Page 9, seventh paragraph, first line

delete Dr DOLGOR
insert Dr DORJJADAMBA
COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE THIRD MEETING

Palais des Nations, Geneva
Tuesday, 11 May 1971, at 9.30 a.m.

CHAIRMAN: Dr A.-R. M. AL-ADWANI (Kuwait)

CONTENTS

1. Situation of the cholera pandemic (continued)

Note: Corrections to this provisional summary record should be submitted in writing to the Chief, Records Service, Room A.271, within 48 hours of its distribution.
1. SITUATION OF THE CHOLERA PANDEMIC: Item 2.6 of the Agenda (Resolution EB47.R31; Official Records No. 190, Appendix 12; Documents A24/A/11 and A24/B/10) (continued)

The CHAIRMAN invited the Committee to resume its discussion of the item.

Dr HENRY (Trinidad and Tobago) said that, although his country together with others in the Western Hemisphere had not so far been affected by the pandemic, it had taken certain preparatory measures. Arrangements had been made to enlarge quarantine and isolation facilities, if necessary. Nursing and medical staff and other personnel of the isolation unit had been vaccinated, as well as travellers to infected countries. The vaccination Certificates of Travellers from infected countries had been carefully checked. Furthermore, the health services had availed themselves of the Pan American Health Organization training course in laboratory diagnosis to bring their knowledge of diagnostic techniques up to date.

Reference had been made to ineffectiveness of vaccine and quarantine measures. In that connexion, he requested classification on a number of points. First, should countries not having such highly developed environmental sanitation facilities as existed in the United States or well-trained surveillance teams abandon traditional control measures before some improvement had been effected in environmental sanitation and surveillance? Second, should there be a difference in approach to the problem between a country such as the United States which was not infected and a developing country in which a few or many cases had occurred, and should infected countries carrying out mass vaccination programmes be advised to stop them? Finally, in view of the vast financial outlay already incurred and likely to be incurred in the production and utilization of cholera vaccine, had cholera vaccine any place in the prevention and control of an outbreak of cholera, or should its use be limited to medical, nursing and ancillary personnel of isolation units?

Dr STEINFELD (United States of America) wished to dispel any misunderstanding that might have arisen with regard to the stand taken by his delegation. Whether cholera should be classed as a quarantinable disease or not did not change the fact that it was a very serious disease, with considerable morbidity and mortality. There was a need for continual research into cholera, from the point of view of immunology, the development of new vaccines, epidemiology and therapy. It was imperative, too, that there should be a constant review of cholera control measures in order to ensure that they were the most effective possible.

But it was a fact that quarantine had not succeeded in controlling the cholera pandemic. Removal of cholera from the list of diseases subject to the International Health Regulations, his delegation hoped, would result in improved surveillance. It was commonly believed, too, that diseases subject to the Regulations were also subject to sanctions. The fear of sanctions would therefore disappear. If the social and economic stigma attached to cholera and the very real fear of economic sanctions disappeared, the problem of cholera could be viewed in its proper context. Naturally, his delegation agreed that environmental sanitation constituted the long-term goal, which would be hard to attain. But since quarantine did not provide protection, the funds utilized to enforce measures at frontiers might be better spent on health education and sanitation.

His delegation therefore proposed that WHO should undertake a careful review of the status of cholera as a quarantinable disease over the following year to determine whether a change was necessary.

Dr OMAR (Afghanistan) said that it was apparent that traditional cholera foci had remained the same and that the pandemic had been caused by the development of international transport,
so that there was a constant threat to neighbouring countries. It would be desirable for WHO and bilateral agencies to concentrate their efforts on the traditional foci, keeping them under continual surveillance with a view to drawing attention to possible threats of a future outbreak, thus ensuring immediate preventive measures. The foci could become centres for research and investigation and the results obtained could be applied elsewhere against the disease.

The climate and geography of Afghanistan were not favourable to cholera, but the country was at constant risk from its neighbours. National action was divided into two distinct categories: preventive and preparatory action by means of training courses, and measures to combat the disease once cases had been reported. Rehydration was essential and in that connexion he fully supported the remarks of the USSR delegate. It was desirable that WHO should assist countries in manufacturing rehydration fluid themselves instead of having to import it. Furthermore, in view of the prime importance of environmental sanitation, he hoped that WHO could find simple methods to improve the situation in developing countries.

Dr. AKIM (Tanzania) believed that the cholera pandemic had demonstrated a rare unity of purpose and concern in WHO and he had been deeply impressed by its action.

Insufficient emphasis had perhaps been laid on the state of panic created by an outbreak of cholera; his own country had some experience of the effect of the threat of cholera spreading from Kenya. There had been a great public demand for vaccination, which the Tanzanian health services had not been able to meet. On the advice of WHO, the health services had told the population that vaccination was of little use, while at the same time, again on the advice of WHO, they had required travellers and certain workers at special risk to be vaccinated. The contradiction was apparent to the general public and did not help the situation.

He appreciated the courageous decision taken by the United States concerning vaccination. It was essential that WHO should come to a clear-cut decision; if vaccination was definitely of little use, then vaccination of special groups should also cease.

Professor AVG (Ivory Coast), recalling that the representative of Italy had raised the question of utilizing sulfonamides instead of tetracycline in the treatment of carriers, stated that an investigation had been carried out in a village of 500 inhabitants near Abidjan, in which a number of cases of cholera had occurred and 20 per cent. of the population had been found to be carriers. The investigation had shown that sulfonamides constituted an effective method of chemoprophylaxis by reducing the spread of the vibrio. The method should be limited to localities with high mortality. Although tetracycline would have yielded similar results, its utilization would have been more expensive and difficult. As for the dangers of sulfonamides, his delegation believed that the situation in that regard was the same as in the case of pesticides and that the position taken should also be similar. In countries of the African Region where the health infrastructure was inadequate and where there was a shortage of qualified staff, the present urgent situation regarding cholera called for the utilization of sulfonamides since they reduced morbidity and mortality by limiting the spread of the disease.

Dr. POATY (People's Republic of the Congo) said that although his own country was not affected by the disease, the proposal to delete cholera from the list of quarantinable diseases called for comment. Reference had been made to the fear of economic sanctions and to the difficulties of notification; it seemed to him, however, that the health infrastructure and environmental sanitation were the essential considerations, since cholera was no longer to be feared once adequate health services and an adequate level of hygiene had been achieved. The problem therefore was whether the criteria on the basis of which cholera had been put on the list of quarantinable diseases were still valid or not.
Dr SÁENZ SANGUINETTI (Uruguay) said that, although his country had not suffered from a case of cholera over the past century, it was not indifferent to the present pandemic since no country could consider itself safe, as had been proved by the outbreak of cholera El Tor in West Africa. Although cholera El Tor exhibited certain differences from classical cholera, it could still be fatal. Accordingly, safeguards should be retained and there should be no implication that the disease was not a serious one because of advances in treatment.

Quarantine was admittedly difficult to enforce adequately in an era of fast international transport.

He commended the sound action taken by the Director-General and approved by the Executive Board, since the notification of the existence of cholera in a country by WHO, in the absence of notification by the government of the country itself, made it possible to follow the course of the pandemic and neighbouring countries could take the necessary preventive measures. WHO action in that sphere was praiseworthy. The essential measures were improvement in bacteriological diagnosis, environmental sanitation, general health education and health education in schools, and strengthening of the medical and paramedical infrastructure.

Certain points called for further study. More extensive epidemiological investigations were needed to solve the question of carriers, and the resistance by the El Tor vibrio to tetracycline encountered in Japan and the Philippines should be looked into.

Dr NUR (Somalia) recalled that his country, like many others in Africa, had been affected by the cholera pandemic in 1970 and 1971. The first case had occurred in December 1970 and had been reported to WHO. Through its own efforts and with help from WHO and from friendly countries, Somalia had been able to limit the spread of the disease. Experience showed that sanitation played a major role in the prevention of cholera. Personal contacts and sharing of food were mostly responsible for the spread of the disease.

Communicable diseases, more especially cholera, knew no political boundary. Accordingly, contacts had been made with neighbouring countries at the district and provincial levels as early as December 1970. WHO could play an important role in assisting contacts between neighbouring countries, whether or not they were in the same region.

Cholera was a disease which was not thoroughly understood by many people and consequently surveillance was not easy for the developing countries. Accordingly, his delegation would emphasize the need for careful consideration of the question of deleting it from the list of quarantinable diseases.

Professor RAJASURIYA (Ceylon) noted that mention had been made of difficulties in obtaining rehydration fluid in an emergency. There had been no cases of cholera in Ceylon for about 30 years. However, he would refer to experience in the use of a natural rehydration fluid for certain cases of dehydration, which should prove useful to other countries and was easily available in most countries in Africa and Asia. It was contained in the young coconut and was a natural, sterile, pyrogen-free fluid, enclosed in a naturally hermetically sealed container. In composition it resembled a five per cent. glucose solution containing potassium, magnesium and calcium, and no sensitivity occurred to the minimal quantities of protein present. Each nut contained between 500 and 600 ml of fluid. However, sodium chloride, which should be easily obtained, would have to be added. Full details had been given in the Ceylon Medical Journal, Vol. 2 (New Series), December 1954. The fluid, which was very cheap, was immediately suitable for intravenous transfusion. It had been used in Cuba, Thailand and the United States of America. He would commend the idea to the technical experts as, with the addition of sodium chloride, it should prove an ideal rehydration fluid.
Professor YANAGISAWA (Japan) said that, although cholera could be prevented in good conditions of sanitation, there were undoubtedly many countries where at the present time those conditions had not yet been achieved. Accordingly, his delegation was unable to agree with the proposal put forward at the previous meeting by the United States delegation. Indeed, his own delegation would emphasize the need to give priority to studies for the improvement of cholera vaccines and for new anticholera drugs; such studies should be supported and co-ordinated by WHO.

In his own country, only a few imported cases had occurred and been reported upon, although Japan was situated very near the cholera-infected area. Mass vaccination for the prevention of cholera was not being carried out in Japan. A satisfactory surveillance system enabling an early diagnosis to be made by laboratory examination had already been established. Consequently, it had proved possible to cope with cholera cases by means of rapid hospitalization and appropriate medical treatment. His health services attached great importance to the speed and accuracy of laboratory diagnoses, in view of the fact that some diarrhoeas presented clinical symptoms similar to those of cholera.

Dr CUMMINGS (Sierra Leone) congratulated the Director-General and his staff for the excellent documentation submitted and the prompt action taken to combat the outbreak of cholera in the African Region. In that connexion, he paid special tribute to the Regional Director for the training courses arranged for health service personnel who had to deal with the pandemic. He referred to the co-operation recently established between a neighbouring country and Sierra Leone in the fight against cholera. A programme of joint action had been arranged for the border areas and it was hoped that the results would be as encouraging for cholera as they had been for smallpox.

Commenting on the proposal of the United States delegation to delete cholera from the list of quarantinable diseases, he said that his delegation had doubts as to whether such a move would be in the best interests of international health. Three main elements had been recognized in the control of cholera, namely, improvement of environmental sanitation, adequate facilities for early and effective treatment and preventive vaccination of the population at risk. Where the first two elements could not be guaranteed, as in most developing countries, he failed to see how it was possible to relax the present alarm system for dealing with cholera. Unless the importance and potential danger of the disease were stressed at all times, there was the risk of whole populations being decimated before the gravity of the condition was realized, and international assistance might be tardy in arriving.

Dr HUSSAIN (Iraq) pointed out that recent studies had shown that many foodstuffs, particularly vegetables and fruit, from markets in endemic areas were free from cholera vibrios. There was no epidemiological evidence to justify the strong measures often taken against countries where cholera had been reported, such as bans on the importation of certain foodstuffs. Such excessive measures might make countries hesitate to notify suspected cases. His delegation appealed to all Member States to adhere to the International Health Regulations, since excessive measures could lead to difficulties in trade, travel and communications.

Professor SHEHU (Nigeria) congratulated the Director-General on his excellent and comprehensive Report. In his statement in plenary, the Federal Commissioner for Health of Nigeria had described the country's state of preparedness, the arrival of cholera, the action subsequently taken, and the success of control measures. The measures taken were similar to those described by the delegate of Kenya.
Professor Shehu confirmed that the method of spread in Nigeria had been by direct contact in nearly all cases. Cholera had arrived in the country during the dry season when there was little surface water. He was concerned about what would happen in the rainy season, when normal sources of drinking water could easily be contaminated. He wondered whether an epidemic of the classical type might occur. Since the answer to this question was not known, preparedness must not be relaxed. WHO should increase its assistance in the provision of supplies and intensify efforts to discover more effective vaccines.

He was interested in the dynamics of the epidemic, which had spread westwards half way along the North African coast, then south to West Africa. He asked if there was any explanation for this. Now that cholera had reached Cameroon, he wondered whether it would continue eastwards across Central Africa or follow the coastline to southern Africa.

Finally, he expressed strong support for comments of the delegate of Sierra Leone with regard to the question of removing cholera from the list of quarantinable diseases.

Dr Kamal (United Arab Republic) paid tribute to WHO's efforts during the cholera pandemic; they had helped very many countries in a short time. He expressed agreement with the delegate of the USSR, who had questioned the assumption regarding the mildness of cholera El Tor by comparison with classical cholera. Those holding the customary view missed the essential difference between the two epochs in the history of cholera. During the first epoch, prior to 1950, doctors and treatment centres had been few, methods of treatment offered no guarantee of cure, roads and transport facilities were poor, and people were fatalistic. All those factors contributed to the apparent severity of cholera. In the second epoch, since 1950, treatment was more effective, more doctors and treatment units were available, and roads and transport were better. People saw their neighbours return fit and well within about 10 days, and that encouraged them to report for treatment themselves at an early stage. Those factors contributed to the impression of the comparative mildness of cholera El Tor.

It had been stated that there were more asymptomatic infections in cholera El Tor than in classical cholera. When the seventh pandemic began in 1960-1961 there had been a massive outflow of people, equipment and funds for research from WHO, the United States, and Japan, and the detection of more asymptomatic infections was due to new knowledge rather than to the El Tor vibrio. It had also been stated that secondary cases of cholera El Tor were rather rare. In an extensive outbreak of classical cholera in 1947 and further outbreaks in Bangkok in 1958 and 1959, more than 90 per cent. of the households affected had only one case. That showed that the occurrence of one case per house was a feature not of cholera El Tor but of cholera in general. He believed that cholera caused by either vibrio was the same in symptomatology and epidemiology. He felt that the terms "classical cholera" and "cholera El Tor" should be replaced by the term "vibrio cholera" until such time as it was possible to distinguish correctly between agglutinable and non-agglutinable vibrios.

Referring to the prevailing opinion concerning the efficacy of vaccination, Dr Kamal drew attention to Article 63 of the International Health Regulations. In paragraph 3 two separate measures were authorized according to whether or not passengers arriving in a country had been vaccinated.

Finally, in WHO documents the present pandemic was referred to as the seventh. He contended that the seventh pandemic, which had started in 1960-1961, had ended in Jordan in 1966. During the following three years there had been no spread of the disease northwards or westwards. The present pandemic had started in 1970 and should be referred to as the eighth.

Dr Anouti (Lebanon) said that in the summer of 1970 a number of bacteriologically confirmed cases of cholera had been hospitalized in Lebanon, where the disease had been
unknown for several decades. The mortality for the country as a whole had been 4.2 per 100 000 population. Most of the cases had occurred in highly populated urban areas and in backward rural areas. Analysis had shown that adults over 40 were most affected, followed by the 5-9 year age-group and young adults. The 0-4 and 10-14 age-groups had been least affected. The mortality rate among patients had been 11.7 per cent. All the deaths had occurred in patients who arrived at hospital in a state of advanced dehydration.

In all cases confirmed by laboratory examination the causal agent had been the vibrio biotype El Tor, serotype Ogawa. The vibrio had nowhere been found in piped urban water supplies, but had been isolated from well water in one village. Vibrios had been found in nine of 47 samples of sewage wastes discharged into the sea. In the early stages of the epidemic, surveys had revealed a considerable number of healthy carriers, as many as 10 per cent. among contacts in some small samples. Carriers had become rarer later, and not a single one had been found among 10 000 travellers visiting Saudi Arabia in October and November 1970.

Dr Anouti made two concluding remarks. First, Lebanon had become a victim of cholera because other countries in the area had failed to notify the disease in accordance with the International Health Regulations. Second, some countries were still demanding vaccination certificates for passengers from Lebanon and were applying measures in contravention of the Regulations. He appealed to all Member States to apply all articles of the Regulations correctly.

Dr BAH (Mauritania) congratulated the Secretariat on the excellent document it had produced. Cholera had not so far reached Mauritania, but the country's public health authorities had been extremely anxious when the epidemic broke out in Africa; they had applied control measures at the frontier, carried out vaccination in the areas that seemed the most likely to be affected, and laid in stocks of rehydration fluid, drugs and vaccines. He expressed gratitude to the Regional Office for Africa for its prompt assistance, and to France and Morocco for the supplies they had provided.

With regard to notification, it was essential that Member States should respect the International Health Regulations and notify cases of cholera in good time. That would enable other countries to follow the spread of the disease and to prepare effective control measures. However, he felt there was an inconsistency in resolution EB47.R31, in which the Executive Board "considers that the Director-General should notify all States if he is satisfied, on the basis of firm epidemiological, clinical and bacteriological information available to him, that cholera exists in a country". He could not see how the Director-General could obtain reliable information of this kind without the co-operation of the country concerned. He felt it was not desirable that WHO should act on behalf of governments; it was preferable to request all countries to comply scrupulously with the International Health Regulations.

In developing countries where there was a shortage of qualified health manpower and an inadequate health infrastructure, surveillance activities at frontiers were essential in order to detect the first imported case of cholera and prevent the spread of the disease. In Africa, unless international assistance with environmental sanitation was forthcoming, it would be difficult to prevent cholera from establishing itself as an endemic disease for a long time to come.

Dr Bah said he had been interested by the views expressed by the delegate of the USSR at the second meeting of the Committee and by those of the delegate of the Ivory Coast on chemoprophylaxis, since they did not agree with the traditional views. He felt that WHO should make a comparative study of those topics, since present information was clearly insufficient.
Sir George GODBER (United Kingdom of Great Britain and Northern Ireland) said that the only case of cholera in the United Kingdom had been an imported convalescent case. He felt there was a danger of the Committee spending too much time discussing whether cholera should be removed from the list of quarantinable diseases. He reminded delegates that the United States proposal was merely to study this question, not to take any action at this stage.

No known vaccines for the prevention of any diarrhoeal diseases were fully effective, but the delegate of Tanzania had been right to ask for guidance on the use of the vaccines that were available. Whatever precautions were taken it was impossible for a country to keep out all cholera cases, but once the disease was introduced the subsequent spread of the disease would depend very much on the circumstances of the country concerned. A serious epidemic was unlikely in a country such as the United Kingdom, but there had been public demand for preventive measures and appropriate action had been taken. Often health authorities had to deal with a panic situation where panic was not necessary. WHO had handled the present outbreak well, and might help further by advising what countries should do if threatened by a cholera outbreak.

He said he would be unwilling for cholera to be removed from the list of quarantinable diseases unless it was absolutely certain that other measures were sufficient to provide the information that was needed by all countries, especially those near to countries where cholera had occurred.

Dr BANA (Niger) suggested that, since many important questions had already been asked, the debate should be suspended in accordance with Rule 61 of the Rules of Procedure, so as to give the Secretariat an opportunity to reply to the questions.

Dr TABONA, Secretary, pointed out that Rule 61 referred to the closure and not to the suspension of the debate on an item.

Dr BANA (Niger) then proposed the closure of the debate.

The SECRETARY, at the invitation of the CHAIRMAN, read out Rule 61 of the Rules of Procedure. He pointed out that Dr Bana's proposal would mean that the Secretariat could not reply to questions.

Dr BANA (Niger) withdrew his earlier proposal and proposed that the Chairman's list of speakers on the item under discussion should be closed.

It was so agreed.

Dr HACHICHA (Tunisia) said that his country had not been spared by the pandemic, but it had been possible to contain it immediately, thanks to a warning from the Libyan Arab Republic, to the measures taken by the Minister of Public Health of Tunisia to prepare the health services, and to the assistance of WHO. He complimented the Regional Director on the promptness of the assistance to Tunisia and other countries of the Region, and thanked friendly governments for their co-operation.

Cholera was less frightening now that more was known about it, and the present discussion had been helpful. However, he was perplexed by the view of certain delegations that cholera should no longer be considered a quarantinable disease. They must know that the introduction of the disease into a country could not be prevented, that there were asymptomatic forms, and that the disease was highly epidemic and dangerous in countries with inadequate medical services and poor sanitation. In those countries, where surveillance was not always possible, vaccination remained a necessary measure of prevention, whatever the value of the vaccine or the duration of the immunity conferred. He wondered what would have happened to his own country if three million of the population of five million had not been vaccinated with all possible speed. Vaccination - at least for exposed populations - and rapid treatment of early cases were especially necessary when there were no laboratories for the early diagnosis of overt and particularly of inapparent cases.
His remarks were of little or no relevance to countries where the environment did not favour infection and spread of the disease. The danger of an epidemic was remote in such countries when they had well-developed sanitation, and he appealed to them to relax their restrictions on travellers and goods from affected developing countries so as not to damage their economy. A result of such action would be that affected countries would notify cholera more readily.

He urged the rapid introduction by developing countries of measures to improve environmental hygiene. For that purpose the assistance of WHO and the United Nations Development Programme (UNDP) would be required. He referred particularly to the need for the provision of safe drinking-water in rural areas, waste disposal systems and the improvement of wells and reservoirs. He hoped that WHO would intervene to persuade governments to give a high priority to sanitation and environmental hygiene.

Dr SAADA (Syria) said that when his delegation had proposed that cholera be removed from the list of quarantinable diseases its aim had been to eliminate the panic caused by the disease and to encourage governments to declare possible cases, thus favouring collaboration between countries in measures to arrest epidemics.

Syria had used a locally produced serum for treatment in the last epidemic. It consisted of 5 g sodium chloride, 4 g sodium bicarbonate and 1 g potassium chloride, and was used in association with tetracycline administered intravenously. There had been no deaths among treated cases.

Dr AFFARA (People's Democratic Republic of Yemen) said that his country, which had an international port, had not been affected by the pandemic. Strict preventive measures had been introduced with the help of WHO.

It was easy for highly developed countries with advanced sanitation that had overcome the serious communicable diseases to press for the removal of cholera from the list of quarantinable diseases, but for developing countries environmental sanitation was still in its infancy. He endorsed the statement of those delegates who had advocated that cholera be kept on the list until every aspect of infection and control had been studied.

Dr DOLGOR (Mongolia) said that his country had so far remained free from cholera but could not afford to be complacent, since the pandemic had extended beyond the epidemic foci of cholera and Mongolia had no experience in the control of the disease. His delegation therefore could not agree with the proposal to remove cholera from the list of quarantinable diseases. Moreover, some thousands of visitors from all countries, including those affected by cholera, were expected for the fiftieth anniversary of the Revolution, and the Government would be lacking in its responsibilities to the population if it did not apply the provisions of the International Health Regulations.

Dr MAHLER, Assistant Director-General, replying at the invitation of the CHAIRMAN to questions raised by members of the Committee, said that the Secretariat was heartened by the expressions of appreciation of regional and inter-regional co-operation. Such co-operation spared the Director-General painful decisions.

Replying first to questions about the epidemiology of cholera, he confirmed that, as the delegate of Indonesia had said, there were many elements missing for the preparation of a complete, infallible mathematical model of the behaviour of cholera. But WHO had derived from its research programme and assistance to countries such information on the mode of transmission and the role of carriers as provided nearly enough elements to construct a model which would be useful in weighing the cost-benefit advantages of vaccination, simple sanitary measures, treatment and isolation. The Organization would have to make further efforts to fill in the gaps in knowledge of the epidemiology of cholera. For example, as the delegate of Nigeria had said, nothing was known of the connexion between the occurrence of rains and cholera outbreaks. In
Calcutta the cholera outbreak had come before in the Philippines during, and in East Pakistan after the rains. Nor was it known why cholera had moved out of the Celebes in 1961. The delegate of Nigeria had also asked how jumps occurred in cholera transmission. It was only known that air traffic from east to west had been partly responsible for the transmission in Africa.

The delegate of the United Arab Republic had felt that it was perhaps wrong to speak of the seventh pandemic at present and that it should rather be referred to as the eighth. WHO saw no reason to doubt that there had been continuity, although there had been a gap of three years in the reporting of its spread that might justify calling it the second phase of the seventh pandemic.

Many delegations, including those of Israel, Italy, Kuwait, Spain, Switzerland and the USSR, had referred to the role of food in cholera transmission. WHO had been involved for many years in studies to simulate natural contamination of all kinds of vegetables and other food products, and had even used stools from cholera patients to try to quantify cholera vibrios, but it had emerged that food was not a likely means of transmission, as was reported in the recent volume in the WHO Public Health Papers, series No. 40. Furthermore, as had been pointed out by the delegate of the USSR, no report from a country could be found to confirm that a cholera outbreak had been due to food imports. That did not mean that food handling in households was not an important factor. It was. But innumerable samples had been taken in endemic foci such as Calcutta and the Philippines and cholera vibrios had not been cultivated from them.

On the question of cholera control, and in reply to the delegate of Poland, he drew attention to the statement in the sixteenth report of the Committee on International Surveillance of Communicable Diseases to the effect that the best way to prevent the spread of cholera was to make the country resistant to it, as its introduction was virtually impossible to prevent. Thus the three measures of early detection, adequate treatment and good reporting seemed to be the most effective method, as had been demonstrated by Czechoslovakia and the USSR when they were threatened by the disease. It was encouraging to note that the same results seemed to have been achieved in a totally different social and economic situation, in Kenya.

WHO had a long record of field studies of various types of complex and monovalent vaccines and of laboratory studies of toxoid and live vaccines including dependent ones, but it could not be said that the chances of developing a better vaccine over the next five years were very good.

On the question of drug treatment, and in particular the usefulness of sulfa drugs in preference to tetracycline, he said that, because sulfa drugs were useful against dangerous infections like cerebrospinal meningitis, it was too risky, in view of the possibility of untoward effects and of induced resistance to the meningococcus, to use them extensively against cholera. It also appeared that there was not much difference in price when tetracycline and the sulfa drugs were bought in large quantities. It was clear from WHO studies that the effect of tetracycline on vibrios was much more rapid and marked than that of the sulfa drugs.

In answer to the question about the use of coconuts for the production of rehydration fluid, he said that there was a danger that the high potassium content of coconut milk could seriously affect a cholera patient receiving large quantities.

The delegate of Trinidad and Tobago had asked how to prepare for a possible cholera invasion. It was most important to make the population and medical staff fully aware of the risks and to decide on priorities for prevention and possible treatment. It was also advisable to train a surveillance team in the epidemiological tracing and diagnosis of early cases. WHO did not wish to exclude the possibility of selective vaccination, but the need must be carefully considered in the light of a country's particular epidemiological situation.
A number of delegations had expressed concern about the presence of cholera on the list of diseases under the International Health Regulations. The delegate of the United States of America had suggested that the Director-General might wish to undertake a study of the possible repercussions of its removal and report to the Committee on International Surveillance of Communicable Diseases, which would then report back to the Health Assembly.

The delegate of Romania had asked about the usefulness of an "exception certificate". In that connexion he drew attention to the section on contraindications to vaccination in relation to international travel in the sixteenth report of the Committee on International Surveillance of Communicable Diseases, where it was recommended that further information should be sought on adverse reactions.

Annex C to that report provided an elaborate legal answer to the question raised by the delegate of the United Arab Republic on the relevant application of Article 63 of the International Health Regulations (1969).

Dr WONE (Senegal), Rapporteur, at the request of the CHAIRMAN, read out the following draft resolution:

The Twenty-fourth World Health Assembly,

Having noted resolution EB47.R31 of the forty-seventh session of the Executive Board;

Having reviewed the report by the Director-General on the present problems caused by the spread of cholera;

Noting the action taken by the Organization in response to the requests of governments during the pandemic; and

Realizing that cholera is a long-term socio-economic problem, in addition to being a public health problem;

1. CONGRATULATES the Director-General on the action taken;

2. REQUESTS the Director-General:

(i) to take appropriate measures so that the Organization can continue to respond rapidly and effectively to the continuing needs caused by the cholera pandemic;

(ii) to give high priority to long-term programmes aimed at the improvement of water supplies and environmental sanitation and personal hygiene, which will prevent cholera from becoming endemic in newly invaded areas and will ultimately lead to its elimination from endemic foci;

(iii) to undertake further studies for the development of more effective methods for prevention and control of cholera;

(iv) to undertake a study of the implications of removal of cholera from the International Health Regulations and to report to the next meeting of the Committee on International Surveillance of Communicable Diseases.

Professor HALTER (Belgium) suggested the addition of a paragraph inviting countries with sufficient means to contribute to the Voluntary Fund for Health Promotion in order to develop the activities requested for cholera prevention and control.

Dr VASSILOPOULOS (Cyprus) seconded the proposal, and stated that his Government had already contributed to the Fund for that purpose.

Professor BURGASOV (Union of Soviet Socialist Republics) said that, since cholera prophylaxis by vaccination had been under study for several years and progress towards the
production of an effective vaccine had been made in the USSR, it might be desirable to include in the draft resolution a request that the Director-General take steps to intensify research on cholera vaccines with the assistance of countries having experience in the matter.

His delegation shared the view that food exported from affected countries played no role in the cholera pandemic. A statement in the draft resolution that that was WHO's opinion would be sufficient to enable countries to work out their own recommendations. In the absence of such a statement, he would request the Director-General to make a special study of the problem, or convene a group of experts to study the information available, with the aim of securing the removal of restrictions on food imports, which were hampering international trade. If the matter could be cleared up it would be easier for WHO to obtain information on the cholera situation.

Dr SULIANTI SAROSO (Indonesia) requested that a more definite comment on the limited value of vaccination could be included in the draft resolution to give health administrations grounds for a more positive stand against those making political capital out of publicity for mass vaccinations.

Professor SHEHU (Nigeria) asked if it was not perhaps necessary to include in the draft resolution a request to the Director-General further to strengthen national efforts in the production of rehydration fluids, antibiotics and cholera vaccine.

The meeting rose at 12 noon