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TWENTY-NINTH WORLD HEALTH ASSEMBLY

GENEVA, 3-21 MAY 1976

PART II

VERBATIM RECORDS OF PLENARY MEETINGS
SUMMARY RECORDS AND REPORTS OF COMMITTEES

WORLD HEALTH ORGANIZATION
GENEVA
1976

MEMBERSHIP OF THE HEALTH ASSEMBLY

LIST OF DELEGATES AND OTHER PARTICIPANTS

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Dr G. R. ROASHAN, Chief, Department of Foreign Relations, Ministry of Public Health

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ALGERIA

Delegates

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Mr A. BRAHIMI, Deputy Director, Oran University Hospital

Mr M. AMIROUCHE, Director, Wilaya of Tizi-Ouzou

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Mr E. LOPES, Director-General of Administration, Ministry of Health

Alternate

Dr J. SANTOS, Director of Health Technical Schools, Ministry of Health

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[1] Chief Delegate from 10 May.

[2] Deputy Chief Delegate from 10 to 12 May.

[3] Deputy Chief Delegate from 13 May.

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[1] Admitted to membership by the Twenty-ninth World Health Assembly on 4 May 1976 (resolution WHA29.1).

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[1] Chief Delegate from 8 May.

[2] Deputy Chief Delegate from 8 May.

[3] Delegate from 8 May.

[4] Chief Delegate from 10 May.

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Dr A. J. COHEN, Regional Director of Health

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DEMOCRATIC YEMEN

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[1] Chief Delegate from 6 to 8 May.

[2] Chief Delegate from 9 to 15 May.

[3] Chief Delegate from 16 May.

[4] Deputy Chief Delegate from 12 May.

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[2] Chief Delegate from 14 May.

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Mr R. S. SCHWEIKER, United States Senate

Mr T. L. CARTER, United States House of Representatives

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UPPER VOLTA

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WESTERN SAMOA

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YEMEN

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YUGOSLAVIA

Delegates

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Professor D. JAKOVLJEVIĆ, Member of the Yugoslav Commission for Cooperation with International Health Organizations; Vice-President, Executive Council of the Assembly of the Autonomous Socialist Province of Vojvodina[1]

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

ZAIRE

Delegates

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[1] Chief Delegate from 12 May.

Dr B. LEKIE, Director-General, Department of Public Health (Deputy Chief Delegate)[1]
Dr B. ILUNGA, Director, Department of Public Health

Alternates

Mr T. BINTU'A, Ambassador, Permanent Representative of the Republic of Zaire to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
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ZAMBIA

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REPRESENTATIVE OF AN ASSOCIATE MEMBER

NAMIBIA

Dr Libertina Inaviposa AMATHILA, Assistant Secretary of Health, Ministry of Health

[1] Chief Delegate from 13 May.

FOURTEENTH MEETING

Monday, 17 May 1976, at 9.30 a.m.

Chairman: Professor F. RENGER (German Democratic Republic)

2. REPORTS ON SPECIFIC TECHNICAL MATTERS

Agenda, 2.5

Smallpox eradication programme

Agenda, 2.5.9

Professor KOSTRZEWSKI (representative of the Executive Board) recalled that the Board had discussed in depth at its fifty-seventh session the smallpox eradication programme, which has constituted one of the most important programme matters before it. The Board had agreed that smallpox eradication should be accorded the highest priority in WHO's activities. The Organization was very close to the goal of final interruption of transmission, as a result of the efforts deployed by Member States, the Organization and individual members of the Secretariat.

The elimination of smallpox, which had been the scourge of mankind, should be acknowledged as the greatest achievement of WHO. On behalf of the Board, he extended special thanks to the Governments of India and Bangladesh, which had succeeded in attaining the eradication of smallpox in 1975; all the field workers involved were included in that expression of gratitude. He also thanked the Ethiopian Government and the workers concerned for the efforts they had made, and hoped that the goal would be attained there as soon as possible.

If "target zero" were to be met, WHO would have to maintain intensive vigilance of all suspected cases, not only country by country, area by area, but also even house by house if necessary. Final victory had not been achieved, but it was to be hoped that eradication could be declared in two years' time, when activities would be merged with the expanded programme on immunization.

Dr HENDERSON (Smallpox Eradication) introduced the report by the Director-General on smallpox eradication which described the present status of the smallpox eradication programme and plans for the immediate future.

Notable achievements during the past year had included the certification of eradication in 15 countries of western and central Africa on 15 April 1976 and the apparent interruption

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[1] Transmitted to the Health Assembly in the Committee's third report and adopted as WHA29.53.

of transmission of smallpox in India in May 1975 and in Bangladesh in October 1975. The occurrence of the last known case of variola major seven months previously had been especially significant, since it had been that form of smallpox which had been fatal for 20% to 40% of its victims. Throughout Asia, more than 120 000 health workers were continuing to search for cases but it was beginning to appear increasingly unlikely that a hidden focus would be found.

Ethiopia remained the only smallpox-infected country. An excellent job had been done there and the tempo of activity was greater than ever before. However, the task was not finished. The discovery within the past week and since the report had been prepared of a small focus of 18 infected villages in the northern highland areas showed that there was no room for complacency or lessening of effort. The number of active cases stood at 40, i.e. only 40 known persons could infect someone else and so sustain smallpox transmission. However, due to communication difficulties in the infected area where most of those outbreaks were located, the efficiency of operations had been compromised. To offset that, additional helicopter support had been authorized, which, while costly, seemed worthwhile so as to stop transmission once so much had already been achieved. The voluntary support provided by 27 countries the previous year, amounting to almost $ 10 million, had been of signal importance in permitting those achievements. Nevertheless, the task had not yet been completed and additional funds would be required if "target zero" were to be achieved on a worldwide basis.

The risk of importation of smallpox by sea or air, now that it had been confined to extremely remote Ethiopian villages, had become almost nil. Only one such importation had occurred during more than two years and that had been from Bangladesh, which was now believed to be smallpox-free. Furthermore, there was no record of smallpox having been exported from Ethiopia by sea or air for more than 25 years. It was accordingly proposed by the Director-General, in accordance with the current International Health Regulations, that smallpox vaccination certificates should now be requested only of travellers who had been in Ethiopia within the preceding 14 days.

Following the apparent interruption of smallpox transmission, it would be important for all countries to have the assurance that the task had been accomplished in view of the important bearing that would have on vaccination policies for every country throughout the world. Accordingly, the Organization had provided for international commissions of respected experts to be convened two years or more after the last case had occurred in a geographical area so as to review carefully activities in the previously endemic countries and to decide whether or not they were fully satisfied that eradication had been achieved; three such commissions had been convened and others were planned. The cooperation of all countries in participating in that procedure was obviously of the greatest importance.

He drew attention to the reference in the report to the important question of the registry of laboratories retaining stocks of variola virus. With the cessation of smallpox transmission, the only known reservoir of virus which might result in the re-establishment of smallpox infection was that retained in research laboratories. Governments and laboratories throughout the world were now being contacted and requested to participate in the preparation of a registry of all laboratories retaining stocks of variola virus with a view to the drawing up of recommended standards of safety. Replies had been received from 92 out of 181 countries or areas and 32 laboratories had so far been registered. That number seemed far beyond that necessary for essential continuing research work. He was sure that all responsible health authorities appreciated what a catastrophe it would be if smallpox infection were in future to occur as a result of laboratory infection and it subsequently spread to the community. It would therefore seem prudent for all governments to examine carefully the rationale for each laboratory to retain stocks of variola virus, to assure destruction of any virus stocks not required for essential research, and to ensure that each laboratory retaining stocks of variola virus had adequate safety precautions to prevent escape of the virus. It would seem that on a worldwide basis, for retaining the virus, a maximum of 10 to 15 research laboratories would suffice.

It was anticipated that the world's last case of smallpox would be detected and isolated in 1976, though exactly when was difficult to assess as it was dependent on continuing national support and commitment to the programme as well as on the ability of the Organization to provide essential support. Following that, concerted efforts would be required to ensure a high level of surveillance as well as the proper maintenance of variola virus stocks in laboratories, and to certify that eradication had been achieved. The continuing moral and financial support of all Member States was essential as never before.

Dr NATH (India) wished to place on record the immense debt of gratitude felt by his delegation and his Government, and indeed by the entire people of India, to WHO for helping to free the world from the great scourge of smallpox. The programme as a whole epitomized what the Organization could achieve through the dedicated and selfless service of its leadership and staff.

Dr VIOLAKI-PARASKEVAS (Greece) said that there could be no doubt as to the excellent progress made internationally in the smallpox eradication programme. While smallpox was now

endemic in only a very few countries, many countries were faced with the need to develop an intensive surveillance programme. That gave rise to the extremely important question of whether the compulsory smallpox vaccination programme should be maintained or whether it would be premature to suspend it. That issue was being widely debated in her own country, where the last case of smallpox had been an imported one in 1951. A variety of factors, such as an evaluation of possible complications following on primary vaccination, had to be taken into account, and she recalled an instance in 1972 when, following an outbreak of smallpox in Yugoslavia, mass vaccination had taken place in Greece, as a result of which, out of 480 000 primary vaccinations, 25 cases of post-vaccinal encephalitis had occurred in children over three years of age, with four deaths. It would be most valuable if WHO could propose uniform recommendations applicable to all countries with the same epidemiological pattern.

Dr HENDERSON (Smallpox Eradication) stressed the need for taking into account certain factors other than of a purely technical nature when drawing up vaccination policies for the future. For instance, it might prove difficult to reintroduce mass vaccination programmes once they had been suspended for a time. The present situation was essentially a transitional phase when each country would have to make its own decisions. It would be appropriate to discuss the matter further once eradication had been achieved. It would be wise to continue vaccination in those countries where smallpox had recently been endemic.

Dr TANAKA (Japan) commended the Secretariat as well as national health workers on their remarkable achievements over the past few years in respect of smallpox eradication. While it was anticipated that the last case of smallpox might occur within a matter of months, he concurred with the report in emphasizing the importance of maintaining vigilant surveillance activities for some considerable time after the occurrence of that last case. His delegation would therefore give its full support to the continuing activities of WHO in that programme.

Dr AL AWADI (Kuwait) expressed appreciation to the Organization for the efforts it had expended on that vitally important programme of smallpox eradication. The results achieved showed what could be done on the basis of truly effective cooperation.

He agreed that there was no room for complacency as to the future, and, in particular, he drew attention to the grave situation which could arise from any laxity in the application of protective and quarantine measures. He emphasized that any future regulations dealing with the relaxation or abolition of protective measures against smallpox should encompass every safety measure especially taking into consideration the rapid means of transport available and the changes in epidemiology and immunology of a disappearing disease.

He requested information as to the situation in Eritrea, in view of its border with Ethiopia. He wondered whether WHO was continuing with its activities in that area, since, in view of the worldwide target of eradication, it was essential not to allow local fighting to impair efforts towards that end.

Dr HENDERSON (Smallpox Eradication), replying to the first point raised by the delegate of Kuwait, said that, even if a strain were to escape from a laboratory to a population which had not been fully vaccinated, the problem might not be as explosive as could be imagined. It would seem that any such outbreak, even if there were a delay of recognition of 2, 3 or 4 months, would be limited to few cases and could be controlled. It had been with such an eventuality in view that the Director-General had proposed that there should be a reserve of vaccines and needles. Vaccines, stored at a temperature of -20°C, remained potent over a long period of years.

The second point raised by the delegate of Kuwait in respect of Eritrea was pertinent. No cases of smallpox had been detected since a year following the initiation of the smallpox eradication programme there in 1971 and vaccination levels were high. There had been no surveillance activities in Eritrea during the previous year, but the province of Tigre between Eritrea and Ethiopia constituted a sizable buffer zone. The nearest outbreak was some 300 miles (500 km) distant and infection was unlikely in view of the difficulties of communications. There had been no cases in Asmara and surveillance activities in the Sudan had indicated no outbreaks. It was therefore possible to infer that there were no cases of smallpox in Eritrea.

Dr EHRLICH (United States of America) said his delegation believed that the registration of laboratories that had cultures of variola virus was not enough and that the national health authorities of countries that had such laboratories should certify annually that the proposed standards were being observed. He also suggested that stocks of vaccines and needles should be maintained in two centres to guard against power failures and other natural disasters. He stated that six weeks after the last case of smallpox had been reported in Ethiopia, the United States Government would no longer require smallpox vaccination from any traveller.

Dr KALISA (Zaire) said that in Zaire the programme of smallpox eradication was becoming more and more inseparable from the expanded programme of immunization. Since the beginning, the smallpox vaccination programme had been associated with vaccination against tuberculosis and later a programme of immunization against tetanus had been instituted for pregnant women. It was hoped to add a programme of immunization against measles in the near future. He drew attention also to the fundamental research on monkeypox being carried out in Zaire. He recalled that the discovery of animal reservoirs of the virus of yellow fever had marked the end of all hope of eradicating that disease in the Americas and said the absence of animal reservoirs of smallpox virus was a decisive factor in assuring the success of the smallpox eradication campaign. It had been shown in the laboratory that serial transmission of the virus of human smallpox in monkeys was impossible and that monkeys were unable to act as reservoirs. In 1959 the virus of the related monkeypox was isolated for the first time from colonies of monkeys in captivity, but no case of infection among persons in contact with the animals was observed. The first case of monkeypox in man was observed in Zaire in 1970 in an unvaccinated nine months' old infant living in a region that had been free from smallpox for two years. So far, 21 cases had been reported in western Africa, 13 of them in Zaire. Most of these cases occurred in the equatorial forest zone and all of them in regions that had been free from smallpox for several years. Nearly all the victims were children who had not been vaccinated. In some children the symptoms were typical of smallpox, in others they resembled chickenpox. In none of the cases was it possible to discover the source of the infection. Cases of person-to-person transmission were exceptional and it would appear that the virulence of the virus was attenuated or lost after the first or second passage in man. All attempts to isolate the virus from monkeys killed near the homes of the victims had been unsuccessful. It was therefore possible that the natural reservoir of the virus was another species of animal and that monkeys could be infected only occasionally. Probably monkeypox had always existed in Zaire alongside smallpox but had been masked by the prevalence of the latter. The discovery of monkeypox was a tribute to the efficacy of the system of surveillance in Zaire. Further epidemiological and ecological research in cooperation with WHO collaborating centres was necessary to clarify several points about the disease that still remained obscure. However, on the basis of present knowledge one could conclude that even if monkeypox caused isolated cases of disease in man there was no danger of an epidemic and no risk of compromising the success of the smallpox eradication campaign. This conclusion also appeared in the report of the informal group of experts that had met to discuss monkeypox and related viruses in Geneva in February 1976.

Dr HENDERSON (Smallpox Eradication) said he believed the best evidence that there was no animal reservoir of smallpox, was that no "spontaneous" outbreaks had occurred in smallpox-free areas, other than those due to imported cases. If there were an animal reservoir, it would be expected that cases would have occurred in such countries as India, Nigeria, and Pakistan. The detection of cases of monkeypox in Zaire was a real tribute to the efficiency of the surveillance mechanism, especially as many of the cases had been found in extremely remote areas. In West Africa a number of surveys had been carried out in the areas where cases of monkeypox had occurred, but there had been no evidence that additional cases had been missed. As the work continued it became increasingly unlikely that there were any reservoirs of smallpox. Nevertheless, the expert group that had met in February 1976 had felt it most important that surveillance should be continued in the previously endemic areas. In addition, laboratory studies of a highly technical nature were being undertaken to learn more about the presence of poxviruses in birds, mammals, etc. although it was unlikely that these constituted any real risk.

Dr GOMAA (Egypt) said that in spite of the very satisfactory results of the smallpox eradication programme, it was essential to study all the possibilities before deciding to relax the preventive measures, especially as modern communications could lead to a very rapid spread of any outbreak.

Dr FAKHAR (Iran) said the question of primary vaccination had already been raised by the delegates of Greece and Kuwait. He, too, believed that, although the last focus of smallpox in the world was likely to have been eliminated in a few months' time, it was necessary to continue vaccination and surveillance in those countries with poorly developed health networks, especially in rural areas.

Dr FLEURY (Switzerland) also emphasized that although the brilliant results of the smallpox eradication programme were to be welcomed, efforts could not yet be relaxed. Switzerland would again make its contribution to the programme in the form of freeze-dried vaccine.

Professor REID (United Kingdom of Great Britain and Northern Ireland) said that in view of the unfortunate United Kingdom experience three years previously, he wished to stress the

importance of the proposed action regarding laboratories. It was necessary to consider at the highest expert level whether the maintenance of variola virus cultures by such laboratories was really essential in the medium or long term. If it was, the number of laboratories handling the virus should be reduced to an absolute minimum and highly specific, carefully devised precautions should be introduced. This was not a matter where national or professional prestige was of any relevance, but it was a global issue on which Member States should accept the guidance of WHO. The international certificate of vaccination against smallpox should clearly be restricted to travellers who had been visiting a smallpox infected country within the preceding 14 days. It was rumoured that the International Olympic Committee was requiring that all athletes going to Canada later in 1976 should be vaccinated. If that were really the case he suggested to the Director-General that some urgent health education was needed. He announced that his delegation would be joining with others in co-sponsoring a draft resolution dealing comprehensively with the matters raised in the report.[1]

Dr HENDERSON (Smallpox Eradication) confirmed that the medical committee responsible for advising the International Olympic Committee had indeed recommended that vaccination certificates should be required from all athletes. He had been assured by the Canadian delegate, however, that Canada would not in fact require such certificates except from athletes coming from countries that had been infected with smallpox within the preceding 14 days. Nevertheless, the opportunity to provide a little health education would not be missed.

Dr RODRÍGUEZ TORRES (Spain) said that at the Twenty-sixth World Health Assembly in 1973 his delegation had had occasion to explain his Government's policy at that time with regard to smallpox vaccination.[2] Having heard the account given by Dr Henderson of the results of the eradication programme, he believed that it was necessary for his country's National Health Council to meet with a view to modifying the policy in the future.

Dr JOSHI (Nepal) said that while the Director-General and his staff and the countries that had participated in the smallpox eradication programme were to be heartily congratulated on its success, he would also like to pay a tribute to Dr Edward Jenner who had invented smallpox vaccine and thus provided the weapon that had made eradication possible.

Dr RAKOTOMANGA (Madagascar) expressed some doubts about the suggestion that international vaccination certificates in future be required only from travellers coming from infected countries. He thought it would be preferable to wait two or three years before taking such a decision. This would also have the effect of encouraging countries not to relax the measures that they had taken so far.

Dr KLIVAROVÁ (Czechoslovakia) said that her delegation was pleased to note the close attention given by the Director-General to smallpox eradication, in accordance with resolution WHA28.52. The fact that the disease now occurred only in one part of the world was a matter for great satisfaction. It was one of WHO's greatest successes in the field of communicable diseases control in general. The extent of that success became more apparent if one considered that 18 years ago, when the delegation of the Soviet Union had proposed to the World Health Assembly a plan for the global eradication of smallpox, the disease had existed in 59 countries in Asia, Africa and Latin America and had been endemic in 49 of them. Amongst the factors that had led to that success, she would stress the importance of the combined efforts and intensive cooperation of the Member States of WHO and international governmental and non-governmental organizations, an up-to-date scientific approach to the solution of the problem, accurate evaluation, systematic programming and improvement of epidemiological surveillance activities.

Czechoslovakia had constantly supported such a scientific approach and had contributed to the implementation of the programme by providing supplies for vaccination campaigns and experts for eradication programmes such as those in India and Bangladesh. During the past years 7% of the short-term and long-term consultants in this field had been provided by Czechoslovakia.

Her delegation congratulated WHO on the successes achieved; the prospects of reaching the target of global eradication of smallpox by 1978 were very real. Nevertheless, she would stress the need to maintain an effective surveillance system and to give more attention to such problems as variola-related viruses, and animal reservoirs (particularly monkeys and other primates) as potential sources of infection. It was essential to ensure adequate financing of the final stage of the programme.

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[1] For text, see p. 391.

[2] See WHO Official Records, No. 210, 1973, p. 286.

Dr BORGOÑO (Chile) stressed that smallpox control had been possible on account of the joint efforts made both by the countries affected and by those countries which had cooperated by providing vaccine, technical assistance, or financial aid. Such cooperation should be encouraged with regard to future priority eradication programmes.

Referring to the vaccination of international travellers, he felt that a resolution should be passed recommending countries to require certificates from anybody who had been in an infected area up to 14 days previously. As far as international vaccination policies were concerned, countries should be left to make their own decisions in the light of the information provided.

As far as epidemiological surveillance was concerned, good communications and a high degree of international collaboration were essential to enable countries to take the relevant measures.

In conclusion he wondered whether it would be beneficial to utilize the infrastructure from the smallpox programme for the expanded immunization programmes, as the experience acquired would be of value.

Dr GEZAIRY (Saudi Arabia) said that in spite of the positive results achieved, his delegation was concerned with the possibility of eradicating smallpox in the last country infected, particularly in view of the reports about the intention of the Government of the country in question to increase its intervention in Eritrea particularly through the mobilizing of volunteers from rural areas. Such a move might well delay and hamper control of the disease, as many of the civilians might take refuge in neighbouring countries. Saudi Arabia, with over 1 000 000 pilgrims each year, would find it difficult to ensure that all pilgrims from that area were not infected, hence it would be impossible to ensure that they would not transmit the disease to other countries of the world. In such circumstances, it would be very difficult to accept the proposal to discontinue the requirement for an international certificate of vaccination against smallpox. He suggested that WHO should issue a circular for guidance. He supported the United Kingdom view that stocks of variola virus should be maintained in only a very limited number of laboratories.

Dr HENDERSON (Smallpox Eradication) replying to the question raised by the delegate of Chile as to the possibility of utilizing the infrastructure developed for the smallpox eradication programme for the expanded immunization programme said that because each country had developed a different smallpox eradication programme which best fitted in with its own health structure, the question was not easily answered. An encouraging aspect was that the smallpox programme had involved health units and health services very intensively and at all levels in every country. Some countries had proved that it was possible to organize an immunization programme quite well and without great expense by obtaining the full cooperation of the local people in terms of acceptance of vaccination and reporting the disease.

Referring to the current concern about camelpox, a report of which had appeared in a reputable medical journal indicating that camelpox looked much like variola minor, he emphasized that that report had unfortunately been premature and that it had since been demonstrated by three different laboratories that many of the characteristics of camelpox and smallpox were different and that as far as it could be determined, human infection of camelpox did not occur.

Dr ONYANGO (Kenya) said that his delegation supported the proposals put forward by the Director-General and the Executive Board, particularly in connexion with the budgetary requirements of the additional studies needed to ensure the elimination of all reservoirs of infection and the measures necessary to prevent possible accidental infection from laboratories carrying stocks of variola virus. It was to be hoped that the international certificate of vaccination against smallpox would shortly no longer be required.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) said that congratulations were, of course, due to all those who had contributed to the smallpox eradication programme, which was now nearing a successful completion. The important thing for the future, however, was to study the reasons for the success of the programme, to determine what lessons could be learned for immunization campaigns against other diseases, and for other WHO programmes. The programme for the final stages of smallpox eradication was clearly defined in resolution WHA28.52, which stressed the need to maintain constant vigilance and to avoid complacency.

He fully agreed that there was a need for increased caution regarding laboratory work with variola viruses and for continued research on any possible natural reservoirs for smallpox or related viruses. Although there might as yet be no evidence of the existence of animal reservoirs, the case of influenza should not be forgotten. With regard to international certificates of vaccination against smallpox, he said that the fact that certain countries no longer required them was a welcome indication of their confidence in the situation. However,

before the Assembly took any official decision to abolish the requirement for those certificates the subject should be referred to the Committee on International Surveillance of Communicable Diseases so that this important question could be considered in accordance with established procedure.

The certification of smallpox eradication was a complicated question, touching as it did upon the sovereign rights of Member States; any government had the right to refuse to accept any experts, observers or international commissions. In fact, there was complete confidence between WHO and governments, and no problems had actually arisen; indeed, the procedure seemed completely reasonable and acceptable. Care was required, however, if it were to be given some legal form; international inspection should never be allowed to infringe any government's sovereignty.

Dr CORNEJO-UBILLÚS (Peru) observed that the world had reached a critical point in terms of smallpox eradication because a change in the modus operandi was necessary, and that a good deal of caution would have to be used by WHO to avoid over-confidence with respect to the measures to be taken in the future. First, due consideration should be given to the prediction that the current year would be the last in which a case of smallpox would appear. Secondly, as vaccination on a world scale was extremely difficult to achieve, he wondered whether research had succeeded in eliminating the possibility of there being clinical forms of smallpox, which, by analogy, might be considered similar to the attenuated forms of other diseases. The question might seem strange but it was essential to cover even the slightest risk of resurgence. Lastly, if widescale vaccination were discontinued, there would be ecological and immunological repercussions involving two basic risks: the first, relating to laboratories, was everpresent but controllable; the second was the biological possibility that smallpox had non-human reservoirs. Epidemiological surveillance was therefore essential.

When the time came, therefore, for recommendations and resolutions, the financial aspect should properly be taken into account, in view of the possibility that some institutions or countries might consider, somewhat exaggeratedly, that smallpox was practically at an end. He consequently strongly recommended that despite virtual eradication, adequate finances should be made available to cover the cost of research into the possibility of non-human reservoirs of the disease. It might also be advisable, once the last case had been identified at world level, to maintain a number of laboratories for an indeterminate period, bearing in mind that immunity could be lost over the years.

Referring to international certificates of vaccination against smallpox, it was perhaps overoptimistic to consider discontinuing them in certain areas or countries. It would be more advisable at the present stage to refer the matter to an expert committee on smallpox or the Committee on International Surveillance of Communicable Diseases for a final recommendation. In the meantime the certificate should be kept in its present form.

Finally, countries would be well advised to accept WHO recommendations on vaccination but these recommendations should provide alternatives to enable countries to act in accordance with their own findings and the world outlook.

Dr HENDERSON (Smallpox Eradication), replying to points raised, explained that the Director-General had proposed that countries should request certificates for vaccination only from those travellers coming from an infected area within the preceding 14 days, a proposal totally consistent with present International Health Regulations. Evidence showed that the majority of imported cases occurring as a result of international travel, had for the most part, over the last 10 to 15 years, been from Bangladesh, India and Pakistan, reflecting travel patterns. The most impressive degree of surveillance and search imaginable was underway in those countries. Although Ethiopia also had smallpox, a review of the records over the past 25 years showed that no case appeared to have been exported either by sea or air by an international traveller during those 25 years, and although the risk of importation from Ethiopia was very small, it would seem prudent to require every traveller coming from that country within the preceding 14 days to carry a valid certificate of vaccination.

WHO had endeavoured since the beginning of the programme to forecast current and future progress. An attempt had been made in the report to reflect the fact that a great deal of work still remained to be done. The procedure of international commissions had to be followed throughout all endemic areas to be sure that two years had elapsed since the last known case had occurred, during which period there would have been sufficiently sensitive surveillance to detect any cases that were present. That was the definition that had always been followed, and experience had shown that the longest period in which smallpox had been present in a country without detection was 8 months, which had occurred on only one occasion. The procedure of international commissions had always been that a group of experts from various countries convened at a suitable centre for a few days to review documents, to consider progress and programmes, and then to visit the field to see how the situation compared with the data presented. The experts would then return to base to reconsider all the information and

determine whether or not they were fully satisfied that there had been no occurrence of smallpox in the country concerned over a given number of years. Such action could indeed infringe the sovereign rights of governments, but in fact commissions had met only with a total willingness to cooperate. Such cooperation would hopefully continue until all countries were confident that a reasonable job had been done and that a group of experts were satisfied on behalf of the international community that there was no smallpox in the area.

The DIRECTOR-GENERAL pointed out that when referring to sacrifices of national sovereignty delegates should realize that their respective governments had signed a Constitution that provided that such sacrifices of national sovereignty might be made for the international benefit of the total membership. Such provision was made under Articles 19, 20, 21 and 22. Members would be well-advised to study the constitutional provisions because sacrifices might become necessary one way or another in order to finalize the issue concerning the status of smallpox eradication on a global scale.

The meeting rose at 11.25 a.m.

FIFTEENTH MEETING

Monday, 17 May 1976, at 2.30 p.m.

Chairman: Dr P. TUCHINDA (Thailand)

2. REPORTS ON SPECIFIC TECHNICAL MATTERS Agenda, 2.5

Smallpox eradication programme (continued) Agenda, 2.5.9

Dr OSMAN (Sudan) said that the eradication of smallpox was one of the most brilliant achievements of WHO. In Sudan eradication had practically been achieved by 1972. However, he endorsed the views expressed by the delegates of Egypt and Peru on the need for serious studies and for strict precautionary measures to ensure that there was no resurgence of the disease. BCG vaccination in combination with smallpox vaccination was being carried out in Sudan, and it was hoped that WHO, in cooperation with national health authorities would mobilize the needed efforts to eradicate tuberculosis also. He expressed his country's interest in WHO's future policy on immunization and vaccination programmes in countries that had recently achieved smallpox eradication. His own country's national health plan, developed jointly with WHO and planned until 1982, gave highest priority to the development of primary health care in all rural areas, which would also carry out vaccination against a group of diseases.

He referred to the serious health problems affecting the large numbers of Eritrean refugees from Ethiopia, and the great efforts being made by the Sudanese health authorities and international agencies to cover their curative and preventive health needs.

Dr COLE (Guinea) stated that smallpox had been eradicated in Guinea but, in accordance with WHO advice, strict surveillance continued. The quality of the vaccine produced in Guinea had been recognized by WHO, and production was continuing, though at a reduced level.

Professor HALTER (Belgium) said that his country had been sceptical about the vaccination programme but now recognized that WHO had pursued the right course. He congratulated the Secretariat on its achievement. As the last case of smallpox had almost been reached, he suggested that a world conference should be held on the eradication of smallpox, which would bring together the experience gained and provide guidelines for the future.

He was concerned at the conservation of highly dangerous viruses in certain specialized laboratories, and suggested that all such stocks should be destroyed. He questioned the necessity of keeping them, despite the risk of populations being deprived of their immunity after cessation of vaccination. The danger of such viruses being used in biological warfare should not be excluded. He would welcome a further statement from the Secretariat.

Dr SETIADI (Indonesia) stated that his country had, together with WHO, been fighting smallpox since 1968. The disease had been eradicated in 1972, and in 1974 his country had been officially declared free from smallpox by an international commission. His delegation expressed its continued support for WHO in its fight against smallpox.

Dr HASSOUN (Iraq) said that his country had had its last case of smallpox in 1972 but that compulsory vaccination would be continued throughout the country until WHO advised that vaccination could cease. The technical and scientific papers on smallpox which had been disseminated through the regional offices had been most important in the campaign against the disease, and he hoped that this service would continue. He paid a special tribute to WHO and to Dr Henderson.

Dr JOYCE (Ireland) stated that his delegation had changed its opinion since the previous session in the face of the magnificent achievement of WHO. He felt that the question raised by Professor Halter, concerning the destruction of virus cultures, was most important.

Professor SENAULT (France) thanked the Secretariat for its work, especially in the field, where conditions were difficult. He expressed his agreement with the report submitted by the Director-General, especially the concluding paragraph of the section on vaccination policies, which

stated that ". . . it is apparent that any broadly applicable proposals in regard to recommended vaccination policies for most countries would, at this time, be premature". In France the advantages and disadvantages of discontinuing compulsory vaccination were being debated. The other question raised by Professor Halter was a matter of international ethics, and it was to be hoped that the situation he envisaged would never arise. The French delegation was conscious of the danger, once smallpox had been eradicated, that medical and public health schools would cease teaching the subject and health workers would, therefore, be unable to diagnose the disease in the future. Perhaps the Director-General should be asked to warn health authorities that no hasty decision should be taken in that respect.

Dr TARIMO (United Republic of Tanzania) stated that his delegation was most satisfied with the progress that had been made in the smallpox eradication programme and felt that it was a good example of what could be achieved by collaborative effort. He paid a special tribute to the father of smallpox vaccination, Edward Jenner, and hoped that scientists at present working on new vaccines or immunization programmes would draw inspiration from him, since in those programmes lay the answer to many health problems, especially in the developing world. He noted the work of the international commissions on smallpox and, while not feeling competent to comment on the usefulness and relevance of the commissions, wondered whether their work was essential in view of the current financial constraints suffered by WHO and Member States. Of course, countries needed assurance that smallpox had actually been eradicated, but there was such confidence in the judgement of WHO that he questioned necessity of having that judgement confirmed by a commission.

Dr KITAW (Ethiopia) noted that, as stated in Weekly Epidemiological Record, No. 19, Ethiopia was the only country which was still reporting smallpox cases. The villages still infected were mainly in the centre of the country in a very remote and rugged part of the northern plateau. Before the smallpox eradication programme started, Ethiopia had been reporting about 2000 cases a year, and with the launching of the programme the figure had been multiplied almost tenfold. He hoped that the last case of smallpox would be reported in 1976, and that the total for the year would be far less than 2000.

Smallpox had always been associated with high mortality and disability in Ethiopia, but in recent years fatalities had been quite low. The eradication programme had had to overcome resistance to vaccination due to religious or cultural factors and belief in variolation. The size of the country, the difficulties of the terrain and communications problems, with widely scattered inaccessible village communities, made the implementation of health services in general extremely difficult; this only served to emphasize the importance of the present achievement. The health status of Ethiopia's population was one of the lowest in the world in those areas where the effects of the recent famine were still felt. He hoped that the eradication of smallpox would open a new era for health service activities in Ethiopia.

Dr AMINUDDIN (Pakistan) expressed his gratitude to WHO on the marvellous achievement of reaching the threshold of global eradication of a disease dreaded throughout the world for centuries. This had proved that near miracles could be attained with determination, and with willing and active cooperation in pursuit of a common, acknowledged goal; it also strengthened faith in the Constitution of WHO.

Thanks to WHO, Pakistan had been the first among the countries of the south-east Asia region, where smallpox had still been endemic in the recent past, to achieve target zero, the last known case being recorded in October 1974.

However in view of rapid technological achievements in communications on the one hand and, on the other, experience of the tricky nature and behaviour of other epidemics in the past - of which cholera might be a pertinent example - it was perhaps unnecessary to stress that continuous and relentless surveillance, with the cooperation of Member countries and the guidance and active support of WHO, should not be relaxed.

Dr COCKBURN (Director, Division of Communicable Diseases), answering the various questions raised by delegates, felt that the Director-General might be interested in a world conference with a view to consolidating knowledge and discussing strategies. On the question of whether or not to retain major and minor strains of smallpox virus, he said that it was important that laboratories should have access to the virus in case a similar virus or a mutant from animal strains arose. On the point raised by the delegate of France, he said that smallpox had been such an important disease that it was unlikely to be forgotten in medical schools for some time to come. The international commissions had been set up because it was believed necessary to have an independent method of assessing the situation. Those commissions were expensive, but he thought that the expense was justified, given the importance of ensuring eradication of smallpox.

The CHAIRMAN noted that a draft resolution proposed by the delegation of the United States of America and others would be distributed in time to be discussed the following day.

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

Expanded programme on immunization (annual progress report) Agenda, 2.5.8

The CHAIRMAN drew attention to the Director-General's progress report, and to the draft resolution proposed by the delegations of Canada, Norway, the Philippines, Sweden and Switzerland, which read:

> The Twenty-ninth World Health Assembly,
>
> Having considered the Director-General's progress report on the expanded programme on immunization,
>
> 1. NOTES with satisfaction the progress made in the planning of the programme and in its initial activities;
>
> 2. EMPHASIZES again the high priority to be given to the programme with a view to ensuring its rapid expansion;
>
> 3. RECORDS its appreciation of the important role that UNICEF is playing, jointly with WHO, in supporting national immunization programmes;
>
> 4. THANKS the governments and the agencies that have already contributed to the programme;
>
> 5. URGES all governments and agencies that are in a position to do so to contribute funds, or their equivalent in equipment and supplies, to the Voluntary Fund for Health Promotion (Special Account for the Expanded Programme on Immunization), or to make sufficiently long-term contributions on a bilateral basis;
>
> 6. COMMENDS the Director-General's intention of merging the smallpox eradication programme and the immunization programme during the next two years; and
>
> 7. REQUESTS the Director-General to keep the World Health Assembly regularly informed of the progress made.

Professor KOSTRZEWSKI (representative of the Executive Board) said that the expanded programme on immunization had been considered by the Board at its fifty-seventh session as a new and important development in WHO work. There was an urgent need for coordination between WHO, Member States and other organizations, and for assurance of long-term support and commitment by all parties concerned. The Executive Board had considered that it was time to move from the preparatory to the implementation stage. The success of the programme on immunization depended on its integration with programmes of maternal and child health and primary health care services and, in particular, on the will of Member States to carry out the long-term effort required. The Board had stressed the importance of getting the programme under way as quickly as possible.

Dr COCKBURN (Director, Division of Communicable Diseases) introduced the progress report by the Director-General which noted the severity of the six diseases, discussed strategies and tactics for the programme, and commented on its implementation, the numerous constraints, and its present state. He stressed the great interest which UNICEF had shown as a partner of WHO and Member countries. Denmark, the Netherlands and Sweden had donated money; Yugoslavia, Nigeria, Egypt and Botswana had given vaccines. He made particular mention of the applied research being carried out in Ghana, where an operational study was being made on the delivery of immunization in a rural and an urban district: it covered the questions of cold chains, vaccine distribution, simplification of transport, and the minimum number of doses necessary to provide satisfactory immunity. There was also a research project in Kenya, in association with the Government of Kenya, WHO and the Royal Tropical Institute, Amsterdam, which was producing remarkable information on the behaviour of measles in Africa which (together with other research in that area and elsewhere in Africa) suggested that the immunological responses of African peoples should be further studied, since they seemed to differ considerably from those of people living in temperate climates.

Other major work was being carried out on the stability of the measles vaccine. Producers of vaccines had been approached, and there was a specific project at the London School of Hygiene on making that vaccine more stable. Arrangements had been made with laboratories in 16 countries to test vaccines. The intention was to concentrate on national rather than on regional seminars. Research on cold chains had been started in Sweden and a consultant was currently studying methods of simplified refrigeration. A development of cooperation in programme planning between Member States, WHO, UNICEF and some of the bilateral agencies was being considered.

Dr BORGOÑO (Chile) said that his country had had long and wide experience with nationwide, integrated vaccination programmes. Smallpox eradication had been achieved 23 years ago. With regard to diphtheria, pertussis, tetanus and measles, morbidity had been reduced by more than 80% and mortality by some 90%. Poliomyelitis had disappeared, and 85% of the newborn and schoolchildren received BCG vaccination. Chile had collaborated with PAHO and WHO in

field studies on the introduction of new vaccination techniques and studies on the efficacy of new antigens.

The expanded programme on immunization should be given high priority amongst WHO's activities, not only because it was aimed at controlling health problems that were important in developing countries, but also because the cost/effectiveness of immunization programmes was high: they resulted not only in a reduction in mortality and morbidity, but also allowed doctors, nurses and other personnel to devote more time to other health problems. Moreover, they were in line with the resolution that had been adopted concerning a new orientation in the distribution of budgetary resources.

He was concerned that the lack of an adequate infrastructure in many countries might give rise to problems in implementing immunization programmes; in particular, in rural areas there would be difficulties in keeping biological substances in good condition. All efforts made by countries, with the help of the Organization, to improve that situation were of the greatest importance; in that connexion, the operational studies being carried out in Ghana and Kenya were to be particularly welcomed.

The studies to improve the stability of measles and poliomyelitis vaccines were vitally important, and WHO should continue its crucial role of stimulating and furthering such studies. An operational manual for immunization programmes should be produced and norms for the standardization of vaccines established, as had been done for the smallpox eradication programme.

The periodical evaluation of programmes was most important; it should include not only the coverage achieved, but also the epidemiological effects, and should cover certain administrative and technical aspects, such as the potency of the vaccine used and the quality of the information collected.

Consideration should be given to establishing a coordinated programme for the provision of vaccines with the cooperation of the producing laboratories, the countries donating biological substances, and UNICEF.

Chile was prepared to provide all technical collaboration that WHO might deem appropriate, and supported the draft resolution.

Dr SUMPAICO (Philippines) said that in his country the activities of the expanded immunization programme were carried out in collaboration with WHO. He expressed appreciation of the assistance provided by WHO, both at headquarters and through the Regional Office for the Western Pacific, in the form of consultant services, planning, coordination and evaluation; and he thanked UNICEF for providing equipment and supplies; the Netherlands Government for technical expertise; and France for awarding three short-term fellowships at the Pasteur Institute. Seminars at regional and national level had helped to ensure that well-informed and trained manpower was available to implement the programme. The targets for diphtheria, pertussis, tetanus, and BCG immunization had been established with the intention of increasing coverage by 15% each year, dependent on the ability of the Philippines to produce the required vaccines and the organizational infrastructure. It was hoped that full immunization would be in force within five years.

Dr GERRITSEN (Netherlands) said that his Government had provided financial support and technical assistance for the production and control of vaccines. It was to be hoped that resources would become available from the smallpox eradication programme and that the expanded programme on immunization would have a good start; the experience gained and the operational structures formed would be of great value, and the difficulties experienced during the smallpox eradication programme could be avoided in the expanded programme. The management of a world programme depended on the activities of public health services within countries, and there therefore should be coordination between them and at the different international levels. An effort should be made to procure extrabudgetary funds, as long as the regular budget could not meet the needs of the expanded programme.

His delegation gave its full support to the draft resolution.

Dr SUDSUKH (Thailand) said that the report before the Committee contained valuable information in relation to programmes of immunization. The variety of diseases against which immunization was to be employed had to be justified in the light of the epidemiological background and local circumstances. For example, in countries like his own, immunization against measles was unnecessary because of the low mortality from the disease. Effective immunization services required planning at all levels and a comprehensive and integrated approach, the immunization services being integrated into the basic health services. In Thailand the programme formed an integral part of the provincial health care project, which was one of 19 projects in the fourth five-year national health development plan covering the years 1977-1981.

The report listed a number of strategies: the mobile team strategy, the static health unit strategy, and the mixed strategy; in his country stress had been placed on a mixed strategy, in which normally static health workers periodically became mobile. Such a strategy seemed the most suitable for his country because of its cheapness, convenience, and general acceptance.

The mobile team did not concern itself only with immunization: it provided comprehensive health care. The strategy was devised in cooperation with WHO, and when it was evaluated the result was found to be satisfactory in terms of cost and increased coverage.

For the success of the expanded programme on immunization, it was essential that there should be a full exchange of information and experience, either in the form of publications or in the form of meetings. WHO should also take part in a full evaluation of the coverage achieved and the effectiveness of the immunization programme.

His delegation approved of the report and would vote in favour of the draft resolution.

Dr ONYANGO (Kenya) said that his country was undertaking some of the studies mentioned in the progress report before the Committee as WHO priorities for the improvement of general immunization practice and techniques, and had the benefit of WHO collaboration in doing so. It was endeavouring to find out the rate of decline of maternally acquired antibodies and the optimum time to give immunization against measles.

One of the problems in Kenya was the low coverage of the childhood population. Another was the presence of fever in children brought to be vaccinated. At present children were being vaccinated even if they had fever, since as yet there did not seem to be any reason why they should not be vaccinated; but he would be glad to have information on the desirability of the practice. His delegation also wished for further technical cooperation with WHO in the planning and implementation of the immunization programme in his country.

Dr DOLGOR (Mongolia) considered that the choice of the six diseases mentioned in the report was excellent, as all the diseases could be prevented by determined effort. As the smallpox eradication programme had shown, much could be done to eliminate those diseases, and vaccination was the basic weapon. In Mongolia there had been no smallpox since the 1940s. In the years 1958-1966 there had been 1402 cases of diphtheria and 47 465 cases of pertussis, but in 1975 no case of diphtheria had been reported, and the number of cases of pertussis had been reduced a hundredfold. Childhood tuberculosis had been reduced six-and-a-half-fold. Measles in 1973 had been reduced ninefold by comparison with 1972, and in 1975 no cases had been reported. The situation was similar with regard to the other diseases mentioned in the report. Those achievements were due to a well-organized programme of immunization, which had been carried out in close cooperation with WHO. The task ahead involved the strengthening of the results achieved, study of the immunity status of the population and maintenance of the required immunity level. So long as there were carriers of bacteria and viruses and the danger of diseases being imported, the absence of cases during one or two years should give no cause for complacency. Mongolia was therefore carrying out a continuing programme of epidemiological surveillance.

He supported the proposed future programme of WHO, particularly with regard to the monitoring of vaccine potency, the training of specialists, and the provision of vaccines.

He expressed thanks to the USSR, Yugoslavia, the Netherlands and other countries that had provided considerable assistance for the eradication of smallpox and control of other infectious diseases and had shown their readiness to support WHO's expanded programme on immunization.

Dr THOMPSON (Nigeria) said that the success of the smallpox eradication programme in Nigeria had been due to the availability of the resources needed, and success in the expanded programme on immunization would depend on the same availability. In the conduct of an expanded programme, WHO had helped in the formulation of a strategy for a pilot project in one of the Nigerian States. Static health care units were being involved, and a mobile team approach was being considered. The problem however was the difficulty of reaching the target population: for example, only about 20% of pregnant women attended for prenatal care, and only a proportion of them returned to have their children immunized. A mobile team approach might perhaps succeed in extending immunization to remote areas. In the pilot project a health education unit was trying to encourage the target population to take advantage of the project. There remained the problem of malnourished children; it was still not clear that such children would benefit sufficiently from vaccination. For the expanded programme to succeed, the same military precision might perhaps be needed as had been employed for the smallpox eradication campaign.

Dr LEAVITT (United States of America) said that the expanded programme on immunization was a timely initiative. It followed the smallpox eradication programme and should be able to take advantage of the demonstration of the effectiveness of immunization as a method of preventing disease. But the expanded programme was not a time-limited programme, and the same dramatic success as had been achieved in smallpox eradication should not be expected. The programme must continue, for if it was interrupted the diseases would recur and the programme would be discredited. For that reason his delegation was pleased to see from the report that it had been stressed in all discussions with national health authorities

that their plans must include measures for the acceptance of full financial responsibility by the countries themselves as quickly as possible.

The success of the smallpox programme had depended very largely on epidemiological surveillance rather than on vaccination alone. The report paid very little attention to epidemiological surveillance, and it was to be hoped that it would receive appropriate attention during the implementation of the programme.

Finally, it was doubtful whether the best method of evaluating the programme was an annual meeting in Geneva of programme directors, donor agencies, UNICEF, UNDP and others. Coordination could probably be carried out without such meetings.

Miss PINTO DE CARVALHO (Mozambique) said that the report provided useful information on immunization and her delegation would support any resolution providing assistance to countries in the conduct of immunization programmes. In her country before independence vaccination had been carried out only sporadically, in an unplanned manner. After independence an epidemiological study had been carried out and it had been decided to give priority to preventive medicine, with the aim of planning immunization programmes as an integral part of national reconstruction efforts. An immunization schedule had been established, and children and pregnant women were being vaccinated. A nationwide mass vaccination campaign would start at the beginning of June, with the support of WHO, UNICEF and UNDP. The success of the programme would depend on the collaboration of international organizations and individual countries and on the integration of the programmes into the basic health services.

Dr BONDZI-SIMPSON (Ghana) said that over 60% of hospital admissions and over 60% of childhood morbidity in his country were due to communicable diseases, many of which could be prevented by immunization. It had been decided that immunization should be extended to cover children in the rural areas, but such an extension created a number of difficulties in relation to transportation, the use of effective vaccines, and the development of immunization schedules. With WHO help, a study was being made of ways of using fixed centres and mobile field teams, the ultimate aim being to provide immunization for the whole country, taking into account the limited resources available. Operational and serological studies would be conducted in the densely populated south and sparsely populated north of the country, using different schedules for the vaccines. A review of the studies would be carried out at the end of the first year to determine how to improve the coverage by the fixed centres and the mobile field teams and to assess the immunological response. After two years an evaluation would be carried out with the help of WHO and SIDA. It was hoped that the programme would start towards the end of the rainy season.

Dr FLEURY (Switzerland) said that the Director-General's brief report contained the first results of long-term preventive effort aiming at giving developing countries a basic health structure that could deal with the enormous health problems facing them. The programme would be faced with many difficulties, not least among them being the conservation of the vaccines. For that purpose, more research would be needed. In his and in other countries, private associations played a large part in health work; in his view an attempt should be made to make them fully aware of the importance of immunization and of the need to coordinate their efforts with those of countries and the international organizations. Now that the smallpox eradication programme was coming to a close, the expanded programme on immunization should take its place. The Director-General's report was very timely, and the preventive approach recommended in it was the best.

Dr del CID PERALTA (Guatemala) said that the expanded programme of immunization would go far towards achieving the same control of the six diseases mentioned in the report as had been achieved by the smallpox eradication programme. One of the essential requirements for its effectiveness would be the strengthening of the health structure in countries, especially in the rural areas. Another requirement was sufficient supplies of stable vaccines. Programmes of immunization were easy to begin but difficult to maintain, and WHO could help by making cheaper vaccines available and providing systems of credit, and by enrolling institutions that could help the developing countries.

Dr JAROCKIJ (Union of Soviet Socialist Republics) said that the decision to expand the immunization programme had in fact already been taken. Experience with smallpox had shown that a clearly elaborated methodology, a scientific approach and the active support of health services yielded excellent results. However, several aspects regarding implementation of the programme required further clarification.

The formulation of any programme called for a clear definition of aim, place, the time and material resources required, strategy and tactics. The objectives were clearly defined in the report before the Committee, but the priorities for individual developing countries, or

groups of countries were not indicated. The programme also needed considerable revision with regard to the definition of requirements concerning time, experts, vaccines and other supplies. That was particularly necessary in view of the fact that countries would have to accept responsibility for the implementation of the programme, and in that connexion he agreed with the remarks made by several delegates, including the delegate of the United States of America. In other words, a more scientific basis was needed for the programme. The discussion had shown that there was a whole series of unsolved problems. It was necessary to envisage the establishment of laboratories and the training of national personnel for the quality control of vaccines. Lack of organization or failure to observe vaccination schedules would prejudice the success of the immunization programme.

The report contained no information on the thermostability of vaccines, a most important factor in hot climates. As was well known, the development of a stable live smallpox vaccine had produced a revolution in the tactical approach to smallpox eradication. In the immunization programme it was proposed to use both live and killed vaccines whose stability under special conditions was either low or had not been sufficiently studied. Further research was therefore necessary to develop highly potent and stable vaccines, particularly suitable for use in tropical countries; the use of stabilized freeze-dried vaccines would seem to be particularly appropriate, and would allow for a considerable saving in requirements for refrigeration facilities. In the USSR killed, freeze-dried pertussis, diphtheria and tetanus vaccines that were stable in high temperatures had been developed, and experience had been acquired in the transport in tropical areas of poliomyelitis vaccine in polystyrene containers with gelatine cooling agents. The Soviet Union would be pleased to cooperate with WHO in those fields.

His delegation agreed on the need for further development of the immunization programme. The USSR was prepared to assist developing countries in that respect by providing specialists, carrying out research on the development of stable combined vaccines and on vaccination schedules, developing methods for evaluating the effectiveness of immunization programmes, and providing advice on the production and quality control of vaccines.

He proposed the following amendments to the draft resolution:

(1) to replace the present text of operative paragraph 1 by the following:

1. NOTES with satisfaction the efforts made to develop the programme;

(2) to combine operative paragraphs 4 and 5.

(3) to insert a new operative paragraph 5 with the following text:

5. COMMENDS the Director-General's intention of merging the smallpox eradication programme and the immunization programme during the next two years with a view to using the many years' experience of smallpox control and at the same time taking into account the considerable differences, peculiarities and complexities of vaccination against other infections;

(4) to insert a new operative paragraph 6 with the following text:

6. RECOMMENDS to the Director-General the carrying-out of special research to evaluate the effectiveness of vaccination in countries with differing climatic and socioeconomic conditions and also to develop qualitatively new, more effective and heat-stable vaccines against the six diseases included in the programme and also other diseases against which vaccines have not yet been developed;

(5) to insert a new operative paragraph 7 with the following text:

7. INVITES the Director-General to intensify efforts to develop a detailed immunization programme that would take into account the multitude of different factors involved, have a thoroughly sound scientific basis, be in harmony with the aims of WHO's Sixth General Programme of Work and have the prospect of being implemented continuously over a long period, particular account being taken of the programmes on primary health care;

(6) to renumber the present paragraph 7 as paragraph 8, leaving it unchanged.

Dr CHUKE (Zambia), supporting the draft resolution, said that his country had benefited from WHO technical expertise in restructuring its immunization programme, a programme that had been designed to take into account the existing communications system, refrigeration facilities, and the feasibility of using cold chain boxes in areas without 24-hour availability of electricity. A special committee comprising health workers, community development officials,

Ministry of Education officials, local political units and the communications media had been set up in each province and had worked out the logistics of immunization in rural areas.

An expanded programme had already been launched in urban areas, but its implementation in rural areas would necessitate greater expenditure on ensuring mobility of staff to deal with the scattered population. His country was grateful to WHO for the provision of vaccines and hoped to see bulk purchase schemes introduced in the future. One important requirement in countries at a great distance from the source of production was for quality control of the vaccines.

Dr DAVIES (Sierra Leone), welcoming the WHO initiative in the field under discussion, said that she had noted the pilot studies that were being carried out in Ghana and Kenya in collaboration with Swedish and Netherlands experts, and also the generous offer of vaccine made by some countries. UNICEF had traditionally supplied a substantial quantity of vaccines to many developing countries. Her experience, however, had been that UNICEF was not always able to meet its commitments as regards such vaccines, and she doubted whether it would be able to assume responsibility for the extra supply of vaccines necessary for the expanded immunization programme.

As a result of the present inflationary situation, national governments were getting smaller quantities of drugs and supplies for their money, and she felt that WHO could play an even greater part than heretofore in that field. The Executive Board considered that the time had come for WHO and Member States to move from the preparatory to the implementation stage, but it was not clear to her how that would be done. The immunization situation was most unsatisfactory in many developing countries, at least in Africa, where the irregular and inadequate supply of vaccines had given rise to an haphazard pattern of immunization.

She supported the draft resolution.

Dr JOSHI (Nepal) said that in Nepal immunization against diphtheria, whooping-cough and tetanus and also against diseases of childhood was going smoothly, but that poliomyelitis vaccination was restricted to the larger hospitals. It was possible that, until more stable vaccines became available, poliomyelitis and measles vaccination would continue to be restricted to the larger hospitals because of poor communications and logistic difficulties. Tetanus of the newborn was quite common in the western part of Nepal, and he would welcome technical advice on its prevention.

Dr GOMAA (Egypt) said that, although the Director-General's report offered hope for the future, there was still cause for concern. Eighty million children were born every year in Africa, South America, and South-East Asia, but only four million were vaccinated annually. There were other problems also, but he believed them to be capable of solution. WHO required more expert knowledge, so as to mobilize in the most effective and economical way the necessary technical staff within the public health services that were necessary to expand and raise the quality of performance of the vaccination programme.

In addition to the normal vaccination programmes, the Egyptian health service was experimenting with a poliomyelitis vaccination programme to cover all children up to the age of five years. It was being run initially as a pilot project in two provinces, before being extended to the whole territory, where the comprehensive vaccination campaign would start after four months. It was hoped to obtain the necessary technical and material assistance from WHO and the Regional Office.

He fully supported the draft resolution, but proposed the addition of the following phrase at the end of operative paragraph 2: ". . . and to meet the needs of governments, as laid down in national vaccination plans".

Dr AUNG MYAT (Burma) said that as a developing country Burma was facing the problem of many communicable diseases, some of which could be controlled by an effective immunization programme. The efforts of the Organization in the expanded immunization programme were therefore greatly appreciated. Nevertheless he believed that an immunization programme, like any other health measure, could only be successful with the full participation of the people and with the support of a sound network of basic health services to maintain its effectiveness.

Dr KLIVAROVÁ (Czechoslovakia) was pleased to see the importance attached to the immunization in accordance with resolution WHA27.57. The expanded programme on immunization, with its practical recommendations and eminently humane aim of reducing child morbidity and mortality, had won the support of the great majority of Member States. Her delegation recommended that the programme be given high priority within WHO's activities, and that all efforts be made to ensure its rapid implementation. Obviously a programme of such complexity required not only serious preparation, but also the solution of a number of theoretical and practical problems. However, two years had elapsed since the start of the planning stage

and her delegation believed that the time had come to move on to the practical implementation of the programme. That was the only way of retaining the confidence of Member States and fulfilling the vital task of promoting the health and welfare of children.

The implementation of the programme would not be an easy matter. Since it was to be implemented at regional or country level, it would be necessary to develop approaches that would suit the particular climatic, social and economic conditions of the countries concerned. WHO would therefore need to coordinate its work closely with national health services and make full use of all the experience, resources and equipment that were available. In many developing countries the implementation of the programme could be speeded up if it was integrated into the national health services or departments dealing with the welfare of mothers or of young people. WHO might play an important coordinating role in that connexion. Her delegation wished to see a programme devoid of any hint of a formal or mechanistic approach and, where possible, implemented in conjunction with other programmes aimed at improving conditions of health and general welfare. She believed that an integrated multidisciplinary programme to improve the health of the population and to protect the environment would have a very good chance of success. The experience of Czechoslovakia in this field would be placed entirely at the disposal of WHO.

She fully supported the draft resolution as amended by the delegate of the Soviet Union.

Professor JAKOVLJEVIĆ (Yugoslavia) said that Yugoslavia strongly supported the draft resolution and would be pleased to be included among the co-sponsors. He would, however, like to have further information on future research plans, especially as regards oral vaccines, and on what was to be done in the future to remedy faults in the cold chain.

Dr ALFA CISSÉ (Niger) said that listening to the speeches of delegations had convinced him, if indeed that were necessary, that the ultimate disease was poverty. Poverty was communicable, either directly as a result of lack of initiative and tenacity or as a result of external conditions, e.g. ideological conflicts. The report before the Committee was certainly well adapted to solve the problem on paper; but immunization was a practical problem and was not in fact a new one.

He was grateful to the Director-General for the report, since it revealed clearly what his views were both on disease and on the underdeveloped countries. One sometimes got the impression that, in discussing immunization programmes, people regarded the underdeveloped countries as a reservoir of disease, and gave their assistance primarily to prevent that disease from spreading.

He had referred initially to poverty, since it was the poor countries that were faced with problems so difficult that they sometimes wondered whether the programme was in fact feasible. Vaccines, for example, were supplied in freeze-dried or liquid form, packed in single-dose or 5-dose containers, the latter of course being cheaper; but the 5-dose container could not always be used up once it was opened, so that there was no saving on it after all. The developing countries were accustomed to receiving assistance, but the method of rendering such assistance on occasion left much to be desired. For example, when ordering or being given vaccines, they would be asked to specify the presentation, the number of doses required, and the delivery date. Having done so, they might then be informed of a year's delay in delivery, with consequent repercussions on the programme.

Moreover the developing countries could not be sure that the vaccines they ordered, whether stable or thermolabile, were really effective by the time they received them. Cases had occurred where an intensive vaccination campaign had been followed by an epidemic outbreak of the disease. If the matter was taken up with the supplier, either the cold chain or the method of injection would be blamed - but never the vaccine. It had nevertheless been proved that flasks containing sterile water had been supplied as vaccines. The African countries had asked on several occasions, both at the Health Assembly and at the Regional Committee, that the developing countries should have available - not thousands of miles away but on their own doorstep - centres for verifying the efficacy of vaccines at the time of receipt, and their effectiveness after administration. Those countries placed their trust in the suppliers of vaccine, and in a certain "science". In return they were told that it was perfectly possible to combine seven vaccines and obtain protection for an indefinite period from a single injection! If that were true, there would be no more measles, tuberculosis, diphtheria, or poliomyelitis in the world. The developing countries were often reproached for their lack of technical expertise, but they were beginning to realize that, even when they could afford the price, they did not get the product or the advice they required.

As an example of the practical difficulties that could arise, he recalled an occasion on which he had ordered vaccines costing 13 million francs, only later to be told - unofficially - that the vaccines had been taken off the aircraft to permit the loading of 3000 million francs' worth of munitions. On another occasion the supplier had given him to understand that, by offering ready money, he could obtain delivery of a shipment previously ordered by another country that was not at the time in a position to pay for it.

He had referred to the fact that defects in the cold chain were being held responsible for substandard vaccine. But the equipment making up the cold chain also originated abroad. The same was true of the vaccinating equipment itself, the syringe or the bifurcated needle, all of which had to be ordered from abroad. The instrument of choice for vaccination was the Pedojet, which would permit immunization on a massive scale. But the Pedojet was manufactured in a country where the ministry of defence held the exclusive rights. Moreover a Pedojet costing 250 000 francs could be put out of action by the breaking of a small plastic part costing only 5 francs - and the replacement part might take six months or a year to arrive. Logistic problems were almost insuperable for the developing countries.

The meeting rose at 5.40 p.m.

Smallpox eradication programme (continued from the fifteenth meeting, section 2) Agenda, 2.5.9

The CHAIRMAN invited the Committee to consider the following draft resolution proposed by the delegations of Australia, Benin, Ethiopia, New Zealand, Sierra Leone, Union of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, United States of America, and Western Samoa:

The Twenty-ninth World Health Assembly,

Having considered the Director-General's report on the smallpox eradication programme;

Noting with satisfaction that smallpox is now believed to be restricted to only a few remote villages of a single country and that interruption of smallpox transmission is believed to be imminent;

Bearing in mind the importance of completing the eradication of smallpox in the shortest possible period of time and of providing to all countries confidence in the achievement through examination of eradication programmes by specially convened international commissions two years or more after the last known case;

Recognizing the need for all laboratories which retain stocks of variola virus to take maximum precautions to prevent accidental infection;

Appreciating the importance of continued surveillance and research to provide further assurance that there is no animal or other natural reservoir of the virus;

Noting that the risk of smallpox importations by persons travelling by sea or air has so diminished that no such importations have occurred during the past 17 months;

Noting also that, as supplies of vaccine now being produced are more than sufficient in quantity to meet all current needs, an accumulation by WHO of vaccine stocks for use in the event of an unforeseen emergency could be established;

1. CONGRATULATES the many countries which have made and are making such a successful and determined effort to eradicate smallpox;

2. EXTENDS special congratulations to the 15 countries of western Africa where smallpox eradication was certified on 15 April 1976 and to Bangladesh, India and Nepal, which interrupted smallpox transmission during the past year;

3. THANKS all governments, organizations and individuals who have contributed to the implementation of the programme and requests that they continue to contribute generously to the programme until global eradication can be certified;

4. ENDORSES the procedures developed by the Director-General in the use of groups of international experts in the certification of eradication and asks for the full cooperation of all countries concerned in carrying out these procedures, so that countries throughout the world may have confidence that eradication has been achieved;

5. URGES that all governments continue to conduct surveillance for smallpox-like illnesses and to inform promptly the Organization should any such cases be discovered;

6. REQUESTS all governments and laboratories to cooperate fully in preparing an international registry of laboratories retaining stocks of variola virus but, at the same time, urges all laboratories which do not require such stocks of variola virus to destroy them;

7. URGES all governments to restrict their requests for international certificates of smallpox vaccination to travellers who, within the preceding 14 days, have visited a smallpox-infected country as reflected in the WHO Weekly Epidemiological Record;

8. REQUESTS Member countries to continue to donate vaccine to the Voluntary Fund for Health Promotion so that a reserve supply of 4 million vials of vaccine (sufficient to vaccinate 200 to 300 million persons) may be accumulated which could be made available to Member countries in the event of unforeseen emergencies;

9. REQUESTS the Director-General to obtain expert advice, through the Committee on International Surveillance of Communicable Diseases or by other means, on questions such as the need for retention of variola virus in laboratories and, if necessary, to make recommendations on the number and distribution of such laboratories and on the precise precautions which should be taken to prevent accidental infection.

Dr JAROCKIJ (Union of Soviet Socialist Republics) proposed that in the first line of the second preambular paragraph of the draft resolution, the words "believed to be" should be deleted, and that the third preambular paragraph should be amended to read:

Bearing in mind the importance of completing the eradication of smallpox in the shortest possible period of time and of ensuring confidence in the achievement by using

international groups of experts to confirm the eradication two years or more after the last known case.

Professor HALTER (Belgium) proposed the addition of an operative paragraph 10, reading:

REQUESTS further the Director-General to undertake a study of the organization of a world conference on the problems of eradicated smallpox and to report on the subject to the Executive Board and the Thirtieth World Health Assembly.

Dr LEKIE (Zaire) supported the draft resolution as a whole but had reservations regarding operative paragraph 7. At busy airports it was often impossible for immigration officials to be certain of the country from which a traveller had come; in particular it was difficult to know what connecting flights he had taken and with whom he had been in contact. The problem was different in different countries. In those where it was easy to find an imported case and to trace the secondary cases, there would be a tendency to exempt passengers from the need for a vaccination certificate. But in countries where considerable time might elapse before all the secondary cases could be traced it was likely that there would be loss of life, the seriousness of which would have to be weighed against any decision to grant exemption from the need for a vaccination certificate. At the present time, he did not think that Zaire would be able to take the responsibility of granting such exemptions, and he therefore proposed that operative paragraph 7 be deleted.

Dr KILGOUR (United Kingdom of Great Britain and Northern Ireland) said that operative paragraph 7 merely "urged" governments to restrict their requests for international certificates to travellers who had visited a smallpox-infected country within the preceding 14 days; there was no obligation. It was for every country to estimate the risk involved. In epidemiology nothing was certain, but the information provided by the Secretariat suggested that the risk was infinitesmal. He believed that the risk from unnecessary vaccination far exceeded that of contracting the disease by natural means. He suggested that a vote be taken on the amendment proposed by the delegate of Zaire.

The CHAIRMAN called for a vote on the amendment proposed by the delegate of Zaire.

Decision: The amendment was rejected by 52 votes to 6, with 13 abstentions.

As there were no objections to the amendments proposed by the delegates of Belgium and the Soviet Union, the CHAIRMAN asked the Committee whether it was prepared to approve the amended draft resolution.

Decision: The draft resolution, as amended, was approved.[1]

2. REVIEW OF THE PROGRAMME BUDGET FOR 1976 AND 1977 (FINANCIAL YEAR 1977) (continued) Agenda, 2.2.1

Smoking and health (continued from the thirteenth meeting, section 2)

The CHAIRMAN invited the Committee to consider the following draft resolution on smoking and health proposed by the working group:

The Twenty-ninth World Health Assembly,

Recalling resolutions EB45.R9, WHA23.32, EB47.R42 and WHA24.48 concerning the health hazards of smoking and ways towards its limitations;

Noting with satisfaction that the recent WHO Expert Committee report on smoking and its effects on health,[2] prepared in accordance with resolution EB53.R31 and reviewed favourably by the Executive Board in its fifty-seventh session, provides a thorough and authoritative summary of current knowledge in the field and contains a number of important recommendations for WHO and the Member States;

Considering that the results of the Third World Conference on Smoking and Health, held in New York in June 1975, gave further support to the evidence and proposals presented by the WHO Expert Committee;

Recognizing the indisputable scientific evidence showing that tobacco smoking is a major cause of chronic bronchitis, emphysema and lung cancer as well as a major risk

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA29.54.

[2] WHO Technical Report Series, No. 568, 1975.

factor for myocardial infarction, certain pregnancy-related and neonatal disorders and a number of other serious health problems, and also has harmful effects on those who are involuntarily exposed to tobacco smoke;

Seriously concerned about the alarming worldwide trends in smoking-related mortality and morbidity and the rapidly increasing cigarette consumption in countries in which it was not previously widespread, and about the growing number of young people and women who are now smoking;

Recognizing that an effective strategy to tackle the problem requires a concerted effort consisting of educational, restrictive and legislative measures, combined with coherent taxation and price policies, and supported by continuous research and evaluation on a multidisciplinary basis;

Noting that very few countries have thus far taken effective steps to combat smoking;

Believing that no organization devoted to the promotion of health can be indifferent in this matter, and that WHO has an important role to play in promoting effective policies against smoking, as envisaged in the Sixth General Programme of Work of WHO covering the period 1978-1983;

1. URGES governments of Member States to identify the actual or anticipated health problems associated with smoking in their countries;

2. RECOMMENDS governments of Member States:
   (1) to create and to develop effective machinery to coordinate and supervise programmes for control and prevention of smoking on a planned, continuous and long-term basis;
   (2) to strengthen health education concerning smoking, as a part of general health education and through close collaboration with health and school authorities, mass media, voluntary organizations, employers' and employees' organizations and other relevant agencies, taking into account the different needs of various target groups, laying emphasis on the positive aspects of non-smoking, and supporting individuals wishing to stop smoking;
   (3) to consider steps which can be taken towards ensuring that non-smokers receive protection, to which they are entitled, from an environment polluted by tobacco smoke;
   (4) to give serious consideration to the legislative and other measures suggested by the WHO Expert Committee in its recent report on "Smoking and its effects on health";

3. REQUESTS the Director-General:
   (1) to continue, and intensify, WHO's antismoking activities;
   (2) to collate and disseminate information on smoking habits, smoking-related health problems and smoking control activities in Member States;
   (3) to give assistance and encouragement to research in smoking and health, with particular emphasis on studies that are directly relevant to the assessment and improvement of the effectiveness of antismoking activities;
   (4) to promote the standardization of:
      (a) definitions, measurement methods and statistics concerning smoking behaviour, tobacco consumption and the occcurence of smoking-related morbidity and mortality;
      (b) laboratory techniques used for the quantitative analysis of the harmful substances in tobacco products;
   (5) to give assistance, upon request, to governments in the formulation, implementation and evaluation of their policies and programmes to combat smoking;
   (6) to continue, in cooperation with the United Nations, the specialized agencies and appropriate nongovernmental organizations, to make all efforts deemed necessary to reduce smoking; and particularly to work out with FAO and the United Nations a joint strategy for crop-diversification in tobacco-growing areas with a view to avoiding the anticipated economic consequences of reducing tobacco consumption in the world as a whole for public health reasons;
   (7) to convene an expert committee in 1977 or 1978 to review and evaluate the world situation in regard to smoking control;
   (8) to report to a future Health Assembly on developments in this field.

Dr LEPPO (Finland), presenting the draft resolution, pointed out how it differed from the draft resolution on the same subject that had been presented to the Committee at an earlier meeting.

Dr ALFA CISSÉ (Niger) said that the word "cigarette" in the second line of the fifth preambular paragraph was ill-chosen, because cigarettes could be made from substances other than tobacco. He therefore suggested that it be replaced by the word "tobacco".

Dr LEPPO (Finland) agreed to that proposed change.

Dr ALAN (Turkey) reaffirmed his reservations about the draft resolution and said his delegation would abstain when it came to the vote. He thanked the delegate of Nigeria for not having insisted on his previous proposal to limit tobacco-crop growing.

Professor ORHA (Romania) said his delegation had co-sponsored the original draft resolution and was willing to give its firm support to the amended version.

Dr KILGOUR (United Kingdom of Great Britain and Northern Ireland) said it was known that tobacco consumption was rising and that tobacco was most dangerous when smoked in the form of cigarettes. He therefore proposed that the words "rapidly increasing cigarette consumption" in the second line of the fifth preambular paragraph should be replaced by "rising consumption of tobacco, especially in cigarettes".

Dr LEPPO (Finland) thought the proposal was excellent.

Dr ALFA CISSÉ (Niger) also agreed with the proposal.

The CHAIRMAN asked whether there were any objections to the approval of the amended draft resolution.

Decision: The draft resolution, as amended, was approved.[1]

The meeting rose at 12.35 p.m.

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA29.55.