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WORLD HEALTH ORGANIZATION
No. 248

**THIRTY-FIRST
WORLD HEALTH
ASSEMBLY**

GENEVA, 8-24 MAY 1978

PART II

**VERBATIM RECORDS OF PLENARY MEETINGS
SUMMARY RECORDS AND REPORTS OF COMMITTEES**



WORLD HEALTH ORGANIZATION
GENEVA
1978

MEMBERSHIP OF THE HEALTH ASSEMBLY

LIST OF DELEGATES AND OTHER PARTICIPANTS

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GHANA

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GREECE

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GUATEMALA

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GUINEA

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HAITI

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LAO PEOPLE'S DEMOCRATIC REPUBLIC

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LIBERIA

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Mr A. G. ALMANA, National Health Administration

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¹ Chief Delegate from 11 May.

MALAYSIA

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MALI

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MAURITANIA

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MAURITIUS

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MONACO

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MOROCCO

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Delegates

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PERU

Delegates

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PHILIPPINES

Delegates

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POLAND

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Advisers

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Department for Foreign Cooperation,
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PORTUGAL

Delegates

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State for Health (Chief Delegate)

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Other International Organizations at
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QATAR

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REPUBLIC OF KOREA

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ROMANIA

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RWANDA

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SAMOA

Delegates

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 Dr S. T. FAAIUASO, Acting Director of Health

SAO TOME AND PRINCIPE

Delegates

Dr F. J. H. SEQUEIRA, Minister of Health (Chief Delegate)
 Dr F. DA COSTA NOBRE DE CARVALHO, Physician, Directorate of Health Services

SAUDI ARABIA

Delegates

Dr H. A. GEZAIRY, Minister of Health (Chief Delegate)
 Dr H. A. AL-SUGAIR, Deputy Minister for Health Affairs (Deputy Chief Delegate)
 Dr Y. AL-HEMEIDAN, Director-General of Administration, Ministry of Health

Alternates

Dr M. I. SHOURA, Director-General of Laboratories and Blood Banks
 Dr H. B. KIRIMLY, Director, Department of International Health, Ministry of Health
 Dr S. S. ISLAM, Technical Adviser to the Minister of Health, Ministry of Health
 Dr J. M. AASHI, Assistant Director-General of Preventive Medicine, Ministry of Health
 Mr N. H. QUTUB, Secretary to the Minister of Health for International Conference Affairs

SENEGAL

Delegates

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Specialized Agencies at Geneva

SIERRA LEONE

Delegates

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(Chief Delegate)
Mr S. E. JOHNNY, Permanent Secretary,
Ministry of Health
Dr Marcella G. E. DAVIES, Chief
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SINGAPORE

Delegates

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(Chief Delegate)
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SOMALIA

Delegates

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Specialized Agencies in Switzerland
(Deputy Chief Delegate)
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Dr A. DERIA, Director, Department of
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Health

SPAIN

Delegates

Mr E. SÁNCHEZ DE LEÓN PÉREZ, Minister
of Health and Social Security
(Chief Delegate)

Mr J. DE PALACIOS Y CARVAJAL, Under-
Secretary for Health, Ministry of
Health and Social Security
Mr A. ÁLVAREZ DE TOLEDO, Deputy
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SRI LANKA

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Sri Lanka to the United Nations Office
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SUDAN

Delegates

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SWAZILAND

Delegates

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SWEDEN

Delegates

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³ Delegate from 15 May.

Dr S. ALSÉN, Acting Deputy Director-General, National Board of Health and Welfare (Deputy Chief Delegate)⁴
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 Miss G. K. NORDSTRÖM, Head of section, Ministry of Health and Social Affairs
 Mr K. STENSTRÖM, Head of section, Ministry for Foreign Affairs
 Mr L. GRUNDBERG, First Secretary, Permanent Mission of Sweden to the United Nations Office and the Other International Organizations at Geneva

Advisers

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 Mr B. STENSSON, Head of section, Swedish International Development Authority

SWITZERLAND

Delegates

Mr H. HÜRLIMANN, Federal Counsellor; Chief, Federal Department of the Interior (Chief Delegate)
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Advisers

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⁴ Chief Delegate from 11 May.

⁵ Delegate from 11 May.

⁶ Chief Delegate from 9 May.

⁷ Deputy Chief Delegate from 9 May.

⁸ Delegate from 9 May.

Mr J. STREULI, Collaborateur
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SYRIAN ARAB REPUBLIC

Delegates

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TOGO

Delegates

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TONGA

Delegate

Dr S. TAPA, Minister of Health

TRINIDAD AND TOBAGO

Delegates

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TURKEY

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¹ Chief Delegate from 13 May.

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UGANDA

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UNION OF SOVIET SOCIALIST REPUBLICS

Delegates

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Mr V. A. VODORACKIJ, Senior Inspector,
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UNITED ARAB EMIRATES

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UNITED KINGDOM OF GREAT BRITAIN
AND NORTHERN IRELANDDelegates

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Alternates

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Mr C. L. MAYHEW, Second Secretary,
Permanent Mission of the United
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Dr J. P. GRIFFIN, Senior Principal
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¹ Chief Delegate from 12 to 20 May.

Mr A. J. MERIFIELD, Under-Secretary,
Head of Industries and Exports
Division, Department of Health and
Social Security

UNITED REPUBLIC OF CAMEROON

Delegates

Mr P. FOKAM KAMGA, Minister of Public
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Mr S. NKO'OTOUNGOU, Ambassador in
Belgium and Permanent Representative
of Cameroon to the United Nations
Office at Geneva and the Specialized
Agencies in Switzerland (Deputy Chief
Delegate)
Dr P. C. MAFIAMBAMBA, Technical Adviser,
Ministry of Public Health

Alternate

Dr KESSENG MABEN, Deputy Director of
Preventive Medicine and Public Hygiene,
Ministry of Public Health

UNITED REPUBLIC OF TANZANIA

Delegates

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Dr J. MWAKALUKWA, Medical Officer,
Ministry of Health

Alternates

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Dr S. J. NKINDA, Senior Medical Officer,
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UNITED STATES OF AMERICA

Delegates

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Dr T. E. MALONE, Deputy-Director,
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Mr P. G. ROGERS, United States Congress
Mr D. ROSTENKOWSKI, United States
Congress
Dr Barbara UNDERWOOD, Visiting
Professor of Nutrition, Massachusetts
Institute of Technology, Boston
Professor A. WOLMAN, Professor Emeritus,
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¹ Chief Delegate on 11 and 12 May.

² Chief Delegate from 13 May.

UPPER VOLTA

Delegates

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Alternates

- Dr M. DIALLO, Director, Centre for Tuberculosis Control, Ouagadougou
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URUGUAY

Delegates

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 Dr A. MOERZINGER, Secrétaire d'Ambassade, Permanent Mission of Uruguay to the United Nations Office and the Specialized Agencies at Geneva

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VENEZUELA

Delegates

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 Dr C. BARRIOS, Chief, Division of Pharmaceutical and Cosmetic Products, Ministry of Health and Social Welfare
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VIET NAM

Delegates

- Dr NGUYEN VAN DAN, Vice-Minister of Health (Chief Delegate)
 Mr NGUYEN VAN TRONG, Director, Department of External Relations, Ministry of Health
 Dr PHAM VAN GIAN, Director, Department of Science and Technology, Ministry of Health

YEMEN

Delegates

- Dr A. M. M. ABDULLA, Minister of Health (Chief Delegate)
 Mr H. AL-MUKBALY, Ambassador, Permanent Representative of the Yemen Arab Republic to the United Nations Office at Geneva and the Specialized Agencies in Europe
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Alternate

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YUGOSLAVIA

Delegates

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

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OBSERVERS FOR A NON-MEMBER STATE

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¹ Chief Delegate from 16 May.

6. SMALLPOX ERADICATION: CURRENT STATUS AND CERTIFICATION

Agenda, 2.6.9

Dr VIOLAKI-PARASKEVA (representative of the Executive Board) said that in January 1978 the Executive Board had noted that the last known case of smallpox in the world had been reported from the town of Merka in Somalia. However, WHO could not categorically consider that to be the last case of smallpox until two years had elapsed with no further cases having been detected. In order to be able to confirm that two years had elapsed with no cases of smallpox being detected anywhere in the world, despite adequate surveillance systems, the Executive Board, at its sixty-first session, had requested, in resolution EB61.R10, that the

Director-General should establish an international commission for the global certification of smallpox eradication. The Global Commission was functioning in accordance with the recommendations of the Consultation on Worldwide Certification of Smallpox Eradication. Those recommendations had been endorsed by the Executive Board at its sixty-first session. The method of certification was clear, but full support from, and the cooperation of, all countries of the world were absolutely essential to bring about the confirmation of smallpox eradication by the end of 1979. Irrefutable evidence must be available from all areas of the world.

The Executive Board had noted that the primary concern of the smallpox programme had been to eliminate the naturally occurring disease which resulted from human-to-human transmission. That signified eradication of the causative virus in its natural state, since there were no subclinical cases and no animal reservoirs other than human. Once smallpox eradication had been certified, the only source of smallpox virus would be in laboratories. Therefore, in order to minimize the risk of contamination, the number of laboratories retaining the virus would be reduced to four and stringent safety standards would be imposed on them.

In response to the concern expressed regarding the availability of smallpox vaccine in the unlikely event of a reappearance of the disease, the Board had been informed that a global reserve of vaccine, sufficient to vaccinate 200-300 million persons, was being established, initially with storage centres in New Delhi and in Geneva. Experience over the past 10 years had demonstrated that vaccine could be delivered anywhere in the world within 48 hours.

Several members of the Executive Board had requested guidance regarding vaccination policy and had been informed that, once global certification of eradication had been confirmed, international vaccination certificates for smallpox could be abolished. At present, however, WHO could only present the current epidemiological situation and it was for individual countries to evaluate the possible risk of smallpox importation as compared with the cost of administering vaccine and treating a number of complications inevitably arising from vaccination. In addition, as recommended by the Twenty-ninth Health Assembly, vaccination certificates from travellers should be required only from people coming from a smallpox-infected area within the previous 14 days. Since 1 January 1978, as reported in WHO's Weekly Epidemiological Record, there had been no areas in the world considered to be infected with smallpox.

Dr LADNYI (Assistant Director-General) recalled that 20 years had elapsed since 1958, when the Eleventh Health Assembly had approved a resolution calling for worldwide smallpox eradication. At that time the disease had been present in 59 countries, and in addition many other areas had had imported cases. In December 1977 an international commission had certified the eradication of smallpox in Bangladesh, where the last case of variola major in that country - and, indeed, in all Asia - had been identified on 16 October 1975. No cases of smallpox had been reported anywhere in the world for almost seven months, the last one being in Somalia, where onset of rash had occurred on 26 October 1977. Repeated search operations had failed to detect any further cases of smallpox in that country or in the surrounding areas, including Ethiopia, Kenya and Djibouti.

Assuming that the current epidemiological situation continued, it would appear that the global eradication programme had reached a turning point: instead of interrupting smallpox transmission, the task would be to prove that such transmission had, in fact, been interrupted. Therefore, in accordance with resolution EB61.R10, the Director-General had already established the Global Commission for the Certification of Smallpox Eradication to assess the current situation and to report its final conclusions to the Health Assembly. The Member States of WHO would be able to celebrate an unprecedented victory for preventive medicine. The considerable support provided by Member States in reaching the final stages of the global programme had been greatly appreciated, and it was hoped that such support would continue during the following two-year period pending its completion.

In conclusion he drew attention to certain errors and misquotations in paragraph 8.52 on page 96 of the Report of the Director-General on the Work of WHO, 1976-1977. The paragraph should read as follows:

"Ethiopian smallpox search operations in the Ogaden were virtually interrupted from July 1977 and surveillance activities were maintained at a low level by local workers. There had been no evidence of smallpox. However, months of continuing search will be needed in order to ensure that foci are completely eliminated. Ethiopia recorded its last known case in August 1976."

Dr BORGONO (Chile) proposed that the draft resolution contained in the Director-General's report should be amended by the addition of a recommendation to countries to collaborate with the Organization in trying to achieve the goal of having only four laboratories in the world stocking variola virus, and to take the necessary security measures to ensure that smallpox was not reintroduced from laboratory sources.

Dr FEDOROV (Union of Soviet Socialist Republics) noted that the thirtieth anniversary of the Organization coincided with the end of the smallpox eradication programme, to which his country had contributed from the outset. The absence of any cases of smallpox for six months was evidence of success, although it would be some time before complete eradication could be confirmed. The latest figures given in the WHO Weekly Epidemiological Record testified to the good work carried out by both national and international staff in the field, and also by the Global Commission.

He stressed the importance of making known in WHO publications the experience gained in the smallpox eradication programme throughout the world. That experience would be most useful for the successful implementation of other large-scale programmes in the health field.

Although the smallpox eradication programme itself was now reaching completion, the possibility of a return of the disease in the future should not be overlooked. Research work on the smallpox virus in order to detect the existence of possible reservoirs would have to be continued in the WHO collaborating centres and notably in equatorial Africa. His country would continue its support of that work within the framework of WHO.

Dr HOPKINS (United States of America) congratulated WHO and the many workers throughout the world who had contributed to the achievements summarized in the report. One could now feel justifiably confident that the unattainable had at last been attained.

His delegation proposed that the first line of the last preambular paragraph of the draft resolution suggested in the Director-General's report should be amended to read "Recognizing that for six months reported incidence of smallpox throughout the world has been nil . . .". Over-confidence at the present critical stage could threaten surveillance for the next 18 months and erode the basis of support for the programme over that period.

Since the only known sources of variola virus were now at the 16 laboratories mentioned in the report, and since WHO's goal was to reduce the number of laboratories retaining smallpox vaccine to not more than four by 1980, he proposed that a further operative paragraph be added reading as follows: "REQUESTS all laboratories except WHO collaborating centres to destroy or transfer remaining stocks of variola virus to a collaborating centre".

Dr TEKA (Ethiopia) said the smallpox eradication programme in his country had begun in 1971, two years later than in other countries where the disease had been endemic. The programme had had to cover a population of 30 million spread over a large country which included much difficult mountainous terrain. Each of the 14 regions had been covered by two teams of two to three persons, each with a vehicle.

By July 1971 activities were focused on the south-western regions, including Addis Ababa, and on Eritrea. During that period 26 329 cases of smallpox had been documented, and that figure was thought to represent only one-tenth of actual cases occurring. Since then the programme had continued to be expanded and the incidence of smallpox had steadily declined, the last case being recorded in August 1976.

At that point the programme had been changed over to a maintenance phase, with the objectives of locating any hidden foci, containing any outbreaks that might be detected, and documenting all activities carried out. Routine surveillance on a regular basis had been supplemented by special surveillance campaigns which covered areas that were difficult of access because of mountainous terrain or poor communications.

In 1977, a total of 9991 rumours had been recorded, but of these 3774 cases had been chickenpox and 6217 other skin diseases. During that year 1 895 258 primary vaccinations had been given, making a total of vaccinations given since the beginning of the programme over the whole country of 15 396 154, or about 54% of the population.

Although because of the war the programme in the Ogaden had had to be discontinued after the last case between August 1976 and July 1977, a full 10 months, there had been a very extensive surveillance programme which had covered that whole area assisted by helicopter. Some 500 people had been deployed. During that time a number of rumours had been checked and 180 specimens had been collected; all had been negative for smallpox.

Surveillance in Ethiopia would continue over the next 18 months, giving priority to the Ogaden area because there had been a 10-month lapse in the programme in that region and because

the nomadic nature of the people increased the risk of infection being brought in from neighbouring countries. The only region not now under routine surveillance was Eritrea. Activity there since the end of 1974 had been restricted to monitoring existing health facilities and to collection of rumours in the course of vaccination campaigns in major towns. However, it would seem unlikely that any smallpox existed in Eritrea, for three reasons: because two years of surveillance throughout the region following the last case had failed to detect any evidence of continuing transmission; because the Tigre area had been free of smallpox since November 1972; and because Eritrea's network of health services and its level of vaccination immunity had been better than anywhere else in the country before the campaign began. It was planned to carry out a special search as soon as practicable, and if possible to establish routine surveillance. He believed that Ethiopia would be ready to receive the Global Commission by October 1979, and it was to receive visits from that Commission in June and November 1978.

His delegation supported the draft resolution contained in the report. He thanked Dr Ladnyi for correcting the misleading information given in the Director-General's biennial report. In conclusion, he thanked the WHO Smallpox unit for its efficient work.

Dr REZAI (Iran) said that smallpox had been eradicated in his country more than seven years earlier. His Government was now carrying out a special plan to confirm smallpox eradication as part of the evidence needed for presentation to the Global Commission appointed by WHO.

The plan, which had been initiated in March 1970, included four specific programmes. The first was chickenpox surveillance, under which all chickenpox cases had to be reported on a weekly basis. The second was epidemiological investigations of chickenpox outbreaks associated with at least one death; in all such cases epidemiological reports were prepared to eliminate all possibility of smallpox. The third was examination of specimens of all rash and fever cases by a recognized WHO laboratory in Geneva. The fourth programme was a special facial scar survey in randomly selected villages in vulnerable border areas.

Two members of the Global Commission were expected to visit his country in November 1978 to see the plan in operation.

Dr DERIA (Somalia) said that since March 1977 a total of 947 outbreaks of smallpox in his country had been reported to WHO, resulting in 3229 cases and 12 recorded deaths. The last known case of smallpox had been in October 1977. Since then, the Somali eradication programme had been geared to detecting smallpox foci in many parts of the country by monthly house-to-house searches in a "risk" region, and on a two-monthly basis in regions which had not recorded smallpox in previous years. During the last six searches that had been carried out between October 1977 and March 1978, an average of 601 specimens had been collected per search and 5915 rumours investigated; 27% had been chickenpox, 10% measles, and the rest miscellaneous skin diseases, but none had been smallpox.

Since January 1978, 74 reporting units had been established throughout the country, each incorporating a rumour register for recording fever and rash cases. Those units submitted weekly reports from the districts to the regional offices of the eradication programme, which in turn reported to headquarters; from there weekly bulletins were sent to WHO in Geneva. The surveillance agents acted as supervisors during each search, and in the intervening periods covered areas which had not been fully investigated previously. At present, about 1250 field workers with 51 vehicles were working for the eradication programme, and 19 WHO epidemiologists were also in the field.

With a surveillance programme of such wide scope, it was unlikely that any smallpox foci had been overlooked, and he was reasonably confident that transmission had been successfully interrupted in Somalia. However, his country was aware of the danger of complacency, and was determined to keep the programme in its present form until final certification of smallpox-free status towards the end of 1979.

He was grateful for WHO's cooperation with his Government in the programme and hoped that that cooperation would continue until the desired goal was achieved. He supported the draft resolution contained in the report.

Dr MOCUMBI (Mozambique) said the victory of man over smallpox was a demonstration of how victories could be won over other diseases if the resources of modern technology were utilized for peaceful and humanitarian purposes. Although there had been no cases in Mozambique since 1969, the Government had decided to include vaccination in the mass immunization campaign which was now reaching its final stage, thus contributing to the worldwide smallpox eradication

programme. These would be the last smallpox vaccinations to be carried out in the country. The high percentage of vaccination coverage demonstrated the confidence of the people of Mozambique in their Party and Government. It was only by mobilizing the masses and persuading them to participate actively in the fight against disease that the promotion of health could be achieved.

He supported the Executive Board's suggestion that the number of laboratories possessing live smallpox virus should be reduced to four, located in strategic points throughout the world under the strict control of WHO. He supported the measures proposed by the Director-General for sufficient stocks of smallpox vaccine to be kept in reserve to meet any possible emergency needs. He suggested that one centre for the storage of such vaccine should be in Africa, and more specifically in Ethiopia, since it was in that part of the world that the final battle against smallpox was being fought.

Although Mozambique was one of the countries in southern Africa which had just been declared smallpox-free by an international commission, he wished to confirm his Government's policy in regard to vaccination requirements for visitors to Mozambique. Any change in that policy would be determined by developments in the world eradication programme.

In conclusion, he supported the draft resolution contained in the report.

Dr PLIANBANGCHANG (Thailand) said that his country had been smallpox-free for more than 20 years with the exception of one imported case in 1965, and had maintained careful surveillance of the disease. However, in figure 1 of Weekly Epidemiological Record, Vol. 53, No. 18, for 5 May 1978, it was indicated that for global certification Thailand required a special visit or documentation in 1978/1979. He would appreciate clarification from the Secretariat on that point.

His delegation supported the draft resolution contained in the report.

Dr LUN WAI (Burma) said Burma was one of the countries in which smallpox had been certified as eradicated in 1977. However, it did not intend to slacken its efforts, and vulnerable groups were still being vaccinated to ensure that eradication was complete.

His delegation endorsed resolution EB61.R10 of the Executive Board, and supported the draft resolution contained in the report.

Dr SMITH (Nigeria) said no cases of smallpox had been reported in his country since June 1970. Certification of smallpox eradication had been carried out in Nigeria by an international commission set up by WHO in 1976. Surveillance was being continued, and all specimens collected had so far been negative for smallpox.

Since vaccination against smallpox was a complex procedure and the probability of becoming infected was now slight, it would be useful if WHO could lay down clear guidelines for Member States in respect of routine smallpox vaccination. A cost/benefit analysis would be helpful in that connexion.

His delegation wished to become a co-sponsor of the draft resolution under consideration. He proposed that in operative paragraph 1 the phrase "successful eradication campaign" should be amended to read "effective eradication campaign". He endorsed resolution EB61.R10, and expressed appreciation to WHO and USAID for their cooperation in Nigeria's smallpox eradication programme.

Dr ARITA (Smallpox Eradication), replying to the question raised by the delegate of Thailand, said that the 1977 Consultation on Worldwide Certification of Smallpox Eradication had recommended that Thailand receive a special visit or certification. It was important to realize that although some countries might be satisfied that they were smallpox-free, elements of doubt might exist among the rest of the world community, and concrete evidence was needed to provide reassurance that the disease had indeed been eradicated.

He had received information the previous week that the 16 laboratories retaining variola virus had now been reduced to 14, and that by the end of 1978 at least three of those laboratories would either have destroyed those stocks or transferred them to WHO collaborating centres. Thus, at the end of 1978 the number of laboratories retaining stocks was expected to be around 10, and it was planned to continue to reduce their number.

Concerning the points raised by the delegates of Iran, Ethiopia and Somalia, WHO had three main methodologies in certification activities. These were, firstly, good documentation of eradication activities carried out in the past; secondly, search operations either in priority areas or over entire countries; and thirdly, special field operations, including a survey of facial pockmarks and collection of specimens from patients with rash and fever, for

laboratory confirmation. In the 31 countries in which certification activities were to take place, one of these methods or a combination of them would be employed.

The CHAIRMAN invited the Committee to consider the draft resolution contained in paragraph 10 of the Director-General's report, as well as the amendments submitted thereto.

Dr CHRISTENSEN, Secretary, drew attention to a typographical error in the penultimate line of operative paragraph 3 of the draft resolution. The words "so that these activities" should be inserted between the word "Eradication" and the words "can be completed".

He then read out the amendments proposed by the delegates of Nigeria and the United States of America. He understood that the delegate of Chile was satisfied that his amendment was covered by the new operative paragraph proposed by the United States delegate and that he would not press his own suggestion.

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

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA31.54.