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No. 227

TWENTY-EIGHTH WORLD HEALTH ASSEMBLY

GENEVA, 13-30 MAY 1975

PART II

VERBATIM RECORDS OF PLENARY MEETINGS

SUMMARY RECORDS AND REPORTS OF COMMITTEES

WORLD HEALTH ORGANIZATION
GENEVA
1975

MEMBERSHIP OF THE HEALTH ASSEMBLY

LIST OF DELEGATES AND OTHER PARTICIPANTS

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Mr K. AL BASSAM, Third Secretary, Ministry of Foreign Affairs

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UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND

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Mr R. K. ALDER, Principal, Department of Health and Social Security

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Mr O. M. O'BRIEN, Second Secretary, Mission of the United Kingdom to the United Nations Office and the Other International Organizations at Geneva

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Dr E. TARIMO, Director of Preventive Services, Ministry of Health

Mr J. D. S. MWAIKAMBO, Second Secretary, Tanzania High Commission in the United Kingdom of Great Britain and Northern Ireland

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Advisers

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Mr J. J. FLORIO, United States House of Representatives

Mr H. J. BINDA, International Health Attaché, United States Permanent Mission to the United Nations Office and Other International Organizations at Geneva

Mr J. S. COTTMAN Jr, Counsellor, United States Permanent Mission to the United Nations Office and Other International Organizations at Geneva

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Mr E. NOZIGLIA, Directorate for Health and Drug Control, Bureau of International Organizations Affairs, Department of State

Dr R. B. UHRICH, Office of International Health, Department of Health, Education and Welfare

UPPER VOLTA

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VENEZUELA

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Mrs M. E. RUESTA DE FURTER, Third Secretary, Permanent Mission of Venezuela to the United Nations Office and the Other International Organizations at Geneva

YEMEN

Delegates

Dr A. M. ABDALLAH, Minister of Health (Chief Delegate)

Dr M. Q. AL AGHBARI, Adviser to the Presidency of the Council

Dr A. TARCICI, Ambassador, Permanent Representative of the Yemen Arab Republic to the United Nations Office at Geneva and the Specialized Agencies in Europe

YUGOSLAVIA

Delegates

Mrs Z. TOMIĆ, Member of the Federal Executive Council; President, Federal Health and Social Welfare Board (Chief Delegate)

Professor D. JAKOVLJEVIĆ, President, Yugoslav Commission for Cooperation with International Health Organizations (Deputy Chief Delegate)[1]

Dr I. MARGAN, Vice-President, Union of Yugoslav Health Organizations Communities

Alternate

Professor R. GERIĆ, Faculty of Medicine, Belgrade

[1] Chief Delegate from 22 May.

Advisers

Mr J. BOGDANSKI, Secretary for Health and Social Affairs of the Socialist Republic of Macedonia

Dr N. GEORGIEVSKI, President of the Yugoslav Red Cross

Mr M. DESPOTOVIĆ, Federal Secretariat for Foreign Affairs

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

ZAIRE

Delegates

Dr B. LEKIE, Director-General, Department of Public Health (Chief Delegate)

Dr MATUNDU NZITA, Chief of Division, Department of Public Health

Dr Y. YOKO, Chargé d'Affaires, Permanent Representative of the Republic of Zaire to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Adviser

Miss K. B. KABANGI, First Counsellor, Permanent Mission of the Republic of Zaire to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

ZAMBIA

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Dr Mutumba M. BULL, Minister of Health (Chief Delegate)

Dr S. H. SIWALE, Assistant Director of Medical Services, Ministry of Health

Dr C. CHINTU, Consultant Paediatrician

REPRESENTATIVES OF ASSOCIATE MEMBERS

NAMIBIA

Representative

Dr Libertina Inaviposa AMATHILA

PAPUA NEW GUINEA

Representatives

Dr W. MOI, Assistant Director (Mental Health), Department of Public Health

Dr K. SUGOHO, Assistant Director (Diseases Control), Department of Public Health

OBSERVERS FOR A NON-MEMBER STATE

HOLY SEE

Monsignor S. LUONI, Permanent Observer for the Holy See to the United Nations Office and the Specialized Agencies at Geneva
Dr P. CALPINI
Dr Marie-Thérèse GRABER-DUVERNAY
Rev. Father P. BOLECH

OBSERVERS

ORDER OF MALTA

Count de NOÜE, Ambassador, Permanent Delegate of the Sovereign Order of Malta to the International Organizations at Geneva
Count E. DECAZES, Ambassador, Deputy Permanent 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

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

DEMOCRATIC REPUBLIC OF VIET-NAM[1]

Professor HOANG DINH CAU, Vice-Minister of Health
Mr NGUYEN VAN TRONG, Director, Department of External Relations, Ministry of Health
Dr DOAN XUAN MUOU, Deputy Director, National Institute of Hygiene and Epidemiology
Mr PHAM NGAC, Counsellor

MOZAMBIQUE[2]

Dr H. MARTINS, President, Committee on Restructuring and Reorganization of the Health Services, Ministry of Health and Social Affairs
Mr F. V. CABO, Deputy Director-General of Public Health
Mr A. MAHECHE, Committee on Restructuring and Reorganization of the Health Services, Ministry of Health and Social Affairs
Miss M.-A. SALOMÃO, Collaborator, Committee on Restructuring and Reorganization of the Health Services, Ministry of Health and Social Affairs

TONGA[3]

Mr I. FALETAU, High Commissioner of Tonga in the United Kingdom of Great Britain and Northern Ireland

[1] Admitted to membership by the Health Assembly in its resolution WHA28.14 on 22 May 1975.

[2] Admitted to membership by the Health Assembly in its resolution WHA28.15 on 22 May 1975.

[3] Admitted to membership by the Health Assembly in its resolution WHA28.16 on 22 May 1975.

Smallpox Eradication (programme 5.1.4)

Dr HENDERSON (Smallpox Eradication), introducing the Director-General's report on smallpox eradication, said that there had been remarkable progress in the preceding twelve months. The most striking indication of that fact was the number of reported cases of smallpox, which was now 90% below that for 1974 and the lowest number ever reported.

In 1974, four countries had been endemic: Pakistan, India, Ethiopia, and Bangladesh. There had been no cases in Pakistan since October 1974 and in India, where there had been devastating epidemics in 1974, only 100 cases had been reported for March/April 1975. Ethiopia now had only 50-90 cases a week. The one setback in the programme was Bangladesh where it had been hoped to eradicate smallpox by January 1975. Because of unprecedented floods and population movements, however, the disease had spread throughout the country. An emergency programme was now under way and it was hoped that smallpox would be eradicated in the coming 4-6 months.

The progress of the past year was due to the priority accorded by governments to the programme, as well as to a contribution of $9 million which had come mainly from the Swedish Government but also from the other governments referred to in the Director-General's report. Smallpox eradication had been confirmed in the Americas and Indonesia and studies were under way in West Africa with a view to convening an international commission there.

Despite the progress achieved there was no room for complacency, and the coming six months would be crucial. It was obvious that, if smallpox transmission persisted beyond October 1975 in Bangladesh - a vastly populated area - the disease could probably not be brought under control for another year. India, with, at present, two to three importations a week, would be at high risk and Calcutta, the nearest and most vulnerable city, was in particular danger. In Ethiopia, diligent and speedy action was required. Additional funds were urgently needed to expedite the programmes but, given such support, there was every reason to hope that, by the same period in 1976, the final stage in confirming eradication would be well under way.

Dr ŠČEPIN (Union of Soviet Socialist Republics) said that the sharp decline in the incidence of smallpox in 1975, and the facts that no similar decrease had ever been recorded before and that never before had the number of epidemic areas been so small, proved that it was possible to eradicate the disease.

The coming months would be crucial for the success of the programme. The success achieved so far testified to the wisdom of adopting, in 1958, resolution WHA11.54, which had initiated the programme. The Soviet Union had always paid special attention to the development of the programme, for which it had supplied more than 1 500 million doses of vaccine between 1958 and 1974, and it was anxious that the programme should be speedily concluded.

The smallpox eradication programme, which had been preceded by a number of national and international efforts at control, had gone through a number of stages. Between 1958 and 1966 it had been financed through national budgets and WHO's Voluntary Fund for Health Promotion. During that time nearly all the countries where smallpox was endemic had included eradication programmes in their national plans and WHO and other countries had given them technical and sometimes material assistance. WHO had convened expert committees and had issued minimum requirements for smallpox vaccine. He attached particular importance to that period, during which experience had been accumulated that had made the next stage possible, and he regretted that a number of articles recently published had given the impression that the programme had not really started until 1967.

His delegation was anxious that the experience gained in the programme should form the subject of a special publication composed of contributions from the experts who had assisted with the programme, and that the contents of the publication should be agreed upon with all the countries that had participated.

There was a need for vigilance during the final stage of the programme, in order to prevent new outbreaks of the disease. Also important were, first, the work already started for objective assessment of eradication; second, the development after eradication of

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[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA28.51.

optimal systems of epidemiological surveillance; third, assessment of the adequacy of such systems and assistance to countries to ensure their proper organization and functioning; and fourth, the compilation of the experience gained in the programme and the evaluation of its results, including its economic effectiveness. The work he had outlined would enable the experience obtained to be used for selecting, planning and implementing programmes against other communicable diseases and, in his opinion, would be particularly valuable at the present time in connexion with programmes for the immunization of children. Moreover, the development of international regulations for epidemiological surveillance following smallpox eradication would facilitate the implementation of the specific tasks connected with maintaining the status of eradication throughout the world.

Finally, when the virus of human smallpox was no longer circulating and when probably smallpox vaccination was no longer practised, it would be particularly important to carry out research on the poxviruses of animals, particularly monkeypox.

His delegation submitted the following draft resolution for the Committee's consideration:

> The Twenty-eighth World Health Assembly,
>
> Having considered the Director-General's report on the smallpox eradication programme;
>
> Noting with satisfaction the considerable successes achieved in carrying out the programme, as witness the sharp reduction in the number of cases of smallpox in countries where it is endemic;
>
> Considering that the progress made and the unflagging efforts and care of WHO and its Member States in carrying out this programme inspire confidence that smallpox eradication will soon be achieved throughout the world;
>
> Bearing in mind that the successful completion of this programme will be the first example of the eradication of a highly dangerous disease as a result of broad international cooperation and the collective efforts of WHO, its Member States and various international governmental and nongovernmental organizations;
>
> Recognizing that the success of the programme has been dependent on its profoundly scientific basis, on unceasing research and practical investigations throughout the course of its implementation, on making correct allowances for the special features of the causal agent of smallpox and the nature of immunity to it, on the considerable improvements achieved in the last few years in the quality and effectiveness of the smallpox vaccine, on the development and wide practical introduction of new methods of mass vaccination and on constant improvements in systems for case-finding and for the recording of vaccinations;
>
> Noting also that the entry of the smallpox eradication programme into its final stage has been the result of lengthy and heroic efforts by numerous countries, international organizations, establishments, physicians and field workers, both in the period up till the 1950s when national campaigns were developing and when the prerequisite conditions were being created for smallpox control on an international scale and after the proclamation and development of an international smallpox eradication campaign in accordance with resolution WHA11.54 in 1958 and the intensification of the programme from 1967 onwards in accordance with resolution WHA19.16.
>
> 1. THANKS all governments, organizations and individuals who have contributed to the implementation of the programme and asks them to continue their efforts for smallpox eradication in this concluding stage of the programme;
>
> 2. EMPHASIZES the need to maintain the utmost vigilance and sense of responsibility in all regions of the world, with a view to preventing possible outbreaks of smallpox so as not to let slip the favourable situation for the successful conclusion of the programme that now exists, by continuing active epidemiological surveillance and the corresponding vaccination programmes;
>
> 3. DEEMS it necessary to summarize and describe in a major publication the experience of smallpox eradication throughout the world, for which purpose the help should be enlisted of scientific experts and practical workers who have taken part in carrying out the programme, having first analysed with great care and thus preserved for mankind the unique historical experience of the eradication of one of the most dangerous communicable diseases as a result of effective international cooperation, experience which will doubtless be used in programmes for the control of other communicable diseases;
>
> 4. REQUESTS the Director-General of the World Health Organization
>
> (1) to draw up recommendations regarding those further activities of the Organization and its Member States that will be needed to maintain smallpox eradication throughout the world, including possible additions to the International Health Regulations;
>
> (2) to ensure the wider development of research on methods of differentiating viruses of the poxvirus group and determining the special features of their

epidemiology, paying particular attention to variola-like viruses (white strains) isolated from monkeys and to other monkey viruses; and

(3) to submit a report on further developments in this sphere to the Executive Board at one of its sessions or to a World Health Assembly.

(For continuation of the discussion on programme 5.1.4, see summary record of the seventh meeting.)

SEVENTH MEETING

Wednesday, 21 May 1975, at 2.30 p.m.

Chairman: Dr Marcella DAVIES (Sierra Leone)

DETAILED REVIEW OF THE PROGRAMME BUDGET FOR THE FINANCIAL YEARS 1976 AND 1977 (continued) Agenda, 2.2.3

Communicable disease prevention and control (programme sector 5.1) (continued)

Smallpox eradication (programme 5.1.4) (continued from the sixth meeting)

Dr FLEURY (Switzerland) said that his delegation viewed the outstanding success of the smallpox eradication programme with much satisfaction and congratulated WHO on its excellent work.

There had been no imported case of smallpox in Switzerland since 1963 and it was unlikely that there would be any new importation. None the less, pending total global eradication, the Swiss health authorities still recommended that vaccination efforts should not be relaxed, for otherwise a single case of imported smallpox could have disastrous consequences.

His country maintained its support for WHO's programme for the provision of additional supplies of vaccine and trusted that the time would soon come when the funds expended in that connexion could be diverted to another programme.

Dr KLIVAROVÁ (Czechoslovakia) said that her delegation considered that the intensified programme against smallpox had begun in 1958, when the Eleventh World Health Assembly had adopted resolution WHA11.54.

Czechoslovakia had taken an active part in the programme, the success of which was attested by the information received during recent years. Her delegation considered that efforts should not be relaxed and therefore supported and wished to co-sponsor the draft resolution presented by the delegation of the USSR at the Committee's sixth meeting.

Dr TOTTIE (Sweden) said that smallpox eradication would relieve many countries of the heavy burden of maintaining vaccination programmes that cost a great deal in terms of capital and personnel; these could subsequently be diverted to other health programmes.

The Swedish Government, which had supported the smallpox eradication programme throughout, was glad to be able to offer a further contribution of approximately $1 million to implement the project in Bangladesh.

The coming months would be crucial and his delegation hoped that it would at last be possible to eradicate smallpox completely. It therefore supported the proposal for a publication to serve as a commemorative handbook that would be of use as a guide for other similar programmes in the future. It also considered it important to pursue surveillance activities in countries freed of the disease.

Professor SULIANTI SAROSO (Indonesia), though gratified at the progress achieved in India, was very concerned about the setback in Bangladesh.

Indonesia had been declared free of smallpox in April 1974, five years after the start of a nationwide programme. At the outset the programme had relied heavily on mass vaccination, but it had been discovered that even a 95% vaccination coverage would not interrupt transmission and that strict surveillance and prompt containment measures were more important. Accordingly, forward and backward tracing of contacts of known smallpox cases had been undertaken and, on detection of a case, all contacts had immediately been vaccinated. Children had proved very knowledgeable and had reported cases in their neighbourhood.

Surveillance measures were still being pursued, health workers reporting on suspect cases and checking specimens for laboratory diagnosis. About 800 specimens had been examined since Indonesia had been declared free of smallpox and all had been found to be negative.

Her delegation trusted that the additional funds requested by the Director-General would be forthcoming and that smallpox vaccination would cease to be necessary.

Dr A. M. HASSAN (Somalia) said that the smallpox eradication campaign was a good example of international cooperation in mankind's efforts to combat disease. It was an experience that deserved to be followed in other fields, with WHO and Member States uniting in the common cause of better health for all.

Although smallpox was not endemic in Somalia, it was prevalent in a neighbouring country and there had been several imported cases in 1974 and 1975. There had been no secondary infections, but surveillance measures would not be relaxed until the disease had been eradicated from the African continent.

During the past year, Somalia had initiated a rural development campaign to reduce illiteracy and to improve health conditions. The chief health measures were immunization against smallpox and tuberculosis, 800 000 persons having been vaccinated against the former and 500 000, in the age group 0-15 years, against the latter.

Agreement had recently been reached with the Ethiopian authorities for vaccination to be carried out simultaneously along the de facto boundary and it was hoped in that way, to eradicate smallpox.

Dr RAHMAN (Bangladesh) fully shared the concern expressed about the setback to the smallpox eradication programme in Bangladesh.

As stated in the Director-General's report on smallpox eradication, progress during the first nine months of 1974 had encouraged the belief that transmission could be interrupted by January 1975, only 91 villages being infected at the end of October 1974. But, owing to devastating floods, famine and unprecedented population movements in the two main endemic areas, Rangpur and Mymensingh, the disease had spread to Dacca and ultimately, following Government clearance of the city slums, throughout the whole country.

As on 17 May 1975, there were 1163 infected villages in Bangladesh. An emergency plan had been drawn up and top priority had been given to smallpox eradication. The President had issued a directive that health personnel resources be pooled and 30 000 people were now working on the programme. He assured the Committee that, given the necessary aid, smallpox would be eradicated by the end of 1975.

Dr SENCER (United States of America) commended WHO on its outstanding leadership in a global effort. He paid tribute to the countries that had achieved eradication and had thereby proved wrong those who had said that it could not be done. All those concerned, whether in outlying areas or in the ministries, had worked with ability and enthusiasm. There was no doubt that the job could be completed if the increased tempo of activity of the past year was maintained and accelerated in the few remaining foci, but it should not be forgotten that eradication meant certification.

Referring to the Soviet Union draft resolution he said that it would be acceptable to his delegation with the following amendments:

First, in the fourth preambular paragraph, the words "eradication of a highly dangerous disease" should be replaced by "eradication by man of a dangerous disease".

Secondly, in the first operative paragraph, the word "continue" should be replaced by "selectively increase".

Thirdly, in the second operative paragraph, the word "maintain" should be replaced by "increase".

Fourthly, in subparagraph (1) of the fourth operative paragraph, the word "additions" should be replaced by "changes".

Lastly, he proposed the addition of two new operative paragraphs to be inserted before the first operative paragraph and to read:

> "CONGRATULATES the following countries, who since the inception of the global programme have made the outstanding achievement of eradicating smallpox from within their borders: Afghanistan, Botswana, Brazil, Burundi, Dahomey, Ghana, Guinea, Indonesia, Kenya, Liberia, Malawi, Mali, Mozambique, Nepal, Niger, Nigeria, Pakistan, Rwanda, Sierra Leone, South Africa, Sudan, Togo, Uganda, United Republic of Cameroon, United Republic of Tanzania, Upper Volta, Zaire and Zambia.
>
> EXPRESSES confidence that with continued effort the three countries so near the end - Bangladesh, Ethiopia and India - will achieve eradication.

Dr TEKLE (Ethiopia) said that Ethiopia was the only country in Africa where smallpox was still regarded as endemic. The programme in Ethiopia had started in February 1971 with only one health officer and 18 sanitary workers. Their number had steadily increased until, by 1974, there were 71 Ethiopian and 22 expatriate staff serving as surveillance officers under four WHO epidemiologists and a senior adviser and carrying out epidemiological work. There were a large supporting staff, a fleet of cross-country vehicles, and radios to facilitate communication.

Soon after the programme began it became apparent that over 90% of the country was endemic, 43 000 cases of smallpox having been detected in 1971 and 1972. The major outbreaks were broadly confined to two regions, one in the south and south-west covering six provinces, and the other in the north covering five provinces. Surveillance and containment had been the methods adopted, mass vaccination being impracticable in a country like Ethiopia because smallpox was predominantly a disease of the rural areas and vaccination of the population of the large towns did not interrupt transmission.

Nevertheless, in the course of surveillance and containment activities 11 million people, or 44% of the population, had been vaccinated between 1971 and 1974, with the result that the number of cases had dropped from 26 000 to 4 439, or by almost 81%. That was a significant achievement, the incidence of smallpox having dropped from 108 per 100 000 of the population in 1971 to 18 in 1974.

At the beginning of 1975 there were only 20 small endemic foci, compared with 79 in 1971, and 9 of the 14 provinces had been freed of smallpox. The remaining endemic areas lay in the most remote parts of three provinces. In the course of a special attack phase, during the latter part of 1974 and the beginning of 1975, the foci in those areas had been reduced to a few isolated cases. Once the attack phase had been concluded, the maintenance phase, which had already started in some regions, would be initiated with teams checking all areas for hidden cases.

He paid tribute to the surveillance officers for their dedicated work, to WHO for its assistance and to the Sudan, the French Territory of the Afars and the Issas, Kenya and Somalia for their cooperation. Close cooperation had also been received from the mission medical services, the specialized public health programmes, the Drought and Relief Commission, Development through Co-operation and the Ethiopian Red Cross.

Dr SHRIVASTAV (India) was glad to be able to report that there were now only 22 villages infected with smallpox in India, 14 owing to imported infection and 8 to indigenous infection. The last indigenous case occurred on 30 April 1975.

While surveillance and containment measures were admittedly more effective than mass immunization, primary immunization of the newborn was also essential and should continue for at least another two years in India and Bangladesh. That was because of the many aggravating features - such as floods and population movements - which could also affect neighbouring countries. He thought that a reference to immunization of the newborn should be included in the draft resolution of the USSR delegation.

Dr AROMASODU (Nigeria) said that the remarkable success of the smallpox eradication programme was a clear demonstration of what could be achieved with WHO's collaboration and with cooperation at all levels. She was confident that transmission would soon be interrupted in the remaining foci of infection and that the disease would be eradicated.

Nigeria was most grateful to WHO as well as to the donor countries, in particular the United States of America, that had provided substantial aid during the first five years of the programme in Nigeria. A WHO smallpox eradication assessment team had recently arrived in Nigeria and she was glad to confirm that the last reported case of smallpox had occurred in May 1970.

In view of the success of the smallpox eradication programme, WHO might wish to consider a similar programme in one of the major communicable diseases still afflicting developing countries. The expanded programme on immunization recommended by the Director-General would help considerably. Despite the expansion of its own immunization programme and numerous resolutions on ways of increasing vaccination coverage, there had been no appreciable drop in the incidence of smallpox in Nigeria until the global programme had been launched. Of course, at the outset, epidemiological services had been weak, if not non-existent, in most developing countries; the programme had helped to strengthen those services by training local staff in communicable diseases control.

She understood that BCG vaccination would provide effective protection against tuberculosis and that WHO would pursue its research into ways of developing effective control until all the major communicable diseases were eventually eradicated. Nigeria had also received generous offers from the developed countries of assistance in the form of vaccines and equipment. In the circumstances, she looked forward to future global eradication programmes, launched by WHO with Member States' full cooperation.

Dr RODRIGUES (Brazil) said that, in Brazil, there had been 4000 recognized cases annually on the average. However, that number had not reflected the actual situation; once epidemiological surveillance had been instituted, investigation had revealed 40 further cases for each case reported. WHO and PAHO had provided technical advice and had convened meetings of experts. As a result, Brazil - which had previously exported cases to its neighbours - had been able to reduce the incidence of smallpox in barely three years from 1771 to 70, and to only nine cases in 1971. No case had been observed since 19 April 1971, and the disease was considered to have been eradicated from the country. The results obtained in the smallpox eradication programme were not limited to that disease. A network of 6372 notification posts, covering 3951 municipalities of Brazil, had been set up. Thanks to that system of epidemiological surveillance, it had been possible to start investigating, within 24 hours, an unconfirmed outbreak of cholera in the municipality of Caravelas, Bahiá State. Furthermore, an epidemic of cerebrospinal meningitis had been delimited, and within five days thousands of persons had been vaccinated in the state capital of São Paulo, where the epidemic had been at its most intense.

His Government had invested about $1 200 000 over three consecutive years in smallpox eradication, had established a system of epidemiological surveillance, and was ready to

carry out further immunization programmes, as had been done for meningitis.

He appealed to countries that were in a position to do so, to contribute to the Special Account in order to ensure the effective eradication of smallpox. The goal was in sight. The Government of Sweden had just made a contribution, and the Director-General should consider allocating to the Account resources already existing in the budget in order to hasten the progress of the programme, which would constitute a glorious achievement on the part of WHO and its Member States. President Kennedy's prediction, in 1961, that man would reach the moon within ten years had been realized. The eradication of smallpox was no more difficult, provided that all countries participated in the final onslaught.

Dr VIOLAKIS-PARASKEVAS (Greece) said that in Greece the last imported case had occurred in 1950. She asked what would be the future policy with regard to vaccination in countries that had been free from smallpox for many years. There was no doubt that epidemiological services would have to be strengthened and surveillance systems set up.

Dr CHITIMBA (Malawi) pointed out that it was not the time for congratulations or complacency. Transmission of smallpox would be completely interrupted only if all countries continued surveillance for at least two years after notification of the last case. In the Introduction to his report on the work of WHO for 1974, the Director-General had given smallpox as a good example of a disease that had been defeated with maximum international effort, but had added that that example should spur Member States on to defeat further diseases. There were many diseases against which vaccines were available. Others, such as leprosy, could be controlled or eradicated. He wondered whether the Director-General already had some idea of the next disease to be eradicated. He agreed with the amendments to the draft resolution suggested by the delegate of the United States of America, but hoped that that country would not be omitted from the impressive list of countries to be congratulated on their efforts in the conquest of smallpox.

Professor SENAULT (France) said that the situation had been appraised with realism and wisdom, since there remained several spots in the world from which smallpox had not been eradicated. Although the disease was not endemic in France, the health authorities intended to maintain vaccination as a legal obligation. There was no treatment for smallpox, and immunization was still the only defence against it. International communications were increasing in both numbers and speed and there were still high-risk groups, such as health personnel, that had to be protected. The risk of contracting the disease was much higher than that of postvaccinal complications, which had been rare in France. It would thus be premature - in France at least - to abandon a method that had proved its efficacy since Jenner and had made it possible to envisage the eradication of smallpox within a few years. The action of all who had worked in the programme was the finest proof of international cooperation.

Dr AGUILAR (El Salvador) said that the success obtained so far in the smallpox eradication programme was a source of inspiration for the fight against the other communicable diseases that were preventable by immunization. He asked whether, in countries from which the disease had been eradicated many years ago, it would be sufficient to maintain epidemiological surveillance, or whether it was advisable to vaccinate children aged one to five years in addition to persons travelling to countries in which the problem still existed.

Dr DAS (Nepal) said that it was gratifying to note that smallpox remained endemic in only three countries. Nepal had been declared non-endemic, as no case had occurred there since April 1975 and the few imported cases that had occurred before that date had been effectively contained. However, there was no cause for complacency. WHO should support surveillance in its Member States and primary vaccination should be continued for two years. His delegation supported the draft resolution present by the Soviet Union.

Dr KILGOUR (United Kingdom of Great Britain and Northern Ireland) said that the campaign was not yet won, despite WHO's support for the eradication programme and the nearness to total success achieved thus far, thanks to the health workers and national authorities concerned. His country had been glad to give extrabudgetary assistance to that extremely important and historic campaign and the Director-General could be assured of the support of all Member States for any additional measures necessary in the next few critical months, when the requisite activity for effective action must be given overriding importance. The latest news from India had been heartening. He wished Dr Henderson, who would shortly be returning to Bangladesh, the success that the operation and his unique efforts deserved. He supported the draft resolution proposed by the Soviet Union, as amended by the delegates of the United States of America and Malawi.

Dr MAFIAMBA (United Republic of Cameroon) paid tribute to the high quality of the reports on smallpox issued in the Weekly Epidemiological Record during the past 12 months. The programme had been a tremendous success. Considering the havoc caused in West Africa until recently by smallpox epidemics that had cut across national boundaries, the results achieved in the worldwide smallpox eradication programme were satisfying. WHO and the country that had originally put forward the proposal, the Soviet Union, as well as all the donor countries and the health workers concerned, deserved congratulations. However, continued vigilance and research into poxviruses were necessary.

He supported, in part, the draft resolution presented by the delegation of the Soviet Union. However, in WHO's difficult financial situation it was hardly wise or desirable to incur heavy expenditure by having a major publication produced by a group of experts and practical workers when WHO had already published detailed documents on the execution of the programme in many countries. The task of writing a historical monograph should be entrusted to the WHO Secretariat. He wondered what modifications to the International Health Regulations the delegation of the Soviet Union had in mind. There appeared to be a tendency to develop the epidemiological services and to lay less emphasis on restricting the movement of people and goods.

Dr HASSOUN (Iraq) also supported the Soviet Union draft resolution. Since the winter of 1972, when an outbreak of smallpox in Iraq had been contained in less than six months, not a single case of the disease had occurred. However, primary vaccination was still being given as a compulsory routine measure to all children before they reached one year of age, and revaccination was performed every three years. The last mass vaccination had been carried out in January 1975. The point of no return had been reached but every effort would need to be made to stay at that point.

Dr BROWN (Bolivia) said that smallpox had been eradicated from his country in 1964, after five years of effort with the active cooperation of PAHO and friendly countries such as the United States of America. Bolivia was continuing to vaccinate its population and was taking advantage of the experience acquired in the smallpox programme in order to offer the people the benefits of BCG and other antigens.

He supported the draft resolution presented by the delegation of the Soviet Union, as modified by the United States of America, and expressed the hope that smallpox would be completely eradicated in the near future.

Dr JOYCE (Ireland) thought that the air of euphoria surrounding the discussion called for a devil's advocate. He doubted very much whether two years' surveillance was sufficient. Meningococcal meningitis had reappeared in recent years in various parts of the world and there was some indication that tuberculosis had not been conquered, even in his own country, as had been thought for some years. Caution was needed before asserting that any disease had been eradicated from the world.

Dr HENDERSON (Smallpox Eradication) said that WHO was grateful for the comments and offers of assistance that had been made.

Questions had been raised as to the adequacy of a two-year surveillance period. Experience gained in 27 countries had shown that 5-8 months might elapse between the moment when smallpox was thought to have been eradicated and an outbreak that could be traced to known cases. The Expert Committee that had decided on the two-year surveillance period had multiplied that maximum time span of eight months by three in order to allow a safety margin. Even in countries where eradication had been determined by the Expert Committee or an international commission, surveillance continued. The delegate of Indonesia had referred to the processing of some 800 specimens since the international commission had decided that eradication had been achieved, and the experience in South America had been similar.

The risk of importing cases, and consequently of further transmission, had to be weighed against the risk of postvaccinal complications in deciding whether to stop or to continue vaccination. Some countries had stopped vaccinating, but most of them were continuing for the time being. If the programme progressed rapidly and eradication were achieved, the risks of importation would be nil and the question of continuing vaccination easily solved. In the meantime, many countries had not taken a firm decision because vaccination might be difficult to reinstate in case the programme took a turn for the worse. Vaccination should undoubtedly continue in countries with less highly developed health services, for instance those in Africa, since cases imported into such countries would be difficult to detect and a higher level of immunity would impede the spread of the disease. Rapid action was needed to stop imported cases from spreading the disease further. In all countries, but especially where smallpox was still endemic, the absolute priority was the detection and containment of outbreaks, the next priority being vaccination.

In reply to the question raised by the Nigerian delegate, he said that it was doubtful whether the technical means for eradicating a second disease existed yet. The expanded programme on immunization was a logical sequel to the smallpox eradication programme. Many countries were using the experience gained in their smallpox programmes to broaden and develop other communicable disease control activities. WHO hoped to be able to strengthen those activities in the future.

He assured the delegate of Malawi that WHO would continue to provide assistance, since it recognized that countries would need support until the transmission of smallpox had really been terminated. There was considerable interest in having a special monograph produced, and it was hoped that the cost might be covered by voluntary contributions rather than from the regular budget of WHO. However, it would be premature to produce such a book, or to think of congratulations, before eradication had really been achieved. The moment when the disease was declared to have been eradicated would be a solemn moment indeed, since eradication would be an unprecedented achievement. Anxiety had been expressed about possible hidden foci. However, as much research had been done and many experts consulted, no surprises were expected. WHO was aware of the grave responsibility that it would incur in declaring the disease to have been eradicated, but eradication was thought to be a feasible proposition.

The CHAIRMAN asked whether the delegation of the Soviet Union could accept the amendments that had been proposed to the draft resolution, omitting the names of countries as had in the meantime been agreed by the United States delegate, together with a number of points of drafting, including, on the proposal by the delegate of India, the addition, in the fifth line of the second operative paragraph, after the phrase "corresponding vaccination programmes", of the phrase "particularly for newborn children".

Dr ŠČEPIN (Union of Soviet Socialist Republics) said that the proposed amendments, which reflected the views expressed during the discussion, were acceptable to his delegation, and he thought that the other sponsors[1] of the resolution would accept them.

Professor SENAULT (France), referring to the French text of the draft resolution, suggested that in the third paragraph of the operative part of the text the phrase "SOULIGNE la necessité d'une plus grande vigilance et d'un plus grand sens des responsabilités dans toutes les régions du monde ..." should be substituted for the wording proposed. That was an editorial amendment which would not alter the sense of the English text.

Decision: The draft resolution, as amended, was approved.[2]

[1] The delegations of the German Democratic Republic and Yugoslavia subsequently expressed the wish to see the names of their countries added to the list of co-sponsors.

[2] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA28.52.