OFFICIAL RECORDS
OF THE
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TWELFTH WORLD HEALTH ASSEMBLY

GENEVA, 12-29 MAY 1959

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GENEVA

November 1959

MEMBERSHIP OF THE HEALTH ASSEMBLY

LIST OF DELEGATES AND OTHER PARTICIPANTS

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United Nations Children's Fund

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The Committee on Credentials was composed of delegates of the following Member States: Argentina, Australia, Belgium, Ethiopia, Finland, Greece, Guatemala, Lebanon, Monaco, Panama, Thailand, Union of South Africa.

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Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Cambodia, Chile, Costa Rica, Czechoslovakia, Dominican Republic, France, India, Israel, Jordan, Liberia, Nepal, New Zealand, Peru, Saudi Arabia, Spain, Union of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, United States of America.

Chairman: Dr Jaswant SINGH (India)

Rapporteur: Mr W. H. BOUCHER (United Kingdom of Great Britain and Northern Ireland)

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General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Canada, France, Ghana, India, Libya, Peru, Spain, Union of Soviet Socialist Republics, United States of America.

Chairman: Sir John CHARLES (United Kingdom of Great Britain and Northern Ireland)

Secretary: Dr M. G. CANDAU, Director-General

MAIN COMMITTEES

Under Rule 34 of the Rules of Procedure of the Health Assembly, each delegation was entitled to be represented on each main committee by one of its members.

Programme and Budget

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Vice-Chairman: Dr C. DÍAZ-COLLER (Mexico)

Rapporteur: Dr THOR-PENG-THONG (Cambodia)

Secretaries: Dr N. I. GRASHCHENKOV and Dr P. M. KAUL, Assistant Directors-General

Sub-Committee on International Quarantine

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Vice-Chairman: Dr M. SHARIF (Pakistan)

Rapporteur: Dr A. BISSOT (Panama)

Secretary: Dr R. I. HOOD, Chief, International Quarantine

Administration, Finance and Legal Matters

Chairman: Dr O. VARGAS-MÉNDEZ (Costa Rica)

Vice-Chairman: Dr A. DIBA (Iran)

Rapporteur: Mr Y. SAITO (Japan)

Secretary: Mr M. P. SIEGEL, Assistant Director-General

Legal Sub-Committee

Chairman: Mr I. T. KITTANI (Iraq)

Vice-Chairman: Mr J. DE CONINCK (Belgium)

Rapporteur: Mrs F. DE HARTINGH (France)

Secretary: Mr A. ZARB, Director, Legal Office

6. Smallpox Eradication Programme

Agenda, 6.6

Dr KAUL, Assistant Director-General, Secretary, introducing the Director-General's report (see Annex 18) recapitulated the main points of the introduction and part III, and added that, since the preparation of the report, official confirmation had been received from the Soviet Union that smallpox had been eradicated there.

Although eradication presented no insuperable difficulties, as proved in a number of areas, considerable problems, mainly financial and organizational, would have to be solved before it could be achieved everywhere. There was no short-cut to success, and failure was mainly due to the inadequate organization or conduct of mass vaccination campaigns capable of covering eighty per cent. of each sector of the population over a period of three to five years. Another cause of failure was the inefficacy of the vaccine used, through exposure to heat. As a result of research sponsored by WHO a method was now available for producing a potent freeze-dried stable vaccine, and that method had been made generally available. In addition, the necessary units of equipment had already been supplied to several countries by WHO or UNICEF and similar units would be provided to others.

The problems connected with the production and provision of such vaccine were discussed in the report. Expert advice on its production had been given by WHO to several countries, and doubtless there would be greater need for such advice in the future, as well as for the expansion of training facilities. To ensure the best use of the services of available experts in the field, international training courses would start in 1960. There were still some technical problems requiring further research, and part IV, section 4, of the report described present investigations on the prevention of post-vaccinal complications. Assistance to such investigations and the study of other problems recommended by the Study Group on Recommended Requirements for Smallpox Vaccine would be necessary, as well as facilities for the laboratory diagnosis of smallpox.

Part V described certain administrative considerations in planning an eradication programme, and guiding lines for the organization of an eradication service. It was recognized that, while WHO must provide expert advice and co-ordinate campaigns on an inter-country and inter-regional basis, the main effort should rest with national administrations which must organize and administer their programme in accordance with local needs and health service structure. But central direction or at least co-ordination, so as to provide a clear line of command from the responsible authorities to field workers, was essential, and a directing cadre from a country's own nationals must be created at the outset for developing the campaign.

Training at various levels could be expanded through fellowships. Inter-regional conferences to discuss common problems and co-ordinate efforts among neighbouring countries had been arranged, and more would be required in the future.

Vaccine donated by Member States would materially assist countries ready to initiate an eradication campaign but lacking facilities to produce the vaccine.

The national and international financial aspects of the problem were considered in part VI of the report in the light of available information, and he drew special attention to the statements made in the first three paragraphs. It would be seen that, according to information received, the average cost throughout the world for mass vaccination had been estimated at $0.10 per head, and estimated costs of campaigns in countries where the disease was endemic had been presented in the report on the basis of that figure. Clearly, more funds than those included in present budgets would have to be made available if effective campaigns were to be waged in countries where the disease was still a grave problem. As international assistance would have to be greatly increased, more would have to be provided for smallpox eradication in WHO's future budgets. There could be no doubt that such a determined effort was worth while and opportune because, if the campaign were successful, heavy annual expenditure by individual countries would become unnecessary. With adequate support and co-operation from national health authorities and international assistance, considerable progress towards eradication could be achieved in a relatively short time.

Dr DÍAZ-COLLER (Mexico) wished to clarify the position in respect of Mexico in connexion with the map showing notification of cases of smallpox, 1948-1957,[1] on the last page of the report before the meeting. Mexico was shown in that map as having an annual average of cases of between 100 and 499; that was correct as an average but might give the wrong impression, since there had in fact not been a single case of smallpox in his country since 1951, as was apparent from the figures given in the table in part III, section 2, of the report.

Dr RAJU (India) gave some indications of the action his Government was taking with regard to smallpox eradication.

An expert committee at national and state level had recently been set up to study the problem and to submit detailed recommendations for a national plan of action. That committee had recommended that the entire population should be vaccinated, primarily before six months of age and thereafter every five years until the age of fifteen; that one month's training should be given to 20 000 persons who would then be qualified to undertake vaccination; that the programme for producing vaccine, at present covering eleven centres, should be extended to all states and a pilot project initiated with a view to working out details; and that a central control commission should be formed. The view had been expressed that if the initial steps were completed in one year, mass vaccination could be achieved within two years. It was estimated that the total cost of such a programme would be 80 000 000 rupees. Those recommendations were at present under active consideration by his Government.

He expressed appreciation to WHO for the technical assistance it had given in the preparation of freeze-dried vaccine.

Dr KIVITS (Belgium) commended the Director-General on his report on the world situation with regard to smallpox.

It was stated, in part III, section 4, of that report, that the Belgian Congo was still an important ende-

[1] Not reproduced in this volume

mic focus, in spite of having an efficient field medical service, and that it was therefore a constant threat to its neighbours. While cases of smallpox still existed in the Belgian Congo, as in its neighbouring countries, their number was rapidly decreasing, as Table 1 of the report showed. In that connexion, he added that 90 per cent. of the 1289 cases reported in respect of 1958 had been variola minor, or alastrim, which proved fatal only in one per cent. of the cases.

He had already referred, in connexion with the report on the African Region, to the efforts made by the medical services in the Belgian Congo to eradicate smallpox. For some years past, more than one-third of the population had been vaccinated yearly. Indeed, if the number of cases notified in the Belgian Congo appeared high in comparison with neighbouring countries, that was probably due to the fact that the network of medical services was the most complete in Central Africa; the health budget in fact amounted to some $30 000 000 yearly. All cases of smallpox, however slight, were notified and it was that complete reporting which made the Belgian Congo appear a threat to its neighbours.

It was, of course, extremely delicate to attempt to establish a comparison of the prevalence of a disease among the different territories in Africa. WHO was accomplishing most valuable work in pursuing its studies of the problem and in providing guidance on vaccines to national health services.

Professor ZHDANOV (Union of Soviet Socialist Republics) noted with satisfaction that the decision taken by the previous World Health Assembly in respect of smallpox eradication was beginning to take shape and that the quantities of vaccine being produced were increasing. Incidence of the disease had been high in 1958 and greater efforts should therefore be devoted to backing the action taken by WHO, especially in territories where there was a danger of the disease spreading to other territories.

Vaccination was the only practical method and, as was well known, dried vaccine was the most satisfactory. The Soviet Union was producing 100 million doses of heat-resistant vaccine annually and that figure could even be trebled if required. The vaccine withstood even boiling and could last from twelve to eighteen months. It was used in the USSR in temperate and hot regions. Naturally, it could also be used in other countries; in 1958, for example, it had been used in Pakistan. There had been no proven cases of encephalitis after its use and only ten suspected cases in a total of more than 1 000 000 000 vaccinations.

The Soviet Union considered, therefore, that it could make a most useful contribution by supplying large quantities of that vaccine to other countries. It was, moreover, prepared to give assistance by sending experts and equipment, and could give advice on techniques of rapid diagnosis, of vaccine production and of titration. Naturally, strict control was essential if the vaccine were to retain its high standard. His country knew the value of such control and was prepared to assist by supplying control equipment with the necessary manuals.

His Government supported WHO's recommendations regarding smallpox and was keenly interested in eradication, as its activities showed. He believed that it would be possible to achieve eradication over a period of two or three years if efforts to that end were intensified. He was grateful to the Director-General for the valuable documentation provided.

Dr LEITCH (Federation of Nigeria) joined other delegates in congratulating the Director-General on the excellence of his report, which contained much useful factual information.

He wished, however, to draw attention to some inaccuracies in part III, section 4, relating to Africa. Where Nigeria was concerned, he was unable to agree with the statement therein that smallpox was an endemo-epidemic disease in the humid areas but that in the savannah and arid areas it occurred in epidemics, with intervals of complete absence. It had been his experience in Nigeria that smallpox was essentially a savannah disease, with seasonal outbreaks confined to the savannah. Even when the disease spread occasionally, possibly for climatic reasons, the occurrence in the forest areas was low. As for the statement that recent epidemics in Nigeria had been occurring mainly in the densely populated forest areas, he explained that 1956 and 1957 had been exceptional years with seasonal outbreaks of smallpox spreading to the forests and to Lagos itself, thus necessitating extensive vaccination of the population; the brunt of the epidemics had none the less occurred in the savannah areas. The statement regarding field medical services, in the same paragraph, was incorrect. The medical field unit organization in Nigeria, although modelled on the sleeping-sickness services, had from the start been designed to serve the whole country and had never been focused on the savannah. The bulk of the vaccination had always been carried out by the personnel of the general medical services.

While he realized that the situation might differ elsewhere in Africa, he stated that there had been no recent change in the distribution of smallpox in

his country and that it affected for the most part the savannah area in the north.

Professor TESCH (Netherlands) said that his delegation had studied the Director-General's report with great interest. He recalled that his delegation had at the Eleventh World Health Assembly expressed the view that eradication was a realistic aim. The only reservoir of smallpox was the endemically affected population and that reservoir could be eliminated on the basis of three prerequisites, namely: a potent and stable vaccine, adequate organization of vaccination to reach the entire population, and health education of the public.

He did not think that the existing vaccines could be greatly improved on. In that connexion, he commended the work of the Study Group on Recommended Requirements for Smallpox Vaccines; the comparability of vaccines was of the greatest importance. He would endorse, from his own experience in public health work in the tropics, the statement made in part V, section 5, of the report to the effect that it was easy to train even illiterate workers to vaccinate satisfactorily but that constant supervision was a necessity. It would be most useful if the Organization could produce a manual on the training and tasks of vaccinators. He stressed the successes achieved in what was termed the "separated" system in Indonesia for intensive vaccination.

In connexion with the question of health education of the public, he recalled that complications as a result of primary vaccination in persons over two years of age had made it necessary to suspend compulsory vaccination on one occasion before the war. Tests carried out on a group of 30 000 young adults to whom gamma-globulin had been given with the vaccination showed that such an addition resulted in fewer cases of post-vaccinal encephalitis than where the vaccine was administered alone.

Dr ATANASSOV (Bulgaria) said that his delegation greatly appreciated the initiative taken by WHO in smallpox eradication. It also commended the Director-General on the excellent report submitted.

He recalled that smallpox had been eradicated from Bulgaria in 1927. It was, therefore, regrettable that Bulgaria should appear in the map showing notifications of cases of smallpox, 1948-1957,[1] as a country in respect of which data were not available. His country regularly communicated its data regarding smallpox to WHO and he hoped that the error would be corrected.

The results achieved as regards smallpox in Bulgaria were due to the vaccination and revaccination of the population. Vaccination campaigns, which were free and compulsory, were always preceded by health propaganda and were accepted quite willingly by the public. The vaccination services were organized by the Ministry of Public Health, and carried out by local health services.

Bulgaria would be able in 1960 to produce one million doses of dried vaccine which it could make available for eradication campaigns in other countries. His Government was also prepared to offer the services of a team of doctors to take part in the campaign.

Dr SCHÄR (Switzerland) called attention to the difficulties for countries which were free of smallpox to maintain adequate vaccination. In Switzerland some resistance in the population had been encountered as a result of the fact that since 1940 there had been 28 deaths due to post-vaccinal encephalitis, although the last fatal case of smallpox had occurred in 1926.

Countries such as his own accordingly appreciated the efforts made by WHO to combat smallpox in the endemic areas.

Dr ANWAR (Indonesia) associated himself with other delegations in commending the Director-General's report. Many countries still needed assistance from WHO in smallpox eradication, although the final responsibility clearly remained with the national authorities.

As had been stressed by the Regional Committee for South-East Asia, the problem was primarily one of organization and administration. He outlined the type of organization existing in Indonesia, where special vaccination services were the responsibility of the provincial health services. Dried vaccine had been found satisfactory although its potency declined after three months. He recalled that smallpox eradication had in fact been achieved in Indonesia before the Second World War but that after that period, and the instability that had followed, epidemics had occurred between 1947 and 1953. The vaccination campaign had now been undertaken with a view to achieving regular vaccination and revaccination of the entire population every three to five years by means of intensifying the services. The fact that Indonesia was considered an endemic area should not be taken as implying any failure of the system of vaccination, but rather as an indication

[1] Not reproduced in this volume

that instability had prevented a regular service for some time. There had been no complications with regard to encephalitis in recent years.

As he had had occasion to state at a session of the Regional Committee for South-East Asia, it would be necessary in order to achieve smallpox eradication to cover all areas of the world and not solely concentrate on endemic areas.

The meeting rose at 5.30 p.m.

SIXTEENTH MEETING

Thursday, 28 May 1959, at 9.30 a.m.

Chairman: Dr H. B. TURBOTT (New Zealand)

2. Smallpox Eradication Programme (continued from fifteenth meeting, section 6)

Agenda, 6.6

Dr ORELLANA (Venezuela) said that, in the report before the meeting, there was a map showing notifications smallpox cases, 1948-1957,[1] which indicated that there had been a yearly average of 1460 smallpox cases reported in Venezuela. That was incorrect; the correct figure was 1297. The map was also misleading in that no date was shown for Venezuela for the year in which the disease had last occurred, whereas figures for the " year of last occurrence " were given for other countries. The Venezuelan campaign against smallpox which had begun in 1947 had brought about a rapid decrease, and in 1957 not a single case had been reported. Nor had any case been reported in 1958.

Dr Tan Hor KEE (Federation of Malaya) thanked the Director-General for the report under discussion. As indicated by Fig. 2 in the report,[2] there had been less than 10 cases of smallpox in his country in 1958 and they had all been imported cases. Vaccination against smallpox was compulsory in Malaya. Children were vaccinated soon after birth and they were revaccinated at the time they started going to school and also during the middle of the period they spent at school.

Professor ETEMADIAN (Iran) said he also was grateful for the report under discussion and for the work WHO was doing towards eradicating smallpox through the world.

The authorities of Iran were engaged in an energetic and effective campaign to achieve smallpox eradication there, which had brought about a marked decrease in the number of cases in 1958. The Pasteur Institute in Teheran could provide all the vaccine needed for Iran's campaign and could supply other countries with quantities of it to meet emergencies, as it had done on several occasions. He was confident that the number of cases of smallpox in Iran would continue to decrease each year and that in the near future the disease would be completely eradicated there.

Dr ALAN (Turkey) said that the map [1] in the report which indicated that the annual average of smallpox cases in Turkey during the period 1948-1957 had been in the category 10-99 was somewhat misleading. It might be supposed from that that there had been between 10 and 99 cases of smallpox in Turkey in each of those years. In fact, there had been imported cases of smallpox in Turkey in 1953 and 1957, but the disease had not spread beyond the areas of the country in which the outbreaks had occurred. Because vaccination against smallpox was compulsory in Turkey, the disease was no longer endemic anywhere there.

He welcomed the plan for world-wide smallpox eradication.

Dr MARTÍNEZ-FORTÚN (Cuba) said that since 1922, when there had been an outbreak of the alastrim variety of smallpox in Cuba (imported by labourers who had come to work in the sugar-cane plantations), no case of smallpox had been reported in his country.

Glycerinated smallpox vaccine of consistently good quality was produced by the official laboratory

[1] Not reproduced in this volume

[2] See Annex 18.

in Cuba; considerable quantities had been exported to other countries. No lyophilized or dried vaccine was as yet produced in his country.

Vaccination against smallpox had been compulsory in Cuba for many years. For a number of years there had been very little opposition to such vaccination; but in recent years many people, particularly mothers of small children, had started questioning whether there was any need for it, since there had been no cases of smallpox in Cuba for so long. A health education campaign was indicated, to persuade the people that it was necessary.

He wished to thank the Director-General for the work he and his staff were doing with a view to achieving world-wide smallpox eradication.

Dr PATIÑO CAMARGO (Colombia) said the report under discussion was an excellent one.

The authorities of his country were very grateful to PASB (WHO Regional Office for the Americas), UNICEF, and the United States International Co-operation Administration for generous aid in carrying out public health work.

In 1955 the incidence of smallpox had been greater in Colombia than in any other country of the Region of the Americas. During the period 1951 to 1955, 23 212 cases of the disease had been notified, and as a result the Colombian health authorities had asked PASB and UNICEF for help to carry out a national eradication campaign. An agreement had been signed, and the proposed campaign had begun on 12 October 1955 in the north of the country. The aim had been to vaccinate at least 80 per cent. of the population of the country within five years; 2 000 000 persons per year were being vaccinated against smallpox in his country. He was confident that, by the end of 1960, 10 000 000 out of the total of 14 000 000 people in Colombia would have been vaccinated against the disease. The campaign was being directed by the head of the epidemiological section of the Ministry of Health, with advice from WHO experts. (He described the composition of the teams employed, and the propaganda work carried out.) There was a special budget of 1 000 000 pesos a year for the campaign and contributions had also been made by the municipal authorities of the larger towns. Vaccine for the campaign was being produced by the Samper Martínez Institute. In 1955 there had been 3404 cases of smallpox reported in Colombia; in 1958 there had been only 1957. And there had been no cases of the disease in areas already covered by the campaign, except for imported cases.

Dr CLARK (Union of South Africa) said that he also appreciated the report under discussion.

Smallpox was a disease which was eminently suited to a large-scale eradication programme. The means of producing immunity to it had been known for well over 150 years and had stood the test of time. Vaccination against smallpox was one of the most effective, simplest and safest measures in the whole field of preventive medicine. In the circumstances it was surprising that better use had not been made of that weapon against what was one of the most infectious of all diseases and was often lethal.

One of the difficulties in the way of making better use of it was the lack of co-operation on the part of the public; that was due in particular to ignorance of the public in under-developed communities, to prejudice against vaccination in certain quarters, and to apathy in communities which had not had smallpox epidemics for many years.

Another difficulty was that of vaccinating people quickly and economically in countries with a hot climate, where the heat might cause the vaccine to lose its potency. That was partly an administrative problem, which could best be solved by national health authorities in the manner most suited to their particular areas. But the technical problem of ensuring that the vaccine's potency had not been affected might be solved by the new types of dried vaccine. It seemed, therefore, that the time was ripe to launch a smallpox eradication campaign.

The Union authorities had been faced with all those problems. Government medical officers and other personnel made annual vaccination tours as an essential and important part of their duties, and by systematic effort over the years had succeeded in getting a large percentage of the population of the country vaccinated and revaccinated against the disease. If the disease was not actually eradicated, it was at least completely under control in his country. The authorities realized however that the disease might break out again, and they were therefore anxious to ensure its total eradication from the country if that was possible.

Enough smallpox vaccine was produced in the Union of South Africa to vaccinate three-quarters of the country's total population each year. Some of it was of course wasted owing to exposure to heat and a large percentage was exported to other African territories; but the bulk of it was used in the Union. So far there had not been any post-vaccinal complications of a serious nature. The vaccine produced there was glycerinated calf-lymph vaccine. Production of the more thermostable dried vaccine in the Union was under consideration.

The organization of effective campaigns to ensure that a large percentage of the population was pro-

perly vaccinated was a matter which should be dealt with by individual governments, with advice and assistance from WHO when required. There was scope for further research regarding the production of stable vaccines which would withstand heat and field conditions, and also research regarding the prevention of post-vaccinal complications; WHO could play a useful role by co-ordinating such research and collecting data for it.

Without knowing the exact position in all other countries he could not say whether world-wide smallpox eradication was a practical proposition. If it were decided to attempt such a campaign, the authorities of his country would be able to give assistance by making more vaccine available and possibly by using their virus research facilities to help elucidate some of the problems.

Dr BAIDYA (Nepal) said that smallpox was still very prevalent in his country. There were no statistics of the incidence of the disease there, but he believed there might be thousands of cases each year. The incidence of the disease was higher in the towns and the almost inaccessible hill country than in other parts of Nepal.

Smallpox vaccination had been started some fifty years previously, but since a wet vaccine imported from India was used and transport facilities were not very good, it had been confined mainly to the capital and the area bordering India. Many of the people of Nepal still thought that the disease was a punishment inflicted by God and others thought that cases of it were due to the use of medicine imported from abroad. Many people refused to be vaccinated with imported vaccine and deliberately infected themselves with fluid taken from smallpox patients—with disastrous results. It was clear that much health education of the public was needed.

In 1958 some 70 000 persons had been vaccinated by public health officials and some 30 000 by other Nepalese health workers. But it would be a long time before legislation could be passed making vaccination compulsory. He was confident that a dried vaccine would prove to be of great help in Nepal. He was grateful for the work against smallpox being done by WHO.

Dr NUGENT (Ghana) said that, although there had been extensive vaccination and revaccination for many years in Ghana, a few cases of smallpox still occurred there. He believed that they were mostly imported cases.

It was stated in part IV, section 1, of the report that the only acceptable criterion of successful vaccination was vesiculation. Many of the people who were revaccinated would naturally have an immunity reaction, and it would be impracticable in each case when such reaction was noted to ascertain whether the vaccine used had been of the quality required. It being virtually impossible to vaccinate all the people of a country on the same day, some persons who had no vaccination marks would say that they had already been vaccinated a short time previously. What was required was not merely legislation making vaccination against smallpox compulsory, but action which would result in all members of the population wanting to be vaccinated against the disease.

Dr LE-CUU-TRUONG (Viet Nam) said that the apparently simple question of world-wide smallpox eradication nevertheless raised a number of problems. The main method of combating smallpox at present was by the preventive measure of vaccination, and the quality of the vaccine was raising certain problems and needed further study. The vaccine used so far had, however, proved effective, since statistics showed a considerable decrease in the number of smallpox cases in most countries.

In Viet Nam vaccination had been carried out for many years, but it had become really effective only in 1954 with the return of settled conditions to the country and the enactment of a law making vaccination compulsory. In the past five years vaccination campaigns had been carried out from January to April each year, and had covered more than 80 per cent. of the population. During the same period the number of cases had dropped from 3564 in 1954 to 30 in 1958, showing a very marked reduction in the incidence of smallpox in south Viet Nam. The Institut Pasteur in Saigon could produce sufficient effective thermostable vaccine and it had even been possible to offer 250 000 doses free to the neighbouring countries. In view of the results obtained it was considered that smallpox could be completely eradicated in the country and although vaccination campaigns would continue for some time to come, it was not intended in the meantime to request the help of WHO.

Professor CORRADETTI (Italy) referred to the suggestion that WHO should assist individual countries to build up vaccine production plants and should organize training courses in vaccine production. The Italian delegation agreed with previous speakers that the existing institutes in the world could in fact produce and supply the required quantity of vaccine.

In regard to post-vaccinal complications, reference had been made to the interesting experiments being carried out in the Federal Republic of Germany and in the Netherlands on the use of gamma globulin.

He wished to draw attention to the difficulty of administering gamma globulin in extended mass campaigns such as those planned.

The organization of the mass campaigns, and the maintenance of their results by revaccination, called for adequate national health services. The Italian delegation considered that the main way in which WHO could help in smallpox eradication would be to assist in strengthening national health services.

Dr OMAR (Afghanistan) thanked the Director-General and the Secretariat for their work in preparing the excellent report before the Committee. Smallpox had been a serious problem in Afghanistan but the efforts of the Government and WHO had met with some success. Vaccination had been made compulsory in 1958. Since climatic and geographical conditions made the transport and storage of vaccine difficult, it was hoped that if dried vaccine became available, success would be even greater.

Dr GAYE (France) said that, in the French territories of Senegal and Sudan, smallpox had been a menacing problem in the past, forcing the authorities to take drastic measures. Vaccination had been made compulsory by law, and teams of vaccinators had been constituted in each area with a four-year plan of vaccination. Success had been due mainly to the mobile health and prophylaxis service which, for the last twenty years, had been employing mobile teams to eradicate the main endemo-epidemic diseases from the country. The teams covered the country systematically and examined each person for leprosy, the treponematoses, onchocerciasis, trachoma, bilharziasis, etc., and vaccinated him against yellow fever and smallpox. The result had been a considerable reduction in the incidence of smallpox. Sporadic outbreaks flared up from to time because it was difficult to reach as many as 80 or 90 per cent. of the population, and much still remained to be learned about the problem of epidemics. The health and administrative services, as well as the public, must be convinced that the disease was not completely eradicated, and the report and recommendations of WHO would help in the effort to undertake a campaign for its complete eradication.

Dr KAUL, Assistant Director-General, Secretary, said that the Director-General had noted the valuable recommendations and suggestions which had been made and which would certainly be kept in mind in the further study of the problem.

The report on smallpox eradication had been difficult to produce since complete and up-to-date information had not always been available. Some replies to the questionnaire had been received after the report had been drafted. Much better information had since become available. The omissions and inaccuracies pointed out by delegates had been noted, and it was hoped that it would be possible to produce a more accurate and complete document in the future.

The maps attached to the report included one showing the notification of cases of smallpox from 1948 to 1957 [1] for which no information had been available for a number of countries. Much more information had been available for the map showing notification of cases in 1958, and it was hoped that in the future the maps and charts would be even more accurate.

The CHAIRMAN drew attention to the draft resolution on smallpox eradication, which read:

> The Twelfth World Health Assembly,
>
> Having considered the report by the Director-General on smallpox eradication,
>
> Noting:
>
> (1) that although great progress has been made in the eradication of the disease in some areas of the world, important endemic foci of smallpox still remain in other areas, especially in South-East Asia and Africa, from which the disease can be exported to countries already free of it;
>
> (2) that eradication of smallpox from an endemic area can be accomplished by successfully vaccinating or revaccinating 80 per cent. of the population within a period of four to five years, as has been demonstrated in several countries;
>
> (3) that sufficient scientific and technical information is available on the production of a suitable smallpox vaccine;
>
> (4) that although an eradication programme may require, for four or five years, an increase in the national efforts and financial obligations for smallpox control activities it will permit the elimination of the heavy continuing expenditure from year to year for this purpose once eradication is accomplished,
>
> 1. EMPHASIZES the urgency of achieving worldwide eradication;
>
> 2. RECOMMENDS to the health administrations of those countries where the disease is still present that they organize and conduct, as soon as possible, eradication programmes along the guide lines provided by the report of the Director-General, making provision for the availability of a potent stable vaccine;

[1] Not reproduced in this volume

3. REQUESTS the Director-General:

(1) to urge health administrations of those countries where the disease is still present to develop eradication programmes, and to offer them any necessary technical guidance and advice;

(2) to provide for the necessary activities to further smallpox eradication programmes and for the assistance requested by national health administrations for this purpose, in his programme and budget for future years; and

(3) to collect from the countries concerned information on the organization and progress of their respective eradication programmes and to report further to the Thirteenth World Health Assembly.

Dr LEITCH (Federation of Nigeria) proposed that the words " along the guide lines provided by the report of the Director-General " should be deleted from paragraph 2 of the draft resolution. The words might be interpreted as requiring countries to conduct their campaign in the way suggested by the Director-General, i.e., by using a limited number of teams of vaccinators, supervised by inspectors and directed by medical officers, operating over a period of four or five years. That was not the only way of organizing an eradication campaign. Different countries might wish to use different methods of approach more suited to their particular circumstances, and the wording of the resolution should not be such as to seem to discourage experimentation with alternative methods.

Decision: The amendment proposed by the representative of the Federation of Nigeria was adopted.

Dr KIVITS (Belgium) said that his delegation supported the draft resolution in general, but felt that the optimism expressed in sub-paragraph (4) of the preamble was somewhat unrealistic. It might encourage some governments to suspend smallpox vaccination too quickly, thus exposing the population to the return of disastrous epidemics. A few latent cases in some part of the world would be enough to cause terrible outbreaks. The impression should not be given that WHO was advising that vaccination should be abandoned.

The Belgian delegation proposed, therefore, that sub-paragraph (4) of the preamble should be redrafted as follows:

(4) that although an eradication programme may require, for four or five years, an increase in the national efforts and financial obligations for the intensified campaign against smallpox, the heavy annual burden of continuing expenditure incurred for this purpose may be considerably lightened by increasing the interval between vaccinations once eradication may be considered to have been accomplished.

The CHAIRMAN asked whether the deletion of the words " for four or five years " in sub-paragraph (4) of the preamble would not meet the Belgian delegation's point.

Dr KIVITS (Belgium) said that the mere deletion of those words would not suffice, since the text would still imply that vaccination should be completely abandoned.

Professor ZHDANOV (Union of Soviet Socialist Republics) supported the Belgian amendment.

Dr METCALFE (Australia) proposed that the whole of sub-paragraph (4) of the preamble should be deleted.

Dr HOURIHANE (Ireland) supported that proposal.

The CHAIRMAN put to the vote the proposal of the Australian delegate to delete sub-paragraph (4) of the preamble.

Decision: The proposal was rejected by 27 votes to 6, with 16 abstentions.

The CHAIRMAN put to the vote the Belgian amendment to sub-paragraph (4) of the preamble.

Decisions:

(1) The Belgian amendment was adopted by 38 votes to none, with 13 abstentions.

(2) The resolution, as amended, was approved (see fifth report of the Committee, section 1).