WORLD HEALTH ORGANIZATION

TWENTIETH WORLD HEALTH ASSEMBLY

ORGANISATION MONDIALE DE LA SANTÉ

A20/P&B/SR/3 Corr.1
24 May 1967

ORIGINAL: ENGLISH

COMMITTEE ON PROGRAMME AND BUDGET

PROVISIONAL SUMMARY RECORD OF THE THIRD MEETING

CORRIGENDUM

Page 27, last three lines, and page 28, first eight lines

delete the whole of Dr González' speech

insert Dr GONZÁLEZ (Venezuela) expressed great satisfaction at the clarity and objectivity of the Director-General's report. He said that his country had had no indigenous cases of smallpox for a number of years, but recognized the global importance of the disease, due to its capacity for international spread. The cost of maintaining a permanent surveillance service was high, but such a service was necessary if a country was to remain free of the disease.

He welcomed the part of the report which stated that particular attention was to be paid to obtaining the active participation of the general health services from the initial stages of the programme. That was essential to avoid the programme being just another vaccination campaign, followed eventually by an epidemic recrudescence as a result of the disease being imported into a susceptible population and the failure of the health services to keep a proper level of immunity and to maintain the required system of epidemiological vigilance. Certainly, smallpox eradication in endemic areas was feasible, but it should not be regarded as an easy job. It was necessary to have financial, administrative and technical resources which, combined with hard work, should bring success within reach.

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

TWENTIETH WORLD HEALTH ASSEMBLY

A20/P&B/SR/3
15 May 1967

ORIGINAL: ENGLISH

COMMITTEE ON PROGRAMME AND BUDGET

PROVISIONAL SUMMARY RECORD OF THE THIRD MEETING

Palais des Nations, Geneva
Monday, 15 May 1967, at 2.30 p.m.

CHAIRMAN: Dr C. L. GONZÁLEZ (Venezuela)

later: Dr A. H. THOMAS (Sierra Leone)

CONTENTS

Note: Corrections to this provisional summary record should be submitted in writing to the Chief, Records Service, Room A.843, within 48 hours of its distribution.

1. DEVELOPMENT OF THE MALARIA ERADICATION PROGRAMME: Item 2.4 of the Agenda (Resolutions WHA19.13 and EB39.R27; Document A20/P&B/1) (continued)

The CHAIRMAN invited the representative of UNICEF to speak.

Sir Herbert BROADLEY (United Nations Children's Fund) thanked members of the Committee for their expressions of appreciation at UNICEF's participation in the malaria eradication campaign and assured them that their comments and suggestions would be communicated to UNICEF headquarters.

The cost of UNICEF's assistance for malaria eradication, affecting twenty-five campaigns mainly in Latin America and the Eastern Mediterranean, had fallen somewhat in recent years and now averaged $ 5 000 000 annually. One of the proposals to be examined at the next session of the UNICEF Executive Board, in June 1967, concerned the allocation of a further $ 2 500 000 for expenditure in 1968 on eradication campaigns in seventeen Latin American countries. The governments concerned would meet all local costs in an amount of approximately $ 20 000 000.

While there were encouraging signs of determination on the part of some countries to see their campaigns through to a successful completion, that was not always the case. Several members of the UNICEF Executive Board had therefore considered, as stated in the report of the meeting held in Addis Ababa in 1966, that the time had come for a serious reappraisal of the malaria eradication campaign and UNICEF's participation in it (a view which, in his opinion, was not incompatible with the recommendations contained in resolution EB39.R27), and it had been agreed that the question of UNICEF policy in that connexion would be discussed at the

next session of its Executive Board. UNICEF was of course fully prepared to co-operate, within its responsibilities, in any new study which might be carried out to re-examine the global strategy of malaria eradication.

UNICEF shared many of the doubts that had been expressed during the Committee's debate on the shortcomings of the malaria eradication programme - for instance, inadequate planning; lack of administrative and technical services; financial limitations; the claims of other aspects of development; and a possible tendency, where there had been progress, to sit back and not finish the job.

At its meeting in February 1967, the UNICEF/WHO Joint Committee on Health Policy had noted with concern that, in a number of countries, the enthusiasm of governments for the malaria eradication programme showed signs of waning. The Joint Committee, whose views would be considered at the forthcoming session of the UNICEF Executive Board, had therefore recommended that the two organizations should use their good offices to maintain the interest of governments in following programmes through to a successful conclusion: where countries failed to provide the necessary counterpart funds, the international agencies would not be justified in continuing their assistance.

UNICEF's present policy with regard to malaria eradication had been laid down in 1964 by its Executive Board in a formal resolution which provided for the continuation of assistance in projects that were already under way and where the country concerned was meeting its agreed obligations satisfactorily. New projects were considered only where malaria was a major factor in child health, its eradication was accorded high priority in the government's plans

and to the extent that UNICEF's resources allowed. On the whole, UNICEF could make its most effective contribution by helping to develop the basic health services, particularly in the rural areas. It was possible that, in line with its agreed policy, UNICEF might decrease its assistance to the malaria eradication programme in coming years. The final decision would of course rest with the UNICEF Executive Baord but, in the event, UNICEF's increased assistance towards the development of health services should be taken into account. The Executive Director of UNICEF was emphasizing the importance of developing rural health services where malaria eradication campaigns had entered the consolidation and maintenance phases and where such services were urgently needed in neglected communities; and he had promised that UNICEF would continue to give substantial support to further the development of health services in Africa.

Research was not the responsibility of UNICEF, which was basically an operational agency, and it therefore looked to WHO for guidance on that score.

While he had every sympathy with those delegates who had requested direct financial assistance to meet the costs of organizing malaria eradication campaigns, UNICEF could not possibly afford to provide assistance on the scale required - nor, probably, could any other international organization. In 1967, UNICEF had advanced over $ 1 000 000 for eradication campaigns in two Middle Eastern countries: the countries themselves, however, had contributed ten times as much.

In referring to some of the problems of the malaria eradication programme, he did not mean to suggest that the future was wholly dark. There was much ground for hope, and a reappraisal of the programme would point the way to deploying further efforts so that the age-old threat of malaria to health and well-being could be finally eradicated.

Mr LAGHDAF (Mauritania) introduced the following draft resolution on behalf of his delegation (A20/P&B/Conf.Doc. No.1):

The Twentieth World Health Assembly,

Having considered the report of the Director-General on the development of the malaria eradication programme;

Fully convinced of the immense economic and social benefits that have been derived from the eradication of malaria in all the countries in which eradication has been achieved;

Noting the very encouraging assessment of the global eradication programme made by the Expert Committee on Malaria;

Considering that the results already obtained in the eradication field represent in fact one of the greatest victories achieved in the cause of health and justify the confidence of WHO and its expert committees in the final result of this campaign undertaken on a world-wide scale;

Noting, nevertheless, the persistence of "problem areas" where transmission is continuing despite all that is being done;

Considering the importance of the development of basic health services;

Stressing, in particular, that the continent of Africa was mentioned by the last Expert Committee as the only area in which no progress had been achieved, which constitutes an intolerable situation to which WHO cannot resign itself,

1. CONSIDERS that the elimination of this disease must be resolutely pursued both in order to secure the protection of the peoples of Africa and in order to eliminate the threat which such a large reservoir of infestation represents;

2. REQUESTS accordingly that international institutions give massive and total support to the various countries concerned, in order to accelerate the development of basic health services;

3. RECOMMENDS that the necessary diversification of means of eradication in accordance with the particular position of each country should go hand-in-hand nevertheless with co-ordination of the development of basic health services between countries having common frontiers, if necessary calling upon inter-governmental bodies;

4. EMPHASIZES the primary importance of operational research, the results of which determine the orientation of programmes and the effectiveness of means;

5. REQUESTS the Director-General to obtain from the interested organs of the United Nations their agreement to regarding malaria eradication as a sine qua non of development programmes and their agreement accordingly to giving the countries still affected all the aid required to rid them of this scourge; and

6. INVITES the Director-General to draw the attention of governments of Member States to the detailed economic and social repercussions of malaria and to eradication requirements.

The draft resolution - which was intended to supplement, and not to replace, resolution EB39.R27 - had been drafted in the light of Africa's need for improved co-ordination, even integration, of measures being carried out by neighbouring countries; and of the need for a new strategy in the fight against malaria. The African group had certain drafting amendments to the resolution, and to these his delegation had no objection.

Dr KRAUS (Yugoslavia) stressed the need for adequate vigilance of malaria-freed areas. Antimalaria services should be maintained even after eradication had been achieved, to prevent the spread of malaria through imported cases as well as its reintroduction when the parasite reservoir had been completely eliminated during the campaign; the latter applied particularly in the case of long-term Plasmodium malariae infections.

In a number of endemic and hyperendemic areas, construction work, e.g. on power stations, factories and ports, attracted a large labour force from malaria-freed regions. If such workers became infected with malaria parasites, they could easily take the disease back to their countries. The health services of the countries of origin of such workers and of the countries where they worked should, therefore, collaborate to ensure that adequate prophylactic measures were taken to prevent the reintroduction of the disease.

It would also be of value if the services of trained personnel from countries where eradication programmes had been carried out over a long period of time, or where eradication had been registered, could be made available to countries initiating pre-eradication programmes.

Lastly, he reported that the malaria eradication programme in Yugoslavia, begun in 1959 and assisted by WHO, was developing very satisfactorily. In 1968, the necessary steps would be taken to certify the eradication of malaria in Yugoslavia.

Dr OSMAN (Sudan) said that the initiation of the malaria pre-eradication campaign in his country in 1963 had brought an awareness of the difficulties involved. Not only did the basic health services have to be strengthened and health centres, dressing stations and dispensaries built, but a number of national personnel also had to be trained. Moreover, the health administrator in any developing country was confronted with the question of priorities: whether, for example, to concentrate on malaria, or on tuberculosis, or to rectify the ill effects of malnutrition. He also had to convince the ministry of finance, itself concerned with priorities, that health projects were revenue-producing. Even then, the problem of inadequate funds remained.

For that reason, the recommendation in resolution EB39.R27 for a re-examination of the global strategy of malaria eradication was important. Research on the immunology of malaria and on ways of achieving eradication at lower cost should also be carried out.

A malaria eradication training centre had been established in Sudan in October 1964 and was proving satisfactory.

In order to ensure that the malaria eradication programme was integrated into the basic health services, staff from the latter had undergone a period of training in malaria eradication before returning to their regular posts to await the start of the antimalaria campaign. In January 1967, a malaria board had been established to stimulate interest in the preparations for the eradication programme. It was composed of representatives from the Ministries of Health, Finance, Local Government, and Information, together with the director of the malaria eradication training centre and the WHO adviser.

An epidemiological assessment had been carried out in a demonstration and training area with a population of 76 000 people living in 134 villages; 355 cases of malaria had been reported, 202 among the inhabitants of the villages and 153 among the nomads and seasonal labourers. The information thus gained was important, since a considerable part of the population in Sudan was nomadic.

Dr NABULSI (Jordan) said that in Jordan the malaria eradication programme was the most important programme being carried out. A few hundred cases of the disease had appeared in 1964 following the premature termination of attack measures but, since

then, there had been significant progress and, thanks to close co-operation with WHO, the number of cases had dropped from 233 in 1965 to 58 in 1966. The programme now had every chance of success. WHO was organizing an inter-regional meeting in October 1967, with which his Government has indicated its agreement, to consider the progress of malaria eradication programmes, particularly in Jordan and in the Eastern Mediterranean Region.

In conclusion, he expressed support for the draft resolution in resolution EB39.R27.

Dr AL-HURAIBI (Yemen) said that, from the Director-General's report in document A20/P&B/1, it was evident that there was a need for the Organization to re-examine its malaria eradication programme.

In the Yemen, the pre-eradication programme started in 1964 had been suspended owing to administrative and financial difficulties. He hoped that, in future, the Organization would make greater efforts to provide his Government with technical, financial and administrative assistance for the programme. It was also to be hoped that the Organization would give due consideration to the excellent proposals made by the delegates of Italy and of the USSR.

He wished to assure the delegate of Kuwait, who had referred to cases of malaria being imported into Kuwait from the Yemen and the Arab Gulf States, that the health authorities in the Yemen applied strict measures to prevent diseases spreading to neighbouring areas. But there remained the problem of how to prevent infectious diseases being imported into the Yemen. A few months previously, for example, a case of smallpox had been imported from the occupied South Yemen, and many other

diseases had also been imported. He would ask the British authorities, who were supposedly responsible for health matters in the area, to look into the matter, and expressed the hope that the Organization would not hesitate to co-operate with those authorities in dealing with the problem as soon as possible.

Dr KEITA (Chad) informed the Committee that his Government was carrying out disinsectization of urban areas, chemoprophylaxis through the maternal and child health services, and the treatment of declared cases.

The remarks made by the delegates of Italy, USSR, Belgium and Senegal had all been most pertinent, and the statement on page 4 of document A20/P&B/1 also merited attention, namely, that "if adequate funds were provided for fully implementing operations according to technical requirements, the eventual prospects of eradication would be good".

Lastly, he expressed his delegation's support for the recommendations contained in resolution EB39.R27 and for the Mauritanian draft resolution.

Dr LOFRUSCIO (Paraguay) said that the main problem in carrying out malaria eradication in his country had been financial. Under the new financial arrangements, however, it was expected that the programme would start up again in 1967.

Paraguay was currently in the grip of a severe epidemic of malaria and the morbidity rate had reached a higher level than for several years. Cases of P. falciparum infection had been registered in which death occurred following meningo-encephalitic complications. A prolonged spell of rains and floods, and the influx of many people into the major agricultural areas, had favoured the epidemic.

At the end of 1966, 83 026 positive cases had been notified, but it was estimated that for every notified case four or five went unnotified. There had been 25 per cent. of positive cases throughout the country in 1966.

Local costs for the malaria eradication programme were estimated at over $ 5 500 000, of which the Government had said that it would contribute more than $ 3 000 000. Measures were being taken to secure a loan of approximately $ 2 000 000 from the United States Agency for International Development. The balance would be met by an increase in the Government's original contribution.

The general lines of the programme had been approved by the Pan American Sanitary Office and by UNICEF. A law had been passed to increase the share of national financial participation and the arrangements for the AID loan were soon to be concluded. It was to be hoped that Paraguay would be able to resolve its problems and that, with the help of the various organizations, the eradication campaign would finally be crowned with success.

Dr CONOMBO (Upper Volta) said that, owing to lack of resources, there was no official malaria eradication programme in his country, nor would it be feasible to introduce one in the near future. That did not mean that his Government was unaware of the importance of such a programme. Both in the bush dispensaries and in the towns, certain measures were being taken to fight the disease, but for the time being such measures were more a matter of environmental sanitation. DDT had originally been used in the towns, but for some time insecticide resistance to it had been noted; latterly, therefore, the health authorities had had recourse to the organophosphorus insecticides. The Service des grandes Endémies, established at Bobo-Dioulasso and serving as a WHO reference centre, had kindly assigned an entomologist and a research

worker to carry out trials on insecticides and anopheline resistance. Once those studies had been completed, it was hoped that further action against malaria, using new products, would be possible.

Such preventive measures, however, concerned only the towns of Bobo-Dioulasso and Ouagadougou, which accounted for possibly two-fifths of the population. Since, even in the towns, sufficient funds were not available to cover the costs of an adequate eradication campaign, what was needed was a new strategy both of vector control and of therapy. Malaria could be eradicated in the Upper Volta with the help of WHO, if there was also concerted action against the disease by the neighbouring countries. Thanks to the combined efforts of Mali, the Ivory Coast and Upper Volta, an onchocerciasis project had been possible; and a similar project was AFRO 0131, for Ghana, Togo and Upper Volta. Failing such concerted action, the eradication of malaria in Upper Volta would not become a reality for many decades.

He did not wish, however, to end on a pessimistic note: despite all the difficulties, he looked with hope to the WHO experts for a solution to the problem of the anopheles and of P. falciparum. He was also gratified to note the terms of the Mauritanian draft resolution, since action should be not isolated, but total and regional. After reading document A20/P&B/1, all would surely agree that the problem could not be resolved at country level, unless a country was very well equipped. The Regional Committee for the African Region, at its last session in Kinshasa, had considered that the possibility of combined action should be examined with a view to rendering the malaria eradication programme more efficient and had also recommended stronger support for those countries which, although unable to launch a programme of their own, were none the less well aware of the scourge malaria represented for their people.

Dr BONICHE (Nicaragua) said that he had listened to the previous speakers with great interest, but was more inclined to agree with those who expressed pessimism than with those who were optimistic. The eradication of malaria was possible, but the measures that had been taken so far were insufficient, and the programmes were not as extensive as the problems required.

In Nicaragua, a national technical commission, accompanied by WHO experts had, in 1957, investigated the problem of malaria in León. The conclusion had been that anti-malaria work should be limited to spraying and ignoring the breeding-places, as it was more important to destroy the Plasmodium than the vector. Experience had proved that this assumption was erroneous since, either because of the natural resistance of the species or owing to the indiscriminate use of insecticides, resistance had appeared. It had now become evident that a combination of larviciding and chemoprophylaxis, along with individual treatment of cases, was required; but the magnitude of the problem had not yet been fully acknowledged.

The participation of the general health services in the malaria eradication programme was a step in the right direction, but it was still not enough. Activities should not depend solely on ministries of health: all government and non-governmental organs should participate. The whole resources of the country should be mobilized for a malaria eradication campaign, and WHO should make a declaration to that effect.

Mr ABRAR (Somalia) paid a tribute to the Secretariat on the valuable report before the meeting. Somalia was mentioned on page 82 of the appendix to that report, and it was quite true, as there stated, that little or no progress had been made in pre-eradication activities. The major obstacles were administrative and financial difficulties, the lack of trained personnel, and an inadequate health infrastructure.

Nevertheless with its meagre financial and manpower resources his Government had made a substantial contribution to the programme in both money and personnel, although the local personnel were not properly trained. The Organization for its part, had done a great deal.

When the programme was first initiated in 1962 the Government had been given to understand that complete eradication was to be achieved by 1968 and it was no doubt disappointed with the lack of progress. That had resulted in a practically complete refusal of further funds for 1967 and it would be even more difficult to obtain funds for the next year. There was no doubt that the problem had been underestimated in the first place and the programme had not been properly studied. That no doubt applied also to other countries in Africa.

In order to obtain better results, at least in malaria control, the campaign had been reorganized with a view to making it an integral part of the basic health services, while an attempt had simultaneously been made to develop the health infrastructure and to take other measures to ensure the success of the pre-eradication programme. Although some personnel had been trained the number was insufficient for the task.

Table 2 on page 22 of the document before the Committee proved that the three international training centres at Lagos, Lomé and Manila were doing excellent work. He felt that in view of the importance of trained personnel for the eradication programme it was essential to have more international centres and suggested that for that purpose the centre mentioned by the delegate of Sudan be upgraded.

Dr ACOSTA (Colombia) referred to resolution EB39.R27 of the Executive Board. The conclusions reached by both the Expert Committee and the Executive Board were that positive advances had been made throughout the world, but that owing to economic and human difficulties eradication would not be achieved for a long time. The strategy of the programme needed to be revised, particularly in countries where the situation was worst; resolution EB39.27 therefore requested multilateral and bilateral agencies to give particular attention to ways of assuring the material resources which would be necessary for the eradication of malaria in Africa.

The cost of an eradication campaign was such that it could not be borne entirely by the country concerned. For that reason, although he was of course in favour of assistance to the African countries and in general supported resolution EB39.R27, he would suggest that the appeal in paragraph 4 of the draft resolution should be amended so that it did not refer to the eradication of malaria in Africa alone.

Dr BUDEIR (Syria) said that in Syria the eradication programme had been started in 1956, following a control programme. It had been hoped, with the help of experts from WHO, to eradicate the disease in five years, i.e. by 1960. But despite the very good results obtained the country still had a long way to go.

When control measures had been started in 1943 one million inhabitants out of a total of four million were suffering from malaria; that number had been reduced to 40 000 by the time the eradication campaign was launched in 1956. By 1960 the number of cases had dropped to less than 1000, although complete coverage of the

malarious areas had not been possible until the end of 1958 owing to technical and financial difficulties. A second programme had then been launched to complete eradication; it was to last for four years, and every effort had been made to remedy the administrative and financial difficulties referred to.

By the end of 1962 transmission had still not been interrupted and there were 250 cases of malaria in the country, despite the fact that there was no evidence of vector resistance to insecticides. Problems continued to occur, although on a reduced scale: in 1963 malaria cases were registered in two districts that had hitherto been considered free of the disease; spraying operations had therefore been reinforced. In 1965 however, malaria reappeared in a district that had been in the maintenance phase for three years; and transmission continued in certain regions in the north-east of the country, despite well-conducted spraying operations.

The new outbreak in 1963 occurred because the health services had failed to take the necessary preliminary measures for the maintenance phase. The reappearance of the disease in 1965 had been the object of a special joint enquiry with WHO experts with a view to establishing the cause. The first findings indicated a change in the living and feeding habits of the vector which rendered the measures hitherto taken ineffective.

In view of the uncertain situation, the ever-present technical and administrative difficulties, and the state of the existing health services, which were not equipped to take over malaria eradication, it had been decided to prolong the programme until the end of 1970, and to reorganize it. The districts in the maintenance phase were

being put back to consolidation, under the supervision of the malaria eradication services. A plan for reorganizing the health services was at present being studied with representatives of WHO and UNICEF so that they could take over eventually complete responsibility for vigilance operations. The health services of his country were most grateful for that assistance from WHO and UNICEF.

Dr BROTHERSTON (United Kingdom of Great Britain and Northern Ireland) said he would indicate his country's full support for the malaria eradication programme by voting for the draft resolution proposed by the Executive Board. He would however emphasize the need for the urgent reappraisal of the policy so clearly indicated by many delegates, such as those of Romania, Italy and the USSR, and which was also called for in sub-paragraph 4 of the Executive Board resolution. There had, of course, always been a risk in committing WHO to such an ambitious, categorical programme as malaria eradication; this did not arise from the objective itself, which was splendid and beyond criticism, but from the fact that over-optimism might lead to depression when difficulties became apparent, and the risk that a certain cynicism might develop that could spread to other activities.

Clearly the answer was to reappraise and state objectives in terms of appropriate goals that were attainable in the very diverse circumstances with which the Organization was concerned. It was known that a step-by-step achievement of attainable and realistic goals was the only way to support planning, and that without the necessary conviction and support not only the malaria eradication programme but other vital activities of the Organization would be jeopardized.

His delegation had read with interest and sympathy the draft resolution of Mauritania before the Committee; it was however not readily compatible with the Executive Board resolution. The Mauritanian draft resolution would in effect commit the Organization to taking appropriate measures in Africa before the Director-General had made a reappraisal of strategy, as indicated in the most significant paragraph of the Executive Board resolution. It was appropriate to draw attention to the special difficulties and the urgent requirements of Africa - difficulties and requirements which were clearly indicated in document A20/P&B/1. He believed however that this could best be done by modifying the wording of the Executive Board resolution, and this task might perhaps be carried out by a small working party.

Dr OSMAN (Sudan), referring to the suggestion of the delegate of Somalia that the malaria eradication training centre in the Sudan should be upgraded to an inter-regional or international training centre, expressed the willingness of his government to act as host for such a centre, with the support of the Regional Director. The present centre had already trained five malaria workers from the South Arabian Federation and three from Yemen.

Dr BERNARD, Assistant Director-General, Secretary, expressed the Director-General's appreciation of the information given by various members of the Committee on the situation in their countries, and of their comments on the general conduct of the malaria eradication programme. The general approval of the programme as it emerged from the report before the meeting, and in particular of the Organization's role in stimulating and co-ordinating activities, was encouraging.

The emphasis in the discussion had been on the need to review future strategy in the light of experience. The Expert Committee on Malaria that had met in 1966 had, in fact, worked in that context, as would be seen from its recommendations for concerted action in certain areas such as the Mediterranean basin, to which reference had already been made. A beginning had been made - but the direction which the eradication programme was to take, and the evaluation of that programme, were part of a continual process based on practical experience and on research.

The intention expressed in the course of debate by one government, to maintain and even increase its already large contribution under bilateral assistance and to extend it to new countries - if those countries showed a similar willingness to make their own contribution - was a good illustration of the collaboration that could be expected. Moreover, many delegations had pressed for the continuation and if possible an increase of multilateral and bilateral assistance, both for eradication programmes proper and for the development of basic health services. The Director-General would do his utmost to obtain such further support, but the chances of doing so would be higher if the governments themselves expressed their readiness to sustain the national effort required for the necessary period.

The importance of evaluation at all stages and all levels of the programme had been emphasized, and striking instances had been given of the economic value of eradication and the interest that could be aroused in the economists responsible for planning programmes. The Organization would continue its efforts in that direction, as requested by the Executive Board; it would also endeavour to intensify the co-ordination of programmes in neighbouring countries and measures to prevent the re-introduction of malaria into countries where it had already been eradicated.

It had been suggested that conferences or seminars, in particular regional meetings, might be useful for the exchange of information on problems and possible solutions. Such meetings had of course been held in various regions in the past and had proved extremely fruitful; they needed to be well prepared if they were to serve their purpose, and the Secretariat would do its best to provide the necessary documentation, based on the work of the Expert Committee and scientific groups, and on the latest experience gained from activities in the field.

In reply to the point made that the Organization should enlist the help of experts not only from the Expert Advisory Panel on Malaria but from other advisory panels, he stated that it was the usual practice of the Director-General to call upon the expert opinion available, from whatever panel.

One delegation had expressed a certain disappointment with the services of some of the staff sent by WHO to its country, although it considered this exceptional. In an international programme of that magnitude, such difficulties were hardly avoidable but they were, it was felt, exceptions which confirmed the rule. The Director-General and the regional directors were constantly endeavouring to remedy them.

With the Chairman's permission, the Director of the Division of Malaria Eradication would reply to some further administrative and technical points that had been raised.

Dr SAMBASIVAN, Director, Division of Malaria Eradication, replied to certain points that had been raised in the course of the discussion.

The delegate of Pakistan had mentioned the efforts that were being made to reduce the duration of the attack phase from four to three years. It would be realized that that had both technical and financial implications. On the other hand, the delegate of Venezuela had recommended that spraying should be continued as long as there was even a single parasite carrier. Those two views had different connotations in different circumstances.

The delegate of Venezuela had suggested that the continuation of spraying should be the practice in all tropical areas. As the issue was a very important one, it had been referred to the Expert Committee on Malaria that was to meet in September 1967. Attempts would be made to adapt methods to local conditions, as emphasized by the delegate of the USSR. The reports of the Expert Committee on Malaria, the members of which were experts of very wide experience, served as guidelines for the global programme; they were not taken as strict orders to be obeyed, and they were all to be utilized with due regard to local circumstances.

The delegate of Romania had made several points of great interest to the Organization. He had mentioned the conditions necessary for starting a malaria eradication programme. The Committee could be assured that, as the normal procedure before accepting a plan of operation, WHO looked into precisely those matters - such as training of personnel, or research that might be needed for formulating methodology and for evaluation.

The delegate of Italy had made several points with which no one could disagree. He had referred to the need for WHO to continue to give technical assistance and to assist in securing financial assistance, to the stimulation of research - on which, with the Chairman's permission, one of his colleagues would give further details - and to the training of malariologists. It had been WHO's policy to give advanced training courses for malariologists who had completed the normal malaria eradication training courses, and several such courses had been held. Though WHO was fully conscious of the limitations of young malariologists, most of the achievements in malaria eradication had been due to the efforts of hundreds of young dedicated

malariologists working under very difficult conditions. That was a fact that should be borne in mind. The older generation of malariologists would soon be retiring and the younger ones would be taking their place.

The delegate of the USSR had emphasized that malaria was a local problem and that methods had to be adapted to local conditions. His own remarks about the duration of the attack phase would serve to show that he was in full agreement with that delegate's remarks. The delegate of the USSR had also pointed out the need for more contact between the malaria service and the general health services.

The delegate of Senegal had made a special case for the African countries and had said in that connexion that the achievements had been mainly in islands or in countries with temperate climates. It should not be forgotten that, out of the 630 million population in the maintenance phase, over 250 million were in the mainland of Asia, which was tropical.

The information requested by the delegate of Kuwait had been partly answered by the delegate of Yemen. All the information in WHO's possession - and it was very inadequate - had been obtained from the Eastern Mediterranean Region. In April 1967, the regional malaria advisers had visited two countries of the Region.

WHO was grateful to the delegate of Sudan for the offer to consider the establishment of a malaria eradication training centre to serve countries in the Eastern Mediterranean Region, and would give it careful attention.

Dr Thomas (Sierra Leone) took the Chair

Dr BRUCE-CHWATT (Research and Technical Intelligence) said that both applied and fundamental research was being carried out through contractual services; the Organization had stimulated and co-ordinated forty-one research projects during 1966, in the fields of chemotherapy, immunology, epidemiology, parasitology and methodology of attack. A further eighteen projects in certain of these fields had so far been receiving WHO support in the current year. The problems of chemotherapy were far from being forgotten, and it was hoped that the report of the second scientific group on the chemotherapy of malaria and resistance of malaria parasites to drugs would be available within the next few weeks.

The field of immunology was expanding so rapidly that the findings of two or three years ago were now somewhat out of date. Problems of immunology, with specific reference to malaria, would be considered by a scientific group later in 1967; the discussions would include techniques for the differentiation of strains, the determination of asymptomatic and sub-potent malarial infection, measurement of the degree of immunity of populations, and the possibility of developing a still hypothetical malaria vaccine. Research on the development of a possible vaccine was of great interest but until further work on monkeys could be carried out, little could be said about its application to human beings. In the search for new ways of approach to the prevention of malaria, the increasing importance of immunoglobulins was clearly recognized. There was no evidence of resistance to chloroquine in Africa.

Dr WATT, representative of the Executive Board, said that he had listened to the debate with interest and would not fail to convey to the Executive Board the expressions of appreciation which had been made. He would however draw attention

to two points in the draft resolution recommended by the Board which did not appear to be reflected in the draft resolution proposed by the delegation of Mauritania. In the first place, the Board stressed, in the third paragraph of the preamble, that the lack of material information on the socio-economic effects of malaria made it difficult to secure priority for malaria eradication in the allocation of resources. It was the view of the Board that additional studies must be made to obtain the required data. In the second place, he felt that there had been general agreement throughout the debate on the wording of the last paragraph of the preamble, with emphasis on the phrase "advisable and timely", and he suggested that the wording of the operative paragraph 4 reflected this consensus of opinion.

The CHAIRMAN asked whether the Committee wished to adopt the suggestion of the delegate of the United Kingdom that a working party be appointed to try to resolve the conflicting elements in the two draft resolutions.

Dr KEITA (Guinea) spoke in favour of the establishment of a working party. Dr AUJOULAT (France), Mr LAGHDAF (Mauritania), Dr DOLO (Mali) and Dr NOVGORODCEV (Union of Soviet Socialist Republics) also expressed agreement.

It was agreed that a working party should be constituted by the delegates of Colombia, India, Iran, Mauritania, the United Kingdom, and the Union of Soviet Socialist Republics, and that it should meet at the close of the present meeting.

2. DEVELOPMENT OF THE SMALLPOX ERADICATION PROGRAMME: Item 2.5 of the Agenda (Resolutions WHA19.16, paragraph 5, and EB39.R20; Document A20/P&B/7)

Dr PAYNE, Assistant Director-General, introducing the report of the Director-General on the development of the smallpox eradication programme (document A20/P&B/7) said that it would be noted from section 1 of that report that almost all the projects

for 1967 had been activated and that plans for projects to begin in 1968 were already well advanced. The figures given for the incidence of smallpox at the foot of page 1 should be amended to read "During 1966, 65 512 cases were reported compared with 64 321 cases for 1965 . . .", to agree with the revised figures given in the tables at the end of the document. The world incidence of smallpox had decreased during the last three years and was expected to be even lower in 1967, but there had been sharp increases in some provinces of India in the early part of 1967. The major endemic foci continued to be South-East Asia, certain parts of South America, and Africa south of the Sahara.

The appropriation of special funds for smallpox by the Nineteenth World Health Assembly had provided an impetus which had met with a gratifying response. All of the regional committees had indicated their full support. A regional plan for eradication within five years had been developed in the Americas; at least twenty-four countries in Africa would have embarked on eradication efforts by the end of 1967; and most countries in Asia would intensify present efforts or initiate systematic vaccination by the end of the year. Substantial bilateral assistance had been offered by the United States of America (for programmes in nineteen West and Central African countries), and by the Soviet Union, which was providing vaccine on a bilateral basis to several major endemic countries and had also offered seventy-five million doses of vaccine to WHO. Other offers of vaccine had been received from a number of countries, as shown in Table 8. WHO staff and consultants had visited most of the endemic countries during 1966 to initiate planning for the intensifying of the global eradication effort. Special emphasis had been placed on the need for ensuring the participation of the basic health services, for the adequate supervision and assessment of the programme, and for surveillance schemes.

The provision of adequate supplies of fully potent freeze-dried vaccine continued to be a difficult problem. Steps being taken to meet it included assistance, in co-operation with UNICEF, to endemic countries in the expansion or development of vaccine production facilities; contractual arrangements with experienced producers to assist and advise producing laboratories in endemic areas; and the solicitation of vaccine donations.

Training courses for national programme staff were planned on an inter-regional basis. It was also planned to open other smallpox virus reference centres, such as the one established in Moscow during the present year. The testing of vaccines from various producers continued to be carried out in Denmark and the Netherlands and would shortly be undertaken in Canada. Scientific groups would be convened to deal with technical matters pertinent to the whole programme and with research.

The difficulties in achieving global smallpox eradication must not be underestimated, but the initial stages augered well for the future.

Dr WATT, representative of the Executive Board, said that the Board had studied the report of the Director-General on the development of the eradication programme during the first year in which it had been financed under the regular budget of the Organization, in conformity with the decision of the Nineteenth World Health Assembly. The Board felt that the plans and development outlined in the report were encouraging but had wished to stress, in the proposed draft resolution in resolution EB39.R20, both the importance of smallpox as a world-wide disease and the need for bilateral or multilateral assistance to those countries in which smallpox was endemic. The willingness of the World Food Programme to collaborate in the eradication programme

gave hope that assistance might yet be received from other still unexplored sources. The Board had felt that the programme would require continued analysis and scrutiny both by itself and by the Health Assembly.

Dr NA BANGXANG (Thailand) said that it was clear from the report which areas of the world were endemic foci of smallpox and which areas were non-endemic. He believed that the cause of endemicity, particularly in South-East Asia, was mainly that large parts of the population did not receive successful vaccination; and that the solution was to revaccinate every year for five or six years continuously. The danger to countries in which the disease was not endemic came from the importation of infected cases; consequently every effort should be made to channel aid, both financial and in supplies and personnel, to the countries which were the main endemic foci. He hoped that WHO would consider using the funds available for the provision of land and water motor vehicles for vaccinating teams, and for supplies of freeze-dried vaccine in small cold-storage boxes.

It was gratifying to know of the bilateral assistance made available by the United States of America to West and Central African countries; he hoped that similar assistance might be offered to some of the countries in South-East Asia which presented a smallpox threat to their neighbours. Smallpox had been eradicated in Thailand with the assistance of WHO and UNICEF, but continuing vigilance was necessary because of the risk of imported infection.

Dr GONZÁLEZ (Venezuela) said that, although his country had no indigenous cases of smallpox, the importance globally of the disease was clearly recognized. The cost of maintaining a permanent surveillance service was high, but such a service was

necessary if a country was to remain free of the disease. He felt that particular attention should be paid to the role of basic health services in eradication programmes; it was essential that they be involved from the initial stages of the programme. Failure to do this might result in a vaccination campaign being followed by an epidemic because the health services were not properly alerted to the need for following up the work of the vaccination teams. Certainly the problems of smallpox eradication in endemic areas were hard to solve, but financial and administrative assistance combined with hard work should bring success within reach.

The meeting rose at 5.30 p.m.