WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

NINETEENTH WORLD HEALTH ASSEMBLY

A19/P&B/Min/3
9 May 1966

ORIGINAL: ENGLISH

COMMITTEE ON PROGRAMME AND BUDGET

PROVISIONAL MINUTES OF THE THIRD MEETING

Palais des Nations, Geneva
Monday, 9 May 1966, at 2.30 p.m.

CHAIRMAN: Dr A. NABULSI (Jordan)

CONTENTS

Note: Corrections to these provisional minutes should be submitted in writing to the Chief, Records Service, Room A.843, within 48 hours of their distribution.

1. DEVELOPMENT OF THE MALARIA ERADICATION PROGRAMME: Item 2.3 of the Agenda (Resolution EB37.R33; Document A19/P&B/3) (continued)

Dr SAYCOCIE (Laos) said that, as would be seen from the section of the report (document A19/P&B/3) which concerned his country, it was not always possible to bring to fulfilment plans for a WHO-assisted pre-eradication programme.

The programme in Laos had begun in 1951, with American financial assistance. The campaign, directed by an American malariologist with the assistance of medical personnel provided by the Government, had achieved only limited results up to 1956, in which year the Government had signed a six-year contract with the United States Overseas Mission with a view to the methodical intensification of irrigation work. The preparation period for the attack phase had begun with some measure of success. A technical adviser from the United States Overseas Mission, together with a medical expert and four technicians from Finland, had from 1956 to 1960 worked with their Laotian opposite numbers, comprising a medical administrator, assisted by three other doctors at the central office and by technical personnel, recruited from among candidates who had completed six years' schooling and followed a six-month accelerated technical course at the malaria school in Finland. After four years of intensive work by the malaria services, the Government had taken steps in 1961 to implement the programme by means of routine malariometric surveys, DDT spraying operations and case-finding. A number of entomological studies had been carried out, but the results had been inconclusive.

Surveys and spraying operations had been carried out in most provinces between October 1959 and March 1960, 813 000 inhabitants being protected out of the 1 200 000 that the programme had been intended to cover. The inability to reach that target had been due to administrative and financial difficulties, the deteriorating political situation in the country and the lack of an adequate health infrastructure.

The training of specialized personnel had been the first concern of the Government from the programme's inception, and with the assistance of the United States Overseas Mission and of WHO, a number of doctors, nurses and technicians had been trained.

From August 1960, however, the national eradication service had been in abeyance, the Government being unable to afford the measure of support that an eradication programme demanded. The possibility was being explored of instituting an experimental polyvalent health programme, beginning with door-to-door case-finding activities in limited areas. An encouraging response to a request for assistance had been received from UNICEF, and it was hoped that the malaria eradication programme in Laos might be resumed at the beginning of the financial year 1966/1967, at least in the regions of greater security. Should UNICEF, however, be unable to finance the programme, he would be grateful for WHO's advice on what should be done.

Dr JALLOUL (Lebanon) congratulated the Director-General on his report. He had little to add to the summary it contained of the situation in his country, whose malaria services remained constantly on the alert against the continuous threat of imported cases.

He drew attention to section 3 of the report, in which mention was made (page 21) of the first meeting of the Malaria Eradication Co-ordination Board of Jordan/ Lebanon/Syria in June 1965. Such meetings would continue to be held periodicially for the exchange of information and mutual aid.

He expressed appreciation of WHO's assistance in the programme.

Dr GONZALEZ (Venezuela) expressed satisfaction with the report, which was an objective one showing neither a negative pessimism nor an unfounded optimism.

He would refer in his remarks more to what remained to be done in Venezuela than to what had already been achieved. The area now in the attack phase represented four per cent. of the originally malarious areas. That relatively small sector had proved a very difficult one, and had clearly demonstrated the truth of the law of diminishing returns.

His country had learned some interesting lessons from its experience with the eradication programme. The first referred to the epidemiology of malaria, which did not conform to any rigid or orthodox rules. It was necessary to adapt to a variety of sometimes unforeseen conditions requiring new measures, frequent changes and rapid decisions. Such epidemiology could not be learned from textbooks but only by day-to-day experience in the field. In many cases the solution depended not so much on economic factors as on the availability of devoted and enthusiastic personnel.

Another lesson was the price that had to be paid for not having secured the interest of the general health services at the outset of the campaign. Even today, in the case of half the slides taken in areas in the maintenance phase, the work was carried out through active case-finding by specialized personnel, although there existed a passive case-finding post for an average of every 3500 inhabitants.

He expressed satisfaction at the attention being devoted to research, particularly with regard to finding long-acting and easily administered drugs. That was a particularly interesting aspect for his country. When considering the general policy of the eradication programme it was necessary to keep in mind what was practicable as well as what was easy, and not be carried away by initial successes.

Dr MONTALVAN (Ecuador) commended the report on the world-wide eradication of malaria, which was one of the most complete ever presented.

Ecuador had been one of the first countries to carry out an eradication campaign. From the outset residual insecticides, mainly DDT, had been used, and in spite of all the difficulties encountered that method remained the main weapon for eradication. Other methods should be applied only in special areas where results could not be obtained by normal means. Large areas throughout the world had benefited from the use of residual insecticides; malaria had been eradicated from many of them, and others had reached the consolidation phase.

In spite of all the economic and political difficulties in his country great results had been achieved, and a large area had reached an advanced stage of consolidation which almost amounted to eradication. There remained, however, some difficult areas in which the problems were due rather to administrative shortcomings arising from economic difficulties than to biological resistance.

Instead of going into the details of the campaign in his country, he would prefer to mention some general principles. First, an eradication campaign was a difficult undertaking, as had been pointed out by the delegate of Venezuela, a country which had been a pioneer in eradication. It was difficult above all because it called for perfection in all its phases, and absolute perfection was not a characteristic of human work. Great tenacity was therefore needed to overcome the imperfections.

Another important point was the need to organize the health infrastructure, particularly in rural areas, to serve as a base for the programme and to take over the campaign in its final phase of epidemiological surveillance. He had to confess that in his country the health infrastructure was still not sufficiently developed. In the face of that problem it was necessary to incorporate in the general health services all the personnel of the malaria eradication campaign, or for the health services to give precedence to the organization of the campaign so that it could carry out surveillance and evaluation and maintain the benefits achieved.

He congratulated the Organization on its work.

Dr HSU (China) said that the report was a very comprehensive one, giving a good presentation of the situation, activities and progress of malaria eradication throughout the world.

His delegation was particularly happy that, as stated in the report, Taiwan had in 1965 been entered in the WHO official register as having achieved eradication, thus bringing the population in originally malarious areas in which eradication had now been achieved from 32 000 000 to 44 000 000. He expressed his Government's appreciation to the Organization, and to the Regional Office for the Western Pacific in particular, for its continuous assistance throughout the operation of the programme.

He recalled that in 1947, when malaria control activities in Taiwan had been started, there had been an estimated 1 200 000 cases annually out of a total population of 6 000 000, i.e., one case in five. After sixteen years' effort by his Government, with WHO assistance, the disease had now been completely eradicated, no new cases having been detected since 1962 in spite of intensified detection activities.

The transfer of surveillance responsibility from the national malaria eradication service to the regular health services had been completed during 1964, the surveillance operations throughout the country thus becoming the direct responsibility of the local health service. One of the established principles in the organization of the malaria eradication programme in Taiwan had been the centralized direction and decentralized execution of operations. With the complete organization of the passive case-detection network and the strengthening of the regular health services, the latter were now assumed to be capable of undertaking vigilance activities in the maintenance phase.

The success of his Government's programme was due to the fact that it had consistently followed the procedures and methodology of malaria eradication established by WHO in 1955.

He emphasized the importance of the programme to economic development. Tremendous improvements had been achieved in his country in agriculture, industry and communications during the past sixteen years. The national gross product was now increasing at the rate of seven per cent. per annum. The economists fully realized the contribution made by health personnel through malaria eradication and were aware of the economic importance of health activities generally.

Taiwan could serve as an example of the feasibility of eradication and of the essential part played by international co-operation.

Mr MAGALE (Central African Republic) associated himself with the congratulations that had been expressed, and supported the amendment to the draft resolution contained in resolution EB37.R33 proposed by the delegation of Romania at the previous meeting, in as much as it called for intensified assistance for the training of national staff. It was for lack of qualified personnel that his own country had been unable to plan a pre-eradication programme. An international centre had been established at Lomé (Togo) for training such personnel. His country was very pleased with that development, but the rate of output was not yet sufficient to provide the necessary numbers. He hoped that WHO would increase its efforts for training of personnel, without whom the execution of a well-established programme could only remain a dead letter.

At present, the campaign in his country was confined to spraying and to the preventive distribution of nivaquine to pre-school children, about 80 000 of whom had thus been protected. His Government intended in the near future to call upon WHO to study the possibility of an eradication programme.

Dr GERIĆ (Yugoslavia) thanked the Director-General for his excellent report, which went a long way towards clarifying the difficulties, which were sometimes subjective, and sometimes objective, in nature. They arose in the first place - particularly in Africa - from a lack of basic health services, and often from the impossibility of applying the requisite methods and procedures for want of sufficient financial resources.

It had been demonstrated that eradication was fully possible. His country had encountered great difficulties, and it was only thanks to constant vigilance that the present phase had been reached. Once vigilance was relaxed the possibility of new cases could arise even if a substantial health infrastructure existed. As could be seen from the report, not a single case of malaria had been reported by Yugoslavia during the past year, and the country was now in the maintenance phase. Vigilance, however, must continue.

The eradication campaign must be pursued energetically, while adapting to new conditions and problems. WHO should concentrate its efforts on difficult zones, particularly in Africa, and upon research, which could help in overcoming many of the technical difficulties that had beset the eradication campaign.

He supported the amendment of the delegation of Romania.

Dr ALAN (Turkey) congratulated the Director-General on the excellent report and on the activities that had been undertaken.

His country had already had a quarter of a century of experience by the time it transformed its malaria control programme into an eradication programme in 1957. In spite, however, of that long experience, and of the great efforts made, it had not yet been possible to eradicate the disease, although the initial plan had foreseen such eradication within five years.

Administrative, financial and technical difficulties had been responsible for that situation. A glance at the section of the report which concerned his country would show that those difficulties remained. It was stated (page 69) that spraying operations had fallen behind schedule owing to financial difficulties, delays to supply of insecticides, and to lack of personnel which there had been difficulties in recruiting owing to inadequate salaries.

Another important point was that of integration of the campaign into the public health services. In that connexion he drew particular attention to the following passage in the report (page 70):

> ". . .The public health services under the nationalization scheme have since 1963 been undergoing a development aimed at establishing a network of rural health centres, each of which will cover 9000 persons. This development is being undertaken first in the eastern provinces and will continue until total coverage of the country is achieved in 1975. The antimalaria activities are being integrated into the nationalized health service from the start but it is too early to say how well this integration is proceeding."

The health centres mentioned in that paragraph would, in fact, cover some 7000 persons rather than 9000. His country placed great hopes in the integration of the services which had already begun to yield satisfactory results. Although difficulties remained, it was, as the delegate of Belgium had said at the previous meeting, important not to be discouraged by them.

His delegation warmly supported the research programme described in section 7 of the report, and emphasized the advantage of drugs with a long-lasting effect. His Government would continue to support the eradication programme and to make its modest contribution.

Dr VAN DER KUYP (Netherlands) congratulated the Director-General on his report; in general, his delegation agreed with its conclusions.

The Netherlands, the European partner in the Kingdom of the Netherlands, was in the preliminary stages of entry in the WHO register of areas where malaria eradication had been achieved. The Caribbean partner, the Netherlands Antilles, had never reported a case of malaria; the disease was prevalent solely in the partner on the American continent, Surinam, a developing country with a wet, tropical climate, 162 000 square kilometres in area. The 1964 census had revealed the number of inhabitants per square kilometre to be 2.0; and in that year forty-six per cent. of the population were under fifteen years of age. The national budget amounted to well over 110 million Surinam guilders (one United States dollar = 1.85 Surinam guilders), of which more than ten million went on public health; of that nearly 600 000 went on the malaria eradication campaign, i.e. 5.8 per cent. of the public health budget or 0.54 per cent. of the total budget.

The Surinam Government had warmly welcomed the assistance in malaria eradication of WHO, PAHO and UNICEF. The malaria eradication campaign in Surinam had begun on 1 November 1957 with the preparatory stage, and the attack phase had started on 5 May 1958; 162 national staff were employed.

For malaria epidemiology purposes, Surinam could be divided into five areas. The first covered Paramaribo, the capital city, with thirty-four per cent. of the population: malaria had occurred sporadically in the outskirts, but on 1 January 1961 the city had been placed in the maintenance phase.

The second area, the flat rural agricultural coastal zone, represented nine per cent. of the total area, in which fifty-four per cent. of the population lived. Disastrous malaria epidemics had occurred from time to time in that area. Plasmodium vivax and malariae infections were predominant, yet P. falciparum constituted fourteen per cent. of the infections. Anopheles aquasalis was the responsible vector. The number of new cases of malaria in this zone as reported by the district physicians had been about 14 000 in 1931, 7000 in 1941, 1000 in 1951 and about 300 in 1957. That meant that malaria had been disappearing gradually in the coastal zone. The malaria eradication programme had accelerated that process, and therefore it had been possible to place the zone in the consolidation phase on 1 January 1961.

The third area, the undulating northern savannah zone south of the coastal zone, constituted six per cent. of the total area with five per cent. of the population, mainly Amerindians. Except for a few parts malaria was hyperendemic, owing to the presence of A. darlingi. Malaria transmission had also been interrupted there.

The fourth area, the hilly mountainous interior zone south of the savannah belt, represented sixty per cent. of the total area and was inhabited by seven per cent. of the population. Plasmodium falciparum malaria was holo-endemic in that part of the

country, where A. darlingi was still present. Although combined attack measures were employed, using residual insecticide house-spraying, mass drug administration and larviciding, total geographical reconnaissance, and total insecticide and surveillance coverage, had not been achieved there. To make things worse tolerance, or immunity, had been interrupted.

The fifth area was the mountainous hinterland zone bordering on Brazil, which represented twenty-five per cent. of the total area. It was inhabited by some 1000 Amerindians. P. falciparum was hyperendemic in children and adults. A. darlingi was found in that region. How the malaria eradication programme should proceed in that hinterland was a real problem. There were no roads; and neither the number of the isolated nomadic Amerindians nor the majority of their settlements were known. The houses had no walls; and the nomad population was shy of strangers. However, medicated salt might bring a solution.

In the problem areas the problems were: personnel difficulties; transportation difficulties, owing to the many rapids and waterfalls; very low population density (about 0.2 per square kilometre), with scattered villages and houses difficult of access; nomadism; sacred villages, where neither an outsider nor spraying was allowed; incomplete geographical reconnaissance; construction of new houses and remodelling of existing ones after the routine spraying; use of temporary huts far from the villages for sleeping; refusal of the population to co-operate, owing to distrust and belief in taboos; disturbance of sprayed surfaces by smoke and wiping off of the insecticide; limited numbers of case detection posts; delayed transportation of slides to the malaria laboratory; incomplete active case-finding; and possible extra-domiciliary transmission by secondary vectors.

Some ninety-three per cent. of the population of Surinam had been freed from the risk of endemic malaria, and the northern and western parts of the interior had reached the pre-consolidation stage. Transmission continued to be quite high in the problem areas in the central and eastern parts of the interior, however, while the hinterland had not yet been considered.

The opinion of WHO experts that malaria would be eradicated from Surinam by 1961 had been too optimistic and had raised false hopes; it had also caused difficulty when the Ministry of Finance had to be convinced of the need for continuing the programme. On the other hand there were good reasons not to be too pessimistic about Surinam. Skilled WHO technical staff were stationed there; a start had been made to collaborate with Brazil, French Guiana and British Guiana, although that collaboration needed to be intensified; there had been good continuity in the programme, as the government financial provision had not been interrupted; there had so far been no resistance of A. darlingi to insecticides, or of the parasite to drugs; a large hydro-electric plant had been built in the Upper Surinam River, and a storage lake of 1350 square kilometres covered one of the former problem areas. The people in the problem areas accepted the chloroquinized salt, and a medicated-salt plant was to be put into operation in May 1966, which promised to be an important new development.

Dr KEITA (Chad) said that his country was one of the malaria problem areas. Malaria was rife, and the methods of combating it were elementary, consisting of DDT spraying in administrative centres, with chemoprophylaxis among defined groups, such as schoolchildren and the army, and some work being carried out in the rest of the

country by the Service des Grandes Endémies, which unfortunately did not cover the whole national territory. There was no fully defined programme, no specialized personnel, and no financial provision. But the Fund for Aid and Co-operation (FAC) was to be thanked for its help with antimalarial drugs.

However, he could inform the neighbouring country of Cameroon, where malaria eradication was in progress, that a WHO consultant was expected in Chad to evaluate the situation with a view to starting an adequate programme. Since the lack of national personnel threatened to compromise such a programme, the draft amendment proposed by the delegate of Romania was to be welcomed.

Dr FERREIRA (Brazil) said that two main events had marked the history of malaria in his country. Brazil had been one of the first countries to eradicate Aedes aegypti - a considerable achievement in a country with an area of 8.5 million square kilometres and with eighty million inhabitants. With that, the idea had begun to emerge that malaria eradication, and not only malaria control, was possible.

Around 1930 Brazil had been invaded by Anopheles gambiae of African origin. It had cost Brazil hundreds of thousands of lives, and malaria became one of the most important causes of death: 300 000 had died in only a few years in Northern Brazil, and that from a disease that was not often lethal.

It was at that time that the possibility of eradication was appreciated. A. gambiae was a new species in the territory, and only a few of the insects had been imported by air from Africa. Attack was concentrated, not on the disease but on the mosquito. In the ten years or more since that work had been completed, not one specimen of that species had been found.

With single-mindedness and determination the idea of eradication could be made a reality; and it was of primary importance to stress that the world was united in the effort. It would be regrettable if governments were given the impression by the Nineteenth World Health Assembly that eradication could not be achieved. Eradication had in fact already been achieved in some places - in Italy, for example, the country which had given its name to the disease.

He himself had worked for forty years in Brazil against malaria. Thirty years previously, when only primitive methods could be used, it would have been considered wild talk to say that a large area could be freed of malaria. But when really effective tools became available, when eradication could be considered a purely technical problem, one no longer had the right to say that eradication was a dream: it was a question of technique, of belief, of money, and of persistence. Countries were not alone in the fight against malaria. Help was available from WHO and its regional offices, from UNICEF and from the United States Agency for International Development, together with help under inter-governmental arrangements.

All delegations, on returning to their countries, would derive support from the idea that WHO was behind their efforts. The Director-General and the Secretariat were to be complimented, together with all those workers who helped to win the very real fight to eradicate malaria.

Dr. SCHINDL (Austria) said that, in countries where no indigenous case of malaria had occurred for many years, the gradual disappearance of physicians who knew the disease from their own experience created a danger that imported cases would not be recognized and treated as necessary. It was for that reason that the Austrian Ministry for Social Administration had asked the university authorities concerned, in accordance with paragraph 6 of resolution WHA18.3 of the Eighteenth World Health Assembly, to introduce a more intensive clinical and epidemiological teaching on malaria within the medical education programme.

Dr NOVGORODCEV (Union of Soviet Socialist Republics) said that consideration of the Director-General's report on the development of the malaria eradication programme in 1965 should take into account the ten years' experience of eradication work that had been carried out in accordance with the principles laid down by the Expert Committee on Malaria in its sixth report in 1956. There was no doubt that great successes had been achieved, and that WHO had played an important part in making them possible. Nevertheless, careful study of the Director-General's

report on the programme in 1965, and comparison with his reports for previous years, gave the impression that the global malaria eradication programme was facing a crisis, for in certain parts of the world little progress had been made. It was evident that the time had come to review the most urgent tasks and aims of the programme, its methods and principles, and also the role of WHO in its realization. The aim of the programme was above all to eradicate malaria in a comparatively short time. At present, ten years after the start of the programme, the final goal was still very far from being reached. Nobody, for instance, would care to predict when it would be possible to free the African continent from the disease.

A campaign of such magnitude as that against malaria could not be pursued without clear understanding of the final aim and of the time it would take to achieve it. The time had come to review and revise plans and time-tables in order that they should be realistic, taking account of the experience acquired and the present situation in the world.

The methods and principles adopted for malaria eradication had been over-simplified and were too much alike for all countries. The many modifications made to the original doctrine had enabled it to be retained, but had made it neither more universal nor more effective.

The principles underlying the organization of eradication measures were particularly open to criticism. The facts had proved that the greatest and most lasting results had been obtained in countries such as Bulgaria, Italy, Romania,

the Union of Soviet Socialist Republics and the United States of America, where the eradication programme was a true continuation of control measures. In many countries, however, where the eradication campaign had been started without previous experience of malaria control, only unstable, temporary successes had been achieved, and their consolidation had often proved more difficult than their achievement. In 1965, reversions from the consolidation to the attack phase had been particularly numerous.

Delays in developing new national programmes had led to a situation where there were, on the one hand, countries that had already eradicated malaria, and, on the other hand, countries that had not yet begun the work; and the number of countries in the preparatory or attack phases was not only not increasing but actually diminishing. That situation would inevitably lead, in a few years' time, to a widening of the gap between the countries where malaria had been eradicated and those which could not start their programme.

The value of WHO's role had been assessed on the basis of the successes achieved in the campaigns, and particularly on indices such as the number of population living in areas freed from the risk of malaria. That index had been obtained largely because of the successes in economically developed countries, and in India; but it should not be forgotten that those countries had had little or no help from the Organization. The contribution made to the success of the programme as a whole by countries carrying out their programmes with the help of WHO was so far not great; and in most of the countries without the necessary resources for undertaking an eradication programme, and also in those where the standard methods recommended by WHO had proved ineffective (as in tropical Africa), WHO had not achieved real success.

It should be noted that WHO, still limited in its relations with the People's Republic of China, the Democratic People's Republic of Korea and the Democratic Republic of Viet-Nam, had not been truly a world body in the fight against malaria. The delegation of the USSR had more than once emphasized that, without co-ordination of malaria eradication efforts in those countries, it was impossible to secure continuous progress of the work in Asia. One could even say that the absence of a united front in South and South-East Asia, as in Africa, was the most important factor hampering the programme.

The choice of methods for preventing the difficulties that lay ahead in the world-wide malaria eradication campaign, although not an easy one, could not be delayed. He was not against the eradication programme as such. But the delegation of the USSR had always foreseen the difficulties and had pointed out that an over-simplified approach was dangerous and might lead to disillusionment. The sending of experts to countries, and particularly to the African countries, should be assisted in every way. In that connexion, the delegation of the USSR proposed the setting up of a commission of leading specialists from ten to fifteen countries, who would make a critical appraisal of the malaria eradication programme in the world over the last ten years and submit recommendations on its continuation to the Twentieth World Health Assembly.

The delegation of the USSR supported the amendment to the draft resolution proposed by the delegate of Romania, and considered that that amendment would improve the situation, particularly in the developing countries.

Dr ESPAILLAT (Dominican Republic) said that originally 81 per cent. of the total area of his country, and 82 per cent. of its population, had been considered as affected by malaria; the population living in malarious areas amounted to approximately 2 932 000. In 1948, spraying with DDT had been started in the worst areas. In 1957, a malaria eradication agreement had been signed between the Government, PAHO/WHO and UNICEF, leading to the preparatory phase of the programme in the same year. In 1958 the attack phase had been started, with annual sprayings with dieldrin, but in March 1960 sprayings were suspended upon the appearance of resistance in the vector. It was then decided to use DDT in nine-monthly cycles, resources being insufficient for six-monthly cycles. Unfortunately, for various reasons the first two cycles had extended over thirteen and twelve months respectively, in the second cycle only 50 per cent. of houses being sprayed. Despite that, the prevalence of malaria had declined in 1961.

The shortcomings of the programme were obvious, and in August 1962 the third DDT cycle was suspended in order to increase staff and provide further training. The fourth cycle was started in November 1962 but even then there were budget deficiencies and 94.3 per cent. of the houses were sprayed over a period of eleven months. In the last quarter of 1963, an adequate plan was prepared and a new tripartite agreement was signed, providing for the establishment, in January 1964, of a national malaria eradication service, with technical and administrative autonomy, an adequate budget, and responsibility to a technical council. In April 1964, when all the staff had undergone in-service training, the first cycle of spraying began, and only 11.2 per cent. of the houses were left unsprayed. The second full DDT cycle was started in

October 1964 and ended in April 1965, with 8.8 per cent. of the houses still awaiting spraying. After the third cycle, from April 1965 to December 1965, sprayings in the eastern region were discontinued, that area moving into the consolidation phase after one year of satisfactory epidemiological studies.

There had been a definite decline in the incidence of malaria, only 84 cases being registered in 1965. Moreover, in recent years there had been signs that malaria was concentrated in certain small well-defined areas.

The progress achieved in the malaria eradication campaign was closely connected with the following factors. First, the indoor spraying carried out during the period 1958-1963, although incomplete, had protected the areas where malaria was most prevalent: from 1964 onwards, three cycles of full coverage had been carried out in accordance with technical requirements and had provided protection for all the population at risk. Moreover, the DDT used from 1962 on had proved effective in interrupting transmission. Secondly, the radical cure of all proved cases of malaria from 1964 on had been a determining factor in the decline of the disease. Thirdly, the necessary measures to interrupt transmission in persistent foci of malaria had been taken without delay. Fourthly, the re-organization of the malaria service had enabled it to take administrative and technical decisions rapidly.

Professor AUJOULAT (France) recalled that every year for the last ten years the Committee, when discussing malaria eradication, had been forced to note that, despite many victories, the ultimate aim of the campaign was still far from being achieved. In vast areas of the world, including South America, Africa and South-East Asia, eradication was incomplete. Even in countries where good progress in eradication had

been made, there were still problem areas. And there were also areas, such as the African savannah, where it had had to be admitted that methods of interrupting the transmission cycle were not known.

Some States admitted that they had been over-ambitious: they had reckoned without the resistance of vectors to insecticides; they had, perhaps, underestimated the need for a network of basic health services when moving from the pre-eradication to the attack phase; or they had failed to assess correctly the requirements of the consolidation phase.

According to resolution EB37.R33, failure was attributable to deficiencies in planning and management, to shortage of material means and to financial difficulties; and the success of the campaign would depend on the sustained effort of governments, the vigilance of technicians, and the continued assistance of bilateral and multilateral agencies. The delegation of France associated itself with that resolution and with the amendment proposed by Romania.

The technical side of the eradication campaign should not, however, be neglected. Everyone was now convinced of the importance of chemotherapy in problem areas, if need be in association with disinfection campaigns. But on that point, too, unexpected problems had arisen: some countries had noted the incomplete results obtained by the systematic distribution of chloroquine. The World Health Assembly had therefore requested that mass pre-eradication or eradication campaigns should be accompanied by research work. The research programme submitted by the Director-General, and which covered epidemiology, immunology and entomology, was very encouraging; WHO was also to be congratulated on the chemotherapy studies which had led to the development and

trial of several very promising antimalarial drugs. The research work had also demonstrated the degree to which WHO had adapted its methods and objectives to the most reliable and up-to-date technical facts, and the determination of the Organization to persevere with the campaign until complete success had been achieved.

Mr GUADEY (Ethiopia) said that on page 17 of the report Ethiopia was listed among the countries of the Eastern Mediterranean Region currently engaged in a pre-eradication programme. It should be noted that, since the beginning of 1966, Ethiopia had entered the attack phase of its malaria eradication programme. The area immediately involved covered approximately one-third of the total area of the country, and had a population of about 4 000 000. It was estimated that malaria eradication would be completed by 1979, thus ridding Ethiopia of one of its gravest public health problems.

His country was grateful for the invaluable assistance given by WHO and the United States of America without which it would not have been able to embark on such a difficult and important venture.

Dr TEELOCK (Mauritius) said there had been no indigenous case of malaria in his country since January 1965. The recommendations of the WHO assessment team were already being implemented. The country was, however, faced with two main problems: first, to prevent the arrival of malaria cases from abroad; and, second, to prevent the introduction of malaria vectors into the country. In so far as the first problem was concerned, his country was pleased to note from the report that Reunion was about to embark on a malaria eradication programme. It hoped, too, that Madagascar and

WHO would soon come to an agreement on an eradication campaign for that country. In so far as the second problem was concerned, the main vector Anopheles funestus, had been eradicated in 1961, but there was always a risk of reintroduction. In that connexion, his country was opposed to the WHO recommendation that the "blocks-away" method of aircraft disinfection should be adopted. Three years previously he had stated that, in his opinion, WHO was unwise to recommend adoption of that method and, unfortunately, his fears had proved well-founded. On two occasions, the health authorities of his countries had been misled, either deliberately or through ignorance by the crews of aircraft, who had stated that their plane had been sprayed using the "blocks-away" method, when in fact it had been sprayed only a few moments before landing. Mauritius had therefore abandoned the "blocks-away" method and had started spraying aircraft upon their arrival in the country. He submitted, therefore, that WHO should reconsider its recommendation in that respect, and hoped that other countries would support his point of view.

Dr MIYAR (Cuba) said that Cuba had embarked on malaria eradication with preliminary studies, started in 1959, to delimit the malarious area of the country. In 1961 it had been concluded that the malarial area comprised 37 202 square kilometres, with a population of 2 267 000. The attack phase had begun throughout the malarious area in 1962. In 1965, 125 cases of malaria had been registered, as compared with 628 cases in 1964; also in 1965, 0.03 per cent. of all slides examined had been positive and no resistance phenomena were observed. In view of those results, the campaign had been evaluated during the first six months of 1966, and on

15 March of that year it was decided, in collaboration with experts from PASB, that an area inhabited by 400 000 persons should move into the consolidation phase. The whole campaign had been carried out with the collaboration of PAHO and in accordance with the principles and general standards laid down in the various meetings of WHO.

2. ORGANIZATION OF WORK

Dr DOUBEK (Czechoslovakia) raised a point concerning the agenda. He suggested that the Committee should not start with the consideration of items such as the smallpox eradication programme (item 2.4) or the extension of WHO activities in research (item 2.6), which needed careful prior examination from the point of view of their budgetary implications, but that at its next meeting it should first examine items having little repercussion on the 1967 budget.

Dr BERNARD, Assistant Director-General, said that it had been considered that the Committee might wish to discuss the items mentioned by the delegate of Czechoslovakia before examining the budgetary implications thereof. Alternatively, the Committee could consider the budgetary implications of those items when it reviewed the main features of the programme, under item 2.2.1 of the agenda. Both courses were open to the Committee and the Secretariat would comply with its wishes in that respect.

Dr EVANG, representative of the Executive Board, reminded the Committee that the question had been discussed at an early stage of the Organization's development. At that time, two views had been expressed. The first was that the Assembly should

decide the budget ceiling and then discuss specific agenda items. The second was that governments could not be invited to invest funds in projects about which they knew little or nothing. The procedure currently adopted was a compromise between those two points of view.

Dr NOVGORODCEV (Union of Soviet Socialist Republics) said that there were a number of items which the Committee could consider, such as the community water supply programme (item 2.12) and the following items of the agenda. It would seem that the Executive Board at its thirty-seventh session had reckoned on the question of the smallpox eradication programme being closely linked with that of the budget level and on its being carefully debated. Therefore, he supported the suggestion of the delegate of Czechoslovakia and proposed that the Committee should continue with the other items on its agenda, starting with item 2.12, and leave the smallpox eradication programme and the extension of WHO activities in research until the review and approval of the programme and budget estimates for 1967 (item 2.2) had been completed.

The DEPUTY DIRECTOR-GENERAL said that an attempt had been made to follow the order of discussion provided for in resolution WHA15.1. There was an alternative, as suggested by the Czechoslovakian delegation, and it would be for the Committee to decide by vote which alternative it wished to follow.

The CHAIRMAN requested the Committee to vote on the programme proposed in the Order of the Day.

Decision: That programme was approved by 58 votes to 14, with 10 abstentions.

The meeting rose at 5.5 p.m.

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

NINETEENTH WORLD HEALTH ASSEMBLY

A19/P&B/Min/3 Corr.1
19 May 1966

ORIGINAL: ENGLISH AND FRENCH

COMMITTEE ON PROGRAMME AND BUDGET

PROVISIONAL MINUTES OF THE THIRD MEETING

CORRIGENDA

Page 2, thirteenth line

delete Finland

insert Thailand

Page 2, seventeenth line

delete Finland

insert Thailand

Page 3, fifteenth line

delete UNICEF

insert the United States Agency for International Development (AID)

Page 3, seventeenth line

delete UNICEF

insert AID

Page 9, fifth line

delete Dr GERIĆ (Yugoslavia)

insert Professor GERIĆ (Yugoslavia)

Page 23, seventh line from bottom

delete disinfection

insert disinsection

Page 25, third line

delete 1961

insert 1951

Page 25, fifth line

delete disinfection

insert disinsection

Page 25, eighth line

delete countries

insert country