WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

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TWENTY-SEVENTH WORLD HEALTH ASSEMBLY

COMMITTEE A

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PROVISIONAL SUMMARY RECORD OF THE TENTH MEETING

Palais des Nations, Geneva
Monday, 20 May 1974, at 9.30 a.m.

CHAIRMAN: Dr O. A. HASSAN (Somalia)

CONTENTS

Note: Corrections to this provisional record should reach the Chief, Editorial Services, World Health Organization, 1211 Geneva 27, Switzerland, before 5 July 1974.

1. SECOND REPORT OF COMMITTEE A (document A27/A/3)

Dr GUILLÉN OVALLE (Peru), Rapporteur, read out the draft second report of Committee A (document A27/A/3).

Decision: The second report of Committee A was adopted.

2. DETAILED REVIEW OF THE PROGRAMME AND BUDGET ESTIMATES FOR 1975: Item 2.2.3 of the Agenda (Official Records Nos. 212, 215, and 216 (Chapter 1, para. 48-347); resolutions EB53.R24, EB53.R30, EB53.R31, and EB53.R38; documents A27/8, A27/9, A27/WP/3, A27/WP/4, and A27/WP/5 (continued)

Maternal and child health (section 3.2.2) (continued)

The CHAIRMAN drew attention to the new draft resolution on infant nutrition and breast-feeding proposed by a working group.

Professor HALTER (Belgium), Chairman of the working group, said that various amendments and changes in wording had been incorporated into the earlier draft resolution on the same subject. The final version of the draft resolution proposed by the Working Group (including the delegations of Bangladesh, Belgium, German Democratic Republic, France, Greece, Lesotho, Malawi, Sweden, Union of Soviet Socialist Republics, and United Kingdom of Great Britain and Northern Ireland) read as follows:

> The Twenty-seventh World Health Assembly,
>
> Reaffirming that breast-feeding has proved to be the most appropriate and successful nutritional solution for the harmonious development of the child;
>
> Noting the general decline in breast-feeding, related to sociocultural and environmental factors, including the mistaken idea caused by misleading sales promotion that breast-feeding is inferior to feeding with manufactured breast-milk substitutes;
>
> Observing that this decline is one of the factors contributing to infant mortality and malnutrition, in particular in the developing world; and
>
> Realizing that mothers who feed their babies with manufactured foods are often unable to afford an adequate supply of such foods and that even if they can afford such foods the tendency to malnutrition is frequently aggravated because of lack of understanding of the amount and correct and hygienic preparation of the food which should be given to the child,
>
> 1. RECOMMENDS strongly the encouragement of breast-feeding as the ideal feeding in order to promote harmonious physical and mental development of children;
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> 2. CALLS the attention of countries to the necessity of taking adequate social measures for mothers working away from their homes during the lactation period, such as arranging special work timetables so that they can breast-feed their children;
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> 3. URGES Member countries to review sales promotion activities on baby foods and to introduce appropriate remedial measures, including advertisement codes and legislation where necessary;
>
> 4. URGES the Director-General to intensify activities relevant to the promotion of breast-feeding, to bring those matters to the notice of the medical profession and health administrators and to emphasize the need for health personnel, mothers and the general public to be educated accordingly; and
>
> 5. REQUESTS the Director-General to promote and further support activities related to the preparation and use of weaning foods based on local products.

Decision: The draft resolution proposed by the Working Group was adopted.

Communicable disease prevention and control (section 5.1)

Dr VELIMIROVIC (Austria) expressed concern about the prevalence of communicable diseases that could be prevented by immunization, and stressed the need to promote immunization activities. The sum of US$ 100 000 allocated under the regular budget to the

integrated immunization programme (Official Records No. 212, page 146) was very small in comparison with other budgetary obligations not related directly to the practical, immediate health problems of Member States.

He hoped that some details would be provided concerning the Organization's programme in that field. Specifically, with reference to the Director-General's remarks about attracting additional resources, he wished to know (1) what steps the Organization intended to take with international agencies and other possible donors to obtain vaccines, equipment, and transport; (2) what programmes had been established to assist developing countries to intensify their immunization activities; and (3) what research was being carried out on operational and technical problems related to the immunization of the largest possible proportion of susceptible children.

Dr GERRITSEN (Netherlands) agreed with the statement on page 142 of Official Records No. 212 that immunization was the most effective and rapidly applicable measure of preventive medicine. In countries where it had been effectively applied, it had contributed immensely to the control of the common communicable diseases. However, in extensive regions of the world immunization was available to only a small proportion of children in the susceptible age-groups. He therefore noted with satisfaction that $ 100 000 had been allocated in the 1975 budget to an integrated immunization programme, but wished to be informed what that programme would entail. In view also of the excellent results obtained in the smallpox eradication programme, he felt that the time had come for WHO to make a comparable effort for other lethal diseases, especially of childhood, such as diphtheria, whooping cough, measles, tuberculosis, and tetanus.

In that connexion, his delegation and those of Ethiopia, India, Poland, Qatar, Somalia, United States of America, and Venezuela submitted the following draft resolution:

> The Twenty-seventh World Health Assembly,
>
> Having considered the statement on immunization against the childhood diseases, and the allocation of funds for an integrated programme on immunization contained in the proposed programme and budget estimates for 1975;
>
> Recognizing the immense contribution immunization has made to the control of many of the common communicable diseases in the countries where it has been effectively applied;
>
> Knowing that in extensive regions of the world immunization is available to only a small proportion of children in the susceptible age-groups;
>
> Aware of the potential for disease control when a well planned and well coordinated programme such as that of smallpox eradication is instituted; and
>
> Expressing its satisfaction at the readiness of the World Health Organization to promote measures to assist countries in extending their immunization programmes to cover the greatest possible percentage of the susceptible populations,
>
> 1. RECOMMENDS
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> (1) that Member States not currently having adequate vaccination programmes develop plans to include in their health services immunization and surveillance against some or all of the following diseases: diphtheria, pertussis, tetanus, measles, poliomyelitis and tuberculosis;
>
> (2) that the Director-General intensify at all levels of the Organization its activities pertaining to the development of practicable immunization programmes especially for the developing countries and assist Member countries:
>
> (i) in developing suitable programmes and providing technical advice on the use of vaccines;
>
> (ii) in assuring the availability of good quality of vaccines;

(3) that the World Health Organization should:

(i) study the possibilities of providing from international sources and agencies increased supplies of vaccines, equipment and transport, for countries that indicate that they can shortly become self-sufficient in these requirements;

(ii) continue its researches on as yet unsolved practical problems encountered in immunization procedures;

(iii) arrange seminars and other educational activities on the design and execution of programmes; and

2. REQUESTS the Director-General

(1) to establish a special account under the Voluntary Fund for Health Promotion to be credited with the values of gifts intended for the expanded programme on immunization and to ensure that vaccines donated to the programme conform with the relevant WHO requirements;

(2) to report progress annually to the World Health Assembly.

Dr JAYASUNDERA (Sri Lanka) said that since 1964, when India had been invaded by El Tor cholera, Sri Lanka had used surveillance methods to guard against its possible importation, particularly in the northern part of the island close to India. El Tor cholera had been reported for the first time in October 1973 on two small islands adjacent to the northern peninsula. Unfortunately, by the time large-scale investigations had been started, the disease had spread to the mainland, where it reached a peak in early November. By 24 April 1974 there had been 680 cases with 62 deaths, giving a case/fatality ratio of about 9%. The serotype responsible for most cases was Ogawa, but the Inaba strain had been isolated in a small proportion. The results of phage typing on several strains sent to the WHO reference laboratory in Calcutta, India, were awaited. A WHO team visiting the island in April to evaluate the situation expressed complete satisfaction with the measures taken to control the epidemic.

The greatest problem faced by his country, and indeed by all developing countries, in combating the epidemic was poor environmental sanitation, particularly in slum areas. Intensive measures had been taken in that regard, and a long-term programme for slum clearance had been drawn up. However, progress had not been overly encouraging, which had led them to believe that the only immediate answer to cholera control and eradication in developing countries was the immunization of all vulnerable groups with a potent vaccine, which he hoped would soon be available. The improvement of environmental sanitation, the ideal corrective measure, was a costly and time-consuming process. He thanked WHO, the Red Cross, and those countries that had assisted Sri Lanka with large stocks of cholera vaccine and drugs. The outbreak occurring in his country after it had been free from cholera for 20 years demonstrated the need for continuous epidemiological surveillance in countries now free from that disease.

Malaria continued to be a major health problem in his country. Recrudescence of the disease had begun in 1964-1965 and had assumed epidemic proportions in 1967-1968. The incidence had declined in 1971 but had again risen in 1972 and 1973, with 143 000 and 217 066 cases respectively. In 1973, 95.72% of cases had been due to Plasmodium vivax, 4.15% to P. falciparum, and the balance to mixed infections; there were no P. malariae infections. Fortunately, there had been only two confirmed deaths from falciparum malaria.

The rising incidence was due to several factors, such as growing vector resistance to DDT, operational and ecological problems, and the recent price rise in petroleum products which had curtailed spraying operations. In addition, increasing proportions of the population had been exposed as a result of prospecting for gems and opening up new agricultural land in jungle areas with a high malaria potential. Therefore, malaria would continue to remain the main health problem for several years to come, even if the control programme could be expanded with the limited resources available.

Dr LEE (Republic of Korea) said that the sum allocated for communicable disease control was dropping continuously - from $ 30 million in 1973 to $ 28 million in 1974 and $ 27 million in 1975. When viewed against the continuous increase in the total budget, that meant a considerable decline in the proportion of funds allocated to communicable disease control and hence a reduction of that programme.

He hoped that careful consideration would be given to that question in preparing the budget for 1976 and that the sum allocated, if it could not be increased, should at least be maintained at the 1975 level.

Dr WANG KUI-CHUN (China) wished, as a barefoot doctor, to say something about how she and other barefoot doctors participated in the prevention and control of communicable diseases in the rural areas, where the policy of "prevention first" had always been adhered to.

First, the barefoot doctors spread information about personal hygiene and prevention of communicable diseases. As they knew the conditions in the rural areas, they could take advantage of, say, a break in agricultural work in the fields to tell commune members about disease prevention. They went to primary schools to educate the pupils about health and mobilize them to carry out health propaganda. Blackboard posters and broadcasts were used in an attempt to make everyone aware of the need for and the methods of personal hygiene and communicable disease prevention. In winter and spring, they asked the people to ventilate their rooms well and air their bedding. They also collected traditional medicinal herbs, which in their experience had some preventive effect on communicable diseases, and sent infusions to each commune member's house. In the summer they sent boiled water to the fields for the commune members to drink during breaks as a preventive measure against gastroenteritis and other diseases.

Second, barefoot doctors reported communicable diseases, carried out inoculations, and supplied preventive drugs. In the communes everyone had a "health card". Immunization and preventive drugs were provided against smallpox, measles, whooping cough, and epidemic encephalitis B, etc. Since immunization coverage was 100%, morbidity from communicable diseases had been reduced.

Third, barefoot doctors mobilized the masses to carry out patriotic sanitary campaigns centred on the elimination of the "four pests", attention to hygiene, the eradication of major diseases, improving the water supply, and nightsoil disposal. Village wells were cleaned once or twice a year and disinfected regularly with bleaching powder. Nightsoil was disposed of in a harmless way. Areas in which animals were kept were sprayed with disinfectant periodically to eliminate breeding grounds for flies, mosquitos and other disease vectors. The incidence of malaria and gastrointestinal diseases had dropped drastically and infectious diseases had been effectively controlled in the rural areas.

As regards the training of barefoot doctors, in her commune those who were to become barefoot doctors were chosen by the poor and lower middle peasants from among their own children; they selected young people who had had some education and loved medical work. The initial training period ranged up to 6 or 12 months in some regions but in her case has lasted 4 months, during which she had studied human anatomy, preventive and curative methods for some common diseases in rural areas, and first aid, e.g. for drowning and electric shock. She had then returned to her production brigade as a barefoot doctor, learning while working and integrating theory with practice to raise her level of competence. In addition, barefoot doctors were assembled for two days every month to receive lectures on seasonal diseases by doctors from the commune health centre and city mobile medical team. During the slack season in winter, they received refresher courses for two months at the commune health centre. In the nine years since she had become a barefoot doctor, she had taken part in five refresher courses and had mastered basic techniques for both preventing and treating common diseases in rural areas.

Her commune had 68 barefoot doctors; the average number in each production brigade was 3, including a female doctor in charge of maternal and child health and family planning. On a weekly basis, one-third of their time was devoted to home visits, one-third to duty at the health station, and the remainder to collective physical labour on rotation.

Barefoot doctors lived in rural areas, where they took part in agricultural production, and were determined to live there for the rest of their lives. While their level of medicine was not high, with practice they were able to tackle more and more problems every year. Cases they were unable to deal with they sent personally to the commune health centre or to the country hospital. They treated the patients as their dear ones and were in turn profoundly welcomed by the peasants.

Dr SHRIVASTAV (India), although a cosponsor of the draft resolution, suggested that a phrase drafted along the following lines should be added at the end of operative paragraph (3) (i): "and also in testing facilities to ensure that the vaccines meet relevant WHO requirements". He felt that testing facilities concerning vaccines should be developed in all developing countries and, later, facilities for the manufacture of vaccines.

Dr KUPFERSCHMIDT (German Democratic Republic) said that WHO should in future pay greater attention to programmes of systematic immunization of children in the developing countries. The experience gained in the smallpox eradication programme, and the personnel that had been employed in it, should be used for the control of other communicable diseases such as measles, tetanus, poliomyelitis and tuberculosis, from which millions of children died in the developing countries.

In his country, as in other socialist countries, following programmes of immunization against the diseases he had mentioned, there had been no cases of poliomyelitis in the preceding few years, the number of cases of measles had declined considerably, tuberculosis had ceased to be a serious problem, and tuberculous meningitis and tetanus had become extremely rare. Twenty-nine years previously, many children were still dying of those diseases in his country.

His delegation considered that the immunization of children in developing countries should be given a larger place in WHO's regular programmes, because resources accruing in the Voluntary Fund for Health Promotion would not be sufficient to enable satisfactory results in that field to be achieved.

Dr CHAUDHARY (Pakistan) noted that increasingly smaller sums were yearly being allocated to the prevention and control of communicable diseases. He asked what criterion was adopted for the allocation of funds to the various regional offices for that purpose and suggested that larger sums should be allocated. Similarly, larger sums should be allocated to immunization because of its effectiveness and rapidity of application.

He also pointed out that more research was needed into new vaccines for simpler administration.

Professor KOSTRZEWSKI (Poland) was convinced that immunization should be one of the most important future activities of WHO. Within a comparatively short time results could be achieved with immunization similar to those achieved in smallpox eradication. He therefore suggested the launching of an expanded programme for immunization in every country in order to achieve better results in the control of communicable diseases.

Dr KIDAME-MARIAM (Ethiopia) said that her country was a cosponsor of the draft resolution because of the importance it attached to immunization in its national health programme. It was an accepted fact that most diseases in the younger age groups were preventable provided effective vaccines were available. Childhood immunization should therefore be an essential component of MCH programmes, especially in the developing countries, where poor environmental conditions played a major role in most of the preventable childhood diseases.

Health service coverage was limited in Ethiopia, but the first priority was given to coverage with minimum basic health services through which MCH services could be provided. The family planning programme, which was not considered as a national priority, was provided by a voluntary organization that operated through existing MCH services wherever possible. Family planning activities now included childhood immunization and because of that positive step had gained greater acceptance. However, the implementation of childhood immunization programmes was beyond the means of many developing countries and therefore her delegation emphasized the role that WHO could play in making the very much needed childhood vaccines available to developing countries through the appropriate international agencies.

Dr TARIMO (United Republic of Tanzania) considered that communicable diseases should be included in WHO's priorities. Admittedly, all the data required by WHO concerning communicable diseases were not available, but much could be achieved as regards prevention and control. Efforts had recently been made by his Government to give priority to infectious diseases taking into account their importance (in terms of morbidity and mortality), their vulnerability to known measures and the cost of the proposed activity. On that basis, measles, which was a disease susceptible of control by vaccination, had been given priority. In other countries too measles was an important problem and therefore WHO should take a lead in coordinating the international fight against it.

Research was urgently needed to develop more stable vaccines, less expensive vaccines, combined vaccines and vaccines administered more easily. While the search for ideal vaccines continued, efforts should, however, be made to use those that were known within their limitations. More aggressive measures should be taken in that field. WHO was to be congratulated on its smallpox eradication campaign without awaiting the discovery of the ideal vaccine.

As regards measles vaccination, it was necessary to have an effective maintenance phase if the initial success achieved was to be maintained. Vaccination programmes should therefore go hand-in-hand with the strengthening of basic health services and manpower development. It was fortunate that immunization programmes could be carried out by multipurpose auxiliaries. The number of schools for such auxiliaries had recently been increased in Tanzania, but the Government was looking into the possibility of reducing the period of training in order to place more auxiliaries in the field. With such auxiliaries serving in health units covering 5000 to 7000 persons and constant supervision from the centre, his Government believed that the maintenance phase of vaccination programmes - as well as other health programmes - could be carried out.

With reference to the smallpox eradication problem, the momentum to which the Director-General had referred in his annual report had taken many years to build up.

In conclusion, his delegation considered that the immunization programme should feature more prominently in future WHO programmes, and wished to cosponsor the draft resolution.

Professor SULIANTI SAROSO (Indonesia) said that the communicable diseases control programme in Indonesia was being developed along the lines described in the proposed programme and budget estimates, which it fully approved. The success of the smallpox eradication programme had been achieved not only by routine vaccination but also by means of very strict epidemiological surveillance.

Her delegation agreed in principle with the draft resolution, but would like it to lay more stress on the epidemiological aspects of immunization. She therefore proposed that the vote on the draft resolution should be deferred until the end of the discussion on the communicable diseases programme.

Dr VALLADARES (Venezuela) said that his country was a cosponsor of the draft resolution on the WHO expanded programme of immunization. In relation to the traditional quarrel between those who supported programmes known as vertical and the supporters of so-called horizontal or integrated programmes, he felt that the two approaches were not opposed, but must necessarily be complementary, the best example being in the field of immunization. His country had always supported the integration of all programmes in the general health services. However, so far as immunization was concerned, Venezuela had found it necessary in campaign-type activities to use both health service personnel and organized community groups. It did so, first, when the susceptible population was great and had to be protected quickly in order to control the disease; second, when health service coverage was low and when the new population could not be immunized routinely, as was the general rule in most countries; and third, when it was necessary to immunize 70 to 80% of the population in a short time, because it was known that the immunizing agent would pass through the normal transmission channels to 30 or 20% of the susceptible population in the area. That was the case with poliomyelitis vaccination, with regard to which excellent results had been obtained in several Latin American countries. The choice of approach therefore depended on the resources available.

Dr JAROCKIJ (Union of Soviet Socialist Republics) expressed his delegation's satisfaction with the progress made in the smallpox eradication programme. The programme should be continued with unflagging energy and he was sure that, if the necessary efforts and resources were brought to bear on it, it would be completed successfully.

The malaria eradication campaign had been less successful. There was a need for intensive research into methods of controlling malaria in the endemic areas of Africa, and especially for research on long-acting antimalarial drugs. Unless solutions for a number of problems were found, the programme was bound to run into difficulties.

He noted that the Committee would be considering a document on the onchocerciasis control programme, which was of great importance for the African countries, especially those of West Africa. In that connexion also research was indispensable, particularly on the immunopathology of onchocerciasis, as well as to find effective non-toxic drugs suitable for use in mass campaigns, since the drugs at present known were toxic, had serious side effects, and could not be used on a mass scale.

Now that WHO was giving priority to programmes of vital importance to the developing countries and that new regional or global programmes were expected to be planned, it seemed to his delegation that research to ensure their effective implementation was essential. If a critical analysis was made of the position regarding control of the most important tropical parasitic diseases, it could be seen that no really effective drugs were available for their treatment; and that was one of the main obstacles in the way of the socioeconomic advancement of most of the developing countries of the tropics and subtropics. Moreover, there existed no sound scientifically based methodology for the implementation of mass campaigns against diseases such as onchocerciasis, schistosomiasis and African and American trypanosomiasis. For those reasons, his delegation and other delegations were presenting a draft resolution on the subject, which he hoped the Committee would approve.

Coordination by WHO of research on the subjects he had mentioned would be of great value and would be in conformity with the changes in the philosophy of the Organization's future work to which the Director-General had alluded.

In conclusion, Dr Jarockij summarized the main points covered in his delegation's draft resolution, which was cosponsored by the delegations of Chad, Cuba, Czechoslovakia, the German Democratic Republic, the Ivory Coast, Kenya, Malawi, Mali, Nigeria, Poland, Sierra Leone, Sri Lanka, Sudan, Togo, Uganda, the United Republic of Cameroon, and the United Republic of Tanzania, and which read as follows:

> The Twenty-seventh World Health Assembly,
>
> Recognizing that tropical parasitic diseases are one of the main obstacles to improving the level of health and socioeconomic development in countries of the tropical and subtropical zones;
>
> Bearing in mind the need to develop research on matters connected with the most important tropical parasitic diseases;
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> Realizing that national, regional or global programmes of tropical parasitic disease control can be implemented only if scientifically based methods and effective means for their control are available,
>
> 1. NOTES with satisfaction that the importance of the medical, social and economic aspects of the major tropical parasitic diseases has been recognized;
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> 2. EMPHASIZES the urgent need for further development and intensification of research in this domain;
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> 3. RECOMMENDS that Member States of WHO extend the activities of their national institutions for the development of research of prime importance for the control of the major tropical parasitic diseases;
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> 4. REQUESTS the Director-General:
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> (a) to intensify WHO activities in the field of research on the major tropical parasitic diseases (malaria, onchocerciasis, schistosomiasis, the trypanosomiases, etc.);

(b) to define the priorities in research on the problem of tropical parasitic diseases in the various regions of the world, bearing in mind the primary needs of the developing countries;

(c) to extend cooperation with national institutions and other governmental and nongovernmental organizations in regard to the coordination of research in this field;

(d) to enlist extrabudgetary resources on a wider scale for these purposes; and

5. FURTHER REQUESTS the Director-General to submit a report on progress in the implementation of this resolution to the Executive Board at its fifty-seventh session and to the Twenty-ninth World Health Assembly.

Dr LARREA (Ecuador) said that the two main health problems in developing countries were communicable diseases and malnutrition. The first could be solved only by mass vaccination programmes and the improvement of the health infrastructure. As such programmes were costly, the developing countries needed the assistance of international organizations in addition to their own resources to carry them out. A fundamental requirement for controlling communicable diseases was better reporting, which was not always satisfactorily carried out in those countries. Not all countries complied with the provisions of the International Health Regulations, particularly as regards international air and sea transport, and there were restrictions on their application because there were no uniform criteria. Another important factor was the divergent systems of epidemiological surveillance adopted by the various countries with regard to morbidity, which often did not follow the universal model recommended by WHO. Certain provisions of the Regulations should be reviewed periodically in order to keep them up to date and to cover all the needs of Member States according to their particular circumstances of morbidity and mortality. All countries should comply with the Regulations through their ministries of health or similar bodies, in order to provide quick and accurate information and restrict the international transmission of communicable diseases.

The delegation of Ecuador approved the draft resolution and asked to be included among its sponsors.

Dr KONE (Ivory Coast) said that communicable diseases were one of the main concerns of developing countries and his delegation therefore unreservedly supported an integrated programme of vaccination against certain of those diseases. Thanks to the experience acquired in the control of smallpox, the developing countries had been able to eradicate that disease within a short time. With adequate assistance, similar success might be achieved with other communicable diseases. However, certain diseases, such as measles, posed problems and required a more careful approach. Different logistic means were needed, immunization campaigns had to be carried over a longer period, and - above all - the same places had to be visited several times yearly - at least twice - in order to achieve adequate coverage. Thus, in his country, where mass measles vaccination campaigns had been undertaken with the help of USAID, it had been observed that all children vaccinated before the age of 9 months were not correctly immunized, since cases of measles quite often appeared among them.

He was disturbed at operative paragraph 1(3)(i), which mentioned the supply of vaccines, equipment, and transport to countries that indicated that they could shortly become self-sufficient in those requirements. That provision seemed to exclude a certain number of the economically least favoured developing countries, and it was precisely those countries that needed long-term assistance. Therefore, although he fully agreed with the sponsors of the draft resolution, he urged that countries without the necessary logistic means should not be systematically excluded.

Referring to the regional onchocerciasis campaign that was about to begin in seven countries of West Africa, including his own, he said that the results obtained in vector control thanks to the assistance of the European Development Fund augured well for the success of the programme. Unfortunately, the same could not be said of the treatment of persons already suffering from the disease. Thousands, if not millions, of individuals were affected, and it was well known that infestation persisted for many years. All appropriate studies of the treatment of onchocerciasis should therefore be undertaken by WHO.

Dr ELOM (United Republic of Cameroon) supported the draft resolution and wished to be included among its sponsors. The recommendations made in it were pertinent, with the reservation expressed by the delegate of Ivory Coast. One point that had not been sufficiently stressed was the need for more research into more effective and stable vaccines with better keeping qualities, especially a vaccine against measles. Techniques for administering several vaccines simultaneously in mass campaigns needed to be improved. Vaccination campaigns undertaken with outside assistance should be more rigorously planned, taking into account financial logistic, and material problems that might arise in the countries concerned once assistance had ceased. His own country had experienced such difficulties after a measles vaccination campaign undertaken with outside assistance. Two years after that campaign, measles had almost completely reconquered the ground gained.

Dr PARNELL (United States of America) said that his delegation was a cosponsor of the draft resolution and supported it in the belief that, in many countries - including his own - too much reliance had been placed on sporadic mass immunization programmes. In the draft resolution, WHO was asked to assist Member States in developing programmes that would obviate the necessity for mass campaigns and lead to a continuing programme on the part of the health services that ensured high levels of immunity in the child population.

Dr HEMACHUDHA (Thailand) understood the resolution to refer only to the free supplies made available to Member States by WHO as part of its assistance to their communicable disease prevention and control programmes. As regards the types of vaccine that WHO was not ready to supply free of charge, he proposed that manufacturers be urged to reduce their prices for certain expensive vaccines, such as those used against poliomyelitis and measles, so that developing countries could expand their vaccination programmes. That might be possible if such vaccines were purchased in bulk for distribution to countries that had previously informed WHO of their needs.

Professor SENAULT (France), referring to operative paragraph 1(3)(i), inquired what help would be given to the other countries.

Dr TAJELDIN (Qatar) pointed out that paediatricians and public health physicians did not agree about the timing of vaccination against certain communicable diseases. In some countries, for example, children were vaccinated against smallpox and tuberculosis within one week of birth; in others they were vaccinated against smallpox during the first three months of life; and in yet others such vaccination was postponed until they were at least two years old. Opinions differed, also, on vaccination against poliomyelitis, diphtheria, whooping cough, and other diseases. Sabin and Salk poliovaccines, for example, which were given by mouth and by injection respectively, were thought to confer greater immunity when administered simultaneously with combined vaccine against diphtheria, chickenpox, whooping cough, and tetanus than when they were given separately. Any programme of vaccination against diseases should satisfy both paediatricians and public health officers.

The meeting rose at 11.05 a.m.