1. Review and approval of the programme and budget estimates for 1969:
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Note: Corrections to this provisional summary record should reach the Chief Editor,
Official Records, World Health Organization, Avenue Appia, 1211 Geneva, Switzerland,
before 12 July 1968.
1. REVIEW AND APPROVAL OF THE PROGRAMME AND BUDGET ESTIMATES FOR 1969 - DETAILED REVIEW OF THE OPERATING PROGRAMME: Item 2.2.3 of the Agenda (Documents A21/P&B/15; A21/P&B/21; A21/P&B/Conf.Doc. No. 3 and Add.1; A21/P&B/Conf.Doc. No. 6) (continued)

Voluntary Fund for Health Promotion

Professor REXED (Sweden) said that his Government had made resources available through its international development agency for technical advice to be provided on the health aspects of world population and fertility problems. The Government would provide a sum of $ 200 000 for the Voluntary Fund for Health Promotion for the Swedish fiscal year 1 July 1968 to 30 June 1969, and hoped to be able to make a similar contribution for the following year. The sum had been accepted by the Chairman of the Executive Board in accordance with resolution EB26.R20.

Dr RAO, Chairman of the Executive Board, drew attention to pages 81 and 82 of Official Records No. 166, in which the Board gave information on the various special accounts under the Voluntary Fund for Health Promotion.

A description was given on the Board's review, arising out of which the Board had adopted resolution EB41.R14, which recommended the following draft resolution for adoption by the Health Assembly:

The Twenty-first World Health Assembly,

Having considered the programmes planned to be financed in 1969 from the Voluntary Fund for Health Promotion, as shown in Annex 3 of Official Records No. 163,

1. NOTES that the programmes are complementary to the programmes included in the regular budget of the Organization;

2. NOTES further that the programmes conform to the general programme of work for the period 1967-1971 and that the research programmes are in accordance with advice received by the Director-General from the Advisory Committee on Medical Research; and

3. REQUESTS the Director-General to implement the programmes planned for 1969 to the extent possible.

Following its consideration of a report by the Director-General on contributions to the Voluntary Fund for Health Promotion, the Board had adopted resolution EB41.R7, in which it expressed appreciation of the contributions received, and considered that all possible efforts should be pursued to obtain increased support of the Voluntary Fund from both governmental and non-governmental sources.

Dr GONZÁLEZ (Venezuela) noted that in paragraph 465, on page 81 of Official Records No. 166, it was stated that, for the 1968 programme, funds were available, in hand or pledged, in an amount of $ 2 592 980, and for the 1969 programme, in the amount of $ 882 068. He asked whether the situation had remained unchanged and what the position was likely to be by 1969.

Dr BERNARD, Assistant Director-General, Secretary, said that, since the forty-first session of the Executive Board in January 1968, total contributions of $ 331 250 had been received, to which must be added the contribution of $ 200 000 announced by the Swedish delegation.
Dr SAUTER (Switzerland), recalling his Government's past contributions to the Voluntary Fund for Health Promotion for the purchase of smallpox vaccine for the countries in which the disease was still endemic, said that, in response to a letter from the Director-General, negotiations were in progress with the Federal authorities for a new contribution to enable the Organization to purchase over two million doses of such vaccine.

The CHAIRMAN put to the Committee the draft resolution contained in resolution EB41.R14.

Decision: The draft resolution was adopted.

International Agency for Research on Cancer

The SECRETARY drew attention to the reference on page 561 of Official Records No. 163 to the effect that, should the Governing Council of the International Agency for Research on Cancer have completed its work in time, the budget estimates for 1969 would be submitted for the information of the Twenty-first World Health Assembly in a separate document. Those conditions had not, however, been fulfilled and no separate document was therefore being submitted.

Additional Projects requested by Governments and not included in the Proposed Programme and Budget Estimates

There were no comments.

Draft Resolutions

The CHAIRMAN said that the Committee had now completed its review of Official Records No. 163. It had two draft resolutions before it. The first concerned the training of national health personnel and was contained in the report of the drafting group (A21/P&B/Conf.Doc. No.6).

Professor PESONEN (Finland), Chairman of the drafting group, recalled that it had met on 18 May 1968 to consider the draft resolution proposed by the delegations of Bulgaria, Czechoslovakia, France, Hungary, Poland, Romania and Yugoslavia, with which the delegations of the Federal Republic of Germany, Finland and Nigeria were associated.

The drafting group, composed of the delegations of Bulgaria, Czechoslovakia, Federal Republic of Germany, Finland, Ghana, Nigeria, Romania and Yugoslavia had elected him Chairman. After discussion, it had decided to recommend to the Committee the adoption of the following draft resolution:

The Twenty-first World Health Assembly,

Considering that the World Health Organization is called upon in accordance with its Constitution to assist governments in strengthening their health services and to promote teaching and training in the health, medical and related professions;

Appreciating the efforts being made by all countries, particularly in the developing countries, to speed up their economic and social development, including the improvement of their health situation;

Being convinced that in order to improve the health situation in all countries it is necessary to intensify efforts to develop and utilize human resources, and particularly to train national staff, taking into account the development plans in each country and its present and long-term needs for qualified health staff at all levels;
Recalling resolution 2083 (XX) of the General Assembly of the United Nations, dated 20 December 1965, in which the specialized agencies are called upon to intensify measures for the full utilization of human resources and the training of national personnel when reviewing their future programme of action,

1. RECOMMENDS Member States to give increasing attention to the training of personnel for the health professions and auxiliaries;

2. REQUESTS the Director-General:

(a) to continue to give high priority to programmes of assistance to Member States in training for the health professions and auxiliaries;

(b) to continue to collaborate with the United Nations and the specialized agencies in the utilization and development of human resources;

(c) to suggest to the Regional Committees, at their meetings in 1969, to undertake an analysis of the problems of training for the health professions and auxiliaries;

(d) to make provision for a general evaluation during the forty-fifth session of the Executive Board of the experience accumulated by the World Health Organization taking into account the conclusions reached by the Regional Committees; and

(e) to submit to the Twenty-third World Health Assembly a report on any concrete measures that may seem appropriate for the World Health Organization to assist further the training of national health personnel at all levels.

Professor REXED (Sweden), strongly supporting the draft resolution, said that education and training had a leading role to play in the development of health services. It would be noted that the subject formed part of many of the additional projects requested by governments and not included in the proposed budget estimates.

In the analyses recommended to be undertaken by Regional Committees, thought should be given to the possibility of co-operation among countries of the Region and to the ways in which inter-regional support could be given to education and training in all countries. His delegation hoped that constructive proposals would emerge from such discussions.

Dr ELOM (Cameroon) said that the aim of the draft resolution appeared to be to give further support to a number of measures already being undertaken by WHO at headquarters and in the regions.

The Regional Committee for Africa at its seventeenth session in 1967 had studied thoroughly the question of education and training of health personnel, on which the Regional Director had presented a detailed report. The measures proposed by the Regional Director for a reorientation of the programme had met with the Committee's full approval. A resolution had been adopted stressing the need for the short-term training of auxiliaries to meet emergency situations, for a long-term programme for training qualified teams at all levels, for setting up pilot areas for the training of teachers, and for establishing a pool of teachers for the Region.

The Region had also recognized the desirability of providing grants to the training centres of Member States to enable them to offer to their nationals fellowships for study within the country, where more appropriate training could be given, better adapted to local conditions. Such a scheme would be less costly than outside fellowships and would be a solution to the "brain drain" problem.
The section on training in preventive medicine and public health on page 42 of the Annual Report of the Director-General for 1967 (Official Records No. 164) gave evidence of the great effort already made in the orientation and adaptation of medical studies to the problems of the day. The introduction to the Proposed Programme and Budget Estimates for 1969 (Official Records, No. 163) showed even more clearly WHO's philosophy with regard to medical education and training, which was in accordance with the objectives set forth in the draft resolution. WHO-assisted training centres such as the Zaria centre in Nigeria and the proposed health science school in Cameroon were founded on that philosophy.

His delegation therefore fully supported the draft resolution.

Decision: The draft resolution was approved.

The CHAIRMAN said that the Committee had before it a draft resolution submitted by the delegate of Peru and co-sponsored by the delegations of Argentina, Brazil, Colombia and Spain concerning the adaptation of medical curricula to modern concepts of integrated-medicine (A21/P&B/Conf.Doc. No. 3). The delegate of Argentina had indicated his opinion that the draft resolution just approved made the adoption of the second draft resolution unnecessary.

Professor SCORZELLI (Brazil), Professor GROOT (Colombia) and Professor GARCIA ORCOYEN (Spain) indicated their willingness, as co-sponsors, to withdraw the draft resolution.

The CHAIRMAN said that, in the absence of the delegate of Peru, it was necessary to put to the vote the proposal to withdraw the draft resolution.

Decision: The proposal to withdraw the draft resolution was adopted by 73 votes to none, with 7 abstentions.

The CHAIRMAN said that the draft resolution proposed by the delegate of Iraq at the previous meeting would be taken up later.

Calling attention to the third report of the Committee on Administration, Finance and Legal Matters (document A21/P&B/21), he said that the Committee now had to approve the appropriations by sections in accordance with the amounts shown therein.

The SECRETARY said that the third report of the Committee on Administration, Finance and Legal Matters to the Committee on Programme and Budget (document A21/P&B/21) indicated the amounts to be inserted in Parts I, III, IV and V of the Appropriation Resolution. The following figures could now be inserted in Part II:

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At the request of the CHAIRMAN, Dr AKWEI (Ghana), Rapporteur, read out the draft Appropriation Resolution, as thus completed.

Decision: The draft Appropriation Resolution was approved.
2. SMALLPOX ERADICATION PROGRAMME: Item 2.6 of the Agenda (Resolutions WHA20.15 and EB41.R18; Document A21/P&B/6) (continued)

Dr ABDUL RAZZAK (Kuwait), noting that a number of delegates had withdrawn their right to speak, asked whether prepared statements not delivered could be included in the summary record.

The CHAIRMAN said that the Legal Office had indicated that that was not possible.

Dr GONZÁLEZ (Venezuela), recalling the interest his delegation had shown at the Twentieth World Health Assembly in the Director-General's report on the smallpox eradication programme, expressed its further satisfaction with the present report, which was concise yet informative.

Although eradication was theoretically feasible, persistent efforts and constant vigilance were needed to achieve it. The general health services had an essential role to play in exercising the necessary epidemiological vigilance.

He hoped that the report of the Scientific Group on Smallpox Eradication, referred to in section IV of document A21/P&B/6, would soon be available. In the part reproduced, no mention was made of the role to be played by the general health services in the execution of the programme. It was important from the outset to see that the programme came within those services. The problems encountered in the execution of the malaria eradication programme had emphasized the need for that concept.

The continuing nature of the programme should help to avoid recurring epidemics.

Dr NGANDU (Democratic Republic of the Congo) said that his country was among the African countries that had put in hand a smallpox eradication programme by bilateral agreement between the Government and WHO. The plan envisaged BCG vaccination in conjunction with smallpox vaccination for all children up to the age of fourteen, thus covering about eight million children. The size of the programme had given rise to the opinion in certain quarters that it might be preferable temporarily to halt the BCG programme to ensure that it did not interfere with the carrying out of a normal smallpox eradication programme. Activities were as yet barely under way, since the dual vaccination programme had only begun in March 1968.

No doubt resolutions WHA19.16 and WHA20.15 related to smallpox alone, but his Government had a particular interest in an integrated campaign to include BCG vaccination, and he hoped the Director-General and the Regional Director could intervene to reassure those who had expressed doubts on the subject.

During 1967, there had been 1500 cases of smallpox in his country, with 112 deaths. Developing countries that had made great sacrifices in order to put in hand a vaccination plan with the aim of progressive total coverage had difficulty in finding the supplementary resources necessary for control of epidemic foci in isolated regions, where no eradication teams were in operation. He hoped that WHO could assist with extra vaccine and transport. It was also imperative for WHO to supply, at the request of Member governments, and within the framework of the operational plan, staff familiar with the material problems and able to carry out necessary repairs to vaccination equipment. Without such assistance the medical officer's task became complicated by supplementary tasks, which had given rise to great difficulties in certain programmes. He hoped that WHO would give particular attention to his country's problems.

Professor PENSO (Italy) said that the problem of smallpox was closely connected with the efficacy and innocuity of the vaccine used. The introduction of freeze-dried vaccine had facilitated storage and practical use, but had not solved the problem of the quality of the vaccine itself. Laboratory research had shown that there were a number of varieties of vaccinia virus of which the immunological value and pathogenicity was unknown.
His delegation had drawn the Director-General's attention to that problem at the Twentieth World Health Assembly, and was pleased to note that the Director-General now envisaged a comparative study of vaccine strains with a view to determining those with the most suitable characteristics. The Higher Institute of Health in Rome had collected a large number of vaccines prepared in various parts of the world, and studied them on a comparative basis. It had observed that the various vaccines were prepared with heterologous vaccine viruses. At least two or three groups could easily be distinguished by ordinary virological techniques such as "T-markers".

His delegation considered it essential to reach a more advanced stage of standardization of vaccines by specifying the strains from which they had been prepared, as in the case of other vaccines. The viruses to be chosen should have two main characteristics: high antigenicity and low pathogenicity.

The various vaccinal viruses in use throughout the world produced on the chorio-allantoic membrane of chick embryos simple pustules or haemorrhagic pustules ringed with more or less haemorrhagic circles. The question was which viruses to choose in preparing smallpox vaccine.

His delegation considered that WHO should encourage or organize research on those problems with priority over other types of research, with a view to a determination by the Expert Committee on Biological Standardization of a vaccinal virus strain particularly indicated for preparation of a standard smallpox vaccine.

Dr MTWALI (United Republic of Tanzania) said that Table 5 of document A21/P&B/6 showed that, of the countries in East and South Africa, Tanzania had had the second highest incidence of smallpox in 1964 and 1965 and the highest in 1966 and 1967. It had therefore accorded top priority to smallpox eradication.

It would appear that following a long period during which the disease had occurred only in its mild form, the present generation, particularly in rural areas, were unaware of its seriousness and reluctant to present themselves for vaccination, some even having run away to escape the vaccination teams. Routine measures had therefore failed to contain the disease, which had now appeared in the severe form of variola major.

It had therefore been decided to launch a mass vaccination campaign with the assistance of WHO, whose prompt response had been greatly appreciated. Staff, equipment and transport were already arriving in the country and the project should soon be under way, starting in one of the worst districts.

Mr MOGA (Romania) said that WHO's efforts for the global eradication of smallpox were of particular importance in view of the fact that the disease was still a cause of considerable morbidity and mortality.

Romania was continuing to operate a strict programme to prevent importation. Measures were being applied by frontier authorities in pursuance of the International Sanitary Regulations. An immunization campaign was being carried out to cover all children from three to fifteen months of age, with re-vaccination in primary schools. All nationals travelling to countries where the disease was endemic were also re-vaccinated.

Dr TEKLE (Ethiopia) said that smallpox was endemic in Ethiopia, where the clinical diagnosis of the normally mild form of the disease had only recently been confirmed by laboratory tests. He stressed the need for good diagnostic laboratory services to supplement the efforts of vaccination teams using potent freeze-dried vaccines. Another essential was good reporting.
The vaccine production unit in Ethiopia had a capacity of fifty million doses per year, but currently only produced three million, which were distributed through the proper channels to health services, which performed vaccinations in all health institutions, including army hospitals and school health services. In spite of satisfactory results, batches sent to a WHO reference centre had proved a little less potent than required, but since the visit of an expert, all subsequent batches checked had been found to fulfil WHO standard requirements. A month earlier two trials—one on ten thousand adults in an army camp, the other on five thousand children—had revealed a take-rate of over 90 per cent.

Further studies were needed to confirm that cases in Ethiopia were due to a milder strain, and to relate it to other African and non-African strains. He asked that the Regional Office study smallpox vaccine production to determine the vaccine most suitable for use in the Region.

Dr KONE (Ivory Coast) said that in 1960, the year of the Ivory Coast's accession to independence, there had been more than four hundred cases of smallpox notified. The eradication programme had started in 1961, and the Institute of Hygiene's five vaccination teams had conducted a mass campaign which terminated in 1962. In 1964, only eleven cases had been diagnosed; in 1965, eight; in 1966, none, and in 1967, two, both of which were imported. The programme was now in the maintenance phase. The vaccination rate was over 80 per cent. The ten millionth vaccination had been performed in 1968. Two five-year surveillance periods were planned to start in 1969, and considerable efforts were being made to integrate vaccination into the routine activities of the health services. Vaccination every four years had been obligatory since 1961.

The difficulties encountered in the programme were of two kinds: financial difficulties, including the renewal and maintenance of the supply of vehicles, seven of which had gratefully been received from the United States Agency for International Development—altogether with supplies of freeze-dried vaccine—in 1967; and difficulties of control at frontiers, where many people used little-known tracks to cross. Those people were sometimes not vaccinated.

He requested WHO assistance in the elaboration of a common strategy for his own and neighbouring countries, as well as in the purchase and maintenance of vehicles.

Dr BURGASOV (Union of Soviet Socialist Republics) said that the delegate of Italy had touched on the important problem of immunogenisis. Delegates should, however, not have the impression that the smallpox vaccines at present in use were not, or were only slightly, immunogenic. Excessive pessimism over the quality of the vaccines used would cast doubts on the feasibility of eradicating smallpox. He recalled that in many countries of the world smallpox had been eradicated with liquid vaccines less effective than the freeze-dried vaccines currently used, although the task had been a difficult one. In the USSR it had taken ten years, after the decree promulgated in 1922 by Lenin making smallpox vaccination compulsory, to eradicate the disease from the country, where it had been endemic. That experience convinced him of the need to believe in the possibility of eradication and to give support to the WHO programme. Without proper organization and financing and—most important in his view—training of national staff, the programme could not be implemented. Just to vaccinate once was not enough; a complete system of vaccination and of revaccination of certain age-groups had to be set up, and that could not be done without the help of WHO. His delegation fully supported the programme, and the assistance his country could give in supplying vaccine and training personnel had by no means been exhausted.
Mr ISSA IBRAHIM (Niger) said that his government would try to carry out the wise recommendations included in the Director-General's report. Although there were no distinct foci of smallpox in Niger, the disease affected 60 to 120 people in eight to ten regions in seasonal outbreaks, giving an average of between 400 and 1200 cases a year. That situation could be explained by three factors: frequent migratory movements, lack of co-ordinated vaccination until 1967, and the difficulty of carrying out vaccination in far-removed parts of the country owing to poor communications and nomadism, particularly in the north. With the increase from 30 cases with four deaths in 1964 to 1187 cases with forty-six deaths in 1967, a mass vaccination campaign had been undertaken with the assistance of the United States Agency for International Development, the Organization for Co-operation and Co-ordination in the Control of Major Endemic Diseases, and WHO. The aim was to vaccinate the whole population in three years. Thanks to the mobile epidemiological teams, two main foci were discovered: one in a narrow band along the border with Northern Nigeria; the other in an area used by shepherds for passing between Upper Volta, Mali and Niger. Control in those places was very difficult. A concerted effort was necessary to ensure the vaccination of nomads, even if it meant that a vaccination team must be given permission to penetrate up to fifty kilometres into foreign territory. There should also be a grouping of information on the movements of nomads.

To deal with the problem of maintaining permanent immunity, Niger was distributing freeze-dried vaccine which could be kept for three months to be used for administration with a bifurcated needle in medical centres; mobile teams were responsible for ensuring re-vaccination every three years; and persons admitted to hospitals for communicable diseases were vaccinated systematically.

Preparations had been made for the maintenance phase, but there were important material problems owing to the bad state of the roads, vehicles and camp supplies, including refrigeration equipment. Jet injectors had proved easy to handle, dismantle and repair, however.

In 1968, for which year the vaccination target was one million, less densely populated areas were being attacked, and the first results were encouraging since – in spite of the interruptions due to the cerebrospinal meningitis outbreaks – 360 000 people had already been vaccinated. Thanks were due to the assisting organizations he had mentioned.

Dr DOUBEK (Czechoslovakia) congratulated the Director-General on his report, especially that part dealing with eradication methodology related to the different epidemiological conditions in various parts of the world. He was sure that if WHO managed to spread the available resources in the right way, definite progress would be observable within three to four years. Smallpox eradication was a challenge to international co-operation, Czechoslovakia had always supported the Organization in its programme, and he was pleased to announce a donation of 500 000 doses of freeze-dried vaccine for the programme in 1968.

Dr KIVITS (Belgium) announced that his government was to donate 100 000 doses of freeze-dried vaccine, independent of bilateral aid, which would be continued.

Dr BADDOO (Ghana) said that since the launching of the smallpox eradication campaign in his country and eighteen other African countries in 1967, 1 300 000 Ghanaians had been vaccinated by jet injectors. There had been a rise in incidence in 1967, with 114 cases and sixteen deaths. So far in 1968 there had only been two cases.

Consolidation and maintenance would be more difficult since the continuity of supplies and staff would have to be greater, with the additional strain to health services of surveillance and vigilance activities. He hoped that the necessary assistance would be forthcoming, in particular with the establishment of vaccine production units in Africa and the provision of spare parts for vehicles and equipment, so as to avoid a recrudescence of the kind experienced in some countries with malaria.
Dr BLOOD (United States of America) announced that in view of the progress achieved and the efforts made in the Director-General's realistic programme, the United States Government had decided to establish a fund to maintain a reserve of 20 million doses of freeze-dried vaccine suitable for use in jet injectors to meet situations in which supplies of vaccine were unexpectedly needed. That would be administered in addition to the usual bilateral assistance.

Dr AUBENAS (Dahomey) said that his country was one of those with the highest incidence of smallpox in 1967, considering its small size. The eradication programme begun in 1967 was proceeding according to plan, thanks to United States assistance, with 791,000 vaccinations in the first year. He stressed the importance of the co-operative character of the programme and those in Togo, Upper Volta, Niger and Nigeria. That was essential in epidemiological terms, especially for neighbouring countries with almost non-existent health surveillance at frontiers. Collaboration between the countries would become indispensable in the consolidation and maintenance phases. It would be desirable for the Regional Office for Africa to advise governments in due time.

Dr ARIF (Iraq) said he had noted with satisfaction the number of eradication programmes initiated in recent years, but was concerned at the increased incidence of the disease. He said that the case of smallpox mentioned in Table 8 of document A21/P&B/6 had in fact never entered the country, since it had been detected and diagnosed on the ship, where all passengers were kept in quarantine.

He suggested that WHO sponsor inter-country border meetings on smallpox like those on malaria.

Dr FOMBA (Mali) said that the eradication campaign in his country was based on geographical, social and ethnological studies with particular regard to conditions in flood areas and to the need for ensuring vaccination in six main regions, as well as vaccination of the nomadic population. The campaign was proceeding satisfactorily and should cover the whole country by 1969. In 1968 there had so far been only 164 cases — less than five per 100,000 population.

He associated himself with the remarks of previous speakers on the need for co-ordination in the frontier areas and for more assistance in the maintenance phase, including the preparation of rural health services for surveillance work.

Professor OMAR (Afghanistan) said that in spite of the 15 million vaccinations covering a population of 16 million since 1958, an increase in the number of cases from 0.5 to 5 per 100,000 had occurred in recent years in Afghanistan, due especially to lack of adequate resources and transport and a shortage of good vaccine. Children had been particularly affected. The solution lay in the concentration of assistance in the production of freeze-dried vaccine and in transport facilities.

Dr TABBA (Saudi Arabia) said that his Government felt that the programme would be more effective with inter-country co-operation, and he supported the remarks of previous speakers in that connexion, stressing the possible role of WHO.

Dr DURAIUSWAMI (India) said that the eradication campaign in his country had been launched in 1962 and covered all the States and Union Territories, with an estimated population of 524 million, by March 1963; some 80 per cent. lived in villages with no proper roads. About 87,980,000 primary vaccinations and 496,960,000 re-vaccination had been performed to date. An assessment conducted in 1967 with WHO assistance, after 80,174 cases of smallpox had been reported as against 32,616 in 1966, had revealed problems in supervision, planning and implementation owing to difficult ecological conditions including population movements, as well as difficulties of storage and transport. There had also been unnecessary re-vaccination in some cases. He expressed gratitude for the 750 million doses of freeze-dried vaccine supplied by the USSR between 1961 and 1968 and for another 100 million doses promised. Other countries had also given supplies. Production capacity in the four centres in India was about 60 million doses, which was to be increased. Requirements were estimated at 200 million doses a year for vaccination of the newborn and for re-vaccination.
UNICEF was also to be thanked for the offer of US$ 380 000 for the purchase of equipment and for assistance, with WHO, in training staff for vaccine production. One of the senior officers responsible for the programme had attended the inter-regional seminar for Asian countries on smallpox eradication held in Bangkok in December 1967.

Dr DE MEDEIROS (Togo) said that the smallpox eradication campaign in Togo was progressing satisfactorily in spite of the occurrence of some 300 cases in 1967 and certain difficulties, which were of two types. The Regional Director had already been informed of the financial difficulties, but there was another: an usually severe epidemic of chickenpox had made diagnosis difficult. Laboratory assistance in diagnosis was required. In the long-term view, attention must be paid to the development of the health infrastructure, since it was not known whether it would be adequate for the maintenance phase.

Dr KENNEDY (New Zealand) announced a donation of 250 000 doses of vaccine to WHO for use in Indonesia.

Dr DIZON (Philippines) said that although the Philippines was a country free from smallpox it formed part of a region where the disease was endemic. He stressed the need for group responsibility for diagnosis, and for WHO training courses, including a practical element to give experience in the field.

He warned against the tendency to neglect smallpox vaccination in favour of control of other communicable diseases. He spoke of the need to make available the most effective vaccines, to use them efficiently and to employ up-to-date vaccination techniques. Full-time efforts should be directed at smallpox eradication, with priority for places where people were most exposed to the disease. He thanked UNICEF and WHO for their co-operation.

Dr VIOLAKI-PARASKAVA (Greece) said that smallpox had never been endemic in Greece, but in 1950 there had been an outbreak in a village outside Athens caused by a visitor with a valid smallpox vaccination certificate. Since 1936 vaccination had been compulsory and must be completed before the age of one year, in order to avoid the possibility of post-vaccinal encephalitis. The lymph for the vaccine was prepared in Greece, and was distributed by the health departments without charge to private physicians. Vaccination was performed extensively by polyclinics, rural dispensaries, maternal and child health centres and school health services.

It was essential, in view of the international importance of smallpox, to establish surveillance systems in all countries, as well as effective vaccination programmes.

Dr OTOLORIN (Nigeria) referred delegates to the remarks on smallpox eradication made by the Commissioner of Health of Nigeria in the plenary Assembly.

Dr CHICAL (Central African Republic) said that the programme in his country, for the eradication of measles and tuberculosis as well as smallpox, was to end in 1969. Three million vaccinations against smallpox had been carried out in nine years. The last focus had been reported in 1962. The only remaining danger was importation. In the Sub-Committee on International Quarantine the delegate of his country had associated it with the countries that had raised the question of control at frontiers in the African Region. As well as nomads, there were lorry drivers and shepherds contributing to that problem, and he would ask WHO to invite States to give priority to those persons in vaccination programmes.
Professor SCORZELLI (Brazil) said that his country with its population of 86 million had the highest incidence of smallpox in the Americas, although the cases were mostly of the milder form. An assessment had revealed 14,000 cases between 1964 and 1967 - that was 94 per cent. of the registered cases in the Region. The disease was more prevalent in the north-east and the south, less frequent in the north. In 1967 São Paulo had revealed an increase of reported cases over the north-east. That was probably due to the internal migration and the intensive vaccination in the north-east.

The target of the eradication campaign was to vaccinate 90 per cent. of the population in three years, using highly potent freeze-dried vaccine. Jet injectors were being used in areas with a concentrated population. Multi-puncture was being used in other areas. There was good co-ordination between federal and local health services.

Brazilian freeze-dried vaccine production had reached 48 million doses a year, which could be increased if necessary. The per capita cost of vaccination was US$ 0.11.

His country was grateful to WHO for its valuable co-operation, and to the United States Agency for International Development for financial assistance.

Dr U KO KO (Burma) said that his country had nearly eradicated smallpox after over ten years of a programme started following the resolution of the Eighth World Health Assembly.

He pointed out that, although universal in importance and highly prevalent in a few countries, smallpox was not as widespread as many other diseases; countries with more than five cases per 100,000 population could be counted on the fingers of one hand. Nevertheless, it would be some time before eradication could be achieved.

On section 2 of part III of document A21/P&B/6, which should be considered together with Table 10, he said that, while agreeing in principle, he had reservations on the general statement that the development of effective programmes of smallpox surveillance in every country was as important as the vaccination programme itself. Surveillance was extremely important in the final phases of the programme, but it was equally important in countries free from smallpox but exposed to it from outside, and in countries with a low incidence, even in the early stages. However, in countries with a high incidence and with limited resources where vital and health statistics and notification systems were poor, he suggested that mass vaccinations should have priority.

On eradication methodology (part IV of document A21/P&B/6) he said that for the field worker smallpox eradication was more an administrative than a technical problem. Technical matters such as vaccine production methodology, vaccine devices and the advantages and disadvantages of combined vaccination might be reserved for high-level administrators and research workers. For a developing country with limited resources, the obtaining of potent vaccine was the most important need of the programme. After that, the greatest need was for the health administration to see that the right people were vaccinated when and where required.

In a smallpox eradication programme, unlike other disease programmes, requirements of supplies and equipment were relatively small. Burma had started with only vaccine. From the report it would be seen that out of 71 countries with a total population of 1352 million, five countries with a population of 872 million constituted the major problem. Out of the other 66, many were free from the disease already. He suggested that without prejudice to the programme in the five large countries, WHO might concentrate support on the smaller countries and complete the attack phase as soon as possible. He recalled that Dr Payne, Assistant Director-General, had said in his introductory speech that there were 16 countries with programmes and six about to start. By concentrating on the smaller countries and removing them from the list of smallpox endemic countries, it would be possible to clear the stage for major operations.
Dr ELOM (Cameroon) said that in spite of a vaccination campaign, there had been sixty notified cases of smallpox in Cameroon in 1967, as against three in 1966. That was due, no doubt, partly to better notification but also to the difficulty of giving full coverage to the population, particularly in mountain regions among people with nomadic habits and suspicious of vaccination. Properly trained staff and a basis of health education were necessary to change the social behaviour of the people. He associated himself with the remarks of other African delegates on the need for co-operation and co-ordination, without which the efforts of his country were doomed to failure. It had the same problems of frontier control and importation as they had mentioned, as had been revealed by an epidemiological study carried out by the United States Agency for International Development.

The CHAIRMAN said that the Committee would be asked to approve at a later meeting the draft resolution recommended by the Executive Board in its resolution EB41.R18.

The meeting rose at 5.10 p.m.