapid availability of information about epidemiological changes, and his Government was concerned that the daily broadcasting of epidemiological bulletins from Geneva had been discontinued. He wondered what arrangements were being made to inform Member States of any outbreak of communicable disease.

As cases of smallpox became more rare, diagnosis would become more difficult. Good virological services must be available to confirm diagnoses - which could be made with confidence where the disease was common, but with less confidence where it was less so or in the case of modified smallpox in vaccinated subjects. In the final stages of control WHO would have an important part to play in ensuring that adequate virological services were available to areas where the final residual foci were being eliminated.

Dr SÁENZ (Uruguay) recalled that, in the history of his country, it had been General José Artigas who, in 1817, had recommended the vaccination against smallpox of the population in territories occupied by his troops. Uruguay had had considerable experience of smallpox, from the time of the epidemics with their high mortality and morbidity to the present state of eradication which had been achieved 10 years previously. Since then nine cases of variola minor (alastrim) had been reported but they had proved to be imported. Smallpox vaccination of children had been compulsory since 1850 and a law making general vaccination compulsory had been enacted in 1911. Vaccine production had started in 1879, and the present epidemiological situation bore witness to the safety and efficacy of the vaccine; there had been very few major postvaccinal complications. The health services had enough qualified staff to ensure clinical and virological diagnosis and consequently the immediate notification of any reappearance of the disease.

His country had signed an agreement with WHO/PAHO concerning participation in the smallpox eradication campaign which had been put into operation on 28 July 1968. The programme was being conducted with the resources available locally and in individual communities. There was no real problem, but control was proving difficult in certain urban and rural frontier areas, where there were no natural barriers and where only the coordinated coverage of all the communities would suffice. In 1971, therefore, his Government had concluded an agreement with Argentina for the coordination of joint vaccination programmes. It was hoped that a similar agreement would be reached with Brazil.

Out of a total population of 2 850 000, 2 151 712 (or 75.4%) had been vaccinated or revaccinated between 1967 and 1971.

The Directing Council of PAHO, at its meeting in Washington in October 1971, had declared that smallpox had been eradicated from the Americas. That privileged situation might prove to be temporary. Uruguay had therefore no intention of ceasing routine vaccination which, together with epidemiological surveillance, was the only means of preventing the spread of the disease and renewed endemicity. He was in full agreement with the recommendation of the Expert Committee on that point. In the developing countries, epidemiological surveillance, if it was to be effective, must be combined with improvement of health statistics and greater assistance to local vaccine production and virological laboratories.

(For continuation, see summary record of the eighth meeting, section 5.)

The meeting rose at 5.30 p.m.

5. SMALLPOX ERADICATION (continued from the sixth meeting, section 2) Agenda, 2.5

Dr PINTO MUSA (Brazil) said he was encouraged to learn from the Director-General's report that the smallpox eradication programme continued to make progress in spite of the imported cases notified in the early part of 1972. His own delegation was gratified at the progress made in Brazil, which had been a black area on the map in 1967 but was now completely white. Smallpox had originally been imported into Brazil by the colonizers in the sixteenth century and had become endemic with frequent extensive outbreaks, often with high mortality. Since the introduction of vaccination in the first decade of the nineteenth century, many campaigns had been carried out but none had been successful in eliminating the disease. Only at the beginning of 1970 had smallpox begun to disappear.

His Government had carried out an extensive vaccination campaign starting in 1966, with assistance from WHO. The attack phase, in which, in addition to a staff of over 900 directly employed for the campaign, other departments of the Ministry, health officers of the states and personnel of the malaria eradication campaign had collaborated, had been completed in 1971; by then over 83 million doses of vaccine had been administered, covering 88% of the population. Three Brazilian state laboratories had produced some 230 million doses of vaccine for the programme at no extra cost to the campaign. The cost of the campaign from 1966 to 1971 had been nearly 29 million cruzeiros of which 6 365 000 had been contributed by various states and the remainder by the Brazilian Ministry of Health. The results, however, had more than compensated for that expenditure. In 1971 transmission had been arrested throughout the country, and out of 445 suspicious cases reported only 19, all in the state of Guanabara, had been found positive. No new cases had been found in the first quarter of 1972 in spite of intensive surveillance activities and the Government considered smallpox to have been eradicated.

The surveillance and consolidation programme was not by any means ceasing its activities, and the network of notification stations was being extended. The vaccination programme was continuing among children who had not yet been vaccinated and in other susceptible groups to maintain a high level of immunity.

Professor BURGASOV (Union of Soviet Socialist Republics) recalled that it was on the initiative of the USSR that the smallpox eradication programme had been started. The progressive decline in smallpox morbidity throughout the world was a direct result of that programme, which was the most effective of all WHO's programmes.

Nevertheless, there had been some deterioration in the situation in the current year. Smallpox had again appeared in countries, including Yugoslavia, that had long been free from it.

The Assistant Director-General, in his summary of the situation, had expressed optimism. However, there had to be a realistic basis for optimism - and, first and foremost, it had to be based on the conviction that every case imported into a smallpox-free country would be rapidly diagnosed. All the smallpox outbreaks in European countries in the 1950s and 1960s had been caused by delay in diagnosis. The generation of physicians who could recognize a case of smallpox without virological diagnosis had disappeared, and difficulties in diagnosing the first few cases had led to serious epidemics.

The delegate of Uruguay had stated that vaccination against smallpox was compulsory in his country. It should be compulsory in all countries where smallpox had long been eradicated, including the European countries. Experience with cholera had shown that negligence or underestimation of danger was always punished. And smallpox was not cholera: its mode of transmission was similar to that of influenza-like infections, which made it vitally important under present-day conditions of huge cities, mass communications and rapid means of transport, to take measures to prevent epidemics.

His delegation therefore considered that the smallpox eradication programme should be intensified. The slightest slackening of effort would have disastrous consequences. He had noticed that in the budget for 1973 the amount to be devoted to the smallpox eradication programme was rather less than in 1972. He would not comment on that situation; it seemed to him that the programme was being competently and energetically directed. He would only emphasize that it was when the disease was receding that the greatest efforts were needed.

In his country vaccination against smallpox was still compulsory. Children were vaccinated during the first year of life, and on entering and leaving school. That provided a guarantee against epidemics arising out of an imported case. However, there were always some individuals who remained unvaccinated, sometimes for medical reasons, and they were a source of concern. It was true that vaccination sometimes had undesirable side-effects; no

vaccine was absolutely safe for everybody. Nevertheless, it was the only means so far available of controlling smallpox. Experience in the Soviet Union had shown that it was better to vaccinate the population according to plan, while there was no danger, than to carry out a vaccination campaign when it became absolutely essential to do so.

With regard to the training of personnel, it was especially important to provide training to physicians who were unfamiliar with smallpox. There was a mass of literature on smallpox, but no single publication on smallpox control that told practising physicians clearly and concisely what measures they should take. He suggested that WHO should undertake the preparation of such a publication. He also emphasized the value of films and other photographic material for training medical students and young physicians in the diagnosis of smallpox.

In conclusion, he reiterated his country's willingness to take part in any programmes and measures that would help to eradicate smallpox from areas where it was still endemic or to consolidate the successes obtained in other areas.

The meeting rose at 5.35 p.m.

NINTH MEETING

Saturday, 20 May 1972, at 9 a.m.

Chairman: Dr F. R. HASSAN (Egypt)

1. SMALLPOX ERADICATION (continued) Agenda, 2.5

Dr ZAMFIRESCU (Romania) noted with satisfaction that the smallpox eradication programme, which had been in operation for six years, had given satisfactory results everywhere: not only had the global incidence declined but notification of cases had been increasingly complete and reliable.

Regarding the strategy to be adopted to give the campaign maximum efficiency, his delegation agreed in principle with the conclusions of the WHO Expert Committee on Smallpox Eradication which had met in 1971.[1] It considered that for operational reasons the present strategy should be modified by concentrating resources in the first instance on those foci that were particularly active, so as to reduce to a minimum the danger that existed especially for countries bordering on areas of high endemicity. Joint efforts to confine and eradicate the smallpox foci still existing in certain territories were of great importance for the community of nations as a whole, since the epidemic potential of the disease was increased by modern transport conditions and the large number of people travelling. While the incidence of smallpox continued to decline, the chances of its being imported were increasing.

The best way to deal with this persistent threat to all smallpox-free countries was to introduce effective epidemiological surveillance, based on continuous vigilance. The Romanian health authorities were concentrating their efforts on increasing their technical capacity so as to provide a sensitive epidemiological surveillance network, based mainly on rapid virological laboratory diagnosis. Diagnosis units had been set up in five university centres in Romania; the tests were checked by the central laboratory in Bucharest. He wished to thank his colleagues in the Research Institute of Virus Preparations, Moscow, who had assisted in standardizing the reagent used in the immunological diagnosis of smallpox.

To improve clinical knowledge of the disease, a number of slides had been prepared from photographs made available by WHO some years earlier and others published in 1966 by the Swedish authorities on postvaccinal complications; the slides had been sent to the various medical centres in Romania, together with an explanatory text.

Romania's recent experience had unquestionably shown the value of modern prophylaxis measures since no case of smallpox had been recorded there. The continuing contact between Romanian and Yugoslav health authorities had enabled them to take joint action for epidemiological surveillance along their common frontier. It was essential that other countries should be promptly informed of epidemiological measures to be taken by health administrations and of any action by WHO.

His delegation would like to see a change in the International Health Regulations relating to smallpox vaccination, in particular with respect to the issue of the required certificate: the latter should be signed only after the result of the vaccination had been observed; and in certain epidemiological circumstances the revaccination of non-reactors should be required, as also the revaccination of high-risk groups.

Research must be concentrated and the emphasis placed on finding simple and effective methods for laboratory diagnosis of smallpox and differential diagnosis of clinically similar microbial infections. Laboratory diagnosis was the key to the success of any surveillance measure, particularly when an epidemic occurred in proximity to a smallpox-free country.

While the Expert Committee on Smallpox Eradication had recommended research to elucidate the mechanisms of immunity in pox virus infections, there was no mention of continuing research on methods of antiviral treatment using suitable inhibiting substances, the selection and screening of which could be carried out by virological laboratories and specialized clinics with WHO support. Study was also required of ways of evaluating the potential danger of, and ensuring effective protection against, postvaccinal complications.

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[1] See Wld Hlth Org. techn. Rep. Ser., 1972, No. 493.

In conclusion, he would stress once again that the success of WHO's work in the eradication of smallpox was very encouraging.

Dr MARTÍNEZ (Cuba) said that Cuba had been free of smallpox since the beginning of the century, and the measures it took were in conformity with the recommendations of the Expert Committee on Smallpox Eradication. Cuba carried out vaccinations year after year, using locally produced vaccines, and the immunity level of the population was therefore gradually rising. Hitherto particular attention had been paid to immunization of port and airport personnel and to those areas where the population came into contact with foreigners; the emphasis was now on the populations of larger towns. Clinical knowledge of the disease was confined to a small number of specialists who had worked in Asia and Africa. Medical personnel were therefore being trained in virological diagnosis in order to extend epidemiological surveillance even further.

Cuba had received experts and supplies from WHO for the production of freeze-dried vaccine, and the process was now in the final experimental stage. It was hoped in the second half of 1972 to go into regular production.

Dr BAHRAWI (Indonesia) said that in the past it had been thought that smallpox eradication could only be achieved by a routine vaccination programme covering at least 90% of the population; as a result of such coverage, Indonesia had been free from smallpox between 1937 and 1947. With changing conditions, however, smallpox had again become endemic and, until 1968, 85% of the population had been living in endemic areas. During that period it had proved impossible to control the disease by a programme of routine vaccination alone. Because of the population explosion, the rapid means of communication, and the changing economy, Indonesia's population had become more mobile; the cities and towns had grown greatly, and people were now unwilling to accept any measure which they felt would interfere unduly with their economic activities and of whose utility they were not convinced. For those reasons, Indonesia now laid great emphasis on surveillance and containment measures, although it still maintained the usual routine vaccination programme. Where surveillance was concerned, it relied not only on reporting but also on active case-finding. Equally, it did not rely unduly on isolation of cases in hospitals and barracks, since this made people reluctant to report cases to the health authorities. Instead, containment measures were introduced as quickly as possible. Since the fullest cooperation of local leaders was needed, health education played an important role.

From the outbreak in December 1971/January 1972, Indonesia had learnt that in the conditions prevailing in Indonesia, smallpox cases would not present themselves spontaneously to the health authorities; and that the authorities would become aware of the existence of smallpox only when it had become comparatively widespread. Case-finding was therefore necessary. No case of smallpox had however been reported in Indonesia in the past three months. Local leaders, schoolteachers and schoolchildren, and all basic health workers took part in case-finding operations and, to help them, pictures of smallpox had been widely distributed. The Government gave a cash reward or a transistor to those who reported a case that was confirmed by the laboratory. The provincial epidemiologist also investigated any case of chickenpox reported to the health authorities or observed at dispensaries or clinics.

He expressed gratitude to WHO for the assistance it had provided for the smallpox eradication programme in Indonesia. The surveillance and containment method had contributed greatly to the development of expertise in epidemiological surveillance. There was now an epidemiological surveillance unit, which could also be used for the control of other diseases, in every province in Indonesia.

Dr FUNKE (Federal Republic of Germany) said that, while the number of cases given in the Director-General's report was larger than previously, that might be because data were more reliable. The Government of the Federal Republic of Germany agreed with the Director-General that the eradication of smallpox was far from being achieved and hoped that the increase in the number of cases recorded would stimulate efforts to complete it.

As a country that had been directly concerned with the handling of imported cases of smallpox, the Federal Republic had been aware of and regretted once more the lack of prompt and complete information. It was unsatisfactory to learn the latest news about an outbreak from the newspapers, which often exaggerated the facts. She urged WHO to continue its efforts to persuade Member States to ensure quick and complete reporting and not to inform the press until Member States had been informed. Since the epidemiological radiotelegraphic bulletin had now been discontinued, some thought should be given to other ways of getting information quickly to Member States in certain circumstances. She considered that the regional offices could play an important role in that matter.

The new term "infected area" was not yet sufficiently well known to achieve its purpose. The change of term from "infected local area" to "infected area" had been intended to identify the area with epidemiological rather than administrative boundaries. Experience in Europe however showed that the tendency was to declare infected smaller areas than previously. She felt that that was contrary to the intentions of the Expert Committee and had, inter alia, led to the unfortunate sentence to be found in the vaccination requirements booklet "- And from all countries any parts of which are infected". The widespread use of that sentence, in spite of the fact that its conformity with the Regulations was doubtful, seemed to indicate the need for reconsideration of the subject.

Dr BAIDYA (Nepal) said that smallpox was still a significant problem in Nepal. There appeared to have been a significant rise in the number of cases reported, but that was due to better surveillance and compulsory reporting.

In 1972 Nepal was expanding the vaccination programme in all its 75 districts, so that in the near future the whole population would have been vaccinated at least once.

As in the case of malaria operations, meetings between officials of neighbouring countries should be held periodically to discuss problems and trace the source of outbreaks, since this would certainly accelerate the eradication of the disease.

Dr GOMAA (Egypt) referred to the occurrence in 1972 of smallpox in 10 of the countries considered as smallpox-free, among them two European countries. These were the first cases of smallpox imported into Europe in two years. That was a serious development from the epidemiological standpoint, but the Director-General's report did not indicate the source of the outbreak or how the disease had spread.

The report contained an excellent list of recommendations made by the Expert Committee in 1971. At the top of the list came the need for strengthening of reporting of cases everywhere. That was rational and justifiable, but it was not feasible unless a network of basic health services already existed in a country, particularly in the rural areas. The basic health services in fact constituted the frontier defence line against the importation or spread of communicable diseases. In developing countries there was usually a marked scarcity of health facilities for the discovering and reporting of foci. Moreover, when vaccination campaigns were launched, people were often frustrated because of difficulties of access to the services carrying out vaccination.

Egypt in 1962 had started to establish a network of rural health units and centres. Today every 5000 inhabitants were cared for by a health unit providing both preventive and curative services.

His last comment related to the recommendation of the Expert Committee that referred to countries "at low risk".[1] In his view, it was preferable to be on the safe side and not to consider any country as being at low risk. Smallpox did not respect the boundaries of States, and the utmost vigilance should be exercised at international, regional and national level. Great emphasis should be laid by WHO on routine vaccination, especially of the newborn. For several decades Egypt had been smallpox-free, thanks to routine compulsory vaccination, and the strict observance of the international sanitary rules and regulations.

Dr SUMPAICO (Philippines) said he was pleased to note the progress achieved through the efforts of WHO, although the attainment of final eradication required the vigilance and cooperation, and also the effective action, of all Member States. What was necessary was a complete programme of surveillance, recognition or diagnosis, adequate reporting, strict quarantine, and immunization of a sufficiently large percentage of the population.

The Philippines had been fortunate in having no cases of smallpox for many years, so that young medical students had probably never seen a clinical case of smallpox during their hospital training. That freedom was probably due to the fact that the Philippine health authorities considered smallpox vaccination as one of its priority immunization programmes. The campaign had been continuous in recent decades, locally produced vaccines being used - until recently, those of the glycerinated liquid type; in spite of the disadvantages of that type of vaccine, the coverage had been large. Thanks to the assistance of WHO and UNICEF, Philippine laboratories were now able to produce lyophilized vaccine that met the requirements of WHO; and the Philippines had been able to donate supplies to other countries through the Regional Office.

Dr VIOLAKIS-PARASKEVAS (Greece) said that there had been no case of smallpox in Greece since 1950. Vaccination was compulsory. In view of the outbreak of smallpox in Yugoslavia, an intensive immunization programme had been carried out and almost two million persons had

[1] See Wld Hlth Org. techn. Rep. Ser., 1972, No. 493, p. 62.

been vaccinated. Five smallpox diagnosis laboratories had also been established; it had been decided to maintain an intensive surveillance programme; and every doubtful case of chickenpox had been checked.

The decline in the incidence of smallpox, and in the frequency of its introduction into non-endemic countries, raised the question whether the European countries should follow the example of Canada, the United Kingdom, and the United States of America, or whether they should continue to make vaccination against smallpox compulsory and, if so, for how long.

There was no doubt of the importance of the WHO reporting system when epidemics occurred. The delegate of Austria had raised a very important point at the third plenary meeting concerning ways of obtaining rapid information from the responsible health services in the case of an outbreak in a neighbouring country.

Lastly, she drew attention to the need for training a certain number of medical personnel from non-endemic countries in clinical and laboratory diagnosis in countries where smallpox was still endemic. The most important step in controlling smallpox in non-endemic countries was the immediate diagnosis of the imported case.

Dr ELOM (Cameroon) stressed the need for very close surveillance even in countries where smallpox seemed to have disappeared as an endemic disease. There was also a need for continuous research, particularly into the best methods of administering smallpox vaccine in association with other vaccines. That was particularly important in Cameroon, where financial resources and manpower were very often in short supply.

He wished to thank WHO and the United States Agency for International Development for the assistance provided to Cameroon in its smallpox campaign; he hoped that they would continue to provide such assistance, so that the successes could be consolidated and further research undertaken on methods of administering polyvalent vaccines that included smallpox vaccine.

Dr SPAANDER (Netherlands) said that the reintroduction of smallpox into 10 countries during 1972 had made it very clear that the time had not yet come to feel safe; on the contrary, there was a need to strengthen the programme, since any case of smallpox that occurred in a non-endemic country was of international concern. He therefore wished to underline the recommendations of the Expert Committee concerning the investigation and containment of cases occurring in non-endemic countries, and concerning the continuation of routine vaccination programmes.[1] He considered that - except perhaps for a few countries - routine vaccination programmes should be continued throughout the world. Figure 4 (page 176) of the Weekly Epidemiological Record of 5 May 1972[2] showed very clearly that that advice was particularly important for countries on the ancient line of communication between Eastern Asia and Western Europe. The fact that three different regions of the Organization were along that line called for interregional programme coordination, combined with flexibility in the allocation of resources.

Recognizing that the Organization urgently needed smallpox vaccine in order to intensify the programme in those difficult areas where the disease was still endemic or had been reintroduced, he was glad to announce that his Government would continue its contribution of freeze-dried vaccine, having specially in view the difficult situation in Bangladesh.

Dr BANGOURA-ALÉCAUT (Guinea) said that the Director-General's report was objective: it drew attention to developments on the world scale in respect of smallpox eradication, while warning against undue optimism and stressing the need for strengthening epidemiological surveillance and for constant vigilance. It was in fact true that smallpox had in most cases been successfully contained but not eradicated.

In his introductory statement, the Assistant Director-General had drawn attention to the main factors contributing to the success of the operation, namely, the quality of the vaccine used, the method of vaccination, and routine mass vaccination accompanied by well-organized epidemiological surveillance.

In Guinea, there had been no setback following the attack phase of the eradication programme in 1968, and the last cases of smallpox had occurred in 1969. The consolidation phase of the operation was now being satisfactorily implemented.

At the present time Guinea had a laboratory in its Institute of Applied Biology which was producing lyophilized smallpox vaccine. It had been established with the assistance of WHO and UNICEF and - according to the potency, sterility and stability tests carried out in international reference laboratories - was producing one of the best vaccines currently produced in the world. The entire range of manufacturing operations, from the production of

[1] Wld Hlth Org. techn. Rep. Ser., 1972, No. 493, p. 62.

[2] Wkly epidem. Rec., 1972, 47, 173-188.

the vaccinal lymph to the different tests on the dry vaccine, were carried out by national personnel. Annual production capacity was estimated at 10 million doses, presented in ampoules of 50 doses for percutaneous administration (conventional scarification or multiple puncture with bifurcated needle). As a result of research conducted in the Institute a vaccine that could be administered by jet injector had been produced, the dilutant being manufactured locally. Unfortunately, full advantage was not being taken of Guinea's vaccine production capacity. WHO's original intention had been that the laboratory in question should supply all the States of West Africa with smallpox vaccine; none of the African States, however, had ordered vaccine from the Institute, although WHO considered it to be of excellent quality. It was essential to strengthen cooperation between the States of West Africa, and to integrate their complementary potentialities.

As part of the international assistance to the Bangladesh refugees, Guinea had placed at the disposal of the United Nations two million doses of lyophilized smallpox vaccine.

Dr WICKREMASINGHE (Ceylon) said that the Director-General's report and the current status of the smallpox eradication programme as summarized in the Weekly Epidemiological Report of 5 May 1972[1] gave cause for some anxiety. There had been an increase in the number of cases in 1971 and 1972, after the dramatic reduction by nearly 75% of global incidence of the disease during the four-year period 1967-1970. There had been an increase in the number of cases in six of the seven endemic areas; and smallpox had been notified during the first four months of 1972 by 18 countries as compared with only 16 for the whole of 1971.

During the past 10 years Ceylon had been free of smallpox except for three imported infections in 1965, 1967 and January 1972. The last case was that of a European tourist with a valid vaccination certificate. Before arriving in Ceylon, she had travelled in two endemic areas for several weeks and had travelled extensively by bus in Ceylon before she developed signs of the disease. Within two or three weeks of the detection of the imported infection over one million persons had been vaccinated. The absence of secondary cases could be attributed to the prompt institution of containment measures and the maintenance of the routine vaccination of children of preschool age.

Ceylon's experience underlined the importance of the recommendation of the Expert Committee concerning the continuation of routine vaccination programmes. The progress of the global smallpox eradication programme in its early years was not very different from that of the malaria eradication programme, which had had phenomenal success in many parts of the world in its initial stages. Then setbacks had occurred. Although the two programmes were not strictly comparable, one should be cautious about optimism based on operational and technical feasibility.

While emphasizing the importance of operative paragraphs 1 and 2 of resolution WHA24.45, Ceylon would support a resolution urging the Director-General to concentrate the efforts and research of the Organization on the interruption of transmission in endemic areas.

Dr SAUTER (Switzerland) expressed his delegation's gratitude and appreciation to countries actively engaged in smallpox eradication programmes. While eradication was not complete, countries now free of the disease had to choose between the risks involved in vaccination and the risk of the introduction of smallpox in an insufficiently protected population. The statement made some months ago in the Weekly Epidemiological Record[2] regarding the attitude of certain countries to vaccination, and in particular the routine vaccination of young children, was a useful piece of information but had provoked a general attack on smallpox vaccination from certain quarters. The conclusion contained in that communication that outbreaks could rapidly be contained in countries with well-organized health services had been confirmed by recent events in Europe. However, those events had also demonstrated the extent of the measures required in such situations. In his delegation's opinion, the Director-General's report proved that the eradication of smallpox was feasible, but that a long and relentless effort would be required. His Government would continue to lend its full support to that effort.

Dr ARNAUDOV (Bulgaria) said that his Government was convinced that the worldwide smallpox eradication programme would make it possible to eliminate the disease from countries where it was still endemic. But that would require intensified cooperation from all Member States; and to increase the efficiency of the programme, mass vaccination would have to be supplemented by other measures.

A study should be made of the need for sufficient immunological defence by means of systematic revaccination of the populations of countries bordering on countries where the disease was endemic. The periodic occurrence of epidemics in certain non-endemic countries,

[1] Wkly epidem. Rec., 1972, 47, 173-188.

[2] Wkly epidem. Rec., 1971, 46, 379 and 426.

despite the marked decrease in the number of cases in endemic countries and in the number of cases imported into Europe and North America, appeared to coincide with a drop in the immunity in the populations of those countries. Such epidemics were a danger to every country in the world. It was still too early to discontinue routine vaccination programmes, which were justified in all countries and particularly in those near to, or having close contacts with, endemic countries. In Bulgaria, smallpox vaccination was compulsory for all children under three years of age, and a certain number of revaccinations were also carried out.

It would be useful for WHO to convene a conference to develop a single strategy for preventing the importation and spread of smallpox in countries from which it had been eradicated. Further studies on the rapid clinical and laboratory diagnosis of smallpox and on its treatment would also be useful.

Some of the provisions of the International Health Regulations regarding smallpox, and also cholera, needed revision. The whole of any country in which there was an infected area should be considered as infected, since it was impossible to tell from a traveller's passport whether he had been in an infected area. Article 31, paragraph 1, should be amended by the addition of a provision that health authorities should take all practicable measures to prevent the export of clothing belonging to an infected person. Chapter II of Part V, dealing with cholera, should be amended to state that cholera vaccination was obligatory for all persons leaving a country where the disease was present. There was also a need to draw up and periodically revise a list of contraindications to vaccination; and to remind countries that international certificates of vaccination had to be printed in English and in French, since there were still some countries that did not comply with that obligation.

Dr DELMÁS (Paraguay) said that smallpox had not been endemic in Paraguay since 1961 as the result of a mass vaccination campaign covering 86.4% of the population and followed by a programme of consolidation and maintenance. Between 1964 and 1966, 44 imported cases had been notified, but there had been virtually no further spread of the disease, and no imported cases had occurred during the last five years. The Ministry of Public Health and Social Welfare had extended vaccination to the populations of remote areas.

In 1971, the Ministry had cooperated with WHO in evaluating levels of protection and in determining whether or not smallpox was present in the country. The study, which had been carried out in urban areas within 50 kilometres of the capital and in some remote rural areas more exposed to the introduction of smallpox, consisted of three stages: preparation, execution and tabulation. The survey team had tried to obtain a representative sample of the school population: it had covered 336 schools and investigated 50 reports of suspected foci. It had been found that 43.3% of the children under five examined in four urban areas were protected against smallpox. In addition, 81.6% of children aged five to 14 were protected, and more than 86% of those over 14. The importance of the survey was in showing that it was not necessary to initiate another large-scale vaccination campaign, but that it was better to limit activities to children under five. His Government believed that such community surveys were extremely useful, and suitable for all developing countries that had already been free of smallpox for some years.

Finally, he expressed his appreciation of the constant cooperation and advice received from WHO in support of his country's efforts to eradicate smallpox.

Dr TABIBZADEH (Iran) said that smallpox had been eradicated in Iran many years ago, but imported cases in 1971 and 1972 had led to a number of contact cases. The second outbreak had been accompanied by an epidemic of chickenpox. All patients with a skin eruption had been isolated so that no smallpox cases could be missed, but only cases confirmed by laboratory examination had been reported to WHO. During the last 10 years all newborn infants had been vaccinated; the imported outbreak in 1971 however had forced the authorities to vaccinate about 80% of the population. So far in 1972 some 12 million persons had been revaccinated. Iran produced its own smallpox vaccine but, because of a defect in the production equipment, supplies had been received from WHO. Owing to the rapid and extensive vaccination programme, smallpox was not now a problem in Iran and no cases had been exported to other countries.

Surveillance activities had been assisted by the expansion of the basic health service network during the last 10 years, with the establishment of 1950 rural health units. He believed that national and international agencies should concentrate their efforts on eradicating smallpox from endemic areas, for while the disease continued to exist in an age of rapid communications, all countries would remain under constant threat of its introduction or reintroduction.

Dr GESA (Uganda) said that the achievements of the campaign showed that it was possible to eradicate smallpox completely; but recent setbacks were a warning of the tenacity of the virus and the need for continued efforts and vigilance.

Thanks to WHO, the eradication campaign in Uganda had proceeded very swiftly, and 93% of the population had been protected during the first three years of the campaign up to 1970. Since then no indigenous cases had been reported, but 30 cases had been imported by refugees. Fortunately the surveillance machinery had permitted the detection of those cases and prevention of the spread of the disease. However, such incidents illustrated the need for a worldwide effort, not only in the prompt reporting of cases but also in effective field work.

He suggested that it would be appropriate for WHO to consider forming an international team of voluntary health workers, on the lines of the United Nations peace-keeping forces, to deal the final blow to the disease, now that the endemic areas were shrinking. Swift and decisive action of that kind would prevent the virus from turning into a form less accessible to known eradication measures. He believed that such a proposal would be equally acceptable to the receiving countries and to the countries providing health workers.

He drew attention to the paradoxical situation by which, as successful public health measures led to a fall in the incidence of a disease, it became increasingly difficult for those authorities to obtain funds to consolidate the position they had won. That was already happening with smallpox and could well affect WHO. He suggested that such a development should be anticipated by building into WHO's budget for some years to come a financial provision enabling the Organization to give prompt assistance to any health authorities in difficulties with their eradication programme. Meanwhile, there should be no relaxation in the production of vaccines and in efforts to improve their quality and acceptability.

He expressed his delegation's agreement with the Director-General's report and the recommendations contained therein.

Dr NABULSI (Jordan) stated that his Government wished to place three million doses of smallpox vaccine, prepared in the national vaccine institute, at the disposal of WHO to assist Member States.

Professor HALTER (Belgium) said that his delegation joined with others in supporting the Organization's smallpox eradication campaign. Belgium would continue to manufacture freeze-dried vaccine and place it at the disposal of WHO. He wholeheartedly supported vaccination as a way of eradicating smallpox and he believed that eradication was feasible. However, it would be useful for a group of experts to consider the possibility of the existence of animal reservoirs of smallpox.

He was disappointed at the way the Organization had handled the question of providing information about smallpox. The role of WHO was to enable Member States to carry out their policies and develop their activities, not to cause unnecessary difficulties by untimely statements. For more than 40 years smallpox vaccination had been compulsory in Belgium for children aged 3-12 months, since that was the period of life in which the risk was smallest. In some countries a comparison had been made of the risks associated with vaccination and those of imported cases. There had been several imported cases of smallpox in Belgium since 1948, but none had resulted in further cases. He was convinced that vaccination during the first year of life provided a satisfactory guarantee against the spread of the disease in the event of its introduction from abroad.

He understood the attitude of the United Kingdom and the United States of America in ceasing to make routine vaccination compulsory. However, the statement of the decisions taken by those two influential countries in the Weekly Epidemiological Record in 1971,[1] with no comment by WHO, had given some people the impression that smallpox vaccination had become superfluous, and had produced confusion in countries where such vaccination was compulsory. In Belgium there had been an immediate reaction from uninformed pressure groups, who denounced the Ministry of Public Health and Family Welfare as out of date, incompetent, and incapable of following modern attitudes. The Ministry had resisted the pressure and been justified by the events of recent months. Professor Halter noted that during the last year the tone of the Weekly Epidemiological Record had changed, and the attitude reflected in the Director-General's report was much more cautious.

The delegate of the Federal Republic of Germany had also commented on the way certain information in the possession of WHO reached the press before it reached governments. That was an improper procedure of which he could not approve, and undermined one of the principal purposes of the Organization, which was to promote worldwide solidarity between public health administrations. It was not the function of sections of WHO to boost themselves by press conferences but to be at the disposal of national public health authorities. If they gave

[1] Wkly epidem. Rec., 1971, 46, 379 and 426.

press conferences in addition to that function, or even adopted a specific standpoint on some question, that was acceptable, but not without the prior knowledge of national health authorities. He apologized for his frankness, but believed that his remarks would be useful in helping to preserve the popularity of WHO with public health authorities and in avoiding a repetition of a situation where a health administration spent weeks coping with difficulties created by a hasty statement from WHO. He hoped that the Director-General would review his policy on the dissemination of information.

He agreed with the delegate of Egypt that no country should be considered as being at low risk. It was difficult to see how any country could be at low risk when aircraft could carry contact cases thousands of miles in a few hours.

Dr TSUKAMOTO (Japan) said that recent events showed that smallpox-free countries still had to make strenuous efforts to prevent the introduction of the disease. However, his delegation believed that, in a few countries with little risk of imported cases and with highly developed health services, the policy of compulsory non-selective vaccination against smallpox might be suspended, in view of the serious side effects of vaccination, such as encephalitis. In Japan routine vaccination had been compulsory since 1909, but a special committee had now been set up to study the feasibility of discontinuing the practice. The outcome of the study would be largely dependent on the success of the WHO eradication programme, and surveillance systems would need to be strengthened before any action was taken.

He suggested that WHO should study and develop international criteria for diagnosing the side effects of vaccination. At present criteria varied from country to country, and a study of those criteria might help to detect individuals for whom vaccination was contraindicated.

Dr ANOUTI (Lebanon) said that WHO's smallpox eradication programme had undeniably met with great success, but recently the disease had reappeared in a number of countries after an absence of many years. The campaign was being fought on two fronts. One front was in the endemic countries, where the campaign was conducted largely through international efforts led by WHO. The other front was in the smallpox-free countries, which relied on purely national efforts, and it was there that difficulties were being encountered because of the progressive decrease in the immunity of the population.

It was of paramount importance that countries at risk - and that meant all countries - should maintain close epidemiological surveillance, with systematic vaccination of young children and revaccination of adults every three or four years. Such immunization was a basic and highly effective means of preventing and eradicating smallpox. Since 1958, the vaccination of the entire population of Lebanon every four years, and of children during the second year of life, had been compulsory. As a result no case of smallpox had been detected in the country since January 1957.

His delegation expressed its gratitude to the Government of Jordan, which had repeatedly provided supplies of smallpox vaccine. A project to manufacture vaccine locally was at present being studied, and he requested WHO to provide any technical and material assistance that might be needed.

Dr HALLETT (Australia) said that, because its population was largely unvaccinated against smallpox, his country was susceptible to the introduction of the disease from infected areas, particularly by air travellers. It had therefore maintained strict quarantine requirements over the years, and had insisted that people arriving in Australia by air (except those arriving from exempt areas) be vaccinated against smallpox. His country was continually reviewing its requirements, and since the last Health Assembly provision had been made to allow air travellers to arrive from the United States of America and Canada without vaccination because those countries had been free from smallpox for many years.

Although the first and third preambular paragraphs of resolution WHA24.45 were not applicable to Australia, his delegation nevertheless strongly supported them.

Dr IMAM (Sudan) said that in the early 'sixties, and until 1966/67, his country had been free from smallpox, but with the beginning of the disturbances in the south there had been a series of outbreaks in the more inaccessible areas. Owing to the general state of insecurity and to the disorganization of most of the health units in those areas, it had not been possible to do much in the way of surveillance and containment of smallpox outbreaks.

In 1971, with the assistance of WHO, Sudan had begun an active surveillance and containment programme in the southern provinces. The programme had not only led to a sharp rise in the number of cases detected and reported but had also helped to contain and abort many outbreaks. Now that a political settlement had been reached in the area, his Government was embarking on an intensive programme of smallpox eradication there.

The attack phase of the programme, which was now being brought to a successful conclusion in four provinces, would shortly be transferred to the three southern provinces, which had hitherto been a continuous source of infection. The plan was to concentrate more effort on the refugees; those who had taken part in the fighting presented fewer problems because they were housed in camps and could thus be more easily examined, vaccinated and followed up. Refugees were brought together in certain villages and camps for vaccination, and kept under observation before returning to their homes. Those activities went hand in hand with the normal activities of the attack phase in the provinces for the rest of the population.

Sudan now had all the resources for launching a successful smallpox eradication campaign in the southern part of the country, and its situation with regard to smallpox would be completely different by the time of the Twenty-sixth World Health Assembly.

Dr NGJELA (Albania) stressed the need for WHO to provide effective assistance in the eradication of smallpox. The disease was widespread in many areas, especially in Asia and Africa, where it took its toll of human lives every year. In an age of great scientific achievements it was inadmissible that there should still be places with thousands of cases and many deaths from smallpox, particularly since mass vaccination campaigns could give complete protection. It was essential that the various countries and other international organizations should cooperate and provide effective help in preventing loss of life from smallpox in the immediate future.

There had been no case of smallpox in Albania for the past 50 years. At the time of the recent outbreak in Yugoslavia her Government had taken a number of measures to prevent the spread of the disease into Albania. Apart from epidemiological measures at frontier posts, there had been mass revaccination of the population, and the administration of immune globulin had also been started.

Professor RODRIGUEZ CASTELLS (Argentina) said that in his country, as in other American countries, smallpox had been eliminated; only in 1970, as a result of an imported case, had there been a small outbreak near the border which had been immediately contained by the epidemiological surveillance service. That service was at present organized to take immediate action anywhere in the country, and it had good diagnostic support in the Virological Institutes of Buenos Aires and Cordoba. Through the work of those Institutes it had been possible to show that two cases had been wrongly diagnosed as smallpox in recent months. The National Institute of Bacteriology at Buenos Aires had stocks of freeze-dried vaccine of the highest quality and in excess of possible needs. They could be made available to other countries whenever needed.

His delegation supported the proposal for the intensification of epidemiological surveillance and for the continuation of systematic vaccination until the disease was brought under control in all countries.

Dr SENGUPTA (India) said that his country was one of those in which smallpox was endemic. In such a vast country with a population of 547 million and varied climatic, geographical, social and cultural patterns, the problems involved in the smallpox eradication programme were tremendous, but India was trying its best to put an end to the problem. A national smallpox eradication programme had been launched in 1962. During the last few years the disease had shown a gradual decline, but in 1971 there had been a slight increase in cases and deaths as compared with 1970, mainly due to better reporting and surveillance. The comparatively lower incidence of smallpox reported reflected the effects of improvements in the programme, such as the giving of top priority to primary vaccination, the change over to freeze-dried vaccine, and the adoption of the multiple puncture method. Emphasis was now being laid on surveillance; all cases and deaths were now reported irrespective of the date of occurrence, and when there were no cases, that also had to be reported; all health staff had been instructed to report any suspected cases promptly. That system had narrowed down the interval between the beginning of the outbreak and the receipt of information. District health officers were now being trained to investigate the smallpox outbreaks, so that the source of infection could be identified, and containment activities were initiated immediately on the receipt of information. Health education and publicity measures were being intensified. It was hoped that, with the development of surveillance and the continuation of the mass vaccination programme, further progress would be achieved and the objective of eradication reached.

As far as the production of smallpox vaccine in his country was concerned, the present production capacity was 60 million doses per annum. After the installation of new equipment, production would go up to 156 million doses per annum, which would be sufficient to meet the requirements of the country. He was grateful to the Government of the USSR for supplying smallpox vaccine to supplement the vaccine produced in India.

His country had donated eight million doses of smallpox vaccine to Bangladesh for meeting immediate needs. An Indian delegation had visited Bangladesh the previous month to find ways and means of controlling the disease in that area.

The CHAIRMAN announced that the United Nations had confirmed the deposit of Bangladesh's instrument of acceptance of the Constitution. Bangladesh was now welcome to full membership of the World Health Organization.

Dr TEKLE (Ethiopia) said that the Director-General's report stated that, because of more complete notification, 25 976 cases of smallpox had been notified in Ethiopia in 1971 as compared with only 722 cases in 1970. The smallpox eradication programme in Ethiopia was based on four main activities: (1) improved reporting; (2) investigation and containment of outbreaks; (3) active case-finding; and (4) improved routine vaccination by the health services in the country. There was an excellent reporting network in his country, achieved through cooperation between health institutions, schools, civic leaders and military stations. The investigation and containment of outbreaks had top priority in the programme. All suspected cases were immediately followed up for epidemiological investigation, and investigations in specific areas were carried out by surveillance teams using maps. For the purpose of containment, every contact was vaccinated, including the inhabitants both of the villages involved and of surrounding villages where cases had been reported. Occasionally the population of whole areas was vaccinated. Areas in which containment activities had been carried out were invariably revisited by the team after four to six weeks to confirm the effectiveness of the work. During the visit the team also inspected surrounding areas to prevent the spread of the disease.

If there were no reports of smallpox in a province, the teams engaged in active case-finding. Health institutions, schools, markets and other institutions were visited to discover if there were any cases in the area, and during the visits the teams vaccinated the local inhabitants so as to boost the immunity of the population. They also distributed vaccines and needles to the local health institutions and trained the staff in vaccination techniques.

Since January 1971, five million people had been vaccinated and in most of the endemic areas, in south and south-western Ethiopia, the disease had been contained. As his delegation had stated in the fourth plenary meeting, it would not be long before smallpox was completely eradicated from the country.

In September 1972 a seminar would be held in Addis Ababa to evaluate the progress achieved, to train more surveillance teams, and to discuss future plans of action. Neighbouring countries were being invited to participate. It was hoped that the use of detailed maps of the border area would enable smallpox surveillance teams from both Ethiopia and Sudan to pinpoint the exact location of outbreaks, and thus be able to combat the disease simultaneously on both sides of the border.

He expressed his Government's appreciation of the active help given by WHO to Ethiopia's smallpox eradication programme.

Professor TIGYI (Hungary) said that no smallpox cases had occurred in his country since the First World War, and thus Hungary had not been directly interested in the smallpox eradication programme. However, the smallpox epidemic that recently had broken out in Yugoslavia had presented an immediate danger, and the Hungarian health authorities had taken action to prevent the spread of the infection to Hungary.

The Hungarian health administration was glad to note the results achieved in the smallpox eradication programme, results which proved that the decision by the Eighteenth World Health Assembly to adopt the programme had been a good one. Hungary was contributing to WHO's smallpox eradication programme, and in 1971 had helped the countries participating in the programme with 500 000 doses of freeze-dried vaccine. In view of the world situation, smallpox vaccination was still compulsory in Hungary, but to minimize complications and side effects primary vaccination was given to old people along with special protective measures. Hungary was investigating the possibility of discontinuing compulsory smallpox vaccination, but it would be easier to do so if countries in which the disease was endemic would include the results of revaccination on international vaccination certificates and make it compulsory to repeat unsuccessful revaccinations.

Dr AUJOULAT (France) said that smallpox was once again emerging as a major threat, and countries that had hitherto maintained strict preventive systems should be cautious about deciding to abandon them. The delegation of France had, of course, welcomed the conclusions of the Expert Committee that had met in Geneva in the autumn of 1971 to adopt a strategy against smallpox in the final years before its eradication; it had expressed the hope that smallpox would in fact be eradicated in a few years. But outbreaks had occurred in countries that had been considered immune, and 1972 would have to be considered as a discouraging year after the optimism of the previous year.

His delegation was convinced that it would be a mistake, even in countries that were free from the disease, to discontinue compulsory vaccination. He fully supported the statement in the Director-General's report that the disease was far from being eradicated, that much remained to be done in countries where the disease was endemic, and that countries free from the disease should exercise increased vigilance. The possibility of the reimportation of the disease induced his country to maintain vaccination, since it would be difficult to reintroduce it if it was temorarily suspended. Another factor that should be taken into consideration was that of setting an example that might be used by other countries more at risk. He therefore urged that the prospect of early eradication of the disease should not lead to a reduction in preventive measures. The teaching of smallpox diagnosis should continue to be included in the curriculum of medical training, audiovisual aids being used in the absence of cases.

Dr ROASHAN (Afghanistan), outlining the eradication programme in his country, where it had been the cause of an 80% decrease in incidence, said that the attack phase of the programme had been initiated in April 1969 and had now been completed in three of the four areas into which Afghanistan was divided. In those three areas the consolidation phase of the programme had begun.

Systematic mass vaccination of the population had been carried out house by house and village by village, and had been preceded by a health education campaign. Out of an estimated total population of 17 million, including 2.8 million nomads, only 10 million had in fact been vaccinated. It was thought that the main reason for the large number not vaccinated was that many semi-nomadic and nomadic groups of people could not be reached at the time of vaccination. Among the objectives of the consolidation phase of the programme were the revaccination of all children of 10 years of age and under and the vaccination of all those missed during the attack phase.

When the programme began there had been no proper system of notification of smallpox cases, and so immediate steps had been taken to develop a nationwide reporting system, which was the most important element in the whole programme. As far as the containment of outbreaks was concerned, specially trained zonal teams had been dealing with reported outbreaks since 1970. The main problems had been the importation of infection from other countries and the still persistent practice of variolation in some remote parts of the country. In order to put an end to the practice, active surveillance was to be intensified in the border provinces.

Because of improved reporting, active surveillance, better investigation of outbreaks and prompt containment measures, the endemic foci in the country had been almost eliminated. Not only had there been a gradual reduction in the areas of endemicity in the country, but there had also been a decrease in case incidence. Training of staff to take part in the eradication programme was a continuous activity, and steady progress was being made.

Dr BUSTAMANTE (Mexico) said that the Director-General's report, together with the Weekly Epidemiological Record of 5 May 1972, gave an account of the progress achieved in smallpox eradication and highlighted the danger of the importation of the disease from countries where it was endemic. The terrible experiences of the countries of the American continent, where there had been no smallpox before 1496, but which suffered millions of deaths over 470 years until the disease was finally eradicated, warned against any premature discontinuation of vaccination which might expose humanity to avoidable suffering and death.

The prospects for the eradication of smallpox were encouraging. The example of Brazil, which was the size of the whole of Europe and included a wide diversity of geographical and social conditions, showed what could be achieved in a short time by efficient organization of the public health services. Mexico, as a country which had been free from smallpox for more than 25 years, considered that the account given by the Brazilian delegate of his country's experience was particularly important for the Americas, the first region to complete a full year without a case of smallpox.

He paid tribute to the activities of WHO and also to the cooperation of the USSR, the United States of America and of 32 other countries which had contributed to the Special Account for Smallpox Eradication. At the risk of being considered over-optimistic, he suggested that doctors might begin to compile material for a history of smallpox to be published at an appropriate date to show that the final eradication of a communicable disease could be effected by WHO with the cooperation of all countries.

On behalf of the delegations of Ceylon and Yugoslavia and his own delegation, he presented the following draft resolution:

> The Twenty-fifth World Health Assembly,
>
> Having considered the Director-General's report on the smallpox eradication programme;

Appreciating the significant progress made to date in programmes throughout the world, and congratulating those countries which have succeeded in eradicating the disease;

Noting with concern, however, that endemic smallpox still exists in parts of Africa and Asia and that smallpox has recently reappeared in several countries which were free from the disease;

1. REQUESTS all Member States to continue to give priority attention to the eradication of smallpox, to intensify their efforts to interrupt transmission of the disease in the remaining endemic areas as soon as possible, and to prevent smallpox from re-establishing itself in countries from which it has been eliminated;

2. URGES all governments concerned:

(a) to cooperate fully in the immediate reporting to the Organization of all cases of smallpox; and

(b) to establish or strengthen national surveillance systems with a view to the identification of sources of infection, the rapid containment of outbreaks, and the elimination of endemic foci;

3. RECOMMENDS further that non-endemic countries where cases of smallpox occur should invite WHO to participate in their epidemiological investigations and thus facilitate international coordination of the measures taken;

4. REQUESTS the Director-General to provide assessment teams on request to countries which have recently interrupted smallpox transmission and wish to have certification from the Organization that the country is smallpox-free;

5. REQUESTS the Director-General to continue to extend every possible assistance to countries in these matters; and

6. THANKS those countries that are generously contributing large amounts of vaccine to the programme, either under bilateral agreements or through the WHO Voluntary Fund for Health Promotion.

Dr N'DOW (Gambia) endorsed the view that smallpox was far from being under satisfactory control. On the other hand, WHO deserved congratulations on the achievements recorded, for the period 1967-1971 in particular. There was no doubt that those achievements were a substantial contribution to the objective of the global eradication of smallpox.

Although many African countries were relatively free of smallpox, the outbreak in Botswana, after four years without detected cases, reinforced the recommendations of the Expert Committee on Smallpox Eradication quoted in the report. As long as there were endemic foci on the African continent, the threat of smallpox would remain.

He supported the view that mass vaccination without proper epidemiological surveillance was not enough to stop transmission of the disease. At a seminar organized some years ago in Lagos by WHO, some participants had urged the establishment of an epidemiological unit to serve the countries of the Region, particularly after the attack phase of the regional programme. The need for such a unit had become more evident during the cholera outbreak in West and Central Africa in 1971. The Gambia depended almost entirely on WHO for the weekly exchange of epidemiological data, and he believed that the establishment of an epidemiological unit would reduce the time-lag between notification and preventive action and thus help to reduce outbreaks of communicable diseases.

Dr VALVERDE (Bolivia) said that there had been no case of smallpox in his country since 1966. The eradication of the disease had been due to the efficient aid given by WHO, PAHO and UNICEF.

Although the disease had been eliminated, Bolivia was continuing with vaccinations in order to avoid a recurrence, and had recently carried out a countrywide vaccination programme. There was also a strict control and surveillance at all airports and points of entry into the country.

Member States of WHO should be pleased that smallpox was now being effectively eradicated throughout the world. The case of Brazil was notable and praiseworthy; it had succeeded in eradicating smallpox and no outbreak had occurred during the last year.

He agreed with the USSR delegate that it was unfortunate that doctors were no longer able to recognize the disease. A recommendation might be made to faculties of medicine throughout the world, but chiefly to those in the developing countries, to include a review of the symptomatology of smallpox in the curriculum, so that, if the disease were to recur, no serious consequences would ensue either for those countries or for humanity as a whole.

He supported the resolution submitted by the delegations of Ceylon, Mexico and Yugoslavia.

Dr LEKIE (Zaire) said that the Director-General's report gave cause for optimism, but there was no reason to slacken the efforts being made. Hitherto the programme in his country had progressed well: there had been 4000 cases of smallpox in 1968, 2064 in 1969, 724 in

1970, 63 in 1971, and no cases so far during the current year. However, Zaire was maintaining its vigilance in the belief that the disease might always reappear locally or be imported from another country where the disease was endemic.

Thanks for the success of the campaign were due to WHO and to the United States of America, which had provided manpower for surveillance teams in the form of Peace Corps volunteers. Eradication of smallpox in his country was vital to the eradication programme of the world as a whole, since Zaire bordered on 10 different States, and he hoped that the volunteers could remain in the country to continue the surveillance programme for as long as was necessary.

Some countries had declared their intention of discontinuing or phasing out compulsory vaccination. Such declarations caused some unease in his country, since they would lead many people to believe that as a result of technical progress it was now possible to dispense with vaccination. He agreed with the views expressed by the delegates of Belgium and France on the subject.

Dr JAKOVLJEVIĆ (Yugoslavia) said that the introduction of smallpox into his country was the first such occurrence for 42 years and he was happy to announce that Yugoslavia was once again smallpox-free. The recommendations of the Expert Committee on Smallpox Eradication, in particular that all cases occurring in non-endemic areas should be investigated and contained by national staff assisted by experienced WHO staff, had been completely applied during the outbreak. His Government had invited not only the experts from WHO but medical study groups from various foreign countries. The cases had been promptly reported and nothing had been kept secret. Yet even after Yugoslavia had been declared free of smallpox in accordance with the International Health Regulations, the newspapers and other news media in some countries had misrepresented the situation, with the result that Yugoslavia was still suffering economically. His delegation felt that WHO could do more to see that the correct information was presented to the public. All the population in the affected areas and over 90% of the total population in the country had been vaccinated, so that there was practically no chance of reinfection for years to come. The direct expenditure on the campaign had amounted to 8% of the annual health budget.

He agreed that early diagnosis of a disease like smallpox was one of the most important preventive measures, but it was not always possible to discover the disease quickly. The first case had occurred in a small village and had been so mild that the patient had not required medical aid. He had been found only as a result of epidemiological investigation. Dr Jakovljević wondered whether the policy followed by WHO in 1970 to warn the world of outbreaks of cholera could be applied to smallpox in future.

The Yugoslav Government would continue to support the global programme of smallpox eradication as in previous years.

Dr SENCER (United States of America) said he was not over-concerned about the increase in the incidence of smallpox, since it indicated improved surveillance and reporting. But he was disturbed to see a decrease in the Organization's budgetary support for the programme, however small. History was full of examples of the premature withdrawal of funds. It was axiomatic that the cost per case would increase as eradication was approached. Of the seven recommendations made by the Expert Committee on Smallpox Eradication, five were in one way or another concerned with the need for improved surveillance. All countries should thank the Government of Yugoslavia for its prompt reporting, which had enabled other health authorities to intensify their surveillance activities in appropriate ways. It had eased the work needed in his own country by limiting concern only to travellers from the affected areas and not from the whole country, and it had been possible to stop requiring certificates of vaccination immediately when Yugoslavia reported that transmission had ceased.

Commenting on some of the views expressed, Dr Sencer explained that routine immunization was no longer needed for children in the United States of America, but it was still strongly recommended for health workers and travellers to endemic areas. Since no vaccine was completely safe, health authorities had to weigh the risks and benefits of vaccinating as against not vaccinating in the light of their own situation.

Dr HASAN (Pakistan) reported that the eradication programme in his country had suffered a setback owing to the splitting up of the single programme for the whole of Pakistan into provincial programmes and to the recent political turmoil. The programme had now been streamlined, WHO consultants had been stationed in the four provinces, and vaccination and surveillance measures were proceeding satisfactorily. One recurrent difficulty was the lack of maintenance facilities for vehicles. Whenever a vehicle broke down it took some time to repair it, which caused delay in containment and surveillance. The fault was mainly that of the Government's financial rules, which did not permit the advancing of money. An attempt

was being made to modify the rules, but since similar circumstances might exist in other countries he suggested that WHO should consider making sums of money available to consultants to meet unforeseen immediate financial needs, to be reimbursed by the government concerned.

The delegate of Egypt had said that notification and surveillance depended on the existence of basic health services, but the smallpox eradication programme could not wait for ideal conditions. It was necessary to depend on people who were not engaged in health work, and to this end the smallpox recognition card described in the Director-General's report was of help. Efforts were being made to prepare smallpox vaccine in Pakistan, but until manufacture could start his country would depend on donations of vaccine from other countries. He was grateful for the help that had been given in that respect.

Dr SUFI (Somalia) said that his country had been free of smallpox for many years but, since the disease was endemic in a neighbouring country, the national vaccination programme was being continued. The immense distances that had to be covered, the poor communication facilities, and the nomadic character of a large part of the population constituted grave difficulties. A road would soon be constructed running across the country from north to south, and in the course of construction wells would be drilled every 10 km along its length. Advantage would be taken of that project to vaccinate the nomads who would gather from time to time at the wells. In most of the major health centres, smallpox vaccination was now being combined with BCG vaccination for the newborn, and it was the intention to integrate those two programmes with other basic health services.

Dr TAJELDIN (Qatar) informed the Committee that no cases of smallpox had been detected in his country for 20 years, and continual efforts were made to prevent importation of the disease. There was compulsory vaccination for all children within the first three months of life, and periodic mass vaccination programmes were carried out for the whole population every three years, or when a case of smallpox occurred in a neighbouring country. Strict surveillance procedures were applied to international travellers. His delegation emphasized the importance of developing simplified and improved methods of laboratory diagnosis, bearing in mind the likelihood of a modification in the signs and symptoms of smallpox due to the residual immunity from vaccination. WHO might usefully arrange short-term training courses for laboratory technicians.

Dr RAMAMBAZAFY (Madagascar) said he considered that his own country's freedom from smallpox for the last 50 years was due to the permanent application of stringent control measures. Madagascar was a central point for travellers and was therefore continually connected with other countries where smallpox was, or had recently been, endemic. Citizens in Madagascar were revaccinated every three years, and the coverage was now estimated at 80%. In addition, the Government subjected all travellers at ports of entry to close surveillance. If necessary, travellers were required to be vaccinated on the spot or to leave the country.

The vaccine production service of Madagascar was in a position to supply smallpox vaccine to other countries on request within the framework of international cooperation.

Dr DARAMOLA (Nigeria), reporting the success of the WHO/USAID eradication programme in his country, stressed the importance of continuing surveillance measures. The lesson of smallpox control was that eradication of a disease was so difficult that it had not been achieved even when effective vaccination procedures had been available for a century and a half. Only the worldwide cooperative programme launched by WHO had made eradication a possibility. It must be recognized that other diseases existed, such as measles, tetanus, and tuberculosis, that were far more dangerous than smallpox in terms of morbidity and mortality and were equally susceptible to control by vaccination. Yet routine vaccination was not available to two-thirds of the population in many countries. When smallpox had been eradicated the control teams should not be disbanded but should switch their efforts to other important diseases. It was to be hoped that the lessons of the smallpox programme would guide the Organization in its fight against other diseases that could be controlled by mass vaccination.

The meeting rose at 1 p.m.

TENTH MEETING

Monday, 22 May 1972, at 9.30 a.m.

Chairman: Dr Marianne A. SILVA (Nigeria)

1. SMALLPOX ERADICATION (continued) Agenda, 2.5

The CHAIRMAN drew the Committee's attention to the draft resolution proposed at the ninth meeting by the delegations of Ceylon, Mexico and Yugoslavia, a copy of which had now been circulated. The delegation of the United Kingdom, with the agreement of the sponsors of the draft resolution, had presented amendments to replace operative paragraph 2(a) by the following:

> (a) to report immediately to the Organization any case of smallpox which occurs in a non-endemic area;

and to insert a new operative paragraph 3 as follows:

> 3. REQUESTS the Director-General to arrange to transmit promptly to all Member States whom it may concern information provided under 2(a);

former paragraph 3 would be renumbered 4 and amended as follows:

> 4. RECOMMENDS further that non-endemic countries where cases of smallpox occur or are suspected should inform WHO fully of their epidemiological investigations, where appropriate invite WHO participation, and thus facilitate international coordination of the measures taken;

Paragraphs 4, 5 and 6 would be renumbered 5, 6 and 7.

Dr HACHICHA (Tunisia) considered the eradication of smallpox to be a difficult enterprise requiring increased cooperation between endemic countries, and well-coordinated regional programmes. More attention had to be paid to surveillance in all countries, particularly those bordering on endemic areas. In view of the importance of rapid diagnosis, special laboratory equipment and trained staff were needed. Such staff were lacking in many countries and there was a need for more training facilities. In Tunisia vaccination was being continued at the rate of 20% of the population each year, but the programme was not systematic because adults did not like to be revaccinated. Children, however, were systematically vaccinated in the second year of life and on entering school.

The remarks made by the delegate of Yugoslavia had brought out the economic effects of problems involving diseases subject to the International Health Regulations; in Tunisia, when cholera had appeared there, the economic repercussions had been felt for several months. WHO should do something about that problem. Where there was a low risk of smallpox, some countries had abandoned vaccination and relied on their public health services to control the disease. He considered that such a policy was insufficient and that those countries were exposing themselves to considerable risks.

Dr PINTO MUSA (Brazil) supported the draft resolution proposed by the delegations of Ceylon, Mexico and Yugoslavia.

Dr CUMMINGS (Sierra Leone) said that his country had been free of smallpox for three years. The epidemiological units had now been decentralized and placed on a regional basis. He paid tribute to the collaboration of 19 States in the African Region and noted the efforts of USAID to develop a regional programme. His Government supported such programmes in the spirit of regional cooperation. He asked whether there had been any further developments in the occurrence of monkeypox.

Professor PENSO (Italy) said he did not doubt that there was now a possibility of eliminating smallpox throughout the world but it was a possibility that was still far from being realized. There was, moreover, always a danger of reintroduction of the disease in non-endemic countries, and the danger would grow with increasing travel. Therefore, countries that had eradicated the disease could not rest on their laurels. Some people said that in countries where smallpox no longer existed vaccination was more dangerous than the risk of

contracting the disease, but that was true only in a vaccinated population. What would be the result, he asked, of introducing smallpox into a population where entire generations had not been vaccinated? He had himself observed that, in the several instances of smallpox introduced into Italy, the virus had affected only people who had never been vaccinated or who had not been vaccinated for 20 years. He wondered what the result would have been if mass vaccination had not been practised. To abandon vaccination at the present time was a dangerous policy and one that did not conform to WHO policy.

Mr MINKO (Gabon) said that no case of smallpox had occurred in his country since 1964, but he did not think that that was a reason for believing that the disease had been eradicated. The rapid and frequent travel made possible by modern means of transport did not permit any relaxation of vigilance. Systematic vaccination campaigns were being carried out and frontiers were being controlled. The lack of satisfactory vaccination coverage in certain areas led his delegation to believe that the programme in Gabon might be threatened by a withdrawal or diminution of bilateral assistance. In expressing his gratitude for the valuable assistance it had received from WHO and USAID, his Government hoped that the assistance would be prolonged for several years so that Gabon could complete its programme.

Dr AL-WAHBI (Iraq) said he believed that the draft resolution and the amendment before the Committee were inconsistent with the International Health Regulations. In suggesting that countries might wish WHO to certify that they were smallpox-free, the resolution went further than the requirments of the Health Regulations. Under those Regulations only airports could be certified as being free of a disease, not entire countries. Moreover, the use of the word "should" in operative paragraph 3 of the draft resolution implied that it was obligatory for countries to invite WHO to participate in their epidemiological investigations. Such language was inadmissible to the sovereign Member States of the Organization. He suggested the use of the word "may" instead of "should" and the deletion from the following paragraph of the words "and wish to have certification from the Organization that the country is smallpox-free".

Dr ZAMFIRESCU (Romania) proposed that an additional point should be inserted in operative paragraph 6 of the draft resolution recommending the intensification of research on the laboratory diagnosis and treatment of smallpox and on the mechanism of immunity.

Dr RESTREPO (Colombia) said that in his country's smallpox programme the aim had been eradication of the disease in the shortest possible time, since the persistence of foci could have jeopardized the success of the programme. He considered that information on the epidemiological aspects of the disease should be disseminated because modified clinical signs and symptoms could make the diagnosis difficult and because many physicians no longer thought of the possibility of smallpox. Those factors could give rise to the kind of outbreak that might be rapidly controlled if measures were taken in time. The training of laboratory personnel and the siting of laboratories were of great importance in view of the difficulties often experienced in clinical diagnosis. No cases had been reported in the Americas for more than a year, and he wished to know whether that period was sufficient for WHO to declare the disease eradicated. The answer had an important bearing on the development of new strategies.

His delegation supported the draft resolution before the Committee.

Dr ELOM (Cameroon) supported the draft resolution and the various amendments that had been presented, particularly the one proposed by the delegate of Romania.

Sir George GODBER (United Kingdom of Great Britain and Northern Ireland) said that the first of his delegation's amendments urged all governments to report immediately to the Organization any case of smallpox occurring in a non-endemic area. On reflection, his delegation now thought that the wording should be revised, since it might convey the impression that only cases occurring in non-endemic areas should be reported. He therefore suggested that the amendment to operative paragraph 2(a) should read:

> (a) to report immediately to the Organization, as already required, all cases of smallpox and in particular to use the most rapid means for any case which occurs in a non-endemic area.

The second amendment, requesting the Director-General to transmit the information to all Member States, had been suggested in order to ensure that information was given immediately to neighbouring countries.

Paragraph 3 of the resolution submitted by the delegations of Ceylon, Mexico and Yugoslavia recommended that non-endemic countries where smallpox occurred should invite WHO to participate in their epidemiological investigations. Such a recommendation would impose

a burden on the Organization and might prove to be a distraction to a country at a critical time. In any case, the first 48 hours were vital, and it was doubtful whether a WHO expert could reach the scene of action in time. Hence the third amendment of his delegation. Sir George did not share the delegate of Iraq's concern about the use of the word "should", since it was governed by the previous word "recommends" and so no obligation was imposed on Member States. None the less, he had no objection to omitting the word from the text altogether and to modifying the third amendment to read:

> 4. RECOMMENDS further that non-endemic countries where cases of smallpox occur or are suspected inform WHO fully of their epidemiological investigations, and give WHO the opportunity to participate and thus facilitate international coordination of the measures taken;

Several speakers had said that countries should not abandon the universal vaccination of children in the second year of life. In the United Kingdom the coverage was in fact far from universal, being only about 40%. But he thought that vaccination or revaccination could not be relied on to prevent the spread of the disease for 20 years. It was the revaccinated person who was likely to acquire a modified subclinical form of smallpox and spread it widely.

Dr MAKOUNDOU (Congo) questioned whether countries could be described as "non-endemic", as they were in operative paragraph 3 of the resolution, because the adjective "endemic" applied to a disease, not to a country. He preferred the phrase "countries normally free of the disease".

Professor HALTER (Belgium) agreed with the amendments of the United Kingdom delegation and of the delegates of Iraq and Romania. He wished, however, to see a further addition made to operative paragraph 5 of the original draft resolution, requesting the Director-General to report to the Twenty-sixth World Health Assembly on the progress of the eradication programme. In order to keep track of the various amendments proposed, he wished eventually to receive a coordinated text.

Dr SENCER (United States of America) considered that certification of a country as free of a disease was not the innovation that the delegate of Iraq thought it to be. The method had been used for some years in the malaria eradication programme. Moreover, to invite WHO's participation was in keeping with paragraph 3 of Article 11 of the International Health Regulations. In his own country the results of following the Regulations had been entirely satisfactory. When a single rodent had been found infected with plague in a particular port his country had informed WHO, which had sent an expert from the Institut Pasteur. There had been no adverse economic effects.

Dr AL-WAHBI (Iraq) said that his previous remarks related to diseases under surveillance within the meaning of the International Health Regulations and not to communicable diseases in general.

Dr HASSAN (Egypt) expressed concern lest, despite the assurances of the delegate of the United Kingdom, the word "should" in the third operative paragraph of the draft resolution and in the original proposed amendment be interpreted as obliging Member States to invite WHO participation in national epidemiological investigations. He therefore supported its deletion. He agreed with the delegate of the United States of America that WHO might participate in those investigations with the consent of the Member States concerned.

Dr CHAPMAN (Canada) fully endorsed the proposals and comments of the United Kingdom delegate. He joined the delegate of Belgium in suggesting that the Director-General should be requested to report on the subject to the Twenty-sixth World Health Assembly.

Dr TATOČENKO (Union of Soviet Socialist Republics) supported the amendments proposed and the views expressed by the delegations of Belgium, Romania and, particularly, Iraq. While he was not opposed to the invitation of WHO teams to assess smallpox eradication, certification of eradication should not be made dependent upon their assessment; there was no reason not to accept the country's own evaluation of the situation. His delegation supported the amendment of operative paragraph 3 of the original draft resolution along the lines indicated by the delegates of Egypt and Iraq.

It would be helpful if WHO produced a good film and an illustrated manual on the diagnosis of smallpox.

Dr EVANG (Norway) appealed to members of the Committee not to be unduly influenced by considerations of diplomacy and to remember that they were taking part in a historic event - the eradication of a dangerous disease. There was nothing in the United Kingdom amendments

to the draft resolution which would detract from the sovereignty of a Member State and he hoped that a majority of delegations would join his own in supporting the amendments.

Dr GOMAA (Egypt) proposed that the Organization should assist Member States in developing laboratory facilities for local production of vaccine to meet national needs and, if possible, some international requests. An addition to that effect could be made to the fifth operative paragraph of the draft resolution.

Dr SUMPAICO (Philippines) supported the draft resolution and the proposed amendments. He suggested that the word "large" should be deleted from the sixth operative paragraph, since it was not the quantity of vaccine donated that determined the gratitude but rather the generosity of the gesture.

Dr BUSTAMANTE (Mexico) suggested that a drafting group should be established to combine the draft resolution and the various amendments into a single text for consideration by the Committee.

There being no opposition to that suggestion, the CHAIRMAN declared the list of speakers closed and suggested that the drafting group include the delegations of Belgium, Canada, Ceylon, Congo, Egypt, Iraq, Mexico, Norway, Philippines, Romania, the United Kingdom of Great Britain and Northern Ireland, and Yugoslavia, and any other delegations wishing to participate.

It was so agreed.

Dr BERNARD, Assistant Director-General, replying to points raised during the discussion, noted with pleasure the general agreement on the Organization's programme, as shown in the favourable reception accorded to the Director-General's report.

In reply to the delegate of the United States of America, he explained that the resources made available for the smallpox eradication programme and the support for Member States in its implementation depended on requirements which varied from year to year. Thus the requirements of the Region of the Americas, so far as WHO was concerned, had decreased since the Region had progressed from attack to surveillance and maintenance. The United States delegate could rest assured that the Organization would make available for smallpox eradication all the resources required at the current crucial stage in the programme's development to enable WHO to fulfil its role. For instance, the interregional teams, which reinforced regional activities as required, would be maintained and strengthened as requested by the delegate of Uganda. Special attention would be paid to the development of the epidemiological survey units mentioned by the delegate of the Gambia, of which there were already two for the African Region, with headquarters in Abidjan and Nairobi respectively. In addition, the Organization had budgetary provision for action in case of epidemics.

In the light of the discussion, he wished to make it clear that the Director-General regarded WHO's participation in national programmes as cooperation with and liaison between governments to promote exchange of experience rather than as assistance.

He assured delegates who had raised points such as the definition of "infected area", vaccination and revaccination, and certification, which concerned the International Health Regulations, that their observations would be carefully analysed and submitted to the Committee on International Surveillance of Communicable Diseases which was to meet in the last quarter of the year. The report of that Committee containing its conclusions and recommendations would be submitted to the Twenty-sixth World Health Assembly.

Where epidemiological information was concerned, speed was essential for efficacy. He wished to stress how greatly rapid reporting by Member States facilitated the Organization's task and contributed to the value of the information. In that connexion he paid tribute to the speed with which the Government of Yugoslavia had reported the recent smallpox outbreak and the regularity with which it had kept WHO informed of the situation.

The Organization had to transmit without delay the information that it received. The method of transmission had been reviewed and recently the system had been changed following a cost/effectiveness analysis to make appropriate use of modern means of communication. After careful study of the use being made of the daily epidemiological radiotelegraphic bulletin, the Director-General had found that the greatly increased cost of continuing that mode of transmission of epidemiological information would be out of proportion with the use made of it. The Director-General had therefore decided that, as from 1 February 1972, the Weekly Epidemiological Record would be despatched to national administrations by the most rapid mail on Friday of each week and, moreover, that incoming information would be sent by telex daily to the regional offices, which would reply by telex or telegram to all requests

for information from the countries of the Region. In exceptional circumstances, such as an outbreak of a disease subject to the International Health Regulations in an unusual location or the cessation of such an outbreak, the regional office would immediately inform the countries of the region. Member States had been informed of the arrangements by the Director-General's circular letter of 16 December 1971. He had been glad of the opportunity to explain the new arrangements, which were perhaps not well known yet, and expressed the hope that Member States would cooperate at the national level in making the new system effective. The Director-General would evaluate it during the coming months and he hoped to be in a position to report on its efficiency to the Twenty-sixth World Health Assembly.

Reference had been made to the appearance in the Weekly Epidemiological Record of notes concerning the new policy of the United Kingdom of Great Britain and Northern Ireland and the United States of America concerning smallpox vaccination. Those notes had been published in accordance with a long tradition of including in the Weekly Epidemiological Record all the information thought to be of use to health administrations of Member States. It appeared however that the information had been seized upon and used by certain bodies of opinion in such a way as to cause problems for the health administrations of some countries. The Organization would do all it could, without curtailing the information which it owed to Member States, to avoid giving grounds for erroneous interpretations.

As for the premature divulgation of information to the press, the Organization never under any circumstances divulged to the press information not already conveyed to its Member States. But information was conveyed to Member States only when it came from a reliable source, and had been confirmed with the Member State concerned if that was necessary. It was therefore natural that the powerful international press, with its rapid means of communication and contacts, not subject to the same exigencies, should sometimes publish information first. Indeed the Organization was on occasion obliged to contact Member States in order to ascertain the truth or untruth of information first obtained from the press. However, he assured the Committee that the Organization would never depart from the principle that Member States would be the first informed. At one point in the discussion, the delegate of Belgium had suggested that those responsible within the Organization might depart from that principle and respond to other considerations regarding information. There could be no misunderstanding on that point; the delegate of Belgium would agree, he was sure, that the responsible services of the Organization were fulfilling their delicate tasks in full awareness of their obligations and with the interests of Member States, and those interests alone, at heart.

On the question of the need for systematic vaccination, Dr HENDERSON (Smallpox Eradication) said that the WHO Expert Committee on Smallpox Eradication that had met in November 1971 had been of the opinion that systematic vaccination should continue in most countries owing to the importance of maintaining a high level of immunity in the population, and that countries where that might not be necessary were very much the exception rather than the rule. However, Member States could not be complacent in the continuation of their systematic vaccination programmes, since vaccination could only facilitate the control of the disease, it could not prevent its importation or subsequent spread. As for the level of immunity required to prevent importation of cases, even a 90% coverage, which itself was difficult to maintain, would not prevent importations and would not necessarily interrupt smallpox transmission, as had been found by studies in Indonesia, Pakistan and Afghanistan. Interruption of transmission could only be obtained in endemic or non-endemic countries by vigilance, rapid investigation of cases, careful epidemiological studies to find their sources, and prompt and effective containment measures. As the delegates of Afghanistan, Indonesia, Ethiopia and Zaire had described so well, active surveillance could be carried out in any country, however well or poorly developed its health services, and that was the real key to success in interrupting transmission.

On the question of a possible natural reservoir of smallpox other than man, he said that in the five years since the beginning of the eradication programme the Organization and its collaborating laboratories had put much study and effort into studies of that problem. Much information had become available. The Expert Committee to which he had referred had carefully examined all the evidence and had come to the conclusion that:

> Although it is not possible on the basis of present information to deny categorically the possibility of an animal reservoir of variola virus, a consideration of the epidemiological facts shows this to be unlikely. In several parts of the world . . . the presence of large populations of simians and other mammals, often in close proximity to man, has not prevented the eradication of smallpox.[1]

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[1] Wld Hlth Org. techn. Rep. Ser., 1972, No. 493, p. 29-30.

During the past three years, nine human cases of a pox disease simulating smallpox had been discovered in five countries of Africa. A number of papers on the subject were to be published shortly in the Bulletin. Those cases were caused by a virus called monkeypox virus which was related to but very distinctly different from variola virus. They had occurred in or near tropical rain forests frequented by monkeys but there had been no transmission between human cases, although over 120 unvaccinated persons had been in very close personal contact with the cases during the acute phase of their illness. It was thus believed, at the moment, that monkeypox was of no more than academic interest.

As regards the training of physicians in the diagnosis of smallpox, which would become more difficult as smallpox became less common, the Organization provided on request two sets of teaching slides on smallpox diagnosis, one showing African and one showing Asian patients. The Organization had also prepared and made available on request a large poster showing a smallpox case and a chickenpox case at various stages in the evolution of the rash. The suggestion by the Soviet delegate of the preparation of a film and an illustrated manual had been noted and would be considered in the light of the limited financial provision for the production of teaching materials.

As regards the inquiry of the delegate of Colombia on the length of time that had to elapse without new cases before eradication could be declared, the Expert Committee had concluded that the term "eradication" should apply to continents only, and not to individual countries, owing to the ease with which the disease could be transmitted from one country to another.[1] Since experience had already shown that cases could come to light eight months after the last case had been reported, it was proposed that a period of two years should elapse before eradication was declared, during which time active surveillance would continue throughout the continent. If experience showed that a longer interval was required, the matter would have to be reconsidered.

The observations of the delegates of Romania and Japan on the need for research and definition of terms had been noted for reference in the planning of the Organization's research programme for the coming year.

The supply of high-quality freeze-dried vaccine continued to be a critical problem. For budgetary reasons, the programme had to rely on vaccine production in the countries themselves and on generous donations. WHO was providing assistance to quite a number of laboratories, but countries had to be of a certain population and thus require a certain quantity of vaccine annually for vaccine production to be economically feasible. He believed that all countries that needed assistance were currently receiving it. The Organization appreciated all the many assurances of continued support, whether the amounts donated were small or large.

In conclusion, he quoted the Expert Committee's statement of a fact of which the Organization was very mindful, namely that ". . . the difficulties of interrupting transmission in the remaining principal endemic areas should not be underestimated. The fact that transmission persists in these areas, whereas most of the world has become smallpox-free, implies special problems that will demand an effort at least equal to that made in the past 5 years." The Committee had added: "Nevertheless, with a full commitment to this programme by the endemic countries, supplemented by necessary bilateral and multilateral support and coordination, there is every reason to believe that the goal of global eradication could be achieved within a few years." [2]

(For continuation, see summary record of the thirteenth meeting, section 1.)

[1] Wld Hlth Org. techn. Rep. Ser., 1972, No. 493, p. 6.

[2] Wld Hlth Org. techn. Rep. Ser., 1972, No. 493, p. 61.