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No. 210

TWENTY-SIXTH WORLD HEALTH ASSEMBLY

GENEVA, 7-23 MAY 1973

PART II

VERBATIM RECORDS OF PLENARY MEETINGS

SUMMARY RECORDS AND REPORTS OF COMMITTEES

WORLD HEALTH ORGANIZATION
GENEVA
1973

MEMBERSHIP OF THE HEALTH ASSEMBLY

LIST OF DELEGATES AND OTHER PARTICIPANTS

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[1] Chief Delegate from 10 May.

[2] Delegate from 10 May.

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Dr A. DIBA, Ambassador; Health Adviser on WHO Affairs, Permanent Mission of Iran to the United Nations Office and the Specialized Agencies at Geneva
Professor C. MOFIDI, Vice-Chancellor for Research and Graduate Studies, University of Teheran

Advisers:
Dr G. SOOPIKIAN, Director-General of Planning and Programmes, Ministry of Health
Dr I. TABIBZADEH, Director-General, Malaria Eradication Organization, Ministry of Health
Dr A. NADERI, Director-General for Pharmaceutical Affairs, Ministry of Health
Dr M. ROUHANI, Director-General, Medical and Health Services, National Iranian Oil Company
Mr A. N. AMIRAHMADI, Director, International Health Relations Department, Ministry of Health

IRAQ

Delegates:
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Dr A. W. AL-MUFTI, Director-General for Technical Affairs, Ministry of Health (Deputy Chief Delegate)
Dr M. IBRAHIM, Director of International Health Relations, Ministry of Health

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Mr T. AL-KHUDHAIRI, Second Secretary, Permanent Mission of the Republic of Iraq to the United Nations Office at Geneva

IRELAND

Delegates:
Dr J. C. JOYCE, Chief Medical Officer, Department of Health (Chief Delegate)
Mr P. W. FLANAGAN, Principal Officer, Department of Health

ISRAEL

Delegates:
Dr A. ARNAN, Assistant Director-General, Public Health Services, Ministry of Health (Chief Delegate)
Mr S. ROSENNE, Ambassador, Permanent Representative of Israel to the United Nations Office and the International Organizations at Geneva
Dr D. PRIDAN, Chief Medical Officer, Judea and Samaria

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ITALY

Delegates:
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Professor F. POCCHIARI, Director, Istituto Superiore di Sanità

Alternates:
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Mr M. BANDINI, Counsellor, Permanent Mission of Italy to the United Nations Office and to the Other International Organizations at Geneva
Professor A. CORRADETTI, Istituto Superiore di Sanità
Professor L. GIANNICO, Inspector-General, Ministry of Health
Professor B. PACCAGNELLA, Director, Institute of Hygiene, University of Ferrara
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IVORY COAST

Delegates:
Dr H. AYÉ, Minister of Public Health and Population (Chief Delegate)
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Dr I. KONE, Director of Social Medicine

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JAMAICA

Delegates:
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Miss F.-M. SHILLETTO, Second Secretary, Permanent Mission of Jamaica to the United Nations Office and the Specialized Agencies at Geneva

JAPAN

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Mr K. TERADA, Deputy Head, Specialized Agencies Division, United Nations Bureau, Ministry of Foreign Affairs
Mr O. WATANABE, First Secretary, Permanent Mission of Japan to the United Nations Office and the Other International Organizations at Geneva
Mr Y. KAWASHIMA, First Secretary, Permanent Mission of Japan to the United Nations Office and the Other International Organizations at Geneva

JORDAN

Delegates:
Dr F. AKASHEH, Minister of Health (Chief Delegate)
Dr T. KARADSHI, Director of Health Services, Ministry of Health (Deputy Chief Delegate)
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KENYA

Delegates:
Dr Z. ONYONKA, Minister for Health, (Chief Delegate)
Dr J. M. GEKONYO, Senior Deputy Director of Medical Services, Ministry of Health
Dr Z. ONYANGO, Deputy Director of Medical Services, Ministry of Health

KHMER REPUBLIC

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Professor SREY SENG, Director-General of Public Health
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KUWAIT

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Dr A. R. AL-AWADI, Director, Preventive Health Services, Ministry of Public Health
Dr A.-M. AL-RIFAI, Director, Curative Health Services, Ministry of Public Health

LAOS

Delegates:
Dr K. ABHAY, Secretary of State for Public Health (Chief Delegate)
Dr P. PHOUTTHASAK, Director-General, Ministry of Public Health

LEBANON

Delegates:
Dr J. ANOUTI, Director-General, Ministry of Public Health (Chief Delegate)

Dr J. HATEM, Director, Central Public Health Laboratory

LESOTHO

Delegates:
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Dr M. PHOOKO, Medical Officer, Ministry of Health

LIBERIA

Delegates:
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Mr H. Q. TAYLOR, Assistant Minister of Health

LIBYAN ARAB REPUBLIC

Delegates:
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Mr B. M. AHMED, Director of Health Services, Province of Sebha

LUXEMBOURG

Delegates:
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Dr E. J. P. DUHR, Director of Public Health (Deputy Chief Delegate)
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MADAGASCAR

Delegates:
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Dr H. RAVELOJAONA, Chief Physician and Director, Tuléar Principal Hospital

MALAWI

Delegates:
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Mr G. G. KUKADA, Secretary for Health, Ministry of Health and Community Development (Deputy Chief Delegate)
Dr N. M. CHITIMBA, Deputy Chief Medical Officer, Ministry of Health and Community Development

MALAYSIA

Delegates:
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Dr S. Y. TOW, Deputy Director of Health Services (Deputy Chief Delegate)[1]
Dr GURMUKH SINGH, Deputy Director of Planning and Research, Ministry of Health

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MALI

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MALTA

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MAURITANIA

Delegates:
Mr O. G. ABEIDY, Secretary-General, Ministry of Health and Social Affairs (Chief Delegate)
Dr A. M. MOULAYE, Director of Health
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MAURITIUS

Delegates:
Sir Harold WALTER, Minister of Health and Population Control (Chief Delegate)
Dr A. Y. WONG Shiu Leung, Principal Medical Officer, Ministry of Health and Population Control

[1] Chief Delegate from 17 May.

[2] Delegate from 17 May.

MEXICO

Delegates:
Dr R. GUZMÁN, Under-Secretary for Health (Chief Delegate)
Dr M. E. BUSTAMANTE, Secretary-General, Health Council
Dr H. ACUÑA MONTEVERDE, Director-General, International Affairs, Secretariat for Health and Welfare[1]

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Delegates:
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MONGOLIA

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MOROCCO

Delegates:
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NEPAL

Delegates:
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Dr B. R. BAIDYA, Director-General of Health Services, Ministry of Health (Deputy Chief Delegate)
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NETHERLANDS

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[1] Chief Delegate from 10 May.

[2] Chief Delegate from 21 May.

NEW ZEALAND

Delegates:
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NICARAGUA

Delegates:
Dr F. VALLE LÓPEZ, Minister of Public Health (Chief Delegate)
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NIGER

Delegates:
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Dr T. BANA, Director-General of Public Health
Dr A. NARGOUNGOU, Physician, Niamey Hospital

NIGERIA

Delegates:
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Dr S. M. HOFGAARD, County Chief Medical Officer

Alternate:
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OMAN

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Dr G. SAMI, Director of Public Health

PAKISTAN

Delegates:
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Dr A. M. ANSARI, Secretary, Health Department, Government of Sind
Mr M. J. KHAN, Third Secretary, Permanent Mission of Pakistan to the United Nations Office and the Specialized Agencies at Geneva

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PERU

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Professor G. JANZ, National School of Public Health and Tropical Medicine
Dr A. CASTELO-BRANCO, Technical Inspector, Directorate-General of Health, Ministry of Health and Welfare

QATAR

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REPUBLIC OF KOREA

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Mr C. H. YOO, Counsellor
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RWANDA

Delegates:
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SAUDI ARABIA

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Dr M. TAIBA, Director-General of Curative Medicine, Ministry of Health

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Dr S. ISLAM, Director of Health Bureaux, Ministry of Health

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SIERRA LEONE

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Dr Marcella DAVIES, Acting Chief Medical Officer

SINGAPORE

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Dr KWA Soon Bee, Medical Superintendent, Outram Road General Hospital; Senior Haematologist, Ministry of Health

SOMALIA

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Dr A. M. HASSAN, Medical Superintendent, General Hospital, Mogadishu

SPAIN

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[1] Chief Delegate from 13 May.

SRI LANKA

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SUDAN

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Alternate:
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SWAZILAND

Delegates:
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Dr Fanny FRIEDMAN, Chief Medical Officer

SWEDEN

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SWITZERLAND

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SYRIAN ARAB REPUBLIC

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TOGO

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Dr E. HODONOU, Chief Physician, Anecho Health Subdivision

TRINIDAD AND TOBAGO

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TUNISIA

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TURKEY

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UGANDA

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UNION OF SOVIET SOCIALIST REPUBLICS

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OBSERVERS OF NON-MEMBER STATE

HOLY SEE

Monsignor S. LUONI, Permanent Observer of the Holy See to the United Nations Office and the Specialized Agencies at Geneva
Dr Marie-Thérèse GRABER-DUVERNAY
Dr G. NICOLAS
Rev. Father P. BOLECH

OBSERVERS

ORDER OF MALTA

Count DE NOÜE, Ambassador, Permanent Delegate of the Sovereign Order of Malta to the International Organizations at Geneva
Count E. DECAZES DE GLUCKSBERG, Ambassador, Deputy Permanent Delegate of the Sovereign Order of Malta to the International Organizations at Geneva
Dr M. GILBERT, Secretary-General, International Committee of the Sovereign Order of Malta for Aid to Leprosy Victims

[1] Delegate from 14 May.

SECOND MEETING

Monday, 14 May 1973, at 2.30 p.m.

Chairman: Dr S. PHONG AKSARA (Thailand)

SMALLPOX ERADICATION: Agenda, 2.3

The CHAIRMAN recalled that the Twenty-fifth World Health Assembly had discussed the smallpox eradication campaign and, in adopting resolution WHA25.45, had requested the Director-General to report progress to the current Health Assembly. He invited the representative of the Executive Board to inform the Committee of the Board's discussions.

Dr MOLAPO, representative of the Executive Board, said that the Board had had before it a report by the Director-General on the situation at the end of 1972[1] and the latest issue of the Weekly Epidemiological Record at that date, both of which it had considered during its review of the programme and budget estimates for 1974.

The Board had considered that three points required emphasis in the current, advanced, phase of the programme: (1) immediate notification and full international coordination in the event of an introduction of the disease; (2) maintenance of an alert surveillance system and of appropriate vaccination programmes by countries throughout the world; and (3) implementation of special programmes and techniques to assure that transmission had been interrupted in areas where the reporting network recorded no cases.

Members of the Board had expressed satisfaction at the progress achieved and, in resolution EB51.R26, the Board recommended that "maximum effort should be developed by the Organization and those countries where the disease is still endemic in order to complete eradication at the earliest possible time".

Dr BERNARD, Assistant Director-General, introduced the Director-General's report (document A26/7). It consisted, as usual, of two parts - a brief report on progress made, difficulties encountered, measures to be taken and problems to be solved; and the number of the Weekly Epidemiological Record[2] which analysed the world epidemiological situation of smallpox.

During the early months of 1973, nearly 47 000 cases had been reported, compared with about 26 600 in the same period of the previous year, an increase of about 79%. The increase was attributable mainly to major epidemics in Bangladesh and in India. Those were the countries which, with WHO assistance, would have to bear the brunt of the effort in the coming year.

Elsewhere gains had been maintained and further progress made. No case had been detected for more than two years in the Americas. In Africa, a small focus in Botswana, discovered in March 1973, had been rapidly contained. In Ethiopia, the progress of the eradication programme was such that there was hope for the achievement of the goal in the not too distant future. Thus the disease would shortly have been eradicated from the whole continent.

In Asia, no cases had been found for more than 16 months in Indonesia and for more than six months in Afghanistan. Only imported cases had been reported in Nepal. Substantial progress had been made in Pakistan where operations were continuing normally.

In Europe, there had been one imported case and one case of accidental infection from a laboratory virus, with three secondary cases. One imported case had been reported in Japan. Those occurrences, though unimportant from the epidemiological point of view, nonetheless pointed to the reality of the risk and to the need for unremitting vigilance in the search for and the elimination of every possible source of infection.

There were a number of lessons to be learned from the current situation. The most important was that every effort should be made to contain the disease and progressively reduce the intensity of transmission in the remaining endemic countries. It was in Asia that the main effort had to be made. Where eradication had been recently achieved, as in the Americas and Africa, strict vigilance was indispensable to make sure that the disease had in fact been eliminated and, should new cases occur, to detect their origin. That was the function of the specially trained surveillance teams mentioned in the report, which should ensure, so to speak, a second line surveillance for at least two years after identification of the last indigenous case. Similarly, an independent international appraisal should be carried out, in close cooperation with the government concerned, to confirm the status of eradication.

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[1] Off. Rec. Wld Hlth Org., 1973, No. 207, Annex 8.

[2] Wkly epidem. Rec., 1973, 48, 189-204.

Countries that had already been free of smallpox for some time had to decide upon their vaccination policy, measuring the cost and risks of vaccination against the danger of re-introduction and its possible consequences. All except three such countries had decided to continue vaccination in order to maintain in the population a level of immunity that would impede the spread of the disease if it was reintroduced.

In 1973, the global eradication programme was reaching a crucial phase. Nothing was certain, however, and caution was necessary both in forecasts and in the evaluation of results. However, it was true that the progress achieved so far carried the promise of eradication in the fairly near future provided that the necessary means were deployed and a strict method was systematically applied.

In parallel with the operational activities, research would have to continue, particularly in order to make sure that there was no biological possibility of survival for the virus.

The Director-General wished to stress how much the assistance of many countries to the programme had been appreciated, particularly the donations of vaccine; that assistance, together with the efforts of the governments themselves, had played a decisive role in the success achieved. It was just as essential today and would, he hoped, be forthcoming as long as was necessary to maintain the programme at its optimum pace until the final result was achieved.

Dr BICA (Brazil) said that enough progress had been made in the previous six years to justify the hope of smallpox being eradicated by the target date that had been fixed in 1967. During the intervening years the number of countries and territories reporting smallpox cases had decreased from 42 to 19, and the number of endemic countries from 30 to 7.

He agreed with Dr Bernard that the difficulties remaining should not be underestimated. There should be no relaxation of effort. If the programme were not to receive the attention and the financial resources required, both at the national and at the international level, smallpox would return.

There were a number of causes for concern. The situation in northern India and Bangladesh appeared to constitute the greatest threat to the success of the programme. But there was also concern regarding the significance of certain variola-related poxviruses isolated in recent years which might indicate the possibility of there being an animal reservoir of the virus. Fortunately, the studies of WHO and its collaborating laboratories showed that a simian reservoir was unlikely. Studies should be continued until the matter had been fully clarified.

As no cases had been discovered in the Americas for over two years despite active surveillance, it seemed that eradication had perhaps been achieved. Members of the Committee might welcome an account of the measures applied in combating the disease in his country, since - except for occasional imported cases in nonendemic areas - all cases recorded in South America between 1967 and April 1971 had occurred in Brazil.

In 1967, Brazil had been the only smallpox-endemic country in the Americas, with an average of 3000 to 4000 cases each year from 1964 to 1968. An eradication programme, carried out under the auspices of PAHO and implemented since 1950, had virtually eliminated the disease from the rest of the continent.

In November 1965, an agreement had been signed with PAHO for a smallpox eradication campaign, PAHO providing technical assistance, fellowships, and equipment and supplies for vaccination and large-scale production of freeze-dried vaccine. Bearing in mind the historical path of the disease, the campaign had been started in the north-east.

In 1967, the Government decided to expand and accelerate activities, reorganizing the campaign and providing adequate financial support. A new agreement was signed with WHO/PAHO for an expansion of their assistance. That assistance had proved a very important element in the success of the campaign and his Government wished to reiterate its thanks to them, as also to the United States Agency for International Development (USAID). Despite the difficulties and obstacles to be expected in a country the size of Brazil, careful organization, resolute implementation, and adequate financial resources, as well as large quantities of vaccine, had enabled rapid progress to be made.

Systematic vaccination had been completed in October 1971, by which time 81 741 290 persons, or 84% of the population, had been vaccinated. Continuing independent assessment of vaccination coverage had consistently revealed coverage rates of 80 to 95% among children under four years of age and more than 90% in children of school age. The "take" rates exceeded 95% in primary vaccinees.

The operation was conducted by first interrupting transmission in the less developed peripheral areas and then converging on the more populous and progressive states of São Paulo and Guanabara, where vaccination had proceeded almost simultaneously.

The last case reported in Brazil had occurred on 19 April 1971. Active surveillance, begun in the attack phase of the campaign, was continuing. On 1 April 1973, there were 27 surveillance units (in all state capitals) and 6298 reporting units scattered throughout the country, covering almost 90% of the 3951 Brazilian counties. They reported weekly on the

situation. Although many suspect cases were being reported, and investigated clinically, epidemiologically and in the laboratory, none since April 1971 had proved to be smallpox.

In an effort to detect possible residual foci, special area-wide investigations were being made in 25 of the 27 federal units by specially trained survey teams, under the direct supervision at national level of WHO/PAHO officials. Those investigations had concentrated on the areas where reporting was believed to be least satisfactory and on those where migrant populations congregated. These study areas had included the vast, sparsely settled Amazon basin, states in the north-east, urban areas in and around the major cities - Rio de Janeiro, São Paulo and Brasilia - and the less accessible land areas of the states of Minas Gerais and Bahia. Although intensive questioning of health staff, community leaders and school-children invariably uncovered cases of exanthematous disease, none had proved to be smallpox. The special surveys had been conducted from July to September, months in which there had previously always been a seasonal increase in incidence.

Surveillance and a vaccination maintenance programme were continuing, in order to ensure a high level of immunity in the population. Between 1966 and 1972 over 260 million doses of freeze-dried vaccine had been produced by three laboratories. The maintenance programme would continue until global eradication had been achieved. Meanwhile the scope of the surveillance programme was being broadened to include other diseases of national importance, such as poliomyelitis.

Active search having failed to bring to light any cases for two years, his Government considered that the eradication requirements agreed upon by the WHO Scientific Group on Smallpox Eradication[1] had been fulfilled, and intended to request an international appraisal of the situation.

Dr ROASHAN (Afghanistan) said that the Director-General's report raised hopes that global eradication of smallpox was in sight: the necessary means and experience existed, and the report indicated an increasing willingness among Member States to cooperate to that end. However, there should be no relaxation of vigilance until the goal was fully achieved.

In Afghanistan the eradication programme had started in 1969 with mass vaccination, which had been completed by mid-1972. A second round of vaccination had now been completed in 19 out of the 28 provinces, and the whole campaign was scheduled for completion by September 1973. From the beginning of the very successful programme being conducted with the assistance of WHO, first priority had been given to the development of effective surveillance and the establishment of a sensitive reporting network. Every suspected case was immediately investigated, regardless of the source of the information; this had given, at the beginning of the programme, an apparent increase in the number of cases, the figures being closer to reality. Active surveillance had begun early in 1970 and was continuing. It had been found that 90% of cases occurred among children, the main origins being earlier outbreaks, importation by nomads and travellers, variolation, and an urban reservoir of infection in Kabul.

Systematic vaccination and improved surveillance had brought about a gradual decrease in the number of cases - from 1044 in 1970 to 236 in 1972. Local transmission had been interrupted in February 1972, since when all the cases reported had been imported or due to variolation.

Arrangements had been made for cross-notification of cases between the eradication programmes in Afghanistan and Pakistan, as the information was essential for the organization of preventive measures in both countries.

In Afghanistan, the final phase had begun in September 1972, the objective being an incidence of nil by the end of March 1973. The last known case had occurred in November 1972. The country was still in the critical period when smallpox might be introduced from neighbouring endemic countries at any time. Early case reporting through the existing network or strong active surveillance had thus become the most important operation. Surveillance would continue until global eradication had been achieved.

Dr VIOLAKIS-PARASKEVAS (Greece) said that the account in the issue of the Weekly Epidemiological Record attached to document A26/7 showed that encouraging progress had been made but that there was still a need for the smallpox-endemic countries to intensify their efforts.

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[1] Report published as Wld Hlth Org. techn. Rep. Ser., 1968, No. 393.

In Greece, vaccination was compulsory. It was still considered best for primary vaccination to be carried out in the first year of life, since Greek statistics showed no case of postvaccinal encephalitis or other serious complication at that age. The last case of smallpox in Greece - an imported case - had been recorded in 1950.

In the nonendemic areas, the need appeared to be for rapid information on epidemiological changes; strict observance of the International Health Regulations; and intensive surveillance and alertness in all health services to detect possible cases for early clinical and laboratory diagnosis.

Dr JAKOVLJEVIĆ (Yugoslavia) said that in his Annual Report the Director-General noted that "During 1972 . . . programmes were extended to include, for the first time, all provinces and states of the remaining countries in which the disease was considered endemic."[1] The apparent increase in the number of cases in 1972 was probably due to improved surveillance and better reporting. The reduction in the number of endemic countries - from seven to five since the end of 1972 - showed that there had been a real improvement.

Whereas progress in Nepal, Afghanistan and Indonesia had been excellent, the same could not be said of India and Bangladesh where, according to the Director-General's report (document A26/7), "the future of the eradication effort is most uncertain" although "the resources available in these countries compare very favourably with those of most other countries which have experienced endemic smallpox during the past six years". It was therefore clear that the eradication programme had not been carried out successfully in all endemic areas. In the circumstances was it really possible to expect that global eradication could be achieved within the next two years?

Smallpox was an international problem and all countries, through WHO, should unite their efforts to solve it. It was most encouraging to see from the Introduction to the Director-General's Report that, by reducing the smallpox vaccination programme in view of the decline of the disease, the United States of America had been able to make a yearly saving nearly equivalent to WHO's annual budget. It was easy to imagine how much a corresponding saving would mean to the developing countries with all their health problems. But most countries would probably feel obliged to continue their vaccination programmes as long as a single case of smallpox existed.

He agreed with the Director-General on the continuing need for support to the programme, particularly in the form of supplies and equipment, vaccine, and cash donations. His Government would continue to support the programme. At the same time it expected more systematic and effective work by the remaining endemic countries. They should be assisted as much as possible in their efforts to achieve the final objective in the next two years.

Sir George GODBER (United Kingdom of Great Britain and Northern Ireland) congratulated the Director-General on the effectiveness with which the campaign was being pursued, and particularly the field workers whose efforts had brought about the successes recorded. From the report before the meeting, it would seem that the countries in which the disease was still endemic had quite a large number of cases and that much remained to be done; whereas most other countries were potential recipients rather than exporters of the disease.

His own country's recent experience had shown the kind of situation likely to arise in the future. It had been without an imported case for five years until 1973, when a traveller returning from the Indian sub-continent - and in possession of a valid international certificate of revaccination - had fallen ill and remained with his family (who also had valid certificates) for several days before a diagnosis could be made. There had been no secondary cases.

Since then there had been four other cases which were somewhat different and had their origin in a very highly modified infection, believed to have been acquired through exposure in a laboratory by a person who had been vaccinated and revaccinated, but about whose last revaccination there was some doubt. That person had been admitted to hospital for another condition and had there developed the modified smallpox infection. The infection was passed - almost certainly through contact with an article handed over - to two visitors to a patient in the next bed. One of them died of haemorrhagic smallpox before producing a diagnosable focal rash; the other died of confluent smallpox. The third secondary case was a variola infection without eruption, certified only because there was an infectious illness. Although

[1] Off. Rec. Wld Hlth Org., 1973, No. 205, p. 7.

the highly modified case escaped immediate attention, as might happen in any country, and despite the severe nature of the two secondary cases, the prompt follow-up and vaccination of all contacts had prevented subsequent spread.

There had since been four false alarms among travellers from India or Pakistan. He thought that any traveller with a skin condition returning to Britain from the Indian sub-continent for some years to come could expect to be investigated. There were, however, absolutely certain virological methods of diagnosis: and indeed virological facilities were essential for effective surveillance at the present time.

Members of the Committee would note that, in the circumstances described, infant vaccination would not have helped. It had been abandoned in the United Kingdom because the normal vaccination risk - normal for any vaccination with an effective antigen - of about 1 death per 100 000 vaccinations, could mean seven or eight infant deaths per year. Until the suspension of routine infant vaccination two years previously, he could not recall a year in which fewer than two or three persons had died from vaccination in the United Kingdom.

Referring to the statement in the Director-General's report (page 2) that monkeypoxvirus was related to but had distinctively different characteristics from variola virus, he recalled that there were strains of monkeypoxvirus in which it was difficult to differentiate by culture methods between the wild white strains and variola strains.

During the final stages of eradication, and within the coming two or three years, it would be necessary to decide whether variola virus should still be kept in laboratories, and if so where and under what conditions. That information should be made available to health services, since great damage might ensue if the virus were to escape some time after the eradication of the disease.

Dr SCHUMACHER (Federal Republic of Germany) said that there was every reason to expect that, after more than twenty centuries, smallpox was about to be eradicated. The much misused term of "eradication" would be fully applicable for the first time in human history. After so long the glory of that achievement would not be lessened, if it were to take a few years more, and the Organization should be careful not to give way to exaggerated optimism. No one doubted the theoretical possibility of eradication within 18 months or two years. However, in the interests of maintaining a minimum level of immunity in certain population groups, the Organization should beware of communicating over-optimistic forecasts to the Press and the population of Member countries.

Dr IMAM (Egypt) said that the smallpox eradication programme was one of the most successful projects carried out by WHO. He hoped that that success would continue until the nations of the world had been entirely freed from the threat of smallpox. Eradication of the disease would have a considerable economic impact on countries, such as his own, in which a continuous vaccination programme was being carried out.

He was optimistic regarding the ultimate success of the programme. But for such optimism to be justified required (1) the certainty that the programme would reach isolated communities in smallpox-endemic countries; (2) compulsory vaccination of newborn children in such countries; (3) revaccination programmes in countries where smallpox had disappeared; (4) continuous surveillance for at least the next five years; and (5) eradication of the disease in countries where it was still a problem.

He fully agreed with the United Kingdom delegation as regards the need for facilities for virological diagnosis.

The success of the programme would serve as an illustration of how many of the infectious diseases could be eradicated, given goodwill and careful planning at international level.

Professor RODRÍGUEZ TORRES (Spain) said that the Spanish health authorities had been following with interest the progress of WHO's smallpox eradication programme and considered that, with the exception of the epidemics in two Asian countries, it showed encouraging results. Spain was particularly concerned with the possibility of imported cases of the disease, and thus attached particular importance to the recommendation contained in paragraph 2 (b) of resolution WHA25.45 and to paragraph 2 (page 3) of document A26/7 regarding the continuation of protective measures.

His Government believed that a high degree of immunity should be maintained in the population through compulsory vaccination and periodic revaccination campaigns, with special emphasis on the revaccination of health personnel. It was endeavouring to perfect its surveillance system and to apply the International Health Regulations in a flexible manner so as to cause the minimum disruption to trade and commerce.

Dr GRANT (Ghana) said that although both the Americas and all Africa except Ethiopia and Botswana were free from smallpox and considerable achievements had been recorded in Asia, it could not be claimed that eradication was complete until the world incidence of the disease

had fallen to zero. Recent importations into countries that were free from smallpox illustrated the need for vigilance, although the failure of the disease to become established showed that the eradication programme had been effective.

Although African countries that were free from smallpox were making continuous efforts to improve surveillance, much remained to be done and they remained vulnerable to the threat of the disease. Ethiopia, the major source of smallpox in Africa, was making considerable progress in its campaign and it was possible to hope that all Africa would be free of smallpox within a short time.

The progress of the eradication programme on the Indian sub-continent was crucial to the success of the programme as a whole, and countries concerned should give high priority to eradication in view of their international obligations. They should be able to do so without too much difficulty, since they were at a much higher economic and technological level than many African countries that had been successful in eradicating the disease.

There could be no room for complacency until smallpox had been entirely eliminated. International assistance to the remaining countries where the disease was endemic should be increased.

Dr BAIDYA (Nepal) said that his country had expanded its smallpox eradication programme that year to cover all 75 local districts. For the previous year a revised vaccination strategy had been instituted whereby for one month during the winter season one vaccinator was appointed for each panchayat with a population of from 3000 to 4500. More emphasis was being placed on surveillance, and smallpox recognition cards had been issued to all field workers. A system of cross-notification of importations had been established between India and Nepal. Since July 1972, all smallpox outbreaks had been traced directly or indirectly to importations, and thus complete eradication would depend on the progress of the eradication programmes of neighbouring countries. Every case reported was fully investigated, but owing to the lack of good roads and airports in the mountainous regions surveillance and containment could not be put into effect as quickly as might be desired.

His country hoped to complete its eradication programme by 1975.

Dr KLIVARÓVA (Czechoslovakia) said that the Czechoslovak delegation had actively supported the smallpox eradication programme. The Czechoslovak health services had done their utmost to assist in carrying it out, considering that the time had come when it was possible to free mankind from the disease.

A preliminary assessment of the results of the first five years of the programme showed that it had been correctly conceived. The fact that, out of the 42 countries reporting smallpox in 1967, only six had reported cases in 1973 was evidence of the success achieved. In only three had the incidence increased during the present year, but that indicated that the Region concerned should concentrate its efforts on the problem.

The time had come to complete the programme successfully and consolidate the results. In the not too distant future the programme would cease to be one of WHO's major undertakings financed from the regular budget; however, the Organization should retain the responsibility of supervising the results. The greater part of the work should gradually be taken over by Member States, since it was only by their efforts that recrudescence of the disease could be prevented.

Dr TOW (Malaysia) congratulated WHO on the progress achieved towards the goal of global eradication of smallpox. If the present trend continued, it was possible that the target of worldwide eradication could be achieved in two or three years.

However, an alarming development in recent months had been that serious smallpox epidemics were raging in two of the endemic countries, despite the fact that WHO was now entering the seventh year of its intensified smallpox eradication programme. Among the reasons for the setback, as given in the Weekly Epidemiological Record of 4 May 1973, were: lack of staff; inadequately developed surveillance programmes; periodic diversion of smallpox staff to other programmes; delayed and incomplete reporting; and inadequate containment measures. Lack of staff should not be an insurmountable problem; it could be overcome by improved deployment of staff and crash recruitment and training programmes. Nor should it be too difficult to organize and develop surveillance programmes. In view of the vital importance of smallpox eradication, any diverting of staff to other programmes would be premature and ill-advised, and inadequate reporting and containment measures indicated a lack of appreciation of the urgency of the problem. He did not wish to criticize any individual country, but he hoped that the points he had raised would be taken in a constructive spirit.

WHO had declared on many occasions that it was willing to send emergency aid on request in the form of medical experts, vaccine, bifurcated needles, etc., to any country facing problems in smallpox eradication. He wondered whether the countries now suffering from outbreaks had taken full advantage of that offer. He was still hopeful that global eradication

of smallpox could be achieved in the near future if all countries viewed the problem as one of top priority and mobilized all their resources to tackle it.

Dr LEKIE (Zaire) said that three countries had decided not to continue with their systematic vaccination programmes. Although, as far as the populations of those countries were concerned, such a decision might be defensible, it might create problems in other countries where systematic vaccination was still a necessity, and he urged that the discontinuance of the programme should be publicized as little as possible outside those countries. The report before the Committee also suggested that countries bordering on those where smallpox was still endemic should continue vaccination and surveillance for two years; he wondered why a period of two years had been indicated.

He feared that countries might conceal the fact that smallpox had broken out in their territory, and he urged that Member countries should notify any cases occurring. Although there was justified optimism about the success of the smallpox eradication programme, WHO should continue to provide assistance to countries where the disease still presented a danger.

He hoped to be able to say in three months that Zaire had completed two years without any new cases of smallpox.

Dr SHRIVASTAV (India) said that the graph on page 192 of the Weekly Epidemiological Record for 4 May 1973 showed that until 1972 the smallpox eradication programme in India had been progressing very satisfactorily, and if the trend had continued there would have been a great improvement. Of all the smallpox cases occurring in 1973 80% had been in West Bengal and its adjoining areas. West Bengal, which had undergone a very serious upheaval in the course of the past two years, had been combating cholera and malnutrition with success. It had not, however, been successful in controlling smallpox, and if steps were not taken at once the disease threatened to become a serious danger.

The West Bengal authorities had been warned in 1972 to prepare to cope with a large-scale epidemic, and the Indian Government had offered it unlimited assistance in the form of bifurcated needles and vaccine. Owing to the explosive political situation in the area, however, the West Bengal authorities had banned the recruitment of staff and thus it had been impossible to obtain any personnel to put the smallpox programme into effect. Recently the ban on recruitment had been relaxed and the situation was beginning to improve. The Central Government was watching the situation closely and was prepared, if necessary, to intervene and take charge of the West Bengal health services.

The situation that had led to the outbreak was an abnormal one; the disturbances in Bangladesh and West Bengal had had their effect on every sector of society. However, great efforts were now being made to return to normal, and he hoped that the control measures that had been instituted would soon begin to produce an effect.

Professor TIGYI (Hungary) said that the results achieved by the smallpox eradication programme approved by the Eleventh World Health Assembly in 1958 had been significant and widely appreciated. The success of the programme showed that WHO was capable of changing the health situation of the entire world through a single concrete activity.

The programme had achieved its greatest success in the Latin American countries; in 1971 South America had become free of smallpox for the first time in 500 years. Despite that achievement, however, the danger of the introduction of the disease into smallpox-free countries had increased with improvements in transport and communications. In the period 1970 to 1972 the disease had been introduced into non-endemic countries 15 times, a notable example being in Yugoslavia, which had experienced the greatest European epidemic for 20 years. The majority of those responsible for introducing the epidemic had been citizens of the same country.

The complications of vaccination in Hungary were similar to those experienced in other European countries. While Hungary was continuing its compulsory vaccination programme, it was giving very serious consideration to the contraindications.

His country was prepared to contribute to the successful continuation of the WHO smallpox eradication programme by making further supplies of vaccine available.

Dr SENCER (United States of America) said that it had been demonstrated that smallpox could be eradicated from large areas of the world, not only from those of high population density but also from those that were sparsely settled. No technical problems remained to be solved. WHO should not let its concern over possible animal reservoirs detract from its efforts to end the disease. Adequate support was available, although he was puzzled by the reduction of WHO support in two of the major trouble spots; if shortages were to develop, a realignment of priorities could make good the deficiency. All that was needed was to convince health

authorities that eradication could and should be achieved. There should be a common determination to reach that goal, on the part not only of the countries in which transmission was continuing but of all countries.

The delegate of Afghanistan had stressed the importance of surveillance as long as the disease continued to occur anywhere in the world. All countries should maintain such surveillance, and once the disease has been eliminated the resources used could be diverted to other health problems.

The Director-General's report each year enumerated the countries in which transmission was still occurring, and it would be unfortunate if only one country were to find itself named in a future report. He urged that all countries should join in working towards the simultaneous accomplishment of eradication; since 1977 had been fixed as the concluding year of the programme, the last smallpox case would have to be in the year 1975. WHO was on the threshold of a major achievement, and it could not afford to fail.

Dr KUPFERSCHMIDT (German Democratic Republic) was in general agreement with the strategy and aims of the WHO smallpox eradication programme. The cornerstones of that programme were complete vaccination coverage of populations of countries where smallpox was still endemic and improved surveillance and reporting of cases detected. The problems experienced by certain countries should not be underestimated, and increased efforts by those countries as well as international cooperation were needed if they were to be overcome.

He did not agree that countries with a low risk of importing smallpox and with highly developed health services and surveillance systems could now stop routine vaccination of the total population. Because of worldwide tourism and international air traffic, there remained a danger that smallpox could be imported from endemic foci to other countries. Vaccination should remain compulsory until only a few residual foci remained, for only then did the risk of importing smallpox become less significant than the risk of vaccination to health.

In his country efforts were concentrated on revaccinating those working in the health services and in international traffic and those travelling to countries where smallpox was still endemic. Efforts were also made to reduce the health risks of vaccination by such measures as improved vaccines, obligatory postgraduate training of all physicians carrying out vaccination, and legal protection for individuals in the case of damage to health caused by vaccination.

His country would support the continuation of WHO's smallpox eradication programme and adopt the necessary measures as circumstances required. The ultimate success of the programme would depend on how far the concerted efforts of all countries could prevent outbreaks in the future. His country was willing to make available to WHO its experience in a number of fields. The first was in the use of formalin-inactivated vaccines and of human immunoglobulin to protect and reduce complications in persons belatedly subjected to primary vaccination. The second, based on almost 20 years of experience, was in the exact evaluation of health damage following smallpox vaccination. The third was in information on antibody levels induced by smallpox vaccination; vaccination was compulsory in his country at the ages of 2, 9 and 16 years as part of a schedule that also included immunization against tuberculosis, poliomyelitis, measles, tetanus, diphtheria and whooping cough. Information was also available on the immunological status of high-risk groups such as physicians and nurses, who were subjected to regular vaccination every three years.

Dr WATKINSON (Canada) said that his country would continue to support the WHO smallpox eradication programme. Efforts to eradicate the disease had met with considerable success, and as a consequence Canada had been able to relax its vaccination requirements since 1972, demanding vaccination certificates principally from travellers entering Canada from endemic or infected areas. Although no case of smallpox had been reported in Canada since 1962, provincial health authorities still encouraged maintenance vaccination as a desirable public health measure.

His delegation fully supported three measures as essential to any global programme of protection against smallpox: immediate notification and full international coordination in the event of the introduction of smallpox; maintenance of an alert surveillance system and appropriate vaccination programmes by all countries; and institution of special programmes to ensure that transmission had been interrupted in areas where no cases were recorded by the reporting network.

His country would support the programme through voluntary contributions of potent, stable vaccine.

Dr ELOM (Cameroon) said that his country had not had a single case of smallpox for four years. It was nevertheless maintaining vigilance since, before the launching of the eradication campaign with the assistance of USAID, his country had suffered from sudden inexplicable outbreaks of smallpox every eight to nine years.

The eradication programme was being pursued on two levels: that of epidemiological surveillance and that of vaccination coverage and revaccination. A system for the detection and confirmation of all suspected cases had been established, using not only permanent health teams but also mobile control teams including trained male nurses. The teams were trained to diagnose smallpox and take samples of pustular fluid and send them under the proper conditions to reference laboratories. Those concerned were responsible for informing the Minister of Health of suspected cases and for launching immediate vaccination operations in the affected communities. Such operations called for close coordination and for the help of the appropriate laboratories.

An evaluation team had been created four years previously to undertake statistical surveys, and the team had found that the vaccination coverage was adequate, even in the areas that for geographical or sociological reasons were most at risk. That it was so was largely owing to improvements in vaccination techniques and to USAID help.

He thought that a recent meeting in Brazzaville sponsored by WHO, USAID and the African countries concerned to coordinate and realign efforts augured well for the ultimate success of the programme.

Dr GASHAKAMBA (Rwanda) said that smallpox control and the vaccination campaign had begun at about the same time in all the African countries and had given very satisfactory results. WHO might use the campaign as a model for the eradication of other communicable diseases. Malaria, for example, was far from being eradicated in Africa, and there was also the problem of typhus, an appreciable number of cases of which had been diagnosed in Rwanda in the past year, with probably others in adjacent countries. It was unreasonable for a single country to undertake an eradication programme in isolation, because the movement of people would make it ineffective. He hoped that neighbouring countries would cooperate with his in eradicating typhus and that WHO would provide assistance for that purpose.

Dr KASUGA (Japan) referred to the great successes achieved in smallpox control in Brazil, Ethiopia, Indonesia, and Sudan, but stressed that they had to be weighed against the 79% increase in the overall incidence of the disease in 1973 as compared with 1972, even though that increase was supposed to be owing to unusual factors in the two countries concerned. Was it realistic therefore, to say that global eradication could be achieved in the next two years? Naive optimism was out of place, so he would suggest that WHO should give top priority to smallpox eradication in India and Bangladesh.

The risk of complications from vaccination could still be somewhat greater than that of imported smallpox. Imported cases could be quickly detected by highly developed health services, as had been demonstrated when a case was imported into Japan from Bangladesh. Cost/benefit analysis, both in Japan and the United States of America had shown that periodic compulsory vaccination might be discontinued in those two countries. Further careful consideration was necessary, however, before a final decision could be reached on this question. Much remained to be achieved before any change was made in vaccination policy, e.g., the surveillance system had to be consolidated, health education strengthened, and cooperation with the areas where smallpox was still endemic further improved.

Professor CHU Chi-ming (China) reported that plans had been made for smallpox eradication after the founding of the People's Republic of China in 1949 and that eradication had been practically achieved by 1959, no cases of the disease having been confirmed since that date. Since the liberation, the highest priority had been given to the control of the most important communicable diseases, including smallpox. All efforts had been based on four basic principles of health policy. Medical and preventive teams had been sent out to the villages, mines, factories, frontier areas, and areas occupied by national minorities, to take therapeutic and prophylactic services to the workers and peasants. A nationwide campaign for the control of smallpox had been put into effect on a free-of-charge basis, and health and epidemic prevention stations then set up. Traditional and western medicine had been united by mobilizing the practitioners of traditional medicine to work side by side with those trained in western medicine. Workers, peasants, teachers, and students had been trained as part-time

vaccinators and health auxiliaries. The entire population had been vaccinated in 1953 and more than 800 million vaccinations had been carried out in the period 1950 to 1956.

The people had been fully mobilized to participate in mass campaigns. No health programme could be successful unless it was transformed into conscious action of the people. In remote areas cases, where only a few occurred, would be hard to find if reliance was placed exclusively on professional personnel. It was therefore necessary to mobilize the peasants. In the eradication campaign emphasis had been placed on health education, and the campaign had also been closely linked with the land reform movement. Peasants had actively reported cases, helped in vaccination propaganda, and had thereby become activists in health movements.

The role of professional medical personnel had been fully developed. Such personnel had formerly been concentrated in the cities, but they had been encouraged to make contact with the people and their determination to serve the people had been aroused. Thus, when more vaccine had been needed, methods had been devised to increase production. In order to reduce undesirable side effects a careful choice of vaccine strains had been made, and later a bacteria-free tissue culture vaccine was developed. Because of the difficulty of cold storage in the villages, a freeze-dried vaccine had been prepared. After nationwide vaccination had been completed, the work had been consolidated by the integration of smallpox control into the general health services, e.g., measures were being taken to strengthen the quarantine and surveillance systems. Everyone now had to be vaccinated every six years between the ages of two months and 18 years, i.e., four times in all. The recent growth of health cooperatives and the barefoot doctor system was a further guarantee of the consolidation of smallpox eradication.

Dr HASSAN (Somalia) said that the smallpox eradication campaign had begun in Somalia in 1970 and 2 150 000 people had been vaccinated over the period 1970–1972. In 1972, five cases were imported from neighbouring countries, but there had been no secondary cases. He considered that the disease could be controlled and that special attention should be paid to frontier areas, since the people living in those areas were the most susceptible to communicable diseases and the most likely to spread them.

Dr CAMARA (Guinea) remarked that the last case of smallpox in Guinea had occurred in January 1969, and that the ending of the attack phase in 1971 had been followed by a maintenance phase in which, over two years, an average of one and a half million doses of vaccine had been used. Guinea was one of the few African countries producing freeze-dried vaccine, the annual output being about eight million doses. The high quality of the vaccine had been recognized by WHO, and large amounts had been given to Pakistan in addition to two million doses given to WHO for use in emergencies.

It was now clear that every country must remain on the alert, and that prudent optimism must be the rule. It was also necessary to continue studies on the monkeypox virus in order to determine its epidemiology and its pathogenicity to man. If it was found to be pathogenic, the monkey population could be a major reservoir of disease that could endanger the results so far achieved. Guinea would be willing, with the assistance of WHO, to carry out research in that field.

Dr ANSARI (Pakistan) reported that there had been a setback last year in the eradication programme in Pakistan, which had started in 1968. Nevertheless, there were no reported cases in the Punjab, North-West Frontier and Baluchistan. In Sind, Karachi was free of the disease, but some cases had been recorded in Northern Sind. It was hoped that it would be possible to contain the disease by the beginning of next year. As far as the importation of cases was concerned, they would welcome arrangements with other countries of the type that already existed with Afghanistan. They were now making a major national effort to control smallpox and would welcome all assistance towards that end.

Professor SENAULT (France) considered it necessary to avoid both excessive pessimism and excessive optimism about the programme. His delegation agreed with those delegates who had pointed out that excessive publicity should not be given to the reasons for which certain countries had abandoned vaccination. The recommendation that a study should be made on methods of providing audiovisual documentation on smallpox deserved support, as many doctors in countries from which smallpox had long ago disappeared were not familiar with the disease, and that led to delays in diagnosis. France would continue its own vaccination programme in spite of the fact that no cases of smallpox had been imported for many years.

Dr HENRY (Trinidad and Tobago) said that, although smallpox vaccination was compulsory in Trinidad and Tobago, it had not been enforced; no case of the disease had been reported for many decades. The main reason for vaccination had been to meet the requirements for overseas travel, but such requirements no longer existed, except for travel to endemic areas. The level of immunity was therefore falling. Following the 1972 poliomyelitis outbreak, however, the immunization programme had been revised, and as from September 1973 children attending a nursery or primary school would be required to have a valid certificate of vaccination against smallpox and poliomyelitis.

Dr GALAHOV (Union of Soviet Socialist Republics) considered that the smallpox eradication campaign was the first such campaign to approach a successful conclusion. However, it was necessary to exercise great care in fixing the length of subsequent phases of the programme, since any shortening of one of those phases might make it more difficult to complete it. Vigilance should not be relaxed on account of the success achieved and systematic vaccination should not be prematurely abandoned.

It would be useful to publish a monograph with contributions from experts concerned with smallpox eradication. The Executive Board could also usefully consider how the experience obtained in the programme could be used in the malaria eradication programme and in future campaigns carried out under WHO auspices. Finally, the collaboration of interested institutions should be enlisted for a more intensive study of monkeypox.

Dr SPAANDER (Netherlands) stressed the need for a well organized laboratory detection system, because of the continuing danger of the importation of cases of smallpox. He said that the strategy described in the last paragraph of page 3 of report A26/7 had been followed by his Government for more than twenty years. It was now offering a combined inactivated vaccine with very potent antigens against diphtheria, tetanus, pertussis and poliomyelitis to all children in the first years of life. Vaccination was not compulsory, but more than 95% of the newborn had been vaccinated. No case of any of those four diseases had been reported in 1972.

Dr SÁENZ (Uruguay) said that smallpox had not occurred in Uruguay since 1968, nor in Latin America as a whole for more than two years. Vigilance was still necessary, however, and systematic vaccination should continue. He agreed that it was not advisable to publicize the fact that certain countries had abandoned systematic vaccination programmes.

Dr BERNARD, Assistant Director-General, wished to refrain from elaborate comments as nearly all aspects of the question had been covered in the discussion. Credit for what had been achieved had to be ascribed to the governments concerned. The function of WHO, with its relatively modest resources, was primarily to assist national efforts, to develop the required operational methodology, to coordinate assistance from various sources, particularly regarding the supply of vaccine, and to effectuate the required transfer of knowledge and experience between countries where the disease was still prevalent and those where it had been eradicated. Smallpox eradication would, in the years to come, continue to be given the very first priority by WHO. While one could not forecast when eradication would be completed, it was always considered important to establish suitable targets in time. On the basis of progress to date and with appreciation of the task remaining, it seemed likely that eradication could be achieved in two years. Much, however, depended on the response of the individual countries affected; also, the versatility and flexibility of the virus must be kept in mind.

Dr HENDERSON (Smallpox Eradication) referred to the problem of monkeypox, and said that eight laboratories were now working on various strains of poxviruses, including three strains isolated from monkey kidneys that more closely resembled variola virus than others; that was in addition to the monkeypox virus mentioned in the report. Intensive work was continuing in many African countries in order to identify other cases, but the evidence to date indicated that those strains did not represent a reservoir of human smallpox.

A further problem mentioned was that of the surveillance necessary after a nil incidence had been achieved. The world could be divided up into four areas - South America, Africa, Asia and Indonesia - between which communication was comparatively slight and the chance of introduction of cases small. The term eradication could only be applied when the whole of one of those areas was free. Indonesia and South America were now free, but it was only possible to guess for how long intensive surveillance was absolutely necessary in those areas. Initially and empirically, a period of at least two years had been

decided upon. Experience over the last seven years had shown that it was never longer than eight months before an unsuspected focus appeared in an area under constant surveillance. The figure of two years thus seemed not unreasonable as it was three times the maximum eight-month period.

With regard to audiovisual materials, a series of slides was available on smallpox as it occurred in African and Asian patients, and had been widely distributed. Films had also been made in Yugoslavia on smallpox in Yugoslav patients in the recent outbreak. Additional slides or teaching aids on patients with atypical forms of the disease were being considered.

The meeting rose at 5.45 p.m.

THIRD MEETING

Tuesday, 15 May 1973, at 9.30 a.m.

Chairman: Dr S. PHONG AKSARA (Thailand)

1. SMALLPOX ERADICATION (continued) Agenda, 2.3

The CHAIRMAN drew attention to the draft resolution prepared by the Rapporteur, which read:

> The Twenty-sixth World Health Assembly,
>
> Having considered the Director-General's report on the smallpox eradication programme,
>
> Appreciating the decisive contribution made to the global eradication effort by the many countries who have succeeded in eliminating endemic smallpox and recognizing with gratitude the efforts being made by those where the disease still exists,
>
> Noticing with concern, however, that in some areas of the countries where endemic smallpox persists the situation presently appears more serious than in previous years,
>
> Reaffirming, therefore, the necessity of making every possible effort to ensure the speedy progress of eradication and to maintain it where it is achieved,
>
> 1. REQUESTS all countries to give the highest priority to the smallpox eradication programme so as to interrupt transmission of the disease at the earliest possible time in the areas where it is still endemic and to prevent re-occurrence of the disease in countries from which it has been eliminated;
>
> 2. REQUESTS the Director-General to continue to give all necessary assistance to the countries concerned in order to support and accelerate national eradication efforts, to determine through independent evaluation whether eradication has actually been achieved, and to identify the additional resources both national and international which may be required for the successful completion of the programme;
>
> 3. THANKS the countries that have generously contributed to the programme, either bilaterally or through the WHO Voluntary Fund for Health Promotion, in the confident hope that continued support will be provided to the programme, especially during the critical years ahead.

Dr ZAMFIRESCU (Romania) proposed the insertion in operative paragraph 1, after the words "the highest priority to", of the words "active surveillance and".

Dr BERNARD, Assistant Director-General, suggested that the phrase "with particular emphasis on active surveillance" be added after the words "smallpox eradication programme" in that operative paragraph.

Dr ZAMFIRESCU (Romania) concurred.

Decision: The draft resolution, as amended, was approved.[1]

[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA26.29.