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No. 218

TWENTY-SEVENTH WORLD HEALTH ASSEMBLY

GENEVA, 7-23 MAY 1974

PART II

VERBATIM RECORDS OF PLENARY MEETINGS

SUMMARY RECORDS AND REPORTS OF COMMITTEES

WORLD HEALTH ORGANIZATION
GENEVA
1974

MEMBERSHIP OF THE HEALTH ASSEMBLY

LIST OF DELEGATES AND OTHER PARTICIPANTS

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[1] Delegate from 11 May.

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[2] Deputy Chief Delegate from 13 May.

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[1] Chief Delegate from 15 May.

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[1] Chief Delegate from 11 May.

Smallpox eradication (subprogramme 5.1.4)

Dr RAMZI (representative of the Executive Board) said that the Board had examined the report of the Director-General on smallpox eradication. That report stressed that, at the advanced stage reached in the programme, three measures deserved particular attention: first, immediate notification and complete international coordination if smallpox was reintroduced into a country; secondly, maintenance of vigilant surveillance and an appropriate vaccination programme; and thirdly, confirmation of the absence of smallpox cases. The Director-General had informed the Board that WHO allotted high priority to the final stages of the programme and was prepared to mobilize other funds if necessary. WHO was actively seeking funds outside its regular budget so that it could assist regions in difficulties. The question of monkeypox had arisen during the Board's discussions, and the Director-General had explained that a group of research workers had made a thorough study of the disease in December 1973. Further studies were envisaged in countries in which cases of monkeypox had been observed.

Dr BERNARD (Assistant Director-General) said that the working paper summarized the existing situation. As in previous years, it included as an annex the issue of the Weekly Epidemiological Record that had appeared at the beginning of the Health Assembly and that reviewed the problems of smallpox surveillance.[2] The zones of smallpox endemicity had been reduced to the smallest dimensions ever known in the history of the disease. Only four countries of endemicity remained, and more than 90% of the world total of cases were concentrated in a region representing less than 15% of the surface of those four countries. Surveillance activities had been considerably improved during the previous year in the Asian countries of endemicity, and now allowed more than 80% of all existing cases or epidemics to be identified and dealt with. The increase in reported cases thus reflected better surveillance, and WHO believed that three times as many cases were currently being identified as had previously been reported. Each of the countries in which the disease had been endemic during the previous year had allotted the highest priority to its smallpox programme. Moreover, the numerous countries that had supported the global smallpox eradication programme had maintained and even increased their assistance, especially in the form of donations of vaccine. It was very important for the Secretariat to stress how much those contributions had contributed to the success of the programme. As an example, he cited the most recent contribution: that of the Government of Sweden, amounting to some three million dollars and intended to speed up smallpox eradication in India. During the previous twelve months, international commissions had made a thorough study of the epidemiological situation in the Americas and in Indonesia and concluded that transmission of the disease had been interrupted, which could be acknowledged as a historic achievement. The aim of the programme remained the total interruption of transmission in the remaining endemic areas during the year 1975, but WHO would refrain from making any strict or definitive forecast, which might be hazardous in a world of uncertainties in which so many factors could influence the evolution of the programme. The date should, however, be maintained as an incentive to pursue the programme with the greatest energy, on the part not only of the countries affected but also of other Member States of WHO.

Dr HOSSAIN (Bangladesh) said that his country was one of those in which smallpox was still prevalent. The situation was better than it had been in 1973 when, owing to the chaos prevailing in the country, health workers had had to concentrate their energies on the more urgent work of relief and rehabilitation and could not be properly distributed

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[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA27.52.

[2] Wkly epidem. Rec., 1974, 49, 157-172.

through the areas infected with smallpox. As a result, a record number of 5000 cases had been reported in April 1973, and the actual number of cases was probably twice as many. Reports of morbidity and mortality in 1973 were being received in 1974. The situation had vastly improved, as had been indicated in an official report a short time previously. Every single case in the country had been identified and welfare workers were visiting families regularly and finding cases wherever they existed. More than two-thirds of the country had been virtually freed from smallpox since September 1973. Efforts had been concentrated on the programme and the entire population had been classified according to age and history of primary or no vaccination. From 21 January to 15 April 1974 about one million persons had received primary vaccination. In addition, over two million had received secondary vaccination. Thus, over three million in all had been vaccinated during the past three months. The latest report on the incidence of the disease during that period indicated 4456 cases and a mortality of 2435. During the month of April, 1700 cases had been reported. About 200 villages had been reported as infected, but very few cases had been reported in them. In three areas bordering India, the disease had been difficult to control, although several hundred medical students had gone from house to house vaccinating the inmates.

The situation had since been brought under control. The medical officer in charge of the WHO smallpox programme had visited Bangladesh twice during the preceding six months and had urged that all available resources be applied to bringing the disease under control. Thanks were due to the WHO staff members who had worked tirelessly to that end. It had been shown that integration of health services was the only realistic approach, and therefore malaria, smallpox, tuberculosis, and family planning had all been tackled in a comprehensive way, with good results.

If Bangladesh was to be freed from smallpox by 1975, it would need a helicopter and several tons of chocolate, because the helicopter attracted thousands of children, who - although they normally fled from vaccinators - would accept vaccination when given chocolate. Apart from those items, Bangladesh was well equipped with vaccine and other materials and did not need many experts, since it had built up its own infrastructure of hard-working and devoted health staff.

Dr SHRIVASTAV (India) said that, in the past year, a remarkable effort had been made in India with the active cooperation of WHO, the Government of India, and the state governments. An intensive campaign had been mounted in which 34 epidemiologists (including 9 from WHO) and 24 state-level teams were working in those parts of the country in which smallpox was endemic. In the past, the states had been reluctant to recruit staff to undertake an intensive immunization campaign because they were not sure of obtaining funds. It was therefore an important point that the programme was entirely financed by the Central Government as part of its fifth Five-Year Plan. In 1973 there had been 22 million primary vaccinations and 76 million revaccinations - 4% instead of the target of 6% for primary vaccinations and 14% instead of 20% for revaccinations. It had been found that the reason why it was not possible to attain the target in some places was lack of staff. Paradoxically, the incidence had increased rather than fallen. Thus, in 1972 there had been 27 000 cases and about 5000 deaths; in 1973 80 000 cases and some 15 000 deaths; and up to May 1974 about 60 000 reported cases and a number of deaths of approximately the same magnitude as in 1973. An intensive search was in operation especially in the states of Uttar Pradesh, Bihar, West Bengal, and Madhya Pradesh - the four states that accounted for 94% of the cases in the country - mobilizing a large number of health staff and the special epidemiological teams. It was estimated that two-thirds of cases had been missed in the past, which accounted for the apparently high increase in incidence. India was self-sufficient in the production of vaccine, but it was grateful for past donations of vaccine, notably freeze-dried vaccine supplied by the USSR through WHO. The budget for 1973-74 was sufficient for the purpose: 35 million rupees for the whole country. The future plan of action, envisaged in consultation with WHO, provided for improved reporting procedures and intensified surveillance, which needed to be heightened during the summer and autumn so as to produce an impact on the smallpox season, which was in the winter. The vaccination programme would continue to receive the same emphasis, especially primary immunization, for which purpose the services of basic health workers and multipurpose workers had been secured. It was thus a combined vertical and multipurpose programme, and would remain so until a substantial dent had been made in the problem. The battle against smallpox had been joined from all angles. It was hoped that it would be the last, and that it would be possible to report its successful outcome to the next Health Assembly. There was no room for complacency, and vaccination and surveillance would continue until not a single case had been reported and at least two years after the end of the programme; indeed, surveillance and primary immunization would go on even after that.

Dr JAROCKIJ (Union of Soviet Socialist Republics) was satisfied with the progress made in the smallpox eradication programme. The Soviet Union, which had originally proposed the programme, was continuing to support it by a further donation to the Organization of 75 million doses of smallpox vaccine, to be delivered between 1974 and 1976.

It was too early, however, to speak of the programme as nearly completed and to envisage a slackening of the efforts of the health services. On the contrary, the epidemiological services would have to be strengthened, effective surveillance systems set up, and revaccination of the population carried out where necessary.

It might also be desirable to include in the International Certificate of Vaccination or Revaccination against Smallpox a note concerning revaccination of persons arriving from smallpox-infected countries.

Research was still required on reliable tests of immunity to smallpox, on the biological properties of monkeypox virus, and on the causes of complications following smallpox vaccination.

The Director-General's report on smallpox eradication referred to difficulties encountered in India, Pakistan and Ethiopia. The Organization and the national smallpox services should make every effort, at the present critical stage of the programme, to avoid prolonging it. From the statement made by the delegate of India, it appeared that that country, where the smallpox situation showed little change, was particularly in need of assistance. WHO was helping to intensify measures in India and some of its experts, including experts from the USSR, were working in the worst affected areas.

The proposals of administrators, health and social workers, and even of the population of the affected villages, on how to increase vaccination coverage, particularly of agricultural workers and those who had to travel about frequently, should be studied attentively. As the delegate of India had stated, it was also important to establish epidemiological surveillance services; it was especially important to work out methods of rapid case-finding. Health education should be intensified and efforts made to encourage the vaccinators and to stimulate the population to cooperate in the programme.

The establishment in Calcutta of an additional regional reference centre for laboratory diagnosis of smallpox, as provided for in the proposed programme and budget estimates for 1975, was timely, and it was hoped that the centre would be designated as soon as possible.

Dr VIOLAKIS-PARASKEVAS (Greece) pledged her country's continued support of the WHO smallpox eradication programme, first approved by the Eleventh World Health Assembly in 1958 and intensified on a global scale in 1967.

The maps on pages 157-158 of the Weekly Epidemiological Record attached to the working paper demonstrated that smallpox could be eradicated not only from areas with high population density but also from sparsely settled areas. However, the problems experienced by certain countries should not be underestimated; to overcome them, increased efforts by those countries as well as international cooperation would be needed.

She did not agree that countries with a low risk of importing smallpox and with developed health services could afford to stop routine vaccination of the total population; there still remained the danger of importing smallpox from endemic areas as a result of tourism. All countries should join in working towards the simultaneous accomplishment of smallpox eradication. WHO was on the threshold of a major achievement and could not afford to fail.

She wondered if the delegate of the United Kingdom of Great Britain and Northern Ireland could provide some information about why the incidence of vaccinia infection had increased from 1972 to 1973, as shown on page 169 of the aforementioned issue of the Weekly Epidemiological Record.

Dr KIDANE-MARIAM (Ethiopia) said that in her country, which was one of the countries still afflicted with endemic smallpox, within the span of three years the eradication programme had effectively controlled the disease in all but 22 of the country's 102 sub-provinces, the uncontrolled areas being located in the rugged and inaccessible central highlands or inhabited by nomads. In a country with an area of 1 221 900 square kilometres and an estimated population of about 26 million, 90% of whom lived in scattered small rural communities with a limited health infrastructure and serious communications difficulties, that result had been made possible only through WHO assistance and guidance and the adoption of an effective strategy. Plans were already under way to bring the last few pockets of smallpox under control by the end of 1974.

She was pleased to report that good cooperation did exist between Ethiopia and the neighbouring countries in regard to smallpox eradication, and she was confident that if

the intensive efforts continued her country would soon be declared free from smallpox.

It was worth pointing out that smallpox surveillance teams in the areas already controlled were also successfully assisting the BCG immunization programme in those areas. She hoped that in the very near future, whenever funds and assistance became available, that cadre of health workers would play an important role in the immunization programme for communicable diseases of childhood.

Dr KHALIQ (Pakistan) said that, although his was one of the four countries in which smallpox was still endemic, it was encouraged by the spectacular results in other developing countries, such as Indonesia, that were endemic areas only a few years before. Benefiting from their experience, Pakistan was now placing increased emphasis on improved surveillance activities and containment procedures. Every outbreak was fully investigated, the source of infection was traced, and containment measures were then implemented.

The reported number of cases of smallpox in his country had risen in 1974 for the fourth consecutive year, although that rise partly reflected improved surveillance. However, the incidence in large areas of the country was low or zero, and comparatively localized problem areas accounted for the great majority of cases. An intensive effort was being made to eradicate smallpox from those heavily endemic areas, where additional WHO and national epidemiologists were working to interrupt transmission within the next few months.

Regular search operations had been implemented in many areas and all health workers, including malaria eradication and population planning personnel, kept watch over their respective areas to detect cases of smallpox. Cash rewards were offered as an incentive to those discovering previously unknown outbreaks. Those measures had proved very effective. However, systematic vaccination of the population as a whole had been pursued as relentlessly as ever so as to raise immunity levels and retard transmission. He hoped that transmission would be interrupted in the very near future.

Dr UPADHYA (Nepal) said that the eradication of smallpox from the world by 1975 would be a great victory of mankind over a dreaded disease that had wiped out the populations of innumerable cities and villages in the past. Smallpox could not spread to that extent now, even though it was reportedly still endemic in four countries, because of the excellent surveillance and containment mechanisms developed by the national governments under the guidance of WHO.

Nepal, though declared a non-endemic country since March 1973, still experienced frequent small outbreaks of smallpox and was reluctant to be over-optimistic until the disease was actually eradicated from it and from neighbouring countries. There were cultural barriers against vaccination in some communities, people being more inclined to rely on supernatural forces than to have themselves vaccinated or report cases to the authorities, despite the fact that vaccination was compulsory. A door-to-door vaccination campaign was being developed. In addition, there were unrestricted migration and travel on either side of the 500-mile open border with neighbouring countries, and some people returned home harbouring the infection. A cross-notification system existed between the countries concerned, but it sometimes did not work very well because transport and communication problems, especially in the hills, made it difficult to locate the individuals and their close contacts.

There was also sometimes negligence on the part of surveillance workers, who did not regularly supervise their assigned areas although they were aware of their responsibilities and the possibility of punishment for negligence. The human factor was a most vital problem and was not very easy to deal with. Unless such lower-level workers were fully motivated, through training and group discussions, to assume their responsibility to the community and the eradication project, smallpox would persist for some years to come despite the very efficient operational mechanism for surveillance and containment developed at a higher level.

Nepal was also attempting to achieve better coverage by assigning malaria house visitors to report suspected cases of smallpox. Their training to date was insufficient; the frequent reporting of false positives caused the smallpox supervisors to make unnecessary journeys. Better training would be required if such personnel were to be entrusted with case-reporting.

The country was making satisfactory progress with its vaccination campaign and, with the continued assistance of WHO in the form of technical consultants, teaching aids, and the vaccine needed, smallpox could be eradicated from Nepal by 1975, provided the above-mentioned problems could be obviated.

Dr FLEURY (Switzerland) said that his Government had donated more than 20 million doses of freeze-dried smallpox vaccine to WHO since it had begun supporting the smallpox eradication programme. It would continue to contribute vaccine, since it was aware that in practice increasingly great efforts were needed as one approached the target.

Professor SULIANTI SAROSO (Indonesia) thought that the success of the smallpox eradication programme in her country, made possible by WHO assistance, was owing not to routine or mass vaccination campaigns but to very strict surveillance and containment measures. In the past few years the health authorities had enlisted the cooperation of children in case-finding after showing them a picture of a case of smallpox. There was also a reward system for the reporting of any subsequently confirmed case, but only once in the past two years had the reward been won.

In Official Records No. 212, Indonesia was still listed as having a "country project of eradication" even though it had been declared smallpox-free. The project being carried out was a vigilance programme, and smallpox vaccinators were now also administering BCG vaccines and would perhaps give other antigens as well in the near future.

Dr SIMÕES (Brazil) congratulated the Director-General and his staff on the excellent results obtained in the smallpox eradication programme. Out of 30 countries where the disease had been endemic in 1967, only four were still endemic. In his country no cases had now occurred for three years; it was grateful to WHO and its Regional Office for the Americas for their assistance to the eradication effort.

Dr JIROUŠ (Czechoslovakia) said that, although the problem of smallpox was not of direct concern to his country, it fully supported WHO's programme, which had achieved notable successes during its seven years of operation. He urged countries not to relax their efforts, but to follow the example of the USSR, the USA and the other countries that had made donations to the programme. In addition to the assistance of its epidemiologists, some of whom had served as members of working groups, Czechoslovakia was providing direct assistance in the form of a donation of 250 000 doses of smallpox vaccine.

Sir John BROTHERSTON (United Kingdom of Great Britain and Northern Ireland) said that the question asked by the delegate of Greece was related to the decision by his country to discontinue recommending routine smallpox vaccination of children. That decision had been taken after it had satisfied itself that the risk of morbidity and mortality from vaccinia was greater than that from smallpox. He was unable to add any information to that contained in Weekly Epidemiological Record No. 19, which indicated that there had been 83 vaccinia infections in 1973 as compared with 35 in 1972. That was only to be expected, since in 1973 about 3.2 million doses of vaccine had been issued (as against 1.7 million in 1972) owing to the small outbreak of smallpox in March-May 1973. If any other information became available, he would inform the delegate of Greece.

Dr HENDERSON (Smallpox Eradication) said that, as noted in the Director-General's report, the remaining endemic areas were comparatively limited, and so the tempo of activity was being stepped up to several times the level of the previous year. A final breakthrough seemed possible and would require the best efforts of the countries concerned and all others throughout the world.

He thanked countries for their assistance, especially for the donations that had been announced at the present Health Assembly by the delegations of Sweden, the Union of Soviet Socialist Republics, Czechoslovakia, and Switzerland, to name but a few. The final stages of the eradication programme were in fact the most difficult, as the delegate of Switzerland had pointed out, but with the strong support of all governments the end might be in sight in a year's time.