OFFICIAL DOCUMENT NO. 69

INDEXED

XVI MEETING
Directing Council of the PAHO

XVII MEETING
Regional Committee of the WHO for the Americas

WASHINGTON, D.C.
27 SEPTEMBER-11 OCTOBER 1965

PRECIS MINUTES
ANNEXES

PAN AMERICAN HEALTH ORGANIZATION
PAN AMERICAN SANITARY BUREAU, REGIONAL OFFICE OF THE
WORLD HEALTH ORGANIZATION
1966

Official Documents
of the Pan American Health Organization

(Published in English and Spanish)

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Annual Report of the Director to the Directing Council of the Pan American Health Organization, in which the activities and accomplishments of the Organization are recorded. These publications are illustrated with maps and photographs and contain a general index. Every four years, when the Pan American Sanitary Conference meets, the Director presents, in addition, a Quadrennial Report to the Conference.

Proposed Program and Budget, which the Director prepares and submits to the Executive Committee and to the Directing Council (or to the Pan American Sanitary Conference). This volume contains an explanation of the proposed programs together with the corresponding budget estimates covering both the regular funds of the Pan American Health Organization and those of the World Health Organization, the Expanded Program of Technical Assistance, and other funds from different sources. The same document also presents the provisional draft budget of the following year for the Pan American Health Organization and for the World Health Organization, Region of the Americas.

Financial Report of the Director and Report of the External Auditor, for each fiscal year.

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No. 68: Financial Report of the Director and Report of the External Auditor for 1965.

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No. 73: 54th Meeting of the Executive Committee (Précis Minutes and Final Report of the 53rd Meeting).

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August 1966

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION
525 Twenty-third Street, N.W.
Washington, D.C. 20037

The XVI Meeting of the Directing Council, held in Washington, D. C., from 27 September to 11 October 1965, was convened by the Director of the Pan American Sanitary Bureau in accordance with Resolution XIV of the 52nd Meeting of the Executive Committee (19-23 April 1965).

Official Document 66 (April 1966) contains the Final Report of the Directing Council meeting, including all the resolutions adopted. The present volume contains the minutes of plenary sessions, the agenda, the list of participants, officers and committee members, and selected working documents, together with the Annual Report of the Chairman of the Executive Committee.

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1. ORGANIZATION OF THE MEETING

CONVOCATION OF THE MEETING

Washington, D. C.
28 June 1965

Sir:

Pursuant to Resolution XIV of the 52nd Meeting of the Executive Committee, and in conformity with Rule 1 of the Rules of Procedure of the Directing Council, I have the honor to convoke the XVI Meeting of the Directing Council of the Pan American Health Organization, XVII Meeting of the Regional Committee of the World Health Organization for the Americas, to be held in the new headquarters building in Washington, D. C., from 27 September to 8 October 1965.

A formal ceremony to inaugurate the new building will be held at this meeting. I would be most grateful, Sir, if you would honor with your presence, as head of your country's delegation, this important event in the history of the Organization.

I am transmitting herewith the provisional agenda approved by the 52nd Meeting of the Executive Committee to which I have added a new item, item 33 (Air and Water Pollution in Latin America), in accordance with the authority conferred on me by the Committee and in response to the suggestions made by certain Governments at the 51st Meeting of the Executive Committee. In accordance with the Rules of Procedure, I shall be pleased to include in the provisional agenda any item your Government may wish to propose for the consideration of the Directing Council. Should you have any item to propose, I would appreciate your informing me before 7 August. The working document that will serve as basis for the discussion of the item should also be submitted.

I take pleasure in informing you that, in conformity with Article 17-A of the Constitution of the Pan American Health Organization, a meeting of the Executive Committee will be held immediately after the meeting of the Directing Council.

Very truly yours,

(signed)
DR. ABRAHAM HORWITZ
Director, Pan American
Sanitary Bureau

LIST OF REPRESENTATIVES AND OTHER PARTICIPANTS

Governments

ARGENTINA

Representative:

Dr. ARTURO OÑATIVIA, Minister of Social Welfare and Public Health, Buenos Aires

Alternates:

Dr. VICTORIO V. OLGUÍN, Director of International Health and Social Affairs, Ministry of Social Welfare and Public Health, Buenos Aires

Dr. JULIO C. BLAKSLEY, Director of Communicable Diseases, Ministry of Social Welfare and Public Health, Buenos Aires

Adviser:

Dr. ENRIQUE MAURICIO ROZITCHNER, Physician in Charge of Preventive Psychiatry Service, Rivadavia Hospital, Buenos Aires

BRAZIL

Representative:

Dr. RAYMUNDO DE BRITTO, Minister of Health, Brasília, D. F.

Alternates:

Dr. ACHILES SCORZELLI, JR., Director General, National Health Department, Ministry of Health, Rio de Janeiro

Dr. MANOEL JOSÉ FERREIRA, Director General, National Department of Rural Endemic Diseases, Ministry of Health, Rio de Janeiro

Dr. MURILLO BASTOS BELCHIOR, Executive Secretary, Commission of International Affairs, Ministry of Health, Rio de Janeiro

CHILE

Representative:

Dr. RAMÓN VALDIVIESO, Minister of Public Health, Santiago

Alternate:

Dr. CONRADO RISTORI COSTALDI, Chief, Technical Department, National Health Service, Santiago

COLOMBIA

Representative:

Dr. JUAN JACOBO MUÑOZ, Minister of Public Health, Bogotá

Alternates:

Dr. ROBERTO ACOSTA BORRERO, Director of the Ministry of Public Health, Ministry of Public Health, Bogotá

Dr. JOSÉ CAMACHO, Minister Plenipotentiary, Embassy of Colombia, Washington, D. C.

COSTA RICA

Representative:

Mr. EDISON RIVERA CASTAING, Chief Coordinator, Sectorial Planning Office, Ministry of Public Health, San José

Alternate:

Mr. MANUEL ENRIQUE FOURNIER, Hospital Planning Section, Costa Rican Social Security Fund, San José

CUBA

Representative:

Dr. DANIEL ALONSO MENÉNDEZ, Deputy Minister of Medical Education, Ministry of Public Health, Havana

Alternate:

Dr. RAMÓN MARTÍNEZ RODRÍGUEZ, National Adviser, Antimalaria Campaign, Havana

DOMINICAN REPUBLIC

Representative:

Dr. MANUEL E. PICHARDO SARDÁ, Deputy Minister of Social Welfare, Ministry of State for Health and Social Welfare, Santo Domingo

ECUADOR

Representative:

Dr. MIGUEL EDUARDO YÉPEZ ASCHIERI, Co-Director, National Malaria Eradication Service, Ministry of Social Welfare and Labor, Quito

Alternate:

Dr. GONZALO PAREDES CRESPO, First Secretary of the Delegation of Ecuador to the Organization of American States, Washington, D. C.

EL SALVADOR

Representative:

Dr. JOSÉ ANTONIO SALDAÑA, Undersecretary of Public Health and Social Welfare, Ministry of Public Health and Social Welfare, San Salvador

Alternate:

Dr. ALBERTO AGUILAR RIVAS, Coordinating Secretary, Planning Department, Ministry of Public Health and Social Welfare, San Salvador

FRANCE

Representative:

Dr. RAYMOND G. HYRONIMUS, Deputy Inspector General for Public Health, Ministry of Public Health and Population, Paris

Alternate:

Dr. JEAN GUEUNIER, Regional Health Inspector, Antilles-Guiana Health Region, Fort-de-France, Martinique

GUATEMALA

Representative:

Dr. ORLANDO AGUILAR HERRERA, Assistant Director of Public Health, Ministry of Public Health and Social Welfare, Guatemala

HAITI

Representative:

Mr. GÉRARD PHILIPPEAUX, Secretary of State for Public Health and Population, Port-au-Prince

Alternate:

Dr. HUBERT DELVA, Technical Director, Rural Domiciliary Health Service (SANDOR), Port-au-Prince

HONDURAS

Representative:

Dr. JOSÉ ANTONIO PERAZA, Minister of Public Health and Social Welfare, Tegucigalpa

Alternate:

Dr. CARLOS A. PINEDA MUÑOZ, Chief, Health Planning Unit, Ministry of Public Health and Social Welfare, Tegucigalpa

JAMAICA

Representatives:

Dr. CHARLES COURTNEY WEDDERBURN, Chief Medical Officer, Ministry of Health, Kingston

Mr. PATRICK W. C. BURKE, Permanent Secretary, Ministry of Health, Kingston

KINGDOM OF THE NETHERLANDS

Representative:

Dr. HEMRADJ SHRIEMISIER, Minister of Health, Paramaribo, Surinam

Alternates:

Dr. HOWARD CYRIL TJON SIE FAT, Director of Health, Ministry of Health, Paramaribo, Surinam

Miss CHRISTINE YVONNE HENNY, Second Secretary, Netherlands Embassy, Washington, D. C.

MEXICO

Representative:

Dr. RAFAEL MORENO VALLE, Secretary of Health and Welfare, Mexico, D. F.

Alternate:

Dr. PEDRO DANIEL MARTÍNEZ, Undersecretary of Health, Ministry of Health and Welfare, Mexico, D. F.

Adviser:

Dr. MANUEL B. MÁRQUEZ ESCOBEDO, Director General, Office of Technical Advisory and Supervisory Services, Ministry of Health and Welfare, Mexico, D. F.

NICARAGUA

Representative:

Dr. ALFONSO BONICHE VÁSQUEZ, Minister of Public Health, Managua

PANAMA

Representative:

Dr. RODERICK ESQUIVEL, Minister of Labor, Social Welfare and Public Health, Panama

Alternates:

Dr. ALBERTO E. CALVO, Director General of Public Health, Ministry of Labor, Social Welfare, and Public Health, Panama

Dr. LUIS DOMINGO ALFARO, Medical Director General, Social Security Fund, Panama

Dr. RAFAEL VÁSQUEZ, Assistant Medical Director General, Social Security Fund, Panama

PARAGUAY

Representative:

Dr. CLAUDIO L. PRIETO, Director General of Health, Ministry of Public Health and Social Welfare, Asunción

PERU

Representative:

Dr. CARLOS QUIRÓS SALINAS, Director of Health and Permanent Representative to International Health Organizations, Ministry of Public Health and Social Welfare, Lima

Alternate:

Dr. PEDRO CARDICH, Director of Health and International Exchanges, Ministry of Public Health and Social Welfare, Lima

TRINIDAD AND TOBAGO

Representative:

Dr. LEONARD M. COMISSIONG, Chief Medical Officer, Ministry of Health and Housing, Port of Spain, Trinidad

Alternates:

Sir ELLIS CLARKE, Permanent Representative of Trinidad and Tobago to the United Nations, New York, N. Y.

Mr. SOLOMON S. LUTCHMAN, Counsellor, Embassy of Trinidad and Tobago, Washington, D. C.

UNITED KINGDOM

Representative:

Dr. CHARLES C. NICHOLSON, Chief Medical Officer, Ministry of Health and Housing, Georgetown, British Guiana

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Representative:

Dr. LUTHER L. TERRY, Surgeon General, Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.

Alternates:

Mr. HOWARD B. CALDERWOOD, Office of International Economic and Social Affairs, Department of State, Washington, D. C.

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Dr. BENJAMIN D. BLOOD, Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.

Mr. LEONARD M. BOARD, Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.

Mr. PAUL J. BYRNES, Office of International Administration, Department of State, Washington, D. C.

Dr. JOHNATHAN E. FINE, Agency for International Development, Bureau for Latin America, Washington, D. C.

Dr. ROBERT D. GROVE, Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.

Dr. FORREST E. LINDER, Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.

Dr. IWAO N. MORIYAMA, Chief, Office of Health Statistics Analysis, Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.

Dr. HEINZ SPECHT, Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.

Mr. SIMON N. WILSON, Bureau of Inter-American Affairs, Department of State, Washington, D. C.

URUGUAY

Representative:

Dr. EMILIO N. ORIBE, Ambassador, Representative of Uruguay to the Organization of American States, Washington, D. C.

Alternates:

Mr. RUBÉN A. CHELLE, Counselor of the Delegation of Uruguay to the Organization of American States, Washington, D. C.

Mr. ADOLFO CASTELLS, First Secretary of the Delegation of Uruguay to the Organization of American States, Washington, D. C.

VENEZUELA

Representative:

Dr. DOMINGO GUZMÁN LANDER, Minister of Health and Social Welfare, Caracas

Alternates:

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Dr. JOSÉ LUIS APONTE-VILLEGAS, Director of Regional Public Health Services, Ministry of Health and Social Welfare, Caracas

Technical Adviser:

Mr. GERARDO E. WILLS, Second Secretary, Delegation of Venezuela to the Organization of American States, Washington, D. C.

CANADA

Official Observers:

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Dr. BASIL D. B. LAYTON, Principal Medical Officer, International Health, Department of National Health and Welfare, Ottawa

Dr. PAUL C. DUBÉ, Assistant to the Principal Medical Officer, International Health, Department of National Health and Welfare, Ottawa

World Health Organization

Dr. M. G. CANDAU, Director-General

Mr. MILTON P. SIEGEL, Assistant Director-General

Miss BERNICE NEWTON, Chief, Administrative Coordination

Mrs. Y. WARNER, Assistant to Director-General

Pan American Sanitary Bureau

Dr. ABRAHAM HORWITZ, Director, Secretary ex officio of the Council

Dr. JOHN C. CUTLER, Deputy Director

Dr. VÍCTOR A. SUTTER, Assistant Director

Dr. STUART PORTNER, Chief of Administration

Dr. RAYMOND B. ALLEN, Chief, Office of Research Coordination

Dr. ALFREDO ARREAZA GUZMÁN, Chief, Zone IV

Dr. MOISÉS BÉHAR, Director, Institute of Nutrition of Central America and Panama

Dr. ALFREDO N. BICA, Chief, Communicable Diseases Branch

Dr. ALFREDO LEONARDO BRAVO, Special Adviser

Mr. EARL D. BROOKS, Chief, Personnel and Management Branch

Dr. EMILIO BUDNIK, International Liaison Officer

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Dr. OSWALDO L. COSTA, Chief, Health Promotion Branch

Dr. MARCOS CHARNES, Chief, Fellowships Branch

Dr. OSWALDO J. DA SILVA, Chief, Malaria Eradication Branch

Dr. CARLOS DÍAZ-COLLER, Chief, Professional Education Branch

Dr. ABRAHAM DROBNY, Chief, Office of Evaluation and Reports

Dr. HUMBERTO FLISFISCH, Special Adviser

Dr. JOSÉ L. GARCÍA GUTIÉRREZ, Chief, Zone I

Dr. RENÉ GONZÁLEZ, Regional Adviser in Mental Health

Dr. MARK D. HOLLIS, Chief, Environmental Sanitation Branch

Dr. E. ROSS JENNEY, Chief, Zone III

Dr. JOSÉ JIMÉNEZ GANDICA, Chief, El Paso Field Office

Dr. HENRIQUE MAIA PENIDO, Chief, Zone VI

Dr. JAMES S. MCKENZIE-POLLOCK, Chief, Office of National Health Planning

Mr. CLARENCE H. MOORE, Chief, Budget and Finance Branch

Dr. RUTH R. PUFFER, Chief, Health Statistics Branch

Dr. JOSÉ QUERO MOLARES, Liaison Officer

Dr. SANTIAGO RENJIFO SALCEDO, Chief, Zone V

Dr. RAMÓN VILLARREAL, Medical Education and Research Training Unit

Mr. JOSÉ RODRÍGUEZ OLAZÁBAL, Chief, Secretariat Services of the Meeting

Mr. ROBERTO RENDUELES, Chief, Office of Public Information

Observers

ORGANIZATION OF AMERICAN STATES

Dr. José A. Mora, Secretary General

Dr. Walter Sedwitz, Assistant Secretary for Economic and Social Affairs

Dr. Jaime Posada, Assistant Secretary for Cultural, Scientific, and Informational Affairs

Mr. O. Howard Salzman, Acting Deputy Director, Department of Technical Cooperation

Mrs. Alzora H. Eldridge, Liaison Officer

Dr. Jesse Perkinson, Director, Department of Scientific Affairs

Dr. Francisco Céspedes, Director of Educational Affairs

Mr. Beryl Frank, Chief, Social Security Unit, Department of Social Affairs

Mr. Armando Cassorla, Special Assistant, Department of Economic and Social Affairs

Mr. José Carlos Ruiz, Special Assistant, Department of Cultural, Scientific, and Informational Affairs

UNITED NATIONS

Mr. Luis Alberto Rodríguez, Assistant Chief, Washington Office, Economic Commission for Latin America, Washington, D. C.

SPECIALIZED AGENCIES OF THE UNITED NATIONS AND INTERGOVERNMENTAL ORGANIZATIONS

International Labour Office

Dr. Luis Alvarado G., Director, Liaison Office in Washington for Latin American Affairs, Washington, D. C.

United Nations Children's Fund

Dr. Oscar Vargas-Méndez, Regional Director for the Americas, UNICEF, United Nations, New York, N. Y.

NONGOVERNMENTAL ORGANIZATIONS

Council for International Organizations of Medical Sciences

Dr. Zygmund Deutschman, National Academy of Sciences, National Research Council, Division of Medical Science, Washington, D. C.

International Council on Jewish Social and Welfare Services

Dr. Arthur J. Lesser, Deputy Chief, Children's Bureau, Department of Health, Education, and Welfare, Washington, D. C.

International Council of Nurses

Miss Julia S. Randall, Nurse Consultant, U. S. Public Health Service, Silver Spring, Maryland

International Dental Federation

Mr. H. M. Christensen, Director, Washington Office, American Dental Association, Washington, D. C.

International Diabetes Federation

Dr. Howard F. Root, President, Joslin Clinic, Boston, Massachusetts

International Federation of Surgical Colleges

Captain David P. Osborne, M.C., Chief of Surgery, United States Naval Hospital, Bethesda, Maryland

International Hospital Federation

Dr. Vane M. Hoge, Director, Pan American Office of the Federation, Washington, D. C.

Dr. José González, Secretary, Pan American Office of the Federation, Washington, D. C.

International Society of Blood Transfusion

Mr. Alton D. Tripp, Assistant Administrative Director, American Red Cross Blood Program, Washington, D. C.

Miss Robina May Walters, Assistant Director, Blood Program Nursing, American National Red Cross, Washington, D. C.

International Union of Architects

Mr. J. Ware, Jackson, Mississippi

International Union for Child Welfare

Mr. Glen F. Leet, Executive Director

Mr. Frank Barry, Latin American Coordinator for Community Development Foundation, New York, N. Y.

Mr. Melvin E. Frarey, Program Director

International Union against the Venereal Diseases and the Treponematoses

Mrs. Josephine V. Tuller, Director, Regional Office for the Americas, New York, N. Y.

League of Red Cross Societies

Miss Ann Magnussen, Nursing Consultant, Division of Medical Care Standards, Bureau of Family Service, American Red Cross, Washington, D. C.

Pan American Medical Confederation

Dr. Jaime Sznajder, Ann Arbor, Michigan

Rockefeller Foundation
Dr. JOHN M. WEIR, Director, New York, N. Y.

W. K. Kellogg Foundation
Dr. EMORY W. MORRIS, President, General Director, Battle Creek, Michigan

World Confederation for Physical Therapy
Mrs. BRUNETTA K. GILLET, Washington, D. C.

World Federation of Occupational Therapists
Mrs. I. R. ACHTER, Chief Occupational Therapist, D. C. General Hospital, Washington, D. C.
Miss MARJORIE FISH, Consultant, Occupational Therapy, Division of Training, Vocational Rehabilitation Administration, Department of Health, Education, and Welfare, Washington, D. C.

World Federation of Societies of Anaesthesiologists
Dr. SOLOMON N. ALBERT, Director, Anesthesiology Department, Washington Hospital Center, Washington, D. C.

World Medical Association
Dr. OTIS L. ANDERSON, Assistant Manager, Washington Office, American Medical Association, Washington, D. C.

World Veterans Federation
Mr. C. STANLEY ALLEN, Executive Secretary, U. S. Council of the WVF, Washington, D. C.

OFFICERS OF THE DIRECTING COUNCIL AND MEMBERSHIP OF ITS COMMITTEES

Officers

The President and two Vice-Presidents were elected pursuant to Rule 18 of the Rules of Procedure. The officers were as follows:

President:
Dr. Raymundo de Britto, Brazil

Vice-Presidents:
Dr. Juan Jacobo Muñoz, Colombia
Dr. José Antonio Peraza, Honduras

Secretary ex officio:
Dr. Abraham Horwitz, Director, Pan American Sanitary Bureau

In compliance with Rule 20 of the Rules of Procedure the Representative of Panama, Dr. Roderick Esquivel, was appointed to preside temporarily over the sessions from which the President and the two Vice-Presidents were absent.

Committee on Credentials

The Committee on Credentials, composed of the following members, was established pursuant to Rule 24 of the Rules of Procedure:

Chairman:
Dr. Carlos Quirós Salinas, Peru

Rapporteur:
Dr. José Antonio Saldaña, El Salvador

Member:
Dr. Leonard M. Comissiong, Trinidad and Tobago

General Committee

The Representatives of Ecuador, Mexico, the United States of America, and Venezuela were elected to the General Committee, which, pursuant to Rule 25 of the Rules of Procedure, was composed as follows:

Dr. Raymundo de Britto
President of the Council
Brazil

Dr. Roderick Esquivel
Acting President
Panama

Dr. Juan Jacobo Muñoz
Vice-President of the Council
Colombia

Dr. José Antonio Peraza
Vice-President of the Council
Honduras

Dr. Miguel Eduardo Yépez Aschieri
Representative
Ecuador

Dr. Pedro Daniel Martínez
Representative
Mexico

Dr. Charles L. Williams, Jr.
Representative
United States of America

Dr. Francisco Castillo Rey
Representative
Venezuela

Dr. Abraham Horwitz (*Secretary ex officio*)
Director, Pan American Sanitary Bureau

Dedication of the New Headquarters Building and Inaugural Session of the Meeting

The inaugural session, which was also the dedication of the new headquarters building, was held in the Council Chamber on 27 September 1965, at 11:00 a.m., under the chairmanship of the Minister of Health and Welfare of Mexico, Dr. Rafael Moreno Valle, Acting President of the XVI Meeting of the Directing Council, and was attended by the authorities of the Government of the United States of America, the Diplomatic Corps, the Delegations

of the various countries attending the meeting of the Directing Council, and representatives of national and international organizations.

Addresses were delivered by the Acting President, Dr. Moreno Valle; the Secretary of Health, Education, and Welfare of the United States of America, Mr. John W. Gardner; the Secretary General of the Organization of American States, Dr. José A. Mora; the Director-General of the World Health Organization, Dr. M. G. Candau; the President of the W. K. Kellogg Foundation, Dr. Emory W. Morris; and the Director of the Pan American Sanitary Bureau, Dr. Abraham Horwitz. Also seated on the rostrum was Dr. Fred L. Soper, Director Emeritus of the Pan American Sanitary Bureau. Finally, the Acting President officially opened the XVI Meeting of the Directing Council.

Donations of Works of Art for the Headquarters Building

In response to suggestions in a circular letter from the Director of PASB regarding the interest of the Organization in having the new headquarters building become, to the extent possible, an expression of the art and culture of the various peoples of the Americas, the Governments made the following donations which were accepted in solemn ceremonies:

An abstract painting by the Montreal artist Jean McEwen, presented by the Minister of National Health and Welfare of Canada, the Honorable Judy LaMarsh.

A painting by the Chilean artist Nemesio Antúnez, "Blue Rays," presented by the Pharmaceutical Manufacturers' Association on behalf of the drug industry of the United States of America. The painting was presented by Mr. Edward Landreth, Vice-President of Winthrop Laboratories.

"Tierra argentina," by the Argentine sculptor Pablo Curatella Núñez, was presented by the Minister of Social Welfare and Public Health of Argentina, Dr. Arturo Oñativia.

"Guanajuato," a painting by José Chávez Morado, was presented by the Mexican Ambassador, His Excellency Hugo B. Margáin.

"Birth of Venus," a painting by Mabé, a gift of the Government of Brazil, was presented by Mr. Jorge de Carvalho e Silva, Minister Counselor in Washington, and the Minister of Health, Dr. Raymundo de Britto.

The Government of Honduras donated four pictures: "Composition" by Mario Castillo; "Portrait" by Max Auceda; "Composition" by Arturo Luna; and "Polychrome of Rodán" by López Rodezno.

Working Parties

Six working parties were established. The first, entrusted with the study of the application of Article 6-B of the Constitution of the Pan American Health Organization, held two meetings, the first being presided over by Dr. Rafael Moreno Valle and the second, by Dr. Pedro Daniel Martínez, both of Mexico. The other members of the working party were Dr. Charles L. Williams, Jr., and Mr. Howard B. Calderwood (United States of America), and Dr. José Luis Aponte-Villegas (Venezuela).

The second working party was appointed to prepare a draft resolution on Item 26 (Relationship between Social Security Medical Programs and Those of Ministries of Health or Other Official Health Agencies) and was composed of the following Representatives: Dr. Pedro Daniel Martínez (Mexico), Chairman; Dr. Manoel José Ferreira (Brazil), Rapporteur; Dr. Ramón Valdivieso (Chile); Mr. Edison Rivera (Costa Rica); and Dr. Alberto E. Calvo (Panama).

The third working party, which prepared draft resolutions on Items 11-A, 11-B, and 11-C, all related to the malaria eradication program in the Americas, was composed of the following Representatives: Dr. Miguel Eduardo Yépez Aschieri (Ecuador), Chairman; Dr. Julio C. Blaksley (Argentina), Rapporteur; Dr. Achiles Scorzelli, Jr. (Brazil); Dr. Alberto Aguilar Rivas (El Salvador); Dr. Manuel B. Márquez Escobedo (Mexico); Mr. Leonard M. Board (United States of America); and Drs. Francisco Castillo Rey and José Luis Aponte-Villegas (Venezuela).

The fourth working party was entrusted with the preparation of a draft resolution on Item 27 (Status of Smallpox Eradication in the Americas) and was composed of the following Representatives: Dr. Claudio L. Prieto (Paraguay), Chairman; Dr. Julio C. Blaksley (Argentina), Rapporteur; Dr. Daniel Alonso Menéndez (Cuba); Dr. Alfonso Boniche

Vásquez (Nicaragua); Dr. Carlos Quirós Salinas (Peru); and Dr. Charles L. Williams, Jr., and Mr. Leonard M. Board (United States of America).

The fifth working party prepared a draft resolution on Item 13 (Status of National Health Planning) and was composed of the following Representatives: Dr. Orlando Aguilar Herrera (Guatemala), Chairman; Dr. Conrado Ristori Costaldi (Chile); Dr. Alberto Aguilar Rivas (El Salvador); and Mr. Gérard Philippeaux (Haiti).

The sixth working party was entrusted with the preparation of a report on Item 21 (Selection of Topics for the Technical Discussions during the XVII Pan American Sanitary Conference, XVIII Meeting of the Regional Committee of WHO for the Americas) and was composed of the following Representatives: Dr. Roderick Esquivel (Panama), Chairman; Dr. Manoel José Ferreira (Brazil); Dr. Roberto Acosta Borrero (Colombia); and Dr. Pedro Daniel Martínez (Mexico).

The working parties presented the reports and draft resolutions in plenary session.

Technical Discussions

The topic of the Technical Discussions of the Directing Council, which were held on 1 October, was "Methods of Improving Vital and Health Statistics". The officers were as follows:

Moderator:

Dr. CHARLES L. WILLIAMS, JR., National Institutes of Health, Department of Health, Education, and Welfare, United States of America

Rapporteur:

Dr. CONRADO RISTORI COSTALDI, Chief, Technical Department, National Health Service, Chile

Technical Secretary:

Dr. RUTH R. PUFFER, Chief, Health Statistics Branch, Pan American Sanitary Bureau

The panel members appointed by the Pan American Sanitary Bureau were as follows: Dr. Alberto E. Calvo (Panama); Dr. Carlos Luis González (Venezuela); Dr. Herman E. Hilleboe (United States of America); Dr. W. P. D. Logan (WHO Headquarters); Dr. Nelson Luiz de Araujo Moraes (Brazil); and Dr. Enrique Pereda O. (Chile).

At the fourteenth plenary session the Directing Council considered the report of the Technical Discussions [1] and adopted a resolution on it at the following session.

[1] *Scientific Publication PAHO* **128.**

AGENDA

1. Opening of the Meeting
2. Establishment of the Committee on Credentials
3. Election of President and Two Vice-Presidents
4. Adoption of the Agenda
5. Establishment of the General Committee
6. Annual Report of the Chairman of the Executive Committee
7. Annual Report of the Director of the Pan American Sanitary Bureau
8. Financial Report of the Director and Report of the External Auditor for 1964
9-A. Proposed Program and Budget of the Pan American Health Organization for 1966
9-B. Proposed Program and Budget of the World Health Organization for the Region of the Americas for 1967
9-C. Provisional Draft of the Proposed Program and Budget of the Pan American Health Organization for 1967
10. Report on the Collection of Quota Contributions
11-A. Report on the Status of Malaria Eradication in the Americas
11-B. Financing of the Malaria Eradication Program in the Americas
11-C. Estimated Requirements for Malaria Eradication in the Americas
12. Planning of Hospital and Health Facilities
13. Status of National Health Planning
14. Report on Buildings and Installations for Headquarters
15. Report on Administrative Rationalization in the Pan American Sanitary Bureau
16. Organization of the Pan American Sanitary Conference and Amendments to Articles 7-D, 12-B, and 14 of the Constitution
17. Place of the XVII Pan American Sanitary Conference, XVIII Meeting of the Regional Committee of WHO for the Americas and Amendments to Articles 7-A, B, and C of the Constitution and Rule 1 of the Rules of Procedure of the Directing Council
18. Amendments to the Staff Rules of the Pan American Sanitary Bureau
19. Technical Discussions: "Methods of Improving Vital and Health Statistics"
20. Election of Two Member Governments to the Executive Committee on the Termination of the Periods of Office of Costa Rica and the United States of America
21. Selection of Topics for the Technical Discussions during the XVII Pan American Sanitary Conference, XVIII Meeting of the Regional Committee of WHO for the Americas
22. Research Policy and Program of the Pan American Health Organization
23. Third Annual Meetings of the Inter-American Economic and Social Council at the Expert and the Ministerial Levels
24. Resolutions of the WHO Executive Board and the World Health Assembly of Interest to the Regional Committee
25. Training of Auxiliary Personnel
26. Study of the Relationship Between Social Security Medical Programs and those of Ministries of Health or Other Official Health Agencies
27. Status of Smallpox Eradication in the Americas
28. Epilepsy in the Americas
29. Nongovernmental Financial Support for Health Activities
30. Establishment of Official Relations with the Pan American Federation of Associations of Medical Schools
31. Procedure for the Presentation of Reports to the Directing Council
32. International Transportation of Human Remains
33. Air and Water Pollution in Latin America
34. Material Support of the Program for Global Eradication of Smallpox by the Countries of the American Region
35. Eradication of *Aedes aegypti* in Argentina [1]
36. Other Matters

[1] Item included by the Council at its eleventh plenary session.

2. PRÉCIS MINUTES OF PLENARY SESSIONS

PLENARY SESSIONS

INAUGURAL SESSION

Monday, 27 September 1965, at 11:00 a.m.

The inaugural session, at which the ceremonies dedicating the new headquarters building were also held, took place in the Council Chamber of the new building in Washington, D.C., on 27 September 1965, at 11:00 a.m. In attendance were authorities of the Government of the United States of America, the Diplomatic Corps, the delegations of the various countries to the Directing Council meeting, and representatives of international and national organizations.

Sharing the rostrum with the Acting President of the XVI Meeting of the Directing Council, Dr. Rafael Moreno Valle, Secretary of Health and Welfare of Mexico, were Mr. John W. Gardner, Secretary of Health, Education, and Welfare of the United States of America; Dr. José A. Mora, Secretary General of the Organization of American States; Dr. M. G. Candau, Director-General of the World Health Organization; Dr. Emory W. Morris, President of the W. K. Kellogg Foundation; Dr. Abraham Horwitz, the Director of the Pan American Sanitary Bureau, and Dr. Fred L. Soper, Director Emeritus of the Pan American Sanitary Bureau.

The following addresses were delivered at the inaugural session:

Address by Dr. Rafael Moreno Valle, Secretary of Health and Welfare of Mexico

In celebrating the inauguration of its Headquarters, the Pan American Health Organization can feel justifiably enthusiastic as this building, through the strength and beauty of its design, the capaciousness of its facilities and the functionalism of its architecture, represents and symbolizes the essential character of the Pan American Health Organization and its executive organ, the Pan American Sanitary Bureau. As an organization, it is impressive both in its efforts to preserve and improve the health of the American peoples; impressive in the disinterestedness of its procedures and the magnanimity of its purpose; impressive, in a word, as an example and demonstration of the united resolve of the peoples of the Americas to seek common goals and to join their efforts in a continuing struggle against disease, in training the teams of workers who are to carry out this task, and in undertaking the scientific research necessary for progress. The Pan American Health Organization is a model of democratic action, in which all the Member Countries work together in a spirit of mutual respect, and in which international cooperation is pursued without detriment to national independence and sovereign rights. Our Organization constitutes a veritable citadel of human solidarity.

This building represents one of the major achievements of the PAHO in the course of its long and fruitful existence over a period of sixty-three years. We feel sure that it represents the realization of the dream of those who came before us and who ardently believed that there would come such a day as this when all the nations of the Americas would be represented, not only to participate joyfully in the inauguration of this splendid Headquarters but also to reaffirm their determination to continue their unremitting and untiring efforts to improve the health of all the peoples of the Hemisphere.

We should like to record our profound satisfaction at the presence of so many distinguished persons, representing their Governments and peoples.

The participation of all has been and will continue to be a decisive factor in the effective role of this health organization. More especially, we should like to express to the Government of the United States of America our Organization's gratitude for the donation of the site on which our Headquarters has been built. Our public thanks also go to the W. K. Kellogg Foundation for its very large financial contribution, which made it possible to erect this building.

From our new home will come the Organization's programs to transform life in the Americas and endow it with increasing security and dignity. Our programs become more numerous and varied each day and demonstrate the interest shown by all in the intensification of health activities in the international sphere. More than 400 field programs are in full course: they include those concerned with the protection of health, in which environmental sanitation and water supply are predominant, and the measures taken in the fight against communicable diseases, especially malaria and smallpox, with the firm intention of eradicating them from the Hemisphere. There are also the programs for the promotion of health, ranging from those concerned with general health services to special programs, such as maternal and child health, medical care, and radiation protection; there are also the rehabilitation programs that are becoming more important each day; and finally, the professional education and training programs, which represent a vital intellectual investment, not only because they bring scientific truth into correspondence with human reality but also because they bring the technical needs into concord with the resources available to us.

In these major tasks, the exemplary devotion and dedication of the Director of the Pan American Sanitary Bureau, Dr. Abraham Horwitz, has been efficiently supported by the entire Secretariat, which has met the challenge of its great responsibility to history. We offer our congratulations and gratitude on behalf of our peoples.

We also consider it only right that we should bear witness to the constant interest and unwaivering support of Dr. M. G. Candau, the Director-General of the World Health Organization, the agency of which we are a part and which our Bureau represents in the Americas.

The growing pace of health and social security programs underlines the urgent and imperative need to secure their proper coordination, if resources are not to be wasted and efforts frustrated. With this essential objective in mind, the Mexican Government recently established a joint coordinating committee for activities in the health, welfare, and social security sectors. At the same time, the Pan American Sanitary Bureau, in response to the requests of Governments, is energetically examining the problem and proposing possible courses of action that will be discussed at the XVI Meeting of the Directing Council, beginning today. This, in my view, is a remarkable example of a combination of efforts and organized cooperation that cannot fail to achieve the desired goal.

I am convinced that our Organization's programs not only meet the needs of our peoples, as they are interpreted by their Governments, but also leave ample scope for the creative initiative of the Bureau's technical staff, so essential if their contribution is to be made effectively in a spirit of self-realization and professional pride.

We believe it to be of vital importance to point out that, although the objectives of the PAHO have always been and continue to be clear and precise, it is evident that they are being refined and modified in the light of the actual situation in each nation and in the world at large. It has thus been established that the health programs must be correlated with the economic development of our countries, as proposed in the program of the Alliance for Progress.

It is natural that it should be so, for we cannot conceive of health in isolation or in the abstract, just as we cannot conceive of the individual other than within the framework of society, or for that matter, just as we cannot conceive of the world's people other than as part of an increasingly interdependent world order.

The statement of the President of Mexico, Gustavo Díaz Ordaz, is therefore particularly fitting and I shall quote him: "We are fully convinced that peace and international cooperation require the effective operation and strengthening of international agencies, both general and specialized, that is to say, of the United Nations and of the inter-American regional agencies. We shall not be grudging in our support of them."

We have said on other occasions, and we should now like to repeat, that health is not only one of the fundamental rights of man, enabling him to develop his capacity for work and production, pre-

serve his dignity and freedom, gain access to culture and achieve well-being and prosperity. For us Mexicans it is also a right guaranteed by society and supported by justice within the framework of our Revolution; it is, moreover, the essential foundation for human progress, for social organization, and for all creative activities. We should develop in all our peoples and all our Governments the realization that the efforts and contributions they make to secure and preserve health are investments in those human resources without which material wealth is useless, as without man it can neither be enjoyed nor produced.

Mexico deeply appreciates the honor and distinction of having received an invitation to speak on this auspicious occasion. It provides us with a magnificent opportunity of expressing our most sincere good wishes for the success and prosperity of the countries of the Americas, and of reaffirming our common determination to pursue the objectives with which we are all associated and, in promoting the health of our peoples, to seek not only their development and welfare but the achievement of mutual understanding and assistance on the firm foundation of reciprocal respect between them and between nations.

Address by John W. Gardner, Secretary of Health, Education, and Welfare of the United States of America

I should like to add my own word of welcome, on behalf of the United States Government, to Your Excellencies the Ambassadors of the other American Republics and the Representatives on the Council of the Organization of American States, to delegations participating in the XVI Meeting of the Directing Council of the Pan American Health Organization, and to all our other friends.

Over the years, our close association with the sister nations of this Hemisphere has brought the United States benefits of many kinds. We cannot begin to count them all. Yet here today is still another—this jewel of a building—which adds such grace to the Washington landscape.

My congratulations to the architect—Señor Román Fresnedo Siri, of Uruguay—and to the Kellogg Foundation for the generous grant which brought this building into being. The United States is honored to serve as host nation to the Pan American Health Organization—the world's oldest agency for international cooperation in health—and to have in our midst its elegant new home.

Health is akin to beauty. It is fitting that a building dedicated to the ideal of better health for the people of the Americas should express that beauty in its form and design.

President Johnson has said that "association with beauty can enlarge man's imagination and revive his spirit." We can be sure that the beauty of this building will illuminate our common quest for a better life.

We have long known that ill health and ignorance go hand in hand, and that both chain the poor to a life of misery. The deeper the poverty, the higher do we find rates of disability and death.

We, in the United States, share these problems with the rest of the Americas. We have begun a vast effort to resolve them. For the goals of the Charter of Punta del Este "to bring a better life to all the peoples of the Continent" are also the goals of this nation.

We know now how to prevent or to heal diseases that for years have taken a terrible toll. Yet to have real meaning this knowledge must be shared, and the capabilities to apply it must also be shared.

The Pan American Health Organization helps all of us to do this—to help ourselves and each other.

Through PAHO, for example, we are waging an intensive campaign to eradicate the *Aedes aegypti* mosquito—the carrier of yellow fever—and to combat other stubborn and costly diseases, such as malaria and smallpox.

Through PAHO we are learning from each other. The United States values very highly the opportunities for manpower training and research that this Organization has opened up among all our countries.

President Johnson has recently voiced our deep concern about the hunger and malnutrition that continue to plague so much of our world. He has directed that new emphasis be placed on our own efforts to aid in combating them.

Here again, PAHO working with and through the Institute of Nutrition of Central America and Panama, has been in the forefront of an international effort to communicate the facts of this massive health problem, and to encourage means of prevention and cure.

Among very young children, especially, the effects of malnutrition are devastating. We know,

for example, that the enormous death toll in some countries from childhood diseases—chicken pox, measles, and whooping cough—is the result not so much of the infection itself as the lack of defenses to combat it. To a well-nourished child, chicken pox is a relatively minor disease. To a malnourished child, it can be fatal.

Moreover, we now have evidence that malnutrition in the early years can cause irreparable physical and mental damage. In our own country we have recognized an alarming link between deprivation and mental retardation. We have seen how cruelly poverty can cripple the mind as well as the body.

Health is without doubt one of the keystones of the Alliance for Progress. We have come a long way together—we, the people of the American nations. Yet I think we can all agree that we have scarcely begun to accomplish the great tasks of our age.

And now I should like to address a few concluding remarks in Spanish to my friends in the other American Republics.

Hace muchos años que viajo por el camino de la amistad panamericana. Mi esposa es de Guatemala. He visitado muchas veces los países de América. Tengo muchos amigos entre ustedes.

Aunque somos de distintos países, estamos estrechamente unidos por lazos de tradición y destino.

Creo innecesario en este momento hablar de la herencia que tenemos en común. Ella ha sido celebrada en innumerables discursos referentes a la unidad panamericana. No tenemos que detenernos a recordar lo que todos sabemos muy bien: que somos herederos de una tradición europea, que nos esforzamos por mantener a salvo la dignidad del individuo, por hacer prevalecer la justicia, y por dar a todos iguales oportunidades.

En los Estados Unidos de América no creemos que nuestro país haya encontrado la solución a todos sus problemas, ni quisiéramos que otros países creyeran eso de nosotros. Sólo creemos que en nuestra tierra los hombres gozan de libertad para buscar la mejor manera de resolver sus dificultades. Nos enfrentamos, como lo hacen las demás naciones, con los eternos problemas del hombre y de la sociedad en que vive, y lo mismo que ellas, hemos efectuado ciertos adelantos. Nos queda mucho por hacer, debemos seguir adelante y mejorar lo que hemos hecho en el pasado. Queremos para el mundo entero un orden de vida en el cual nosotros y todas las naciones seamos libres de seguir esos esfuerzos.

Vivimos en tiempos tan difíciles que todo lo que podamos hacer para fomentar de manera eficaz las comunicaciones entre las distintas naciones traerá consigo la supervivencia de la raza humana. Compartimos con los hombres sensatos de todas partes la necesidad de mantenernos unidos para cimentar un mundo mejor.

Es necesario que los hombres de buena voluntad se unan, y unidos luchen por la solución de los problemas que son comunes a todos. Considero esta reunión y la dedicación de este edificio como una parte integrante de ese gran esfuerzo.

Address by Dr. José A. Mora, Secretary General of the Organization of American States

The inauguration of the new Headquarters of the Pan American Health Organization is an event of particular significance for the Organization of American States, as this fine building both reflects and symbolizes the increasing importance that the countries of the Americas have shown they wish to attach to health problems.

It is a privilege for me to take part in this event and to express the wish of the OAS that the activities of this regional institution, in the service of the well-being of the Hemisphere, will in the future continue to develop and expand at the rapid pace that has marked their progress since its inception.

The Pan American Sanitary Bureau is the oldest specialized agency in the regional system. Our basic Charter recognizes this Organization as one of the organs of the OAS. For a long period of years, ending in 1947, its offices were located in our own building. We therefore regard the growth of the Pan American Health Organization and of the Pan American Sanitary Bureau as one of the most eloquent demonstrations of the vitality of the regional system.

The protection of health constitutes one of the basic principles governing our efforts to assure the future of the New World. The Alliance for Progress has attached high priority and overriding importance to it, regarding the protection and development of potential human resources as one of the basic elements in progress. When the OAS ex-

pert group laid down the basis for planning economic and social development in Latin America, it established the improvement of health conditions as an essential prerequisite to economic growth and one that should therefore be an indispensable part of regional development programs.

Dr. Abraham Horwitz, the eminent Director of this Regional Office, gave a profound and lucid interpretation of the concept of development when he said, in the course of one of his recent statements, that it was manifestly true that the final objectives of economic growth and structural changes in society could be none other than the improvement of the living conditions of the people.

Certainly, we can note with satisfaction that all those of us who are involved in this work and are responsible for coordinating efforts to this end are fully aware of the need to work together within this framework. The Pan American Sanitary Bureau and the Ministers of Health of all the Member Countries have taken positive steps to establish health policies, the successful results of which are now becoming evident; they have interpreted the proposals in the Charter of Punta del Este as calling for a cooperative effort to promote social progress in Latin America in association with, and as the outcome of, sustained economic growth; they have declared that they regard health problems as being conditioned by the whole range of factors that cause diseases and effect their incidence in a society; and they have been able to establish the relative roles of housing, malnutrition, unhealthful working conditions, ignorance, poverty and high morbidity rates and their bearing on the infant mortality rate in Latin America.

On this memorable occasion it is fitting to praise the efforts being made by those responsible for health programs in the Americas to deal with these very serious problems. The OAS is constantly stressing the need to include health authorities in planning organs, so as to ensure that national development plans take full account of those social factors that are so important to the future of our Hemisphere. We know that the study of health plans is being undertaken in close association with the analysis of investments in the development field. It is therefore becoming increasingly necessary to correlate health projects with other requirements of foreign capital along the lines already suggested. I have been able to see from the studies undertaken by the various authorities concerned that consideration is being given to that need and that it has been recommended that each Government should formulate an over-all plan that will make it possible to determine the ratio of needs to resources and of targets to investment funds available. To this end, and in view of the OAS's primary responsibility for guiding the development of activities under the Charter of Punta del Este, the OAS would like the Pan American Health Organization to be represented at and participate in all the stages of Latin American development.

Through meetings and missions, sponsored both by the General Secretariat of the OAS and by the Pan American Health Organization, we have encouraged closer coordination between the programs of ministries of health and those of social security agencies in order to ensure that, to the fullest possible extent, the resources of each country, both human and material, are used in the best interests of the community. This is an example of the kind of teamwork that we believe will progressively improve the machinery for coordination between the various agencies responsible for medical care at the national level.

On the completion of the first four years of the Charter of Punta del Este, the Inter-American Committee on the Alliance for Progress (CIAP) has approached the Presidents of the American Republics with a view to instituting a study that would provide the basis for a systematic review of the results being achieved by the Alliance and give it renewed momentum. It is recognized that there is a need to improve national programming procedures and to ensure the participation in them of representatives of all the various sectors of society —politicians, industrialists, workers' leaders and leaders of agricultural unions, economists, and of course, health authorities—so that they may become familiar with the problems and possibilities of national and regional planning.

In the health and population sectors, too, the factors to which I have been referring have been taken into account in connection with the need to fight malnutrition, especially when it occurs during the first six years of life, when the capabilities of the individual can be permanently injured. The expansion of public health institutions of all kinds has accordingly been recommended. It is clear from the latest reports that marked progress is being

made through the employment of Latin American funds in association with contributions from external financing agencies, but these efforts need to be applied systematically so as to ensure that they correlate with national development plans. Some mention should be made here of the joint measures of the OAS General Secretariat and the Pan American Health Organization to deal with the demographic problems that frustrate any success achieved in the area of economic growth and make it difficult to satisfy housing, health, and education requirements. Joint study groups, composed of members of our two organizations and of the finance agencies that provide external capital, have been set up for the purpose of making adequate advisory services available to Governments.

The OAS fellowship programs are a further example of cooperation; they cover various specialized fields in medicine, scientific research, and many aspects of public health and are designed to assist, up to the limit of the funds available, in the preparation of trained professional personnel, a problem that we know is engaging the attention of the PAHO. The technical services of the Pan American Sanitary Bureau participate in the selection of our fellowship-holders and we are most grateful for the valuable assistance they have given us.

The health authorities have very clearly stated that "as the number of health technicians trained in programming is increased, as the planning units in ministries are strengthened, as methods of planning through research are perfected, and as procedures for ensuring that due emphasis is given to the health sector in national development plans are improved, it will be possible to adopt a system of investments better adapted to the real needs and based on the decisions of the political authorities in each country."

With reference to the Program of Technical Cooperation, the Pan American Sanitary Bureau has been, and still is in some instances, the collaborating agency for various projects from 1951 onward, such as the Pan American Foot-and-Mouth Disease Center in Brazil, the Zoonoses Control Training Course in Argentina, the Training Course in Nutritional and Dietary Surveys in Argentina, the Workshop on Teaching of Communicable Disease Nursing in Guatemala, and the Courses on the Planning of Water Supply Systems in Brazil.

I should like to refer to the valuable assistance that the Pan American Sanitary Bureau has given us and is continuing to give us in the Dominican Republic in connection with the unfortunate events that have taken place in that country in recent months. From the outset, the Bureau's Mission participated in our aid programs, with the establishment of a Coordinating Committee that handled the distribution of food supplies, medicines, hospital maintenance, medical care, and other related services with the cooperation of the many Governments that sent medical and nursing missions. I therefore signed an agreement with the Pan American Sanitary Bureau, under the terms of which the General Secretariat of the OAS transferred to the Bureau the amounts required to cover the minimum costs of maintaining hospitals and other institutions that offered their services for humanitarian purposes. The Bureau assumed responsibility for the direction and control of those operations throughout the emergency period. I think it is only fair that I should take this opportunity of bearing witness to the efforts made by the Bureau, which largely succeeded in preventing the development of epidemics.

The building that we are inaugurating today commemorates the lives and hopes of our peoples. It expresses a profound faith in the future of our Hemisphere. We have given the Organization great responsibilities but we also have great confidence in its ability to triumph over disease and misery. This inaugural ceremony therefore constitutes the most effective tribute to the seventy-five years in which the Inter-American System has been in existence.

In expressing my sincerest good wishes for the future success of an institution with which so many men of good will are associated, I should like especially to congratulate Dr. Horwitz and his colleagues, who were initially responsible for the decision to construct this building, and Mr. Román Fresnedo Siri, the architect, who has added lustre to his professional reputation and to the name of Uruguay.

I should also like to pay my respects to the Ministers of Health and to the representatives of the countries of the Americas present here for this occasion and to the World Health Organization.

I am also pleased to convey our feelings of profound gratitude to the Government of the country in which the Headquarters is located, to the W. K. Kellogg Foundation, and to all those eminent per-

sons who have so generously contributed to the realization of this beautiful edifice that is now to serve the well-being of all the Americas.

Address by Dr. M. G. Candau, Director-General of the World Health Organization

It is both a great privilege and a great honor for me to be able to attend this ceremony of the dedication of the new headquarters building of the Pan American Health Organization, which houses the Pan American Sanitary Bureau, WHO Regional Office for the Americas, and to bring to you, assembled here this morning, the greetings of the World Health Organization.

This beautiful building symbolizes the achievements of the Pan American Sanitary Bureau over its sixty-three years of existence, and more particularly the progress made in the last eighteen years under the leadership of Dr. Fred L. Soper and Dr. Abraham Horwitz.

In the name of the World Health Organization, I wish to express my congratulations to Dr. Emory W. Morris, President of the W. K. Kellogg Foundation, on his understanding, imagination, and confidence which made the realization of this building possible.

The history of the Pan American Sanitary Bureau is a long record of achievement. Side by side with the Rockefeller Foundation, the Kellogg Foundation, and the bilateral programs of the United States of America, the PASB has played a very important role in the improvement of health throughout the Americas. I realize, however, that we cannot be complacent so long as many of the Hemisphere's health problems remain unsolved. The eradication of malaria has been slowed down by technical and administrative difficulties. The eradication of *Aedes aegypti* is facing a setback due to the increasing resistance of the insect to the insecticides in the northern part of South America and in the Caribbean area. Plague continues to be a problem in several areas of Latin America. Smallpox is still far from being eradicated and many areas from which it had been eradicated are now unfortunately being threatened by reinvasion. In addition schistosomiasis, Chagas' disease, and onchocerciasis are all major problems requiring careful evaluation and the development of programs for their control and final eradication.

However, it is my belief that we have every reason to be optimistic. The number of educational institutions created during the last few years and the numbers of trained health personnel are high. Practically all countries in the Americas now have medical schools and nursing training throughout the Hemisphere has increased. The profession of sanitary engineering, nonexistent twenty years ago, is now well established, to the great benefit of the countries of the Americas. In addition we have large numbers of centers for the training of ancillary and auxiliary personnel. I believe that the existence of larger numbers of trained personnel and the availability of more and more material resources give us the right to look to the future with more optimism than we have been able to hitherto.

Today I cannot avoid remembering, with certain feelings of emotion, when our Bureau was housed in a corner of the Pan American Union. Then it moved to Connecticut Avenue, and there too space became accutely short. How pleased we were when Dr. Fred L. Soper, with the help of the Rockefeller Foundation and the Kellogg Foundation, acquired buildings near the Dupont Circle. Later on the steady growth of the Bureau made the acquisition of future buildings necessary.

Imagine my pleasure this morning, therefore, to see the happiness of all the staff at being housed once more under the same roof. All credit should go to Dr. Horwitz for his courage in facing the problem and making this possible. This morning, too, I was very happy to see so many old friends and colleagues with whom I had worked so closely years ago. To the whole staff I wish to offer my thanks on this occasion for all they have contributed to the development of the Organization.

This building symbolizes the spirit of the countries of the Americas and their ability to cooperate together in overcoming their health problems. It is a symbol of friendship, understanding, and mutual respect. In it we shall work together toward the attainment of our ideal—the improvement of health conditions in all the Americas—and thereby contribute to the prosperity and peace which should be the lot of man throughout the world.

Address by Dr. Emory W. Morris, President of the W. K. Kellogg Foundation

This beautiful building, designed by a Uruguayan architect on land provided by the United States

Government, stands as a symbol of cooperation among all the Republics of the Americas. It is, of course, more than just a symbolic monument; it is the Headquarters for programs that affect the health and welfare of every person in the Americas, developed under the guidance of outstanding leaders such as Dr. Hugh S. Cumming, Dr. Fred L. Soper, Dr. M. G. Candau, and Dr. Abraham Horwitz.

The Kellogg Foundation is proud to be associated with those programs. Our interests in Latin America have paralleled those of the Pan American Health Organization and the Rockefeller Foundation, which pioneered in public health in Latin America. We have had the same objectives, and in numerous cases we have collaborated on the same projects, in the fields of education in medicine, dentistry, nursing, public health, hospital administration, and nutrition. It is entirely appropriate, therefore, that this building should represent our joint interest in the improvement of education and service in the health fields as a fundamental means of promoting the welfare of the people.

It is the privilege of foundations to encourage and strengthen the efforts of farsighted leaders in the achievement of goals of great importance. This has been the privilege of the Kellogg Foundation in helping the progress of the health sciences in the Americas. We have always given emphasis to leadership as the primary factor in accomplishment. And this is the underlying reason for our faith in the Pan American Health Organization and its critical role in the progress of civilization in this Hemisphere.

The funds for the construction of this building were made available as a loan to the Organization, rather than as an outright grant. The loan is being repaid by the Governments through the annual deposit of $250,000 in the Organization's Special Fund for Health Promotion, for the support of new and expanded programs supplementing those financed from the regular budget. In other words, the repayment results in increased activity guided by the Organization in the accomplishment of its purposes. We feel, Mr. President, that there could be no better or more rewarding investment of those funds on behalf of the people of your Member Countries.

We believe in what you are doing; we know of its far-reaching significance and benefit. And you have our wholehearted best wishes for continuing success in the pursuit of the objectives of your Organization in the future.

Address by Dr. Abraham Horwitz, Director of the Pan American Sanitary Bureau

It is indeed a very great pleasure for us, the officials of the Pan American Health Organization and of the World Health Organization, to place this building at the disposal of those to whom it rightfully belongs: the Governments of the Americas, as represented by yourselves, its Ministers of Health. Implicit in this act is our gratitude to those who have made possible the undertaking of this work: to all the Governments of the Hemisphere for their understanding, interest, and guidance in converting our policies into reality and facilitating the performance of our task; to the United States of America for the use and ownership of the land on which this building has been erected; to the Kellogg Foundation for its generous contribution and for the unusual and sensitive way in which it was made; to the architects of the firm that built it, for their dedication to the task, and in particular to Mr. Román Fresnedo Siri, the architect and designer who carried out the work and who succeeded in incorporating into its design the ideals that are the inspiration of our Organization and rouse in its members an unremitting will to serve.

Without failing to pay tribute to the restrained and elegant lines of the building's façade, we are even more moved by its ideal form and conception, which give living expression to the humanitarianism that dominates our endeavors. In its design it partakes of both the formal and the functional—the underlying principles of our Constitution. It has been our responsibility in the past, as it will be in the future, to translate those ideals into coherent aspirations and the objectives into tangible human well-being.

We have inherited a spiritual legacy that was conceived with great vision sixty-three years ago; time has shown the soundness of its principles, as demonstrated by the continued survival of the venture, despite the vicissitudes through which the nations of the Hemisphere have passed. It has also proved the flexibility of our undertaking, which has adapted itself to the dominant social movements of each period. For in all the activities undertaken

by the Organization in the course of the century, its essential preoccupation has been with human beings and their culture, which it has understood to be "the way in which people live, including their social, political, and economic forms of organization and their characteristics of thought, the nature of their emotions, and their relations with one another." Human beings are more than a series of needs, desires, and fears and any undertaking that fails to take into account their qualities of spirit will not survive, whatever its objectives may be, and any success it may achieve will be short-lived.

The history of the Organization is bound up with the development of public health as a social service in the Americas and is the epitome of what has been achieved by the Governments, a fact that demonstrates that there is no conflict between realistic policies and high ideals. The importance of its contribution to this work can be inferred from the continued decline in general and specific mortality rates and from the changes that have occurred in patterns of morbidity. It should also be measured by those other and more complex indicators that reveal the changes in conduct and attitudes on the part of those who have benefited from the measures taken and have felt moved to undertake more than before and even more than they intended. It should be measured, too, by certain factors and positive environmental changes that have not only increased well-being by reducing the element of risk but have also made social living a more pleasurable experience. In recent years, without ceasing to expand its traditional activities in the area of communicable diseases, the Organization has, in addition, taken a whole range of measures designed to secure for health its rightful place in the general development process. It has vigorously sustained the argument that investments in the prevention and cure of disease and in improvements in the social sector directly contribute to economic growth and therefore constitute an essential element in such growth.

In the Americas of today the disparity between needs and resources has compelled increasing attention, the clamor for social action has become more strident, the need to apply the advances of science and technology has grown more urgent, and it has become more than ever essential for the State and the people and for public and private institutions to take joint action. Similarly, however, the possibilities are many more, the objectives are better defined, and the responsibilities are therefore more apparent. For a number of reasons the prevailing spirit is one of renewal of old forms and outmoded traditions which have created unjustifiable distinctions and inequalities that can only foster doubts; there has been kindled a passionate desire to serve the needs of society, to break down vested interests and conventional forms, to widen the range of opportunities, and to promote social progress and the well-being of all—a desire expressing itself in a spirit of social cooperation, rather than that of rebellion. And the achievements are the more remarkable, the less they are distorted by anger and will be even more so in the future insofar as they are rooted in ideals.

The social services protecting the health of the individual and of society cannot stand aside from this continental movement, which is reflected in the proposals recorded in the Act of Bogotá and in the Charter of Punta del Este, documents that have achieved historic status in a brief period of time, expressing, as they do, the hopes of millions of people. On the firm basis of its record of creative achievements and of its established tradition, with that quality of flexibility with which it was endowed by its visionary founders, our Organization has demonstrated its ability to adapt itself to the new era and will continue to do so. It has no easy task; it must advise Governments but never assume their responsibilities; it must keep them informed of advances in science and technology and offer solutions for each problem and situation according to the needs of each society; it must record the more significant occurrences in the dynamics of diseases and especially those affecting more than one country; it must analyze data and translate its conclusions into practical recommendations to be made to Governments; it must contribute to the complex processes of training professional and auxiliary health workers and to the investigation of problems, some of which require basic studies and others the creation of systems that will facilitate their solution on a nation-wide scale. At the same time the Organization serves as a forum in which the policies to be adopted are discussed and determined and where there is an interchange of experiences that are of common value, for they have their origin in cultures that are dissimilar in accidental characteristics but not in their essential nature.

From the generations that came before us in the service of the health of the Americas we learn that dedication to the interest of others, although it involves sacrifices, is an ennobling experience. Only those who look beyond their own immediate concerns, who are inspired by great principles and place their faith in the happiness and well-being of mankind, can devote their lives to work whose results are not readily associated with those who undertook it. No one can give himself fully to such a venture unless he is deeply immersed in the life of the Continent. And these spiritual factors will be even more essential in the future, as is already evident from the experience of the recent past. Whatever the difficulties that may arise, the higher purpose to which we are committed will prevail, a purpose that guides the Americas in their search for their own identity, rooted as they are in their old cultures, and enables them to assimilate, on these solid foundations, the progress that civilization brings for the common weal. This is how we see the essence and implications of a work that has today taken on a new lease of life with the inauguration of this building, designed by an artist with a clear vision of its destiny who has found in it a source of inspiration. To symbolize the handing of this building over to the Governments, I should like to present you, Mr. President, with this key, which we hope will be passed on at all meetings of the Governing Bodies in the generations to come.

Opening of the Meeting by the Acting President

The ACTING PRESIDENT, after thanking the speakers for their addresses and the representatives for their attendance, declared open the XVI Meeting of the Directing Council of the Pan American Health Organization, XVII Meeting of the Regional Committee of the World Health Organization for the Americas.

The session rose at 12:15 p.m.

FIRST PLENARY SESSION

Monday, 27 September 1965, at 3:20 p.m.

Acting President: Dr. Rafael Moreno Valle (Mexico)

President: Dr. Raymundo de Britto (Brazil)

Item 2: Establishment of the Committee on Credentials

The ACTING PRESIDENT opened the session and, in his capacity as Secretary of Health and Welfare of Mexico, expressed the gratitude of the people and Government of Mexico to the Organization for having held the XV Meeting of the Directing Council in their capital city. He voiced the hope that the work of the XVI Meeting would be equally fruitful and announced that the next item of business was the establishment of the Committee on Credentials.

Dr. SUTTER (Assistant Director, PASB) read Rule 24 of the Rules of Procedure of the Directing Council on the establishment of the Committee on Credentials.

The ACTING PRESIDENT proposed that the Committee be composed of the Representatives of El Salvador, Peru, and Trinidad and Tobago.

Decision: The Representatives of El Salvador, Peru, and Trinidad and Tobago were designated to form the Committee on Credentials.

The ACTING PRESIDENT announced that he would suspend the session so that the Committee on Cre-

dentials could meet immediately and present its report.

It was so agreed.

The session was suspended at 3:40 p.m. and resumed at 4:10 p.m.

First Report of the Committee on Credentials

Dr. SALDAÑA (El Salvador), Rapporteur of the Committee on Credentials, read its first report:

The Committee on Credentials, established at the first plenary session and composed of Dr. Carlos Quirós Salinas (Peru), Chairman, Dr. José A. Saldaña (El Salvador), Rapporteur, and Dr. Leonard M. Comissiong (Trinidad and Tobago), held its first session on 27 September at 3:30 p.m.

The Committee examined and found the credentials submitted by the Representatives, Alternates, and Advisers of the following countries to be in good order: Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, France, Guatemala, Haiti, Honduras, Jamaica, Kingdom of the Netherlands, Mexico, Nicaragua, Panama, Paraguay, Peru, Trinidad and Tobago, United Kingdom, United States of America, and Venezuela, as well as those of the Observers from Canada.

The following intergovernmental and nongovernmental organizations also sent observers: the Organization of American States, the United Nations, the United Nations Children's Fund (UNICEF), the Council for International Organizations of Medical Science, the International Council on Jewish Social and Welfare Services, the International Council of Nurses, the International Dental Federation, the International Diabetes Federation, the International Federation of Surgical Colleges, the International Hospital Federation, the International Society of Blood Transfusion, the International Union of Architects, the International Union for Child Welfare, the International Union against the Venereal Diseases and the Treponematoses, the League of Red Cross Societies, the Pan American Medical Confederation, the Rockefeller Foundation, the W. K. Kellogg Foundation, the World Confederation for Physical Therapy, the World Federation of Occupational Therapists, the World Federation of Societies of Anaesthesiologists, the World Medical Association, and the World Veterans Federation.

The Committee will meet again to examine the credentials of the Representatives of the Governments that have not yet deposited them.

Decision: The first report of the Committee on Credentials was adopted without change.

Item 3: Election of the President and Two Vice-Presidents

The ACTING PRESIDENT announced that the next item was the election of the President and two Vice-Presidents.

Dr. SUTTER (Assistant Director, PASB) read Rule 18 of the Rules of Procedure, pertaining to the election.

Dr. TERRY (United States of America) proposed as President of the XVI Meeting of the Directing Council Dr. Raymundo de Britto, Minister of Health of Brazil, and as Vice-Presidents Dr. Juan Jacobo Muñoz, Minister of Public Health of Colombia, and Dr. José Antonio Peraza, Minister of Public Health and Social Welfare of Honduras.

Dr. AGUILAR HERRERA (Guatemala) supported the proposal made by the Representative of the United States of America.

Decision: There being no other nominations, the Representative of Brazil, Dr. Raymundo de Britto, Minister of Health, was declared President of the Directing Council and the Representative of Colombia, Dr. Juan Jacobo Muñoz, Minister of Public Health, and the Representative of Honduras, Dr. José Antonio Peraza, Minister of Public Health and Social Welfare, were declared Vice-Presidents.

Dr. Britto took the Chair.

The PRESIDENT expressed his appreciation for the honor that had been conferred both on his country and on himself and expressed the hope that the Organization would continue its work with increasing determination in behalf of the health and welfare of the Americas. He referred to the efforts that had been made by the Director of the Bureau, Dr. Horwitz, to obtain a building of the kind that had just been inaugurated and expressed the hope that education, health, and closer collaboration between peoples would assure for them a peaceful and democratic future.

Dr. MUÑOZ (Colombia) also thanked those present for his appointment and said that he hoped the meeting of the Directing Council would be a successful one.

Dr. PERAZA (Honduras) also expressed his appreciation for his appointment.

Item 4: Adoption of the Agenda

The PRESIDENT submitted for consideration the draft agenda appearing in Document CD16/1, Rev. 3.

Decision: The agenda contained in Document CD16/1, Rev. 3, was adopted.[1]

Item 5: Establishment of the General Committee

Dr. SUTTER (Assistant Director, PASB) read Rules 25 and 26 of the Rules of Procedure relating to the establishment and functions of the General Committee.

The PRESIDENT proposed that the Representatives of Ecuador, Mexico, the United States of America, and Venezuela be elected to form the General Committee.

Decision: The Representatives of Ecuador, Mexico, the United States of America, and Venezuela were elected members of the General Committee.

Item 6: Annual Report of the Chairman of the Executive Committee

Dr. WILLIAMS (United States of America), speaking as Chairman of the Executive Committee, presented his report (Document CD16/28)[2] for the period September 1964 to April 1965, during which the Committee held its 51st and 52nd Meetings.

Dr. QUIRÓS (Peru) congratulated the Chairman of the Executive Committee and its members on the work that had been done and pointed out that he had been present as an Observer at the last meeting of that Committee and, on that occasion, had been able to assist in clearing up some questions that had not been fully dealt with at the XV Meeting of the Council but had subsequently been resolved, as had been indicated in the report read by Dr. Williams. He stressed how important it was that the Governing Bodies should act effectively and rapidly and that their discussions should be simplified so that the time taken up by the meetings could be reduced and the cost they occasioned could be further cut down.

Decision: It was agreed to accept the annual report of the Chairman of the Executive Committee, Dr. Charles L. Williams, Jr., Representative of the United States of America (Document CD16/28), and to commend him and the other members of the Committee on the work accomplished.[3]

The session rose at 4:45 p.m.

[1] See p. 12.

[2] The complete text of the report appears on pp. 211-216.

[3] Resolution I. *Official Document PAHO* **66**, 56-57.

SECOND PLENARY SESSION

Tuesday, 28 September 1965, at 9:00 a.m.

President: Dr. Raymundo de Britto (Brazil)

General Committee Decisions

The PRESIDENT opened the session and announced that Dr. Sutter, the Assistant Director of PASB, would read the report of the General Committee on the decisions taken at its first session.

Dr. SUTTER (Assistant Director, PASB) said that the General Committee, at its first session, after having decided on its program of work and the order for the examination of the agenda, considered whether, in connection with Item 10, there should be a discussion on the application of Article 6-B of the Constitution. He reported that the Representatives of Venezuela and Mexico, seconded by those of Colombia and Ecuador, were in favor of postponing consideration of the item and of forming a special committee to advise on the procedure to be followed with respect to the application of that constitutional provision. The Representative of the United States of America had expressed his

agreement with the initial proposal of the Representative of Venezuela, as amended by the Representative of Mexico, and made it clear that his proposal was not intended to raise any constitutional question, indicating that he wished to support the adoption of some rapid and expeditious procedure for the settlement of the problem so that it would have no repercussions on the activities of the Directing Council. Dr. Sutter stated that the Chairman of the General Committee was expressing the unanimous view of its members in recommending that the plenary session appoint a special committee responsible for the preparation of a draft resolution on the application of Article 6-B of the Constitution.

The General Committee had also decided to hold the Technical Discussions on Friday, 1 October.

With regard to Item 24 of the agenda (Resolutions of the WHO Executive Board and of the World Health Assembly of Interest to the Regional Committee), it had been noted at the meeting of the General Committee that to Document CD16/19 had been added two addenda and one annex to Addendum I, referring to population dynamics. The General Committee had agreed that, if the matter were of interest to the representatives, it would be examined in the course of the week in order to take advantage of the presence of the WHO Director-General, who could report to the plenary session on the resolution adopted on that subject by the Eighteenth World Health Assembly.

Establishment of a Working Party on the Application of Article 6-B of the Constitution of the Pan American Health Organization

The PRESIDENT designated the Representatives of Mexico, the United States of America, and Venezuela to form a working party to prepare a draft resolution on Article 6-B of the Constitution, and suggested that the group should meet at midday in order to commence its work and draw up the resolution as soon as possible.

It was so agreed.

Item 7: Annual Report of the Director of the Pan American Sanitary Bureau

The PRESIDENT announced that the Director of the Pan American Sanitary Bureau, Dr. Abraham Horwitz, would present the Annual Report.

Dr. HORWITZ (Director, PASB) stated that the Annual Report for 1964 (*Official Document 63*) had been distributed to the Governments one month in advance in accordance with the current rules. The Report surveyed the background of those health activities for which the Governments had considered it necessary to have the international cooperation of the Pan American Sanitary Bureau, either directly or in association with the United Nations Children's Fund (UNICEF), the Food and Agriculture Organization (FAO), and foundations such as the W. K. Kellogg and the Rockefeller Foundations, the Milbank Memorial Fund, the Williams Waterman Fund, and others. He indicated that in a certain number of projects the participation of the Agency for International Development (AID) of the United States of America had been coordinated by the interested Government with that of the Organization.

The Report covered 430 projects undertaken in 1964, presented under three main heads. The introduction analyzed the principal features of what had been achieved as a whole and contained observations on some essential activities and their projection into the future. The second section was prepared according to budgetary categories by programs, which were themselves broken down into the corresponding subcategories. It was concerned with health protection, health promotion, education and training, planning, research, publications and information, and organization and administration. In a third section the action taken on each project was summarized, a clear distinction being made between the assistance provided by the Organization and the work undertaken by Governments. By presenting the activities in such a way, it was not difficult to compare what had been achieved with what the Directing Council had approved in September 1963, when the program had been drawn up and the total budget fixed, after a process that had been initiated two years previously, as the members of the Directing Council were fully aware.

Dr. Horwitz noted that if a comparison were made it would be seen that a large majority—more than 85 per cent—of the projects that were approved by the Council had in fact been carried out. Exceptionally, there were some that had not been completed, and at the request of Governments some new ones had been initiated, within

the framework of the general policies laid down by the Organization.

In the face of the complexity of the undertaking, in which so many Governments were participating in projects that were by no means easy to execute, and given the complex character of the administrative and financial structure of the Bureau, the ratio of projects completed bore witness to the efforts that the Secretariat had made to carry out the decisions of the Governing Bodies. Since the figures were available, he had wished to draw that comparison. Naturally, the aim of the efforts should be to achieve a perfect correlation between plans and their realization. On the other hand, because of the very diverse nature of the Bureau's functions, and because of the prospect that where health plans had not been established the views of Governments might change over a two-year period, it was to be expected that there would always be some measures that had not been programmed but would have to be carried out because of their importance to the country concerned.

The Report made it clear that all the Organization's activities were directed by one guiding principle: that health constituted an essential function of social life and that the services devoted to it should form an integral part of all communities and of all development and welfare undertakings. The imagination and skill of health experts should therefore always be ready to meet the challenge of those occasions when it was clear that the incorporation of measures for the prevention and cure of disease into the complex social fabric could no longer be postponed. Theirs was a function that was always being modified, both as a result of scientific and technical progress and as a direct consequence of education, environmental changes, political maturity, and increased resources. It was, of its nature, a dynamic function, and within the process of change it was essential to recognize what was important to the largest number of individuals and at the same time feasible. Even though it was currently accepted that health was a component of development, the grounds for such acceptance had varied widely and exerted an influence on the distribution of national income and on applications for loans of capital funds from abroad.

There were some who argued that prevention and cure constituted an economic factor, a productive investment and not merely an item of expenditure, a capital good not a consumption item. At the other extreme, there were those who regarded health appropriations as the element that distinguished a civilized society from one that was not, and who therefore considered that moral arguments alone were sufficient to justify the funds that were to be used for the prevention and treatment of disease and for health promotion. Without underestimating the value of such approaches, the Organization had endeavored, in interpreting the wishes of its Member Governments, to demonstrate how the two variables—increased revenues and improved health—could be brought into harmony, and had also drawn attention to the need for an economic theory of health similar to that which existed for education. With that objective it had participated in 1964, as in other recent years, in the meetings of the political organs of the Inter-American System; it had collaborated with international lending agencies and had also cooperated with Governments in seeking a solution for the problems of each country and in making specific suggestions for long-term policies that had been reflected in national health plans. What had been achieved in 1964 bore witness to the success of that general approach, based on a sincere interpretation of the resolutions of the World Health Organization and of the Pan American Health Organization, adapted to the special conditions of the Americas of today. The general program would, he believed, succeed in striking the best possible balance between measures that would have an immediate impact and those of a long-term character and, at the same time, attach the right degree of emphasis to resources, especially those available for the training of professional and auxiliary personnel.

The Governments had agreed that health, as a social service, should be planned in the context of development and they had recommended that the Bureau should take the necessary action to put that principle into practice. Over the previous four years arrangements had been made to train health experts, both in cooperation with the Latin American Institute for Economic and Social Planning (Chile), and within the countries, with the result that, in varying degrees, some 300 health experts in the Hemisphere had already been taught the fundamentals of planning and a planning methodology which had been devised by economists and officials of the Organization, at the latter's request, with valuable assistance from the Government of

Venezuela. A considerable number of countries had organized planning divisions within their ministries of health but very few of them were yet represented on national development boards or councils. Consequently, the relationship between the ministries of health and the governmental authorities that made decisions on the investment of revenues was not as close as could be desired if the health function was to be given a place in national budgets that would ensure proper consideration of its needs. At least eight countries, however, had prepared either preliminary or advanced health plans.

Rather than dwell on the details, which were included in the Report, the Director wished to stress the promise that such plans held for the future: the Organization considered that the course of action, as planned, should be pursued for it would facilitate a more balanced investment of funds in relation to the priorities laid down by each Government. With that in mind, the training of experts should be intensified and each country should draw up a first health plan. If the Directing Council continued to give its approval to these activities, it was probable that by 1970 every Government that was so disposed could have its first health plan or could have brought its services into line with the requirements that had arisen in the years subsequent to the inception of those services. The Organization would then be in a position to provide such assistance as the Governments might require. Moreover, planning had brought to light the kinds of difficulties that had been expected but which it was urgently necessary to overcome so that the method could function as had been originally envisaged.

Improvements in health organization and administration were very necessary and were being made through the realization by Governments, as they entered the planning field, of the need to reorganize their technical and administrative services within the framework of national plans.

Moreover, the adoption of planning would focus attention on the need, in some countries, to regulate and define the activities and functions of the professional and auxiliary personnel with a view to making the fullest use of all skills and evaluating their role. There was also no doubt that, in the administrative field, planning had already clearly drawn attention to the pressing need to modernize accounting systems and personnel and purchasing procedures, *inter alia,* in order to make it possible to realize the objectives of the plan. There had been serious miscalculation of the timing of purchases of medical supplies in relation to the numbers of patients to be treated as a result of ineffective liaison between the technical divisions of the corresponding ministry or department and the administrative divisions.

The technique of budgeting by program, inherent in any method of planning adopted, was a primary cause of the urgent need to review administrative practices. As the Report indicated, the Organization had given and was continuing to give its advice here, a field so vital that the Bureau proposed to develop its activities still further on lines approved by the Directing Council. Planning had also brought to light the weaknesses in the area of statistics and it was a matter of urgency to intensify the action being taken in this field both by the countries themselves and by international agencies.

The Report noted that in 1964 special emphasis had been laid on training in statistics, as evidenced by the training of 127 medium-level technicians from 17 countries at schools of public health in the Hemisphere, and 182 such technicians in the Latin American Center for Classification of Diseases, sponsored jointly by the Organization and the Government of Venezuela.

In 1964 a start had been made, particularly in Argentina, on the training of auxiliary personnel at hospitals and health centers who are responsible for gathering preliminary data concerning patients. Insufficient attention had been given to such auxiliary personnel, who performed an essential role in the assembly of statistical data; they were employed in hospitals of all sizes and at health centers and were generally untrained, an indication of the extent and importance of the efforts required. The training of top-level statisticians was being accelerated in the current year and would bear fruit in the forthcoming year and, together with the training of more than 500 medium-level statisticians, would provide more highly skilled human resources in the statistical field. Zone statisticians had continued their advisory work aimed at improving the recording, analysis, and employment of vital and morbidity statistics. In spite of everything the Organization had endeavored to strike a balance in the face of the changing character of

the major problems of health in the Americas in the 20th Century and, although the weaknesses in the results achieved had to be accepted, it had also to be recognized that substantial progress had been made.

Planning had also drawn attention to the urgent need to undertake operational research designed to measure the efficiency of existing resources of manpower and equipment, so as to be able to determine more accurately the objectives that could be realized in each period. Some Governments had decided to initiate such a research process by recasting their existing organizational framework, gauging the efficiency of their resources, and subsequently fixing objectives. Although the Organization regarded such an approach as being very satisfactory, its view was that, with or without a plan, accelerated and relevant studies of the efficiency of existing services would make it possible to attend to the needs of a larger number of human beings. Experience had also shown the need to undertake research into various aspects of the procedures used for reporting of diseases.

On many occasions, the Organization had pointed out that the act of planning was not an end in itself but merely a means or process, and that in no event should a national or international institution suspend the activities that it had under way in order to devote itself exclusively to the formulation of plans. Very much to the contrary, it should intensify such activities for, at least at the present stage, the methods of planning could do no more than provide a more rational system of criteria, not based exclusively on experience, for the fixing of priorities. The health experts of the Hemisphere fully realized which were the most important problems so that, if a more satisfactory system of priorities were introduced, there was no need to break off activities but rather a need to extend them, as the Organization had continued to do, a course that was in line with the views of the Governments.

With regard to the specific activities carried out in 1964, Dr. Horwitz said that he would mainly draw attention to those that, in his judgment, deserved special comment.

On the whole, as progress had continued in the campaign against those diseases which the World Health Assembly and the PAHO Directing Council had instructed the Organization to assist Governments in eradicating, it had become increasingly apparent that such activities could not be undertaken in isolation but would have to be closely coordinated with the organized and administrative services of each country.

Dr. Horwitz then read the following paragraph, which appeared on page xi of the Report: "In the Americas today there are technical and other reasons why programs are being directed at a single health problem or a single disease—the 'vertical' approach. But there are also good reasons for making increasing investments to improve permanent services which deal with day-to-day programs and not solely with emergencies—the 'horizontal' approach. Both approaches must be brought into harmony, for they are not mutually exclusive but complementary. Besides, the objective of both these patterns of organization is the common welfare of persons and of societies. In the Americas the time of the great epidemic diseases that decimated the population is fortunately past. The present time is one of organized programs for sustained development, and that calls for permanent institutions established by the law and designed to serve the common weal."

It was in that light, he stated, that the Organization would like to see the approach made to programs of eradication, especially those against malaria and smallpox. It was with that in view, following both the recommendations of the WHO Expert Committee on Malaria and the resolutions of the World Health Assembly and the PAHO Directing Council, that in 1964 the first seminar on the role of the general health services in the eradication of malaria was organized and held in June-July at Poços de Caldas, Brazil, for the countries of South America. In March 1965 a second seminar was held at Cuernavaca, Mexico, for the countries of Central America, the Caribbean, and Mexico. The seminars[1] examined the joint responsibility of health services and malaria eradication services at the various stages of the program and made precise recommendations. It was judged necessary to provide rural areas with minimum services, as in no other way would it be possible to protect the achievements of eradication programs. The Organization regarded the question to be of such importance that it should be discussed, for it affected many of the activities of Governments in the health field and,

[1] The papers on both seminars were published in Spanish in *Scientific Publication PAHO* **118.**

moreover, the outcome of such discussions would help to guide the Organization in its future activities.

The Director was convinced that, in view of the large areas of the Hemisphere that had already reached the consolidation phase in malaria eradication, the question was assuming great urgency and he invited the Council to re-examine Table 1 on page 2 of the Annual Report, which showed the status of malaria eradication on 31 December 1964. It could readily be seen that of the population in originally malarious areas 57,414,000 persons were currently in regions in which eradication was claimed. The table reflected what had been achieved in the Americas during the present century, mostly in the last 20 years. There were 32,277,000 persons who lived in areas in the consolidation phase, where there was a minimum risk of infection and where the cases that arose came from outside the areas. There were 34,426,000 persons living in areas at various stages of the attack phase and therefore, with the exception of the problem areas, the number of persons exposed to the risk of infection and the frequency of attacks were progressively diminishing. There were also 34,525,000 persons in areas in the preparatory phase, where eradication programs had not yet been initiated, but fortunately the number would be reduced as a result of positive steps to be taken by the Government of Brazil—where the exposed population amounted to 31,819,000 persons—as it was expected that that country would enter the attack phase by the end of 1968. Dr. Horwitz had drawn the attention of the Council to the table in order to offset the natural tendency of health experts to forget what had already been achieved, overemphasize the difficulties, and create an image of disaster when, on the whole, the successes realized had been much greater than anything previously accomplished.

It was impossible to tell when malaria would be eradicated from the Americas because the factors that exercised an influence on the current situation were of a biological character and could not have been foreseen at the outset of the venture. Nevertheless, progress in scientific research was so rapid that there was every reason to believe that new methods would be discovered and that the importance of the disease as a problem of public health could progressively be reduced. Meanwhile it should be remembered that, as a result of the efforts of the peoples and their Governments, 90 million persons in the Americas currently lived in areas where they were practically free from the danger of contracting malaria. The problem areas did not include more than 15 per cent of the exposed population and, as would be reported in detail later, positive steps were being taken to reduce the incidence of the disease in the light of the latest scientific information, including the revolutionary technique of maintaining tens of thousands of persons under preventive therapy for more than a year. That effort could not be maintained, as it should be, if action were not taken to ensure that the rural areas or, at least those in which the incidence of malaria was greatest, were provided in some measure with a health service that would make it possible to consolidate what had already been achieved.

The same criteria applied to smallpox and Dr. Horwitz referred the Council to Table 6, on page 12 of the Report, which summarized the cases registered in the Americas between 1963 and 1964. The XV Directing Council Meeting had been informed that in the period 1961-1963 the Governments had received reports of 20,000 cases of smallpox in the Americas, of which 7,126 occurred in 1963. Up to the time of the publication of the current report only 2,996 cases were known, although it was possible that that figure, which was to be subject to a thorough review, would be increased. The table should be examined in conjunction with Table 7 on page 13, which showed the number of smallpox vaccinations and the production of smallpox vaccine, both glycerinated and lyophilized, in 20 countries and 14 territories in the Americas (excluding the United States and Canada) between January and June 1964. It was gratifying to note that the production of vaccine was sufficient to complete or undertake a systematic program of immunization in all the countries, and praise was due to the producing countries for the great generosity they had shown in providing to other countries supplies of vaccine to meet emergency situations as well as for their regular programs. On the other hand, the table also revealed, on the basis of data from the interested Governments, that of a total population of some 210 million persons, about 21 million had been immunized, that is, some 10 per cent. The figure was perhaps on the low side because it was not known how many of the cases were primary vaccinations and how many revaccinations.

It did mean however, that at least 10 per cent of the total number of persons had been vaccinated once with, it was to be hoped, a positive reaction and that a basis existed for more intensive action that could put an end to the disease. On the other hand, with the extensive travel undertaken in the present-day world, nations would always be exposed to the risk of infection from outside. In due course, consideration would be given to the resolution approved by the Eighteenth World Health Assembly,[2] which not only attached immense importance to the problem but fixed deadlines on which all Governments had agreed for the intensification of their efforts to bring the campaign to a conclusion, an undertaking that should not prove excessively difficult in the Americas.

The Director then expressed regret that, despite a very thorough system of surveillance, *Aedes aegypti* had reappeared in 1965 in the course of the sixth monthly survey in San Salvador and the Government of that country had therefore been obliged to adopt, with the Bureau's assistance, the measures it was currently putting into effect to prevent the spread of the mosquito. He went on to report that Argentina had completed its program, but he stressed that the problem had become especially serious with the outbreak of epidemics of dengue in the Caribbean countries and Venezuela, with the appearance in the countries of the Eastern Americas of epidemics of hemorrhagic fever, transmitted by the same mosquito and, throughout the Americas, with the emergence of vectors entirely resistant to chlorinated insecticides. On the other hand, he was pleased to report the good news that, as a result of research sponsored by the World Health Organization, there currently existed two organophosphorous insecticides suitable for trial at the community level which would be effective against the resistant strains and would not be toxic to man. It was to be hoped that, as soon as sufficient quantities were available, they could be tried in the Caribbean area, in order to make a fresh start in an undertaking that was launched in 1947.

In 1964 special importance had been attached to the tuberculosis program, as a consequence of the Technical Discussions[3] held in 1963. At the Regional Seminar[4] on the control of that disease, held in Caracas in November 1964, the problem had been fully examined and a distinguished gathering of experts from the Americas had agreed on the steps that should be taken to accelerate the decreasing trend in the mortality rate and reduce both the number of cases and their seriousness.

The Annual Report referred to the assistance rendered to 11 countries in antituberculosis activities. The dominant fact that once again emerged was that, as a result of the progress realized in methodology, it was already possible to incorporate tuberculosis control functions in regular health services so that the officials who were regularly engaged in combating the disease at such health centers could provide treatment for a large number of cases and decide which ones required treatment by specialists. The progress made in Venezuela along those lines was deserving of mention. The Organization would be in a position to advise Governments on the problem, which continued to be an extremely important one.

With regard to leprosy, the Director read the following paragraph from page xxi of the Annual Report: "As obscurantism about leprosy diminishes in the Americas, there emerge the magnitude of the problem, the progress that has been made, and the enormous job that still remains to be done. This is reflected in the information contained in the Report. Of all cases registered—which are only a part of the total—barely 50 per cent were under control. Furthermore, if the lepromatous forms are added together—and granted that half of the indeterminate forms will become lepromatous unless treated —about 60 per cent of the cases are highly infectious. In addition, 40 per cent of the known cases were not receiving treatment and fewer than two contacts per case—less than half the usual number of household members—were registered. As of 31 December 1963, there were 167,038 cases in Latin America being served by active programs. Between January and June 1964, 3,570 cases were reported, and during the same period the total number of registered patients was 116,052. The true prevalence and incidence, it should be noted, are unknown. With more systematic organization of knowledge and of its application in leprosy control, a matter which was the subject of a Seminar[5] (Cuernavaca, Mexico; 12-29 August 1963), it has

[2] See p. 74.

[3] Published in Spanish in *Scientific Publication PAHO* **112**, 3-67.

[4] *Ibid.*, pp. 71-148.

[5] Published in Spanish in *Scientific Publication PAHO* **85**.

become plain in many countries that the technical and administrative structures are inadequate for the fight against this disease and should be modified. The Governments are undertaking this task with the collaboration of the Organization."

Following the policy of correlating health with the economy, increasing importance had been attached to the zoonoses and, among them, principally to hydatidosis, rabies, brucellosis, and anthrax. The losses attributable to paralytic rabies suffered by agriculture in Latin America were enormous and although no estimates were available they must have amounted to some tens of millions of dollars. The same was true of brucellosis, in respect of which very significant data was available from Argentina. The Organization had concentrated its efforts on the Pan American Zoonoses Center, and Dr. Horwitz paid a public tribute to the Government of Argentina, which had made the Center's work possible. It was especially appropriate that he should do so at the present time, as he had decided to present a proposal to the United Nations Special Fund for the expansion of the Center, so as to enable it to undertake its activities on a continental scale. The Organization hoped that as a result of the initiative of WHO, the United Nations Special Fund would reach a decision on the project in January 1966, provided of course that it was possible for it to do so, as the decision rested entirely with the Fund itself as an agency of the United Nations.

The same concern with the protection of animal proteins in Latin America justified the interest in the Pan American Foot-and-Mouth Disease Center, which, as the Council was aware, was administered by the Pan American Sanitary Bureau with funds from the Program of Technical Cooperation of the OAS. The latter Organization had requested an evaluation of the Center's activities by a group of experts, who made their report [6] in 1964, emphasizing the importance and excellence of the work the Center had been performing.

With regard to the Foot-and-Mouth Disease Center, Dr. Horwitz was pleased that he could also pay public tribute to the Government of Brazil, which had assisted in its development from the outset. In June 1964 the South American Conference on Foot-and-Mouth Disease had been held in Rio de Janeiro, under the sponsorship of PAHO, and had been attended by the Ministers of Agriculture of practically all the South American countries. The Conference had established the enormous volume of losses attributable to foot-and-mouth disease, and research in that field should be pursued as a matter of urgency. The extent of the losses varied considerably according to the criteria used in determining them, but whichever criteria were used, the losses were very heavy in comparison with the cost of a systematic program of immunization.

He was pleased to report that the Inter-American Development Bank and the World Bank, as a consequence of the decisions at the Rio Conference and the remarkable results achieved at the Center as well as through the Inter-American Committee on the Alliance for Progress (CIAP), had decided to include in their policies the grant of loans for systematic programs to reduce the incidence of foot-and-mouth disease wherever it occurred, that is, only in the South American countries. Central America was not plagued by the disease and some years ago Mexico had mounted a determined campaign against it and succeeded in eradicating it.

The Center had studied, identified, and isolated modified viruses that produced greater immunity than killed viruses. On the other hand, the use of modified viruses as a vaccine gave rise to a problem of international scope; some countries did not accept meat from others that employed vaccine of modified live virus, as they considered there was a danger of importing a live virus that could increase its virulence in the future. According to reports, the Government of France, for instance, was preparing legislation along those lines and it was possible that such legislation might extend to the other European countries. It was for that reason that some South American countries, especially Argentina, which had developed a very well organized program in that field, were employing vaccine of the Frenckel type only, with immunizations every four months, involving an enormous outlay when there were many millions of head of livestock to be immunized. There still remained, however, a number of problems to be resolved: the vaccine was ineffective in the case of foot-and-mouth disease in pigs and further research was needed in that field.

The decision made by the banks had increased the range of the Center's activities and the advice it gave to Governments in preparing their projects

[6] *OAS Official Records,* CIES/648 (Eng.), 1964.

and explaining the amount of external credit that would be required; it had also expanded the Center's role in organizing laboratories to control the use of the vaccine, facilities that had not existed previously on an organized basis, save in exceptional cases, in the countries in which the disease was prevalent.

The Director then referred to Table 17 (page 32 of the Report), which listed cases of plague. Between 1963 and 1964 the number of cases reported in five countries (actually, in four in 1964) had increased by 50 per cent. Those figures explained the urgent need to reactivate investigation and control programs, especially with respect to sylvatic plague, wherever the incidence of the disease was heaviest. The Organization hoped to continue and even extend such measures in both Peru and Ecuador in the very near future.

For evident reasons, and by decision of the Council, basic sanitation had been given all the significance and importance that was it due. The distinctive feature in 1964 had been the stress laid on rural conditions. As the Council was aware, a proposal to establish a Rural Welfare Fund had been presented to the XIV Meeting in 1963,[7] as a means of dealing with the problems of rural sanitation in a way that would ensure the progressive extension of the program and enable it, in successive years, to be carried forward entirely with national resources. While the decision was being reached on that proposal, still under active consideration, activities had continued in 1964 in normal channels, the Governments concerned having applied for external loans whenever that had been regarded as necessary, and for the Bureau's advisory services whenever they deemed it essential. The action taken by Governments during the year in respect to external financing was shown in Table 19 (page 40 of the Report), which gave details of the cost of the project, the nature of the financing, and the responsible governmental agency in 11 countries which, in one way or another, were making efforts to intensify their rural sanitation programs. Special mention should be made of the programs of Venezuela and Peru and of the one that had been begun in Chile; the Organization believed that the other countries that were mentioned would develop their activities with the same intensity throughout the year and, particularly, during the forthcoming year. The table reflected not only the interest taken by Governments but also the extent of the demand for such facilities on the part of the rural population, a demand that, it had to be recognized, had been largely neglected. Such neglect was not so much attributable to non-technical factors as to having misjudged the capabilities of the rural population, which were as real and positive as those of urban dwellers. The experience of the countries in question showed that wherever the energies and cooperation of the rural population had been properly and disinterestedly enlisted, there had been a really moving response and the people had not only offered their own labor, efforts, and local materials but had also been prepared to contribute funds for both rural sanitation and other purposes, for once they had realized what they could do by their own efforts they had wished to participate in other activities for the common good. The Director was convinced that the rural question in Latin America, not only as far as sanitation was concerned but throughout the whole range of problems raised by the need to achieve a minimum standard of living, could not be solved until external capital had established a catalyzing fund that would permit the formation within each country of what had been called "national revolving funds," which would in turn ensure the continuity of enterprises in each rural community and free them from absolute dependence on capital from outside. Although the figures in Table 19 represented a remarkable achievement, it should be remembered that each of the projects, as had been said before, would die if its countinuity were not ensured owing to the failure to create a machinery in which the community itself would have a direct interest or through which its efforts could benefit neighboring communities.

He requested the Ministers of Health to consider once again the idea of a Rural Welfare Fund for he was convinced that in Latin America, in the light of the experience of the two years since the proposal had been made, it was the right path to follow.

Efforts had continued to be made in urban sanitation and the achievements of Governments were reported in Table 20 (page 42 of the Report), which showed the distribution of funds used for the construction of water supply and sewerage services between 1960 and December 1964, dates that were closely bound up with the founding of the Inter-American Development Bank. The important factor was that, whatever the origin of the external financing—and the sources were given in the table—

[7] *Official Document PAHO* **54**, 15-16, 106-115.

38,420,000 persons would benefit either because their daily supply of water would increase or because they would, for the first time, have a sufficient supply of water of adequate quality. An estimate had therefore been made of all national funds, whether obtained from loans or from the budgets of ministries of public works, water resources, or health.

The Organization had continued to cooperate directly with Governments and with the Inter-American Development Bank through the activities of 46 engineers participating in its sanitary engineering program and by making use of high-level consultants from sanitary engineering and other fields, more than 40 such professionals having been employed in 1964. Dr. Horwitz was convinced that what had been done would exercise a lasting influence on the history of public health in Latin America and the total volume of investment, a figure exceeding 640 million dollars, was a remarkable sum for so short period, benefiting as it did so many human beings. The Report also described other activities in the field of sanitary engineering, including the important work of training engineers, based in two principal lines of approach: short courses, which had been successful because of the close relations existing between the ministries and the universities and in which the Organization had also collaborated; and two basic programs, designed to accelerate the training of high-level sanitary engineers and also to initiate research into the environmental characteristics of each country, a study on which a start had been made in 1963 although it had not been possible to approve it until 1965. One of the programs had been undertaken in Rio de Janeiro, in SURSAN (Superintendency of Urban Development and Sanitation), and the other in Venezuela, with the assistance of four of the country's universities, in four engineering schools. Other countries were known to be carrying out similar studies with the same end in view.

Turning to health promotion, the Director mentioned the program of medical care, for which only 4 per cent of the funds for 1964 had been made available. The figure should be interpreted in the light of the general trend, as it was a field that had been given special attention in recent years. It was important to make it clear that the policy being followed by the Organization in the medical care field was to provide guidance on those aspects of the problem—an extremely complicated one—that affected the general organization of medical care services in one country or in a series of countries. An international agency should not participate directly in providing medical care for sick persons, whatever the nature of their illness and the numbers involved, and the emphasis had therefore been placed on the training of hospital administrators; the Report referred to a series of such courses. The Organization had provided guidance on the improvement of hospitals of certain types, arrangements having been made through the Zone advisers after the Governments had decided on the function of the hospital and on the aspects they wished to improve; it was planned to extend such activities still further. The Organization was now undertaking, in compliance with a mandate given by the Council at the XV Meeting, a study on how to achieve a higher return in medical services from the whole range of resources possessed by a Government, whatever their origin, especially those falling within the public sector, a study that was naturally related to the increasing growth of social security institutions. At the meeting in Mexico it had been made clear that the Council had no intention of encroaching on the legislative field or attempting to interfere with well-established responsibilities, but that its actions were primarily directed to achieving better coordination and closer correlation with a view to using existing funds to provide care for an increased number of patients. The measure of a Government's determination was reflected less in its desire to improve institutions than in its efforts to contribute to the welfare of its people to the greatest possible extent. On that occasion instructions [8] had been issued to set up a committee of experts to study the relationship between social security programs in the medical sector and similar programs of the ministries of health. That committee would report its recommendations [9] to the present meeting of the Council so that the latter could judge what course should be followed on such a sensitive issue.

Under the terms of Resolution XXV [10] of the XV Meeting of the Council, the Organization had been requested to study the problem of the

[8] Resolution XL. *Official Document PAHO* **58**, 90-91.
[9] See *Scientific Publication PAHO* **129**, 48-59.
[10] *Official Document PAHO* **58**, 78-79.

planning of hospitals, including their construction, complement of personnel, and operation, within the framework of national health plans and as an integral health responsibility. This study had been assigned to an advisory committee,[11] whose report had been distributed and would be discussed in due course at the current meeting, in order to obtain the Council's guidance.

On the subject of nutrition, the Report indicated that food production per person was currently the lowest in 10 years, especially in terms of quality, and that the situation was such as to justify more rapid steps to modernize methods of working the land, reforms in land-utilization and land-holding, and research into those crops best adapted to the environmental conditions and social and cultural patterns of the Latin American countries. It also justified measures to reformulate agricultural policies in order to strike a balance between the biological needs of the population and the economic demands of exports. It was not difficult to see that not every country could produce sufficient to meet the needs of its population and it was therefore most important to develop a common market. Moreover, it appeared illogical to emphasize those forms of production that promised a good return but provided little nutrition at a time when it was difficult to obtain the proteins essential to the people. Such a reformulation of agricultural policies should also include the modernization of food-canning, food-distribution, and food-consumption procedures as the wastage was enormous—it would be interesting to calculate it—and the introduction of well-tried techniques to improve the fertility of all areas under cultivation.

In 1964 the Organization's work in the nutrition field had been undertaken through five Zone advisers, short-term consultants, and in Central America, through the Institute of Nutrition of Central America and Panama (INCAP), which, as the Council was aware, was financed by direct contributions from the six Governments of the Region, contributions from the Organization, and funds from research appropriations.

What had been achieved was fully documented in the Report: the number of nutritional recovery centers had been increased in various countries; there had also been a rise in the output of vegetable-protein mixtures and of INCAPARINA, which had become the best known of them and which, not surprisingly, had reached the two million pound level in three countries, representing a 320 per cent increase over the quantity produced in 1963. That fact gave some indication of the magnitude of the problem of malnutrition among children. In the present year measures had been taken which, it was hoped, would make it possible to introduce or extend the production of INCAPARINA in other countries.

INCAP had continued with its important role in the training field, which had assumed an international character. In 1964, 85 fellowship-holders from 22 countries attended training programs and the number of those trained from countries all over the world had risen to more than 500, which was hardly surprising for, as had been pointed out by Dr. René Dubos, the distinguished member of the PAHO Advisory Committee on Medical Research, INCAP was the only center in the world currently studying the problem of nutrition as a whole and from every standpoint. Dr. Horwitz was convinced that it was essential to place the Institute on a sound financial footing after 14 years of such brilliant achievements, and he was therefore requesting an increase of $200,000 in the 1966 budget to cover PASB's contribution to INCAP.

There had been a remarkable reduction in goiter in Guatemala from 37 to 7 per cent, as a result of the salt iodization program, a fact that demonstrated that the 30 million known cases of goiter in Latin America should never have existed and should not continue to increase. A reference laboratory for goiter had been set up in 1964 to study iodine metabolism and a similar laboratory had been established for the anemias in Caracas. The Director believed that the problem of nutrition should be considered in conjunction with those presented by sanitation and education and in association with the techniques of applying preventive and curative medicine to children under the age of five years, if a substantial reduction in infant mortality rates was to be achieved.

With regard to the current position in the field of education and training, Dr. Horwitz read the following paragraph from page xxiv of the introduction to the Annual Report:

"Data on the estimated total number of nurses and nursing auxiliaries in the South American

[11] See *Scientific Publication PAHO* **129**, 124-132.

countries indicate a ratio of 2.6 nurses per 10,000 population, whereas the ratio for physicians is 5.5 if the ratio for all Latin America is applicable to South America. This relationship is obviously the reverse of the needs. It might be compensated for by adding in the total of auxiliaries; this would increase the ratio to 10 nursing workers per 10,000 population, or double the proportion to physicians. Unfortunately, no more than a third of the auxiliaries have been properly trained."

That ratio indicated how urgent the need for training was, although, as the Director-General of WHO had observed at the inaugural session, the progress achieved in the training of technical personnel in the Americas in recent years had been quite remarkable. Dr. Candau had emphasized that 20 years ago there had been no sanitary engineers and their existence was in itself a clear indication of the determination with which Governments were approaching the problem of sanitation. Very few medical schools had existed, whereas in recent years their numbers had doubled and reached the current figure of 110. Therefore, as the Director-General had emphasized, the future should be envisaged with optimism, although further efforts would be needed. It was the objective of the Bureau's policies to ensure that such efforts were made. The purpose of such measures would be to create, to the maximum possible extent, resources of human skills related to the special characteristics of the countries of the Americas and not to others in which the spectrum of morbidity, as well as the quantity and quality of the resources available, were different.

With the assistance of the Milbank Memorial Fund and the distinguished patronage of the Government of Colombia and of the Colombian Association of Schools of Medicine, a two-year project had been initiated in the latter country during 1964, with a view to determining a methodology applicable to human resources that could not only be used by other countries but would also enable the Government to obtain data more closely related to the realities of health requirements and to the needs of societies, which would provide a basis for programming the activities of the Ministry. It was hoped that the results of that study would be suitable for extensive dissemination among Governments with those ends in view. Meanwhile, in the course of 1964 direct advice on various matters had been given to 37 medical schools through the services of the Organization's short-term consultants and activities in the field of medical education had been extended. One consultant, Dr. Edward M. Bridge, had commenced work on a book [12] covering medical teaching, which would be published at the end of the year and would be widely distributed. The unsatisfactory quality of the teaching in 10 schools and the disparities that existed between them had become evident and, under the terms of Resolution WHA18.39 [13] of the Eighteenth World Health Assembly, the services of two short-term consultants had been obtained. They were currently visiting various representative schools in the Americas to study the status of medical libraries, with a view to presenting to the Council a plan for dealing with that problem, so that students could have access to texts in their own language, selected by groups of professors from the Hemisphere, a measure that would help to improve the quality of education. In general, the inadequacy of library facilities in universities of the Latin American countries had become almost proverbial.

Some part of each of the Bureau's programs was devoted to training; thus in the advisory programs for general health services in 1964, the Governments, with the assistance of the Bureau's technical personnel, had organized 143 courses in which 4,124 persons had been prepared for work in various health fields. The number of fellowships for studies of an average duration of five months increased by 12 percent in comparison with 1963 and provided assistance to 639 persons, a relatively high figure if the large proportion of fellowships of an academic character were taken into account.

Dr. Horwitz observed that it was no simple matter to summarize 430 projects, as the length of the Report indicated. In conclusion, he said, its pages clearly demonstrated the intention of the Secretariat to continue traditional patterns of activity, which had been the cornerstone of the Bureau's efforts throughout the century, without neglecting the search by Governments for new forms of action that would accelerate progress and increase well-being, and it was the responsibility of the Organization to collaborate with them in realizing those ends.

The PRESIDENT congratulated Dr. Horwitz on the clear and precise manner in which he had presented

[12] *Pedagogía Médica. Scientific Publication PAHO* **122.**
[13] *Off. Rec. Wld Hlth Org.* **143,** 24-25.

his Report, an achievement that was a reflection of his personality, intellect, and culture. He believed that the Council might well feel satisfied with the solid progress that had been made by that great institution, the Pan American Health Organization.

Dr. FERREIRA (Brazil) stated that, on behalf of his Delegation, he wished to make a few observations on what, over a number of years, he had interpreted as the Council's desire to have a Report that accurately described the execution of the programs, in accordance with the projects drawn up and the mandates received, and that provided a basis for evaluating what had been done and what had not been done. In his judgment the Director of the Bureau had met those needs so completely that it could be assumed that 85 per cent of the programs had been carried out, the balance of 15 per cent having remained incomplete as a result of unforeseen circumstances or because it had been necessary to modify the programs themselves. He recognized that for sanitarians it had always been difficult to plan the following year's programs, as it was almost impossible to predict the events of the forthcoming year, so that in practice projects and programs could never be completed exactly as planned. Therefore, not only was the Report exactly what the Council wished to have but, in addition, the Director's statements pointed to other achievements, already in course of realization, that were not recorded in the text of the Report. In fact, in presenting the programs that had been carried out in 1964, all of them fully justified, the Director had practically outlined the program of activities for 1965 and for the future, supporting his arguments with some very apt observations of a philosophical character.

There were two important points to note for the future that had already been considered in the Report for 1964: the first of these was the relation between economic planning and health planning. Fortunately the stage at which medical care, preventive medicine, and health protection were regarded as an unproductive investment had already been superseded. Moreover, the need to associate development plans with public health plans had become widely recognized. He pointed out that the President of Brazil was a leader convinced of the importance that should be attached to health in economic development. It should not be forgotten that in the Act of Bogotá and in the Charter of Punta del Este, which reflected world attitudes to development in public health, there were extensive references to the revolutionary concept of the investment of funds for the protection of health that it would have been impossible to draw from economists and those responsible for planning 15 or 20 years ago. It was also very important to ensure that ministries of health, ministries of planning, and governmental agencies responsible for promoting national development always acted in coordinated fashion, a point that should be stressed because planning and development were terms that came more readily to the lips than public health and health protection. There was, moreover, a certain tendency to regard the planner as a kind of superman who could make plans without reference to the functions and responsibilities of preventive medicine.

Another matter that was deserving of attention and on which the Director had laid considerable stress was the problem of health protection for population groups of scant resources in rural environments, together with the need to expand health infrastructures so that they could provide a basis for really effective eradication campaigns, especially since, in his view, the countries of the Americas, with the possible exceptions of Canada and the United States of America, lacked a proper rural infrastructure. Health activities in the rural sector were undertaken fortuitously in the form of temporary campaigns or in makeshift programs launched by sanitarians in the hope of obtaining further budgetary resources that would make it possible to achieve something in those sectors. Nevertheless, once the campaign had been completed, matters fell into abeyance and little by little the situation reverted to what it had been previously, demonstrating the need for such campaigns to be adequately planned and incorporated at the proper stage into the health infrastructure itself. In other words, whatever the actual length of a particular campaign, the efforts made should be sustained, as no limit could be set on either the length or duration of programs.

Taking Brazil's experience as a basis, it could be said that 80 per cent of the medical care facilities were still provided by private institutions. It was the religious orders and the charitable institutions that bore the burden of the maintenance of such services, and the proportion of such undertakings

that were becoming increasingly expensive and difficult to operate in the private sector was progressively increasing. The time had come, as the Director had pointed out, for the agencies responsible for the protection of health, which were the ministries of health, to find how the important field of social security could be released from its ivory tower of isolation from the medical profession.

In regard to the problem of libraries, to which the Director had also referred, he regretted that the majority of vocational training agencies in Latin America had been unable to obtain such an essential instrument. He stressed the importance not only of the accumulation and systematic deposit of publications but also of giving active support to teaching methods that encourage the regular use of libraries, so that they could perform a positive role in education, a field in which the role of the Pan American Health Organization would undoubtedly be of great importance.

Summing up, he considered that the Director's commentary had been illuminating and had presented a clear picture of what had been done, what was being done, and what should be done in the future. The Delegation of Brazil could therefore give its wholehearted approval to the Report of the Director.

Dr. VALDIVIESO (Chile) observed that the Report presented by the Director was quite outstanding both for the clarity of his presentation and for the proportion of the projects that had been implemented in the course of the past year, showing, as it did, a very favorable balance. As the Director had said, the year had started with a total of 430 projects, of which 85 per cent had been completed. Even though the target should be to achieve a ratio of 100 per cent, there was no doubt that, if due allowance were made for the various circumstances and for those activities for which the countries themselves and not the Bureau were responsible, the ratio achieved had been a remarkably favorable one. An examination of the progress made, especially in connection with those problems toward which the Director had adopted the vertical approach—which was the classical and traditional approach to such problems—made it evident that in the area of communicable diseases the progress made had been notable. Although his country had benefited extensively from such projects, what interested him most at the current stage—both personally and officially, as it was a ministerial responsibility and also a question of importance to Chile—was the fact that the Report clearly revealed that in the preceding year it had been possible to achieve, if not an integrated approach, a remarkable extension in the scope of the Bureau's activities. When the Director spoke of a horizontal approach—that is, when he was regarding health as an integral part of development, forming a component part of the structure of the economy, in a similar way to housing, education, and food—and when measures to protect health were being based on such a horizontal approach, it was clear that new and wider horizons were opening up. The opportunities offered by some of the programs in Chile that fell within that category were unlimited in their scope. For instance, in Chile as in many other Latin American countries in which water was scarce, sanitation programs for a rural population that still accounted for 30 per cent of the total number of inhabitants represented the most effective of all catalytic agents for securing the organization of the community. Thus, in a venture that was still very much in its early stages, the people, after achieving their primary objective of obtaining potable water for communities of less than 1,000 inhabitants, which served to give cohesion to their social efforts, resolved to seek further gains and on their own initiative went forward with other projects in which very often the health authorities had no direct part.

In conclusion, he congratulated the Director on what had been achieved and expressed the hope that, by continuing along similar lines, the health programs of the Organization would be crowned with even greater success.

Dr. SALDAÑA (El Salvador) expressed his sincere congratulations on the Report presented by the Director. He had two observations to make, one relating to malaria and the other to the antituberculosis campaign. As in other countries, the malaria eradication campaign in El Salvador had suffered a series of setbacks attributable to a number of difficulties which were well known, the most important of which were the biological changes in the vector and the lack of sufficient funds at the right stage to carry out the various measures involved in the eradication. So far as the latter was concerned, there was no doubt that in many Latin American countries the shortage of funds was the

determining factor in whether or not a particular eradication program for communicable diseases was carried out. However, there were other circumstances that had a bearing on the failure to obtain sufficient financial support, such as the sudden political changes to which some of those nations were still subject and the consequential loss of everything that had been achieved in the campaigns. He wondered whether it would not be possible to set up a special fund for those countries which, for reasons beyond their control, could not or were temporarily unable to continue with such programs.

Furthermore, greater emphasis should be laid on programs for the execution of drainage works, following the example of those countries which had been extremely subject to malaria and which, as a result of satisfactory drainage programs, had eliminated the malaria problem largely by their own efforts. He stressed the importance that such a special fund would have, for it could be used by countries which, because of special circumstances, could not continue with their malaria eradication programs, and it would also enable them to step up their drainage programs to the fullest possible extent.

Turning to tuberculosis, he referred to the problem of those patients regarded as incurable and who represented an important factor in the transmission of the disease. Such patients might be of two classes: those who, because of the advanced stage that had been reached by the destructive organic lesions, could not be cured but who did not represent a health problem; and those who were constitutionally resistant to all known drugs. The number of cases of incurable tuberculosis falling into the second of those groups in Latin America was legion, and in many of the hospitals and sanitaria for the treatment of the disease they constituted more than 50 per cent of the patients. They were regarded as incurable as they had acquired resistance to drugs, and they represented a serious public health problem because it was impossible to keep them in hospitals and they also transmitted strains that were resistant to all drugs.

The question was a serious one, he believed, because the treatment of tuberculosis patients was often entrusted to non-specialized personnel and when the patient reached the specialist the problem was already insoluble. Finally, he suggested that the possibility of setting up special advisory programs for national antituberculosis campaigns should be explored.

The session was suspended at 10:55 a.m. and resumed at 11:30 a.m.

Dr. MUÑOZ (Colombia) added his own congratulations to those that Dr. Horwitz had already received on his Report, a document that showed what an outstanding sanitarian the Director of PASB was. Referring to the importance of health activities undertaken in rural areas, he stated that they were wholly consistent with the objectives of Colombia, where more than 50 per cent of the population lived in rural sectors. His country had therefore commenced a sociological study of the rural population, which was principally concerned with the structure of the family, a factor that was regarded to be of overriding importance. The projections based on that study would be fundamental in any Colombian health program, and efforts were being made to set up a permanent horizontal organization to benefit rural populations, so that the inhabitants could enjoy better preventive services and improved medical care through the agency of centers which, although simple in character, would link the rural areas to the major fields of health activity. In conclusion he again congratulated Dr. Horwitz.

Dr. AGUILAR HERRERA (Guatemala) declared that the Report presented by the Director of the Bureau deserved the highest praise, and he wished to add his congratulations to those that had already been offered. He then mentioned a reference that had been made in the Report to the improvement of administrative methods and practices. All countries had met and would continue to meet difficulties of an administrative nature in carrying out their public health programs. The activities initiated by the Bureau in that field were therefore of the highest importance and should be continued to the maximum possible extent and expanded, especially those concerned with the training of technical personnel. He recommended an intensification of PAHO's programs in that field so that, within a reasonable short period of time, administrative structures might be brought into line with the objectives of the programs that were undertaken in the various countries.

Dr. COMISSIONG (Trinidad and Tobago) congratulated the Director on the excellent Report and on its presentation. He stated that in Trinidad and Tobago they had recently been honored with a visit from the Director, during which he had expressed some favorable comments on several of the activities that were being carried out.

The speaker made special mention of the program in relation to health service planning which was under way in Trinidad and Tobago, and mentioned that in the document which set forth the second five-year development program of his country, special emphasis had been laid on the need for establishing sector planning activities within the Ministries as a part of the general planning activities of the development program.

In Dr. Comissiong's opinion, the following quotation from the above-mentioned document reflected such a feeling: "The long-run objective of our national development must now be the full utilization of our human and natural resources, together with our capital resources, so as to yield to the broadest segments of our society such levels of living as are commensurate with modern requirements of human dignity."

In 1964 the Ministry of Health, in an attempt to simplify and at the same time strengthen its structural organization, requested international advisory assistance in the field of health service planning and administration. The assistance provided by PASB had enabled the Ministry to record the following achievements during 1965: First, an evaluation of its structural organization, of the performance of administrative services, and of its ability to implement health programs. It should be pointed out that, prior to that new approach, several studies had been conducted by the present and previous administrations, but the resulting recommendations dealt with specific problems, rather than with the over-all evaluation of the efforts of the Government in the field of health. The natural consequences of those previous efforts had been the selective implementation of corrective measures which, while producing temporary relief, nearly always added to the complexity of the existing organization by increasing the number of isolated units that reported directly to the central command of the Ministry. That proliferation of separate units not only increased the cost of operations, but also significantly contributed to a weakening of administrative and technical control throughout the services.

Secondly, in accordance with the provisions of the second five-year development program, there had been established a Sectoral Planning Committee, headed by the Minister herself, the aims of which were: (a) the assessment of the level of health in relation to the level of socioeconomic development of the country; (b) the formulation of a national health plan that was feasible within the limits of available resources; (c) the development of an organization for the implementation of the plan; and (d) a periodic evaluation of the plan during its implementation, with the object of introducing necessary modifications. In connection with those sectoral planning activities, a health planning unit had also been established in the Ministry of Health and a planning officer had been appointed to that unit.

As a third measure, there had been indoctrination of 35 senior officers of various health disciplines in a methodology of health planning which was adapted to a country where resources were limited, the data-collecting machinery was deficient, and the demands of health services were rapidly increasing. That training course had emphasized the vital need for making the best use of available resources, rather than planning for a utopia beyond the realms of economic possibility.

The fourth measure was the establishment of regional hospital committees to assist the Ministry of Health by recommending means for improving such institutions, especially with respect to internal organization and management. The participants in the First Course on National Health Planning had independently arrived at conclusions basically similar to the findings of the survey carried out by PAHO/WHO experts, done earlier, which had suggested guidelines for instituting corrective measures. Having accepted that evaluation of existing conditions, the Ministry was taking active steps to provide the machinery for initiating the necessary reform. It was hoped that those steps would make possible the systematic planning of its activities and provide for a more rational utilization of the Government's investment in health. That process would facilitate the objective assessment of the current and future health needs, the determination of measures designed to fulfill those needs, and the establishment of an organization capable of

implementing the programs planned in the most efficient and capable manner. For that purpose the Ministry had accepted and was now implementing a new structural organization that would provide for three clearly defined levels of responsibility and authority: (a) policy-making, at the level of the Minister; (b) program-formulation, at the level of the Chief Medical Officer; and (c) program-execution in the country, divided into three regions.

Dr. Comissiong stressed the fact that the new organization also reflected the importance of defining and differentiating between line, or primary, technical functions and staff, or supporting administrative, functions. The main responsibility of the latter was the provision of the requirements for the implementation of programs. The concepts of centralization of policy-making and program-formulation and of regionalization—that is, decentralization—of executive operating authority had been incorporated in that structure. Furthermore, the structure provided for the complete integration of services involving the elimination of all barriers between the various activities designed for the promotion of health, that is, the prevention of disease, the treatment of illness, and the rehabilitation of the patient.

Such a planned approach should reduce considerably the involvement of central services in decision-making at operational levels and should facilitate the closest supervision of the implementation stages of the program. The integration of the preventive and curative services was expected to provide a more complete medical coverage at the local level and avoid duplication of similar health facilities within the same geographic area. Such an approach was particularly important in combating health problems in the context of limited human and material resources. It was fully appreciated that the process of health planning in itself could not function unless a revision in depth was undertaken of related supporting services. To that end the budgetary system needed to be reviewed, the accounting system should be adjusted in order to better reflect the costing of activities, and a greater interdepartmental and interministerial coordination should be achieved.

In that new setting the Minister had outlined specific targets for accomplishment within the next two years. Among them were the formulation of the national health plan during 1966; intensive training programs organized within the country by their own national personnel with the aid of international experts; overseas training of key personnel necessary for the proper implementation of the plan; an internal reorganization of existing hospitals in accordance with the over-all organizational structure of the Ministry; and a re-examination of the conditions of service of health personnel at all levels. The speaker stated that they were aware of the imperfections of previous efforts of health planning and of current thinking in such a highly specialized field. They realized the futility of merely copying from other countries and, for those reasons, they had decided to establish the machinery for evolving a national health plan tailor-made to meet their own peculiar needs within the resources available to them.

Dr. Comissiong stated that although he realized his statement had been somewhat detailed, he felt that it was important because Trinidad and Tobago was trying to do some of the things that the Pan American Health Organization considered important in the field of health planning.

There were two other aspects in regard to which he wished to express some comments. The first dealt with the field of nutrition. For the last three years an expanded nutrition program had been under way in Trinidad and Tobago, although it perhaps had been moving less rapidly than they would have liked it to. However, the program was progressing and they were looking forward to the possibility of establishing a nutrition institute in Trinidad. He understood that the Organization would be interested in setting up a nutrition institute for the region to which his country belonged, and Trinidad was interested in having the proposed institute established. That interest had been communicated to the Organization and it was hoped that shortly negotiations in that regard would be brought to a decision.

Dr. Comissiong stated that, as in previous years, he would like to emphasize again the need for eradicating *Aedes aegypti* from the entire Caribbean area. Although *A. aegypti* had been eradicated from Trinidad and Tobago, unfortunately it was surrounded by countries which had not been successful in their eradication programs, and that had placed it in a very vulnerable position. Thus, every year he had to report to the Organization that there had been infiltrations of *A. aegypti* from the neighbor-

ing countries. The fact that Trinidad and Tobago consisted of islands surrounded by sea did not prevent such yearly infiltrations, which placed the country at great risk and kept the Government ever vigilant to suppress and eliminate such infiltrations.

The islands of Trinidad and Tobago were particularly vulnerable because the monkeys in the forest of Trinidad had the yellow fever virus, and unless *A. aegypti* could be kept at bay the country was at risk from yellow fever. They were familiar with the problems of insecticide resistance in mosquitoes, but they still felt that something more could be done to eradicate *A. aegypti* from the Caribbean area.

Dr. ALONSO MENÉNDEZ (Cuba) praised the Report of the Director as a record of the achievements of 1964 and of the progress made in that year. In his country health protection programs had also continued to make progress. In Cuba it was hoped that by the second half of 1965 no further cases of malaria would occur, and the eradication campaign was currently in the attack stage. Referring to poliomyelitis, he stated that no cases had been recorded since 1962. In the course of the current year 98 per cent of the children less than six years old had been inoculated.

As a result of the profound economic and social changes that had occurred in Cuba, it had been possible to develop the infrastructure and set up health centers under the direction of physicians throughout the national territory. He shared Dr. Horwitz' views on education and training and pointed out that, although his country did not need and would never need financing in the form of foreign capital for its health programs, the health authorities of Cuba had found the advisory services that had been provided by the World Health Organization and by its Regional Agency, PASB, to be fully satisfactory.

The session was adjourned at 12:10 p.m.

THIRD PLENARY SESSION

Tuesday, 28 September 1965, at 3:10 p.m.

President: Dr. Raymundo de Britto (Brazil)

Item 7: Annual Report of the Director of the Pan American Sanitary Bureau (*continuation*)

The PRESIDENT opened the session and announced that the discussion on the Annual Report of the Director of the Bureau would continue.

Dr. CASTILLO REY (Venezuela) stressed the importance of the Report which, in his view, was a model of conciseness and objectivity. He conveyed his warmest congratulations to the Director of the Bureau and to the Secretariat on its preparation. He observed that, as the document itself revealed, public investments in health activities were productive in the long term and should be included in national development plans in order to ensure that each individual was fit and able to make an effective contribution to progress in his own country.

He was gratified by the excellent relations that Venezuela continued to enjoy with the Bureau, from which it had received valuable services in the form of technical advice and assistance in carrying out its health programs, especially those relating to the training of personnel, which were essential to the execution of the corresponding plans.

The time had come, he considered, for the creation of special machinery for health planning, but in the full awareness that such planning was only a means, at both sectoral and national levels, of ensuring the incorporation of health programs into national development plans. A major preoccupation of countries was the need to provide services for the rural population, and in Venezuela the authorities had put into practice a program of "simplified medicine" to provide medical care—based on aux-

iliary personnel, under proper supervision, using the simplest techniques—for communities of less than 600 inhabitants and for isolated groups.

With respect to the status of tuberculosis in Venezuela, the problem had been put into the hands of public health administrators, not necessarily specialists, who were linked to the network of tuberculosis services that existed in the major cities. The measures taken on those lines had succeeded in reducing the mortality rate, although the morbidity problem still existed. Nevertheless, constant surveillance of patients was maintained to ensure that they followed the prescribed treatment.

So far as environmental sanitation was concerned, Venezuela would meet, one or two years in advance of the prescribed time, the requirements of the Charter of Punta del Este with respect to the supply of potable water.

As to the campaign against *Aedes aegypti*, he recognized that the progress his country was making was slow, owing to reinfestation from outside, but he pointed out that the Government was attacking the problem decisively in order to meet its commitments under the program.

Dr. PRIETO (Paraguay) joined in the congratulations addressed to the Director of the Bureau and the Secretariat on the Report that had been presented. He attached importance to the rapid development of a system of local health services, permanent in character and capable of consolidating and maintaining the levels achieved in vertical campaigns. It would still be a long-term undertaking for Paraguay to form such an infrastructure, as its resources were insufficient to provide protection for a rural population constituting 63 per cent of the total inhabitants and which was, moreover, widely dispersed. He expressed his gratitude for the aid received from the United Nations Children's Fund (UNICEF) and from the Alliance for Progress and for the assistance furnished by the Organization.

He reported that the recent appearance of smallpox cases, amounting so far to some 35, had been the result of a lack of the services required to maintain smallpox immunization after the vaccination campaign undertaken in 1957-1958, which had provided protection for 86 per cent of the population and covered the entire national territory. He thanked the Governments of Argentina and Brazil for the assistance they had given Paraguay in that emergency in the form of large quantities of vaccine. He also expressed his appreciation to Argentina for its consignments of poliomyelitis vaccine, and to Brazil for the yellow fever immunizations of a sector of the population on Paraguay's northern frontier, threatened by jungle yellow fever. Finally he pointed out that the investigations made had not revealed the presence of the vector either in the threatened areas or in the capital.

Dr. DELVA (Haiti) expressed his satisfaction with the Annual Report presented by the Director and declared that the Council was unanimous in its desire to congratulate him on what had been accomplished.

He then referred to the problems of rural public health, noting that it was significant that the President of Haiti, Dr. Duvalier, was a country doctor. His Government was giving priority to the improvement of the health conditions of the rural population.

With respect to the smallpox campaign, Haiti was carrying out a general vaccination campaign which had already covered almost half of its inhabitants and was continuing.

He then spoke of the problem of the medical surveillance of those diseases which might at any time become endemic, particularly yaws. The reported cases of yaws had recently increased in Haiti, and he believed that the increase was due to the fact that in some sectors it had not been possible to undertake surveillance measures. He hoped that the Organization would assist in remedying that state of affairs. In 1950 the incidence of yaws in Haiti had been 70 per cent and, after the eradication campaign undertaken at that time, it had been reduced to 0.006 per cent.

Turning to nutrition, he stressed the importance of undertaking nutrition education programs in certain parts of the country. The aid that the Bureau was to give Haiti in preparing its nutrition programs would, he considered, be extremely valuable and he wished to express his Government's appreciation.

Mr. BOARD (United States of America) congratulated the Director on his important and significant Report, and commended especially the inclusion of information on performance and achievement in the various programs and projects. The prediction that by 1970 most Governments that wished to do so

would have begun to operate long-range national health plans, suggested the undertaking by the Organization itself of long-range planning of program priorities, goals, and needs in total cooperative programs, both for its own guidance and that of the Governments. He hoped that national health planners would allocate realistic priorities and seek guidance in the areas in which international cooperation could most effectively be offered.

He hoped, too, that the absence from the agenda of the *Aedes aegypti* eradication program did not represent a downgrading of its priority, for it was as yet uncompleted. The second operational year of his own country's program found activities under way in the Virgin Islands, Puerto Rico, Hawaii, Florida, and Texas, and during the year operations would be extended into Alabama, Georgia, Mississippi, and South Carolina. Special mobile forces were being used to accomplish eradication in lightly infested areas of Louisiana, Arkansas, Tennessee, and North Carolina. The 10 southern States he had named, which represented the region of indigenous infestation on the United States mainland, encompassed almost one quarter of his country's territory, some 40 million persons, and about 10 million buildings subject to inspection and treatment.

Recent field investigations suggested that Mexico and El Salvador may have been reinfested by the agency of used tires, contaminated by viable eggs, which had been imported from the United States of America. Used tires were one of the most common sources of transmission of *A. aegypti* infection, and certainly a major means of its dispersal through interstate and international commerce. Special treatment was being directed to storage and distribution sites of used tires on a monthly cycle, instead of the usual three-month cycle followed for other affected premises. In San Antonio and the border cities of Texas, rail and truck terminals also received attention. Malathion was the insecticide of choice in areas where resistance to DDT had become a matter of serious concern, and of the newer insecticides DDVP and Abate showed most promise.

The Director's evaluation of the progress made in the last four years toward the goal of complete eradication of *A. aegypti* in the Western Hemisphere by 1966 was revealing, he said. Regretfully, his country would probably not be able to complete its task by that year, and he would recommend that the Organization coordinate more positively the activities of infested countries with a view to the achievement of complete eradication, perhaps even calling a special meeting to that end, before areas of the Continent already cleared at great cost became reinfested. Indeed, the whole Hemisphere had an interest in the prevention of urban yellow fever and dengue, and he would suggest the creation of a permanent mechanism with PAHO for the revalidation from time to time of the certificates of freedom from *A. aegypti* which had been issued.

He supported the references that several representatives had made to the importance of sanitary engineering, environmental sanitation, and water supply in national health programs. As a sanitary engineer himself, he felt that the Directing Council could well afford to devote the whole of its meeting to the discussion of this fundamental health activity.

Dr. Quirós (Peru) expressed the regret of the Minister of Public Health of his country at his inability to attend the meeting and added his congratulations to those already expressed to the Director of the Bureau, and to the staff members concerned, on the Annual Report presented and the work carried out during the year. He shared the view that health protection measures were a social function as well as being a service, as it was impossible to conceive of economic development in isolation but only as a function of those social improvements that were essential to enable the peoples to raise their standard of living. It was especially important to be able to distinguish what were the major problems in the Americas, as the Director had pointed out in his Report in citing a declaration of the Task Force on Health at the Ministerial Level, held in 1963. He stressed the persistence in Latin America of such problems as infectious diseases, malnutrition, defective sanitation, inadequate housing, unhygienic working conditions, ignorance, unsuitable clothing, the low level of real per-capita income, all of which resulted in high morbidity and mortality rates, especially in the case of children less than five years old. It was of overriding importance to draw up a plan for the systematic allocation of the scant resources available among the many needs created by such problems.

He referred to the various efforts that had been made to do so and recalled that the Director of the

Bureau had made it clear that the need to draw up health plans had become even more apparent in 1964, with the initiation of the activities of the Inter-American Committee on the Alliance for Progress (CIAP). Nevertheless, at the meeting of that Committee held in Peru in 1964, preference had been given to the examination of economic problems and investments of a social character had not been duly considered. It was significant that at that meeting only three countries, among them Peru, had been represented by officials from the health sector, in contrast to what had happened at the São Paulo meeting in 1963, which had been attended by 17 health technicians from as many countries. He stressed the need for the Organization to arouse the interest of Governments in having health experts attend such meetings and referred to the misconception held by some economists that health programs had helped to aggravate the problems of the so-called population explosion in the less developed countries, when what was really wrong was the unequal distribution of wealth both within the countries and in the world as a whole. For that reason the Organization should not be absent when that subject came up for discussion. He was pleased to note that the resolution [1] on population problems approved at the Eighteenth World Health Assembly recently held at Geneva was to be brought before the Council.

He agreed with the view of the Director of the Bureau that ministries of health should, at the least, submit a program budget, preferably a plan in which priorities would be laid down in respect of the most frequently recurrent problems together with the objective in each case, the procedures to be followed, the funds that were essential, etc. In his view, the same applied to the Organization's programs. Consistent with that position, he had continued to stress in recent years the need to present and implement the Organization's budget functionally, or by programs, but that had only been done to a limited extent. It was essential to insist on the need to plan development, especially of the health sector, at all levels, both nationally and internationally, and above all to intensify research and the improvement of vital health statistics so as to facilitate the application of planning methods.

It was also necessary to improve the organization and administration of services and ensure that they provided adequate coverage in rural areas in order to avert the situation in which the so-called vertical or eradication programs met with failure in the maintenance phase; he pointed, in that connection, to the program of simplified medicine that was being undertaken in Venezuela.

The contagious diseases had persisted in the Americas and he believed that the Organization had not assigned the requisite priority to them. He pointed to the reappearance of smallpox in a number of countries, including Peru, a country that contained "the major focus for plague in Latin America." He noted, too, that *Aedes aegypti* had not yet been eradicated.

Programs of medical care were a matter of general concern, as the Director had declared in his Report, and they should therefore be given more attention than they had been receiving, as well as a more generous allocation of funds. He stressed the statement in the Report that "in relation to the size of the medical care problem in the Continent the funds allotted to it by the Organization in 1964 were insufficient by far." In his judgment the programs should correspond to the needs of the majority of the countries.

It was, he thought, a mistake that the Governments of many countries in Latin America had made the social security services, especially those concerned with hospitalization and maternity, the responsibility of government departments in the labor sector rather than in the health sector, and he believed that was the reason why such social security systems were defective, discriminatory, costly, inequitable, and provided inadequate coverage.

He regretted that no positive steps had yet been taken with respect to the establishment of a special fund for sanitation and rural welfare, which would help reduce the social tensions that arose in areas of economic depression in the countries of the Americas.

Finally, he was pleased to note that the Organization was giving a proper measure of priority to education and training programs.

Dr. HYRONIMUS (France) congratulated the Director of the Bureau on his Report and emphasized his concern at the persistence of *Aedes aegypti* in the French Departments as well as in the rest of the Caribbean area, despite the eradication cam-

[1] Resolution WHA18.49. *Off. Rec. Wld Hlth Org.* **143**, 35.

paign that had been waged for 12 years. Although the mosquito had been eradicated for seven years in French Guiana, it had returned, possibly carried by aircraft or in small vessels on clandestine visits. In his view it represented the most serious health problem faced by France in the Americas.

With regard to tuberculosis it was now mandatory to report all cases of the disease occurring in the Department.

Leprosy was still present but the French Government had decided that the control of the disease should be the financial responsibility of the State rather than be chargeable to the budgets of local communities. In the current State budget a sum representing 92 to 94 per cent of the cost of the program would be appropriated to combat leprosy in the French Departments.

Dr. NICHOLSON (United Kingdom), in complimenting the Director on his very lucid and informative Report, said that it underlined both the rapid progress being made by the Organization and the increasing diversity of its participation in the health of the Hemisphere—for instance, in the attack upon leprosy, smallpox, tuberculosis, venereal diseases, the zoonoses, dengue, and malnutrition, and in the areas of health planning, vital statistics, operational research, legislation, and the training of auxiliary personnel. He hoped due heed would be given the warnings of the Director on inadequate administrative methods and practices, the decrease in the quantity of food for human consumption, and the general need for increased training.

On a more heartening note, the Report had recorded the rapid progress made in malaria eradication and the development of inexpensive protein foods by INCAP. The role of malnutrition in infant mortality had also been emphasized, and he applauded the advice of the Director to incorporate nutrition activities in the routine work of the local health service, rather that permit mere concentration on treatment. Education in the nutrition field was also important.

Dr. MORENO VALLE (Mexico) expressed his satisfaction with the Report of the Director of the Bureau, which had set forth a broad program and also showed how much still had to be done. He congratulated Dr. Horwitz and the staff of the Secretariat on what had been accomplished.

The session was suspended at 4:20 p.m. and resumed at 4:55 p.m.

Dr. BONICHE VÁSQUEZ (Nicaragua) also conveyed his congratulations to the Director of the Bureau on his Annual Report and on the statement and summary he had provided at the preceding session.

He was encouraged by Dr. Horwitz' promise to promote special research aimed at discovering new drugs or finding new formulas for insecticides that would solve the problem presented by the resistance of the vectors of malaria. He considered that it was essential to develop new and more effective drugs, as the people could never hope to be entirely free of the disease with those currently in use.

With regard to tuberculosis he took a more optimistic view and believed that the targets set were gradually being realized by the countries, with the aid of the Bureau and of UNICEF.

Turning to medical care in rural areas, he declared that, step by step, a solution was being found to that extremely important problem. Nevertheless, the health authorities were concerned at the high price of medicines and the difficulties over their supply. He suggested that the question should be studied and reports made to national health services on the various prices charged for essential medicines, so that doctors would be in a position to prescribe for their patients those medicines which were both effective and reasonably priced.

Dr. WEDDERBURN (Jamaica) expressed the appreciation of his country for the Organization's continued support of its programs, especially in the field of mental health, an activity in which he had, during the XIV Meeting of the Directing Council,[2] urged a wider participation. A short-term consultant sent to Jamaica in 1964 had submitted a very useful report, whose major recommendations had the added merit of requiring little expenditure of funds for their implementation. The consultant would return shortly to help carry out the new program. In the previous month Jamaica had been host to the Caribbean Seminar on Mental Health organized by PAHO (5-11 September 1965), and that had assisted in bringing before the public of Jamaica the importance of community participation.

In common with his colleague, the Representative of Trinidad and Tobago, he wished to raise the question of *Aedes aegypti* eradication, but for a different reason. Jamaica had eradicated malaria but was still plagued with *A. aegypti* and other species of

[2] *Official Document PAHO* **55**, 68.

mosquito. A final major assault on them, using classical methods of control, pending the discovery of an effective insecticide, was planned. Jamaica, he said, had also been selected for field trials of some of the newer types of insecticide. He commended to delegates the recommendation of the Representative of the United States of America on cooperative efforts to eradicate *A. aegypti*. In seeking funds for the fight against malaria it had been possible to specify a date when eradication might be expected, but in seeking funds for the eradication of *A. aegypti* one could speak with no such definiteness, especially in the light of the resistance of the virus to the insecticides currently in use. In the circumstances, Governments were disinclined to make adequate funds available. All countries that had been concerned with the control of *A. aegypti* could well share their experiences. With the help of those that had been successful, it might be possible to design a program which could permit the citing of a specific target date for eradication.

Other mosquitoes had also been creating problems in Jamaica. About two years earlier one area had suffered an outbreak of equine encephalomyelitis which had resulted in a number of human deaths. It had been introduced by birds migrating southward, and recent investigations had indicated that the virus was probably now seated in the country. Local birds which had been negative zoologically to the virus had recently been let loose and later found to be positive. He wished to appeal to the Organization for assistance in dealing with that and other vectors, in addition to the past practice of concentrating on malaria and *A. aegypti*.

Finally, he joined the other representatives in commending the Director and the staff for the very useful Report that had been presented. It was perhaps of historic significance that it should appear in its new format on the occasion of their occupancy of the new headquarters building. It was very simple to see from a glance at the Report what had been achieved and what it was hoped to achieve.

Dr. YÉPEZ (Ecuador) extended his congratulations to the Director of the Bureau on his Report, which in his view provided the countries with a full commentary on the work to be done.

He stated that 45 per cent of the malarious area in Ecuador was in the consolidation phase of the eradication campaign, including extensive rural zones; the problem of persistence was localized in the two regions in which the maximum possible efforts were being made.

With regard to smallpox, the eradication campaign had ended in May 1964 and no new cases had been reported since 1963. The latest campaign covered 85 per cent of the population and in the maintenance phase 20 per cent of the country's inhabitants were being vaccinated each year.

A most unfavorable situation existed, however, in the case of plague, Ecuador's figures for that disease being among the highest. Three provinces suffered from infestation: one in the interior; another in the border region, which had the same epidemiological characteristics as those observed in the northern region of Peru; and finally, the most serious focus of all, located in the central and coastal regions of the country. It was hoped that, with the technical guidance of the international agencies, it would be possible to deal with the difficult situation that existed.

The position with respect to urban yellow fever was favorable; *Aedes aegypti* had been eradicated and there were no areas of reinfestation.

Turning to the problems of environmental sanitation, he reported that in February an agency responsible for the supply of potable water and the construction of sewage disposal facilities had been set up in Ecuador.

In conclusion, he observed that vertical programs required an adequate horizontal structure to consolidate the results that were being obtained and to provide for the coordination of plans. With that end in view, it was the intention of the Government of Ecuador to reorganize its National Health Service.

Dr. PERAZA (Honduras), after congratulating Dr. Horwitz on his Report, expressed his country's gratitude to the international agencies for the valuable aid they had furnished in the fight against diseases, and indicated that several days previously a poliomyelitis epidemic, with more than 70 cases, had been reported in Honduras. Mexico had reacted rapidly and generously, having sent a considerable quantity of vaccine to Honduras, and WHO had also sent a consignment from Toronto, Canada, although it arrived in poor condition because the firm responsible for the transportation arrangements had failed to keep it under refrigeration while in transit. A claim had been made for the replacement of the consignment. The "World

Church" had also made a donation of 100,000 doses. He drew attention to the threat to neighboring countries posed by the epidemic.

The eradication of malaria was an accomplished fact in two-thirds of the national territory, thanks to the assistance furnished by AID, although one focus persisted in the south and measures were being taken against it.

Finally, he announced the introduction of a rural community development program, beginning in November 1965, which would be undertaken with the encouragement and assistance of the Government of Mexico. The objective was to counteract, through educational measures, the tendency of the rural population to abandon its land in order to migrate to the cities where, in the majority of cases, it failed to find the means of subsistence.

Dr. PICHARDO (Dominican Republic) apologized for the absence of the Minister of Health and Social Welfare as a result of the present situation in his country, and he congratulated the Director of the Bureau on his Report. He expressed his gratitude to the Organization and to the Governments of neighboring countries which, like Venezuela and Brazil, among others, had furnished assistance to the people of the Dominican Republic in the recent critical days, responding to a demand for public health services that went beyond frontiers and political ideologies.

The health services of his country had suffered from shortcomings that the new administration intended to correct by training the personnel involved and by undertaking a thorough reorganization of its agencies, reviewing the human and administrative aspects of their operation.

He was interested in the programs designed to deal with rural problems and considered that the Bureau should have at its disposal a body of specialists in community organization, for a system based on cooperative principles might well provide the best means of solving the financial and health problems of the rural sector.

Dr. ESQUIVEL (Panama) also expressed his appreciation and congratulations to the Director of the Bureau. The Report presented was more than an Annual Report; it was a statement of the objectives and achievements toward which the Bureau had been working for some years. Panama had always received the support of the Organization and had endeavored, on every occasion, to respond to the latter's efforts in the service of the health of the nations of the Americas. In his view, none of the representatives could complain of the achievements of the Director of the Bureau in that field.

The Report set forth the facts and outlined projects which, he believed, had been soundly conceived, within the limits of the financial and human resources of the countries; and the assessment of those human resources, in particular, called for a much more finely balanced judgment than did questions of a purely technical character.

He emphasized that the Organization's meetings were important because of the opportunities they offered for contact and thus mutual understanding of problems and, especially, because of the moral encouragement they offered health officials to go forward with their programs with an increasing sense of urgency. He suggested to Dr. Horwitz that he should urge countries to make changes in their methods in the health field; he was thinking more especially of the need for statistical services which involved, in some of the countries of the Americas, the introduction of new administrative procedures. He emphasized the importance of statistics in planning and in establishing the right priorities in both the economic and the technical spheres.

He drew attention to the desirability of forming teams of permanent health officials, for without such teams it was impossible to make effective use of the resources available, and he noted that changes in the personnel of such services hinder the implementation of programs.

Turning to staff training, he asserted that not only was it necessary to train high-level personnel but there was also an urgent need to provide training for auxiliary and subordinate staff. He suggested that the Bureau might study the problem in order to be able to give Governments advice on the proper direction to follow.

He went on to discuss the role of private enterprise in the solution of the public health problems of countries, and considered that it was the responsibility of the private sector to assist financially in the realization of many such programs. The Government of Panama had been studying the question with a view to finding a solution to the problem of financing specific plans, and he stressed the fact that there was an upper limit to a country's capac-

ity for debt that could not be exceeded without the risk of mortgaging the future of the present generations.

Dr. LAYTON (Observer, Canada) expressed his regret that Miss Judy LaMarsh, the Minister of National Health and Welfare for Canada, should have been obliged to return to Ottawa the previous evening. She had directed him to express her warm appreciation for the generous reception she had been given by the Directing Council. Tangible evidence of Canada's expanding interest in, and attachment for, its friends in Latin America had been provided by the announcement the previous week at a meeting of the United Nations that it would place a substantial sum of money at the disposal of the Inter-American Development Bank for use—as in the case of the previous year's contribution—in economic, technical, and educational assistance projects in Latin America. It was to be hoped that those funds might to some extent at least be channelled into projects in the health and related fields.

He concurred heartily in the references that had been made to the importance of health planning in the general development of a country. More than three years before he had referred to the appointment in Canada of a study commission on national health. That commission's report had now given the Canadian people a pattern for development in the health field. A highlight of the report had been its enunciation of a health charter for Canadians, from which he would like to quote: "The achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity involving individual and community responsibilities and action." One of the means of accomplishing that was to be: ". . . the full cooperation of the general public, the health professions, voluntary agencies, all political parties and Governments, federal, provincial and municipal."

He had listened with regret to the reference by the Representative of Honduras to the unfortunate mishandling of a consignment of polio vaccine, and said that it was unfortunate that it had happened. Obviously, he had not been personally concerned, but he now intended to concern himself with it. On his return to Canada the following day he would endeavor to have the mistake rectified at the earliest possible moment.

He was happy to turn, he said, from what was unfortunate mishandling to what represented the highest expression of quality and performance, the Annual Report of the Director of the PASB. It had been said that the Director had been showered with congratulation. He could only add that they were very well deserved.

The session rose at 5:45 p.m.

FOURTH PLENARY SESSION

Wednesday, 29 September 1965, at 9:00 a.m.

President: DR. RAYMUNDO DE BRITTO (Brazil)

Item 7: Annual Report of the Director of the Pan American Sanitary Bureau (*conclusion*)

The PRESIDENT opened the session and announced that the Council would continue its discussion of the Annual Report of the Director.

Dr. HORWITZ (Director, PASB) said that all the officers of the Pan American Sanitary Bureau joined him in thanking the representatives for their generous praise of the Annual Report, and also in congratulating the Governments of the Americas on the results achieved, which reflected the diligent efforts of the technicians under the guidance of the Ministers of Health, who had considered that international cooperation was essential in connection with some activities.

The shorter the duration of such cooperation, the more successful it would be, for it would enable the Government concerned to extend the field of activity with its own resources and skills. Nevertheless, as

the Report indicated, there could not always be a direct correlation between international and national investment in health. Governments that had all the necessary facilities for undertaking certain activities did not have to call upon international agencies such as the WHO and PAHO, whose resources could thus be particularly directed toward assisting the really needy countries. On the other hand, the international organizations should cooperate with Governments in anticipating health trends in the general context of development and should study them with a view to suggesting solutions, but leaving the Governments themselves to decide whether and how to accept and apply them.

It had been most gratifying for him not only to hear the laudatory remarks of the Representatives of Venezuela, Peru, and other countries but also to note the endorsement given to the general proposition—which served as a guide to the Organization —that health should be a factor of development which simultaneously promoted and benefited from development. He had also had the opportunity to observe the great interest aroused by the rural problem. He underlined the importance of the Venezuelan Government's activities in that regard, which covered not only concentrated but also scattered rural areas through the execution of a simplified medicine program whereby simply but carefully trained technicians were given responsibilities that only a few years before doctors would not have dared to accept. It was clear that the time had come to review old principles.

He welcomed the agreement that had emerged from the discussion as regards the need to coordinate the so-called "vertical," i.e. eradication, programs and at the same time give greater impetus to local and national health services by embarking on an activity that appeared more urgent each day, namely, the proper training of professional and auxiliary personnel.

The various views expressed by the representatives on planning were highly interesting and, in that connection, special mention should be made of the method adopted by the Government of Trinidad and Tobago: a careful survey was first made of the available resources and of the administrative practices; then the officials were encouraged to take training; and, lastly, an attempt was made to formulate a plan. In the opinion of eminent experts of the Hemisphere, that was the most logical course to follow. He thanked the Government of Trinidad and Tobago for its interest in the Bureau's continuing cooperation; the Bureau was carefully watching the results achieved by that Government in adopting that approach to the problem.

With reference to a question raised by the United States Representative concerning what provision the Bureau had made to enable any Government that so desired to have a national health plan in 1970, or a reformulation of previously established plans, he assumed that Mr. Board wished to know (1) whether the Bureau could set the priorities in advance, and (2) what action the Organization had taken to that end.

As the Peruvian Representative had pointed out in referring to the report of the Task Force on Health at the Ministerial Level (April 1963), in the Americas the top priorities in health had been known at least for one generation and in the final analysis the aim of planning was to determine an order of investment related to specific and measurable objectives, the main emphasis always being given to that which affected the largest number of people. Hence, owing to the experience accumulated by Governments, the Organization was able to follow the order of priority set by the Ministers and, as far as the major problems were concerned, those priorities could be changed in the light of further experience. In his opinion it would be simplest, for the purposes of international cooperation, to adjust the resources for each project to the extent decided on by Governments, provided that such cooperation was deemed necessary.

As regards the proposal that each Government should have a health plan in 1970, he thought that if the current trends of the PAHO budget continued the Bureau would, in its turn, be able to discharge its responsibilities in the way requested by Governments.

He then stressed the great interest aroused in the *Aedes aegypti* eradication campaign and, in general, in the fight against all vector-borne diseases. The Representative of Jamaica had emphasized the seriousness of the situation prevailing in his country as a result of equine encephalomyelitis and had requested that attention be paid to that disease which had assumed such grave proportions in the past two or three years. The Organization was interested in completing that work in order thus to fulfill the obligation assumed by the Bureau in 1947.

Referring to the United States Representative's suggestion that there should be a meeting of representatives of the group of countries infested with *A. aegypti*, Dr. Horwitz said that, to the extent that budgetary resources permitted, the Bureau would be very pleased to study ways and means of putting that useful idea into effect. The World Health Organization was taking the necessary action to expand a large-scale program of scientific research on that vector, and its research would undoubtedly be of use to the Regional Office in the future. With regard to the U. S. Representative's observation on the testing of two new insecticides in addition to those being tested by WHO, the Bureau was confident that sufficient experience would be available in the near future to apply them in areas where resistance existed, in order to complete the campaign.

As regards tuberculosis, he referred to the remarks of the Representative of El Salvador concerning the serious problem connected with chronic incurable patients. According to the reports by the Bureau's Regional Adviser, the chronic active cases were estimated to be in the neighborhood of 10 per cent. That situation should encourage the speedier application of measures designed to prevent new cases of tuberculosis, such as BCG immunization, chemoprophylaxis where appropriate, and early diagnosis and treatment. The solution to the problem of chronic sufferers lay in the fact that they should not be kept in sanatoria, which were expensive; cases which were only slightly infectious should be kept comfortable in colonies or day hospitals, which did not cost the State very much so that the beds in sanatoria could be reserved for the curable acute sufferers who really needed them.

Recalling the observations made by the Minister of Public Health of Panama and the Representatives of Guatemala, Trinidad and Tobago, and other countries, Dr. Horwitz welcomed the fact that growing importance was being attached to administrative problems. In the opinion of the Minister of Panama, the administrative aspect had acquired real priority, as was shown by the judicious decision of the Organization to include the subject, in 1957, in its policy and in currently seeking to give it fuller treatment to the extent that its facilities allowed. The need for the various countries to have larger resources with which to care for present and future populations was obvious, as was the possibility of obtaining a better return from the available resources. The main shortcomings were to be found in administrative practices rather than in the application of technical standards. PAHO was therefore proposing to intensify its action to improve those practices by ascribing to that task the importance it deserved according to the statements of the Governments concerned.

In reply to the Representative of Haiti, he explained that the necessary steps had been taken to evaluate the status of the yaws eradication program in that country and to make appropriate recommendations to the Government in the light of the results achieved. The Zone epidemiologist, Dr. Michel François Lechat, had taken the first steps in that direction and a group of specialists would soon proceed to Haiti.

The Director expressed his appreciation to UNICEF, FAO, the W. K. Kellogg Foundation, the Rockefeller Foundation, and the Milbank Memorial Fund, and also to the Government of the United States of America for its work of coordination through the Agency for International Development and other bilateral programs. All such cooperation had been vital to the achievement of the desired objectives during the preceding year and would certainly continue to be so in the future. In conclusion, he reiterated the Bureau's gratitude and congratulations to the health experts of the Hemisphere under the able guidance of the respective Ministers of Health.

Decision: It was agreed to take note of the Annual Report of the Director for 1964 (*Official Document 63*), to congratulate him on the excellent work accomplished during the year and the manner in which the Report was presented, and to extend congratulations to the staff of the Bureau.[1]

Draft Resolution Prepared by the Working Party on the Application of Article 6-B of the Constitution of the Pan American Health Organization

Dr. WILLIAMS (United States of America) stated that the working party on the application of Article 6-B of the PAHO Constitution, composed of the Representatives of Mexico, Venezuela, and the United States of America, had met the previous day

[1] Resolution II. *Official Document PAHO* **66**, 57.

at 12:00 noon and had prepared a report and a draft resolution. The Secretary of Health and Welfare of Mexico, Dr. Rafael Moreno Valle, had acted as Chairman. Since Dr. Moreno Valle had left for Mexico for an important series of budget hearings, he had asked the speaker to read, in his absence, the following report:

The working party,

In view of the terms of Article 6-B of the Constitution, which provides:

"If a Government fails to meet its financial obligations to the Organization by the date of the opening of the Pan American Sanitary Conference or a meeting of the Directing Council, by being in arrears in an amount exceeding the sum of its quotas for two full years, the voting privileges of that Government shall be suspended. Nevertheless, if the Conference or the Directing Council is satisfied that the failure of the Government to pay is due to conditions beyond its control, it may permit the Government to vote."

Taking into consideration also Resolution XII [2] approved by the Council at its XV Meeting, especially paragraph 2 which recommended to Governments that they establish a financial plan for the payment of arrears within a specified period;

Bearing in mind that the straitened financial condition in which the Organization is placed by delays in the payment of quotas, as well as the effect which this delay has on the relative proportions of services rendered among the contributing Members, and the consequent necessity of taking all possible steps to eliminate such delays;

Having considered carefully the circumstances of those delayed quotas which come within the provisions of Article 6, above cited, and taking into account the intentions of each of the Governments concerned as follows:

that the Government of Argentina has adopted a plan for payment which would cancel its arrears, has made partial payment, and has payments in process to fulfill the plan;

that the Government of Bolivia has adopted a plan for payment within a definite period and has substantially fulfilled it in 1965;

that the Government of Haiti is in the process of formalizing a plan for payment within a definite period and has during 1965 made a substantial quota payment;

that the Government of Paraguay adopted a plan for payment within a definite period, which it substantially fulfilled in 1963, 1964, and 1965; and

Considering that these developments represent a substantial improvement in quota collections during the first year since Article 6 of the Constitution was amended,

RESOLVES:

To recommend to the Directing Council that it permit the afore-mentioned countries to vote at its XVI Meeting.

In view of the foregoing, the working party submits to the Directing Council the following proposed resolution:

THE DIRECTING COUNCIL,

Having received the report of the working party which indicated, with respect to those countries attending the XVI Meeting of the Directing Council and affected by Article 6 of the Constitution, substantial progress in the development and fulfillment of plans for payment of quota arrears within a definite period in accordance with the policy established in Resolution XII of the XV Meeting of the Council,

RESOLVES:

To note the progress of those Governments and to permit them to vote in the XVI Meeting of the Directing Council.

Decision: The draft resolution was accepted.[3]

Item 8: Financial Report of the Director and Report of the External Auditor for 1964

Dr. PORTNER (Chief of Administration, PASB) presented Document CD16/2 [4] and *Official Document 59*, containing the Financial Report of the Director and the Report of the External Auditor for 1964. He explained that *Official Document 59* had been presented to the Executive Committee at its 52nd Meeting, which after careful review had approved Resolution I.[5]

The Financial Report gave an accounting of the Organization's funds in accordance with the Financial Rules and Regulations. Moreover, it was a report on managerial stewardship in the wise utilization of resources and control of funds.

Although the primary objective was to report on PAHO funds, for which detailed information was presented in the respective exhibits and schedules, the Financial Report also reflected expenditures of PAHO and WHO funds from all sources. Consequently, the document served also for the purpose of analyzing the implementation of the program.

The introduction to the report contained a review of the Organization's financial situation and related it to the main policies that had been followed over

[2] *Official Document PAHO* **58**, 66-67.

[3] Resolution III. *Official Document PAHO* **66**, 57-58.

[4] Mimeographed document.

[5] *Official Document PAHO* **62**, 27-28.

a period of years. Three analytical tables facilitated that review. The Pan American Health Organization was in a sound financial situation. Evidence of that was the fact that the Working Capital Fund stood at the highest percentage level since the beginning of 1958. Expenditures had been held within income, while a modest but steady increase in activities had been achieved from year to year.

A further element of financial stability were the reserves established to meet staff termination costs, which were especially important in relation to programs supported by voluntary contributions.

The improved financial condition was due mainly to the consistent application of three policies over a period of years. The first was that adopted in 1959 for the purpose of maintaining expenditures within income. As could be seen from Table B of the report, that objective had been reached without depleting the Working Capital Fund; expenditures for the period 1958 through 1964 were lower than income by $348,339. Averaged in round figures over the seven-year period, the Organization had received as income 94 per cent and had expended 93 per cent of the authorized appropriation.

The second important policy that had contributed to financial stability, while permitting continuous growth, was the establishment of an effective procedure for steadily increasing the Working Capital Fund. That step had been taken in 1959, when the XI Meeting of the Directing Council [6] instructed and authorized the Director to include in the PAHO regular budget for 1961 and future years an amount for gradually increasing the Fund and maintaining it at its authorized level of 60 per cent of the budget. Beginning in 1961, an amount of $300,000 had been included each year, and although some setbacks had occurred, the current situation showed that the policy adopted by the Council had been wise and effective.

A third policy had been adopted in 1962 to ensure the Organization against risks arising out of the uncertain situation with reference to continuation of grants and voluntary contributions. Reserves for staff termination costs had been substantially completed for most of the voluntary funds, except for the Institute of Nutrition of Central America and Panama (INCAP), reserves for which would be started in 1965. In 1964 a beginning had been made on the expansion of reserves in the PAHO regular budget for repatriation entitlements to further include all staff termination costs. Thus with the major part of the required reserves already established, the Organization had an assured capacity to meet future financial obligations that might arise from program terminations, without endangering the PAHO regular budget or the Working Capital Fund.

To facilitate the financial analysis, a new table (Table A) showed a comparison of the budgeted figures with the funds actually available during the year and the obligations incurred. For all PAHO funds, the amount available was 97 per cent of the budget figure shown in *Official Document 52*; for all WHO funds, the amount available represented 108.8 per cent of the amount shown. The increase was due to the allocation of additional funds to the Region of the Americas for malaria eradication.

For PAHO regular funds, the amount shown as available during the year represented the income for 1964 minus the amount of $1,000,000 which had been received early in January as a delayed payment of the 1963 contribution of the largest contributor. That amount had been held outside the expenditure plan for 1964 because, for financial management purposes, it was considered to be part of the 1963 picture. The remaining PAHO regular income represented 95.3 per cent of the budget figure. Of the amount available, almost 100 per cent had been utilized for obligations in 1964. With reference to other PAHO funds; the availability in relation to the budget and the utilization in relation to availability had been variable. For example, the amount available for the community water supply program had fallen far below expectations and amounted to only 58.9 per cent of the amount anticipated in the budget. Funds received late in the year from grants and other contributions brought the total funds available from those sources to somewhat above the amount anticipated in the budget. Those funds would be available for use in 1965.

A further analysis of PAHO regular funds was provided in Table B, which showed appropriations, income, and obligations during the period 1958-1964. In 1964 the income represented 95.3 per cent of the appropriation, compared with a seven-year average of 93.9 per cent. Obligations represented 95.2 per cent of the authorized appropriation, compared with

[6] Resolution VII. *Official Document PAHO* **32**, 17-18.

a seven-year average of 92.8 per cent. The obligations for PAHO regular funds included the amount of $300,000 budgeted for increasing the Working Capital Fund, as well as the amount of $250,000 contributed to the Special Fund for Health Promotion according to the agreement with the W. K. Kellogg Foundation. In accordance with a procedural recommendation made by the Internal Auditor, the latter Fund was shown in a separate column in Exhibit IV.

Owing to the fact that the amount of quotas and other income received late in the year had been greater than anticipated, it had not been necessary to make any expenditures against the Special Fund for Health Promotion, and that sum would therefore be available for health promotion programs in 1965 and future years.

The situation with respect to the collection of quota contributions remained unsatisfactory. The Organization's favorable financial position had been achieved by keeping obligations at an average of 7 per cent below the appropriations for the seven-year-period 1958-1964.

Aside from quotas, the income from other sources amounted to about $80,000 more than in 1963, and that increase was due largely to increased income from interest.

Dr. Portner then reviewed the notes, exhibits, and schedules contained in the Financial Report for the PAHO regular budget, INCAP, and the Program of Technical Cooperation of the Organization of American States. He called attention to the Informational Annex, which presented the summary and distribution of expenditures for PAHO and WHO by source of fund, by object of expenditure, and by budget parts and individual projects. That Annex facilitated the study of the utilization of funds in relation to the budget.

He then presented the Report of the External Auditor and called attention to the most important portions, among which was the statement referring to the surplus of $1,001,828 which had resulted from the payment early in January of $1,000,000 of a delayed 1963 contribution. The External Auditor had noted that the Director had stated in his Financial Report for 1963 that, for financial management purposes, that amount was considered applicable to 1963. The Auditor had commended the Director on his financial integrity in maintaining that amount outside the expenditure plan for 1964, thereby ensuring an increase in the Working Capital Fund.

Dr. QUIRÓS (Peru) wished to make some comments on the document presented. He welcomed the fact that the Financial Report of the Director and the Report of the External Auditor were being presented immediately after the Director's Annual Report, because the two matters were clearly connected. It was really gratifying to note, with regard to the Financial Report and the Auditor's Report, that the Organization's funds were being properly handled, but it was regrettable that the situation with regard to the payment of quota contributions left much to be desired, with the result that the program could not be carried out in its entirety as it should. In that connection he referred to the statement in the Auditor's Report to the effect that the quotas of countries other than the major contributor amounted approximately to $2,000,000, of which $800,000 had been collected. That showed that the situation was not satisfactory as regards the payment by Member Countries of their assessments. On the other hand, the adoption of a resolution on the matter which would make it possible to improve the situation was very welcome.

As had been noted by the Director and the External Auditor, the reported surpluses and the improvement in the Working Capital Fund had been due to the chance circumstance that the major contributor had fallen in arrears in the payment of its quota to the extent of $1,000,000, an amount that had been credited in 1964, the payment having been made in January 1964; that had led to a surplus of approximately $400,000, of which $300,000 had been transferred to the Working Capital Fund, and a further $300,000 in 1964, which had accounted for the favorable position of the Working Capital Fund. Nevertheless, that situation was rather artificial and it had obviously been achieved at the expense of part of the program which it had not been possible to carry out.

As regards the execution of the budget, an aspect to which he had referred on previous occasions, he pointed out that, while the budget was presented by programs, it was executed in the traditional manner, i.e., by parts, the Director being authorized to make the necessary transfers from one part to another. In that connection he drew attention to the table on pages 14 and 15 of *Official Document 59*, which showed the transfer of $74,974 to Part II (Head-

quarters) at the expense of field programs, and asked for what purpose the transfer had been made.

With regard to Item 15 of the agenda, on administrative rationalization in the Pan American Sanitary Bureau, he emphasized that once again the External Auditor mentioned in his report that the recentralization of the administrative services had resulted, as had happened the previous year, in an increase in the amount of overtime worked by Headquarters staff and in the constant recruitment of temporary staff. In conclusion, he hoped that, when that item was taken up, it could be discussed at some length because he had some questions to ask.

Mr. BYRNES (United States of America) said that the Government of his country was pleased with the Financial Report of the Director. It was appropriate that such a document should follow the very satisfactory report on the activities of the Pan American Sanitary Bureau which had been presented and discussed at length at the previous session. Although, as Dr. Portner had pointed out, the financial situation continued to plague the Organization, it appeared to be improving. Although not all program activities had been carried out, the Director had managed to keep expenditures within the income received, for which he should be commended.

On page 11 of the budget *(Official Document 61)* certain breakdowns by fund and by object of expenditure were used. It would be helpful if that table were to include the breakdown of expenditure shown on page 50 of the Financial Report *(Official Document 59)*. The additional information given there would be helpful to the Council for the purposes of comparison and review when examining the budget.

Mr. Byrnes then proposed the following resolution:

THE DIRECTING COUNCIL,

Having examined the Financial Report of the Director and the Report of the External Auditor for the year 1964 *(Official Document 59)*,

RESOLVES:

1. To approve the Financial Report of the Director and the Report of the External Auditor for 1964 *(Official Document 59)*.

2. To urge Governments that have outstanding quotas to pay them as soon as possible.

3. To recommend that the Director continue the policy of prudent administration in maintaining budgetary expenditures within income.

Dr. PORTNER (Chief of Administration, PASB) answered the questions raised by the Representative of Peru. In regard to the item of recentralization of administrative services and the reference made by Dr. Quirós to the External Auditor's comments appearing on page 77 of *Official Document 59*, he believed that the full context of that statement should be read, and he quoted the entire paragraph of the document. As the External Auditor had indicated, there had been a need for some overtime in the Administrative Services, and the engagement of temporary staff had also proved to be a necessary measure. There were several reasons for that. As the Directing Council knew, the Organization had undertaken an administrative organization whose main objective was the integration of its administrative activities; that had required the reduction of the staff working in that particular field by more than 40 per cent. During that process, which as the External Auditor had indicated, was completed in 1964, some persons had had to work overtime. Those in the lower grades had been compensated, while those in the professional levels had been glad to give such extra time out of loyalty to the Organization and because they were conscious of the significance of those activities for the pepole and the Governments of the Hemisphere. However, that practice would not continue indefinitely since it was primarily due to the fact that the Organization was undergoing a period of tremendous change, the sole purpose being to make more funds available for the work of the ministries of health in the Member Countries, so as to enable the people of the Hemisphere to attain a better state of health. Another factor that had made the hiring of temporary help imperative had been a high rate of sickness in the organizational unit concerned.

With regard to the Representative of Peru's comment's on transfers, (Exhibit I of *Official Document 59*), there was a legal basis for making transfers. They included $30,967—less than 1 per cent—of the original appropriation figure for field and other programs (Part III), to Headquarters (Part II).

It was the hope and purpose of the Organization to continue to reduce Part II to the very minimum so that as much of the funds as possible could be available for program activities. In his opinion, the Organization, by keeping the transfer of funds from field programs to other parts of the budget to

less than 1 per cent, was moving toward the attainment of that objective.

The PRESIDENT announced that, since there were no further speakers, he would submit to the Council for consideration the proposed resolution put forward by the Representative of the United States of America.

Decision: The proposed resolution on the Financial Report of the Director and Report of the External Auditor for 1964 *(Official Document 59)* was unanimously approved.[7]

Second Report of the Committee on Credentials

Dr. SALDAÑA (El Salvador) read the second report of the Committee on Credentials, which stated that the Committee, composed of Dr. Carlos Quirós Salinas (Peru), Chairman, Dr. José Antonio Saldaña (El Salvador), Rapporteur, and Dr. Leonard M. Comissiong (Trinidad and Tobago), had held two meetings and had examined the credentials of the Representaive of Uruguay, which it had found to be in good order.

Decision: The second report of the Committee on Credentials was approved without change.

Item 9-A: Proposed Program and Budget of the Pan American Health Organization for 1966

Dr. HORWITZ (Director, PASB), in presenting the Proposed Program and Budget of the Pan American Health Organization for 1966 (*Official Document 61* and Document CD16/8 [8]), stated that Item 9 was divided into three parts: A, B, and C. The first referred to the Proposed Program and Budget of the Pan American Health Organization for 1966; the second to the Proposed Program and Budget of the World Health Organization for the Region of the Americas for 1967; and the third to the provisional draft of the Proposed Program and Budget of the Pan American Health Organization for 1967. At the Eighteenth World Health Assembly the appropriations for the Program and Budget of WHO for the Region of the Americas for 1966 had been adopted.[9] In order to facilitate the Council's consideration of the three aspects mentioned, which were covered in the Proposed Program and Budget (*Official Document 61*), he explained that he would make some general remarks on the program and that Dr. Portner would take up the general budgetary aspects. Both statements would be as brief as possible because, at the 52nd Meeting of the Executive Committee, held from 19 to 23 April 1965 under the able chairmanship of Dr. Charles L. Williams, Jr., the subject had been clearly analyzed and discussed and the relevant précis minutes had been published [10] and were available to the representatives. In addition, the pertinent resolutions [11] had been issued and the Council had also heard Dr. Williams' report, which had been submitted at the first session.[12]

For the last three and possibly four years, the Organization had been striving to apply the administrative technique of program budgeting, a method which might be regarded as unusual in an international organization not performing direct services, except in exceptional circumstances, because it was not simple to determine measurable targets that could be expressed as an item of the budget. Nevertheless, after consulting an eminent group of experts in 1959 and 1960, it had been decided to introduce that procedure. That decision, which had been adopted in its entirety by the Council, had been logical, and considerable headway had been made in rendering it more effective, although experience showed that the efficiency of the method depended upon the momentum of the program of the organization concerned and on the possibility of determining, as accurately as possible, the time taken by each officer in completing a given task relating to the purpose of the program.

In international health work, in which the staff, which was the main factor, acted in an advisory capacity, it was not an easy matter to measure accurately the time employed in terms of functions, and the advantage of program budgeting therefore consisted in determining the breakdown in terms of time of those who participated in the over-all program.

In view of those considerations, he would proceed to analyze Table 6 (*Official Document 61*, pages 12-13). As in previous years, that table compared the budgetary appropriations for a three-year period

[7] Resolution IV. *Official Document PAHO* **66,** 58.
[8] Mimeographed document.
[9] Resolution WHA18.35. *Off. Rec. Wld Hlth Org.* **143,** 21-22.
[10] *Official Document PAHO* **64,** 8-44, 49-52.
[11] *Official Document PAHO* **62,** 28-29.
[12] See p. 26.

(1965, 1966, and 1967). It gave a breakdown of activities by category and hence by category of program approved by the Council, namely: health protection and sub-headings—communicable diseases and environmental sanitation; health promotion, with general services and specific programs; education and training; program services; administrative direction; Governing Bodies and increase to assets, generally in the Working Capital Fund. It also showed the amounts invested by activity in planning and execution, development of professional staff, research, and the indirect program costs for the last four categories. He pointed out that, as Dr. Portner would later explain in detail, the document outlined the policy followed for each of those categories and gave a breakdown of projects by countries.

The question had been discussed whether the breakdown of projects by countries was a disadvantage so far as the technique of functional or program budgeting was concerned. In the Bureau's view it was not, because on many occasions Governments had expressed interest in knowing how much was invested in their own administrations and that was, of course, an order. It was also not a disadvantage because it was obviously possible to deduce from the document how much was invested by program as a whole and, in addition, the process was a continuing one, as had already been pointed out, and also dynamic and subject to improvement. The time would thus come when the format could be refined still further and thus made even clearer, if necessary. The Bureau's experience had shown that it was essential to be rather careful in formulating program budgets so as not to exaggerate the enumeration and analysis of items and make it a costly operation in relation to the advantages. The desire to specify in unduly great detail to what ultimate purpose funds were put might be very interesting scientifically speaking, but highly unnecessary from the administrative viewpoint. Hence it was inadvisable to change, without prior and thorough study, the formats used at a given time in selecting a category and a breakdown by category, by program, and by project, of an institution's activities.

He reminded the Council that the table had been presented in detail in the Executive Committee. It had been felt that the proposed presentation was well balanced, a view which was justified by the percentage breakdown of activities. Referring again to Table 6, page 12, he explained that in 1966—the year under consideration—35.6 per cent was allotted to health protection activities, a little over 25 per cent of which were concerned with communicable diseases and almost 10 per cent with sanitation. Of the communicable diseases, malaria received 16 per cent of the total funds. The appropriation for health promotion was 35.0 per cent, of which virtually one half was for general services and the other, with slight differences, for specific programs, including maternal and child health, nutrition, mental health, medical care, and others. A little over 10 per cent was intended for education and training, and the table indicated the breakdown by categories. The emphasis was essentially on advisory services to educational institutions, i.e., direct services. The amount of 4.6 per cent was for program services, a series of activities which affected the whole system, viz., the administration of fellowships, library, scientific publications, and others; 5.4 per cent was for what might be called administrative services proper: staff, finance, budget, supplies, etc. The remainder was for the Governing Bodies and the increase to assets, the amount of which was laid down in the Financial Regulations.

Even though there were grounds for considerable satisfaction with the fact that 32 per cent of the PAHO total budget was used as a working capital fund, the Financial Regulations specified 60 per cent. Nevertheless, in the desire to invest increasing amounts in the programs while, of course, being careful not to jeopardize the Organization's stability, the proportion had been kept as low as possible. He believed that the distribution of funds was efficient and well balanced. It made it possible to continue the activities in accordance with the set policy; it attributed special importance, in the matter of eradication, to malaria, but in that connection, as had already been pointed out, the time had come when it would be imperative to coordinate those activities with rural action programs and—to repeat the apposite remarks of the Representative of Brazil, Dr. Ferreira—in many countries the eradication program could be converted into the basic health program to follow up the successes of the first. By that he meant that, at the country level, no reduction in funds was foreseen, provided that continuity was maintained in the interim in

malaria eradication, and that at the international level there were good grounds for continuing investment in general services which would also further malaria eradiction activities. In order to carry out the recommendations of the two Seminars on the Role of General Public Health Services in Malaria Eradication, to which he had referred at the second session, it would certainly be necessary over the years, beginning in 1966, to earmark part of the funds for general health services in order to collaborate with Governments in implementing those recommendations which, in the final analysis, would help improve rural care in that field and, of course, in others as well.

The allotment for smallpox seemed relatively small, particularly now that the Eighteenth World Health Assembly [13] had attributed such particular importance to that disease. But it must be borne in mind that, in the Americas, PAHO had been active in smallpox eradiction since 1950, that more than $1 million had been spent, that there was ample production of high-quality vaccine, and that all countries had some experience of that program, in the sense that they knew how to carry it out, so that international collaboration in terms of technical advisory services should therefore be much less, and the appropriation was therefore commensurate. Of course, if more funds were available—and an increase would be very welcome to the Bureau—there could also be international cooperation in supplying equipment in addition to the lyophilization apparatus which the Organization had had the great pleasure over the past 15 years of providing to laboratories that produced vaccine in the Hemisphere. To the extent that existing facilities permitted, there was no problem in earmarking funds for transport and other items which would accelerate the eradication of the disease.

The allocation for communicable diseases made it possible to continue the work undertaken so far and to advise Governments on the expansion of their control or eradication activities. The chapter concerned with zoonoses could be substantially increased if the proposal concerning the Pan American Zoonoses Center, submitted by the Argentine Government to the United Nations Special Fund, was adopted in January 1966, in which case the amount obtained from the Special Fund, through the World Health Organization, would be included under that item.

The same remarks applied to the other chapters. As regards sanitation, although the total proportion remained unchanged, there was an increase of $100,000 for 1966 over the figure for 1965. Unfortunately, the Program of Technical Cooperation of the Organization of American States, which had made available to the Organization an allocation of $60,000 for short courses on selected subjects for engineers, launched 18 months previously with great success in the universities of the Americas, would certainly not make that allocation in 1966, for which reason it had been largely incorporated into the regular budget. The importance of the training of engineers was beyond question.

As regards health promotion and, in particular, the chapter relating to administrative methods, he pointed out that, as was indicated by the very interesting remarks made at the second and third plenary sessions by the Minister of Public Health of Panama and the Representatives of Guatemala, the Dominican Republic, and other countries, the relevant item was very small. It covered advisory services to Governments for the improvement of their administrative practices. However, as would later be shown, greater efforts in that direction were called for, and the Annual Report contained some proposals to that effect. It was believed that Latin America should have centers for the training of technicians in administrative practices from the ministries of health, and the Organization had taken some first steps in that direction using extrabudgetary funds. It was to be hoped that its action would be successful.

An increase of approximately $200,000 was earmarked for nutrition, and he emphasized the existing proposal to stabilize the financial position of the Institute of Nutrition of Central America and Panama (INCAP), which, as had been pointed out at the second plenary session, had become an advisory body and therefore one providing services, basic and applied research, and training that was serving the whole world. It was believed that the Institute had done outstanding work and that the Central American Governments and Panama deserved to be heartily congratulated on the decision they had taken 15 years before to launch the project and on their sacrifices in maintaining it; praise was also due to all the Governments of the Americas for

[13] See Resolution WHA18.38. *Off. Rec. Wld Hlth Org.* **143**, 24.

the funds from the regular budget of PAHO that had been used to maintain the Institute, which had technicians of international renown whose services were invaluable. Some of them had had long years of training. For all those reasons, the increase of $200,000 had been requested for the Institute. The Director of INCAP, Dr. Moisés Béhar, was present and, if the Council was interested in hearing some detailed explanations, he would be only too pleased to give the necessary clarification.

With regard to medical care, there might also be changes in the future. Everything would depend on the decision taken by the Council on the reports of the Advisory Committee and the Study Group to which reference had been made at the second plenary session and which appeared in the agenda. One referred to the medical services provided by the various social security institutions and those of the ministries of health, and the other to hospital planning in its broadest sense. He considered that the decision reached [14] should be reflected in the structure of the Pan American Sanitary Bureau, in its relations with the international capital market, and in the search for a group of experts to assist Governments in that connection. The items mentioned were obviously small but would make it possible, as the 1964 Annual Report indicated, to provide the Governments of the Americas with a series of advisory services.

The same was true of the chapter relating to the various categories of education. The Bureau was extremely interested in, and particularly encouraged by, Resolution WHA18.39 [15] of the Eighteenth World Health Assembly, concerning action to improve the quality of medical training. There was interest in accelerating the training of nursing auxiliaries by using the modern technique of programmed instruction, for which some steps had already been taken. The technique involved the training of technicians capable of preparing texts which the auxiliaries could use as a guide in self-training. Hence, if those projects for which PAHO was seeking extra-budgetary funds were adopted, the respective items as a whole would also undergo changes without affecting the balance of the budget.

The other headings followed much the same pattern as in previous years and the projections for them as a whole were the same for 1967. The Bureau had therefore ventured to propose, as indicated in Table 1 (page 6), an increase in the regular budget of the Pan American Health Organization, including the special item for INCAP, amounting to 12.4 per cent over the figure for 1965. The customary increase of approximately 10 per cent per annum had been included, and since INCAP made a valuable contribution to the Hemisphere as a whole and to other regions of the world, he considered the investment for that Institute to be justified.

The session was suspended at 10:45 a.m. and resumed at 11:20 a.m.

Dr. PORTNER (Chief of Administration, PASB), continuing the budget presentation, described the content of *Official Document 61*. The format of the document followed that approved by the Executive Committee at its 50th Meeting (Resolution II).[16] Aside from the introduction, the draft appropriation resolution, and the scale of assessments, the main document consisted of two principal parts. The first, which had been presented by the Director, included the program analysis on page 4, followed by analytical tables and a narrative presentation for each subject (pages 6-34). The second section presented the budget detail, starting on page 37 with the narrative justifications for each office and project and continuing on page 118 with detailed cost estimates, also by office and by project. The detailed schedules made it possible to identify each source of funds and to identify the individual posts as well as the numbers of fellowships and consultant-months by office and project.

A wide variety of supplementary information was provided in the seven annexes. Annex I gave information on the method of preparation of the budget. Annex 2 presented a summary of professional and local posts, by fund and by organizational unit. Annex 3 provided a listing of projects by fund and by the program subject grouping that had been used for some years in the WHO budget document. It also included estimates of Other Extra-Budgetary Funds as they related to the various projects. Annex 4 gave a breakdown by source of funds and by program for all the funds other than PAHO regular, WHO regular, and WHO/TA. Annex 5 showed the Special Fund for Health Promotion, which had been established as a means of repaying, in the form of expanded program the generous contribution of the

[14] See pp. 172 and 200.

[15] *Off. Rec. Wld Hlth Org.* **143**, 24-25.

[16] *Official Document PAHO* **57**, 20.

W. K. Kellogg Foundation to the PAHO headquarters building. Annex 6 listed the costs for the headquarters building. Annex 7 listed some two and a half million dollars of projects desired by Governments which could not be included within the budget ceilings.

Dr. Portner began the presentation of the budget content with Table 1 (page 6), showing the multiple sources of funds for carrying out the program outlined by the Director. PAHO sources included the PAHO regular budget supported by quotas from the Governments of the Organization; the PAHO Special Malaria Fund and the Community Water Supply Fund, derived from voluntary contributions; the Program of Technical Cooperation of the Organization of American States; the Institute of Nutrition of Central America and Panama (INCAP); and grants and contributions from various private and governmental agencies. PAHO sources accounted for 67 per cent of the total in 1965, 66.5 per cent in 1966, and 69.7 per cent in 1967. It was to be noted that the figures included only approved grants and contributions and that further contributions might be forthcoming in future years.

WHO sources included the funds allocated to the Region of the Americas from the WHO regular budget and the WHO Malaria Eradication Special Account. Also received through WHO were the funds related to programs requested by Governments from the United Nations Expanded Program of Technical Assistance and the U. N. Special Fund.

The total budget showed an increase of 7.1 per cent, from $17,414,910 in 1965 to $18,646,028 in 1966, and in 1967 rose 3.7 per cent to $19,328,530. The increases for the PAHO regular budget were 12.4 per cent for 1966 reflecting increased program support for INCAP, and 9.6 per cent for 1967. For the WHO regular budget the increases were 16.2 per cent in 1966 and 9.4 per cent in 1967.

In addition to the analysis and review of the program as a whole, it was incumbent on the Directing Council to take three specific actions: (1) to appropriate funds for the PAHO regular budget for 1966; (2) to review the WHO regular budget for the Region of the Americas and make recommendations to the Director-General for the budget for 1967; and (3) to note the provisional draft of the PAHO proposed program and budget for 1967 and give such guidance as might be considered appropriate.

Dr. Portner reviewed the history of the proposal for the PAHO regular budget for 1966. It had first been presented to the Directing Council at its XV Meeting in 1964, which had noted that the plan contained "well-conceived and much-needed public health projects."[17] After consultation with Governments so as to reflect their current needs, the Director had presented the revised proposal for 1966 to the 52nd Meeting of the Executive Committee, which had made a detailed review thereof and approved Resolution II as follows:

THE EXECUTIVE COMMITTEE,

Having studied in detail the provisional draft of the Proposed Program and Budget of the Pan American Health Organization for 1966 (*Official Document 52*) and the modifications thereto appearing in Document CE52/3 prepared by the Director;

Considering that the XV Meeting of the Directing Council, in Resolution VII, noted that the provisional draft of the Proposed Program and Budget for 1966 (*Official Document 52*) comprised soundly conceived and much-needed health projects; and that it authorized the Director to increase the contribution of the Organization to the Institute of Nutrition of Central America and Panama (INCAP) by $200,000 and to include this sum in the Proposed Program and Budget of PAHO for 1966, so as to ensure the normal development of the Institute;

Considering that the modifications appearing in Document CE52/3 were made after consultation with each Government and reflect the latest known desires and requirements of Governments, with due regard to priorities of needs; and

Bearing in mind Article 14-C of the Constitution of the Pan American Health Organization and Financial Regulations 3.5 and 3.6 of the Organization,

RESOLVES:

1. To submit to the XVI Meeting of the Directing Council the Proposed Program and Budget of the Pan American Health Organization for 1966 (*Official Document 52*) and the modifications thereto appearing in Document CE52/3 prepared by the Director.

2. To recommend to the Directing Council that it establish the level of the Pan American Health Organization budget for 1966 at $8,080,000.

Dr. Portner then reviewed the detailed budget estimates, starting with the summary on page 118 of *Official Document 61*. He called attention to the figures for PAHO regular funds. The amount for Part I (Organizational Meetings) for 1966 was $236,752, an increase of $39,959, or 20.3 per cent, over 1965. That increase was attributable to the additional costs of the quadrennial meeting of the

[17] Resolution VII. *Official Document PAHO* 58, 62-63.

Pan American Sanitary Conference, as compared with the meetings of the Directing Council.

Part II (Headquarters) was concerned with the technical services and headquarters staff located in Washington. For 1966 the proposed allocation was $2,294,865, an increase of $141,821, or 6.6 per cent. That increase covered statutory staff costs, which was partly offset by a drop of one P-2 administrative officer post and one housing specialist. Of that amount, $105,771 was for changes in costs of personnel and duty travel and $36,050 was for increases in common services, as detailed on page 126, and library acquisitions. The largest increase in common services was in maintenance of premises of the new building.

Part III (Field and Other Programs), summarized on page 127, contained estimates for the Zone Offices, projects, and editorial services and publications. The estimate for that part for 1966 was $5,248,383, an increase of $733,220, or 16.2 per cent. The principal increase was in the projects, which the Director had already described and which were detailed on pages 130-217.

Parts IV and V appeared on page 218. Part IV covered the amount of $250,000 which the W. K. Kellogg Foundation had made available for the Special Fund for Health Promotion, the details of which were given in Annex 5. Part V (Increase to Assets) included the amount of $300,000 budgeted for the increase to the Working Capital Fund; there was a decrease in that Part of $25,000, which amount had represented a one-time increase in the Emergency Revolving Fund in 1965.

Dr. Portner summarized the budget by saying that there was an increase in Part I due to higher costs of holding the meeting of the Pan American Sanitary Conference, and an increase in Part II due to statutory changes in costs of posts and estimates for the maintenance of the new building; Part III contained little change in the cost estimates for the Zone Offices, the major increase of a little less than $750,000 being for projects; there was no change in Part IV; and in Part V there was a decrease of $25,000 since the Emergency Revolving Fund would not be increased again in 1966. The total amount proposed for the PAHO regular budget was $8,080,000. The resolution relating to the proposed budget was presented on page 2 of *Official Document 61* for consideration by the Council.

Mr. RIVERA (Costa Rica) asked how much of the annual increase in the budget, estimated at 10 per cent for the coming year, was intended for fixed costs and how much was for the expansion of programs, because it was possible that, either by mistake or by some oversight—and, although that seldom happened in the Bureau, the position should be made clear—the facilities or services made available to countries might not expand commensurately with the increase, especially as a result of the Bureau's transfer to the new headquarters building.

Dr. AGUILAR HERRERA (Guatemala) welcomed the proposed increase in the appropriation for INCAP and described the efforts that his Government had been making for several years, in particular to provide premises for that Institute. He recalled that, at the outset, his Government had allocated a site in Guatemala City for the construction, at a cost of $250,000, of the building currently occupied by INCAP. As the Institute's activities had expanded and the premises had become inadequate, the Government had established a fund for the construction of two further buildings, valued at $500,000, chiefly intended for the Institute's research and training services.

He reiterated Dr. Horwitz' opinion that INCAP's activities already extended beyond the boundaries of the zone for which they had been meant. For example, only 40 per cent of the training services were intended for the area of Central America and Panama, while 50 per cent were for the countries of South America and 10 per cent for other countries of the world. Moreover, the scientific research being carried out was not merely of local but also of universal benefit, which was a further reason for approving the increase requested of the Council.

With reference to the services rendered to Guatemala by PAHO under project Guatemala-3300, Public Health Laboratories, he was surprised to note that the funds for laboratory equipment had been discontinued, as indicated in the relevant agreement. Assistance for that purpose had been provided in 1965, and Guatemala had hoped that the cooperation would continue, because even on a limited scale it spurred the Government's efforts. The Government was currently organizing training courses at the local level for laboratory personnel to serve in the health centers; its budgets included laboratory posts for those centers and it was intended that that personnel should start work on 1

January 1966. The central laboratories were also being extended and, owing to the state of the premises currently occupied, orders had been given for the construction of a new building to start in January 1966. For all those reasons, he requested the Director of the Bureau not to discontinue the assistance in question.

Dr. DELVA (Haiti) congratulated Dr. Portner on the presentation of the proposed budget and pointed out that Table 6, on page 12 of the budget document, showed a substantial increase in the allotment for communicable diseases, from $4,499,771 in 1965 to $4,802,889 in 1966, or 7 per cent. He wondered whether consideration had been given to the current problem faced by his country as a result of the rise in the incidence of yaws, one of the more easily communicable diseases. Whereas only 15 cases of yaws had been recorded in the past three years, in the first six or eight months of 1965 there had been an increase which constituted an obvious danger not only for the population of Haiti but for the inhabitants of other countries of the Americas.

He therefore requested that the Council take his comments into account and authorize the Director of the Bureau to increase the Organization's contribution commensurately with Haiti's efforts, in order to completely eradicate the disease, because, as the number of cases rose and available funds diminished, there was a risk that the progress registered during the past 10 years in reducing the incidence of yaws in Haiti from 70 per cent in 1950 to 0.006 per cent through the cooperation of the Pan American Sanitary Bureau might go for nothing.

Dr. PORTNER (Chief of Administration, PASB) replied to the Representative of Costa Rica's question as to what percentage of the annual increment was assigned to the increment of fixed costs, and what proportion went for the expansion of the program of the Organization. He stated that the question had been studied carefully and that approximately 4.3 per cent was required for increased costs. The remainder of the increase in each of the years would be going into the expansion of programs including the allocation of $200,000 to INCAP.

The Representative of Guatemala had brought to attention the situation on supplies and materials for Project Guatemala-3300. As the Directing Council would recall, two grants had been received, one from two interested private citizens who wished to express their appreciation for the work of the Organization, and the other from the U. S. Agency for International Development. There had been no indication that such grants would be continued, but the Representative of Guatemala could be sure that when the budget was reviewed his remarks would be taken into consideration and, if necessary, the possibilities of continuing the project with funds from the Organization would be explored.

The Representative of Haiti had brought up the matter of continuing the allocation of funds in order to vigorously pursue yaws eradication from his country. Dr. Portner wished therefore to assure him that his request would, of course, be given careful consideration when the operating budget was prepared, in order to set up the program definitely for the next year.

Mr. CASTELLS (Uruguay) explained that Sr. Francisco Rodríguez Camusso, the Minister of Public Health of Uruguay, had been unable to attend the meeting because, at the last moment, he had been obliged to cancel his flight. Mr. Luis A. Vidal Zaglio, the Minister for Foreign Affairs, who had been in Washington at the time, had attended the inaugural session. His Government had instructed the Permanent Delegation of Uruguay to the Council of the Organization of American States, to which he himself belonged, to represent it at the meeting of the Directing Council. The Uruguayan authorities were extremely gratified to be represented at the meeting, particularly as it was the first to be held in the new headquarters building, which was the work of the outstanding Uruguayan architect, Román Fresnedo Siri.

The session rose at 11:45 a.m.

FIFTH PLENARY SESSION

Wednesday, 29 September 1965, at 3:15 p.m.

President: Dr. RAYMUNDO DE BRITTO (Brazil)

Item 9-A: Proposed Program and Budget of the Pan American Health Organization for 1966 (*conclusion*)

The PRESIDENT opened the session and granted the floor to Dr. Williams.

Dr. WILLIAMS (United States of America) described the budget as a very good one indeed, and very much in line with the needs of the areas which the Organization served. As always, his Delegation had confidence in the ability of the Director to carry out a forward-looking, intelligent, and dynamic program. He wished to congratulate him on a program well perceived, and a budget assembled with the skill they had come to expect of him and his staff.

It was with regret that the United States of America, because of the serious financial problems which had persistently beset the Organization in recent years, including the current year, found itself unable fully to support the budget proposed for 1966. It hoped that these problems would soon be resolved, but until they were its position must remain unchanged.

On the more positive side, he said, his Department had compared with interest the growth rate of individual programs in the regular budget with that of the growth rate of the budget as a whole. For instance, the expenditure on public health administration in the previous five years had shown a growth rate somewhat less than, though almost the same as, that of the regular budget and that was, of course, reasonable and proper. On the other hand, expenditure on public health nursing, though increasing somewhat irregularly, was doing so much faster than was the regular budget. That was counterbalanced by the fact that a greater proportion of PAHO regular funds, and a lesser proportion of WHO and other funds, had been devoted to that activity, and he did not believe it represented an undue or improper rate of growth.

Disappointingly, he said, the rate of growth of the environmental health program appeared considerably slower than that of the regular budget, though it was of great importance and urgency. The United States of America would prefer to see the rates more nearly paralleling each other.

In education and training, which was perhaps the core of the Organization's entire program, the growth rate was a little faster than that of the regular budget, and in his opinion that was good programming practice.

Though the Organization had an officially recognized priority for the smallpox eradication program, the line on the growth rate comparison chart fell sharply, almost leaving it, when the budget for that activity was analyzed. That program, indeed, was making rapid progress in reverse, a cause for considerable concern. In the current year most of the funds were to come from WHO, but the hemisphere-wide importance of the program seemed not to have received the budgetary recognition by PAHO which it deserved.

In the case of tuberculosis control a similar situation was noted. For the previous five years the growth rate had been slower than that of the regular budget. Though no PAHO commitment had been made for the eradication of tuberculosis, it was clearly a major health problem in most countries of the Hemisphere and justified considerable emphasis being placed upon it.

The United States was in complete accord with the Director's statements on the fundamental importance of the nutrition problem in the Americas and noted with pleasure the significant increase in funds for that purpose in 1966, including the additional sum which was to go to INCAP. The Director had underlined the fact that in Latin America as a whole during the past few years the per-capita production of food had not kept pace with the population increase. That was cause for concern, but as his Delegation had stressed on other occasions, consumption was perhaps of more importance. Staff studies had made it plain, at least in the Latin

American countries, that food consumption had increased moderately in recent years. Certainly, perhaps because of the importation of food by some countries, it had not fallen. It seemed to his Delegation that food consumption was of more importance than production levels.

Drawing attention to a policy change in the United States Food for Peace Program, Dr. Williams said that President Johnson had several times declared that malnutrition in children was currently perhaps the prime public health problem of the world. In a message to Congress on 31 March 1965, he had said: "We now recognize that food deficiencies are more serious in infants, the preschool-age, and to a lesser degree school-age children. Not only does malnutrition result in high death rates and widespread disabling diseases, but research has now established that it produces permanent retardation of mental as well as physical development."

President Johnson had further stated that about 40 per cent of his Government's economic development assistance overseas was currently given in the form of agricultural commodities, and local currencies received from the sale of them. Yet the Food for Peace Program, which had more than 70 million child participants, reached only about 15 per cent of children aged 7-14 years and fewer than 2 per cent of preschool-age children, in the recipient countries. There were currently an estimated 667 million children in the 0-14 age group in the developing free world. That number was expected to increase to 815 million by 1975. Studies indicated that approximately 70 per cent of those children were, or would be, malnourished and that 50 per cent of the group under 6 years and 30 per cent of the group 7-14 years, or a total of 269 million children, were suffering from serious malnutrition, a figure that could rise to 330 million within the next 10 years.

In a message to the overseas missions of the U. S. Agency for International Development, Mr. David E. Bell, AID Administrator, had on 1 August 1965 proposed a series of programs to combat child malnutrition, which involved the coordinated efforts of agricultural, health, industrial, and community development groups within each country. The new programs would be built around five principles: (1) increased attention to nutrition of children, especially the preschool child; (2) ensuring that all feeding programs were of maximum nutritional value; (3) feeding programs to provide for participation on an increasing scale by recipient countries; (4) maximum participation by private enterprise; (5) a comprehensive approach to the problems of malnutrition in each country, with involvement of all relevant interests. Several of those points had already been made by the Director in presenting his Report.

AID had asked its overseas missions to suggest pilot model programs that would include: (1) bolstering of food industries of most significance for the child in the host countries; (2) enrichment of locally milled grain; (3) shift of emphasis in child-feeding programs from dole-type family-feeding distribution to feeding activities through institutional channels, and encouragement of the establishment of home and school gardens; (4) technical assistance—agricultural technology, food processing, health education, home economics, child care, and dietetics; and (5) establishment of voluntary community nutrition committees. It was hoped that pilot programs could be initiated in several countries in the coming years. That would depend on the willingness of host Governments to join the United States Government and private investors in coping with what he believed was possibly the greatest single deterrent to economic development.

That major change in United States policy paralleled United Nations activities in the same field, largely carried out through FAO and UNICEF, which consisted in a global effort to increase the use of oilseed products as protein resources for humans, especially children. The Freedom from Hunger Campaign and the World Food Program had awakened the interest of many Governments in the real food issues. UNICEF's program of fortification of foods, encouragement of the development of local industries, food processing improvement, and nutrition education served as a model for all. At the Third Inter-American Seminar on Child Feeding ("Operation Niños"), held in June 1965 in Petrópolis, Brazil, Mr. Herbert J. Waters, AID Assistant Administrator for Material Resources, had stated that any major lasting improvement in nutritional levels in developing countries would require both change in dietary habits and an ability to secure local nutritionally adequate food. To encourage the involvement of private enterprise in the development and marketing of formulated foods, Mr. Waters had suggested tax exemptions to small in-

dustries that developed low-cost nutritional food; the enforcement of practices designed to reduce food wastage; reduced rates in government-owned transportation for high priority nutritional food products; and lowering of import duties on special equipment necessary for those new food industries. Modern food and nutrition programs, Dr. Williams said, reflected a growing awareness of the relationship between malnutrition and social and economic development. As AID had told its missions: " . . . the shortened life, decreased resistance to infectious disease, impaired physical and mental growth, and decreased productive capacity, may gravely impede social and economic development."

A subject of long-standing debate had been the relative priorities that were to be afforded specialized or categorical programs, as distinct from what might be termed generalized programs. It appeared to the United States of America that the former must be relied upon to push forward the frontiers of world health. Certainly, in the United States most of the health gains which were demonstrable were clearly traceable to such campaigns as that to eradicate malaria, that initiated against venereal disease by Dr. Thomas Parran in the thirties, and that begun in the forties to control tuberculosis. The same was apparently true of various other countries. The specialized or categorical programs might be termed the "forefront" or "pushing type," and the generalized programs the "holding type," though both must co-exist in proper proportion. He would like to see in PAHO more of the frontier-pushing type programs, which he believed to be at the moment more suited to the Americas than the generalized type. Latin America was a very dynamic region, a region on the march, and programs which would improve health status rapidly were to be preferred. Thus malaria eradication, smallpox eradication, water supply improvement, *Aedes aegypti* eradication, and yaws eradication were of the type of program which might well be given increasing priority in future budgets.

In defining "priority," Dr. Williams said that the mere adoption of a resolution by PAHO on the eradication of malaria, smallpox, or yaws, for example, seemed of itself to create a strong priority for action in the particular field. To the extent possible, it would be wise to depend more heavily upon the regular budget for the carrying out of programs which had been agreed to be of high priority, rather than on less stable voluntary-type sources of funds.

He hoped there would be no apprehension that what he had said was a preamble to the reduction or elimination of voluntary contributions made by the United States of America to the carrying out of certain programs. His statement had been rather one of principle which he hoped would be of some value to the Director and his staff.

Dr. QUIRÓS (Peru) said that he agreed with some of the remarks made by Dr. Williams. He was surprised that the budgetary appropriations for the campaign against diseases such as plague and smallpox were smaller than required. He referred in that connection to the items included in Annex 7 (page 245) of *Official Document 61* and remarked that there was no provision for staff costs and supplies for Project AMRO-0307 (Seminar on Smallpox Eradication) nor for staff costs for Project Ecuador-0900 (Plague Control). At the Eighteenth World Health Assembly, during the discussion of the budget, he had pointed out something similar, for among the programs that could not be carried out because of the lack of funds was one for $30,000 for plague, which was to have been carried out jointly by Peru and Ecuador. For that purpose, an agreement had been signed by the Governments of both countries, which were aware of the international importance of the problem. Plague was not only ravaging the forest areas but also invading other regions; it constituted a serious danger which could have far-reaching economic repercussions for Ecuador and priority should therefore be given to taking the necessary action.

The malaria eradication program was being financed from a special account, with voluntary contributions and some funds provided by WHO, but no figure was included for that program in the proposed budget of the Pan American Health Organization. On the other hand, the pledge made by Dr. Williams on behalf of the Government of the United States of America that that country would continue to contribute to the antimalaria campaign was reassuring. It would be useful to know the Bureau's plans for financing that program until its completion, since, in his view, its implementation was unduly prolonged.

He agreed with Dr. Williams' opinion that it was better, both at the international and the national level, to embark on a small number of programs and to ensure that they produced the

optimum results rather than to launch a large number of them without obtaining the desired effect. By way of example, he cited the case of his own country, in which there were numerous health services which were unable to delve deeply into their problems in order to find a solution. It therefore seemed necessary to focus efforts on three or four programs and to provide them with the necessary economic and human resources, so that their results could be of genuine benefit to the population. As an illustration he mentioned the so-called "simplified medicine" program being undertaken by the Government of Venezuela. He considered that it had been realistically conceived with the regard to health priorities.

Dr. CASTILLO REY (Venezuela) said that he appreciated the interest shown by the Bureau in steadily improving the presentation of its budget in order to tackle the health problems of the various countries with increasing efficiency. Dispersal of effort should be avoided and a balance should be maintained, having regard to the requests from Governments, in order to more effectively utilize resources for very specific programs that would rapidly raise the level of health by controlling communicable diseases that were still widespread in the countries of the Americas. He referred to smallpox and venereal diseases, which were on the increase again, and stressed the need to expand the health services in rural areas.

He then passed to the problem of malnutrition, especially as reflected in the mortality of infants under five years of age.

With respect to environmental sanitation, he said that the greatest possible emphasis should be laid on the development of water supply and sewage disposal programs, with the cooperation of Governments and the assistance of international financing agencies. Industrial hygiene problems arising in the developing countries as the result of the stage of industrialization they had reached should also be studied.

Dr. PERAZA (Honduras) considered that one of the vital problems for the countries of the Americas was malnutrition and he stressed the importance of the work of the Institute of Nutrition of Central America and Panama. He suggested that Dr. Moisés Béhar, Director of INCAP, who was present at the meeting, be invited to report on the activities and financing of the Institute, which was worldwide in scope.

Dr. FERREIRA (Brazil) remarked that the Organization's proposed budget which was under discussion showed a rise of 12.4 per cent over the previous financial year, a fact which the various Governments should bear in mind with a view to increasing, in their turn, their national health budgets. The increase recommended to the Directing Council, though small, would make it possible to enlarge the scope of fundamental programs such as those concerned with communicable diseases, rural endemic diseases, and infant mortality. It was incumbent on the countries to take the initiative in extending the Bureau's activities to new fields, and that would necessitate greater assistance from Governments for the purpose of strengthening the Organization. He then referred to the contribution which they should make in order to keep the Organization operational.

Dr. BÉHAR (Director, INCAP) outlined the activities carried out by the Institute over the past 16 years in cooperation with the Governments of the six countries of the Central American Isthmus. The Institute was a technical organization whose main purpose was to advise Governments on nutrition problems. INCAP, with the cooperation of the Bureau, of other international bodies, especially UNICEF, and of official bodies and private foundations of the United States of America, had succeeded in building up a group of professionals highly skilled in the various disciplines connected with nutrition, including agriculture, animal feeding, economics, biochemistry, social sciences, anthropology, education, and public health.

INCAP was concerned about the problem of food production. It was one that could be solved if countries gave high priority to agricultural development programs capable of satisfying the minimal nutritional requirements of their inhabitants without resorting to imports. Importing should be regarded only as an interim measure to deal with an emergency and it usually had dangerous economic implications. INCAP was striving to increase the output of foodstuffs which contained protein and would provide the populations with vitamins.

In addition to the question of production, there was also the problem of consumption, which was affected by educational factors connected with feeding habits and dietary practices and also by eco-

nomic factors. INCAP was trying to extract the maximum benefit from the local supply potential available in each area and to persuade the inhabitants to make proper use of the products accessible to them and thus to avoid intestinal disorders, diarrhea, which was so prevalent among children, and parasites. The research undertaken by INCAP was focused on those three aspects—local supply potential, consumption, and utilization of foodstuffs. The Institute also provided advisory services and staff training facilities.

INCAP had very limited resources (its current budget was approximately $1,300,000, of which almost $1,000,000 consisted of grants from foundations or official agencies of the United States of America). Those grants were largely used for research work, much of it in the field, but there was a shortage of the outside assistance necessary for the advisory and training programs. It was important to increase the resources for the latter programs, but not at the expense of the funds required for research.

The research carried out by INCAP was also used by the other countries of the Americas and still others outside the Hemisphere, which also used the technical training facilities, as could be seen from the number of fellows attending the Institute: of 551 fellows, 217 came from the six countries of the Central American Isthmus which were members of the Institute; 284 came from other countries of the Americas, as follows: Argentina 27, Bolivia 19, Brazil 23, Canada 1, Chile 11, Colombia 39, Cuba 1, Dominican Republic 3, Ecuador 18, Haiti 3, Jamaica 5, Mexico 10, Paraguay 6, Peru 11, Surinam 1, Trinidad 1, United States 84, Uruguay 8, Venezuela 13; and 50 from other countries situated outside the Hemisphere in Africa, Asia, or other parts of the world.

As regards publications, INCAP had, during the past five years, distributed in the countries of the Americas some 159,000 copies of technical publications bearing on subjects relevant to its field of activity.

Lastly, he emphasized the shortage of the funds available to INCAP for its own development.

Dr. PICHARDO (Dominican Republic) said that the problem of parasitosis was extremely serious in many countries and he urged that a solution should be found. It would be useless to provide adequate nutrition for people while their bodies were infested with parasites. He welcomed Dr. Béhar's report on INCAP.

Dr. QUIRÓS (Peru) expressed his country's gratitude to INCAP, whose work was not only useful to Central America—which, with the organization of INCAP and with its common market, provided a striking example of what regional planning should be—but also a model of international planning. In due course he would prepare a draft resolution congratulating the Governments of Central America and Panama on their brilliant initiative and thanking them for their cooperation.

Dr. HORWITZ (Director, PASB) said that he was gratified at the course taken by the discussion, which would serve as a guide for the future work of the Organization, and he thanked Dr. Williams, the United States Representative, for his commendation of the management of the Bureau.

The focal point of the discussion had been the efforts made to determine whether the Bureau would replace Governments in discharging their functions or should supplement action by Governments when the latter so decided. He referred, by way of example, to the smallpox question and observed that since 1950, if not before, the Organization had been cooperating with Governments in the eradication of that disease; it had invested approximately $1 million of its budget in the relevant campaign, but the fact that there currently existed, in a population of 420 million, a maximum of 7,000 cases of smallpox in a given year, was to some extent indicative of the magnitude of the task accomplished. During the past year, 20 per cent of the population of Latin America had been vaccinated and, in order to eliminate that disease; it was essential to intensify systematic vaccination. The Council should decide whether the Bureau was to use funds to pay local staff because, apart from transport and the jet-injector vaccination system, he failed to see in what other way the Organization could be of assistance.

The current allotments were small because they were intended to supplement the programs, and it would be interesting to study the correlation between national and international funds in respect of a given program, which would show to what extent the Organization could decrease its contributions once Governments reached a certain level of self-sufficiency in carrying out a campaign. That would enable the Organization to earmark larger

amounts for the new activities requested by Governments.

In that connection, he endorsed the views expressed by various representatives to the effect that the amount appropriated by the Bureau to combat communicable diseases was small. He also referred to other programs of interest to Governments, stressing that the Bureau carefully complied with the instructions of the Governments. He trusted however, that time would show that the well-balanced course followed by the Bureau was the logical one.

He invited the representatives to examine Table 6 (*Official Document 61*, page 12) and to note that 35.6 per cent of the budget was for Communicable Diseases and Environmental Health, 35 per cent for Health Promotion, 10.8 per cent for Education and Training, and 4.6 per cent for Program Services. Those were direct technical services, accounting *in toto* for 86 per cent, and he wondered whether the 35 per cent included in that percentage—i.e., more than 40 per cent of the cost of the program for the four groups as a whole—which was allocated to the item for communicable diseases and environmental health, could be considered a low figure. It should be added that 16 per cent of the total budget would be allocated to malaria. It should not be forgotten that eradication campaigns were not effective unless, at the same time, the general services were improved; it was for that reason that the aforesaid percentages were assigned to Health Promotion and to Education and Training.

He promised that he would carefully study Dr. Williams' comments on the budget in order to make whatever future adjustments were advisable.

Latin America had already passed through the stage of the great quarantinable diseases which had decimated its populations; the incidence of those diseases was negligible, particularly when compared with the situation 20, 30, or 40 years before. As the countries developed, new health services would be established, and in that connection he referred to a statement [1] made by the Delegate of Peru at the Seventeenth World Health Assembly concerning the proposed highway skirting the forest region, in which that Delegate had emphasized the need to incorporate such health services in a typical development project. In his opinion, to incorporate health services was tantamount to incorporating, in development projects, campaign services when that was necessary and definitive services where appropriate.

He believed that the thoughts which had arisen in the minds of representatives during the consideration of the proposed program and budget would serve as a basis for a careful review in the future of the details of the program as a whole, in the light of requests from Governments.

As regards the statement that the Bureau did not allocate any of the funds in its regular budget to malaria, he referred the Council to page 224 of *Official Document 61* (Summary of Projects by Fund and Major Subject) and pointed out that the amount of $1,713,492, consisting of voluntary contributions from Governments, especially from the United States Government, was included for 1966. The three remaining items of $324,084, $684,596, and $86,105 were regarded as contributions from the Bureau's regular budget and amounted to approximately $1,000,000. The $684,596 were from the WHO Malaria Eradication Special Account and had been paid, although the amount for 1967 would not be known until the negotiations with the Headquarters in Geneva had been concluded, but it was expected to be substantial. Page 124 of the same document showed the figure of $185,212, for 1966, for the Malaria Eradication Branch, an amount that came from the regular budget. That meant that for the next year approximately $1,200,000 had been appropriated from that budget for the malaria campaign.

He thanked the Government of the United States of America for deciding, as explained by Dr. Williams in the Council, not to reduce its contributions for malaria eradication.

Lastly, he drew attention to the figures in Annex 7, page 245 (projects requested by Governments and not included in the preliminary draft of the Proposed Program and Budget of PAHO/WHO for 1967) and referred to project Ecuador-0900 (Plague Control) and project AMRO-0300 (Smallpox Eradication), adding that in the footnote to page 249 of the same document it was explained that those items referred to part of the program which exceeded the amount budgeted. Hence there was a plague control program and a smallpox eradication program for the coming year. He recalled that, when presenting the Annual Report, he had stated that the incidence of plague had risen

[1] *Off. Rec. Wld Hlth Org.* **136, 164-165.**

by 50 per cent between 1963 and 1964 and that, so far as the budget permitted, the possibilities were being explored of increasing PAHO assistance to Peru and Ecuador, under the fund transfer arrangement available for emergencies, which of course did arise because the budget was prepared two years in advance.

He stressed the fact that, although the Organization's funds came from such a variety of sources and the budget was extremely complicated to prepare because there were 26 participating Governments, in 1964 there had only been a very slight discrepancy between the estimates, based on anticipated income, and the amounts actually collected.

Dr. SUTTER (Assistant Director, PASB), at the President's request, read the draft resolution on the Proposed Program of the Pan American Health Organization for 1966.

The PRESIDENT then put the draft resolution to the vote.

Decision: By 21 votes in favor, none against, and one abstention, it was agreed: [2]

1. To appropriate for the financial year 1966 an amount of $8,080,000 as follows:

Purpose of Appropriation	
Part I: Pan American Health Organization Organizational Meetings	$ 236,752
Part II: Pan American Health Organization Headquarters	2,294,865
Part III: Pan American Health Organization Field and Other Programs	4,998,383
Part IV: Pan American Health Organization Special Fund for Health Promotion	250,000
Part V: Pan American Health Organization Increase to Assets	300,000
Total—All Parts	$8,080,000

2. That the appropriation shall be financed from:

a) Assessments in respect to:	
i) Member Governments assessed under the scale adopted by the Council of the Organization of American States in accordance with Article 60 of the Pan American Sanitary Code	$7,930,000
ii) Jamaica (based on assessment of those Member Governments having comparable size and per-capita income)	23,790
iii) Trinidad and Tobago (based on assessment of those Member Governments having comparable size and per-capita income)	23,790
iv) France (Resolutions XV and XL of the V Meeting of the Directing Council)	12,760
v) Kingdom of the Netherlands (Resolutions XV and XL of the V Meeting of the Directing Council)	9,497
vi) United Kingdom (based on assessment of those Member Governments having comparable size and per-capita income)	23,790
b) Miscellaneous Income	56,373
Total	$8,080,000

3. That in accordance with the Financial Regulations of the Organization, amounts not exceeding the appropriations noted under paragraph 1 shall be available for the payment of obligations incurred during the period 1 January to 31 December 1966, inclusive.

4. That the Director shall be authorized to transfer credits between parts of the budget, provided that such transfers of credits between parts as are made do not exceed 10 per cent of the part from which the credit is transferred. Transfers of credits between parts of the budget in excess of 10 per cent may be made with the concurrence of the Executive Committee. All transfers of budget credits shall be reported to the Directing Council.

The session was suspended at 4:20 p.m. and resumed at 4:55 p.m.

Item 9-B: Proposed Program and Budget of the World Health Organization for the Region of the Americas for 1967

Dr. PORTNER (Chief of Administration, PASB), in introducing for consideration the WHO regular budget proposals for 1967, called attention to page 118 of *Official Document 61* and read the gross amounts of the WHO estimates for 1965, 1966, and 1967. He pointed out that the Council should make recommendations on the proposal of $4,156,000 for 1967. That amount represented an increase of $355,900 over the 1966 budget, a rise of 9.4 per cent.

He then reviewed the budget by parts. In Part I (Organizational Meetings) the 1967 decrease of $13,997 was related to the reduction in Part I of the PAHO budget, which had been discussed earlier and which was attributable to variations in costs of meetings; the 1966 meeting would be the more expensive Pan American Sanitary Conference, held

[2] Resolution V. *Official Document PAHO* **66**, 58-60.

every four years, and the 1967 meeting would be that of the Directing Council.

For Part II (Headquarters) the amount proposed for 1967 was $1,252,894, an increase of $37,542 over 1966 (3.1 per cent). The increase was attributable to incremental costs and to the WHO portion of the maintenance of the new headquarters building.

Part III (Field and Other Programs) totaled $2,821,531, an increase of $332,355 (13.4 per cent) over the previous year. The only significant increase was for projects, which the Director had already described when he presented the program for PAHO. Dr. Portner also explained that footnote 1 on page 127 needed clarification. The WHO/ regular amounts for 1965 were $2,041,832; for 1966, $2,489,176; and for 1967, $2,821,531. The summary on page 127 included the total funds made available by WHO. Details of these funds were to be found on pages 118 and 241.

In summary, the total for 1967 amounted to $4,156,000, a rise of $355,900, of which the basic increase was in projects.

Dr. SUTTER (Assistant Director, PASB) read the draft resolution on the topic.

Decision: It was unanimously agreed to approve the Proposed Program and Budget of the World Health Organization for the Region of the Americas for 1967, contained in *Official Document 61*, and to request the Regional Director to transmit it to the Director-General so that he might take it into consideration when preparing the WHO budget for 1967.[3]

Item 9-C: Provisional Draft of the Proposed Program and Budget of the Pan American Health Organization for 1967

Dr. PORTNER (Chief of Administration, PASB), in introducing the provisional draft of the proposed program and budget of PAHO for 1967, contained in *Official Document 61*, said that it would be reviewed in detail by the 54th Meeting of the Executive Committee in the spring of 1966.

For Part I (Organizational Meetings) of the PAHO proposal for 1967, the total amount was for $208,567, a decrease of $28,185 (11.9 per cent) from the 1966 estimates. The decrease was due to the lower costs of holding a Directing Council meeting instead of the quadrennial Pan American Sanitary Conference scheduled for 1966.

For Part II (Headquarters) the total amount was $2,412,091; the increase of $117,226 (5.1 per cent) over the 1966 estimates was attributable to $30,000 estimated for temporary personnel to provide for the possible need of additional staff after one year's experience in the new headquarters building. Exact requirements are not yet known but an increase was anticipated for operation of a machine room, parking facilities, and other services the cost of which had not yet been clearly defined, $20,252 in maintenance of premises, contractual services, and equipment replacement, and the remaining $66,974 in recostings and statutory increases in personnel costs.

The figure for Part III (Field and Other Programs) was for $5,935,022, a rise of $686,639 (13.1 per cent) over the 1966 estimates. There was essentially no change for the Zone Offices ($10,051; 2.0 per cent increase related primarily to statutory changes in personnel costs) and for the editorial services and publications ($10,588; 4.2 per cent increase related to statutory changes in personnel costs and a $6,000 increase in Special Publications). The major portion of the increase, $666,000 (14.8 per cent), was for projects in accordance with program activities described earlier by the Director.

There was no change in Part IV (Special Fund for Health Promotion) or in Part V (Increase to Assets).

Dr. WILLIAMS (United States of America) said that it had not been the practice of the Directing Council to approve the budget for the year following that next ahead. That budget was ordinarily considered, of course, at the following meeting. The practice of making available the budget for study six or seven months in advance of its detailed consideration by the spring meeting of the Executive Committee was an excellent one and much appreciated. However, as Chairman of the Executive Committee, he was acutely aware that during the last two or three years the Committee's agenda had become so laden that its examination of the budget had been directed more to the changes which the Director had suggested since the previous Directing Council meeting than to its line by line details. He wished to propose a resolution which would remind the Executive Committee that the

[3] Resolution VI. *Official Document PAHO* 66, 60.

Directing Council was depending on it to make a specific and careful examination of the budget.

Dr. Williams then offered a draft resolution on the subject.

The PRESIDENT announced that the draft resolution presented by the Representative of the United States of America would be translated and distributed among the representatives for consideration at the next session.[4]

Item 10: Report on the Collection of Quota Contributions

Dr. PORTNER (Chief of Administration, PASB) presented Document CD16/26 and Addendum I [5] on the current status of the quota contributions. He then gave the percentages of collections to date: 45.7 per cent of current quotas had been paid as compared with 43.4 per cent at the same time the previous year. Collections of arrearages amounted to 27.6 per cent, as compared with 34.2 per cent for the same period in 1964, not counting the late payment of $1,000,000 representing a quota for 1963 received in January 1964.

Dr. Portner reported that the Director had brought Resolution IV [6] of the 52nd Meeting of the Executive Committee to the attention of the respective Governments and had followed-up through the Zone Offices and Country Representatives to stimulate payment. With respect to countries in arrears more than two years, considerable progress had been made. By the time of the Directing Council meeting one country had made sufficient payments to emerge from that category. Of the five countries remaining in that group, three had established plans for payment within a definite period, and a fourth was in the process of doing so. Consultations with the fifth country had been undertaken, but there were no definite results to be reported.

Dr. CASTILLO REY (Venezuela) read the following draft resolution:

THE DIRECTING COUNCIL,

Having considered the report on the collection of quota contributions (Document CD16/26 and Addendum I), as well as the information and comments on quotas contained in the Financial Report of the Director and the Report of the External Auditor for 1964 (*Official Document 59*);

Bearing in mind that the XV Meeting of the Council, acting on a recommendation of the 50th Meeting of the Executive Committee, adopted an amendment to Article 6 of the Constitution of the Pan American Health Organization providing for suspension of voting privileges for failure to meet financial obligations to the Organization; and

Considering the importance of the prompt and full payment of quota contributions to assure financial support of the entire approved program,

RESOLVES:

1. To take note of the report on the collection of quota contributions (Document CD16/26 and Addendum I) and of the information and comments on quotas contained in the Financial Report of the Director and the Report of the External Auditor for 1964 (*Official Document 59*).

2. To commend the Director for his efforts to obtain settlement of the outstanding arrearages and to request his continued efforts to have quotas paid on a current basis.

3. To express its concern, nevertheless, over the continuing serious quota situation, especially the arrearages of more than two years standing.

4. To recommend that the Director continue to keep the Governments amply informed of the status of quota payments and of the implications of non-payment on the prosecution of the program of the Organization.

5. To urge the Governments whose arrearages would bring them within the loss-of-vote provision of Article 6-B of the Constitution of the Pan American Health Organization, to pay their quota arrears as soon as possible in order to assure the full participation of all Governments, which is so vital to the work of the Organization.

Decision: The draft resolution was unanimously approved.[7]

The session rose at 5:55 p.m.

[4] See p. 73.

[5] Mimeographed documents.

[6] *Official Document PAHO* **62**, 30-31.

[7] Resolution VIII. *Official Document PAHO* **66**, 61-62.

SIXTH PLENARY SESSION

Thursday, 30 September 1965, at 9:10 a.m.

President: Dr. JUAN JACOBO MUÑOZ (Colombia)

Item 9-C: Provisional Draft of the Proposed Program and Budget of the Pan American Health Organization for 1967 (*conclusion*)

The PRESIDENT called the session to order and announced that the draft resolution submitted by the United States of America would be read.

Dr. SUTTER (Assistant Director, PASB) read the following draft resolution:

THE DIRECTING COUNCIL,

Having reviewed *Official Document 61*, presented by the Director of the Pan American Sanitary Bureau, which contains the provisional draft intended to constitute the basis for the preparation of the Proposed Program and Budget of the Pan American Health Organization for 1967, to be submitted to the 54th Meeting of the Executive Committee;

Noting that this provisional draft contains soundly conceived and much needed health projects; and

Taking into account the provisions of Regulations 3.4 and 3.5 of the Financial Regulations of the Pan American Health Organization,

RESOLVES:

1. To thank the Director for the provisional draft of the Proposed Program and Budget of the Pan American Health Organization for 1967, contained in *Official Document 61*.

2. To request the Director, in submitting the Proposed Program and Budget of the Pan American Health Organization for 1967 to the 54th Meeting of the Executive Committee pursuant to Article III of the Financial Regulations of PAHO, to give due consideration to the resolution and recommendations adopted by the XVI Meeting of the Directing Council, in accordance with established priorities.

3. To request the Executive Committee at its 54th Meeting, in considering the Proposed Program and Budget presented by the Director of the Bureau, pursuant to Chapter IV of the Constitution of the Pan American Health Organization, to conduct a careful and thorough examination and review of the provisional draft, and to submit a report with recommendations to the XVII Pan American Sanitary Conference.

4. To request the Director to consult with Governments in the preparation of the Proposed Program and Budget for 1967.

Dr. WILLIAMS (United States of America) stated that the proposed resolution read by Dr. Sutter was that agreed upon by the Delegation of the United States of America, with certain minor changes which had been suggested by members of the Secretariat. However, he would like to suggest that the first paragraph of the preamble begin with the words: "Having noted *Official Document 61* . . ."

Decision: By 17 votes in favor, none against, and one abstention, the proposed resolution was approved with the amendment suggested by the Representative of the United States of America.[1]

Item 24: Resolutions of the WHO Executive Board and the World Health Assembly of Interest to the Regional Committee

Dr. CUTLER (Deputy Director, PASB), in introducing Document CD16/9 and Addenda I and II,[2] reviewed the series of resolutions adopted by the WHO Executive Board at its Thirty-Fifth[3] and Thirty-Sixth Sessions[4] and by the Eighteenth World Health Assembly[5] of interest to the Regional Committee for the Americas. He stated that the presence at the meeting of the Director-General of WHO, Dr. M. G. Candau, and of the Assistant Director-General, Mr. Milton P. Siegel, was most fortunate in that they would be able to make whatever further comment they deemed necessary on those resolutions.

The report mentioned in Resolution WHA18.3[6] (Development of the Malaria Eradication Program) would be considered in detail when the Directing Council discussed that item. However, from the point of view of the progress of malaria eradication throughout the world, it was of par-

[1] Resolution VII. *Official Document PAHO* **66**, 60-61.
[2] Mimeographed documents.
[3] *Off. Rec. Wld Hlth Org.* **140.**
[4] *Off. Rec. Wld Hlth Org.* **145.**
[5] *Off. Rec. Wld Hlth Org.* **143.**
[6] *Ibid.*, pp. 1-2.

ticular importance to note that about 52 per cent of the population originally in the malarious areas was currently living in regions where malaria had been eradicated. The Eighteenth World Health Assembly,[7] in reviewing the situation, had again called attention to the fact that in those countries where pre-eradication programs were under way Governments should give priority to the development of a network of rural health services to sustain the malaria eradication programs. The resolution also emphasized the importance of continuing multilateral and bilateral assistance for the training of personnel and the provision of supplies. Finally, it was stressed that, once eradication had been completed, the Governments of the countries concerned should take the necessary steps to ensure the collaboration of all medical and health personnel in maintaining vigilance against the re-establishment of the disease.

In adopting Resolution WHA18.33[8] (Fourth General Program of Work Covering a Specific Period, 1967-1971), the Assembly had approved the general program of work for that period. Dr. Cutler stressed the fact that the general principles which had guided the previous three programs had been maintained in the fourth. In particular, attention had been given to the need for strengthening national health services; for increasing professional and technical education; for strengthening measures for the maintenance of control of communicable diseases; and for working toward more effective control of the major communicable diseases in those areas where they still existed. The Assembly had taken note of the importance of medical research and of the coordination of health programs and activities with other social and economic programs. It had also pointed out the Organization's increasing responsibilities for cooperating with a growing number of Member Governments. It had laid emphasis on the importance of national health planning and reiterated the need for achieving the eradication of malaria and for recognizing the growing importance of the non-communicable diseases, even in those nations in the early developmental stage. Environmental health was also given special attention and, finally, the importance of research on problems of a world-wide character was stressed.

With respect to Resolution WHA18.31[9] (Voluntary Fund for Health Promotion; World Health Foundations), the speaker said that the Assistant Director-General of WHO would later discuss the matter.

As to Resolution WHA18.37[10] (Organizational Study of the Executive Board: Methods of Planning and Execution of Projects), the Assembly had emphasized the importance of WHO's playing an active role in the development of requests for projects and in their planning. A detailed study[11] had been made of the causes of delays in starting projects, and suggestions had been given as to measures which the Director-General might take for reducing such of the delays as were within the control of the Organization. Finally, the resolution called attention to the relationship between the effectiveness of the Organization's assistance and the readiness of Governments to carry out their share of the responsibility for WHO-assisted projects, including the provision of adequate staff and work facilities.

In Resolution WHA18.38[12] (Smallpox Eradication Program) the Assembly had taken note of the fact that the Director-General had estimated that smallpox might be eradicated within 10 years with an international expenditure estimated to be between 23 and 31 million dollars, in addition to the budgeted expenditures of the countries themselves. It had then declared that the world-wide eradication of smallpox would be one of the major objectives of the Organization and requested that the Member States give the program greater support than in the past and provide the substantial contributions essential for its execution. It had requested that those Governments which carried on bilateral programs of aid include smallpox eradication in their programs, and once again recognized the importance, in that particular area, of establishing the basic health services fundamental for undertaking and maintaining the eradication of smallpox. From the point of view of the financial requirements, the Assembly had also requested the Director-General to seek anew the necessary financial and other resources needed to achieve the world-wide eradication of smallpox. The question would be considered by the Directing Council when it dealt with that agenda item.

[7] *Off. Rec. Wld Hlth Org.* **144**, 49.
[8] *Off. Rec. Wld Hlth Org.* **143**, 20-21.
[9] *Ibid.*, p. 20.
[10] *Ibid.*, p. 23.
[11] *Off. Rec. Wld Hlth Org.* **140**, 115-146.
[12] *Off. Rec. Wld Hlth Org.* **143**, 24.

Resolution WHA18.48 [13] (Amendments to Article 7 of the Constitution) had been the subject of a great deal of debate. The final proposed amendments to the WHO Constitution had been circulated to the Member Governments for consideration and appropriate action.

With reference to Resolution WHA18.36 [14] (Quality Control of Pharmaceutical Preparations), Dr. Cutler drew attention to the report which appeared as Addendum II, Annex II, to Document CD16/19, entitled "An International Pharmaceutical Control Laboratory,"[15] which had been prepared by a consultant of the Organization and had been distributed to the members of the Directing Council.

The Eighteenth World Health Assembly resolution had reviewed the report of the Director-General on that matter and noted that large parts of the world population used pharmaceutical preparations without having in their countries adequate facilities for quality control. Therefore, it had invited the Governments to take the necessary measures to subject pharmaceutical preparations, imported or locally manufactured, to adequate quality control, and requested the Director-General to continue to assist Member States to develop their own laboratory facilities or to secure access to such facilities elsewhere, and to study methods of securing, in the countries of origin, control of the quality of pharmaceutical preparations intended for export. The Director-General had also been requested to pursue the establishment of internationally accepted principles and specifications. The appended report provided recommendations and a plan for the establishment of the type of laboratory called for in the WHO resolution, which would serve not only as a reference laboratory but also as a training center for scientists who would serve in national laboratories.

Finally, Resolution WHA18.49 [16] (Program Activities in the Health Aspects of World Population Which Might Be Developed by WHO) requested the Director-General to develop further the program proposed in the Document A18/P&B/4,[17] in the fields of reference services, studies on medical aspects of sterility and fertility control methods, and health aspects of population dynamics, as well as in the field of advisory services, as outlined in his report, on the understanding that such services were related, within the responsibilities of WHO, to technical advice on the health aspects of human reproduction and should not involve operational activities.

Mr. SIEGEL (Assistant Director-General, WHO) referred first to Resolution WHA18.31 [18] (Voluntary Fund for Health Promotion: World Health Foundations), dealing with nongovernmental financial support of health activities. He was very pleased to be able to report to the meeting that the Director-General of WHO had been requested by the Seventeenth World Health Assembly [19] to study ways and means of developing a system of nongovernmental support, with the aim of supplementing, but not supplanting, the governmental resources available to enable the Organization to carry out its services of assistance to Governments. As a result of the study the Director-General had proposed to the Executive Board and to the World Health Assembly the establishment of national World Health Foundations with both nonprofit and nontaxable status, for the purpose of enlisting support from nongovernmental sources, i.e., commercial organizations and other types of foundations, in order to obtain supplemental financial resources for the Organization. The concept was to establish a system of multinational World Health Foundations and a Federation of National Health Foundations with headquarters in Geneva. In three countries—the United States of America, the United Kingdom, and Switzerland—national World Health Foundations were in various stages of development and the aim was to have them become operational early next year. It was of interest to mention that the organizing meeting of the Board of Directors of the United Kingdom Foundation had taken place the previous week, and that it was expected that before the end of the year they would be in a position to initiate operations. Of course it would not be practical to expect that large sums would immediately become available as a result of that arrangement, but it was hoped that, if handled carefully and aimed at long-term objectives, such

[13] *Ibid.*, p. 32.
[14] *Ibid.*, pp. 22-23.
[15] Mimeographed document.
[16] *Off. Rec. Wld Hlth Org.* **143**, 35.
[17] *Ibid.*, p. 153-160.
[18] *Ibid.*, p. 20.
[19] Resolution WHA17.19. *Off. Rec. Wld Hlth Org.* **135**, 9.

an arrangement would bring some lasting effects to the Organization in the future.

Dr. QUIRÓS (Peru) said that, among the WHO resolutions enumerated in the document presented by Dr. Cutler, Resolution WHA18.33, on the Fourth General Program of Work for the period 1967-1971, was especially important because it expressed the earnest desire of all the Member States of the World Health Organization as well as of PAHO to ensure that the relevant priorities were established in the programs and that a plan was prepared in the light of those priorities which would make it possible to pursue a policy in accordance with each country's requirements. He recalled that he had had occasion to suggest an amendment to that resolution which unfortunately had not been adopted. He emphasized the importance of the WHO's efforts to formulate a long-term plan which would make it possible to know the future trends of the general program of work.

He then spoke of the smallpox eradication program. It had been said that the progress of the program gave no grounds for concern inasmuch as the Organization had been working on it since 1950, that well-known procedures were being applied and there were adequate supplies of vaccine, and that the program was therefore the exclusive responsibility of Governments. However, he believed that it was necessary to emphasize, even if the general arrangements were acceptable, that the Organization, in addition to providing technical advisory services to countries, was obliged to bring to the attention of Governments the need to implement certain programs which were vital not only to the Americas but to the world at large. Therefore, along with the technical advisory services, there should be a service for arousing the Governments' interest in solving certain problems which had no reason to exist any longer. That point had been brought out by the Eighteenth World Health Assembly when, in paragraph 6 of its resolution [20] on the subject, it had requested "the Director-General to seek anew the necessary financial and other resources required to achieve world-wide smallpox eradication, with special reference to resources that might be made available through voluntary contributions and bilateral programs, as well as through programs such as those of UNICEF and the United Nations Expanded Program of Technical Assistance." The Pan American Health Organization should follow exactly the same course in respect of the Hemisphere and press for the resources required to eliminate smallpox, which was an international problem as well as one of the Organization's main concerns.

With regard to the resolution [21] on the program activities in the health aspects of world population which might be developed by WHO, the subject was, in his view, a matter to which PAHO should devote more attention. It was a source of concern throughout the world, but it should not be studied, as it had frequently been, by being immediately placed in the context of birth control. He reiterated the statement he had made previously at the meeting, to the effect that, although those who were working to improve health and well-being were reproached, in a manner of speaking, for contributing to the increase in the world's population—a problem which, in his view, would become almost insolvable in the future—the least that could be done was to show serious interest in it and study all its aspects until the facts of the matter were clear. Although he considered that reproach to be unjustified, they were duty bound to study the problem of population dynamics in order to help clarify it to the satisfaction of all. In view of the fact that at its XV Meeting held in Mexico City the Council had adopted a resolution [22] recommending that the subject should be taken up, it was essential to stress the need for intensifying the relevant studies.

Dr. WILLIAMS (United States of America) said that his Delegation wished to offer some comments on two of the resolutions of the Eighteenth World Health Assembly. Although the item on smallpox would be considered later in the agenda, he wished to state that Resolution WHA18.38 adopted by the Assembly on that matter was most satisfactory. It clearly stated the intention of the nations of the world to get on with the job of eradicating smallpox. It emphasized that the eradication of smallpox was a high-priority objective of the WHO, and it requested, very clearly also, that the Director-General take certain actions such as seeking additional financial resources and providing technical guidance and advisory services to Governments

[20] Resolution WHA18.38. *Off. Rec. Wld Hlth Org.* **143**, 24.

[21] Resolution WHA18.49. *Off. Rec. Wld Hlth Org.* **143**, 35.

[22] Resolution XXXI. *Official Document PAHO* **58**, 83-84.

that requested them in order to continue the world campaign for the eradication of the disease. That was indeed an excellent statement of principle and policy with which the Delegation of the United States of America was delighted to be associated.

With regard to Resolution WHA18.49, on program activities in the health aspects of population dynamics, the speaker said that he had been present at the Eighteenth World Health Assembly when the resolution was discussed and adopted. It had been most satisfactory to observe the evident desire on the part of all of the delegates to arrive at a practical solution. Although that had not been an easy task, the resolution finally adopted, and subscribed by virtually all of the delegations present, had been passed unanimously.

The Delegation of the United States of America, added Dr. Williams, wished to propose a resolution that had essentially two objectives: first, to recognize the value and the statesmen-like character of the resolution adopted by the World Health Assembly; and secondly, to place the Directing Council of PAHO squarely with WHO in those activities which the World Health Assembly had requested the Director-General to assume. It dealt also with the solidarity of the PAHO Directing Council with the Inter-American Committee on the Alliance for Progress (CIAP) and with the Inter-American Economic and Social Council (IA-ECOSOC), both of which had given considerable attention and interest to the problem. The speaker then read the following draft resolution:

THE DIRECTING COUNCIL,

Having considered Resolution WHA18.49 of the Eighteenth World Health Assembly;

Considering Resolution XXXI of the XV Meeting of the Directing Council, XVI Meeting of the Regional Committee of WHO, which recommended various studies in population dynamics; and

Recognizing the interrelationships and interactions of health, population growth, and socioeconomic development, and the importance of active programs of cooperation among organizations of the Inter-American System,

RESOLVES:

To request the Director:

1. To provide technical advice, as requested, on the health aspects of population dynamics, in line with Resolution WHA18.49 adopted by the Eighteenth World Health Assembly.

2. To cooperate with the Inter-American Committee on the Alliance for Progress in studies assigned to it by Section 1, paragraph 16, of the progress report on the Alliance (adopted at the Third Annual Meeting of IA-ECOSOC at the Ministerial Level, 9 December 1964), as well as to engage in any other activities of CIAP on the population question.

3. To conduct studies as may be desirable on population dynamics related to the program activities of PAHO, and to support professional training as appropriate.

The PRESIDENT announced that the draft resolution presented by the Delegation of the United States of America would be distributed so that it could be taken up at a future session.[23]

Dr. NICHOLSON (United Kingdom) proposed the following resolution, based on Item 29 of the agenda (Nongovernmental Financial Support for Health Activities):

THE DIRECTING COUNCIL,

Having considered the report of the Director on nongovernmental financial support for health activities (Document CE52/12), which mentions the establishment of the World Health Foundation of the United States of America and the plan for the establishment of similar national foundations in other countries;

Bearing in mind Resolution V on this matter, adopted by the Executive Committee at its 52nd Meeting; and

Considering Articles 3 and 9 of the Agreement concluded between the World Health Organization and the Pan American Health Organization,

RESOLVES:

1. To take note of the report of the Director of the Bureau on nongovernmental voluntary contributions for health activities (Document CE52/12).

2. To take note, also, of the agreement signed by the Director-General of the World Health Organization and the Director of the Pan American Sanitary Bureau on 15 October 1964, in Washington, D.C.

3. To instruct the Director of the Bureau to continue to cooperate in the plan for world health foundations and to take such steps as he deems necessary to further the fundamental purposes set forth in the Constitutions of the Pan American Health Organization and of the World Health Organization.

The PRESIDENT suggested that the draft resolution presented by the Delegation of the United Kingdom should be taken up when Item 29 of the agenda was discussed.[24]

It was so agreed.

Dr. VALDIVIESO (Chile) said that he would speak briefly about smallpox and malaria eradication and, at greater length, about the problem of population

[23] See eighth plenary session, p. 107.
[24] See tenth plenary session, p. 134.

dynamics, concerning which the Chilean Delegation had recently formulated a proposal at Geneva.

Both smallpox and malaria had been eradicated in Chile, so that those two programs were no longer conducted in that country. During the discussion of the subject he had noticed that, in some respects, there was a tendency to believe that in the matter of smallpox eradication the responsibilities of each country, and especially of each ministry of health, should be delegated to the Organization, which in reality was an international, not a supranational, agency. He therefore considered it advisable to point out that the responsibility of each ministry of health in that respect was beyond question and that PAHO's sole function was to provide technical advisory services, guidance, and financial assistance.

As regards population dynamics, he recalled that the Director-General of WHO had submitted to the Eighteenth Assembly a progress report [25] on WHO's activities in the health aspects of world population, in accordance with the request of the Thirty-Fifth Session of the Executive Board [26] and on the basis of Resolution 1048 (XXXVII) of the United Nations Economic and Social Council. The request had been addressed to the U. N. specialized agencies, which had been asked to expand the scope of, and intensify, their work in that field. An analysis of Part II of that report, which outlined the activities conducted up to 1965, revealed the following facts: certain biological aspects of human reproduction had not been thoroughly studied and well understood, and there were still gaps in the knowledge both of the facts leading to conception and of the biology of the period following conception. Nor was sufficient information available on the geographic and ethnic variations of human reproduction, especially as regards the effects of modern living conditions. For all those reasons it was considered necessary to undertake research on a series of medical and biological questions relating to reproduction, lactation, amenorrhea, and postnatal infertility, which were connected with fetal and placentary physiology, while at the same time bearing in mind the enormous importance of social and cultural factors. The WHO had therefore sponsored a series of studies by experts in various branches of the biology and physiology of reproduction and was also preparing a world bibliography on the subject.

The consideration of the report in question during the Eighteenth Assembly had given rise to an extensive debate on the future work, the program of which had been adopted without important changes except with respect to advisory services. Two proposed resolutions had been submitted in that connection. The first—sponsored by the Delegations of Ceylon, Denmark, Finland, Iceland, India, Norway, Pakistan, the Republic of Korea, Sweden, Tunisia, the United Arab Republic, and the United Kingdom of Great Britain and Northern Ireland—considered that it was a matter for national administrations to decide whether and to what extent they should support the provision of information and services to their people on the medical aspects of human reproduction, and expressed the hope that it would be possible for the WHO to provide technical advice on the subject to the countries requesting such assistance. The second—submitted by the Delegations of Brazil, Chile, Panama, Paraguay, Peru, and Venezuela—recognized more explicitly that the solution of demographic problems involved not only the health sector but also economic, social, psychological, and other factors. A relationship was also established between the changes in a population's size and structure and the over-all economic development process. Since the two proposals had not been contradictory, but rather complementary, a working party had been appointed to prepare a joint proposal for submission to the Assembly's Committee on Program and Budget. The working party, of which the Delegation of Chile had been a member, had prepared a proposal which had been unanimously adopted without amendment by the Committee and had formed the basis of the resolution,[27] which had been duly submitted to the Governments members of the Pan American Health Organization. The resolution not only contained all the principles and provisions proposed by the countries which had drafted the second proposal but also approved the future program activities and stated that it was not the responsibility of the World Health Organization to endorse or promote any particular population policy. It also laid down that the size of the family should be the free choice of each individual family, and that the advisory serv-

[25] *Off. Rec. Wld Hlth Org.* **143**, 153-160.

[26] Resolution EB35.R31. *Off. Rec. Wld Hlth Org.* **140**, 21.

[27] Resolution WHA18.49. *Off. Rec. Wld Hlth Org.* **143**, 35.

ices provided by WHO at the request of Governments should not involve operational activities in connection with that policy.

Dr. Valdivieso emphasized the role played by the Delegation of Chile at the World Health Assembly in preparing the second proposal and the final resolution on the subject, and he repeated the reasons adduced when they had been discussed. The accelerated rate of growth of the world's population, which varied during the current century from country to country, tended to nullify the efforts made to promote the well-being and social progress of mankind. The slowness of economic development compared with the pace of population growth made the latter even more striking, a fact of major importance in Latin America whose population had been expanding, since 1950, at an annual rate of more than 3 per cent, with nine countries exceeding that figure. The continuing high birth rate, in a predominantly young population, and the substantial reduction in the death rate, due to medical progress, had an impact on the nature and characteristics of health problems and on medical care requirements, especially in the younger age groups.

The changes that had occurred in population dynamics could, as might well be expected, give rise to two kinds of problems: overpopulation and underpopulation, which because they were interrelated were of at least equal importance. Attempts were often made to solve the former without taking into account the serious implications that subsequent underpopulation could have for a country's development. The question, even though studied independently of the problems of economic and social development, could not be expressed solely in demographic terms, because to do so, without considering how it affected or was related to the other factors of development, could lead to an incomplete solution which, if hastily applied, could later result in irremediable situations. Since each individual in society was both a producer and a consumer of goods and services, any change in the size of the population would have an impact on economic development, because manpower was needed to produce and people to consume. Hence, any change in the ratio of the economically active to the nonactive population was reflected in the level of living. For a demographic policy to be effective, it was therefore necessary, when formulating it, to bear in mind all the relevant factors, including in particular the economic social, cultural, and other aspects. It should also be noted that a high density of inhabitants per square kilometer—i.e., a dense population—was not sufficient reason for dismissing the problem *a priori;* when considering the area, thought should be given to the proportion of agriculturally useful land that would feed the population.

So far as apparent requirements were concerned, the attention given to human reproduction, and especially to birth control, had been focused more on the efficiency of methods than on the basic scientific research that was essential to justify certain procedures. That had, in his view, helped to create an atmosphere of confusion and uneasiness. He recognized that many medical projects also contributed to the current bewilderment. The inadequate knowledge of various aspects of the problem made it imperative not to be impatient to arrive at a solution, because a superficial and insufficiently scientific analysis could lead to failure. Any study of human reproduction should take human respect and dignity into account first and foremost, so that each individual might decide freely and conscientiously.

In recognizing its obligation to respect human freedom and dignity, the State was in duty bound to ensure that everyone freely exercised his rights, including that of determining the size of his family to the extent that his resources allowed. It was incumbent on the State to determine whether a problem of overpopulation existed not only in numerical terms but also in relation to the country's potential capacity to absorb the population increase, for which purpose it was necessary to set targets for economic and social development that would promote a higher level of living. That would make it possible to avert the dangers of future underpopulation in terms of development. It was the responsibility of the State, and of the health services in particular, to protect the health of the family and especially of mothers and children. State action must therefore follow a positive course and create the conditions necessary for the normal development of the human being. It was imperative, in order to create a sense of parental responsibility, to inform parents not only of the risks of irresponsible parenthood and of the existence of various ways and means of avoiding it, concerning which they should be able to decide freely and as their conscience dictated, but also of the matter of

having more children and of the housing, educational, and other facilities that would be available. It was also for the State to decide on the dissemination of adequate information on the provision of services and on the extent to which they should be made available to the population so that the latter might face the problems connected with human reproduction. Nevertheless, any action taken by the State in that respect should be secondary, in the sense that the State should care for the community insofar as the latter did not have the necessary resources and was not properly organized to assume its responsibilities.

Dr. Valdivieso then made reference to the work done in Chile in that connection. Activities related to birth control had been started, on a more or less organized basis, in 1962. Previously—since 1938—some doctors had been prescribing, privately and on a limited scale, contraceptives for their hospital and private patients. In May 1962, following certain action by the International Planned Parenthood Federation, an organization financed by private United States sources, and after the round-table discussions held on the subject, Dr. Gustavo Fricke, Director General, National Health Service at the time, had set up a Chilean family protection committee. The committee had later joined the above-mentioned international federation. The committee had focused its attention on controlling induced abortion, because epidemiological research carried out in Chile had revealed that it was very common and that the mortality rate was very high. The committee had received funds from abroad intended for the purchase of contraceptives. In late December 1963, Dr. Alfredo Leonardo Bravo, then Director General of the National Health Service, had decided that the committee should continue as a private body and that the NHS would therefore no longer participate officially in family protection activities. Nevertheless, through its members, who were heads of obstetric and gynecological departments in Santiago, it had continued to use its resources for its programs and to assist the various heads of the obstetric and gynecological department of the National Health Service. Under that system, that type of activity was continuing, to a varying extent, in some 14 cities in Chile, besides Santiago.

Those facts, together with the provisions of the resolution adopted by the Eighteenth World Health Assembly on demographic problems relating to health, and the great importance which the Government of Chile ascribed to the birth problem, had led to the establishment of two commissions with more or less similar aims but operating at different levels. The first, which had been established at the Ministry of Health level, operated on a permanent basis in an advisory capacity to the Ministry and its subsidiary organs on population and family matters, formulated proposals bearing on demographic policy, promoted research studies, and proposed standards for coordinating and supervising the relevant activities of State and private bodies. It was laying the foundation for a demographic health policy which, since it was coordinated with other high-level State organs and private bodies, facilitated national demographic activities in line with Government policy. It had been set up some six months before by the Ministry—with Dr. Valdivieso himself in charge—and was already in operation. In addition to establishing liaison with the various national and foreign organizations concerned with the subject, it was laying down the principles that would govern all active policy relating to population and family.

The second commission, established at the National Health Service level, was a temporary body responsible for reporting to the Directorate of the Service on the abortion and birth control action being taken by the private bodies using the facilities available to the Service. It was collecting relevant information with a view to submitting a report on the subject to the National Health Directorate and to providing proper technical and administrative support for that type of activity.

Dr. CASTILLO REY (Venezuela) stated that smallpox had been eradicated in his country several years before. Nevertheless, he would have some comments to make thereon when the subject was discussed.

At the forthcoming Venezuelan Congress of Public Health, to be held in 1966 on the occasion of the thirtieth anniversary of the Ministry of Health and Social Welfare of Venezuela, the entire subject of population would be discussed in all its complexity. Children under 15 years of age constituted 47 per cent of his country's population and adults had a passive burden to carry that was

almost twice as heavy as that carried by adults in more developed countries, thus creating educational problems and problems in the labor market, into which approximately 80,000 new workers entered every year. There was also a problem of internal migration, with the usual disruption of cultural patterns and the consequent adjustment to new modes of life. Thus, in the demographic complex of a developing country, a series of difficulties were emerging which, as the Representative of Chile had remarked, created not only health problems but also other general problems connected with economic and social progress. Those problems deserved to be carefully, cautiously, and seriously studied so as to avoid changing each country's cultural and moral concepts. He believed that it was perhaps better to stress the importance of the problem without suggesting specific ways and means of solving it.

With regard to the national health foundations, he wondered whether they were exclusively concerned with arousing interest in the community and in soliciting private funds with a view to strengthening and supporting the programs of national health services, or whether they themselves would carry out such programs, for which purpose some other kind of machinery might be necessary which would avoid duplication and therefore confusion. It might be a good idea to consult the statutes of some existing foundations in order to study the nature of each agency, its field of activity, and especially its method of operation.

Dr. OÑATIVIA (Argentina) outlined his country's position on the problem of population growth. He agreed with the Representative of Venezuela that the question was of vital importance, especially for the development and progress of the Latin American peoples. The relevant resolutions adopted by the Eighteenth World Health Assembly and those that would emerge from the current meeting of the Directing Council should be strictly limited to recommending that the countries devote to the subject the attention it deserved, and to calling upon the international agencies to provide the technical advice necessary to ensure that the studies on the subject carried out in the respective countries were not limited to health aspects but were broader and deeper so that the economic and social implications of population growth were taken into account. He thought it advisable not to encourage any birth-control policy, because each country had to face its own particular problems with its own special peculiarities and features. The problem should not be presented the wrong way round, and it should be the ambition of all to promote the relevant studies and provide the appropriate advisory services and assistance required to ensure that the population increment in the various countries was absorbed by an improvement in their economic and social conditions. In other words, progesterone birth-control pills should not take the place of the bread and health that the peoples needed.

He stressed the interest shown by the Directing Council in Resolution WHA18.36 of the Eighteenth World Health Assembly, on the quality control of pharmaceutical preparations, and he recommended in particular that the report [28] of Dr. C. A. Morrell, PAHO/WHO Consultant on the possibilities of establishing an International Laboratory for the Analysis of Pharmaceutical Products, should be taken into account. He expressed thanks, on behalf of his country, for the direct help which the Pan American Health Organization had provided to Argentina in installing laboratories for controlling the quality and purity of medicinal products. There was no need to elaborate on the importance of the problem, in view of the rapid growth of the chemical and pharmaceutical industry in the world, which was reflected in the emergence of numerous national enterprises, and even of subsidiaries of world-renowned companies, which with a few exceptions were a striking illustration of the headway made by the drug-processing industry. Nevertheless, the lack of control over quality, purity, and posology disorganized and disrupted the market and therefore compelled Governments to take strict measures. In that connection Argentina was restructuring its technical services and had established an Institute of Pharmacology and Standardization of Drugs and Medicaments. He then announced that his country would submit a draft resolution congratulating the Director of PASB on the promptness with which the Bureau had begun its collaboration with the Governments in compliance with Resolution WHA18.36 of the Eighteenth World Health Assembly, recommending that the Bureau continue studies on the possibilities of establishing international laboratories for the analysis of pharmaceu-

[28] Mimeographed document CD16/19, Addendum II, Annex II.

tical products which might serve as reference laboratories for Member Countries, and requesting the Director to report to the next meeting of the Directing Council on the results of those studies and on the ways in which PAHO could provide further assistance in the development of projects of that type.

He believed that the draft resolution should also include a reminder to the various countries of the recommendations formulated at the Meeting of the Task Force on Health at the Ministerial Level, held in April 1963, to the effect that measures should be taken to regulate the prices of pharmaceutical products so that they remained within the reach of most people, bearing in mind the fact that the technical and the economic aspects of drugs on the market formed parts of the same whole.

Dr. FERREIRA (Brazil) expressed his views on smallpox eradication and population growth. He recalled, with reference to the former, that in most, if not all, of the countries of the Americas, and especially in Latin America, public health organizations were founded on the campaigns launched against the major current epidemics. Public health action had begun, so to speak, with campaigns against verminoses, malaria, bubonic plague, yellow fever, and other diseases. Those had been the vertical activities which had led, particularly in Latin America, to the emergence of public health organizations. In his opinion that action and vertical structure lacked the corresponding horizontal structure, consisting of basic services constituting the public health infrastructure. The current problem derived from the fact that, although it was possible to eradicate diseases—and even to eradicate them from certain zones—there was still no infrastructure on which all the efforts in that direction could be organized on a permanent basis. Considering the fact, mentioned in the report before the Council, that 50 per cent of the malarious area of the Americas was still at the pre-eradication or study stage and that the eradication campaigns were still at what might be termed an "initial" stage, thought should be given to the advisability of embarking on such vertical activities in such a way as to provide the required infrastructure.

As an illustration of what happened in Latin America, he referred to the situation resulting from the introduction of a malaria eradication system. Usually some illiterate person was recruited to spray the walls of certain dwellings, and complex bureaucratic machinery was set up for the purpose. That person was the only one in direct contact with the interior zones of the countries concerned and the only public health representative known to the population; there was no corresponding infrastructure of any kind. The time had therefore come to organize vertical campaigns and services in such a way that, once they had accomplished their mission, they could automatically be converted into the infrastructure so sorely needed in the Americas. From the medical standpoint, the rural sectors of the region were still in a primitive state and at the mercy of charlatans and local healers; there was no permanent organization providing health services, but such an organization could be built up by using the personnel employed in the vertical campaigns.

As regards the population problem, Dr. Ferreira referred to his participation in the Eighteenth World Health Assembly and remarked that there always seemed to be a compulsion to deal with the item under discussion in terms which offended Latin American sensibilities. Demographic problems and population dynamics were regarded as no more than birth control. Under whatever name it was discussed, the problem had moral, cultural, traditional, and economic implications and, as the Representatives of Chile and Venezuela had so aptly pointed out, Latin Americans were in a manner of speaking, virtually held responsible for the problem of overpopulation and sentenced to pay for the crime of allowing it to happen by introducing birth control schemes. In any case, that could not be done free of charge: contraceptives, whether of plastic or in the form of pills, cost money. So far there was no information to show whether any country had determined the cost of birth control or whether such control would be more expensive than maintaining a low death rate, which would be paradoxical. Many people apparently even considered letting people die in peace to be a satisfactory way of limiting population growth. But that was not an attitude to adopt but one to fight against.

In his opinion, the problem was so important that neither the WHO nor the PAHO should volunteer to take part in birth-control campaigns nor seek to engage in direct operational activities, as the speakers who had preceded him had so clearly brought out. His interpretation of the problem was

therefore similar to the view already expressed by most members of the Directing Council.

Dr. VALDIVIESO (Chile), referring to the question of pharmaceuticals, said that they constituted one aspect of the health problem which existed in his and in many other countries. So long as economic development was limited, medicaments would represent a large item in health budgets. In Chile, expenditure on pharmaceutical preparations amounted to 18 to 20 per cent of the health budget. In 1963 per-capita expenditures on health had risen to 66 escudos, or about 50 dollars. During the same year expenditure on pharmaceutical preparations had amounted to exactly 18 per cent of health expenditure, or 12 escudos per capita.

In his opinion, the correct approach to the problem was the one indicated in the report by Dr. C. A. Morrell, an eminent expert on the quality control of pharmaceutical products, who was currently in Chile advising the Ministry of Public Health on the organization of the future services for controlling those products. The problem had many aspects, among which the establishment of strict quality control deserved to be mentioned. Another point was that pharmaceuticals were often misused. All clinical doctors were well aware that, if 50 per cent or more of those products on the market were abolished, no one in the whole wide world would be any the worse, far less lose his life, on that account. The proper and careful selection of such products should be another of the measures adopted to improve the administration and supply of pharmaceuticals in health services. In that connection, a national pharmacopoeia was being prepared in Chile by a committee of experts consisting of pharmacologists, clinicians, specialists, and professors of the schools of chemistry, pharmacology, veterinary medicine, and dentistry, which would decide on the usefulness and acceptability of each product. He stressed the need to prescribe in advance the quality of the pharmaceutical preparations that were to be used by the National Health Service and all State services in Chile for distribution to the population.

Although the problem of the quality of pharmaceutical preparations was largely solved in Dr. Morrell's report, especially as regards their identity, purity, sterility, and potency not only at the time of distribution but also before their processing, the Latin American countries, which imported large quantities of pharmaceutical raw materials, had to control the quality of such imports, for which purpose they needed technical assistance not only in order to set up laboratories—often for the training of chemists and pharmacologists—but also in order to formulate requests for the requisite raw materials on the world market. It was far from easy for those countries to make such purchases and at the same time control the quality of the items purchased. In that connection the Organization could promote a policy that would be genuinely useful and thus help solve a problem that affected both Chile and a number of other countries.

It was self-evident that the cost of pharmaceutical preparations was no burden for the economically highly developed countries. In the United States of America, a person who bought a medicament usually paid the price asked without having to deprive himself of food or having to curtail his expenditure on clothes or education. But in a country like Chile, where the State was primarily responsible for the people's medical care (currently to the extent of 60 per cent of the population, a figure that would rise to 80 per cent when the pending legislation was approved), serious consideration had to be given to the cost of pharmaceutical preparations.

The session was suspended at 10:45 a.m. and resumed at 11:15 a.m.

Dr. ALONSO MENÉNDEZ (Cuba) stated that he had listened carefully to the comments made on the world demographic situation and the recommendations of the Eighteenth World Health Assembly, at which Cuba had expressed its views, as it had also done at the recent meeting at Belgrade. For the time being Cuba, a country of approximately 115,000 km^2 with a population of 7.5 million, a population density of 58 inhabitants per km^2, and a birth rate of 3.3 per cent, saw no need for birth control, although its maternal and child welfare program, scheduled to begin in January 1966, provided for family planning. The reason for that provision was the fact that the population was concentrated in the large cities but very sparse in the richer zones, such as the north coast of Oriente Province and the Province of Camagüey. The population had continued to grow, probably because of the prevailing social system which guaranteed the family's security. Serious problems were arising as regards the manpower required to execute the national

plans, particularly in the agricultural zones but also in the large towns, and even voluntary workers had had to be used to carry out and develop the agricultural and industrial plans. Nevertheless, every individual in Cuba was free to determine the size of his family as his conscience dictated. Advisory services would be provided to the population in that connection and the authorities would ask the Organization in due course for whatever assistance it deemed necessary for carrying out those plans.

So far as pharmaceutical preparations were concerned, Cuba had a nationalized industry and foreign trade monopoly which had completely changed the picture. Previously there had been over 15,000 different preparations. The national pharmacopoeia, drawn up for the purpose of planning and controlling national manufacture, contained 800 products, a quantity which was more than sufficient for public health purposes. On the other hand, Cuba had no chemical industry and would have to import all the raw materials, so that difficulties would probably arise with regard to pharmacological research and manufacturing techniques, but they were being overcome by means of advisory services and fellowships.

Some headway had been made with the control of pharmaceuticals, but not sufficient for the situation to be regarded as fully satisfactory. In any event, the medical situation was now completely different in Cuba. Prices had been cut by 58 per cent as compared with 1958, and the social security service provided medicaments free of charge at all the health centers. That had promoted the development of some programs and had alleviated the major problems. In conclusion, he stated that for the time being Cuba did not propose, in view of its national requirements, to introduce birth control as a government program.

Mr. SIEGEL (Assistant Director-General, WHO) said that the Representative of Venezuela had raised a pertinent question concerning the nature of the national World Health Foundations, which he would be happy to answer. Evidently, in his effort to keep his introductory remarks as brief as possible he had not presented a sufficiently detailed explanation of the proposed plan which WHO was in the process of implementing. In fact, the precise problem raised by Dr. Castillo Rey was one to which the World Health Organization had given considerable attention because its desire was to ensure no possibility of duplication of WHO's activities anywhere in the world. Therefore, from the very beginning they had envisaged that the foundations which they were endeavoring to create would direct their financial resources through the WHO or its regional organizations. Such financial resources could be earmarked for specific projects, in specific countries, or for general objectives of the Organization. However, the operations themselves would be carried out through the facilities of WHO and its regional organizations. He thought it important, however, to call the attention of the Directing Council to the fact that each of the Boards of Directors of the national World Health Foundations would be independent and would have independent judgment, deciding for themselves which projects would be financed with funds provided from each of the foundations. WHO had also developed an agreement to be signed with each of the World Health Foundations, which provided that WHO's facilities would be used for technical advice to the national foundations, granting them also the right to use the title of World Health Foundation. If any difficulties arose in the future, under the provision of the agreement the authority to use the title World Health Foundation could be withdrawn. The speaker added that he would be glad to make available to the members of the Directing Council a copy of the Articles of Incorporation of the Foundation in the United States of America, but it could not be available until the coming week, as it was desirable to have a Spanish translation made of it.

Dr. HORWITZ (Director, PASB) said that, of the resolutions of the Executive Board and the World Health Assembly discussed at the meeting, those referring to malaria and smallpox appeared as special subjects in the agenda of the Directing Council and Regional Committee and he therefore would not comment thereon for the time being. Two of the resolutions which had aroused the greatest attention in the Council related, respectively, to the control of pharmaceutical preparations and the demographic problem. He was grateful for the interest shown by the representatives, especially in the former subject, and for their support of the relevant activities carried out by the Organization in accordance with the Assembly's resolutions.

He then emphasized that in connection with pharmaceutical preparations, the role of the Bureau,

as an international body, was to advise Governments, first, in order to facilitate the training of technicians; secondly, in order to organize their own quality control services, and thirdly, in order to help establish laboratories or institutes which the countries could utilize in solving the quality control problems that could not be solved by each of them individually. There were differences of opinion on the results achieved. For that reason the Bureau had invited Dr. C. A. Morrell—who had been head of the Canadian Drug and Food Control Laboratory for 25 years and who had also cooperated with the Organization in the past by advising some countries—to give the Bureau the benefit of his valuable experience and to express his opinion on the idea of establishing a center for training technicians, analyzing samples of imported preparations which the various countries packaged but which were fairly often unsuitable for analysis, and solving the problems which constantly arose in such a complex branch of science where great strides had been made and would continue to be made at a swifter pace. Dr. Morrell believed that it was feasible to set up such a center and had outlined a suitable structure in his report. The project was not a simple one but it was in keeping with the general policy of the Organization, which was tackling problems of international concern with increasing frequency. He announced that the relevant report would be presented to the Council in due course for its consideration. PAHO was convinced that the headway made in the past 20 or 30 years had provided many of the Governments with the resources they required to solve basic health problems, since it had the necessary skills, although its activities were constantly limited by the shortage of funds. He was confident that, with the support so far offered, which he hoped would be confirmed by the adoption of the resolution prepared by the Government of Argentina, it would be possible to put those measures into effect.

An institute of the kind proposed would not be cheap. In his opinion it must have the equipment necessary for analyzing any type of medicament on the market currently or in the future, but he did not think that would prove to be an obstacle. It should also have very highly skilled technicians, and they were very scarce throughout the world. For a long time the Organization had been unable to launch projects of that kind which had been included in the budget, because the services in which those technicians had been working had been unable to release them even for a short period, a fact that demonstrated the urgent necessity of organizing one or two of those institutes in the Americas in order to expedite the training of skilled personnel. Such training should be on a long-term basis to ensure that the technicians were of high quality. The objective was that every country should have its own control laboratory and that the future center should then be able to limit its activities to remedying the shortcomings from which the national laboratories might suffer at a given moment. That was, of course, a very long-term objective.

He explained that the Bureau had addressed a very preliminary inquiry to the United Nations Special Fund, through the WHO, to ascertain whether the afore-mentioned idea fitted into that agency's policy, and that it had received a preliminary reply in the affirmative, with the suggestion that it should proceed to prepare a document which should be acted upon by one of the countries, because the headquarters of the international center would have to be in one of them. Moreover, following an idea similar to that of INCAP, the Central American countries had agreed, through their respective Ministers of Health at their IX Meeting in 1964, that the Drug Control Laboratory of the Government of Panama, whose headquarters was in the University of Panama and which was providing excellent services, should serve as reference laboratory for the six Governments of the Isthmus. That decision had been ratified at their X Meeting, which had been attended by the Director-General of WHO and the Director of the Bureau on the invitation of the Minister of Public Health of Panama. The Bureau had reiterated its desire to collaborate in some project, along the lines proposed, which would form part of Latin America's economic integration, because it was actually one aspect of an over-all process. In order to give the requested information, the Bureau would report to the Executive Committee if by the time of its next meeting headway had been made in solving the problem, and in any event it would report to the next Conference on the progress of the project. He was confident that it would be possible by then to state what was involved in precise terms. Meanwhile, the Organization was in a position to advise interested Governments on the national aspects of

the matter, as it had done in response to requests from the Governments of Argentina and Chile.

He had been gratified at the trend of the discussion on the World Health Assembly's resolution concerning the problem of population growth (WHA18.45), and he referred to the measures taken in the past two years on the basis of the recommendations of the WHO Advisory Committee on Medical Research and the PAHO Advisory Committee on Medical Research. He recalled the highly important research being conducted at the Headquarters of WHO into the physiological, biochemical, and other aspects of human reproduction. By common agreement with the WHO Director-General, the Bureau had engaged in epidemiological research, studying what might be termed the epidemiology of human reproduction, and consultations had been in progress for some time with the Government of Peru with a view to having the Ministry of Public Health carry out an area study in selected communities, in order to record the various factors closely and directly connected with reproduction. It was hoped that that study, which was far from simple, could be carried out in Peru and other countries, because that would be, to a large extent, a practical application of what had been said at the current meeting and a contribution toward establishing the true facts of the situation in countries, so that the Governments could reach decisions in line with their own policies.

He was aware of the fact that Latin America did not have technicians to tackle the demographic problem as a whole in the way described by Dr. Valdivieso, i.e., in accordance with the planning process, and he was pleased to report that a Committee of Experts had met in São Paulo, Brazil, early in 1965 to study the bases for a training program. Excellent advisory services had been provided by the Universities of Harvard and Princeton and by the Milbank Memorial Fund, and very advanced talks were currently being held with the Schools of Public Health of São Paulo and of Chile for the purpose of launching a four or five months' course on population dynamics and health, beginning in 1966. He trusted that, at the course, experts or other persons selected by the Governments of the Hemisphere would deal with the question as a whole and discuss suitable ways of collecting the relevant information in each country, so that in a few years' time a group of people with the necessary background could be formed at the national level to provide the information which every Government wished to have, irrespective of its general policy. The Bureau also hoped that, with one or two years' experience, other countries could organize similar courses and expedite the process, because in that way the Organization would be able to assist in a matter which was intrinsically very delicate. He therefore thought that the debate, which always served as a guide, had been extremely stimulating.

On 7 January 1965 representatives of United States public and private organizations interested in the subject had been invited to a meeting which had also been attended by prominent members of universities, private institutions, and foundations; they had outlined the policy they had been following in the matter and had suggested that the Bureau should serve as the future focal point for an exchange of opinions on the subject. For that purpose it was planned to organize a further meeting early in 1966 and subsequently to circulate the information thus obtained. That showed that the Regional Office had not been indifferent to the problem but, on the contrary, had tried to interpret the World Health Assembly's resolutions in the same way as it would interpret the decisions of the Council, where the matter of population growth was being dealt with so fully for the first time.

Dr. QUIRÓS (Peru) expressed his very sincere thanks to the Director-General of WHO and to the Director of PASB for the cooperation they were extending to the Government of his country in connection with the population problem. The Director of PASB had made an officer available to the Government of Peru for the purpose of organizing the executive office of a population and development study center, which had been set up in that country on the initiative of the President of the Republic, who had a special interest in studying population problems and economic and social development programs. The speaker said that he had recently received from his Government a document requesting the cooperation of the World Health Organization in carrying out the studies referred to by Dr. Horwitz.

The PRESIDENT announced that the draft resolutions submitted would be distributed and subsequently presented for discussion and voted upon.

Item 26: Study of the Relationship between Social Security Medical Programs and Those of Ministries of Health or Other Official Health Agencies

Dr. BRAVO (Special Adviser, PASB) pointed out that, on many occasions during the past few years, the representatives and other participants in various meetings of the Pan American Sanitary Bureau and other international organizations, including the Organization of American States, had expressed their concern at the lack of coordination existing in most Latin American countries between the medical services belonging to social security agencies and those of the ministries of health, which was frequently reflected in the inadequate utilization of resources and duplication of services and was becoming an obstacle to the orderly planning of economic and social development in the countries of the Americas.

The PAHO had been dealing with the problem ever since medical care had been included in the integrated health programs that formed part of the technical assistance provided to countries. Document CD15/15,[29] which had served as an introduction to the subject at the XV Meeting of the Directing Council, had traced the various stages in the history of the program of activities.

Among those stages one that deserved special mention was the occasion, in May 1964, during the 50th Meeting of the Executive Committee of PAHO (April-May 1964), when the Representative of Mexico, referring to the tenuous relations between the ministries or departments of health and the social security agencies, had asked [30] whether the time had not come for the Organization to take part in the study of such a vital problem. It had therefore been agreed to include the subject on the agenda of the XV Meeting of the Directing Council.

Prominent among the views expressed in the course of an extensive discussion [31] at that meeting had been the opinions of those representatives who, recognizing the importance of social security as a financial instrument of social welfare, had emphasized the absolute necessity of establishing close cooperation between those services and those of the ministries of health, and had stressed the fact that such collaboration should be the result of the overall planning of the relevant services under a single authority responsible for health policy, a function constitutionally devolving upon the ministries of health.

At the same meeting, the Director of PASB had stated that political, financial, and institutional complications entered the picture, so that the matter should be handled with caution. All the data should be placed before a Study Group, whose members should meet, not as representatives of their Governments but as purely technical experts with experience in social security and public health, make an analysis of the problem in all its aspects, and submit proposals on the measures that might be taken to promote the coordination desired by all.

The representative of the International Labour Organisation had remarked that the ILO was "charged with promoting social justice throughout the world and with protecting the workers against diseases and occupational accidents." For the purpose the ILO was guided by the Declaration of Philadelphia, which prescribed as one of its functions that of promoting "the Governments' application of principles and measures to preserve, improve, and restore the health of workers."

In compliance with Resolution XL,[32] adopted by the Directing Council at the conclusion of the debate, the Bureau had recruited a Special Adviser, who had prepared a working document [33] which analyzed all aspects of the relationship between the ministries of health, the social security agencies, and the medical profession. That document had been submitted to a Study Group, which had met in Washington, D.C., from 12 to 16 July 1965, and whose final report was before the Directing Council in Document CD16/25.[34]

The report outlined the historical background that had apparently contributed to the present lack of coordination between the public and private bodies providing medical care to the community and stated that the lack of coordination existed not only between but also within institutions, between the various departments of ministries of health, and between the different social security

[29] *Official Document PAHO* **60**, 328-335.
[30] *Ibid.*, p. 216.
[31] *Ibid.*, pp. 105-108, 108-114, 193-194.
[32] *Official Document PAHO* **58**, 90-91.
[33] Published in *Administration of Medical Care Services. Scientific Publication PAHO* **129**, 6-47.
[34] *Ibid.*, pp. 48-59.

funds in their mutual relationships. It also stated that the same situation prevailed even in the international organizations, whose technical assistance was not always provided on the basis of the same principles or by the use of similar working methods.

The Study Group had defined coordination as "orderly arrangement in the use of all the available manpower and material resources in the various public and private health care institutions." It had been unanimous in recognizing that planning, provided it included the health sector in economic and social development, was the best method of intrasectoral and extra-sectoral coordination, and that if the ministries of health cooperated with the social security agencies some day they could be expected to pursue common ideals and engage in joint activities. It had stressed the value of environmental health and epidemiological activities which, through disease prevention, lowered morbidity rates and hence lessened the demand for medical care services.

The Study Group had also been of the opinion that the necessary action must be taken to ensure that rural inhabitants also enjoyed the benefits of social security and that that goal could be achieved only through land reform which would provide the resources for the progressive financing of the scheme. It had been recommended, in addition, that the benefits should be standardized as a method of coordination. An analysis had been made of the human resources, especially of the physicians and other professionals constituting the health team, and attention had been drawn to the advisability of inviting them to participate in the planning process.

Lastly, with reference to costs and financing, the Study Group had advised that the first step should be to ensure optimum use of installed capacity and available human resources, and that only later would it be possible to plan for additional resources on the basis of a series of studies on estimated requirements and demand, so that the new resources would be exactly commensurate with actual needs.

In view of the serious lack of information on the problem, statements were sometimes made which were not based on objectively analyzed data, and the Study Group had therefore unanimously recommended that a survey, conducted and supervised by the international agencies, should be promoted in those countries that wished to participate, for the purpose of going to the root of the problem and seeking a solution from the technical point of view, having regard to the traditions and characteristics of each country. It had been further recommended that a continuing international effort should be made to promote the coordination of those services in the various countries, that at the same time study seminars should be organized, especially for groups of trade-union leaders, and that the organization of local communities should be encouraged in order to enlist their interest and active collaboration for the purpose of improving coordination between the various public services responsible for medical care.

The Director was submitting the Study Group's report to the Directing Council for its consideration, as a preliminary document for analyzing a problem which was intrinsically complex and controversial. Since there was no single formula applicable in all countries, solutions to the problem would have to be found which were compatible with historical traditions, the existing legal system, national administrative and demographic realities, and also the human and material resources available. In order to start studying those various aspects, it was essential to collect the local information necessary for undertaking, in successive stages, a realistic analysis of the national situation and recommending the best solutions.

As was stated in the report of the Study Group, it was obvious that only through the over-all planning of economic development and social advancement as a coordinated process involving the rational utilization of existing installed capacity, would it be possible effectively to coordinate the resources of the different public and private bodies engaged in providing the community with medical services. In order to achieve those results, each country, after taking stock of its resources, would have to make a careful statistical and cost analysis of its anticipated requirements, in terms of the demand for services and its capacity to train suitable personnel, within a reasonable period, to operate the new services. For that purpose centralized planning of the health sector was necessary and should be undertaken in the ministry of health as the body responsible for the Government's health policy and hence for coordinating the health activities of all public and private services to the maximum extent.

Nevertheless, it was likely that a good many of the Latin American countries were not yet ready for the over-all planning of their economies and of their medical and social services. Meanwhile, some initial steps could be taken to further progressive coordination, with a view to making better use of their available resources. Among such steps, mention should be made of sharing premises, equipment, and facilities and the reciprocal provision of services in places where there was only one agency.

During that preliminary period, the PAHO should serve as an information, reference, and advisory center for countries, in order to acquaint them with the organization and results of all those local experiments. It could also organize seminars, courses, study groups, and other activities in order to disseminate within the region the theory and practice of coordination, not only among those administering services but also among medical personnel and the people using those services.

Dr. Bravo concluded by stating that, in countries which had reached more advanced stages in their health planning, the Bureau could organize courses for training and instructing specialized personnel in the administration of medical and social security services, and also disseminate those ideas in labor and community associations, with a view to enlisting the active and intelligent cooperation of the people using such services.

Dr. ESQUIVEL (Panama) said that Dr. Bravo's statement summed up the contents of the report of the Study Group in which the following countries had participated: Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Mexico, Panama, Paraguay, Peru, and Venezuela. A large number of advisers had also taken part. The work done met a need that was recognized by all the public health officials of Latin America and constituted a problem that was extremely difficult to solve. The multiplicity of functions, the duplication of services, and the inefficient use of the available funds were only too evident, as was the fact that the social security agencies were dissociating themselves more and more from the over-all public health problems of the various countries. In the report, Dr. Horwitz had presented the problem in very simple terms and had asked: "One wonders whether the present lack of coordination between the medical services of social security agencies and those of health ministries is due solely to conventional causes arising out of the fact that the two spheres of action are not clearly defined in juridical terms. Or does it have deeper roots in an economic and social process characteristic of developing countries? How can the State be helpful in fulfilling its obligations of providing health care, if possible to the entire community, and in fully coordinating the resources at its disposal?"[35] It is an established fact that the needs of countries must be properly planned within the context of the resources available to them.

In the same report, Dr. Beryl Frank, Chief of the OAS Social Security Program, stated: "We are all aware that this is a historic moment, which I hope will initiate a new phase in the relations between the ministries of health and the social security institutions."[36] That statement also implied that the current stage was an ineffective or negative period in the relationship between the ministries of health and those agencies.

The Director of the Pan American Sanitary Bureau had requested that representatives or medical directors of the social security services of the different countries should be invited to attend the current meeting of the Directing Council, since that was considered a vital step toward ushering in the historical era of better coordination and toward setting up the planning bodies which could link the two services. Dr. Esquivel did not know what the outcome of Dr. Horwitz' invitation had been, but it was his understanding, from very personal inquiries that he had been addressing to the Ministers of his acquaintance, that the invitation had not been acted upon as the Director had hoped. It was most regrettable that that should have happened, because the matter was of such major importance that it was being dealt with at the current meeting of the Directing Council and the discussions would be vitally important if the medical directors of the social security services of the countries of the Americas could listen to and discuss some of the problems that faced them.

Before concluding, he asked the President whether he could invite the General Medical Director of the Social Security Fund of Panama, Dr. Luis Domingo Alfaro, to address the Council on behalf of the Delegation of Panama and of the Social Security Fund of Panama, since he had read the study and discussed it with that country's representatives.

The session rose at 12:05 p.m.

[35] *Scientific Publication PAHO* **129**, 4.
[36] *Ibid.*, p. 49.

SEVENTH PLENARY SESSION

Thursday, 30 September 1965, at 3.10 p.m.

President: Dr. JUAN JACOBO MUÑOZ (Colombia)

Item 26: Study of the Relationship between Social Security Medical Programs and Those of Ministries of Health or Other Official Health Agencies (*continuation*)

Dr. ALFARO (Panama) welcomed the opportunity to express the views of his country's social security services on the subject, and he congratulated the Study Group on the excellent reference document it had prepared.

He agreed that it was essential to make the fullest use of the limited resources available in developing countries—which could not hope to attain economic levels as high as those of Switzerland, Sweden, Norway, the United States of America, or Britain—in order to provide proper protection against disease and health care services for all. The social security bodies represented a major step forward in the social development of Latin American countries, and those advances should be sustained and strengthened by the Governments, which should seek to establish schemes and devise ways of ensuring the mutual understanding necessary to better fulfill their social responsibilities.

Obstacles to such mutual understanding had existed in the past and continued to exist. Among the major drawbacks was the lack of participation of the social security agencies, and especially their medical departments, in the health planning process. It was imperative and urgent that those agencies form part of the planning bodies at the national level.

Clearly, coordination was an effective means of providing for the joint execution of programs, especially when the activities were directed toward common objectives. He therefore believed—and he was certain that all his colleagues who directed social security medical programs in the Americas shared his view—that through rational planning it was possible to establish effective coordination with the programs of the ministries of health, in such a way as to provide services of better quality and ensure that they reached the large needy groups of the population.

In Panama steps had been taken toward that end, by bringing the medical directors of the social security agencies and of the public health services closer together. Wherever such contacts were established among medical directors, they were certain to pave the way for the movement toward coordination. In his own country, it had been possible to achieve the following: (1) establishment of common funds, even though on a limited scale, with the aim of improving the quality of services in the health subsectors; (2) establishment of similar programs for professional and technical training and financial aid to the Ministry as required for training programs, such as those in the nursing field; (3) provision of financial support, directly or through loans to the Government, for remodeling and expanding hospitals operated by the Ministry, for the purpose of experimenting with the provision of medical services on a joint basis; and (4) provision of professionals, especially physicians, to work in the medical care services attached to the Ministry, in order to supply the best care to the insured patient in local institutions in rural areas of the country.

Dr. Alfaro thanked the Council for the opportunity of explaining the position of the Social Security Fund of Panama. He suggested that the Pan American Sanitary Bureau should officially invite the medical directors of the social security services of the different countries of the Americas to participate in joint discussions, at the continental level, with the heads of the public health services, in order to take steps as soon as possible to achieve the desired coordination in the health sector in the countries of Latin America; those discussions should take into account the principles and concepts expressed in the course of the current discussion.

Dr. BRITTO (Brazil) stressed the concern with which his country viewed health problems, since health was a crucial factor for economic and social

development. He therefore considered that the solution to those problems lay in careful planning, with due regard to technological and scientific advances and to the value of the human element as the basis of national advancement. The foundations of a system of health care services must be based on each country's social, economic, and geographic characteristics, and so far no consistent and systematic medical care policy had yet been introduced in most communities of the Americas.

In Brazil, medical care policy had unfortunately suffered from fragmentation, discrepancies, and lack of coordination. For various reasons, great attention had been paid to the curative aspect and little interest had been shown in prevention and rehabilitation. The inadequacy of personnel, in both quality and quantity, had added to the problem.

He therefore thought that, as a rule, future policy must follow a different course in keeping with the needs of the times. The shortcomings of the present system were due to the multiplicity and wide variety of care agencies and to the consequent dispersal of resources, as was apparent from the fact that health activities were being carried out independently by eight groups: the Ministry of Health, the Ministry of Labor, the Ministry of Industry and Commerce, the Ministry of Education and Culture, social security agencies, philanthropical institutions, welfare institutions, and private profit-making institutions. The very diversity of the bodies which were trying to solve the same problems was responsible for their technical and financial insecurity and had disastrous effects on their operations and services.

He then enumerated the various hospital and hospital-type establishments maintained by the state governments and those supported by private entities. For a population of about 80 million, there was a shortage of between 127,000 and 167,000 hospital beds, taking 4.5 to 5 beds per 1,000 inhabitants as the coefficient of demand. Among other statistics that were indicative of the prevailing situation, he pointed out that 16 per cent of the medical care establishments in Brazil belonged to governmental bodies, the remaining 84 per cent being privately maintained.

In order to provide the community with proper medical care, the health services should be built on solid foundations, based on a comprehensive policy that combined and coordinated all the resources available, if health—the legitimate and fundamental right of every human being—was to be protected as it should. That pressing social need had prompted President Castello Branco to adopt a policy based on the organization, coordination, and structural planning of health activities. Precisely because of Brazil's geographic extent, modest resources, and the different attitudes of its various populations to disease, the Government had been compelled to apply a health policy that made it possible for preventive, curative, and rehabilitation activities to be properly coordinated.

He drew attention to the disadvantages of a medical care policy formulated by different bodies whose activities and objectives were sometimes far removed from the problems that directly affected the community's health. Indeed, decisions on health problems taken by laymen could jeopardize the operation of services and frustrate the objective of providing medical care to the community, in the broad sense of that term which included preventive, curative, and rehabilitation services, properly provided and available to all.

He then made a series of points on the subject of concentrating the medical care resources of an effective organization, such as the Ministry of Health of Brazil. He stressed the need to coordinate public health, preventive medicine, and rehabilitation activities and to unify medical care services; the need to mobilize and utilize material and human resources to the fullest possible extent and to rationalize activities; and the need for a better understanding of technical and professional work, in accordance with the requirements and obligations of medical care services, and of the value of the human element to the country's economy. He also thought that higher priority must be given to preventive medicine, which would thus reduce the demand for curative services, and advocated the participation of private enterprise in health programs that would be of genuine benefit to the community.

In view of the circumstances, the Ministry of Health of Brazil was trying, by every possible means, to implement the recommendation [1] formulated at the Meeting of the Task Force on Health at the Ministerial Level (Washington, D. C., April 1963), to the effect that "ministries of health

[1] *Official Document PAHO* **51**, 37.

should take steps to secure the legal and institutional instruments required for the effective coordination of the planning and executive elements responsible for preventive and curative services of the State, as well as coordination between these and private, semiautonomous, and autonomous organizations providing health services of any type. The aim is to incorporate the medical care activities of those institutions, including hospitalization, into the basic health services at all levels—local, intermediate, or national. . . ."

Dr. Britto added that the Ministry of Health of Brazil, in line with the current concept of medical care for the public, had adopted a constructive position based on the integration of medical care and the unification of medical services under proper direction and control. Pursuant to that policy, it was trying to adjust itself to realities in Brazil, while bearing in mind that the contribution it was making to the work and executive activities of many of the country's health bodies because of the local authorities' inability to carry them out would cease as soon as the local assistance services became self-supporting.

Moreover, the Ministry of Health had decided to encourage the participation of private enterprise in the system in order to improve the hospital establishments through medium-term and long-term plans for financing at low rates of interest.

In conclusion, he remarked that the day on which health would come into its own was not far off and that the Government would fulfill the objectives of peace and security for the Brazilian people, with devotion, patience, and resolution.

Dr. VALDIVIESO (Chile) stressed the importance of the document under discussion. In his country, the government agency concerned with hospitals had two main sources of finance: first, the Government provided funds to enable the public or municipal health services to organize care centers; and second, such centers were financed by social security which, in that case, assumed responsibility for organizing them. There were two ways in which social security provided medical care for its members: it could either contract for such care to be provided by State or semi-State services, or build its own establishments. Chile's position in the matter of health policy was that curative medical care for the social security beneficiary was not sufficient and must be combined with preventive action, i.e., whatever form such care took, it should not be dissociated from the protection and promotion of health.

There had been criticism of the fact that in his country medical care was generally based on membership in a social security scheme, with the result that some population sectors were better protected than others. In the circumstances, so long as there was no general medical care service, the Government took the view that the obligation rested with the public health services and was delegated in the case of members of security social schemes. Organization along those lines had materialized with the establishment, in 1952, of the National Health Service, which was providing health protection for all the population that required it and engaged in health promotion and the provision of medical care for two-thirds of the population, i.e., insured manual workers, the indigent, and other groups of limited means. The social security scheme, which had 1,400,000 manual workers, or almost half the country's economically active population, had delegated the responsibility for medical care to the National Health Service, and its members received the benefits of complete medical coverage based on a combination of preventive, curative, and rehabilitation activities. The National Health Service received a contribution from social security equivalent to 14 per cent of its total resources; the balance of its funds came mostly from government subsidies amounting to about 60 per cent.

The public and private workers' sector, exclusive of members of the armed forces and the employees of certain specialized services, totalled 1,250,000 people, covering wage-earners and family groups, and represented 15 per cent of the population. Even though covered by social security, that sector had so far lacked comprehensive medical care, which was largely provided by the National Health Service or private doctors, either directly or by agreement with firms or with the professional groups to which the persons concerned belonged. To solve that problem, the Chilean Parliament was studying a bill which, if passed, would satisfactorily extend the benefits of the National Health Service to meet the requirements of that part of the population which was not yet properly covered.

The aim of Chile's health policy was to provide comprehensive medical care for members of the

social security scheme in such a way that there would be no clear dividing line between preventive and curative activities, with the idea that the family group should form the basis for such action.

Under the National Health Service, medical care was in line with the objectives of an over-all plan, but there still remained the problem of preventive and curative care with regard to work accidents and occupational diseases, hazards that were not covered by a social security scheme because old legislation remained in force whereby compensation was provided for the workers concerned, with the employer bearing direct responsibility and with no provision for compulsory insurance. In that connection, his Government's intention was to integrate social security so completely that no difference existed, as regards the treatment provided to workers, between common diseases or injuries and those contracted or sustained at work. To that end the Chilean Parliament was studying a draft scheme of insurance against work accidents and occupational diseases for all the country's manual and non-manual workers, whereby the administrative management of the scheme would be the responsibility of the respective social security institutions, in the case of manual workers, and of the provident funds, in the case of non-manual workers.

The intention was to assign preventive activities to the National Health Service, and curative and rehabilitation services to social security, in the case of manual workers, and to the provident funds in the case of non-manual workers, although the latter agencies could delegate the relevant responsibilities to the National Health Service when they were unable to assume them themselves.

Dr. QUIRÓS (Peru) reiterated the opinion he had expressed when commenting on the Annual Report of the Director of the Bureau, namely, that the social security schemes in most Latin American countries were inadequate, discriminatory, costly, unfair, and narrow in coverage. To his mind the system was one that had been introduced without a thorough study and in many cases it had been modelled exclusively on the systems operating in more developed countries.

In Peru social security had been inaugurated with the establishment of two Security Funds: one for manual and the other for non-manual workers. The sponsor of the scheme had also set up a National Health and Social Welfare Fund, based, like social security, on deductions from salaries and wages. At recent meetings held in Venezuela and Chile to deal with social security problems, the financing of such services had been discussed. Theoretically it was the employee, on the one hand, and the employer, on the other, who made their respective contributions to social security and the State made an auxiliary contribution. In practice, however, the employer did not bear the cost of his proper share, regarded it rather as an indirect tax, and added it to the cost of his product. His presumed contribution to social security was also deductible from the progressive income tax he had to pay to the Government.

In Peru the social security services, which served approximately one million people, had a budget equivalent to twice as much as the State had available to serve nine million inhabitants, who, moreover, were helping to finance a scheme from which a privileged group benefited. The social security schemes started off by establishing their own services with the aim of providing better care than the State health services, but a time had come when they could no longer build new facilities for want of funds, since the number of persons insured was limited. Also, since it had been impossible to expand those services in order to extend social security to other zones of the country, the coverage provided had had to be limited.

The Ministry of Public Health, on the other hand, utilizing the National Health and Social Welfare Fund, had constructed during the past three years a network of hospitals throughout the country: 15 of them, in different zones. Those hospitals were now serving the social security scheme, with the result that an agreement had been concluded with it whereby it paid 6.5 per cent of its income to the health services. The possibility was being explored of extending family social security to the rural zones.

The subject of social security should be carefully studied in order to find a fair solution. In the view of an economist with whom he had recently exchanged views on the matter at a meeting sponsored by the National Planning Institute, the financing of social security services might eventually become an inflationary factor in some areas. The Peruvian Delegation believed that efforts

should be directed not toward coordinating health services with social security but rather toward finding a more radical solution. In many cases the social security schemes had been installed without the participation of physicians, and it would therefore be interesting to know all the technical and political aspects on which the views of those professionals were based.

At the Medico-Social Congress of the Pan American Medical Confederation, which would be held in Lima in 1966, that subject would be discussed, and he invited the representatives to attend. He reiterated his concern about the item under discussion and, passing to another aspect of the same subject, referred to the patient's free choice of a physician, a topic that also deserved to be thoroughly studied, as also the other facets of the problem, in order ultimately to establish systems that would provide the entire population with the health protection facilities to which it was entitled.

Mr. RIVERA (Costa Rica) said that in his country social security covered at least one quarter of the population. Nevertheless, virtually half of the amounts invested in public health was devoted to medical care and preventive medicine. The social security schemes tended not to participate in preventive programs, preventive medicine being rather the responsibility of the services of the Ministry of Public Health, which spent 8.6 per cent of its budget on such activities, the balance going to medical care. He referred to the number of beds available in the hospitals and remarked that they were geographically badly distributed. Moreover, the tendency of social security to build hospitals seemed to him misguided, because it was proposed to build some in places where there already existed others built by the Public Health Ministry.

He agreed with Dr. Quirós that in some countries social security had been promoted not by the physicians but by the economists, although at the moment, in Costa Rica for example, it had become a stronghold of the physicians, so that in his country there had been a desire to transfer some health care services for workers from the Health Ministry to social security, all of which led to a certain amount of administrative confusion.

It was essential that the functions of the health services and those of social security should be clearly differentiated, in order that medical jurisdiction in all its aspects would be clearly vested in the Health Ministry. He drew attention to the great economic power wielded by the social security funds and to the demagoguery practiced under their protection, indulged in by certain persons ensconced in the social security agencies apart from the physicians.

The problem at issue would be solved by promoting a single national health plan in the countries of the Americas to which social security schemes contributed, in order to eliminate the inequality of treatment currently existing between the insured and non-insured.

Dr. ALONSO MENÉNDEZ (Cuba) stated that in his country the Social Security Act promulgated in 1963 provided protection for all members of the labor force, namely, the 94 per cent in the socialized sector, those who were self-employed, and the remainder who were engaged in private enterprise. The Ministry of Public Health was solely responsible for all health services, and he stressed the fact that formerly there had been 51 separate bodies, including autonomous, semiautonomous, and State agencies.

Certain obstacles nevertheless remained, because the plan launched by the Ministry was very ambitious. Comprehensive medical care was already provided by the units of the health services, but some objectives, which called for greater efforts than had been exerted so far, had not yet been achieved. Still, the balance was better than anticipated.

The social security services were closely coordinated with the Ministry of Finance, the Central Planning Board, and the Ministry of Labor. Centralization of the various functions connected with social security was the most effective procedure and offered the most promising prospects.

Dr. SALDAÑA (El Salvador) stated that the conflict existing in some countries between the health services and the social security agencies was an obstacle to attainment of the goals to which all aspired. Instead of forcing a given policy on the social security system, agreement should be reached with those institutions by means of a thorough examination of the health problems, which would make it possible to lay down the most suitable policy. In his view, whenever important questions bearing on the health services of ministries and those of social security agencies were discussed, the

best qualified physicians of the latter agencies should be invited to participate in the discussion with a view to convincing them that the ministry authorities were not hostile to them and that the sole objective was to unify efforts and utilize economic and human resources to the maximum.

Personal interests or the interests of institutions should not be placed before those of health, and ways should be sought to make proper use of available resources, through intelligent coordination that would promote the health of the peoples of the Americas.

Perhaps the moment had not yet come to speak of integration, because the deficient hospital facilities of the public health services in many countries did not enable the members of social security schemes to receive adequate attention. Such an attempt at integration might be feasible when countries embarked on large-scale hospital and clinic construction programs. By way of example, he cited the case of Peru, where the social security agencies used the medical services of the Public Health Ministry, thus showing that coordination was essential to avoid dispersal of effort.

Dr. OÑATIVIA (Argentina) said that the problem of medical care in the social security services suffered from shortcomings similar to those besetting the health services of the ministries, and in some countries it was possible that the security machinery might even have added to the confusion.

He emphasized the role played by the State in maintaining social security by making up the deficits occurring in its administration because of the lack of rationalization in the technical and administrative services. It should be the main concern of Governments to organize health infrastructures through the ministries of public health, and he drew attention to the desirability, mentioned in the document under discussion, of planning health services as a whole and on a national scale.

In Argentina it would be impossible to coordinate or integrate the national medical care services with those of social security unless there was an improvement in the former. The first national survey of Argentina's medical care resources and services had been completed in 1964. It had covered all such services, both official and private, and he was convinced that the resultant findings would make it easier to form a complete picture of the situation, which would be extremely useful to planners and health administrators. Studies were being carried out in collaboration with the National Development Council and the Federal Investment Council on the costs of medical care and other aspects of importance for the purpose of approaching the problem with a thorough knowledge of the facts and possibilities. In his opinion it was imperative to go to the root of the crisis in the medical care services and to overcome the obstacles, one of which was the fact that countries wished to base such services on the principles of individual medical care. After Argentina had completed the aforesaid national survey, it would pass on to the staff recruitment stage in order to direct the services along multipurpose lines, i.e., to guide them into the phase of preventive, curative, and social medicine, without which it would be impossible to proceed to the stage of coordination and integration with the social security services, a development which would in its turn necessitate the administrative decentralization of the health services if they were to be effective.

The Senate of his country was currently studying a bill, submitted by the Ministry of Social Welfare and Public Health, designed to transform the services by transferring hospital organization and administration to the community medical care services and making the provision of free services available only to needy persons. Services would be provided directly or indirectly, which, he believed, would help improve the financing of the services and make administrative decentralization possible. He thought that the subsequent stages should be the integration of medical care services into a general social security scheme covering most risks and protecting most of the population. The entire system should be planned at the national level, with the collaboration of non-health sectors, and as part of the activities of the various national development councils.

Dr. ESQUIVEL (Panama) pointed out that the social security agencies in Latin America were actually funds—banking institutions—which in some countries were governed by statutes based on economic considerations, and with social projections, although it was true that their activities were centered mainly on medical assistance. The efficiency of such institutions was undeniable and their autonomy should be respected, for in a sense it protected them from political interference. It

was less important to discuss their composition and operation than to determine in what way their activities should be used in order to increase their participation in national health programs, to make their activities correspond more closely to those of the official government health services, to avoid discrepancies and unnecessary duplication, and to ensure that their responsibilities were commensurate with the sometimes substantial resources at their disposal.

He believed that the social security officials of the various countries performed their duties with a great sense of patriotism, and he reiterated his opinion that the important point was to prepare the ground for coordinating health activities through over-all planning that would lead to lower costs and higher efficiency.

Dr. Esquivel then presented a draft resolution on the topic, for consideration by the Directing Council.

The PRESIDENT announced that the draft resolution on Item 26, submitted by the Delegation of Panama, would be distributed for discussion later.[2]

The session was suspended at 4:55 p.m. and resumed at 5:15 p.m.

Election of Acting President

The PRESIDENT announced that the Council should elect an Acting President for the sessions scheduled for Monday and Tuesday of the following week, because the President and the two Vice-Presidents and he would be absent during those days.

Dr. CASTILLO REY (Venezuela) nominated Dr. Roderick Esquivel, Minister of Labor, Social Welfare, and Public Health of Panama, for the office of Acting President.

Dr. WILLIAMS (United States of America), Mr. RIVERA (Costa Rica) and Dr. BONICHE VÁSQUEZ (Nicaragua) supported the nomination.

Decision: The Representative of Panama, Dr. Roderick Esquivel, Minister of Labor, Social Welfare, and Public Health, was unanimously designated to serve as Acting President of the Meeting on 4 and 5 October 1965.

Dr. ESQUIVEL (Panama) expressed his thanks for the honor conferred upon him.

[3] See eighth plenary session, p. 108.

Item 27: Status of Smallpox Eradication in the Americas

Item 34: Material Support of the Program for Global Eradication of Smallpox by the Countries of the American Region (*Item proposed by the Government of the United States of America*)

Dr. BICA (Chief, Communicable Diseases Branch, PASB) introduced Document CD16/29[3] and pointed out that the XIII Pan American Sanitary Conference (Ciudad Trujillo, Dominican Republic, 1950), recognizing the importance of the problem of smallpox in the Americas, had recommended[4] that the countries should undertake systematic smallpox vaccination and revaccination programs in their respective territories with a view to eradicating the disease. It had also recommended that the Organization should coordinate the implementation of those programs in agreement with the countries concerned.

In a total of 13 resolutions, adopted in subsequent years, the Governing Bodies of the Organization had expressed their concern over smallpox in the Americas and their desire to see that disease eradicated from the Western Hemisphere.

In 1958, the Eleventh World Health Assembly, "noting that smallpox still remains a very widespread and dangerous infectious disease and that in many regions of the world there exist endemic foci of this disease constituting a permanent threat of its propagation and consequently menacing the health and life of the population" (Resolution WHA11.54),[5] had requested the WHO Director-General to investigate the means of ensuring its world-wide eradication. In 1959, the Twelfth World Health Assembly (Resolution WHA12.54)[6] had requested the Director-General "to collect from the countries concerned information on the organization and progress of their respective eradication programs and to report further to the Thirteenth World Health Assembly." At the Thirteenth and Fourteenth Assemblies similar requests had been made. The Fourteenth Assembly (Resolution WHA14.40, par. 2)[7] had urged "those

[3] See Annex 5, pp. 374-380.
[4] Resolution XIX. *PAHO Publication* **257**, 17-18.
[5] *Off. Rec. Wld Hlth Org.* **87**, 41-42.
[6] *Off. Rec. Wld Hlth Org.* **95**, 47.
[7] *Off. Rec. Wld Hlth Org.* **110**, 16.

countries more economically advanced to make voluntary contributions in cash or in kind so as to increase the funds of the WHO Special Account" for smallpox eradication. All of those resolutions reaffirmed the priority assigned by the Governing Bodies of PAHO and WHO to the smallpox problem. Since they had been adopted unanimously, the Governments Members of both Organizations had assumed a commitment to eradicate the disease.

In conformity with the successive resolutions of the Governing Bodies, the PAHO, in agreement with many countries, had been actively participating since 1950 in a continental program designed to eradicate smallpox. It had advised Governments in the planning of smallpox eradication programs, based on antismallpox campaigns that could be incorporated, at an appropriate time, in the general public health services of the different countries. That collaboration had been given in the form of technical advisory services for the production of smallpox vaccine and equipment for the preparation of lyophilized vaccine. In other cases, the Organization had furnished vaccine ready for immediate use, consultant services for the organization and execution of vaccination campaigns, and fellowships for the training of national personnel. The services of an accredited laboratory had also been made available to the Governments for testing the purity and potency of the smallpox vaccine prepared in national laboratories.

Since 1950 headway had been made toward eradication of the disease. The progress varied from country to country; although one large group had succeeded in eliminating the disease and others were approaching that goal, there were still some where smallpox existed and they should launch the requisite campaigns without delay. It was also necessary that countries in which eradication programs had been prolonged indefinitely and where the incidence of smallpox was still high, should devote full and careful attention to that activity.

The mutual collaboration of countries in the eradication programs had not yet been attained. The smallpox foci still remaining in the Americas constituted not only a problem for the countries where they existed but also a continuous threat to and a source of anxiety for others which, thanks to their spirit of perseverance and continental solidarity, were already free from that disease. The persistence of foci compelled the affected countries to continue their efforts to maintain the immunity of the population at a high level, and, faced with the threat of further outbreaks, some countries that had considered smallpox already eradicated from their territories had been obliged to repeat their national collective vaccination campaigns.

The efforts made by Governments and by the Organization to produce stable, lyophilized smallpox vaccine in adequate quantities had been successful. With the Organization's collaboration, several countries were producing vaccine in sufficient volume both for their own needs and for other countries that did not produce it. Generally speaking, countries did not make good use of the facilities offered to them for testing vaccine. Some were encountering difficulties in preparing it, since some lots did not meet the minimum standards of potency, innocuity, and stability prescribed by WHO. He considered it essential for vaccine tests to be carried out regularly in order to maintain its high quality, and stated that the Organization was prepared to provide advisory services to promote the efficient operation of the relevant laboratories. The services of an internationally renowned laboratory was at the disposal of countries to make tests that would guarantee the quality of the smallpox vaccine prepared in national laboratories.

The smallpox eradication campaign in the Americas was moving forward more slowly than anticipated and, notwithstanding the excellent results scored by some countries that had concluded their eradication campaigns or reduced its incidence to a low level, it continued to be a serious health hazard in the Americas. In order to eradicate smallpox from the entire Hemisphere, countries must pool their efforts both to protect their own populations and to ensure the safety of those which had taken the requisite steps.

In his opinion, the fact that progress had not been faster was due to the grade of priority assigned to the problem and to political, economic, and administrative factors, both individual and combined. He stressed that, in their national budgets, Governments should allocate the funds necessary for continuing smallpox eradication activities. It had been demonstrated that, wherever the disease prevailed either epidemically or endemically and Governments were firmly resolved to carry out pro-

grams designed to eradicate it by providing the necessary resources, smallpox disappeared in a short time. That proved that the persistence of smallpox was due not to the lack of experience or technical know-how regarding ways of eliminating it, but to a lack of determination to do so and to the fact that the resources required for such an undertaking were not assigned to it.

He reiterated his opinion that it was indispensable to launch smallpox eradication programs, or to expedite them as the case might be, and that it was urgently necessary to vaccinate the population which had a low level of protection in countries close to others where the disease existed. The levels of vaccinated population in zones or countries where national vaccination campaigns had been carried out were below the standard recommended (see Table 3 of the working document).[8] At the same time, the reporting of suspect cases in zones where the population had already been vaccinated was deficient, and clinical and epidemiological research and laboratory diagnosis were undertaken on a very small scale and covered only a small proportion of the cases reported. That situation showed the need to organize epidemiological surveillance services in countries where the smallpox eradication campaigns had ended or were at the development stage.

Once epidemiological stations had been established in all the Zone Offices, the Organization would be able to cooperate more effectively with the various countries in setting up the above-mentioned surveillance services. Preparations were well advanced for organizing two courses on the laboratory diagnosis of smallpox which would be held in 1966. It was to be hoped that such training would make a major contribution toward improving diagnosis and the reporting of cases.

It was difficult to determine the current incidence of smallpox in the Hemisphere because reporting was incomplete and not timely. In 1964 Brazil, Colombia, and Peru had been the only countries to report a large number of smallpox cases. Brazil continued to report the great majority of the cases in the Hemisphere (2,502 in 1964, or 83.5 per cent), and although a smallpox vaccination program had been launched in 1962, the disease persisted in many areas of the country. In Peru, where the disease had been eliminated in 1954, it had reappeared in 1963 in zones adjacent to Brazil and 454 cases had been reported in 1964. In Colombia, Uruguay, and Argentina 21, 3, and 12 cases, respectively, had been reported. In 1965, up to 31 August, Brazil had reported 448 cases, Argentina 11, Colombia 146, and Paraguay 10.

Brazil was the key country so far as smallpox eradication in the Americas was concerned. Once the attack on the disease in that country was organized and coordinated with the programs of neighboring nations, it would be possible to eradicate it from the Americas.

He then enumerated the following conclusions on the subject.

Since the sole reservoir of the smallpox virus was the human body and vaccination was an effective method affording protection for several years, the eradication of smallpox in the endemic zones was within the capabilities of modern preventive medicine.

Furthermore, although the methods of preventing smallpox had been known since the end of the Eighteenth Century, the disease continued to be endemic in many countries of the Hemisphere. The fact that it had not yet been eradicated was due to various factors, the most important of which were that vaccination of the population was incomplete because the health services were both scant and inadequate, low priority was given to the problem, and economic and administrative difficulties existed.

The expenditure that a successfully concluded eradication program entailed, while substantial, was modest when compared with the cost of smallpox in terms of money and, especially, of lives and suffering. Its eradication was of paramount importance to all countries both for protecting their own populations and for safeguarding the others which were rid of it. It was therefore necessary to urge those countries in which smallpox still prevailed to take the necessary action to overcome the economic and administrative difficulties that impeded their smallpox vaccination programs, and to assign to the eradication program the priority it deserved from the point of view of both national and international health.

It should be stressed that the eradication of the disease was a national responsibility and the objective could be achieved only by national effort;

[8] See p. 376.

and that smallpox eradication was a source of concern not only to the countries infected but to all countries as a whole, because those currently free from smallpox ran the risk of reinfection from endemic zones.

The eradication program required a steadily greater national and international effort if satisfactory results were to be achieved in the near future. It was his opinion that, even if more national resources were allocated to smallpox eradication programs, the countries in which the disease was endemic would not manage to eradicate it without substantial assistance from international organizations and from those countries in which it had ceased to be endemic.

The countries in which smallpox was endemic could rapidly bring it under control and, in the long run, eliminate it, if they took active steps and received assistance from countries free from the disease, provided that they took the legal and budgetary action required to fulfill the international obligation assumed by all Governments when they had endorsed the resolutions of the Governing Bodies of PAHO and WHO.

Dr. AGUILAR HERRERA (Guatemala) said that, although smallpox had been eradicated in his country since 1953, the Government had taken pains to comply with the various resolutions and recommendations of the successive World Health Assemblies and the meetings of the Directing Council of PAHO, in order to keep its population immunized against possible further outbreaks. The Ministry of Public Health had taken the necessary steps to improve the quality and increase the production of vaccine, for which purpose it had requested the Bureau's assistance. In 1964, 1,417,165 doses had been produced and equipment had been purchased for the manufacture of dried vaccine.

A vaccination campaign had been launched in Guatemala and, in 1964, 500,000 of the country's 4,000,000 inhabitants had been vaccinated.

He concluded by expressing his Government's thanks to the Bureau and Organization for the material assistance rendered to Guatemala in improving its biological laboratory and for the advisory services of a consultant.

Dr. QUIRÓS (Peru) stated that it was sometimes alleged that the problem under discussion was the responsibility of countries and, at other times, it was adjudged to be that of the Organization. He believed that neither the countries nor PAHO could shirk the responsibility, because the problem continued to be as important as it had been some time before, although the number of reported cases was small.

A review of the epidemiology of the disease in the Americas showed that there was no smallpox in the Hemisphere from Colombia northward, but from Colombia southward it existed in almost all the countries, with the exception of Chile and, at the moment, of Ecuador. However, it was beginning to recur in countries where it had already been eradicated, such as Peru and Paraguay, and some imported cases had already been reported in Argentina. There were occasional cases of smallpox in both Uruguay and Colombia.

In Peru, before smallpox had been eradicated, there had been infested areas in the zone of the Andes, but that situation had been successfully remedied; the same was true of Colombia and Ecuador, and the problem of alastrim, mainly prevalent in Brazil and the countries adjacent thereto, had not existed. The outbreak which had affected Peru had been introduced by nomadic tribes, as had occurred also in Venezuela. Four cases had been reported in Lima, two of which had not even been recognized by physicians, because they had not been classified as smallpox owing to their benign nature. A laboratory worker, who had been testing virus diagnosis techniques, had taken some samples and the presence of the disease had then been discovered. In view of the existence of those cases, the Government of Peru had decided to launch a mass vaccination campaign, which had reached 1,700,000 people in 10 days, and the program had been intensified in the remote Amazon regions. The same action was being taken in connection with the antimalaria campaign, for which purpose use was being made of the Summer Institute of Linguistics, which was well acquainted with the tribes inhabiting the forest regions and had an aircraft service that made it possible to reach otherwise inaccessible places.

With regard to smallpox, the Government of Peru had to undertake a continuing vaccination campaign in the more vulnerable zones. While the countries suffering from the disease were few, they were extensive in area, and in Brazil the problem assumed major proportions. For that reason and to

prevent the disease from spreading, the campaign must be continued and Brazil must be provided with the requisite facilities. He concluded by stating that, for the reasons he had outlined, it could be said that the problem, which was essentially one of international public health, continued to persist.

Dr. SCORZELLI (Brazil) recognized that his country, which had scored major triumphs in other health activities, such as the eradication of *Aedes aegypti* and *Anopheles gambiae*, continued to be one of the foci of smallpox in the Americas. The campaign against smallpox had been started more than 150 years before, and he referred in that connection to the outstanding achievements of Oswaldo Cruz. Nevertheless, when the serious form that the disease had assumed at the beginning of the century had developed into the benign form, or alastrim, its importance had been underestimated by the population and even by the authorities themselves. They had reduced the number of vaccinations and, in addition, a low-potency vaccine had been used, giving the impression of a state of immunity that actually had not existed. Brazil had therefore launched an eradication campaign in 1963, as a result of which the number of cases had been substantially reduced.

Although some 20,500,000 people had been vaccinated, the figure was not high enough because, in order to cover 90 per cent of the population in 1968, more than 62,000,000 vaccinations were required. General legislation on campaigns would be submitted to Congress for approval and would promote greater flexibility of action. In any event, given the large area of the country, assistance was needed in the form of equipment such as jet injectors, which made it possible to intensify the vaccination program, and means of transport. Brazil could, on the other hand, supply vaccine because its output was considerable, or could collaborate in the campaign in some other way.

In conclusion, he invited the more prosperous countries and the international organizations to cooperate in that important task.

Dr. CANDAU (Director-General, WHO) expressed regret that he must leave the meeting the following day. In the current month he had attended two other regional conferences—at Lusaka, Zambia, for the meeting of the Regional Committee for Africa, and at Seoul, Korea, for the Western Pacific Regional Committee meeting, and he was reluctant to remain longer away from his Headquarters. He wished to thank the Representative of Brazil for his forecast of accelerated activity against smallpox in his country. Brazil, Pakistan, India, and tropical Africa were the sites of smallpox foci which most worried the World Health Organization, he said. Dr. Scorzelli's review offered great hope for a solution of the problem in Brazil. At the same time, he wished to thank Dr. Quirós for stressing the need for universal action to eradicate the disease.

In the light of Resolution WHA18.38[9] of the Eighteenth World Health Assembly, to the effect that smallpox could be eradicated within 10 years if sufficient resources were made available, he wondered what proportion of the additional $2.5 to $3 million needed annually could be found from the WHO regular budget, which he was shortly to prepare, and what proportion from voluntary contributions. Smallpox eradication was all the more important for an international organization such as WHO because the disease was the subject of International Sanitary Regulations. Smallpox anywhere was the responsibility of Governments everywhere. Currently, however, it was relatively more important for countries where it had been eradicated than it was for some of the less developed areas—India, for instance—where other health problems were as yet even more pressing.

Again, for certain countries, such as those of tropical Africa, finding the resources to conduct campaigns against smallpox would be difficult and he was inclined to feel that the countries which could afford to do so should make an effort over the next 10 years to help furnish such resources to the others for the common good. Complete dependence upon the regular budget of WHO would mean significant contribution increases for some countries that needed the money to carry on their own campaigns. It might be more logical to depend only partly on the regular budget, and if countries that could afford to participate directly in addition to their contributions through the regular budget would indicate the extent to which they would be prepared to do so, that course might become possible. He sought the guidance of Member Governments on that matter, for it was they who must

[9] *Off. Rec. Wld Hlth Org.* **143**, 24.

find the money; and what was needed was money, and resources, not mere statements of intention.

As Dr. Quirós had stressed, the stage was being reached where a solution of the world smallpox problem would have to be found. They could not forever continue to be complacent, each year producing beautiful resolutions which offered goodwill but gave little promise of solving the basic problem. It was his responsibility as Director-General to find the ways and the means, but he must also know precisely where the money to carry out the complete program, and for the length of time required, was to come from.

The matter would, of course, be discussed much more fully and finally at the Nineteenth World Health Assembly in May 1966, but he presented the problem at the moment because he felt that the countries of the world must soon decide what they were willing to do to eradicate smallpox, a disease which is, along with the other quarantinable diseases, the chief reason for the existence of the international health organization.

Election of Moderator and Rapporteur for the Technical Discussions

The PRESIDENT announced that the Council would proceed to appoint a Moderator and a Rapporteur for the Technical Discussions.

Dr. SALDAÑA (El Salvador) nominated Dr. Charles L. Williams, Jr. (Representative of the United States of America), for the post of Moderator and Dr. Conrado Ristori Costaldi (Representative of Chile) for the post of Rapporteur.

Dr. WEDDERBURN (Jamaica) and Dr. QUIRÓS (Peru) supported the proposal.

Decision: Dr. Charles L. Williams, Jr., of the United States of America, and Dr. Conrado Ristori Costaldi, of Chile, were unanimously elected Moderator and Rapporteur, respectively, for the Technical Discussions.

The session rose at 6:30 p.m.

EIGHTH PLENARY SESSION

Saturday, 2 October 1965, at 9:10 a.m.

President: DR. RAYMUNDO DE BRITTO (Brazil)

Item 27: Status of Smallpox Eradication in the Americas (*continuation*)

Item 34: Material Support of the Program for Global Eradication of Smallpox by the Countries of the American Region (*continuation*)

The PRESIDENT opened the session and announced that the debate would continue on the status of smallpox eradication in the Americas.

Dr. PRIETO (Paraguay) wished to supplement the information presented by the Paraguayan Delegation in an earlier statement on smallpox, so as to bring out the difficulty experienced, at least in his country, in maintaining the levels of immunity achieved through the vertical action programs.

In 1957 and 1958 Paraguay had carried out a large-scale smallpox vaccination campaign which reached 85 per cent of the population; and as a result smallpox cases had ceased to occur. A maintenance campaign had then been established, on the assumption that immunity would last five years and that during that time the local health services would undertake to vaccinate each year 20 per cent of the inhabitants in their respective areas. He referred to Table 3 [1] in Document CD16/29, which indicated that since 1960 Paraguay had vaccinated only 10 per cent of its population of 1,900,000. There had been years when the local health services had not been able to vaccinate more than 2 per

[1] See p. 376.

cent, and the epidemic of recent months had been the consequence. In other words, the level of immunity had dropped considerably, causing a smallpox epidemic to break out. In countries like Paraguay, the local health services lacked the means to provide protection for 100 per cent of the population; thus vertical programs had to be combined with horizontal services so as to ensure the maintenance of a satisfactory level of immunization.

Finally, he submitted to the Council the following draft resolution, which took into account the possibility of coordinating both types of programs as well as the other aspects of the problem raised on the various occasions when the problem of smallpox had been discussed:

THE DIRECTING COUNCIL,

Having considered the report of the Director on the status of the smallpox eradication program in the Americas (Document CD16/29) and bearing in mind Resolutions XIX, XIII, VI, and XXX of the XIII, XIV, XV, and XVI Pan American Sanitary Conferences regarding the eradication of smallpox in the Hemisphere;

Bearing in mind its previous resolutions, especially Resolution XLI approved at the XV Meeting;

Considering that smallpox is an eradicable disease and that techniques and means that have been scientifically established and proved in practice are available for its eradication; and

In view of the WHO resolutions regarding the smallpox eradication program and considering that its eradication is one of the principal objectives of the Organization, as declared by Resolution WHA18.38 of 19 May 1965,

RESOLVES:

1. To reiterate and confirm the previous resolutions of the Governing Bodies of the Organization to the effect that smallpox must be eradicated from the Hemisphere.

2. To recommend to the Governments that, side by side with the conduct of intensive programs, they organize activities aimed at maintaining, through the years, a high level of immunity among the population vaccinated in the course of those activities, and also to recommend to those governments which have already completed their smallpox eradication campaign but which have not yet initiated the corresponding immunity maintenance campaign, that they do so as soon as possible.

3. To urge the Governments of countries in which there is no smallpox and in which the level of immunity of the general population is low that they institute, by such means as they deem appropriate, a program for progressively increasing the vaccinated proportion of the population.

4. To invite the Governments, when the intensive vaccination campaigns are complete, to organize epidemiological surveillance services for the early detection of suspect cases of smallpox and the prevention of the spread of the disease and, for this purpose, to take special measures for the clinical laboratory confirmation and epidemiological investigation of suspect cases of smallpox occurring in their territories.

5. To remind the Governments that the organization and execution of national smallpox vaccination programs is an obligation incumbent upon them.

6. To emphasize the need for the Pan American Sanitary Bureau to continue to act as the coordinating agency of the national smallpox campaigns and to provide those campaigns with technical assistance.

7. To invite the Pan American Sanitary Bureau to continue to assist the Governments in obtaining financial and material resources for their national programs.

8. To urge the Governments to supply the national programs of other countries of the Continent that need them, not only with smallpox vaccine but also with financial and material resources and specialists, either directly or through the Pan American Sanitary Bureau.

9. To express its thanks to the countries of the Continent that have so generously donated smallpox vaccine to nonproducer countries in need of it.

The PRESIDENT said that the draft resolution presented by the Representative of Paraguay would be distributed to the Council for consideration at a future session.[2]

Dr. WILLIAMS (United States of America) recalled that in 1902, at the First International Sanitary Convention, the then Surgeon General of the United States of America, Dr. Walter Wyman, had said: "We shall discuss the question of quarantine, which is still a necessary guard against the common enemy of mankind, contagious disease, which needs at times to be strengthened, but which fortunately may be made less severe with our increasing knowledge of disease, and which in time, it is hoped, may become almost perfunctory as the importance of the third subject of our deliberation, sanitation, is appreciated and promoted. Our deliberations will relate to scientific investigations, which alone enable us to be rational in both quarantine and sanitation, and which form the stone foundation and the iron girders of our hygienic structure." [3]

The past six decades had seen great changes in man's ability to cope with the communicable diseases, Dr. Williams said, but it was still necessary to maintain quarantine services, though the rapidity of modern travel had greatly reduced their effi-

[2] See ninth plenary session, p. 120.

[3] *Transactions of the First General International Sanitary Convention of the American Republics*, p. 14. Government Printing Office, Washington, D.C., 1903.

ciency. The United States of America had had no confirmed outbreak of smallpox for more than a decade and a half, but it still spent $15-20 million annually in maintaining its defenses against the importation of the disease. Neither that expenditure nor the continued vaccination of the population, with its attendant discomfort and even danger, would be necessary were there global eradication.

Document CD16/29 outlined the many unanimous resolutions on the priority of smallpox eradication that had been passed by the nations of the Americas since 1950, and by the nations of the world since 1958, especially in 1964 and 1965. Since 1948 PAHO had spent $600,000 for that purpose (Document CD16/29, Table 1), certainly not an excessive amount in view of the results obtained. Might not the expenditure of a somewhat larger amount, to achieve the goal more rapidly, have been justified.

The Directing Council at its XV Meeting had instructed [4] the Director to provide the Governments with the necessary advisory services, and that leadership by the Organization was essential in the final push to vanquish smallpox in the Americas. At the same time, the basic responsibility for the task resided in the individual Governments.

Dr. Candau had estimated that an additional sum of perhaps $2 to $2.5 million would be needed annually from international funds for the next 10 years to achieve global smallpox eradication. The United States of America had placed Item 34 on the agenda, first, to emphasize the need for all Member States of WHO and PAHO to do their utmost to eradicate smallpox, and secondly, to permit an assessment to be made of the financial and other resources needed and determine when they would become available.

In response to the Eighteenth World Health Assembly resolution [5] on the subject, approved in May 1965, the United States of America had been exploring possible ways in which it might support the program in the light of such action as other Member States might be prepared to take. It was therefore very grateful for the information provided during the current discussion, and particularly for the comments of Dr. Candau. The Director of PASB might wish to report to the Executive Committee meeting in April 1966, and the WHO Director-General to the Executive Board meeting in January 1966, on the results of their efforts to find financial and other resources, as well as on the cost estimates for the program from 1967 through completion of eradication.

North and Central America, and all of the West Indies, had been free of smallpox for more than a decade, and several countries in South America practically so for several years. In 1964 there had been no smallpox reported in all of Europe, in the USSR, in Africa north of the Sahara, nor in the Western Pacific Region of WHO, a situation not hitherto known in modern times. The campaigns against smallpox were obviously curtailing its international spread, and its rapid and complete eradication was obviously in the interest of all. Countries already freed of smallpox had a very real stake in its eradication in other countries also. Peru, for instance, had during the past two years known the high cost of reinfection.

Cholera, which had been rather quiescent and limited in extent for a decade after World War II, had in the past five years been able suddenly to spread throughout many countries of the Middle East, South-East Asia, and the Western Pacific. It was clear that the spread of the disease had not been adequately controlled by existing quarantine services, and that in the case of cholera the experience of several European countries with smallpox a few years earlier was being repeated. Surely it was time that all nations joined in not merely preventing communicable diseases from moving from one country to another, but in eradicating them from the face of the earth.

On the day that the Eighteenth World Health Assembly had resolved that it would seek the eradication of smallpox everywhere within 10 years, the President of the United States of America, Lyndon B. Johnson, had announced his strong support of that action, and had pledged aid in the form of technical personnel and resources, including the establishment of laboratory facilities in the developing countries to help provide the vaccine needed in the intensified program. He had also stated that to help in the world-wide eradication of smallpox, his program of action included: (1) full support for the adoption by the World Health Organization of a smallpox eradication program with a goal

[4] Resolution XLI. *Official Document PAHO* **58**, 91-93.
[5] Resolution WHA18.38. *Off. Rec. Wld Hlth Org.* **143**, 24.

for completion within a decade; (2) contribution of technical personnel and other necessary resources to the Pan American Health Organization, the regional agency of WHO, to step up the war against smallpox in Latin America; and (3) assistance in the establishment of laboratory facilities in the developing countries to help meet requirements of vaccine for the intensified programs. President Johnson had added: "This Government is ready to work with other interested countries to see to it that smallpox is a thing of the past by 1975."

In short, Dr. Williams said, the United States of America felt very strongly about the program but wished to support it in association with others and with the aggressive leadership of WHO and PAHO in identifying what needed to be done. It did not feel that in the world of 1965 it could perform, or should try to perform, the task by itself. Without such leadership no country, irrespective of its size or resources, could hope soon to succeed in what was after all a universal undertaking.

Dr. MARTÍNEZ (Mexico) said that in his view the Pan American Sanitary Bureau's policy in regard to the problem under discussion should comprise, *inter alia*, the preparation of a report that would act as a reminder to countries still troubled by smallpox of the urgent need to adopt stringent measures to combat the disease, and would illustrate for the benefit of those countries that had eradicated smallpox the desirability of intensifying and maintaining their state of immunity. At the same time the Bureau should bring home to both groups of countries the price to be paid for the maintenance of immunity not only in money but in human lives. He recalled that a few years earlier a British doctor had published an article in which he showed that the vaccination of children in England caused some loss of life, since the imperfect state of immunization at the time gave rise to cases of smallpox, and vaccination caused a number of deaths. An investigation of the extent of immunization required in those parts of the world already free from smallpox would show that, if the situation was to be maintained, it would mean a considerable annual investment. In the same way, an estimate could be made of the number of human lives lost owing to the failure of a few countries to eradicate the disease so far.

It might be useful if the Bureau were to carry out a study on the subject and submit it to WHO so that the latter might transmit it to all its Member States and bring home to them the cost in money, effort, and human life implied in an immunity maintenance campaign if a recrudescence of smallpox throughout the world were to be avoided.

Dr. QUIRÓS (Peru) endorsed the statements made by Dr. Candau on the important subject of smallpox, especially in regard to the need for unabated action. There was no denying—and the fact was borne out by the Brazilian Representative's reference to the status of the eradication campaign in his own country—that resources were needed; and resources were obtainable, in his opinion, through international agencies. As an example, he cited the loan *sui generis* obtained for the construction of the Organization's new headquarters building, and he thought that something similar would be possible in connection with smallpox eradication. The Pan American Health Organization was not merely an organ for multilateral aid; it frequently had recourse to bilateral aid, obtaining funds from other bodies such as UNICEF, or from banks; or it studied ways and means of obtaining the necessary resources through loans or similar procedures, or through other organizations. Hence countries which for financial or other reasons had not yet been able to eradicate smallpox, as Dr. Scorzelli had said, should be able to do so within a short time.

Dr. CASTILLO REY (Venezuela) supported the various points made by previous speakers in regard to the necessity for all Member Countries, with the help, encouragement, and guidance of the Organization, to pursue their efforts for the eradication of smallpox.

Even though, as had been pointed out, the knowledge essential for combating the disease was already at hand, as were simple techniques and adequate production of vaccine, it should be emphasized that there was a problem of coverage involved. Basically, eradication implied not only the availability of know-how and resources, but the possibility of making them fully accessible to the entire population exposed to the disease; and as he had urged in an earlier statement, he felt that the highest priority should be given to that effort.

Although the procedure established for the smallpox campaign was a simple one, the situation in his country was that until the end of the fifties,

by which time the Organization had achieved a considerable degree of development, the local public health services in Venezuela were concerned mainly with the control of epidemic outbreaks. It had then been necessary to supplement the horizontal services with a vertical service—an expensive operation as a rule. The result had been an example of vertical action supported by the ordinary horizontal action. Although there had been no autochthonous cases of smallpox in Venezuela since the middle of the decade, the operation was proceeding along the same lines. Thus, in view of the need to expand the coverage of those services to the maximum degree and to maintain a level of immunization guaranteeing 100 per cent protection of the population, it seemed to him that the importance of that operation must not be forgotten—in conjunction of course with satisfactory development of the local public health services.

He warned against undue confidence in regard to immunization—for even in countries which like Venezuela had already succeeded, some years earlier, in ridding themselves of smallpox, some concern was felt about the danger of a recurrence of the disease through exposure due to the ease and speed of communications and transport. It was therefore imperative to maintain a high level of protection at all times, and that inevitably involved expense. In his opinion, the Pan American Sanitary Bureau should take up the matter, considering it both technically and from the budgetary viewpoint, not with any idea of assuming global responsibility for it, since that was the task of the countries themselves, but in order to provide guidance and encouragement and to ensure that they did not lose interest in so vitally important a question.

Dr. BICA (Chief, Communicable Diseases Branch, PASB), referring to the issues raised by the Representative of Peru, pointed out first of all that the data available to the Bureau clearly did not provide a true picture of the incidence of smallpox—the actual documents on the subject recognized as much—but they did give a pointer to the trend of the disease. Furthermore, there was no doubt that reporting of smallpox cases had improved enormously over the past few years, and might be expected to improve still further, especially once the various countries began to establish surveillance services and once they had more adequate funds for diagnosis of the disease.

Secondly, with reference to advisory services, the Bureau had been furnishing that type of aid to a number of countries, including Bolivia, Colombia, and Ecuador, not only in connection with the planning of the vaccination campaign but also in organizing it and carrying it out. In addition, a dozen or more countries had been provided with advisory services in regard to the production of vaccine, and the Bureau had also awarded a considerable number of fellowships for training national personnel. The Bureau was always ready to advise countries at their request, both concerning the different aspects of the vaccination program and in establishing surveillance services for the diagnosis of the disease, for the preparation of lyophilized anti-smallpox vaccine, and for the training of national personnel. It would be a good thing if countries made more frequent use of the services of the Copenhagen Laboratory for vaccine testing, as that was the only way of ensuring that the product used was of good quality.

Dr. HORWITZ (Director, PASB) said he would like to inform the Council—and in that connection he had greatly welcomed the statement by the Mexican Representative, Dr. Martínez—that the Bureau had made arrangements for a group of three or four experts to undertake a tour within the next few months, and with the consent of the ministries of public health and their distinguished fellow-workers, to study in detail the various issues that had been raised during the current debates with respect to countries where some endemicity still remained. In 1948, when the data available were far less satisfactory than they were today, there had been 30,000 recorded cases of smallpox. He was convinced that in 1965 the number would not reach 5,000—and the figures were more accurate. Countries where smallpox endemicity still persisted should therefore indicate their global requirements for eliminating the disease. The totals should cover every type of expenditure, and the Governments concerned should specify what resources they possessed and what they hoped to obtain by way of international aid. With regard to the other countries—those which had been fortunate enough, through their own resourcefulness and effort, to eradicate smallpox, as Dr. Martínez had so aptly put it—should specify what they needed in order

to maintain a sufficient level of immunity to prevent smallpox from gaining a foothold in the event of smallpox carriers crossing their coastline or frontier.

Dr. Horwitz thought that on the basis of a study, which would be as thorough as Governments might wish to make it by their zeal in investigating the background of the problem, the Bureau would not only be in a position to place before the Council a definite scheme, consonant with the magnitude of the problem, for the decade beginning a year hence, but would be prepared to coordinate its efforts with those of the World Health Organization, in accordance with the general policy laid down by the Assembly. He shared Dr. Castillo Rey's view that the matter should be considered from both the maintenance and the coverage angles. It would be most unfortunate if countries were to achieve virtual immunization and then, within 10 or 15 years, high morbidity rates were again recorded merely through failure to organize a minimum maintenance service; and of course, human contact was bound to increase as time went on.

With regard to the question of estimating the level of investment required, allowance should be made for the possibility of contributions by other government departments whose staff, being directly in touch with local communities, could easily be given whatever training was needed to use the devices available today. For example, a jet injector was simple to operate and required no special training. There were many governmental services spread over the national territories that could participate at the coverage stage, thereby reducing costs and speeding up the immunization process. In that connection it might be desirable to draw up an estimate of what the establishment of minimum services would involve—a point aptly raised by the Representative of Brazil—vertical operation in depth being converted into horizontal stability as far as the circumstances and the level of development permitted. The time was short, and it was desirable to avoid hasty action that might raise queries later on; nevertheless it was hoped that the data in question would be available for presentation to the Executive Committee in April 1966. Although thought had been given to the desirability of appointing a three or four-man advisory team, it was unlikely that the information would be ready by the time the WHO Executive Board was due to meet in January. What was wanted was as realistic an analysis as possible of the conditions existing in the various countries—and that would inevitably depend on what Governments were prepared to do—rather than superficial estimates based on highly unreliable figures of per-capita costs.

The problem had always interested him profoundly, and looking back to 1950, when he had first joined the Pan American Health Organization, he recalled that Dr. Fred L. Soper had appointed him specifically for work in the field of smallpox. He had been concerned with it ever since, though other duties had prevented him from pursuing the activities begun at the time.

The question of smallpox diagnosis was another matter that warranted study: the smallpox outbreaks recorded during the past few years had shown evidence of tardiness in reporting cases, owing to the uncertainty of diagnosis. The truth of the matter was that over the years, medical knowledge in regard to the clinical characteristics of smallpox was being gradually whittled away, for want of cases. Hence there was no alternative but to turn more and more toward biological diagnosis, a field in which distinct progress had been made. The techniques as such presented no complications, and it was hoped that in the course of the coming year, with the generous cooperation of Governments —and in the case in point, especially that of the Brazilian Government—it would be possible to organize at the Adolfo Lutz Institute in São Paulo a course at advanced level for technicians on the diagnosis of smallpox and other diseases clinically similar, even though their etiology was different. In due course the public health ministries of the various countries would be asked to nominate experts to take part in the proposed practical seminar on diagnosis. The Bureau was also hoping that all the various countries would set up appropriate services since, as had been pointed out, case-detection was unsatisfactory because of the uncertain state of clinical diagnosis, and the uncertainty could not be remedied except through etiological diagnosis.

He trusted that when the Bureau submitted the itemized Program and Budget for 1967, as laid down in the relevant resolution,[6] it would be in a posi-

[6] Resolution VII. *Official Document PAHO* **66**, 60-61.

tion to incorporate in the appropriate document, as accurately as possible, the findings of the overall continent-wide study in question. Even though the Executive Committee was to take a decision on the matter and inform the Directing Council of the Organization accordingly, he would like to repeat what Dr. Bica, Chief of the Communicable Diseases Branch, has said, namely, that under the policy laid down by the Council in regard to smallpox eradication there had been no lack of funds for emergency cases, and he saw no reason why there should be any in the future. He felt obliged to point out, however, that it was the duty of the Council to make it perfectly clear how far international collaboration should extend, since it could stretch from mere technical advice to the payment of local salaries. In conclusion, he said that in accordance with existing general policy, the Bureau had quite specific functions in regard to technical advisory services, and in his opinion the trend observable in the data recorded indicated that it had carried them out successfully.

Item 24: Resolutions of the WHO Executive Board and the World Health Assembly of Interest to the Regional Committee (*continuation*)

Draft Resolution Proposed by the Delegation of the United States of America

The PRESIDENT announced that the draft resolution proposed by the Delegation of the United States of America on population dynamics would be read.

Dr. SUTTER (Assistant Director, PASB) read the following draft resolution:

THE DIRECTING COUNCIL,

Having considered Resolution WHA18.49 of the Eighteenth World Health Assembly;

Considering Resolution XXXI of the XV Meeting of the Directing Council, XVI Meeting of the Regional Committee of WHO, which recommended various studies in population dynamics; and

Recognizing the interrelationships and interactions of health, population growth, and socioeconomic development, and the importance of active programs of cooperation among organizations of the Inter-American System,

RESOLVES:

To request the Director:

1. To provide technical advice, as requested, on the health aspects of population dynamics, in line with Resolution WHA18.49 adopted by the Eighteenth World Health Assembly.

2. To cooperate with the Inter-American Committee on the Alliance for Progress in studies assigned to it by Section 1, paragraph 16, of the progress report on the Alliance (adopted at the Third Annual Meeting of IA—ECOSOC at the Ministerial Level, 9 December 1964), as well as to engage in any other activities of CIAP on the population question.

3. To conduct studies as may be desirable on population dynamics related to the program activities of PAHO, and to support professional training as appropriate.

Dr. WILLIAMS (United States of America) suggested that the following words be deleted at the end of the second operative part of the draft resolution: ". . . as well as to engage in any other activities of CIAP on the population question."

Decision: By 18 votes in favor, none against, and one abstention, the draft resolution proposed by the Delegation of the United States of America on population dynamics was approved.[7]

Draft Resolution Proposed by the Delegation of Argentina

The PRESIDENT announced that the draft resolution proposed by the Delegation of Argentina on pharmaceutical preparations, would be read.

Dr. SUTTER (Assistant Director, PASB) read the following draft resolution:

THE DIRECTING COUNCIL,

Bearing in mind Resolution WHA18.36 of the Eighteenth World Health Assembly concerning the need for Governments to take steps to ensure that pharmaceutical preparations, both imported and of national manufacture, are subject to an adequate qualitative inspection, for which purpose it is necessary that analytical laboratory services be established;

Considering the report of the PAHO/WHO temporary consultant on the possibilities of establishing an International Laboratory for the Analysis of Pharmaceutical Products (Document CD16/19, Addendum II, Annex II) which would also serve as a training and research center in this field; and

Considering recommendations VII.C.2 contained in the Final Report of the Meeting of the Task Force on Health at the Ministerial Level (Washington, D.C., 15-20 April 1963) on the quality and cost of essential drugs,

RESOLVES:

1. To commend the Director for the promptness with which the Bureau has begun to collaborate with Govern-

[7] Resolution IX. *Official Document PAHO* **66**, 62-63.

ments in the implementation of Resolution WHA18.36 approved at the Eighteenth World Health Assembly.

2. To recommend that the Bureau continue studies on the possibilities of establishing international laboratories for the analysis of pharmaceutical products which may serve as reference laboratories for the Member Countries.

3. To draw to the attention of Governments the importance of recommendations VII.C.2 on the quality and cost of essential drugs, contained in the Final Report of the Meeting of the Task Force on Health at the Ministerial Level, which met in Washington, D.C., in 1963.

4. To request the Director to report to the next meeting of the Directing Council on the result of these studies and on the possibilities offered by the Organization for providing more extensive assistance in the development of projects of this type.

Dr. WILLIAMS (United States of America) pointed out that since the draft resolution proposed by the Representative of Argentina had just reached their hands, and owing to the importance of the subject, he would prefer that it be discussed and voted upon by the Directing Council at a future plenary session.[8]

It was so agreed.

Item 26: Study of the Relationship between Social Security Medical Programs and Those of Ministries of Health or Other Official Health Agencies (*continuation*)

Draft Resolution Proposed by the Delegation of Panama

The PRESIDENT announced that the draft resolution on the coordination of medical care in Latin America, proposed by the Delegation of Panama, would be read.

Dr. SUTTER (Assistant Director, PASB) read the following draft resolution:

THE DIRECTING COUNCIL,

Having considered the final report of the Study Group on Coordination of Medical Care in Latin America (Document CD16/25);

Bearing in mind that the enjoyment of the highest attainable standard of health is a right of all human beings without discrimination, a right that must be guaranteed by the State through the organization of a system of services for the protection, promotion, and restoration of health;

Recognizing that government health services and social security medical services complement each other and consequently are essential components of the national health organization; and

Recognizing that the planning of economic development and social progress requires the countries to make rational use of existing installations and to program the development of their human and material resources in a methodical and coordinated manner,

RESOLVES:

1. To take note of the final report of the Study Group on Coordination of Medical Care in Latin America.

2. To thank the Director of the Bureau and the members of the Group for their profound analysis of the problem, and the Organization of American States for its efficient cooperation.

3. To reiterate its previous resolution to the effect that this report be transmitted to the Governments, together with an invitation to apply progressively the recommendations in it concerning machinery for coordination between ministries of health and social security institutions, especially that which refers to the need for a survey to measure the real magnitude of the problem and to ascertain its characteristics.

4. To recommend to the Governments that national health planning cover the entire health sector, including social security and private institutions, so that high level Government authorities may take decisions aimed at the formulation of an appropriate national health policy.

5. To recommend to the Director of the Bureau that, in the exercise of his powers, he enlarge the medical care program in order to carry out the following activities:

a) To provide the national health authorities with information and advice on how to achieve the maximum degree of coordination between public, semiautonomous, and private institutions that have medical care services.

b) To organize courses, seminars, or other meetings, in collaboration with the international agencies concerned with social security, for the education and training of staff specialized in the administration of medical care and social security services.

c) Through the Governments concerned, to help spread modern concepts of health care among trade unions and throughout the community, in order to secure their active and intelligent cooperation in efforts directed at coordination.

d) To sponsor joint meetings of directors of the health services and the ministries of health and of the social security institutions of the Member Countries.

Dr. ESQUIVEL (Panama) pointed out that the word "autonomous" had been omitted in the operative paragraph 5 (a), which should read "of coordination between public, autonomous, semiautonomous, and. . . ."

Dr. FERREIRA (Brazil) said that even though it had not been possible to study the draft resolu-

[8] See eleventh plenary session, p. 143.

tion carefully, it seemed clear from a mere perusal that his Delegation would be unable to vote for it, since in Brazil the position involved a matter of principle, all types of governmental activity in health protection matters being regarded as the exclusive domain of the Ministry of Health. It was a very delicate point, since in many countries, including Brazil, medical care services were part of social security and did not come under the Ministry of Health. The Brazilian Delegation did not wish to propose or to adopt a straitlaced attitude, but as it now stood the draft resolution implied the acceptance of a duality of principle; meanwhile so long as the Brazilian attitude was not paradoxically different from what was appropriate from the international point of view, his Delegation would abstain from voting.

There was no doubt that social security embraced a vast field of endeavor and that there must be inter-relationships between the organs of social security and those concerned with medical care; but in that respect the Brazilian Delegation's position was clear, namely, that it could not accept the categorical principle that there should be duality in the method of furnishing medical care and social security.

Mr. RIVERA (Costa Rica) said that the draft resolution submitted by Panama covered a number of distinct points, and though they were interrelated, they could be discussed and put to the vote separately. His country shared the view of the Brazilian Representative concerning medical care, and, furthermore, it endorsed the definition of the health service policy given by Dr. Ferreira. Costa Rica considered that the policy, and the establishment of regulations, were the exclusive prerogative of the State, which exercised it through its Health Ministry. Without ignoring the resources the social security services had available, and without thrusting them into the background or denying the freedom they enjoyed to carry out their function satisfactorily, they should be subject to the country's health policy as organized in accordance with a plan designed to provide adequate care for the entire population and not merely for a part of it. Thus the Costa Rican Delegation would be unable to vote in favor of the draft resolution in its present form; he therefore suggested that it be discussed one part at a time, and that each part be voted on separately.

Dr. CALVO (Panama) shared the view of the Representatives of Brazil and Costa Rica; he proposed that a working group be established, with the representatives of both those countries, for the purpose of reviewing the text and preparing a definitive draft resolution.

Dr. BONICHE VÁSQUEZ (Nicaragua) proposed that the final version of the draft include an idea he had already suggested, namely, a recommendation to Governments that social security institutions embody in their work programs systematic campaigns for immunizing the population, to be carried out with technical advice from the respective ministry of health.

Dr. QUIRÓS (Peru) fully supported the arguments presented by the Representatives of Brazil and Costa Rica, and endorsed by the Delegation of Panama. He emphasized the importance attached in the draft resolution to the need for studying the coordination of the social security services with the public health services; and he felt that the Organization could make quite a specific and objective contribution toward coping with the existing inequitable situation in most of the social security services in the Americas.

Dr. BRAVO (Special Adviser, PASB) said that the debate was most gratifying to the members of the Bureau, both because it demonstrated how much the topic interested all the Representatives and because it had at the same time made for an extraordinarily comprehensive picture, as a result of which the Organization undertook to comply with the requests made by the Representatives of the various countries. He recalled that Professor René Dubos had defined man as a biological and social being, subject to the laws of heredity and at the same time under the influence of ecological factors derived from spending his life in a given environment. A broad and over-all view of such factors, which affected his state of health or sickness, would enable the World Health Organization to achieve its purpose, that is, the highest possible level of physical, mental, and social well-being for all men, without distinction. Such a state of social well-being meant that States incurred responsibilities in regard to education, housing, and

recreation, as well as to the protection, maintenance, and recovery of health, through the organization and operation of appropriate services available as of right to every citizen.

At the current stage of development of the health services in the different countries of the Hemisphere, the Bureau's position should be broad enough to enable the various Governments, without prejudice to their own historic tradition, their legal system, and their administrative structure, to tackle the problem realistically and according to prevailing conditions. While possibly some Governments were already in a position to achieve complete integration, others had not yet reached that stage of development; therefore, international organizations such as the Pan American Sanitary Bureau had to devise systems sufficiently flexible to enable them to work together with each country, with due regard to their peculiar situation, goals, and particular attitude toward the subject under discussion.

The important point was to bear in mind that there should be steady progress toward closer and closer coordination and a realistic confrontation with the agencies active in the field. Whatever the policy adopted by the Organization on the theoretical side, the truth was that in practice the social security institutions administered, directed, and maintained medical services in practically all countries. If such facts were not recognized, it was almost tantamount to ignoring the facts of the situation.

He referred to the point made by a number of Representatives to the effect that the Delegations sent by Governments did not include social security personnel, and he recalled that the Executive Committee, at its 52nd Meeting held in April 1965, had adopted Resolution XVI,[9] which emphasized the importance of having senior officials responsible for the medical care benefits of social security services take part in the discussion of that problem and requested that the Director suggest to Governments that such officials be included in their delegations. The Director of the Bureau, he concluded, had complied with the Executive Committee's instructions, and in response to his appeal, a number of countries, though not all, had included social security officials in their delegations. He hoped that future meetings would see the participation of larger numbers of social security officers.

Dr. MARTÍNEZ (Mexico) recalled that during the 50th Meeting of the Executive Committee held in 1964, the Mexican Delegation had proposed [10] the study of that topic with the idea and in the hope that the Pan American Sanitary Bureau would make available its valuable assistance so that the social security systems in all the countries of the Americas would continue to collaborate in the improvement of public health throughout the Hemisphere. In Mexico, social security was daily becoming more important, and since its establishment to the present, it had been one of the major factors in the development of public health.

The Mexican Government, and more specifically the Ministry of Health and Welfare, was proud of the progress and the achievements of social security in the country. But while social security was an administrative procedure of the utmost importance in speeding up the process of improving health, it should be remembered that administratively speaking it could take a great variety of forms, according to the legislation of the particular country concerned. In his opinion, the point that called for thorough study was not so much the situation in the individual countries or the function of any particular social security system—or its economic capacity in relation to that of the ministries of health—as the role of the Pan American Sanitary Bureau in seeing to it that the activities of any administrative system set up to protect and promote health were coordinated with the activities of the other systems.

He did not agree with Dr. Bravo that integration should be the ultimate goal. He felt that to be an encroachment upon the social organizations of the various peoples. Such a situation might be acceptable to some countries, but not to all. There was no reason why health services should necessarily constitute a single administrative unit, for it should always be remembered that there was great institutional diversity in the countries of the Americas. Mexico, for example, had a federal structure in which each state enjoyed freedom and autonomy, and the idea of social security as a single administrative unit was impossible and unthink-

[9] *Official Document PAHO* **62**, 38-39.

[10] *Official Document PAHO* **60**, 216.

able. He therefore thought it desirable for the working group set up to bear in mind that the basic aim was to establish the most appropriate ways and means so that the PASB could help speed up and improve the mutual relations between all the administrative systems responsible for health in the different countries, irrespective of their own internal structure. Any insistence that social security established an economic discrimination between social groups would merely have the effect of calling into question a system which produced beneficial results, without any predetermined aim. It was nevertheless undeniable that as a rule, social security benefited those population groups which by definition had work and hence enjoyed a higher economic status than others. Thus they were fully entitled, in his opinion, to take advantage of that situation as they thought fit, *inter alia* by organizing systems for the improvement of health of their members.

In conclusion, Dr. Martínez requested that the working group take into account the point of view of Mexico, which merely meant that the Bureau would be requested to establish an effective machinery for providing assistance to the countries and thus promoting the necessary coordination of all the various national administrative systems operating under the law in the interests of the various groups within those countries.

Dr. VALDIVIESO (Chile) said that the Delegation of his country was willing to vote in favor of the draft resolution, but that he wished to explain that from the theoretical point of view he concurred in large measure with the views expressed by the Brazilian Representative. The Chilean Delegation believed that it was the State's responsibility to safeguard the health of the population in its various aspects and that that function should be performed, beyond the shadow of a doubt, by the Ministry of Health. In his personal opinion, the social security institutions should play a strictly supervisory role; however, since many countries were still far from achieving that objective, the proposed interministerial coordination would provide a distinctly useful measure.

Dr. FERREIRA (Brazil) thanked the Representative of Panama for proposing that a working group be established to draft a resolution acceptable to the members of the Council without requiring Governments to adopt a particular principle. Flexibility was the Organization's guiding rule, and for that very reason the Delegation of Brazil had from the outset advocated a procedure which would leave participating countries free to decide for themselves what course they would follow, instead of approving a resolution that might seem somewhat tendentious, recommending simultaneous activities in the field of health—a task which in some countries was the domain of an agency set up specifically for that purpose. The question at issue was a very delicate one, and it could not be resolved by imposing coercive procedures; hence, in any resolutions adopted, it would be well to state the principle very clearly that countries were at liberty to follow whatever path they chose in laying the legal foundations of institutions for the protection of health. It was not a question of establishing the principle that ministries of health were necessarily responsible for all aspects of the matter. The Bureau's function should be concerned with the interlocking, encouragement, and active participation with state bodies, whatever the particular political structure of the countries concerned. But it would surely not be going too far to assert that the basic principle on which governmental decisions were based should be based on a doctrine or on a philosophy.

Concluding his remarks, he strongly supported the Panamanian Representative's proposal; and he requested the Presidency to include in the proposed working group particularly those representatives who had expressed their willingness to incorporate their differences in a single resolution based on the Panamanian proposal, subject to such adjustments as might be required to make the Brazilian Delegation's views fit in more homogeneously.

The PRESIDENT suggested that the working group to review the draft resolution presented by the Delegation of Panama might comprise the Representative of Brazil, Chile, Costa Rica, Mexico, and Panama, and that it should be requested to submit a text by the following week, including all the points of view expressed during the debate.[11]

It was so agreed.

The session was suspended at 10:45 a.m. and resumed at 11:15 a.m.

[11] See thirteenth plenary session, p. 172.

Item 11-A: Report on the Status of Malaria Eradication in the Americas

Dr. DA SILVA (Chief, Malaria Eradication Branch, PASB) presented Document CD16/13,[12] XIII Report on the Status of Malaria Eradication in the Americas, covering the period through December 1964.

He explained that the statistical data, both technical and administrative, given in the document had been supplied to the Bureau by Governments through their National Malaria Eradication Services, and he invited Representatives to turn to the maps giving a general picture of the campaigns undertaken in the Hemisphere during 1963 and 1964. A mere glance would make it possible to compare the progress achieved during that period and to interpret Table 1 correctly (Comparison of 1963 and 1964 Population and Area in Various Phases of the Malaria Eradication Program in the Americas, and Percentages of Change by Phase).

Table 2 showed the areas in the maintenance and consolidation phase and how they had been decreasing since 1960. Anyone not conversant with the matter might well interpret that as a dangerous retrograde trend but in actual fact it was a step forward. In explanation of that statement he referred to the fact that in 1961 many programs had completed the classic four years of intradomiciliary spraying with a residual insecticide, and the inadequate information available suggested that transmission had been halted over wide areas. Yet from 1962 onward many of those areas had had to return to the attack phase, since the intensification of surveillance activities made possible by the savings effected when the spraying ceased showed the need for that. In 1962 and 1963 the same thing had happened, though on a lesser scale. From 1964 onward, the decision had been taken to suspend the attack phase as a result of the experience of the earlier years.

The decisions in question had been taken in most instances with the full cooperation of the Pan American Sanitary Bureau's advisers on malaria at both the local and the central level.

The economic basis on which the execution of many of the programs depended, and the problems due to the persistence of transmission, were of so serious a nature, especially when there seemed little prospect of increased funds in the immediate future, that there was no alternative but to suspend the attack phase in areas where the incidence of malaria was relatively low, and to concentrate the limited resources on those areas where the number of malaria patients was greater.

Between 1961 and 1963, in particular, there had been a general feeling that mere intradomiciliary spraying was not enough to interrupt transmission in a number of important areas. Furthermore, the epidemiological data for the areas in the consolidation phase were not satisfactory, and the problem was aggravated by internal and external migration movements—in many instances resulting from the development of the Alliance for Progress program.

Late in 1963, the Government of the United States of America had decided to increase its cooperation in the campaign by making loans, at extremely favorable rates, through the Agency for International Development (AID) to Governments interested in receiving them. Since September 1963, the Bureau had cooperated with interested Governments in preparing operational plans for tackling the malaria problem simultaneously in all the national territories.

Table 5 gave a conspectus of the extent and nature of problem areas and remedial measures taken and planned. A problem area, according to the definition given in the Tenth Report of the WHO Expert Committee on Malaria,[13] was a defined geographical area within which an adequate epidemiological evaluation showed that the transmission of malaria persisted despite total, complete, regular, and sufficient coverage with residual insecticide, and where careful studies had revealed that administrative or operational factors were not responsible for the persistence of transmission and where additional measures were required in order to prevent the occurrence of new cases.

Table 6 showed the programs of collective treatment carried out during 1964—an operation which had been intensified in large measure during 1965, especially in El Salvador, Guatemala, and Haiti.

Tables 7, 8, 9, 10, and 11 gave a picture of the national personnel that participated in the pro-

[12] See Annex 2, pp. 217-335.

[13] *Wld Hlth Org. techn. Rep. Ser.* **272,** 3-4.

grams; Table 12 showed the means of transport available; and Table 13 gave the national budget figures for 1963, 1964, and 1965, the projects considered underfinanced being marked with an asterisk.

It might be worth mentioning, Dr. da Silva said, that on 28 and 29 April 1965 the Ministers of Health of Central America and Panama had met in Washington, at the invitation of the Director of the Bureau, for the purpose of discussing the technical and administrative aspects of the malaria eradication program in the Isthmus. The documents of the meeting were published in Spanish in *PAHO Scientific Publication 116.* At that Conference it had been recognized that because of its epidemiological characteristics, malaria was a regional problem, and that the success of the different programs depended not only on the efficiency of Governments in carrying them out, but also on the degree of effectiveness with which they were applied in the other participating countries. In that spirit of reciprocity, the Ministers had signed an agreement [14] in which they stated that proper financing was an essential condition for the success of eradication programs, and that if such financing was to be achieved, there should be recourse to external aid; the recommendation was also made that the signatory Governments should negotiate the relevant loans at the earliest possible date. A coordination working group had established under the Higher Health Council (*Consejo Superior de Salud*) of Central America and Panama, comprising the Directors of the National Malaria Eradication Services of the countries of the region, with the participation of the international agencies cooperating in the programs; and it had already held two meetings. At the second, held in Guatemala from 6 to 8 September 1965, a thorough study had been made of plans for operations to be carried out in those countries during the period 1966 to 1968, with a view to furnishing the Governments with the necessary elements to procure adequate financing for their campaigns. At the same time, a report had been prepared for the Higher Health Council, showing how activities were coordinated as between the participating countries.

Table 14 gave the comparative results of active and passive case detection during 1964; it was clear that in passive detection the percentage of positives was almost invariably higher than in active detection—though that did not mean that the latter should be abandoned, for the two were complementary. There were still many rural malarious areas in the Hemisphere where it had not been possible to establish notification posts and where it had been necessary for the different campaigns to utilize their own personnel for house-to-house searches for patients and suspected cases.

Table 15 was purely informative and of no special significance as it did not reveal the true epidemiological situation in the Hemisphere. There were still malarious areas that had not entered the attack phase or where it had only begun, which meant an over-all increase in the number of cases, although they had decreased in some countries.

After referring to pages 24 to 105 of the document, giving detailed figures on operations in the individual countries, he turned to the chapter on "Special Technical Problems." He recalled that preceding reports had described the technical problems which impeded progress toward eradication and increased the cost of successful achievement. No new problems had arisen in any of the countries, though in some the extent of the known problems had changed.

The chapter entitled "Research on Malaria" gave an account of special studies carried out during the previous year. In that connection the Director of the Bureau had convened the PAHO Advisory Committee on Malaria Eradication in Washington from 31 August to 3 September 1965; the participants had had occasion to discuss the operation of the program and the studies carried out with a view to solving current problems, and had made important recommendations for the further development of the campaign.

Finally, he pointed out that the chapter on "International Cooperation" outlined the collaboration between the international organizations, AID and the Governments in carrying out the activities in question. One of the most important events was the Second Seminar on the Role of General Health Services in Malaria Eradication, held at Cuernavaca, Mexico, from 4 to 13 March 1965; the Bureau had published the results [15] of the seminars held at Poços de Caldas, Brazil, and at Cuernavaca.

[14] See *Scientific Publication PAHO* **116**, 59-60.

[15] *Scientific Publication PAHO* **118** (published in Spanish only).

Dr. QUIRÓS (Peru) congratulated the Director and the staff of the Bureau on the document presented, and stressed the need for the Organization to continue to pay the utmost attention to the very pressing problem of the persistence of malaria in the Americas—a phenomenon which until very recently had been the main cause of morbidity and mortality throughout the world. He took the opportunity while Dr. Fred L. Soper was present at the session to pay a warm tribute to him as "the outstanding personality of the present vital age of eradication programs."

Referring to the so-called vertical and horizontal programs, he stressed that the ones did not exclude the others, and that experience pointed to the need for redoubling efforts. Referring to the allocation of the Bureau's resources earmarked for the malaria campaign, he recalled that during an earlier session when the budget was being discussed, it had been stated that the Organization was spending more than $1,000,000 on the program. Yet the document entitled "Estimated Requirements for Malaria Eradication in the Americas" mentioned as the figures under the Organization's regular budget a mere $76,223 for 1965, $79,761 for 1966, $80,742 for 1967, $84,000 for 1968, and $87,000 for 1969—disturbing data which gave the Bureau no alternative but to adopt appropriate financial measures, since there were wide areas where nothing had been done so far; thus there was every reason for continuing to give due priority to the treatment of the problem.

Referring to what he believed to be a gradual lack of interest on the part of the UNICEF, Dr. da Silva said that a concrete case in point was the renewal of the fleet of vehicles in the service of the campaign in Peru; only 50 per cent of the fleet had been replaced, and that only after lengthy discussions between PASB officials and UNICEF. He considered that the technical arguments advanced by the Bureau's personnel should prevail over the administrative reasons brought up by UNICEF, and he urged the necessity for procedures which would be applied whenever voluntary financial contributions, whatever their origin, should fall short.

Dr. YÉPEZ (Ecuador) said that the malaria eradication campaign was the most important health program in operation in his country, and it could be stated that it was the only one that was in the active phase, the other vertical program—smallpox eradication—being in the maintenance phase. Ecuador had largely covered the attack phase, though certain zones still remained to be dealt with. He thought that both theoretical research and active programs should be intensified, and that a thorough scrutiny should be made of the causes underlying the persistence of the disease.

In Ecuador, the campaign had been financed decisively by the Government, which had furnished the majority of the funds required for the operation. The Government of the United States of America had provided funds during the past five years, but the contributions, made through AID, had been gradually dwindling and would cease altogether during the current year. In connection with a visit made to Ecuador by a joint PAHO/AID Commission requested by the Government to carry out a technical and administrative evaluation of the program, the necessity for continuing AID assistance had been brought home to the representatives of the Agency.

Naturally, his Government made its financial plans annually, but the malaria program called for financing by phases as a single unit, and the Government had to have adequate resources; that question had not yet been resolved—a request for a loan from AID to cover the attack phase and part of the consolidation phase had so far not been granted. He asked the Bureau to bear in mind the peculiar position of the program in Ecuador, in view of the fact that only three months remained for completing the plans.

Dr. Yépez then submitted the following draft resolution for the consideration of the Council:

THE DIRECTING COUNCIL,

Having examined the XIII Report of the Director of the Pan American Sanitary Bureau on the status of malaria eradication in the Americas (Document CD16/13);

Bearing in mind the progress made, especially in plans for the adequate financing for various campaigns after 1965;

Bearing in mind the plans of the international organizations and of the Government of the United States of America to continue and, if necessary, to increase their collaboration to enable the national malaria eradication campaigns to proceed without stoppages until the final objective is attained;

Considering the importance for the Hemisphere of the coordination of antimalaria activities which are being carried out by the Governments of Central America and Panama, in recognition of the regional epidemiological nature of the problem;

Bearing in mind the conclusions of the Seminars on "The Role of the General Health Services in Malaria Eradication"; and

Considering the Report of the First Meeting of the Advisory Committee on Malaria Eradication, of the Pan American Sanitary Bureau,

RESOLVES:

1. To take note of the XIII Report on the status of malaria eradication in the Americas (Document CD16/13).

2. To express satisfaction with the continued interest of the Governments in eradicating malaria from their territories by means of the more adequate financing of their campaigns.

3. To reiterate the need for increased international and bilateral assistance in solving the biological problems that have arisen.

4. To congratulate the Governments of Central America and Panama for the results of the Meeting of Ministers of Health of Central America and Panama (PAHO *Scientific Publication* 116).

5. To take note of the observations and conclusions of the Seminars on "The Role of the General Health Services in the Eradication of Malaria" (PAHO *Scientific Publication* 118) and to recommend that they be put into practice as soon as possible.

6. To take note of the Report of the First Meeting of the Advisory Committee on Malaria Eradication of the Pan American Sanitary Bureau, Regional Office for the Americas of the World Health Organization, urging that the research recommended in the aforesaid document be intensified.

7. To express appreciation for the assistance rendered to the Governments by the Pan American Health Organization, the World Health Organization, UNICEF, and the Government of the United States of America, through its Agency for International Development, in the 1964 campaigns.

Dr. MARTÍNEZ RODRÍGUEZ (Cuba) congratulated the Director and the Bureau on the report presented. In his country the status of the malaria eradication program was most encouraging, for both in 1964 and during the months of 1965 already elapsed, a considerable increase in epidemiological activity had been recorded. In 1963, 833 positive cases had been found on examination of 125,324 slides, while in 1964, examination of 276,470 slides had shown positivity in only 624 cases. In the first eight months of 1965, with a proportionately larger number of slides, not more than 100 positive cases had been discovered.

The intensification of those activities was attributable to the fact that the numbers of the auxiliary evaluation staff had increased, and their work had helped to supplement considerably the data obtained through the State-aid services responsible for receiving reports of cases.

With regard to spraying operations, which had now entered their fourth year, the seventh cycle had been completed in some of the malarious zones of Cuba. During 1964, UNICEF had become associated with activities under the program, and its assistance combined with the contribution made by WHO had provided the country with the equipment and mobile units needed to carry on the work. In the course of the first half of 1965, some 397,000 dwellings in the malarious zone had been sprayed.

The program was being carried out in its entirety with government financing, and the Bureau provided advisory services and UNICEF contributed equipment and supplies.

He mentioned a recent meeting attended by all types of officials and leading figures in the country's national health services, at which views had been exchanged and guidelines laid down for the specific purpose of stepping up the campaign.

In Cuba there was only a small area in attack phase, with a population of under 5,000—a strip 100 km² long and 1 km² wide which had long ago been defined as malarious. He hoped that by the end of the current year it would be possible, in conjunction with the Bureau, to designate the areas which would move into the consolidation phase. He also hoped that by the next Pan American Sanitary Conference Cuba would be in a position to announce that malaria had been completely eradicated in its territory.

Dr. PERAZA (Honduras) said that the excellent results achieved following the malaria campaign in his country were most gratifying; the extraordinary position had been reached where out of a total area of 112,088 km², 9,869 km² were at present in the attack phase and 97,100 km² in consolidation phase. The remainder could be regarded as consolidated, and there was reason to hope that the extent of consolidation would increase before long, since the sector in attack phase was adjacent to the part of El Salvador going through the same phase. It seemed likely that the problem would be solved very quickly, with the help of the international organizations and especially of AID.

Dr. CASTILLO REY (Venezuela) congratulated the Director of the Bureau and his co-workers on the report under discussion. He endorsed the views

expressed by other representatives that it was essential to ensure the financing of the eradication campaign if the progress made over the past few years was to be maintained. Citing his own country as an example, he said that the campaign had slowed down somewhat, and that although it did not affect what had been accomplished in terms of the area of eradication, it did reveal the need for maintaining epidemiological research and adequate measures for preventing transmission. He emphasized the usefulness of joint country programs in halting transmission, which incidentally was in danger of becoming aggravated as a result of migration brought about in the Americas by the construction of new road networks. He also pointed out that the use of certain insecticides in agriculture could at times impair the effectiveness of insecticides intended to wipe out the malaria vector.

Dr. NICHOLSON (United Kingdom) recalled that following the introduction of DDT residual spraying in British Guiana in 1945 malaria had virtually disappeared from its coastlands by 1949. That region, approximately 250 miles long and 5 to 10 miles wide, accounted for 90 per cent of the country's inhabitants, and the remainder lived on the banks of the upper reaches of the rivers and in the interior. It had never been anticipated that the areas of the interior would be freed of malaria, since its inhabitants, who were aboriginal Indians, were for the most part nomadic in habit. Except for a few villages, their houses consisted of uprights with a palm leaf roof, which were difficult to find and when found had no walls that one could spray. The feared resurgence of malaria in the coastlands had indeed occurred in 1961 when laborers from that area had contracted malaria following the introduction of manganese mining in the northwest district.

Interestingly, a new vector, *Anopheles aquasalis*, had been involved in the spread. Formerly it had been considered innocuous as it had been largely zoophilic in habit, but with the recent mechanization of agriculture, the disappearance of draft animals and the relative increase in the human population, the mosquito had taken to biting man, which had been confirmed by the finding of the oöcyst stage of the parasite on one of the mosquitoes. Fortunately, it was susceptible to DDT and within a year had disappeared from both banks of the Demerara River estuary, where the disease had regained a foothold.

In January 1961 chloroquinized salt had been introduced in interior areas with a view to the total eradication of malaria from the territory. Only two cases of *Plasmodium vivax* infection, in the northwest district bordering Venezuela, had since been discovered. On the Pakaraima Plateau and in the valleys of the Cuyuni, Magaruni, and Potaro Rivers, no positive case had been discovered. Thus, exclusively through control with chloroquinized salt, two sections of approximately 30,000 square miles and containing a population of 30,000 appeared to have been free from malaria for almost four years. However, in the Rupununi Savannahs the campaigns had been impeded near the border by the smuggling of non-medicated salt from Brazil.

Dr. Nicholson said it had been noted that numerous *P. falciparum* infections which had received medical treatment with chloroquine in the approved dosages had lapsed after four or five weeks. *P. falciparum* rings had been found in the blood of persons who had made regular use of the salt, and presented a fully positive Haskins urinary test for chloroquine at the time the sample was taken. Plasma samples from six such cases had been sent to the United States National Institutes of Health in Bethesda, Maryland, for estimation of plasma chloroquine levels and those had been found to range from 32 to 191 micrograms per liter.

To offset that, DDT residual spraying had been combined with medicated salt distribution—issued free in the Rupununi since August 1964 to ensure full usage. Brazil had also undertaken to introduce DDT residual spraying in adjoining territory to a depth of 10 miles from the border.

Those combined measures appeared to have achieved the elimination of malaria from that area. Since the beginning of 1965 only 17 cases had been discovered, and in the two remaining sectors of the country the consolidation phase had already begun. He wished to thank the Organization for its great assistance with reference to technical personnel and supplies, and to congratulate the Director and his staff on the excellent report presented.

Dr. YÉPEZ (Ecuador) recalled that during a meeting of Directors of Public Health held two years previously in Bogotá, a report had been given on a project initiated by the Pan American Sanitary Bureau consisting of the organization of courses

in malaria epidemiology for senior officials. The project did not appear to have materialized, though it would be extremely valuable for the development of eradication programs, in view of the very varied causes underlying the persistence of transmission of infectious diseases.

Dr. BONICHE VÁSQUEZ (Nicaragua) said he was in favor of the draft resolution submitted by the Representative of Ecuador, and suggested the addition of a paragraph inviting Governments to encourage municipalities in one way or another to earmark a specific percentage of their total budgets for health campaigns.

In his view, municipal authorities should show an interest in solving those problems, since they affected the local population and therefore warranted contributions proportionate to their economic possibilities.

Dr. MÁRQUEZ ESCOBEDO (Mexico) said that the malarious area of Mexico was extensive, covering 1,100,000 km², with a population of 20,000,000 inhabitants occupying 4,500,000 dwellings. Nevertheless, the work done by the National Malaria Eradication Commission had been responsible for eliminating the disease from 78 per cent of Mexican territory. The remaining parts consisted of areas still malarious, but it was hoped to eradicate the disease completely during the next few years.

The administrative problems that impaired the development of health campaigns were financing, and especially the vexatious redtape which made it difficult to obtain the necessary funds, when obviously every program had to have the resources assigned to it as promptly as possible and to be assured of a considerable measure of flexibility in administering them. Equally disturbing was the lack of integration of malaria eradication services within the health services. What usually happened was that workers assigned to the latter were reluctant to take part in malaria eradication, disregarding the fact that it was precisely the national health services that were called upon to ensure that eradication was followed up by maintenance measures.

As a means of furnishing guidance on such matters, the Bureau had organized the aforementioned seminars in Brazil and Mexico, and important conclusions had been reached, which revealed the need for that integration. Agreement should be reached between the health authorities of the various countries and actual workers in the health organizations, with a view to establishing friendly cooperation so as to eliminate frontier problems—a vital point in preventing the transmission of diseases from country to country. In that connection, Mexico was working jointly with Guatemala to combat malaria, and national frontiers were ignored in the operation.

In conclusion, Dr. Márquez Escobedo congratulated the Director and staff of the Bureau on the report.

Dr. HYRONIMUS (France) associated himself with the tributes paid to the Director and his fellow-workers for the able and interesting report submitted.

The only French Department in the Americas where malaria still existed was French Guiana, where the population of the interior and of the Amazon region was the most difficult to treat, among other reasons because it was largely nomadic; but in the coastal region, the disease had practically disappeared. He referred to the problem of emigrant workers from neighboring countries who entered Guiana and who constituted the majority of cases. That problem would inevitably become more important during 1966 and 1967, when it was proposed to take on about 3,000 such workers, not counting family members. The intention was therefore systematically to examine the state of health of each individual, and if possible, to arrange for their examination by the authorities of the countries of origin.

Dr. AGUILAR RIVAS (El Salvador) supported the views embodied in the draft resolution presented by the Representative of Ecuador. He wondered whether it might not be useful, as a means of seeking the greatest possible cooperation for the campaigns, to consider setting up national antimalaria committees, like those existing to promote collaboration between different sectors in other branches of activity, such as the national statistical committees of a number of countries. He felt that although the malaria campaign, like any other eradication campaign, was a vertical program, it did not mean that it had no connection with other sectors whose interest it was desirable to arouse. As an example he cited the agricultural sector and cotton-growers of El Salvador, whose activities

were regarded as being responsible for the fact that the mosquito had developed resistance to DDT and dieldrin. Such cases would justify the formation of national committees.

The problem of resistance of the mosquito had grown worse, and El Salvador was tackling it with the help of UNICEF and of the Bureau. During the past two years it had received a grant of $200,000 from AID. Assistance was due to end during the current year, so that the Government would have to increase its budgetary allocations for the campaign. For that reason, it had requested for 1966 a budget of 3,160,000 colons, representing an important increase when compared to the 950,000 invested in 1965.

Dr. FERREIRA (Brazil), after expressing gratification at the quality and sincerity of the report prepared by the Director and his collaborators on malaria eradication in the Americas, spoke of the gigantic size of the Brazilian program, in which not only the Government, but international agencies such as the World Health Organization, the Pan American Sanitary Bureau, and the bilateral aid programs of the Alliance for Progress, participated. The inference to be drawn was that Brazil could not cope with so vast a problem unaided.

He pointed out that with the introduction of DDT the annual number of malaria cases had fallen from 8,000,000 to 500,000, by which time it was evident that there was a possibility of eradicating the disease. In that connection he paid a warm tribute to Dr. Fred L. Soper, whom he described as the "high priest" of the malaria campaign.

Referring to the difficulties of the eradication problem, he expressed the conviction that it could be solved, despite the obstacles presented by the problem areas, and he agreed with the Director that what needed stressing was not the negative factors and the obstacles, but the prospects for overcoming them. There was no doubt that the obstacles could be removed, though it was essential that financial resources be forthcoming. He also mentioned that a law had been enacted recently in Brazil which would simplify the administration and utilization of government funds, a considerable portion of which were allocated for public health programs.

If it were possible to place in a bank account everything that had been done so far by way of economic control of malaria, not to mention eradication, the capital thus assembled would be sufficient to tackle the eradication problem.

In conclusion, he supported the proposal put forward by the Representative of Ecuador; in actual fact, it reflected the concern of all countries that there should be no interruption in the inflow and use of funds and no bureaucratic or administrative obstacles in that respect.

Dr. YÉPEZ (Ecuador) gave an account of the problem as it existed in his country, and as it presumably existed in a number of other American countries, namely the difficulty experienced by eradication services in obtaining the funds earmarked in State budgets. Some administrative departments responsible for the distribution and control of funds lacked the flexibility and speed required for certain operations. The nature and requirements of a health control or surveillance program were different from those of an eradication campaign, and hence budgets could not be administered in the same way.

The technical evolution of an eradication campaign could not be tailored to a rigid monthly or half-yearly distribution of the budget items, as was the principle and practice followed by certain technical officials of finance or economic departments. The Bureau should therefore recommend the application of flexible procedures likely to ensure that funds for malaria eradication were both adequate and furnished in good time.

Dr. QUIRÓS (Peru) agreed with the Mexican Representative's views in regard to the need for inducing administrators to adopt a more responsible attitude in regard to eradication campaigns. It was a subject that called for thorough study.

With regard to the proposal, likewise outlined during the meeting, that the various social sectors and local agencies should be induced to take part in such eradication campaigns, he described how on one occasion the Peruvian farmers had contributed funds for the malaria program on a voluntary basis, being convinced that their own economy would reap the benefit. In that connection he thought it would be most useful if an analysis were made of the economic effects of malaria eradication, and the time seemed opportune for the task, since the world was going through a stage of eco-

nomic and social development planning, and it was desirable to study all its implications.

The problem of population growth increased the obligations and responsibilities of Governments and necessitated steadily growing investments. As a result, there seemed no way of avoiding a bid for more funds. He referred to the policy adopted by Mexico for the execution of its malaria program, in the light of the exceptional increase in the population and the consequent need for heavy investment. In conclusion he expressed agreement with the criterion put forward by the Representative of Ecuador.

Dr. PICHARDO (Dominican Republic) said it was precisely the lack of administrative flexibility that had prevented his country from carrying out a genuine malaria eradication campaign, but the picture had changed completely once the National Malaria Eradication Service had achieved administrative autonomy.

The Dominican Republic was currently in attack phase, having succeeded in localizing malaria in a small number of areas where transmission still persisted. One such area was situated in the heart of the country where farmers were using DDT. It had now been arranged for DDT spraying to be replaced by insecticide sprays more effective in combating the mosquito. Another such zone was contiguous with Haiti, and he thought it both important and urgent for the Government of the Dominican Republic to reach agreement with Haiti for a joint effort to deal with the problem.

In conclusion, he supported the view expressed by other representatives to the effect that it was essential, if health campaigns were to be successful, that Governments allow the relevant services such administrative flexibility as was appropriate to the seriousness of the problem in their particular country.

Dr. PRIETO (Paraguay) said that toward the end of 1957, Paraguay had established a malaria eradication campaign based on yearly treatment with dieldrin, and embracing a sector covering about one-third of the area of the country—the sector regarded as malarious. When the fourth year of spraying was about to begin, malaria was found in zones not regarded originally as malarious, possibly because the boundaries of the affected area had not been delimited precisely at the beginning, or perhaps because there had been an unusually large internal migration into the area regarded as non-malarious, encouraged by the construction of roads and by colonization programs started during the first three years of spraying. Thus, when the fourth spraying cycle began, it was found that the malarious area was larger than estimated, and that transmission had not been interrupted in those areas under treatment. At that point it was recommended that the malarious areas should be extended, and that the insecticide used should be replaced by DDT. Shortage of funds for that expansion held up the program. With more thorough epidemiological studies it had been possible to trace a malarious area which for practical purposes today covered the entire country.

Part of the current plan involved the execution of an eradication program based on spraying with DDT over a period of eight years. The plan had obtained the technical approval of the Bureau and an offer of cooperation from UNICEF; but the latter's assistance would not be sufficient to finance the plan in its entirety. The Government was awaiting a decision from AID in respect of a request for a loan.

The situation seemed to him to be fraught with danger, for as time went on, Paraguay could become a focus of malaria infection for the neighboring countries—Argentina, Brazil, and Bolivia, which were much further advanced with their eradication programs.

He was in favor of the draft resolution submitted by the Representative of Ecuador, subject to the proposed addition concerning administrative promptness and flexibility in the use of funds earmarked for the program; and he concluded by congratulating the Director and his co-workers on the report submitted.

The PRESIDENT announced the appointment of a working party, composed of the Representatives of Brazil, Ecuador, El Salvador, Mexico, the United States of America, and Venezuela, to study the proposal of the Representative of Ecuador and submit a draft resolution for consideration at a future session.[16]

The session rose at 1:03 p.m.

[16] See twelfth plenary session, p. 166.

NINTH PLENARY SESSION

Monday, 4 October 1965, at 9:15 a.m.

President: Dr. RODERICK ESQUIVEL, Panama

The PRESIDENT called the session to order and announced that the Representative of Argentina would also be a member of the working party on malaria eradication established at the eighth session. He added that he had distributed the text of the draft resolution on the status of smallpox eradication in the Americas proposed by the Delegation of Paraguay. In view of the amendments proposed, a working party, composed of the Representatives of Argentina, Cuba, Nicaragua, Paraguay, Peru, and the United States of America, would be appointed to prepare a new text reflecting the observations made by various Representatives.

It was so agreed.

Statement by the President of the Inter-American Committee on the Alliance for Progress (CIAP), Dr. Carlos Sanz de Santamaría

Dr. SANZ DE SANTAMARÍA (President, CIAP) began by thanking the Council for having given him an opportunity to speak and stressing the unity of purpose that existed between the Organization and the Inter-American Committee on the Alliance for Progress. He recalled that of the various names suggested for the movement initiated by the late President of the United States of America, John F. Kennedy, the name Alliance had been chosen because it implied human solidarity, mutual aid, and reciprocal understanding among human beings, through a confrontation of ideas that would lead to common solutions rationally arrived at. As a consequence, the Alliance was a joint, cooperative effort of solidarity to seek better ways of achieving the economic and social development of the Region. The primary responsibility lay with the countries themselves, since no one outside a country could tell it how to achieve its economic development. In the fulfillment of its purposes the Alliance was neither a technical, political, or social movement but a combination of all three, seeking to improve the human condition, for the Alliance was made for man and not man for the Alliance. When development was thus envisaged, the role of health was a basic one—health in its material aspects in the sense of nutrition, and health in its intellectual aspects in the sense of education, the progress of man as man. As one of the signs of the new era was the upsurge of the masses, it was natural that the primary objective should be to achieve their well-being.

CIAP had been set up on the initiative of former Presidents Juscelino Kubitschek of Brazil and Alberto Lleras Camargo of Colombia in order to correct some of the defects that had been noted in the first two years of the Alliance's activities. The idea might have come from the Marshall Plan although it was evident that in Europe the human component, the keystone of development, had achieved a more advanced status. There the goal had been to reorganize the social and political structures and the general framework for the distribution of goods, whereas in Latin America the task was more difficult since it was necessary to lay the foundations of social organization. It followed that the Committee was not a theoretical body but an instrument of action, performance, and promotion, which interpreted the wishes of the different Governments and the various agencies that worked with it and promoted the measures that were needed.

CIAP was composed of seven distinguished personalities of the Americas, elected by the countries and headed by a President, its only full-time member. It met two or three times a year, as necessary, for some eight to 10 days, for the purpose of examining the problems of the Alliance, deciding on which campaigns should be mounted, and advising not only the Latin American Governments but also the Government of the United States of America itself on the best ways in which it could provide the assistance that it had furnished so efficiently

and generously. The United States of America found itself in the exceptional position of being the only country that could export both capital and an abundance of technical information, while at the same time providing financial assistance of an international character on broad and generous terms favorable to development. On the other hand, the United States Government could not act and would never act as more than a catalyst of national efforts and of the resolve of the peoples of the Americas themselves to achieve an accelerated pace of development over the next 10 years.

From the first meeting of CIAP held in Mexico in 1964, it had been realized that there was an urgent need for the Alliance for Progress to collaborate closely with the Pan American Health Organization and especially with the Director of PASB, Dr. Abraham Horwitz, who had devoted himself fully to its tasks and to whom was due not only the inauguration of the headquarters building but the great progress achieved by PAHO in recent times. It might also be said that all Dr. Horwitz' waking and sleeping hours were dominated by his deep concern for world and regional health. That had been evident to him over the long years of friendship that bound them in which he had seen that Dr. Horwitz had devoted his every moment to encouraging, insisting, appealing, and even demanding that positive efforts be made to achieve one or another objective connected with health.

The Alliance and the Committee's work could only reflect the wishes of the Member Countries. It was therefore the responsibility of the countries themselves to formulate their programs and determine the priorities to be given to the problems of sanitation and health. The Alliance considered the proposals that the countries made in the development programs presented by Governments in accordance with the Charter of Punta del Este and on the basis of the studies made of such programs each year. The latter were prepared by the Executive Secretariat of CIAP and IA-ECOSOC and outlined the progress made by each country in the various sectors since the previous study. Such studies were discussed with representatives of the country in question and of international agencies associated with the Alliance, such as the Inter-American Development Bank, the Agency for International Development, and also with representatives of agencies in countries outside the Continent that were interested in the economic and social development of Latin America and, therefore, in the realization of the objectives of the Charter of Punta del Este. A year previously direct relations had been established with the countries members of the Development Assistance Committee (DAC) which now participated in the reviews that took place annually in Washington from June to October; the document finally prepared by them reflected the consensus of the participating organizations and provided CIAP with a basis for determining requirements of external aid in the following one or two years.

The first example of collaboration between CIAP and PASB had been the animal health campaign against foot-and-mouth disease and other zoonoses that could be prevented or eradicated by means of vaccinations. It was logical that such a campaign should assume a multinational character and should be carried out regionally. If the disease was successfully eradicated, as had been done in Mexico, continuous surveillance was still necessary to guard against its reappearance, as was preventive action in neighboring territories to ensure that the disease did not reenter through the frontier. In that campaign CIAP had cooperated with the International Bank for Reconstruction and Development, AID, and the Inter-American Development Bank, with whose support it had been possible to establish a system of multinational financing. As an initial step, a program has been established covering Argentina, Uruguay, part of Brazil (Rio Grande do Sul), part of Bolivia, and possibly certain regions of Chile, but would have to be extended to other countries. During the first meetings with technical experts, it had been concluded that to eradicate foot-and-mouth disease from the Americas over a period of five years, would cost at least $200,000,000, whereas it was estimated that each year South America was losing cattle, milk, and proteins suitable for human consumption valued at $400,000,000. There could therefore be no doubt that the campaign, designed, as it was, to improve health and nutrition, would make a positive contribution to the economy of the Americas. It was, moreover, essential to urge the Governments concerned to give health campaigns, prevention of disease, and the execution of sanitation works priority over infrastructure projects in general; it was

of little value to a country to have highways and electric power plants if the human beings served by them continued to live in such conditions of physical misery that they were incapable of escaping from their poverty. It seemed strange that, whereas it was possible to improve the quality of maize, for instance, there was a lack of sufficient resolve to improve the human race, by increasing its capacity to produce more and obtain a better education and, similarly that an underfed and sick man was expected to think in the same way as a man who was properly fed. CIAP was fully aware of the situation and was already convinced that education, health, nutrition, and maternal and child health were the bases of development.

He therefore appealed to members of the Council, as representatives of the Executive Branches of their respective countries, to lay special emphasis in the development plans they would be submitting under the provisions of the Charter of Punta del Este, on the importance of such aspects of health campaigns, in the sure knowledge that CIAP would lend its support and assistance in that connection.

CIAP had established very close ties with the Food and Agriculture Organization of the United Nations (FAO) with a view to increasing food production in the Region and, if such an increase had not yet been made, it was the result of the lack of international purchasing power for development, in other words, of the scarcity of hard currencies and the inadequate remuneration of exports. But the countries had already begun their industrialization and the development of their domestic infrastructures, for which they required an increasing volume of foreign currency.

Later in October a group of technicians would meet in Rome with Dr. B. R. Sen, the Director-General of FAO, with a view to studying the so-called "Indicative World Plan for Agricultural Development." Possibly an initial measure would be to analyze the ways of providing the countries of the Americas with a certain market for those products that exceeded their requirements for domestic consumption and their regular export demands, in order to distribute them among those countries with greater food shortages, as there were many countries that could produce more if they were sure of the existence of an international market at reasonable prices for such foodstuffs.

He pointed out that Dr. Walter Sedwitz, the Executive Secretary of CIAP and of the IA-ECOSOC was present at the meeting should the Council wish for explanations on any aspects of his statements with reference to national programs. Finally, he stressed that the countries were engaged in a common struggle, with CIAP providing the driving force for the Alliance in Latin America, to achieve the realization of the great purposes of the Charter of Punta del Este which were to improve the status of man and humanity in the Hemisphere.

Mr. RIVERA (Costa Rica) observed that there was no doubt that the President of CIAP was deeply committed to the work of the agency he represented and was an enthusiastic advocate of its ideas. Nevertheless, in his experience of the presentation of plans to the Alliance and to CIAP, he had found that capital investment programs, especially those intended for the development of the infrastructure, had been given greater importance to the detriment of investments in health and even more, of those devoted to the operational expenses of the health sector, as many economists responsible for the preparation and analysis of health plans regarded the funds for public health as being costs rather than investments. He was therefore surprised at Dr. Sanz de Santamaría's statement that man was the key-stone of development and believed that, if that principle were taken as the point of departure, all health expenditure could and should be regarded as an investment. It was of course, much easier—as was borne out by his work as an engineer—to express requirements numerically in terms of bags of cement or cubic meters of soil than to determine the needs of a foot-and-mouth disease or tuberculosis campaign for which no easy yardstick was at present available. Moreover, what was often needed was to increase operational expenditure rather than to build new hospitals.

He urged the President of CIAP to act on the valuable principle he had laid down, in which he would undoubtedly have the support of the representatives of the various countries, and suggested that Dr. Sanz de Santamaría should attempt to convince economists and those responsible for approving development plans of the fact that health expenditures represented an investment in the im-

provement of the economic structure, so that they might take action accordingly.

Dr. FERREIRA (Brazil) said that 4 October was a memorable date for the world at large and for the peoples of the Americas. On the one hand, through the catalytic skill of Pope Paul VI, the various religions of the world had been brought closer together, whereas religious differences had previously created an unsurmountable barrier to human understanding; on the other, at the present meeting he had listened to an official statement from Dr. Carlos Sanz de Santamaría, who had spoken as if he were a public health worker himself. It was a fact that the current stage of economic development could not afford to disregard the essential factor of health. In that connection, Dr. Gunnar Myrdal had once described economics as "the horrible science," as it failed to take into account the value of man as the fundamental factor in any economic development process. However, it was no longer the countries that sought the aid of PAHO but rather the Organization that offered them its assistance and participation. It was a new attitude that should, in the future, throw a completely different light on the understanding of the weaknesses and shortcomings of the countries of the Americas. He stressed the importance of public health in all sectors of the population, including the young people who would be required to undertake military service. Health was indeed a basic component of economic development and not a by-product of it. That revolutionary idea, which had already been accepted and recognized, had been born at Punta del Este. It might well be said that we were a part of CIAP and that the Pan American Health Organization was the organ that provided the focal point for the examination of bilateral and multilateral questions and the pursuit of common ends. All the countries had suffered from a shortage of capital and especially, as Dr. Sanz de Santamaría had so clearly indicated, from the absence of its catalytic force, for it was extremely difficult for them, in point of fact, to realize their aspirations with their own resources. For the countries of Latin America the principal value of the international organizations lay in the fact that their assistance involved a multilateral responsibility and a clear understanding of the principle that all countries were responsible for what might occur in isolation in any one of them.

He drew attention to the views held by two distinguished economists, as when physicians or any other group of public health officials discussed the question of health, the impression that was sometimes left was of a certain distortion or inflation of ideas. Dr. Kingsley Davis had observed that a remarkable phenomenon had occurred in the developing countries which he had called the "amazing fall in death-rate," irrespective of any change in their political and economic structures. The population explosion was, in his view, as in that of the Representative of Costa Rica, an illustration of what could be done on behalf of health with the new techniques available for measuring and evaluating the results of investments in the health field. Another internationally known economist, Dr. Gunnar Myrdal, had defended the theory of the cumulative causal determinant. The gist of that theory was that when one of the component factors in development was increased, such as, for example, health, there was a tendency for all the other factors to rise proportionately. In practice it was a clear demonstration of the fact that all could contribute, independently and by their individual efforts, to the economic development of countries. The best way of reducing the rate of population growth, a question on which divergent views had been heard in the course of the discussions, was to accelerate the pace of economic development and enable peoples to achieve a higher standard of living. The birth-rate fell proportionally as prosperity increased and it was simpler and less costly to promote economic development rather than to control birth by methods, the cost and consequences of which could not be foreseen.

In conclusion, he reiterated his firm conviction that the Alliance for Progress was an effective, deep-rooted, and indissoluble alliance.

Dr. CALVO (Panama), after associating himself with the expressions of satisfaction expressed previously by the Representatives of Costa Rica and Brazil, referred to the major commitments entered into under the terms of the Charter of Punta del Este and, more especially, under those of Resolution A.2. Some of those undertakings, which related directly to human needs in the health sector, were in course of being acted on, but others would be more difficult to realize.

In the planning sector priority had been given to certain problems, among them the supply of

water. There was no doubt that Governments were very satisfied with the way in which external investment resulting from the Alliance for Progress was, in various countries, facilitating the task of supplying the population with water. Such assistance was given not only because water was regarded as essential to health but also because of systems of piped water supply were self-financing. In the case of projects that would be self-financing it was possible to assist countries to obtain external capital to meet the development needs of their peoples; the same did not apply to such equally important activities as providing medical care for the sick. In such cases it was extremely difficult to obtain that assistance as the projects were regarded as being non-self-financing. If such a view were accepted it would be difficult to honor a number of the commitments in the Charter of Punta del Este, such as the undertaking in paragraph 1-e of the operative part of Resolution A.2 [1] concerning the combination of the functions of prevention and cure to obtain a better return from medical care services, since there were, in his opinion, very few countries that could increase that return with their own unaided resources.

It was therefore important to stress the fact that all economic efforts made to provide better medical care for man, in sickness and in health, involved a high level of investment and that that applied as much to investments in direct medical care as it did to investments in water. There could be no question of waiting until health services were self-financing before obtaining outside assistance to improve their quality. If such services were not improved, it would be impossible to realize the general target for health programs over the next 10 years and to increase each person's life-expectancy at birth by five years as stated in paragraph 3 of Resolution A.2. The same could be said of paragraph 2(a) of that resolution, which referred to the eradication of communicable diseases, sanitation, nutrition, medical care, and other aspects of health.

There could be no doubt that the Alliance for Progress had drawn attention to the importance of medical care and indicated the paths that would lead to the integration of medicine and to its being regarded, in its philosophical, practical, preventive, and curative aspects, as a single whole. That attitude was reflected in the transformation of the traditional hospital into a care center dealing with all the human problems of health and sickness. But it was also necessary to recognize that the resources available to Latin America for the realization of those objectives were extremely defective. He wished to draw the attention of the President of CIAP to the problem so that he could give guidance to countries on the prospects for the future. The immense efforts so far made by some countries, including Panama, were, as the Representative of Costa Rica had said, non-recoverable expenditures for which the Governments themselves have had to assume responsibility.

He therefore urged that the efforts expended in medical care should be regarded as self-amortizing and that a way should be found in which countries could rationalize medical care provided by all sectors, by the Government as well as by the autonomous institutions, in order to be able to recover some part, if not all, of the investment. External financial sources should, he believed, grant, as in the case of water supply, long-term "soft" loans at low-interest rates and the investment banks working with the Alliance for Progress should do the same. Such action was essential in order to protect the health of future generations and find a solution to the organizational problems that beset medical services of low efficiency and would make it impossible to achieve the objectives of the Charter of Punta del Este, more especially in view of the situation in rural areas, which were so much in need of good-quality services.

Dr. Castillo Rey (Venezuela) said that he wished to associate himself with the statements made by the other Representatives as he was convinced that they expressed and reasserted the principle that had already been established at Punta del Este with respect to health protection, that man was an indispensable part of the development process in any country of the world. It was therefore undeniable that the human component was the essential factor in progress and in economic development for, without its participation, such progress could not become a reality. Furthermore, man himself was the objective of economic development and a realization of that fact was the beginning of wisdom and understanding.

[1] *OAS Official Records,* OEA Ser. H/XII.1 (Eng.), 31.

He fully shared Dr. Calvo's view that at no stage should a veto be imposed on direct health costs and believed that it was wrong to regard them as non-self-financing or non-recoverable, for no one could say to what extent the investment in health, through the better opportunities it provided for human beings to engage in the economic and social activities in which they had a right to engage, would be reflected in the development, productive capacity, and solvency of the nations. Moreover, it was, indeed, a remarkable fact that in the care of a large enterprise the funds needed for the maintenance of plant and machinery for the production process were provided as a natural course of action, whereas man was not accorded similar treatment.

Venezuela had received very valuable assistance and collaboration from the Alliance for Progress in obtaining international financing to back up its own contribution to the realization of certain programs, which in terms of such an approach, would be regarded as self-financing programs or even as recoverable programs. As an illustration he referred to the Venezuelan program for the supply of potable water, of which mention had been made at a preceding session and which had made some measure of progress toward the achievement of the targets set at Punta del Este. Satisfactory progress had also been made in the rural housing program, the aim of which was not to replace all unsanitary housing, but mainly to initiate a change in the cultural pattern, as exemplified by the traditional image that people had of their housing. One such village, which bore the name of "Alianza" and had been inaugurated by the late President John F. Kennedy when he had visited the Republic of Venezuela, was in itself a symbol of the international support given to Venezuela in the financing of this program.

In addition to the importance of expenditure on health and medical care, which brought man himself into the process of economic development, he made specific mention of those outlays which, in his view, should be regarded simply as forms of direct human aid, among them the malaria eradication program, which would be considered further later in the session. If land-recovery and land-reclamation schemes based on improved methods of agricultural development, for instance, were clearly defined as investment outlays, there was, aside from the question of what might be regarded as measures to improve the existing state of health of individuals, every justification for including the continental program of malaria eradication—a source of so much concern to countries—within the same framework and for allocating the necessary resources for its financing.

Dr. QUIRÓS (Peru) declared that he had been impressed by what the President of CIAP had said and especially by his reference to the fact that, when the Alliance for Progress had been formed, it had been realized that the problems that had emerged in Latin America were entirely different from those of Europe after the Second World War, particularly in those essential aspects that related to the social infrastructure.

He considered that it was impossible to think in terms of economic and social development unless the standard of living of the peoples were raised. It was a vicious circle to the extent that insofar as a direct and resolute effort was not made to effect a complete transformation of the economic, social, and political structure of the Americas, it would be impossible to go forward with the plans of the Alliance for Progress. In Peru, for instance, the dollar assets of the country's millionaires exceeded those of the Reserve Bank; moreover, if the system of land-tenure were regarded as inequitable and if, indeed, the economies of the countries of Latin America continued to depend excessively on foreign markets—a vulnerable situation referred to by economists—and if the efforts to integrate the common market moved slowly and were beset with difficulties, if the inter-regional markets were small, and if the political implications made it impossible to carry out such measures of economic integration, it would be extremely difficult to obtain the resources essential to meet the goals of the Alliance for Progress. It was therefore essential to stress the need for the organs of the Alliance to urge countries to undertake a complete reorganization of their structures for, until that was done, the situation would remain unchanged, with the attendant risks of the loss of liberty and of the democratic way of life. Those arguments, he believed, applied not only to small countries but also to the great powers for, while the latter continued to invest enormous resources for the exploration of space, for the development of atomic energy capable of destroying humanity, millions of human beings were dying of hunger in the developing countries. There-

fore, if the objective was to live in peace, as Dr. Ferreira had declared, it was essential to consider such factors since everything else was subordinate to them.

Dr. AGUILAR HERRERA (Guatemala) also congratulated Dr. Sanz de Santamaría on his important statement. He shared the views expressed in the various comments and observed that the tendency in the Latin American countries to regard health costs simply as expenditure and not as an investment was perhaps due to certain defects in the technical education of the economists, as the same attitude had, as a general rule, been shared by economists serving in the planning agencies. He therefore suggested that, so far as possible, some means should be found to make the principle clear in the teaching of economics, as he believed that that would lead to a better understanding between economists and health officials.

Dr. SANZ DE SANTAMARÍA (President, CIAP) thanked the representatives for their questions and comments, which coincided with those that he himself had been making during the year. He was very encouraged by the fact that his views had been given such an enthusiastic welcome.

In reply to a question from Mr. Rivera who, in referring to planning procedures, had indicated that, from time to time, the economists refused to accept some of the principles they had been discussing and that, in general, health was not accorded its rightful place in economic development, Dr. Sanz de Santamaría said that, when they had signed the Charter of Punta del Este, the nations of Latin America and the United States of America had not been ready to act on the important principles set forth in that Charter. It was a document of more significance than any international treaty in force; it constituted a manifesto on economic development and social progress by which a group of free peoples had resolved to accelerate the pace of their development within a fixed period of years, as a symbol of their common alliance and as an example of their firm resolve to work for the future of mankind. In point of fact, no parallel existed in the recent history of mankind.

The Latin American countries and the United States of America had been progressively increasing their understanding of the significance of economic development and its relationship to man. The Representative of Panama had reiterated earlier what his country had declared before CIAP only two weeks previously. For Panama the most important factor at the present stage was social investment in the various aspects of health and education. The United States Government, for its part, had approved only four months previously the bill implementing the coffee agreement, that applied, so far as that product was concerned, to those provisions of the Charter of Punta del Este that recommended, rightly so, that until such time as countries could achieve a more diversified export structure and a more rapid rate of production, it was essential to maintain the price and volume of those staple exports that were shared by the countries of the Americas. It was not only necessary to review whether what had been achieved in that period was adequate. It had been possible, he believed, to direct the efforts of the Governments of the countries of the Americas and of other countries into the right channels and, as a result, there had been a fundamental transformation in the nature of the relationships between bankers, lending agencies, and economists, as well as undeniable progress in the approach and objectives the countries of the Americas and of other regions were adopting with respect to their own development. In effect, progress had been made in understanding the problem and there was a growing conviction that measures that did not give priority to the improvement of human conditions would not yield positive results. Five years previously any investment in man himself had still been evidently regarded as merely an outlay on maintenance and not an investment, but there was a beginning realization that it was essential to begin with man, so that if some progress had already been made in the construction of water supply and sewerage services, there was nothing to prevent extending it to include campaigns for the betterment of human health.

Turning to the Venezuela Representative's observation on the financing of the malaria eradication program, he declared that there was no reason for not undertaking such campaigns in a joint effort for the good of mankind, which would benefit all countries.

In replying to the very opportune remarks of the Representative of Peru, he reiterated that the silent revolution that the Alliance for Progress was to bring about should be based on the transforma-

tion of those antiquated structures that had created bias. In that connection he recalled the difference, to which he had previously called attention, between the concepts of pessimism and optimism in the last century and the way in which they were generally envisaged in the present one. In the 19th century pessimism and optimism were psychological or philosophical conceptions. The liberalism of Manchester had carried humanity along on a wave of optimism with its doctrine that natural systems, as they were then called, would promote the well-being of humanity. At that time, the pessimistic approach was embodied by socialism, which was followed by Marxism, with its pessimism of upheaval and its assumption that, if a radical change were to be made all existing institutions would have to be overturned. He said that he in fact was an optimist by temperament and believed that current forms of optimism and pessimism were neither philosophical nor political in character; the optimism of today was the conviction of those who believed that scientific progress was the servant of all men and that humanity would learn to accept that technical advances in all fields of knowledge, from health to electronics and chemistry, should be used to promote human welfare and improve social systems. On the other hand, pessimism was best exemplified by those persons who feared or opposed change in order to defend the *status quo* or protect privileges that by one means or another, would have to be limited or transformed, or by those persons who possessed neither the capacity nor the desire nor the strength of character to participate in a radical change.

Commenting on Dr. Ferreira's remark, he said that the Bureau and CIAP were collaborating closely with one another; Dr. James S. McKenzie-Pollock was participating in the country reviews, Dr. A. Peter Ruderman was linked closely with the economists and Dr. Emilio Budnik was the permanent liaison officer. Dr. Horwitz was official adviser on health and he himself was acting as a kind of orchestra leader, harmonizing and blending its various elements. He declared that CIAP could not act until the countries themselves had formulated their plans.

Finally, he stressed that the betterment of human conditions in the Americas was a factor of such importance to world harmony and the establishment of peace that, little by little, all would wish to participate in the efforts to promote economic and social progress in the Hemisphere.

The session was suspended at 11:05 a.m. and resumed at 11:35 a.m.

Second Report of the Working Party on the Application of Article 6-B of the Constitution of the Pan American Health Organization

The PRESIDENT announced that the reading of the second report of the working party on the application of Article 6-B of the Constitution would follow.

Dr. MARTÍNEZ (Mexico) read the report in question, as follows:

Not having considered the status of Uruguay at its first meeting in the absence of any payment plan and in view of the fact that the Delegate of Uruguay had not yet arrived, the working party subsequently consulted with the Delegate of Uruguay to ascertain the situation. The latter, after consulting with his Government, presented to the working party a provisional plan for bringing its quotas, now in arrears for the period of 1960-1964, to a current status within a period of five years. In essence, the plan is as follows: In each of the years 1965 through 1969 payment would be made in an amount equivalent to the sum of the quota for the current year and the quota for the year farthest in arrears.

The working party considers the provisional plan of Uruguay to be in accord with the policy of the Directing Council, as expressed in Resolution XII [2] approved at its XV Meeting. Accordingly, the working party hereby amends the list of countries mentioned in its first report so as to include Uruguay, subject to acceptance of this report by the Directing Council, thus permitting that country to vote under the terms of the resolution [3] on this matter adopted by the XVI Directing Council at its fourth plenary session.

Mr. CASTELLS (Uruguay) thanked the Representatives of Mexico, the United States of America, and Venezuela, the members of the working party on the application of Article 6-B of the Constitution, and requested that the minutes record that the Delegation of Uruguay had voted in favor of the draft resolutions concerning the following items approved at previous sessions: the Financial Report, *Official Document 59*, at the fourth plenary session; the Provisional Draft of the Proposed Program and Budget, *Official Document 61* and Document CD16/36, at the fifth plenary session; the Proposed Program and Budget of the Pan American

[2] *Official Document PAHO* **58, 66-67.**
[3] See p. 53.

Health Organization for 1967, Document CD16/37, at the sixth plenary session. He added that he also wished the minutes to record that his Government had given him special instructions to support the candidature of Dr. Raymundo de Britto, Minister of Health of Brazil, as President of the meeting.

The PRESIDENT congratulated the members of the working party on the accomplishment of their task.

Decision: The second report of the working party on the application of Article 6-B of the Constitution was unanimously approved.

Item 11-A: Report on the Status of Malaria Eradication in the Americas (*continuation*)

Dr. DA SILVA (Chief, Malaria Eradication Branch, PASB) said that the Director of the Bureau and its staff deeply appreciated the encouragement given them during the discussion on malaria eradication. The Bureau accepted the good wishes of the representatives as an active expression of the determination of the Governments of the Americas to continue the malaria eradication program in the Hemisphere, since the positive gains were far larger than the biological problems still to be solved.

In the statements made by the delegations there were two points that called for comment. The first was that the funds provided were insufficient to carry out the program and the Governments would therefore have to provide the administrative facilities needed for a vertical program. The second was that the assistance provided by local health services would have to be increased, whatever the sources of financing.

With reference to the first point, it should be emphasized that the Bureau was concerned at the tendency of some Governments to ignore the need to continue the campaign on a vertical basis. In the reorganization plans of some health ministries the campaign organization was already being envisaged as an agency forming part of one of the traditional divisions of the regular health services. It should be remembered that the malaria eradication campaign required, as did any other such campaign, a special concentration of effort, as it would cease to exist as such when its specific objective had been achieved. It therefore needed its own special administration and sufficient flexibility to achieve that objective.

He pointed out that, in Article 3 of their Declaration, the Ministers of Health of Central America and Panama had agreed, among other things, on the following:

To put into practice the theoretical plans prepared in agreement with the Pan American Sanitary Bureau, Regional Office of the World Health Organization, and such amendments to these as it may in due course be necessary to make.

To appoint to the directing posts professional personnel of recognized technical ability who will efficiently discharge their responsibilities.

To arrange for selection, entry, and approval procedures in the case of all personnel.

To fix adequate remuneration and allowances for all campaign officials, consistent with those obtained in domestic labor markets, so as to provide stable employment for trained personnel.

To introduce proper procedures for the purchase of materials and equipment with a view to satisfactorily meeting campaign needs.

To so manage the financial arrangement for malaria eradication campaigns that the necessary funds are available at the appropriate stages.

To form a National Directing Council for Malaria Eradication constituted in accordance with the recommendation made in the Sixth Report[4] of the WHO Expert Committee on Malaria.[5]

The latter paragraph included, it appeared, the very pertinent suggestions of the Representatives of Nicaragua and El Salvador on the need for increased support from municipal authorities, that was to say local government authorities, in the case of certain activities and control services relating to mosquito breeding places, and also for the participation of other ministries in the fight against the disease.

With regard to the second point, it should be pointed out that, from the outset of the campaign, PASB/WHO had been urging the formation of a National Committee for Malaria Eradication with a view to coordinating national efforts. Although many countries had already set them up, they had failed to meet or did not have any effective membership. The problem had been satisfactorily studied at the Seminars on "The Role of the General Health Services in the Eradication of Malaria.[6]

As had already been mentioned, the "Observations and Conclusions"[7] of those Seminars were

[4] *Wld Hlth Org. techn. Rep. Ser.* **123.**

[5] *PAHO Scientific Publication* **116,** 56-57 (published in Spanish only).

[6] *Scientific Publication PAHO* **118** (published in Spanish only).

[7] *Ibid.,* pp. 97-106.

regarded as extremely important, since they were the outcome of free discussion among the participants, principally members of the directing staffs of the Hemisphere's General Health Services, after a study of the problem of malaria eradication and its implications. It was clear that those services had obtained a better idea of their responsibilities and it was desirable that the principles established at such seminars should be publicized. With that in mind the Council had already approved the plan presented by the Director of the Bureau for the engagement of two health experts to promote the holding of meetings at national, regional, and local levels. The Bureau hoped that the representatives would carry back to their Governments a report emphasizing the "Observations and Conclusions" of the seminars to which he attached the highest importance.

When the word "integration" was used with reference to the malaria eradication campaign in the Americas, he stressed the importance of bearing in mind what was stated in that document, particularly in the following paragraph:

> The Seminars agreed that the malaria eradication campaign was part of the work of the general health services but that, because of its special nature, it should be entrusted to a service devoted entirely to achieving its objectives.

With regard to the observations of the Representative of Ecuador, he reported that the Bureau was still working on plans for courses in the advanced epidemiology of malaria, which should begin shortly.

Item 11-B: Financing of the Malaria Eradication Program in the Americas

Dr. DA SILVA (Chief, Malaria Eradication Branch, PASB) presented Document CD16/7,[8] in which it was reported that the Directing Council, in Resolution XX[9] approved at its XV Meeting, had requested the Director to consult with the Director-General of the World Health Organization with a view to evolving a suitable method of ensuring the financing of the malaria eradication program in the Americas and to report on the matter to the Executive Committee at its 52nd Meeting.

Under the provisions of that resolution, the Director had submitted a report[10] on the progress made to the 52nd Mecting of the Executive Committee. After a careful study, the Committee had adopted a resolution[11] in which it had taken note of the report presented by the Director; had stressed the importance to the continuation of the malaria eradication program in the Americas of the voluntary contributions to the PAHO Special Malaria Fund and to the WHO Malaria Eradication Special Account; had expressed the hope that those contributions would continue at the level necessary to achieve all the objectives of the program; and had resolved to transmit the Director's report to the XVI Meeting of the Directing Council, together with any other information as might be available on the matter.

In conclusion, he said he had heard nothing further on the subject since the 52nd Meeting of the Executive Committee.

Dr. QUIRÓS (Peru) observed that sufficient time had already been devoted to the discussion of the subject of malaria and, as the Executive Committee had adopted a resolution with respect to it, he proposed that that text should be reaffirmed.

The CHAIRMAN suggested that the working party on malaria eradication should also prepare a draft resolution on the topic that had just been considered.[12]

It was so agreed.

The session rose at 11:55 a.m.

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[8] See Annex 4, pp. 372–373.

[9] *Official Document PAHO* **58, 73.**

[10] See Appendix to Annex 4, p. 372.

[11] Resolution III. *Official Document PAHO* **62,** 29-30.

[12] See twelfth plenary session, p. 166.

TENTH PLENARY SESSION

Monday, 4 October 1965, at 3:15 p.m.

President: Dr. RODERICK ESQUIVEL (Panama)

Item 20: Election of Two Member Governments to the Executive Committee on the Termination of the Periods of Office of Costa Rica and the United States of America

The PRESIDENT called the session to order and announced that the first item of business was the election of two Member Governments to fill the vacancies on the Executive Committee created by the termination of the periods of office of Costa Rica and the United States of America. He proceeded to explain how the vote would be taken and appointed the Representatives of Jamaica and of the Dominican Republic as tellers.

Dr. SUTTER (Assistant Director, PASB) read the articles governing voting in the Rules of Procedure of the Executive Committee, in the Constitution of PAHO, and in the Rules of Procedure of the Directing Council.

A vote was taken, with the following results: number of representatives casting ballots, 25; ballots cast, 25; votes received: Ecuador, 22; Guatemala, 14; Argentina, 10; and Colombia, Chile, Dominican Republic, and Trinidad and Tobago, 1 each. Ecuador and Guatemala were therefore considered elected.

Decision: The Governments of Ecuador and Guatemala were elected to membership on the Executive Committee for a period of three years, and the Directing Council extended its thanks to the Governments of Costa Rica and the United States of America for the services rendered to the Organization by their Representatives on the Committee.[1]

Dr. AGUILAR HERRERA (Guatemala) thanked the Council for the honor bestowed on his country in electing it to membership of the Executive Committee.

Dr. PAREDES (Ecuador) said that he appreciated the honor of having been appointed to membership on the Executive Committee and expressed the hope that his country's representatives would prove worthy of the confidence and the responsibilities bestowed on them.

The PRESIDENT congratulated the new members of the Executive Committee and said that he would proceed with the agenda.

Item 11-C: Estimated Requirements for Malaria Eradication in the Americas

Dr. DA SILVA (Chief, Malaria Eradication Branch, PASB), in presenting Document CD16/14,[2] explained that it contained the estimated annual requirements for malaria eradication for the years 1965 to 1969 inclusive, for country programs, for Zone and regional Zone projects, and for Headquarters projects. The requirements were shown by source of funds, i.e., Government, other sources, and PAHO/WHO.

The section relating to PAHO/WHO included information on the PAHO Special Malaria Fund and on financing with funds from the regular budgets of PAHO and WHO, from the WHO Malaria Eradication Special Account, and from the United Nations Expanded Program of Technical Assistance. In the case of PAHO/WHO separate details were also shown of the estimated requirements for personnel, supplies, and equipment, fellowships and grants, and other expenditures for each of the programs in which PAHO/WHO participated.

The tables showing the distribution of personnel by type and year for each program were given in the usual form as was also a brief description of the status of each program and of the Organization's plans for future activities that indicated, where applicable, UNICEF and AID participation.

The estimates of requirements had been made in May 1965, and had been based on the best information available at that time. Experience had shown that frequent evaluation of the programs was necessary, involving a continuing review of the estimated requirements.

[1] Resolution X. *Official Document PAHO* **66**, 63-64.

[2] See Annex 8, pp. 336–371.

He instanced as an example the fact that, after the documents had been prepared, the Bureau's technical personnel, in association with national technical staff, had reviewed the programs of Guatemala, Honduras, and Nicaragua, which had indicated further financial requirements, occasioned by the deterioration in the situation since January, as a result of the reinfection of areas that had been in the consolidation phase. He observed that El Salvador's program had been revised twice, the last time during the second half of August, and that then there had been an apparent need for more funds than originally estimated. He hoped that, if further funds for the campaigns could not be obtained, it would become necessary to revert to the attack phase in areas that had already been regarded as clear.

In some countries the position had become even worse as a result of delays in the payment of subsistence allowances to staff engaged in the campaigns. As a result of such delays hundreds of officials who continued to receive their salaries had been unable to leave their headquarters for long periods, a situation that had had serious repercussions on the measures in hand.

In that connection he referred to the Declaration [3] signed by the Ministers of Health of Central America and Panama during their meeting in Washington, D. C., in April 1965, in which they set down the prospects for success in the campaigns in their countries, a document that was of interest not only to Central America and Panama but to the entire Continent.

He also drew the Council's attention to the Agreement signed by the Ministers of Health of Central America and Panama [4] on that occasion, and observed that coordination problems in malaria eradication were not peculiar to the Isthmus.

With the Bureau's participation, various border discussions had been held between other countries and he wondered whether it would not be wise to give consideration to following the example of Central America and Panama and determine whether such discussions might not be repeated in other regions of the Continent. The Bureau would be prepared to assist any interested Government to make arrangements along those lines.

[3] *Scientific Publication PAHO* **116**, 55 (published in Spanish only).
[4] *Ibid.*, p. 59.

The PAHO Advisory Committee on Malaria Eradication, at its First Meeting (Washington, D.C., August-September 1965), examined the document that was currently under consideration, and had stated in its Recommendation 19 that the estimates of requirements submitted should be regarded as a minimum, in the light of existing information, but called attention to the problem of inflation and to the fact that there was a possibility that others would arise that would render them inadequate, especially for 1968 and 1969.

Turning to the question of international advisory personnel, he stated that the information presented reflected the wishes expressed in the national programs and declared that each post had been thoroughly reviewed in association with the Directors of National Malaria Eradication Services. He regretted that specialists in malaria eradication were so scarce, which was why the Bureau had been unable to fill all the existing vacancies. Nevertheless action to obtain such personnel was continuing, although it was by no means an easy task, as many high-level experts were already participating in programs in their respective countries. With respect to this question, the Bureau was at a crossroads and would welcome suggestions from the Directing Council.

He outlined the situation in the following terms: the Bureau had a number of vacant advisory posts for physicians, engineers, entomologists, and sanitarians, who specialized in malaria; there were qualified members of all those professions in the various national malaria eradication programs although, if the problem were to be solved, it was clear that it would be necessary to provide training for a larger number of each group, both for national and for international service. The logical thing would be to recruit for service with PAHO/WHO members of national services who had already acquired experience and to train new personnel for national programs; that would presuppose the cooperation of Governments in the selection and training of technical personnel for the national campaigns with a view to enabling those with the widest experience to be employed in international service. Alternatively, it would be possible to recruit new personnel, possessing experience in public health administration with a view to training them in malaria eradication techniques and, on the completion of the theoretical and practical course, followed by a period of in-service training, to appoint

them as consultants. In the former case it would be necessary to study a plan for the selection, recruitment, and training of the new national personnel who, in due course, would have to replace those selected for international service. In that connection he wished to point out that it was essential for national malaria eradication program budgets to provide funds to recruit new personnel, and allow sufficient time for their technical training and orientation.

Mr. BOARD (United States of America) congratulated the Bureau's staff on the excellent report, which gave a comprehensive analysis of a large and complex subject in a clear, objective, and factual manner. PAHO had made important contributions to malaria eradication in the Americas through coordinating leadership, planning advisory services, fellowships, laboratory and other types of training, and the provision of drugs and other supplies and equipment.

The report warned that the long and difficult task ahead demanded a high price in terms of perfection in operations and unremitting support. Administrative efficiency was undoubtedly paramount, as revealed by past shortcomings in funding, staffing, and so on. Throughout the report there were indications of plans that, though showing good technical promise, simply could not be implemented. The best of plans was useless unless carried out in strict accordance with the required schedule and intensity. That indicated the necessity for either realistic support of malaria eradication by all concerned, or facing the very real possibility of failure.

It had been gratifying to hear so many representatives reaffirm their determination to continue supporting national malaria eradication campaigns until success was achieved.

His Delegation was therefore pleased to report that, subject to the availability of funds, the United States of America would in 1966 make a voluntary contribution of $2,190,000 to the PAHO Special Malaria Fund. That would not provide all the funds needed for the program, but he was confident that the Director of the Bureau and his staff would continue their efforts to ensure adequate financial support from other possible sources, such as other Governments, UNICEF, the United Nations Expanded Program of Technical Assistance, WHO, and the PAHO regular budget.

Dr. FERREIRA (Brazil) stated that the financial program under consideration was not based on the commitment to complete the eradication of malaria throughout the Hemisphere by 1969. Some of the programs had not achieved the results expected; moreover, the eradication campaign required the use of all possible techniques to interrupt transmission, which were frequently impossible to use because of administrative and financial reasons.

Referring to the voluntary contributions for the malaria eradication program, he expressed concern at the fact that a large part of the funds available were obtained from that type of contributions which were, as some representatives had already pointed out, in the nature of a sword of Damocles.

In his judgment Governments and the Organization itself, through its function as a catalyst, should devote their energies to securing the inclusion of funds for malaria eradication in the Organization's regular budget.

He stressed that another aspect that should be considered was the transfer of responsibilities for malaria eradication programs to general health services or to infrastructural services, which were very weak in the Americas, and as a result believed that, even on the assumption that eradication could be completed within a period of four or five years, those infrastructures would not be in a position to discharge adequately the essential functions of surveillance and control.

Dr. HORWITZ (Director, PASB) stated that both in the discussion on the program and budget for 1966-1967 and in the examination of the subject of malaria eradication, reference had been made to the measures the Bureau might adopt to ensure the financing of that part of the program for which the Organization was responsible. He recalled that on that occasion he had pointed out that, as indicated in *Official Document 61*, the total funds administered by PASB for 1965-1966 from the Pan American Health Organization and the World Health Organization amounted to approximately $1,000,000. In that document was a summary table,[5] the second part of which was entitled "Sources of PAHO-WHO Funding," but he wished to point out, that it only referred to that part of the funds obtained from the PAHO regular budget, which was given on the first line of the table, the vertical total of the funds not having been taken

[5] See p. 337.

into consideration. He had for that reason felt obliged to explain to the Council.

A document, containing all the relevant figures, had been prepared to illustrate the relationship between the voluntary contributions to malaria eradication and the total funds obtained from the Pan American Health Organization and the World Health Organization between 1961-1965 and, if the Council so wished, would be distributed. It showed that whereas in 1961, 90.9 per cent of the funds appropriated for malaria eradication had come from voluntary contributions to the PAHO Special Malaria Fund, by 1965 that figure had been reduced to 63.3 per cent; that was to say, the sums provided from the WHO budget and the PAHO regular budget stood at 36.7 per cent. For 1966, voluntary contributions to the PAHO Special Fund would be 57.5 per cent and the total from other sources, detailed in the document, would be 42.5 per cent. The figures were a measure of the Bureau's concern over the uncertainties surrounding the voluntary contributions, subject, as they were, to variations in emphasis arising from changes in policy; for that reason and despite the general shortage of funds, efforts were being made to increase all alternative sources of funds. He was convinced that the need was real and, taking advantage of the presence at the meeting of the Director-General of WHO, the Bureau had obtained an assurance that the proportion that WHO was allocating for 1967 would be similar to the amount that had been granted for 1966. However, if the Council considered that the malaria eradication program should not be entirely dependent on voluntary contributions, it would be a question of increasing the regular budget of the Pan American Health Organization by amounts which, as was shown by the document under consideration, would exceed $2,000,000 in 1967-1968 and amount to $1,633,906 in 1969. In the existing situation and in the light of the trends in the economies of the Governments of the Americas, he believed that it would be better to continue with the current arrangements for financing the campaign and to rely on the generosity of the Government of the United States of America, thereby avoiding a sharp increase in the Organization's regular budget; if, however, the situation should change in any stage, proposals for whatever budgetary action was necessary would be submitted to the Council.

In his view it would be difficult to eliminate other programs and replace them with the malaria eradication program, since the Governments themselves had established the present framework and regarded it as important to meet other needs as well. He emphasized that, on that assumption, the Organization had been progressively increasing its budget in a prudent manner and that it was closely watching the course of events. In particular, a sum of $1,000,000 from sources other than voluntary contributions had been made available for 1965, and it was intended to continue to proceed along the same lines, unless the Council should decide otherwise.

The PRESIDENT announced that the names of the Representatives of Peru and Venezuela had been added to those of Argentina, Brazil, Ecuador, El Salvador, Mexico, and the United States of America to form a working party to consider a draft resolution on Items 11-A, 11-B, and 11-C.

Dr. CASTILLO REY (Venezuela) read the following draft resolution:

THE DIRECTING COUNCIL,

Having considered Document CD16/14 on the estimated requirements for the PAHO Special Malaria Fund;

Bearing in mind the increasing efforts of Governments to eradicate malaria from their territories, and the fact that some Governments have decided to negotiate foreign loans for this purpose;

Noting that the PAHO Advisory Committee on Malaria Eradication considered the estimates of the requirements to be minimal, in the light of available information; and

Considering the need of the Pan American Sanitary Bureau to have more specialists available for providing the campaigns with appropriate assistance and for intensifying research on current problems,

RESOLVES:

1. To take note of the estimated requirements for the PAHO Special Malaria Fund.

2. To express to the Governments its deep satisfaction with the financial efforts they are making to provide the campaigns with the funds necessary to continue the campaigns.

3. To commend the Government of the United States of America for the facilities offered through the program of the Alliance for Progress in the granting of loans, under very favorable conditions, for the Governments requesting them in order to continue their campaigns.

4. To recommend to the Governments that they bear in mind the Declaration of the Ministers of Health of Central America and Panama, approved at the Meeting held in Washington, D.C., on 28 and 29 April 1965, insofar as it applies to all the malaria eradication campaigns.

5. To recommend that the Governments cooperate with the Pan American Sanitary Bureau in providing the specialists required by the Bureau in order to intensify its technical assistance to the malaria eradication program in the Hemisphere.

6. To recommend to the Bureau that it continue its negotiations with international credit institutions with a view to having them include in their policy the financing of malaria eradication programs through long-term low-interest loans.

The PRESIDENT said that the draft resolution of the Representative of Venezuela would be referred to the working party.[6]

Item 29: Nongovernmental Financial Support for Health Activities (*conclusion*)

Resolution Proposed by the Delegation of the United Kingdom

The PRESIDENT submitted for consideration by the representatives the draft resolution presented by the Representative of the United Kingdom at the sixth plenary session during the examination of Item 24 of the agenda (Resolutions of the WHO Executive Board and the World Health Assembly of Interest to the Regional Committee). He recalled that the Council had then been considering Resolution WHA18.31[7] relating to the Voluntary Fund for Health Promotion: World Health Foundations. At that time the Representative of Venezuela had requested the distribution of the statutes of one of the foundations already established, which had subsequently been arranged.

As the request of the Representative of Venezuela had been met and the views of the Council on the question of nongovernmental financial contributions to health activities had been heard, consideration of Item 29 of the agenda relating to that question could now be regarded as having been completed, with the consequent saving in time.

If there were no objections he would ask Dr. Sutter to read the draft resolution.

Dr. SUTTER (Assistant Director, PASB) read the draft resolution:

THE DIRECTING COUNCIL,

Having considered the report of the Director on nongovernmental financial support for health activities (Document CE52/12), which mentions the establishment of the World Health Foundation of the United States of America and the plan for the establishment of similar national foundations in other countries;

Bearing in mind Resolution V on this matter, adopted by the Executive Committee at its 52nd Meeting; and

Considering Articles 3 and 9 of the Agreement concluded between the World Health Organization and the Pan American Health Organization,

RESOLVES:

1. To take note of the report of the Director of the Bureau on nongovernmental voluntary contributions for health activities (Document CE52/12).

2. To take note, also, of the agreement signed by the Director-General of the World Health Organization and the Director of the Pan American Sanitary Bureau on 15 October 1964, in Washington, D.C.

3. To instruct the Director of the Bureau to continue to cooperate in the plan for world health foundations and to take such steps as he deems necessary to further the fundamental purposes set forth in the Constitutions of the Pan American Health Organization and of the World Health Organization.

Decision: The proposed resolution was unanimously approved.[8]

Item 13: Status of National Health Planning

Dr. MCKENZIE-POLLOCK (Chief, Office of National Health Planning, PASB), in presenting Document CD/15,[9] said that the subject of the Technical Discussions[10] at the Eighteenth World Health Assembly in May 1965 had been "Health Planning." The interchange of ideas offered by that international forum had served to fortify one's faith in the planning method to which at least 16 countries in the Hemisphere were committed.

The close association developing between health planning and economic development planning had been further strengthened during the past year both at the national and international levels. More frequent dialogue leading to better understanding had taken place between the planning units in most ministries of health and the national economic development offices. The fact that the PAHO had been requested to take an active part in the country review proceedings carried out by the Inter-American Committee on the Alliance for Progress (CIAP), demonstrated closer association at the international level, an indication of which had also been given by Dr. Sanz de Santamaría at the ninth plenary session.

To meet what some had called the "revolution of rising expectations," the economic development

[6] See twelfth plenary session, p. 166.

[7] *Off. Rec. Wld Hlth Org.* **143**, 20.

[8] Resolution XI. *Official Document PAHO* **66**, 64.

[9] See Annex 6, pp. 381–390.

[10] See *Off. Rec. Wld Hlth Org.* **144**, 181-183.

planner was now reluctantly compelled to allocate a percentage of development investment capital for the creation of a social as well as an economic infrastructure for development, of which the organization of basic health services was an integral part.

Health planning was attempting to form a framework that would bring together the many forces contributing to total health. The specific science of hygiene, national health planning could offer a systematic approach for implementing the high principles of preventive and social medicine.

The time had come to consider an academic home for health planning in the Hemisphere. A draft proposal had been forwarded through WHO to the United Nations Special Fund for assistance in establishing a Pan American center for health planning. The functions of such center would be threefold: (a) to continue the training of national health planners; (b) to offer technical assistance to countries in further developing their national health plans; and (c) research into and codification of health planning methodology.

Table 1 of Document CD16/15 gave a summary of the status of national health planning in the various countries, in accordance with the available data. The situation was constantly changing and the Organization would amend the table should any additional information be received.

Attention should be drawn to the fact that in Table 2 reference was made only to central government expenditure. Especially in federated countries, that constituted only part of the national expenditure on health. Difficulty had been encountered in collecting total national expenditure figures, but it was hoped that those would be available for the following year's presentation.

Table 3 indicated the number of health planners trained, and their utilization within the various countries.

In conclusion, he stated that planning was now receiving much more cooperation from the health-related professions, as more and more specialist groups became intimately involved in planning their own standards and norms within the framework of the planning process.

Dr. Aguilar Rivas (El Salvador) said that his country had been one of the first to engage in health planning, which was started in El Salvador in 1963 with the assistance of the Pan American Sanitary Bureau. In his view, although planning was something of a novelty, it still contained many older and essential components of public health administration, such as statistics, epidemiology, and administration itself. What was new was the inclusion of the health sector in economic and social development programs, providing more effective guidelines for the establishment of priorities in operational programs. In El Salvador, six months after the initiation of the planning unit's activities, the first evaluation had been undertaken during the first half of 1964, which was in the process of being completed. All the information obtained for the evaluation had been used to review the results achieved in the principal centers for each region, an analysis in which all professional and technical staff had participated and which would be used to detect operational shortcomings and difficulties. The evaluation had brought real benefits, such as providing an analytical conspectus of the actual situation and a clearer understanding of the extent of damage to the population, and of the availability and utilization of resources. The results obtained had helped to indicate the health services the right lines of approach to the measures needed and had enabled the establishment of priorities based on technical procedures rather than on the opinions of executives. Essentially the aim was to meet the demand for medical care and reduce the mortality rate. Technical criteria had been established and applied on a common basis throughout the country so that health care could be provided on a consistent basis, securing the most effective utilization of resources without detriment to technical efficiency. The criteria were primarily intended to cover fundamentals but were being expanded and improved in the light of experience; a special characteristic of such criteria was that they had been based on the realities of the national scene. Planning provided for the execution of health measures with precise objectives that could be achieved by a proper observance of the criteria established; it was essential to pursue realistic objectives consistent with the resources available.

Changes had been made in the administrative organization with a view to the integration of services, the centralization of standards, and the decentralization of operations, the results of which were being progressively reflected in the form of a rapprochement, where none had existed formerly, between hospitals and health centers and units. A systematic staff training program was being undertaken, designed to meet national targets.

Health establishments already possessed statistical services, which used similar forms and instructions, providing for the timely collection, only one month in arrears, of all the comparative data required for the purposes of evaluation.

The plan had shown the need to undertake a redistribution of resources with a view to strengthening the weaker regions and that was being done, so far as possible, within the limits of the available and forecast supplies of trainees. The plan had also had an important and favorable effect on the morale of those working in health services.

The National School of Nursing had modified its educational program so as to bring it into line with the requirements of the national health plan; similarly, the School of Medicine had included health planning in the curriculum of the chair of preventive medicine and was devoting more attention to it in the current year than in 1964. The systematic publicizing of the plan was being undertaken through the training of field personnel, and in revision and training courses that were preceded by a short course on health statistics. The Department of Planning had collaborated with the National Board for Economic Planning and Coordination in the preparation of the Five-Year Plan for 1965-1969, which had already been published by the National Publications Committee on terms of reference, covering the following aspects: diagnosis of the situation, measures undertaken in the period 1950-1964; prognosis; health policy; 1965-1969 health plan; minimum personnel requirements; personnel estimates for 1965-1969; and an investment plan for the five-year period. The latter plan had to be revised annually, according to requirements, to bring it in line with the desired objectives. It also included an estimate of costs, which represented the first formal step taken by the Ministry to ascertain the real facts as to how the community's contributions to health care were employed and distributed. Although the effort being made was still not enough, there was no doubt as to its value and, it would, moreover, be improved with time; the information obtained would be of benefit to administrative and technical personnel at managerial levels in health services as it would be used as a basis for preparing a program budget and for showing which of those was least productive in relation to the expenditure it entailed. Such data would make it possible to identify planning errors and seek the best ways of solving them.

Mr. RIVERA (Costa Rica) stated that in 1963, when the Bureau had increased the assistance for the creation of planning units, there had been a marked improvement in such planning activities; judging from the data that were being examined considerable numbers of persons were available in the countries who could be employed for such work. He agreed with the statement made by Dr. Karl Evang at the Eighteenth World Health Assembly that the important thing was to integrate health planning with the whole planning effort of each country, since health planning was a form of sectoral planning that should be included in the general process of national planning; there were also shortcomings in the integration of the activities of the various bodies concerned with health. Mr. Rivera emphasized that it was essential that the health sector should constitute a fully integrated part of national development plans although he considered that it was also essential that that sector itself, together with all its services and activities, should form a compact and uniform whole.

An attempt was being made in Costa Rica to achieve unification at the level of the technical personnel of the various agencies, with a view to achieving it later at the political level, as it was sometimes easier to do the former than the latter.

Currently, efforts were being made to quantitatively evaluate problems, the extent of which had formerly been unknown. The major problem in Costa Rica was the training of personnel, particularly at the physician level, a problem which, he believed, was common to all the countries of the Americas. The situation with respect to nursing personnel and auxiliary nursing personnel was also serious and represented a problem of which planning had had to take the measure. He believed that planning required an approach based more firmly on the realities of health problems in the Continent.

In conclusion, he recommended that the Bureau continue its studies of the question with a view to achieving more positive results that would bring other sectors to a realization of the very important bearing such problems had on the economic and social development of the countries.

Dr. PERAZA (Honduras) reported that during the year the Higher Council for Economic Planning had been established in his country and was known formerly as the National Economic Council; at the same time, four sectoral bureaus had been

created: one for the health sector, one for education, one for natural resources, and one for communications and public works. In 1964 the planning unit had been operating on a provisional basis in the Ministry of Public Health and had attempted to produce a five-year health plan. A new diagnosis of the problems was currently being undertaken and the necessary adjustments and corrections were being made to the original plan. Furthermore, personnel were being trained at national, regional, and local levels, and for that purpose a small planning manual had been prepared, in which every effort had been made to present and develop the subject matter in an original manner. The manual summarized the views developed at the course on health planning held annually at Santiago, Chile, at the Latin American Institute for Economic and Social Planning and it had also made use of ideas obtained from a document [11] of the Center of Development Studies (CENDES) of the Central University of Venezuela, prepared at the request of the Pan American Sanitary Bureau, a basic document that, in broad terms, developed the same series of ideas as those on which the Chilean course was based.

In general, the aim was to treat the subjects in a simple lucid manner, within the reach of persons who had not been trained in the disciplines of public health, in order to provide those responsible for making decisions on investment policy with a better understanding of the problems and also to adopt a mathematical approach that would furnish a basis for comparison in establishing priorities in each country. As in the case of any method in the process of being developed, there was ample opportunity for research, experiment, and improvement, a task that was the responsibility of national planners.

Dr. OÑATIVIA (Argentina) stated that it was hardly necessary to stress the fundamental importance of planning in the preparation of national health programs and reaffirmed the need to correlate such programs with general development plans, even in the case of those developed nations where it had become essential to make better use of surplus human and material resources. It was therefore vital to coordinate activities in the public health sectors with those in the general development sectors of the various Governments.

Among the shortcomings that beset health planning in Argentina, he said he would refer more particularly to basic data, trained planning personnel, methodology, and organization that would facilitate planning, although certain positive steps had, nevertheless, been taken. Efforts had been made to establish relations between the ministerial sector and the development agencies of the national government, and a diagnosis made of the country's health in the preparation of the first national survey of public health resources and services, a first-hand survey in the field of all forms of national activity, official, semiofficial, and private, with a view to obtaining the real facts on what the Ministry actually had available for the preparation of health plans.

Moreover, considerable progress had also been made in the provision of adequate basic information, both in the form of vital and health statistics, efforts having been made to secure the necessary uniformity in the data, an important factor if a country with a federal structure such as Argentina wished to obtain satisfactory statistical data at the national, state, and municipal level.

Argentina had also made advances in the training of the auxiliary personnel responsible for the collection of such basic data at all levels, with a view to securing the maximum uniformity in procedures. All those steps indicated that progress had been made in diagnosis, health planning, and in the formulation of the future national health plan.

Dr. CALVO (Panama) reported that in his country, the Ministry of Public Health was implementing a National Health Plan which was currently at the preliminary stage. Health planning terminology in Panama had recently been brought up to date as a result of the experience obtained in a course given by the Latin American Institute for Economic and Social Planning and held in Santiago, Chile. He believed, however, that notwithstanding its name, the National Health Plan was, in fact, a subsectoral plan, as it had not been possible to include either social security or the private sector.

The Bureau's efforts should be directed toward obtaining, as soon as possible, comprehensive health planning in all the countries of the Hemisphere and its inclusion in national development plans. He said that he should like to ask Dr.

[11] *Health Planning—Problems of Concept and Method. Scientific Publication PAHO* **111.**

McKenzie-Pollock how many of the so-called national public health plans included the entire national health sectors of each country and, furthermore, how many of those plans were fully integrated in the over-all economic and social planning structures of the countries.

As a general rule, health planning experts were acting separately from the general body of economic and social planning and, as the corresponding plans were not fully integrated, their realization was becoming increasingly difficult.

Although intensive efforts were being made to create a mystique of health planning, there was a failure to realize that it was essential to understand the problems at the level of the countries themselves, adopting, step by step, each new technique of integration, so that a steadily increasing number of persons came to understand the nature of the new approach and could launch subsectoral health plans on a realistic basis.

Since 1962 the original conception of the Panama health plan, based on an administrative approach generally regarded as sound, had brought the various sectors much closer together; the plan had also sought to apply a systematic approach at the local level that would provide an opportunity for acquiring the technical experience necessary to make a rational evaluation of what was being undertaken. As a result, it would shortly be possible to present to the Government a comprehensive plan for the country's health sector, based on an economic approach consistent with social needs and possibilities.

Mr. BURKE (Jamaica) said that the information on Jamaica in the report did not present a fair picture of what that country was doing, perhaps because that information was drawn largely from the Inter-American Development Bank, of which his country was unfortunately not yet a member. It might be of interest to mention that Jamaica's expenditure on the health sector would represent 6.4 million pounds out of a total budget of 64 million pounds for 1965-1966. That did not include expenditures on water supplies, sewerage, or other services provided by local Government authorities, which were fully reimbursable. A planning unit had not yet been established within the Ministry of Health, but that did not mean that they were not engaged in planning. The Ministry of Health had been required, with all the other ministries, to prepare its section of a national plan for the years 1962-1967. That had been largely in terms of capital development works.

There was also the planning associated with training, the collection of data, and other activities pertaining particularly to health. For instance, during the past three years the kind of administrative rationalization applied so successfully by the Organization had been employed in achieving, within the limits of finance and general policy, the decentralization of hospital services. The main feature of the program of capital works was the simultaneous planning and execution of a project for three hospitals of varying sizes, including their physical construction, the training of the necessary personnel, and the financial aspect. Within the Ministry of Health a project team of four had been set up with a principal medical officer whose specialty was hospitals, the principal nursing officer, an administrative officer especially trained in economics, and the chief architect of the Ministry of Communication and Public Works. That was the Ministry of Health team, and they, together with the Chief Medical Officer and himself, were chief advisers to the Minister on that particular project. That was the way Jamaica approached projects of this size. On the public works side, architects were available, as was the valuable assistance of a consultant from the Pan American Health Organization.

All senior officers of the Ministry of Health, under the Minister himself, had a responsibility for planning. So far as possible, that planning was integrated with that of other ministries.

Jamaica was also surveying the needs, requirements, and resources for the next 10 years and there again, was receiving great assistance from the Organization.

In that area also, the Ministry of Health was using not only its own personnel but statisticians and such people as the officers of the Government's Central Planning Unit.

Dr. AGUILAR HERRERA (Guatemala) said that a health planning unit had been formed in Guatemala on a provisional basis, and was so considered because although it was under the direction of two capable individuals, they had been loaned for the purpose by other departments of the Ministry of Health and their appointments were not of a permanent nature. Nevertheless, the unit had continued to work on its analysis of the situation and had completed its report, though it had not made such

rapid progress as might have been desired in the formulation and implementation of the health plan.

Judging from the tables presented by Dr. McKenzie-Pollock in the document under discussion, it appeared that other countries might be more or less in a similar situation. He therefore proposed that a committee be formed to prepare a draft resolution recommending that in those countries in which national health plans had not made satisfactory progress, Governments should give all their support to sectoral planning units, facilitate their integration with national planning agencies, and assist in the implementation of such plans.

The PRESIDENT found Dr. Aguilar Herrera's proposal interesting and appointed him and the Representatives of Chile, El Salvador, and Haiti, with the assistance of Dr. McKenzie-Pollock, to prepare a draft resolution along those lines.

Dr. MARTÍNEZ (Mexico) said that he had asked for the floor because he wished to support publicly the views put forward by the Representative of Panama which were similar to those of Mexico and coincided with its experience; furthermore, he believed it necessary to state clearly his country's position on planning since the report presented differed from the facts, although he believed that that might be due to shortcomings in the answers received from the Mexican health authorities or to defects in the scope of the questions themselves.

Mexico had been officially and formally planning its society since 1924 when, after the revolution, the Government had first introduced comprehensive five-year plans, including plans for the public health sector. He believed that, as a result of the Bureau's enthusiastic sponsorship of planning measures, efforts had been made to create a mystique that was to be centered on, or so it was hoped, a methodology and based on a terminology. He pointed out that each country, in undertaking its health activities, had to adapt those to its cultural and economic life so that it was not possible to apply the same methods everywhere. Lastly, he pointed out that the Government of Mexico had decided not to organize a planning unit within its Ministry of Health and Social Welfare. He explained that, at one point, it had been stated that such a unit was being created, but that during that process it had been decided, after extensive discussion, that it was not convenient to have it within the Ministry, which should not in any way be regarded as indicating that the Mexican Government was opposed to planning. The decision made reflected a different context and a different approach.

Mr. PHILIPPEAUX (Haiti) declared that in connection with the item under discussion, his country's situation was almost identical to that of Mexico in that it had taken and was standing by a decision not to organize a planning unit in its Public Health Department, whether in response to the objectives of the Alliance for Progress or to recommendations of specialized agencies in the health sector.

Although Haiti had been one of the authors of the Alliance for Progress, it had so far not received a single dollar from external sources toward financing its programs, notwithstanding its requests and efforts and the visits of special missions sent by financing agencies. With its own limited resources it had endeavored to carry out the objectives of the Charter of Punta del Este, objectives that Haiti had adopted even before the Alliance.

Haiti, through its Public Health Department, was operating on the basis of a plan that had not been communicated to the Bureau and it had not, moreover, replied to the pertinent questionnaire. The immediate objectives of that plan were to secure the reorganization of public health services on the basis of a rational and realistic program, and secondly, to provide training for key personnel at both technical and auxiliary levels. At the end of the fiscal year, which had expired on 30 September 1965, both those objectives had been realized; in the forthcoming fiscal year, which had begun on 1 October 1965, the plan would reach the advanced stage, but all the resources that were to be employed would continue to come from strictly national resources. Nevertheless, he wished to thank WHO and PASB for the assistance they had given Haiti both in the technical sphere and in the form of equipment.

Dr. VALDIVIESO (Chile) announced that, for the first time, his country would have a national health plan, conceived in close integration with the nation's general economic development plans, which was currently being prepared at the presidential level, the level at which the other sectoral plans had been drawn up. That plan would be truly national in scope as it would coordinate the activities of all institutions, including those in the private sector, that worked in the health field. A number of limit-

ing factors had nevertheless been encountered, such as a lack of the proper data, legal impediments, and deficient training in the sociological field, obstacles that could not be rapidly overcome and that would make it impossible for the system to be complete at its outset; on the other hand, he wished to stress that the welcome that the proposal had received in the private and other non-public sectors had been a favorable one.

The plan was a realistic one in terms of the resources currently available and would be adjusted to regional and local needs, as there was a wide variation between health problems in the north of the country, a subtropical region, and those in the extreme south, which was a very cold region. In order to associate those concerned with the formulation of the plan with the responsibility for its execution, a preparatory planning committee had been formed, in which the former and the latter would be brought together with a view to securing its early implementation.

Included in the plan would be the program budget system to be implemented over the forthcoming 10 years on a province by province basis. In that system the diseases had been classified as either avoidable or nonavoidable and gynecological and pediatric care, though not diseases as such but required activities in the health field, had been placed in a separate group. Following that, a decision was taken on the best means of combating each disease and, on that basis, procedures would be determined and objectives defined in each instance. A start would be made with minimum targets, but their realization would ensure that there be no loss of ground in relation to the current situation. In that minimum plan, targets would be set for each province and for each health unit and would subsequently be expressed in a budgetary program that would show the cost of each measure provided as well as the total cost of all of them. Other alternative solutions were under consideration, whose feasibility would depend on the existence of adequate budgetary resources; it was envisaged that over the 10 years in question it might be possible to increase gradually the funds available, so that the plan could be transformed from a minimum plan to one with more ambitious objectives.

He declared that the Chilean health plan would be submitted to the Bureau within the first half of the forthcoming month as it was closely related to the completion of the country's 10-year economic development plan.

Dr. McKENZIE-POLLOCK (Chief, Office of National Health Planning, PASB) thanked the representatives for their very valuable comments, which he felt improved the whole approach to planning. Planning and the methodology of planning were still in their infancy; there was no such thing as a blueprint of national health planning that could be applied to a national situation and that could fit it exactly. Certainly some of the planning methodology and some of the newer methods of analysis and of proceeding in a systematic manner could fit many situations, but planning was essentially unique to a particular country. No system would apply equally to a unitarian political administration and to a large, complex federal structure. After all, planning was a fluid not a static process.

As Dr. Calvo had brought out so clearly, at the macro planning level no country had made a true analysis of what could be termed the health sector of the gross national product. That would involve a complete analysis of government health services, social security health services, the private sector, military medicine, industrial medicine, and a host of other facets of the total health scene. He doubted whether a single country in the world had made a total analysis of its health industry. Progress was being made, but he did not believe perfection would ever be attained. Planning was a systematic gathering of the many and complex forces involved in health promotion, in an endeavor to correlate them with the resources available. The very stimulating discussion was in itself proof that planning was a dynamic process.

The session was recessed at 5:45 p.m. and resumed at 6:00 p.m.

Item 15: Report on Administrative Rationalization in the Pan American Sanitary Bureau

Dr. PORTNER (Chief of Administration, PASB) presented Document CD16/16,[12] which represented a further report on the progress made with reference to administrative rationalization in the Pan American Sanitary Bureau and brought up to date the statements made on that subject to previous meetings of the Organization's Governing Bodies.

The objective of the administrative rationaliza-

[12] See Annex 13, pp. 431–433.

tion program was the centralization in the Washington Office of virtually all the Organization's administrative activities, thereby ensuring greater efficiency and lower costs. That objective had now been reached. As a result, it had been possible to effect a net reduction of 68 administrative positions, which represented annual savings of some $530,000 that could be used instead for direct program assistance to the Governments.

Reference had been made to increased expenditure on overtime and temporary assistance, principally in the Finance Section. That represented less than 3 per cent of the total savings effected in the rationalization program. Much of that increase bore no relation with the program itself and was largely attributable to illness and the need to meet deadlines, as for the closure of accounts.

As previously reported, the program of administrative rationalization had also been introduced in 1964 in the Institute of Nutrition of Central America and Panama and initial savings there had amounted to 21 positions, representing estimated annual savings of about $53,000.

As the work increased in the Washington headquarters office, partly through the centralization of administrative operations and partly due to the growth of the Organization's program and staff, concentrated efforts were being made to further improve internal processes and procedures and to introduce new techniques. Several significant steps had already been taken to emphasize the role of mechanization and electronic data-processing in administrative functions. One such step was the purchase in 1961 of two accounting machines which were subsequently modified to permit them also to punch paper tape for use as a computer input. Another important step was the change-over early in 1964 to a computer-produced payroll, which had led at the same time to numerous computer-produced reports of a financial nature.

In the personnel area the change-over to the new process was accomplished during April and May. New forms were devised and new equipment purchased which now permitted computer-produced reports on staff employed, staff strength, staff distribution by nationality, and a variety of other reports.

Simultaneously, several staff members were being trained in programming and related techniques with the aim of creating a cadre of regular staff able to program the Organization's computer work. For the time being, that work was being processed on a service bureau basis. However, as experience was acquired and volume of work increased, it might be appropriate to consider alternative arrangements.

In conclusion, Dr. Portner stated that through continued streamlining of procedures and increased use of the most modern equipment and techniques in the Organization's administration, it would be possible to achieve a high level of efficiency and production without corresponding increases in staff or costs.

Mr. BURKE (Jamaica) said he felt it would be ungracious not to say a few very sincere words of appreciation for the administrative rationalization achieved in the Bureau and that proposed for the future.

He knew from experience that a tigress defending its young was nothing compared to the opposition sometimes encountered in reducing administrative staff, and he believed that the reorganization achieved was probably unique among international organizations. Pleasing too was the promise of further improvement, not only in terms of personnel but of better utilization of resources and the employment of improved practices. He therefore wished to propose the following draft resolution:

THE DIRECTING COUNCIL,

Having examined the report of the Director on administrative rationalization in the Pan American Sanitary Bureau (Document CD16/16);

Noting the progress made to date in accomplishing the objectives of the program;

Bearing in mind the economies effected as a result of the program of rationalization and the investment of these funds in program service to the Governments; and

Cognizant of the continued efforts that are being made to improve the internal methods and procedures through the implementation of data-processing applications,

RESOLVES:

1. To take note of the report of the Director on administrative rationalization in the Pan American Sanitary Bureau (Document CD16/16).

2. To commend the Director and the staff of PASB for their efforts to date in effecting economies in administration through the recentralization of administrative activities and the introduction of data-processing techniques.

3. To request the Director to continue the program of rationalization and to report progress to future meetings of the Governing Bodies.

The PRESIDENT stated that the draft resolution presented by the Representative of Jamaica would be submitted to the Council at the eleventh plenary session.[13]

Mr. BYRNES (United States of America) said that the achievement of a sound administration was not always a popular thing, and his Delegation therefore wished to join the Representative of Jamaica in commending the Director and his staff for their success in that regard and in encouraging them to continue their efforts in the future.

Dr. FERREIRA (Brazil) expressed his full support for the draft resolution presented by the Representative of Jamaica and said that he considered that the staff reductions achieved through the application of the administrative rationalization system set an example for the countries themselves, especially since the Bureau had demonstrated how it had been able to achieve such results without detriment to its efficient operation.

Item 23: Third Annual Meetings of the Inter-American Economic and Social Council at the Expert and the Ministerial Levels

Dr. CUTLER (Deputy Director, PASB) stated that the detailed and excellent presentation of Dr. Carlos Sanz de Santamaría at the previous session made it unnecessary for him to give other than a very brief report on Document CD16/10,[14] Third Annual Meetings of the Inter-American Economic and Social Council at the Expert and Ministerial Levels (Lima, Peru, 30 November-11 December 1964). The Executive Committee had noted[15] with satisfaction and interest the report of the Director (Document CE52/2, Rev. 1)[16] on the meetings, and had requested that it be transmitted to the Directing Council. The Director wished to draw attention to the important change in the procedures for the annual review of the Alliance for Progress occasioned by the establishment of the Inter-American Committee on the Alliance for Progress (CIAP). That Committee had taken over much of the work previously assigned to the Special Commissions, one of which dealt with health matters.

In 1964, when CIAP had initiated the procedure for conducting country reviews, emphasis was placed on international financial considerations. In 1965 the country reviews had included an analysis of national and international investments in the social sector, of which health was a part.

In preparation for those national confrontations the PAHO Zone Offices and Country Representatives under the direction of Headquarters in Washington, had given assistance to ministries of health in interpreting CIAP procedures. At the national level, that was serving to foster increased appreciation of the requirements of the health sector at central offices of economic development planning responsible for preparing the national plans to be submitted to CIAP.

As pointed out by Dr. Sanz de Santamaría, the presence of a PAHO representative on the CIAP review subcommittee was helping to bring to the attention of the international financial agencies the role of health in national development.

In the case of the countries so far reviewed by the CIAP in 1965, the attention of the Committee had been drawn to one or two aspects of health of particular importance to national development and requiring substantial international investment.

So far Representatives of the Governments of Argentina, Bolivia, Haiti, Panama, and Venezuela had appeared for confrontation by CIAP. The reviews would continue until November 1965, and proved an excellent medium through which the various agencies assisting countries toward balanced economic and social development could interchange ideas with the countries concerned.

Mr. PHILIPPEAUX (Haiti) referred to the statement made by Dr. Sanz de Santamaría and to the discussion it had led to on the place of health in economic and social development. In that connection a number of representatives had expressed the view that health was not being given the attention it deserved in economic development programs. That situation was, in his view, a very real one, the result of a prejudice that would have to be overcome.

He was pleased to note that the Pan American Health Organization and the Inter-American Committee on the Alliance for Progress were seeking to pave the way toward an understanding that would satisfy the requirements of technical personnel and health experts and, at the same time,

[13] See p. 145.
[14] See Annex 12, pp. 427–430.
[15] Resolution XII. *Official Document PAHO* **62**, 35-36.
[16] See p. 427.

persuade economists and planners to make certain concessions.

He then read the following draft resolution, which reflected the comments made and the concern expressed by several representatives:

THE DIRECTING COUNCIL,

Having considered the report of the Director on the Third Annual Meetings of the Inter-American Economic and Social Council (IA-ECOSOC) at the Expert and the Ministerial Levels, transmitted by the Executive Committee (Document CE52/2, Rev. 1); and

Bearing in mind the recommendations approved by these meetings, especially those relating to health in the Americas,

RESOLVES:

1. To note with great satisfaction and interest the report of the Director on the Third Annual Meetings of the IA-ECOSOC at the Expert and the Ministerial Levels, held in Lima, Peru, from 30 November to 11 December 1964 (Document CE52/2, Rev. 1).

2. To express its satisfaction with the interest shown by the Third Annual Meetings of the IA-ECOSOC in health in the Americas, and especially the recommendations approved at the Expert Level on foot-and-mouth disease, rural and urban water supply, health investments, and requests for international loans for land settlement, road building, urbanization, and other programs.

3. To instruct the Director of the Bureau to continue to develop and strengthen relations between the Organization, IA-ECOSOC, and the Inter-American Committee on the Alliance for Progress (CIAP), in order to bring about the integration of health activities in economic and social development programs.

4. To urge that the Governments of the Organization include representatives of ministries of health in their delegations to the Annual Meetings of IA-ECOSOC, and that they also endeavor to have included in the agenda of those meetings specific items concerning the participation of the health sector in the dynamic process of development of the countries of the Americas.

Dr. FERREIRA (Brazil) expressed his satisfaction at the points made by the Representative of Haiti, but pointed out that the enthusiasm with which Dr. Philippeaux had declared earlier in the session that Haiti's health programs would be carried out without external assistance had given him cause for some concern. He also expressed his pleasure at the proposals in the draft resolution that national and international resources should be combined to serve the needs of the peoples of the Hemisphere.

Mr. PHILIPPEAUX (Haiti) explained that he had not said that Haiti did not need external aid in its health program, but merely that it was carrying out that program without any assistance other than that provided by PASB in the form of technical services and material resources.

The PRESIDENT said that the draft resolution presented by the Representative of Haiti would be circulated and put to the vote at the next session.[17]

The session rose at 6:40 p.m.

[17] See eleventh plenary session, p. 145.

ELEVENTH PLENARY SESSION

Tuesday, 5 October 1965, at 9:15 a.m.

President: Dr. RODERICK ESQUIVEL (Panama)

Item 24: Resolutions of the WHO Executive Board and the World Health Assembly of Interest to the Regional Committee (*continuation*)

Draft Resolution Presented by the Delegation of Argentina on the Quality Control of Pharmaceutical Preparations

The PRESIDENT declared the session open and stated that he would put to the vote the draft resolution which had been submitted by the Delegation of Argentina at the eighth plenary session [1] concerning the preparation of pharmaceutical products, the text of which had been circulated to the representatives.

Dr. WILLIAMS (United States of America) expressed his appreciation to the Directing Council

[1] See p. 107.

for accepting his request to defer voting on the draft resolution under consideration, so that his Delegation could study it. After thanking the Delegation of Argentina for its forebearance in the matter, he stated that the proposed resolution was very satisfactory and that he would take great pleasure in voting for it exactly as drafted.

Dr. SCORZELLI (Brazil) said that his country's Delegation was in favor of the proposed draft resolution, provided that some amendments were made to it, for reasons he would explain.

In his opinion, the economies of the countries were perhaps reflected most adequately in the pharmaceutical industry, where major progress had been achieved through research and discoveries, the development of new products, and the use of improved methods. The industry had an obvious interest in controlling the quality of its products in order to gain increasing acceptance on the consumer's market. He stressed that controls were necessary from the raw materials stage to that of the finished product, including storage. Therefore, in its own interest, the pharmaceutical industry conducted a series of scrupulous checks and tests, which should not be duplicated. Government services should therefore confine themselves to verifying, through qualified experts of unquestioned integrity, that the above-mentioned controls were being applied in accordance with established rules, bearing in mind that the period of pharmaceutical effectiveness of some medicaments was longer than that of others, and also that it varied according to normal environmental variations. Large-scale pharmaceutical industry also faced the problem of distribution of the products and of possible changes occurring in transport.

If research were to be carried out to determine the influence of environmental conditions on the stability of pharmaceutical products, so that the rules governing the length of their effectiveness could be clearly stated in print, control would be easier and less work would have to be done by the control laboratories.

It was much more difficult for small firms to maintain control laboratories; nor could they readily join forces in maintaining a laboratory to serve them all. Consequently, Governments should give such firms the necessary means of testing their products, but in a spirit of cooperation at the same time as for control purposes. Such control would be generally improved if products of little or no therapeutic value were eliminated. In that regard, Brazil relied on the advice and recommendations of technical commissions composed of biologists, pharmacologists, clinicians, and chemists. Control would also be simplified if the products always bore a printed statement of the date beyond which they should not be used.

On the other hand, where the control of the quality of medicinal products was concerned, stress should be laid on training and refresher courses for personnel in the techniques to be used and in setting inspection standards. There could be no doubt that countries must be given assistance to enable them to set up laboratories of that type, according to their needs and possibilities. Once the laboratories were installed, agreements could be concluded for intercountry aid.

In Dr. Scorzelli's view, the proposal for the reference laboratory was excellent; its primary functions should include training and refresher courses for technicians; formulation of minimum standards for inspection; and technical assistance for the installation of laboratories by interested countries, in addition to the research already mentioned. The Delegation of Brazil would vote in favor of the draft resolution on international reference laboratories if a paragraph were added to it specifying the functions which they should perform, which should be those he had outlined.

Dr. OÑATIVIA (Argentina) thought the remarks of the Brazilian Representative were cogent, but pointed out that the operative paragraph of the draft resolution was based on the report presented to the Council on the need to establish reference laboratories and that the text of that report described in detail the organization and basic functions of such laboratories, including those very activities which the Representative of Brazil had enumerated.

The PRESIDENT remarked that apparently the Delegation of Brazil wished a fuller or more detailed definition of what constituted a reference laboratory. He agreed with the Representative of Argentina that the draft resolution took account of the fact that the Pan American Sanitary Bureau had already furnished such a definition, which included the functions recommended by the Representative of Brazil. Consequently, he felt that Dr. Scorzelli's remarks were extremely pertinent but did

not necessarily have to be included in the text of the draft resolution; he therefore put it to a vote.

Decision: The draft resolution was unanimously approved.[2]

Item 15: Report on Administrative Rationalization in the Pan American Sanitary Bureau (*conclusion*)

Draft Resolution Presented by the Delegation of Jamaica

Dr. QUIRÓS (Peru) declared that his country's Delegation would vote against the draft resolution presented at the tenth plenary session [3] because it was not satisfied with the explanations given in that connection, although it had been enthusiastically in favor of administrative rationalization. The Report of the External Auditor was regrettably somewhat vague and failed to make it clear what the measure would mean from the economic standpoint and whether or not it would endanger the field programs.

The PRESIDENT called for a vote on the proposed resolution.

Decision: By 21 votes in favor, 1 against, and no abstentions, the draft resolution was approved.[4]

Technical and Financial Support to the Institute of Nutrition of Central America and Panama (INCAP) (*conclusion*)

Draft Resolution Presented by the Delegation of Peru

The PRESIDENT said that the draft resolution presented by the Delegation of Peru, in accordance with the discussion of the fifth plenary session,[5] would be put to a vote.

THE DIRECTING COUNCIL,

Considering that the countries of Central America and Panama have contributed, through the instrumentality of the Institute of Nutrition of Central America and Panama (INCAP), to the solution of the problem of malnutrition in the Americas, and have given an example of multinational planning,

RESOLVES:

1. To congratulate the countries of Central America and Panama and thank them for their valuable help in solving the problem of malnutrition not only in the member countries of INCAP but also in the Americas and throughout the world.

2. To recommend to the Director of the Bureau that he continue to give all possible technical and financial support to INCAP.

Decision: The draft resolution was unanimously approved.[6]

Item 23: Third Annual Meetings of the Inter-American Economic and Social Council at the Expert and the Ministerial Levels (*conclusion*)

Draft Resolution Presented by the Delegation of Haiti

The PRESIDENT called for a vote on the draft resolution presented by the Delegation of Haiti at the tenth plenary session.[7]

Decision: By 21 votes in favor, none against, and 2 abstentions, the draft resolution was approved.[8]

Item 22: Research Policy and Program of the Pan American Health Organization

Dr. ALLEN (Chief, Office of Research Coordination, PASB), stated that the documents for the agenda item were: the Director's Annual Report (Chapter V, *Official Document 63*), and Document CD16/20,[9] which consisted of a summary account of progress since the XV Meeting, the Report of the Fourth Meeting of the PAHO Advisory Committee on Medical Research, held 14-18 June 1965 (CD16/20, Annex 1),[10] and the Current PAHO Collaborative Research Program (CD16/20, Annex 2).[11] He reported that Annex 2 gave a listing of 22 voluntary and governmental organizations which had made 55 grants, active this year, representing an investment of $2,769,213. The amount requested to complete those projects in future years (which did not terminate this year), amounted to $7,915,005. The grant requests under current consideration totalled $1,146,249. Those figures did not include the sums of the PAHO regular budget for

[2] Resolution XII. *Official Document PAHO* **66**, 64-65.
[3] See p. 141.
[4] Resolution XIII. *Official Document PAHO* **66**, 65-66.
[5] See pp. 67-68.
[6] Resolution XIV. *Official Document PAHO* **66**, 66.
[7] See pp. 142-143.
[8] Resolution XV. *Official Document PAHO* **66**, 67.
[9] See Annex 7, pp. 391-395.
[10] Document RES4/13 (mimeographed).
[11] Mimeographed document.

the support of the Pan American Foot-and-Mouth Disease Center, the Zoonosis Center, INCAP, and malaria research, nor that assigned to the PASB Office of Research Coordination.

The speaker stated that the staff of that Office was in charge of planning and coordinating the research program, and functioned as secretariat for the Advisory Committee on Medical Research (ACMR), the Director, and the technical branches. Its budget, of around $200,000 annually, was established in 1962 with a grant from the National Institutes of Health, with a similar supplementary grant in 1963. That was absorbed in the PAHO regular budget for 1964, which funded the staff of three professional officers, the meetings of the ACMR and expert consultants, at the same expenditure level.

Dr. Allen then referred to the substantive research matters as they were considered by the Advisory Committee at its Fourth Meeting and which were listed in its report. The document covered the major agenda items for that meeting, including a review of current research projects, new projects, and program proposals. He called the attention of the Council to the fact that the Advisory Committee went through periodic infusions of new blood. He cited as example the participation, in past meetings, of Dr. Roberto Caldeyro-Barcia, a distinguished physiologist and obstetrician from Montevideo, Uruguay, and in the 1965 meeting, of Dr. Alberto Hurtado, from Lima, Peru, a world-known figure in the field of physiology. He also cited the participation of Dr. John C. Waterlow, a distinguished scientist in the field of tropical metabolic and nutrition research, who had brought PAHO in a very close working relationship with the Standing Advisory Committee for Medical Research in the British Caribbean (SAC). Dr. Horwitz—added the speaker—had been eager that that group, composed of internationally renowned scientists, educators, and public health officials, should continue to serve and increasingly reflect the Bureau's interest. He added that all of the persons that served in the Secretariat of the Bureau were greatly indebted to the ACMR, and expressed the hope that that feeling would be shared by the Directing Council and reflected in its resolution on that item. It was felt that the PAHO research policy and program, as approved at successive meetings of the Council, was developing, according to plan, with increasing emphasis on the biosocial and biosanitary engineering fields, without neglecting biomedical studies in communicable diseases and problems of psychobiological determinants of human behavior.

For long-term development, measured in decades, a substantial program proposal was being developed for Regional Centers for faculty teaching and research training. Increasing attention had also been given to the problems of national policy and structure for the support of biomedical, biosocial, and biosanitary engineering studies and training. And, to round out the policy proposal of supporting the development of institutional resources for teaching and research, a recommendation had been made for the establishment of a Regional Medical Library for Latin America for bibliographic and reference purposes and for research and training in library and communication science.

Latin America was in the main stream of international medical science and technology, but its resources for self-sustained activity needed strengthening. The ministries of health and the universities carried the main responsibility for marshalling local resources to take advantage of the international cooperative support available, and which PAHO endeavored to help materialize in support of the Governments' health programs.

Dr. Allen added that he would like to make a few other comments to summarize his own personal view on the direction followed by PAHO's policy under the Directing Council's guidance, as to what were the main points of thrust and strength as that policy evolved. He stressed that, in connection with the statement made by Dr. Sanz de Santamaría at the ninth plenary session,[12] his opinion was that the policies and programs of PASB, the Regional Office of WHO for the Americas, were being shaped to meet the great challenges of rapidly growing populations and inadequate health care resources.

Concurrently, other institutions of the Inter-American system, such as the Organization of American States, the Inter-American Economic and Social Council, the Inter-American Development Bank, and others, under the leadership of the Inter-American Committee on the Alliance for Progress, were emphasizing social progress and human resources development in health, education, and welfare. They were creating a flexible framework

[12] See pp. 120-122.

of broad policy and resources within which the Americas could shape realistic national development plans in harmony with country and regional requirements, resources and capabilities.

While the needs seemed overwhelming, the patient work of planned development in the Americas was being built on solid pillars of strength. These were:

(1) Studies of specialized health manpower needs and demands at all levels, including auxiliary and paramedical personnel. Such studies had been carried out in the broad context of the efficiency and degree of coverage of existing institutional health services and of socioeconomic development to meet expanding and changing technical requirements of fast-growing populations.

(2) Promotion of the need for better statistics on health conditions, and the training of large numbers of health workers capable of accumulating and collating accurate health data for planning and program purposes.

(3) The marshalling of all public and private health service agencies in a coordinated attack on unmet health needs and demands, including the allocation of ministry of health funds for research and training in problems of a public health nature.

(4) The rapid acceleration of the development of institutional resources for education, training, and research to solve health problems and to meet the enormous need for teachers and researchers on a national and regional basis. Regional centers for such programs in a variety of fields, including population dynamics, were being organized. A program of library modernization was also being developed including: (a) a center—in cooperation with the National Library of Medicine—for the exchange of contemporary, scientific, and health information, training in library and communications science, and technology and of research in those fields, and (b) an imaginative book-bank proposal to provide modern textbooks in Spanish for students.

(5) The oldest pillar of all were programs for the control and eradication of communicable diseases, using both vertical and horizontal organizational instruments which had proved their effectiveness, for example, smallpox, malaria, and foot-and-mouth disease, as well as for the prevention of malnutrition and undernutrition, especially in infants and children.

(6) Finally, mention should be made of a program for the advancement of biomedical science and science generally, a hitherto neglected but important component of national and regional culture in Latin America. Dr. Allen finished his presentation stating that through those means, the Organization attempted to create a climate of attitude and opinion favorable to the national support of science and the use of scientific methods in the solution of problems of health and well-being for the peoples of the Americas.

Dr. WILLIAMS (United States of America) stated that the Government of the United States of America had been greatly interested in the medical research program carried out by the Pan American Health Organization since its very beginning. Therefore, it was pleasing and gratifying to note the very sound and satisfactory manner in which the program continued to develop. He was particularly interested in it since, as Chief of the Office of International Research of his country's National Institutes of Health, his responsibilities were directly concerned with the activities of the Organization in that field. He had had the opportunity to attend one or two meetings of the PAHO Advisory Committee on Medical Research convoked by Dr. Horwitz, and which usually met once a year in Washington. Undoubtedly it was a very outstanding group in the field of medical sciences from all over the Hemisphere, and their deliberations were both interesting and very stimulating. In his opinion, their advice was of great value to the Director and to Dr. Allen in the development of the Organization's research program.

It was to be expected that that program would continue to grow as satisfactorily as in the past. Therefore, the Delegation of the United States of America would like to propose a resolution on that item, the text of which would be translated into Spanish and distributed in due course for consideration by the Directing Council.

The PRESIDENT stated that the draft resolution presented by the Representative of the United States of America would be translated into Spanish and then submitted to the Council for approval.

Dr. VALDIVIESO (Chile) remarked that the document on the PAHO research policy and program deserved high praise. The innovations introduced during Dr. Horwitz' term of office were distinguished for proposals of this type, every aspect of which merited attention. The scientific research projects should be supported and reasonably expanded in the future. In his view, the research

budget mentioned in the document was inadequate and better financing should be provided in the future.

Referring to research subjects of particular interest to his country, he mentioned nutrition, alcoholism, mental health, early cancer diagnosis, and, generally speaking, all environmental factors which were related to physical well-being.

His own university studies made him feel that, even as universities could not confine themselves to turning out professionals, medical schools should not be concerned solely with training physicians, nor should health organizations be concerned with medical care problems; they should join forces and engage in research. Research projects should be carried out in close collaboration with the universities, since those and their hospitals, many of which were operated by the health services which offered medical instruction, could carry on research activities with greater chances of success.

Dr. FERREIRA (Brazil) associated his country's Delegation with the congratulations extended to the Director and to Dr. Allen on the report, which he thought excellent, and remarked on the great variety of matters dealt with by the Advisory Committee. He agreed with the Representative of Chile that it was normal for universities to take part in applied research relating to public health. The Ministry of Health of his country of which he was the head had an auxiliary body known as the National Institute of Rural Endemic Diseases, which not only carried out its own research but supported the research done by the universities and by Brazilian research institutions. In his view, the Pan American Health Organization, which took so active a part in national health campaigns, must also have a research section of its own.

The Constitution of the State of Bahia provided that one-half of one per cent of the State's revenues must be allocated for scientific research; the country as a whole was making an effort to finance on an appropriate scale the activities of the National Research Council, on the assumption that improvement of the curative and preventive medical services must be backed up by medical research. He therefore felt that the Organization should devote special attention to that type of work, so that countries could rely on its assistance both as regards their health services and in matters of research.

Dr. QUIRÓS (Peru) said that he attached fundamental importance to research, and recalled that, on earlier occasions, his country had advocated the establishment of national scientific and technical research commissions, such as existed in Argentina and Venezuela. A commission had been set up in Peru to draft a bill creating the National Research Commission. Unfortunately, the proposal had miscarried, and the OAS, on learning of that, had offered its technical collaboration, in the form of the services of a short-term consultant or of a travel fellowship for a technician who would study the operation of such commissions in other countries and prepare a preliminary draft law establishing that National Research Commission.

He had not examined the text of the draft resolution presented by Dr. Williams, but he believed the Organization could give technical assistance in that field. In his country's view, such assistance could usefully take the form of the appointment of a short-term consultant to collaborate with countries in the establishment of the above-mentioned national commissions.

Dr. OÑATIVIA (Argentina) stated that his Delegation emphatically supported the PAHO research policy, and expressed his satisfaction at the broad, yet profound treatment of the subject in the report presented by Dr. Allen. Those responsible for health policies in their respective countries were well aware of the overriding importance of applied research in the public health field for the support of the health activities currently being undertaken by the different ministries.

He emphasized that the subject under discussion was but another example of the beneficent influence exercised by the policy of the Pan American Health Organization in the public health sector, as regards both scientific research and other matters. One of the basic features and aims of that policy was to create an awareness of the need for sanitation on the American Continent, so that henceforward there would be a full realization that it was essential for health programs to be an integral part of general development plans. Of equally capital importance was the endeavor to change the concept which had prevailed in the past in the training of doctors, that medicine was purely curative, and to replace it by the idea that it was an integral whole, which also had preventive and social aspects. In that way, health in the Americas would be better served.

The fundamental significance of the report lay in the fact that the action described in it would awaken Latin American universities to the realization that they must not only carry out basic research in biology, but must also make an effort to become research centers in matters of public health. That should be among the most positive results of the policy currently pursued by the Organization. He recalled that at the XV Meeting of the Directing Council in Mexico, the Delegation of Argentina had submitted a draft resolution [13] calling on Governments to endeavor to rectify the shortcomings in their public health research programs.

The establishment of national funds to support such research was of the greatest importance if countries were to make up for lost time and to modernize their health research programs. Stimulation of the type of applied research in which the community was used as a laboratory and a broad approach to the epidemiological and sanitary problems of the region would do away with many of the serious shortcomings now plaguing the Latin American countries in the field of health.

His Delegation wished to study carefully the draft resolution presented by the Delegation of the United States of America, and would then either support it as it stood or propose a few amendments, in line with the general ideas he had expressed.

Mr. CASTELLS (Uruguay) stated that the Government of his country took a special interest in the establishment of a Regional Pilot Center of Medical Libraries and offered it a site at the School of Medicine of the University of Uruguay, in Montevideo. During a visit to his country on 27 April 1965 by Dr. Mortimer Taube and Dr. David Kronick, PASB/WHO consultants, consideration had been given to the installation of the aforesaid pilot center for South America, under the auspices of the Pan American Sanitary Bureau and the World Health Organization, using as a basis a medical library already in existence in a South American country. On 29 April 1965, the Libraries Commission of Uruguay had sent the reports relating to that proposal to the Board of Directors of the School of Medicine, which had reacted favorably to the project.

If Uruguay should be chosen as the site for the regional pilot center, the possibility would be explored of constructing a library building, and then of providing living quarters for fellowship holders who would be trained as librarians in the regional center. The University of Uruguay, in a resolution dated 6 September, had decided to "approve the proposal of the School of Medicine concerning the establishment, in the library of that department of the University, of the Regional Pilot Center of Medical Libraries for South America; make the necessary application to the Executive Branch of the Government, through the Ministries of Education and Social Welfare and the Ministry of Public Health, and make an application for the same purpose to the international organizations which are to take a decision in the matter—the United Nations, the World Health Organization, and the Pan American Sanitary Bureau—either directly or through their Representative in our country."

Dr. CASTILLO REY (Venezuela) remarked that the document before the Council was of major importance and that the Bureau's efforts in widely different areas of research deserved commendation. The report manifested concern for general epidemiological research, which was essential for identifying the problems each country had to cope with. In Venezuela, the Ministry of Health and Social Welfare was very interested in advancing and broadening research on equine encephalitis and Chagas' disease. He thought that more research should be done on new sources of nourishment in every country, with a view to finding foods which could be used to improve local diets without departing too much from traditional eating habits. With the increase in population and the influx from the countryside to the cities, rural problems were transplanted to the city. In consequence, the entire field of mental hygiene acquired outstanding importance; the same phenomenon was attendant on the process of industrialization, which entailed adjustment to new methods of work, concentration of new means, and adaptation to new ways of life.

Research should not be circumscribed to what might be termed strictly scientific research, but should be extended to areas which belonged within health administration proper; it might be useful to launch projects to find simple and practical ways of increasing the attention capacity of public health staff with a view to raising their efficiency and broadening their field of action. In dealing with

[13] Resolution XXXI. *Official Documents PAHO* **58**, 83-84, and **60**, 155, 180.

such aspects of community organization and development, the community should be involved in identifying its own problems and shown how it could actively contribute to their solution.

The Delegation of Venezuela agreed with the Chilean Representative that, generally speaking, national universities should be associated with the work of research, as such collaboration was a good way of pooling resources and expanding work capacity. As he had said at the XIV Meeting of the Directing Council in 1963, there must be an interchange of information, with a view to avoiding duplication of research and to coordinating what was being done, since the Latin American countries did not have much money to spend on research.

Dr. CALVO (Panama) associated himself with the congratulations to the Organization on its work in the field of research. Small Latin American countries, particularly those in the Caribbean area, were so short of resources that it was virtually impossible for them to do basic research in the important subject of public health. He emphasized that research which was urgently needed in the Americas could be carried out only if all resources and efforts were pooled through PASB. As an example of what could be achieved, he cited the Institute of Nutrition of Central America and Panama (INCAP), in which six small countries collaborated through the Pan American Sanitary Bureau and which was performing a tremendous task of nutrition research.

He thought it important to use Latin American communities, with their large population resources, as subjects for research, applying the means and facilities available in the large research institutions of the United States of America. He referred specifically to the Communicable Disease Center in Atlanta, Georgia, some of whose field projects were carried on outside the Americas. He wondered whether the Bureau could not arrange to have such research take place in some Latin American communities. A similar attempt had been made in Panama, where, in collaboration with INCAP, a research project had been carried out on the model of those possibly undertaken in Africa and Chile, people being vaccinated against measles at the same time as against smallpox with a view to finding the best ways, systems, or techniques of introducing these new methods of community protection. If, instead of being performed in other continents, such research were carried out on a large scale in the Americas, the population of those countries would also benefit, since such activities were both stimulating and educational.

Dr. HORWITZ (Director, PASB) felt that the present discussion was perhaps the best confirmation of what had often been said—that the Council's views served as guidance for the Bureau's work. In the specific field of research, those who, like himself, had had the pleasure of following the progress of the Organization for over 10 years, were bound to agree that the firmness of the views expressed today was evidence of tremendous progress on the Continent, and of progress in several respects. The document entitled *Science Policy in Latin America—Substance, Structures, Processes,*[14] which had been circulated to representatives, was a result of the work of a special group of the PAHO Advisory Committee on Medical Research; on the whole, it showed that much more was being done in Latin America than anyone had realized. The Bureau had proposed that scientific research should be institutionalized within each Government administration and in the Continent as a whole. He reiterated his gratitude to the national health services and to the National Institutes of Health of the U.S. Public Health Service for—as Dr. Allen had pointed out—enabling the Bureau, through voluntary contributions over two years, to launch and organize that initiative and for having, in fact, been the principal contributors to projects whose quality met the requirements set by the Organization for the approval of certain studies and research. He had been gratified by that attitude, since that particular field called for original ideas and lofty objectives. All those endeavors made clear the valuable part played by the Bureau, which acted basically as a catalytic agent for scientific work by specialists of the highest caliber, who analyzed certain problems and offered their aid to Governments. He stressed that, since the problems in question were multinational, they could not be solved unless there existed a coordinating body, a role which could well be filled by the Organization. As an example of work of that kind, he cited the Inter-American Investigation of Mortality, the first findings of which were now available and which offered a wealth of material for future analysis of the dynamics of diseases in the Continent. He was convinced that the Governments which were organ-

[14] *Scientific Publication PAHO* **119.**

izing or structuring their health research, as had been shown by the previous speakers, would find in that study interesting information on what might be termed "comparative continental epidemiology."

The problem of human reproduction had been considered at the Council's current meeting; it had been brought out, both in the relevant document and in the course of the debate, that the Bureau, as the Regional Office of the World Health Organization and as the executive organ of the Pan American Health Organization, was more interested in the epidemiological and social approach than in the purely biological and physiological approach, since the World Health Organization was actively concerned with the latter.

The Representative of Peru had mentioned the first efforts which were being made in that connection and which it was hoped to extend to other Governments. He questioned the exactness of the figures on abortion which were current in the Hemisphere and thought that the studies already made in some countries should be made continent-wide, so that every Government should know for certain the magnitude of the problem and its influence on the demographic situation in its country. More profound research was needed on the important subject of the epidemiology of human reproduction in order to dispel the many subsisting doubts. Some Governments had expressed an interest in operational research, i.e., qualitative and quantitative measurement of resources available for specific purposes. That was a field in which the greatest scientific advances of recent years were being gradually incorporated and in which the Bureau would wish to collaborate and participate.

As regards the proposal to create a Regional Medical Library for Latin America, which was based on a suggestion by the National Library of Medicine of the U.S. Public Health Service and was mentioned by the Representative of Uruguay, a group of experts had been consulted and the pros and cons were being analyzed prior to submitting the proposal to the Council. The proposal rested on the fact that a little over half of all the requests for bibliographical information received by the National Library of Medicine (U.S.A.), which had the largest number of publications in the world, came from Latin America. That was an indirect indication of the fact that the Latin American countries had a keen intellectual curiosity in matters of biology and the medical sciences; Dr. Martin M. Cummings had therefore felt that it might be desirable to decentralize his work and to bring it, as it were, closer to the sources of that curiosity. Moreover, demand for bibliographical information increased as new educational and research institutions were established. The proposal was highly commendable, but greater stress should be laid on education than on research; if the establishment were to be organized under the auspices of the Bureau, it must be dynamic and must be able to offer the latest information to all schools of medicine and of other health disciplines on the Continent, without, however, neglecting information required for research. Everything was being done to put the proposal into effect, using extra-budgetary funds emanating from direct contributions by Governments. It was no simple undertaking, and therefore in its early years it ought to be financed by some foundation, an arrangement which would give Governments and the Organization time to acquire the necessary experience and then stabilize it under the general budget. As the Council was aware, that method had been successfully used in the past.

In conclusion, he stated that the Bureau was not in a position at the moment to give an opinion on the site of the proposed Library, and added that it hoped to be able to inform the Executive Committee at its meeting in April 1966, and naturally the Council, of the negotiations which would by then have taken place and the details concerning the item which would have to be settled by the Governing Bodies.

The PRESIDENT declared the discussion on Item 22 closed, pending the presentation of the draft resolution of the United States of America, which would be translated, circulated, and then put to vote.[15]

The session was suspended at 10:30 a.m. and resumed at 11:05 a.m.

Eradication of *Aedes aegypti* in Argentina

The PRESIDENT requested the permission of members to include a new item in the agenda at the request of the Delegation of Argentina, concerning the eradication of *Aedes aegypti* in that country.

Dr. PAREDES (Ecuador) asked whether there was a campaign to be initiated in Argentina or recognition was to be given to a completed campaign.

[15] See thirteenth plenary session, p. 174.

The PRESIDENT replied that recognition was to be given to a completed campaign. In accordance with the Rules of Procedure, he put to the vote the inclusion of the item in the agenda.

Decision: The inclusion of the item on eradication of *A. aegypti* in Argentina was unanimously approved.

Dr. OÑATIVIA (Argentina) thanked the representatives for approving the inclusion of the item, under which the Council could declare that it regarded as terminated the campaign for the eradication of that vector in his country after satisfactory conclusion of the special verification procedure by the Pan American Sanitary Bureau. The delay in presenting the item had been due to unavoidable delays in the submission of the relevant documentation.

Dr. PRIETO (Paraguay) warmly congratulated the Argentine health administration on having succeeded in eradicating *A. aegypti*, a most commendable performance in view of the difficulties encountered.

Dr. QUIRÓS (Peru) associated himself with those congratulations and expressed the hope that other countries would attain that major goal.

Dr. CASTILLO REY (Venezuela) also joined in congratulating Argentina on the eradication of *A. aegypti*. His Delegation particularly appreciated the effort required because his country had experienced various difficulties in its own campaign.

Mr. CASTELLS (Uruguay) also congratulated the Argentine health administration expressed by the Representatives of Paraguay, Peru, and Venezuela.

Dr. FERREIRA (Brazil) also congratulated Argentina on an event which was of importance not only for that country, whose efforts he hoped would be crowned with success, but also for its neighbor, Brazil.

The PRESIDENT announced that the report on the eradication of *A. aegypti* in Argentina would be circulated shortly, as well as the formal resolution whereby the Council would declare that it considered the vector eradicated in Argentina.[16] Until that time, the debate on the subject was closed.

Item 16: Organization of the Pan American Sanitary Conference and Amendments to Articles 7-D, 12-B, and 14 of the Constitution

Dr. QUIRÓS (Peru) remarked that, as the Executive Committee had considered the subject at length, it would be useful if Dr. Williams were to report briefly on its deliberations in order to facilitate the Council's debate.

Dr. WILLIAMS (United States of America) stated that, as he had reported to the Directing Council in a previous session, there had been considerable discussion of this subject at the 52nd Meeting of the Executive Committee.[17] That Committee had suggested three amendments to the PAHO Constitution in order to make it possible for the Organization to hold the meetings of the Pan American Sanitary Conference at Headquarters in Washington. That was necessary because the present provisions of the Constitution made it impossible for the Organization to hold two consecutive meetings of the Conference in the same country. In essence, the amendments proposed by the Executive Committee would make possible for the Conference to meet regularly, if it had to do so, at Headquarters. Those three amendments also made provision to the end that if the Conference were invited to meet in any other country, it could do so; it also required the inviting country to nominate a committee to work with the staff of the Pan American Sanitary Bureau and its Director, in order to make the necessary arrangements for the meeting in that country.

Dr. SUTTER (Assistant Director, PASB) said that Document CD16/22,[18] which had been submitted to the Directing Council for consideration, represented the final stage of a study begun in 1962 at the request of the Executive Committee. It dealt with the internal organization of the Conferences. Governments had made comments in that connection, and the Bureau had described the salient features of its own experience. In Appendices 2 and 3, the suggestions made had been analyzed and copies of communications from the Governments of the Organization were included.

After examining all that material, the Executive Committee at its 52nd Meeting had endorsed[19] the conclusion of the working party it had established, deciding as follows:

[16] See thirteenth plenary session, p. 178.

[17] *Official Document PAHO* **64**, 57-66, 67-81, 85-87, 90-95, and 99-100.

[18] See Annex 11, pp. 409–426.

[19] Resolution VIII. *Official Document PAHO* **62**, 33.

To recommend to the Directing Council that the XVII Pan American Sanitary Conference keep the same general organization as was established for previous Conferences, but that the suggestions of the Governments regarding the work and organization of the main committees should be taken into account. The experience gained at the meeting may well be useful in organizing future Conferences and in assessing their cost.

The Executive Committee had also decided:

To ask the Directing Council to draw the attention of the Conference to the change in the Rules of Procedure proposed by the Government of the United States of America, which the Executive Committee considers would improve the text of the Rules of Procedure of the Conference in substance and in principle.

Consideration of the organization of the Pan American Sanitary Conference had led to the submission of amendments to Article 7-D and 12-B of the Constitution and of a favorable proposal to add a new paragraph to Article 14 of the Constitution. All those proposals had been duly communicated to Governments in accordance with Article 28 of the Constitution and examined by the Executive Committee, which had reached the following conclusions, as recorded in its report:

To inform the Directing Council that it was the unanimous opinion of the Executive Committee, with which the Observer of Peru also agreed, that the functions assigned to the Executive Committee by Article 14 of the Constitution, particularly paragraphs D and E, are so broad that the amendment proposed at the XV Meeting of the Directing Council by the Representative of Peru is unnecessary.

However, the submission of the proposed amendment by the Government of Peru had served a very useful purpose in that it had led to the study and the definition of the functions and responsibilities which the Executive Committee could discharge and fulfill to effectively reduce the work and shorten the duration of the meetings of the Governing Bodies of the Organization when these Governing Bodies deem it advisable.

The Executive Committee unanimously accepted the proposal of the Observer of Peru to the effect that the Executive Committee be officially represented at the meetings of the Directing Council and the Conference by its Chairman or by another member appointed by the Executive Committee. The expenses of transportation and subsistence of this representative of the Executive Committee should be borne by the Organization.

As regards the amendments to Articles 7-D and 12-B relating to the payment of travel expenses of one representative of each Government to the meetings of the Conference and the Directing Council, the Executive Committee had recommended that the Directing Council bear in mind the following two points:

a) That in both cases the expenses of one representative of each Government who is a high-ranking technical official of the ministry of health will be paid; and

b) That such expenses will include only the cost of the round trip, by an authorized route, from the capital city of the Member Government to the place of the meeting.

On the same occasion, the Executive Committee had requested the Director to submit a report on the practice of other organizations of the inter-American system and of the United Nations system in the matter. The Director would make available to the Directing Council all information received to date.

In summary, the Directing Council had to examine three separate questions: (1) the organization of the Pan American Sanitary Conference; (2) the amendments proposed to Articles 7-D and 12-B of the Constitution; and (3) the amendments to the Rules of Procedure of the Conference suggested by the Government of the United States of America.

Dr. YÉPEZ (Ecuador) submitted two draft resolutions for the Council's consideration. The first, which dealt with the organization of the Pan American Sanitary Conference, recommended to the Director that the XVII Conference keep the same general organization as had been established for previous conferences, but that the suggestions of the Governments regarding the work and organization of the main committeees should be taken into account, and also that he should assess the costs of the XVII Conference as resulting from its organization, with a view to the optimum organization of future conferences at minimum cost.

The second draft resolution reiterated the amendments to Articles 7-D and 12-B of the Constitution presented by the Representatives of Ecuador at the XV Meeting of the Directing Council [20] held in Mexico in 1964. Under Article 7-D, as amended, the Bureau would pay the expenses of the chief, or sole, delegate of each Government to the Conference, while under amended Article 12-B the Bureau would pay the expenses of one representative of each Government.

He was handing in both draft resolutions to be circulated and examined by the Council.

The PRESIDENT stated that the Council must first consider the constitutional amendments and vote on

[20] *Official Document PAHO* **60**, 187.

them separately. Before that, however, he asked Dr. Sutter to read Article 28 of the PAHO Constitution which prescribed the manner of voting.

Dr. SUTTER (Assistant Director, PASB) read Article 28, as follows:

> Proposals to amend the Constitution shall be communicated to the Member Governments at least three months in advance of their consideration by the Conference or the Council. Amendments shall come into force for all Member Governments when adopted by the Conference by a two-thirds vote of the representatives of all Member Governments or when adopted by the Council by a two-thirds vote of those representatives.

Mr. CALDERWOOD (United States of America) stated that as the members of the 52nd Meeting of the Executive Committee (April 1965) would recall, the proposal for amending Article 7-D and Article 12-B of the Constitution had aroused great interest and considerable discussion. It had been recognized that—if adopted—that would be a departure from a long-standing practice, not only in the Pan American Health Organization, but in other organizations of the inter-American as well as the United Nations systems. Some questions had been raised as to what was the practice in other organizations. The Executive Committee had therefore requested the Director to provide information in that regard, both in the inter-American system and in the United Nations system, and also with reference to the consequences of such practice, that is, if payment by other organizations of the expenses of Governments' representatives to their meetings resulted in a greater or lesser attendance. He suggested that since documentation had not been provided in advance and his Government had therefore been unable to study the pertinent information, consideration of the proposed amendments be deferred until 1966, at the time of the Conference. That would provide ample opportunity to examine the information on the practice established by the other organizations of the inter-American system, as well as of the United Nations system.

The PRESIDENT invited Dr. Sutter to read the information requested by the Representative of the United States of America.

Dr. SUTTER (Assistant Director, PASB), after explaining that the information in question had not been circulated earlier because the Bureau had not received it until late August and early September, said that it could be summarized as follows:

United Nations Educational, Scientific, and Cultural Organization (UNESCO) (Communication of 13 August 1965)
- General Conference:
  - Governments.
- Executive Board:
  - Travel and subsistence, the organization.

International Monetary Fund (Communication of 13 August 1965)
- Board of Governors:
  - Travel and subsistence ($50), the organization. (Annual). Sec. 14(a) of the Rules of Procedure.
- Board of Executive Directors:
  - The organization pays travel and subsistence for attendance at meetings of the Board of Governors outside Washington.

International Bank for Reconstruction and Development (Communication of 13 August 1965)
- Board of Governors:
  - Travel and subsistence ($50).
  - (Annual and combined with the preceding.) Sec. 14(a) of the Rules of Procedure.
- Board of Executive Directors:
  - The organization pays travel and subsistence for attendance at meetings of the Board of Governors outside Washington.

Universal Postal Union (Communication of 16 August 1965)
- Congress:
  - Government.
- Executive and Liaison Committee:
  - Travel, the organization.
  - General Rules of Procedure, Vienna, 1964. Art. 102, paragraph 9.

International Telecommunications Union (Communication of 17 August 1965)
- Plenipotentiary Conference:
  - Governments.
  - (In 1959: 89 participants, 101 Members and Associate Members.)
- Administrative Council:
  - Travel and subsistence, the organization (25 members, 5 weeks, annually).

World Meteorological Organization (Communication of 23 August 1965)
- Congress:
  - Governments (every 4 years).
- Executive Committee:
  - Travel, the organization (annual).
  - Has special Regulations on payment of travel and subsistence expenses.

International Atomic Energy Agency (Communication of 24 August 1965)
- General Conference:
  - Governments (Article V-B of the Statutes).
- Board of Governors:
  - Governments.

Food and Agriculture Organization of the United Nations (FAO) (Communication of 24 August 1965)
Conference:
Governments (every 2 years).
Council:
Travel and travel subsistence, the organization.

International Civil Aviation Organization (Communication of 25 August 1965)
Assembly:
Governments.
Art. 63 of the International Civil Aviation Convention.
Council:
Governments.
Permanent delegations, 102 assistants, 109 Members. Large proportion of officials.

International Labour Office (ILO) (Communication of 2 September 1965)
Conference:
Governments pay their representatives and the organization pays representatives of employers and workers.
Governing Body:
The organization pays subsistence costs only for representatives of employers and workers. Special Regulations.

The *Organization of American States (OAS)* has forwarded (Communication of 17 September 1965) the following information concerning inter-American bodies:

Inter-American Economic and Social Council (IA-ECOSOC)
Pays neither travel nor other expenses.

Inter-American Committee on the Alliance for Progress (CIAP)
Pays travel and other expenses.
Resolutions of the Council of the OAS, 9 January and 2 March 1964.

Inter-American Council of Jurists
Pays neither travel nor other expenses.
Art. 11, Statute.

Inter-American Cultural Council
Pays neither travel nor other expenses.
Art. 43, Statute.

Inter-American Defense Board
Pays neither travel nor other expenses.

Inter-American Institute of Agricultural Sciences
Board of Directors:
Pays travel (annual).
Art. VII, paragraph 3 of the Constitutional Agreement.
Technical Consultative Council:
Pays travel (annual).

Inter-American Child Institute
Pays neither travel nor other expenses.

Summary

Inter-American Organizations

Total replies	7
Paying travel and other expenses	1
Paying travel	1
Paying neither travel nor other expenses	5

International Organizations

Total replies	10
Paying travel and other expenses for Conference or Congress	2
Part of same	1
Paying travel and other expenses to Council or Executive Committee	5
Part of same	1
Paying travel for Executive Committee	2
Paying neither travel nor other expenses for Conference	7
Paying neither travel nor other expenses for Council or Executive Committee	2

The World Meteorological Organization and the International Labour Office had special regulations governing payment of travel costs and subsistence allowances.

The PRESIDENT stated that Mr. Calderwood had made a proposal to the effect that the vote on the amendments should be deferred until the following year because his Delegation needed some time to study the information presented by Dr. Sutter.

Dr. YÉPEZ (Ecuador) said that the Delegation of his country was not in favor of postponing the vote for a year. Latin American countries might find it extremely difficult to send qualified representatives to such meetings as those of the Directing Council unless their travels were financed. He therefore pressed the proposals formulated by his country's Representative the previous year.

Dr. QUIRÓS (Peru), after remarking that his country's Delegation was in entire agreement with the Representative of Ecuador, stated that, as mentioned on previous occasions, the Bureau was following the same procedure in the matter as the World Health Organization, which paid the travel expenses of representatives to the Assembly. In his view, that was the most important fact brought out in the documentation before the Council, which he felt had sufficient information on the matter.

Mr. CALDERWOOD (United States of America) thanked the President and Dr. Sutter for the information provided. He had made his previous comment because his Delegation had not received

the desired information in advance of the meeting. His comments had not been intended as criticism of the Secretariat. When that information was requested by the Executive Committee, it had been understood that that would require some time to collect, since it involved international organizations of the United Nations as well as of the inter-American system. He added that since the amendment proposed was a departure from what was the general practice, it was a matter his Government wished to consider with great care.

Therefore, he reiterated his request to defer action on the matter until the meeting of the Conference in 1966. Such a deferral would, in his opinion, provide all Governments with an opportunity to consider the proposal in the light of the information on the general practices followed by other organizations and the effect of such practices on attendance at meetings. Although payment of the passage for a delegate of each country would be in line with the precedent established in WHO, it would also mean a departure from the practice in most of the inter-American organizations and in most of the other international organizations. Mr. Calderwood therefore considered that the Governments needed time to study the implications involved.

Mr. RIVERA (Costa Rica) did not agree with the United States Representative. In point of fact, many representatives did not attend meetings of that type, their places being taken by members of the diplomatic or consular corps, despite the high technical level of the subjects discussed and despite the fact that only a small group of professionals in each country were qualified to discuss them.

If, as requested by the Representative of the United States of America, the Council postponed the vote in order to ascertain how many delegates with the requisite technical knowledge actually attended those meetings, there would be a surprisingly small number. In his view, the difficulties were not merely financial, as it was sometimes impossible to obtain the necessary travel funds, so that Governments had to take the line of least resistance and appoint as representative some diplomatic official in the country in which the meeting was held or some person traveling there on private business.

The Council should decide without further delay whether or not it accepted the amendments, since there was sufficient information and experience on which to base a decision, taking into account each country's position.

Mr. CASTELLS (Uruguay) agreed completely with the arguments advanced by the Representatives of Peru, Ecuador, and Costa Rica against postponing the vote on the proposed amendments.

The PRESIDENT put to the vote the proposal of the United States Delegation to postpone the vote on the amendments.

The result of the vote was as follows: One vote in favor, 18 against, and no abstentions.

The PRESIDENT declared the proposal rejected.

Mr. CALDERWOOD (United States of America) suggested that the Observer of the Organization of American States might be asked to comment on the proposal under consideration.

The PRESIDENT called on the Observer of the OAS to report on her Organization's experience in the matter.

Mrs. ELDRIDGE (Observer, OAS) stated that in regard to the participation of Government representatives in meetings of the inter-American organizations, the experience with the Inter-American Child Institute was a clear case. For several years, prior to the incorporation of the budget of this Institute into that of the Pan American Union, the travel of Government delegates to attend the Directing Council meetings had been paid by the Institute. With the incorporation of this specialized agency of the OAS into the budget of the Pan American Union, it had been brought into line with the usual Inter-American policy of requiring Governments to pay the expenses of their own delegates to attend inter-American meetings. She indicated, however, that at the last meeting of the Directing Council of the Inter-American Child Institute, it had again requested consideration of a plan whereby, within its budget, it could cover payment of travel of those members attending the meetings.

Mrs. Eldridge pointed out that, in the case of the last meeting of the Directing Council of the Inter-American Child Institute, there had been some differences of opinion as to whether that policy would raise the attendance of technical representatives of its countries, in contrast with that of diplomatic representatives. In summary, the Directing Council had thought that under the new procedure, that of requiring the Governments to pay travel ex-

penses, attendance had been perhaps higher, or at least equivalent in technical representation, than under the earlier system.

Dr. QUIRÓS (Peru), commenting on Mr. Rivera's analysis of the situation, pointed out that, inasmuch as PAHO paid the travel and subsistence expenses of persons attending the meetings of experts and advisory groups and the seminars arranged by it, there was even more reason to pay the costs incurred through the presence of at least one technical representative from each country, in order to emphasize the technical nature of the Organization itself. He therefore thought that the proposal before the Council was highly commendable.

Dr. CASTILLO REY (Venezuela) stated that he had been instructed by his Government to support the proposal of the Ecuadorian Representative, but that he would prefer the new drafting to state clearly the limitations laid down by the Executive Committee, so that there would be no doubt regarding the highly technical level of representation of the respective ministries of health. In his view, it must be stated that the expenses of the chief delegate would be borne by the Organization in the case of high officials of such ministries, and also that payment would be limited to costs of transportation by an authorized itinerary.

Dr. YÉPEZ (Ecuador) thought that the preamble of the resolution was sufficiently explicit to dispel the doubts and misgivings of the Representative of Venezuela; that text made it clear that travel expenses would be paid for only one high-level representative who was an official of the ministry of health and that only travel expenses would be paid.

Dr. QUIRÓS (Peru) said that he was concerned not with the resolution, but with having the provision clearly stated in the text of the Constitution itself, as that was what mattered. He shared the view of the Venezuelan Representative.

Dr. CASTILLO REY (Venezuela) remarked that his country's Delegation wished the constitutional amendment to have a certain pedagogical value, so that health policy on the Continent should be shaped by the representatives attending the meetings of the Governing Bodies. While the preamble of the Ecuadorian draft resolution certainly contained adequate material, the amendment would be more affirmative if it were included into the Constitution itself. He therefore proposed that the amendment be redrafted to include the comments made by the Executive Committee in submitting the amendment to the Council, i.e., paragraphs 7-A and 7-B.

Mr. RIVERA (Costa Rica) thought that the disagreement related not to substance but to drafting. A drafting committee might therefore be established to prepare an acceptable text as quickly as possible. The words "high-ranking technical official" ought to be replaced by "very high-ranking technical official."

Dr. QUIRÓS (Peru) proposed that the same group which had examined the subject for the Executive Committee should be asked to draft and submit a text which could be put to the vote.

Dr. YÉPEZ (Ecuador) accepted the Venezuelan Representative's amendment to his draft resolution, to the effect that conditions under which the travel expenses of one representative were to be paid should be stated in the text of the Constitution itself. As for the drafting, he thought the Secretariat could prepare a text that could be voted on.

The PRESIDENT stated that once Article 7-D of the Constitution had been voted on, the Council would proceed to examine the draft resolution presented by the Representative of Ecuador, which was an elaboration on the aforesaid article. Once the article was approved, procedural rules would be available that would fulfill the purpose and reflect the ideas that had been expressed. Article 7-D simply established that the Bureau should pay the expenses of the chief, or sole, delegate of each Government to the Conference, as well as the expenses of the Bureau personnel, whereas the Ecuadorian draft resolution specified that the Bureau would pay the expenses of a high-ranking technical delegate.

Dr. HORWITZ (Director, PASB) thought that the question under discussion was one of procedure. The political experience of Latin America showed that Constitutions, generally speaking, should be amended as little as possible, but that, on the other hand, they should be drafted in the broadest and most flexible terms. If they were unduly detailed and, as time went on, circumstances changed, amending them was a long and complicated process. The proposed constitutional provision was entirely clear, in that it stated that the expenses of the chief, or sole, delegate to the Conference or to the Directing Council would be borne by the Bureau. The draft resolution, for its part, laid down what the

Council deemed to be the qualifications which the said chief, or sole, delegate ought to have, without prejudice to the authority of the appointing Government. To include those qualifications in the Constitution would be to restrict unduly a text which should be as broad and flexible as possible in order to remain suitable in the future. He supported the President's idea that the constitutional text should be left in the form in which it had been submitted to Governments, and that its application should be specified in the resolution. He emphasized that the World Health Assembly had settled the matter simply by means of a resolution, the very method now proposed by the President.

Dr. QUIRÓS (Peru) pointed out that Article 11 of the WHO Constitution specified that those Delegates should be chosen from among persons having the highest technical qualifications in the field of health and preferably representing the national health administration of the Member Country. He thought that the addition of a text similar to that suggested by the Delegation of Ecuador would solve the problem.

Dr. HORWITZ (Director, PASB) pointed out that the same idea was to be found in Article 10 of the PAHO Constitution. He had understood that the intention was to include in the Constitution not only the qualifications expected of the chief delegate, but also, and in detail, how his expenses were to be paid, as proposed in the resolution.

Dr. CALVO (Panama) remarked that he had been a member of the working party of the Executive Committee which had drafted the text of that resolution, and that on that occasion, as now, the matter had given rise to a long and complicated debate. The Executive Committee had discussed the question of substance, i.e., that the purpose of the financial effort made by the Bureau in paying the round-trip expenses of one delegate was to ensure the attendance of a high-ranking technical official, on the assumption that the chief of delegation might easily be a minister—who might satisfy that requirement —but who could readily arrange to have his travel expenses paid by the Government. The intention was to ensure that delegations always had highly qualified technicians. In Latin American countries, the ministers often did not have sufficient experience in public health, and therefore wished their public health directors or other highly qualified technicians to attend the meetings of the Directing Council, if only in an advisory capacity.

It should be simple to amend the proposal so that the operative part would state explicitly that the proposed amendment applied to Article 7 of the Constitution, that being apparently the object of the Ecuadorian draft resolution.

Dr. CASTILLO REY (Venezuela) observed that if it was stipulated in Article 7-D of the Constitution that the Organization paid the expenses of a high-ranking technical official of the ministries of health, the Governments' freedom of decision in the matter would in no way be infringed. If the minister wished to attend the meetings and could arrange to have his travel expenses paid, he would be able to have himself accompanied by a competent representative; but it should be made clear that the companion must be a "high-ranking technical representative," since apparently that was what the members of the Council had in mind.

The PRESIDENT asked whether, in view of the explanations given, the Representative of Venezuela would withdraw his counter-proposal.

Dr. CASTILLO REY (Venezuela) said that he would be glad to withdraw his counter-proposal if the purpose of the proposed amendment was clearly indicated.

The PRESIDENT, before declaring the debate closed, asked the Representative of Ecuador to explain his position, as there was an impression that his draft resolution was an elaboration of Article 7-D.

Dr. YÉPEZ (Ecuador) reiterated that the draft resolution was in full conformity with the proposal presented by his Delegation the year before.

The PRESIDENT suggested that, in view of the close connection between the draft resolution presented by the Representative of Ecuador and the amendment to Article 7-D, and in view of the importance of the subject, the debate should be postponed to the twelfth plenary session, so as to enable the Secretariat to prepare a generally acceptable proposal concording the two texts.

It was so agreed.

The session rose at 12:30 p.m.

TWELFTH PLENARY SESSION

Tuesday, 5 October 1965, at 3:20 p.m.

President: Dr. RODERICK ESQUIVEL, Panama

Item 16: Organization of the Pan American Sanitary Conference and Amendments to Articles 7-D, 12-B, and 14 of the Constitution (*continuation*)

The PRESIDENT declared the session open and suggested that the following order be followed for the discussion of item 16: (1) the draft resolution submitted by the Representative of Ecuador on the organization of the Conference; (2) the amendment to Article 7-D of the Constitution; (3) the amendment to Article 12-B of the Constitution; and (4) an appropriate decision should be taken on the Executive Committee's proposal that the amendment relating to Article 14 of the Constitution should be considered withdrawn.

As far as the first point was concerned, the draft resolution would be distributed to the representatives and examined at the thirteenth plenary session.[1] With regard to the second point—the amendment to Article 7-D of the Constitution—the relevant draft resolution would be submitted to the plenary Council forthwith. It concerned the text presented by the Representative of Ecuador at the last session of the Directing Council, reading as follows:

Article 7-D: The Bureau shall pay the expenses of the chief, or sole, delegate to the Conference, as well as the expenses of the Bureau personnel.

He pointed out that that text, which appeared in Document CD16/22,[2] had been transmitted to the Governments three months in advance, according to regulatory provisions. The Executive Committee had made some recommendations to the Directing Council concerning that article. That Committee was now submitting it to the Directing Council and, although it was not recommending that the amendment should be accepted or rejected, it suggested, in the event of its acceptance, "(a) That in both cases the expenses of one representative of each Government who is a high-ranking technical official of the ministry of health will be paid"; and "(b) That such expenses will include only the cost of the round trip, by an authorized route, from the capital city of the Member Government to the place of the meeting."

The relevant amendment should therefore be submitted to the Council for its consideration. If approved as it stood, or amended in a way that still favored payment, the Director could be instructed by appropriate resolutions to take into account, when implementing it, the two points made by the Executive Committee or any others that might be deemed advisable.

As regards the amendment to Article 12-B of the Constitution, the observations made earlier remained fully valid. The text to be submitted to the Council was as follows:

The Bureau shall pay the expenses of one representative of each Government, as well as the expenses of the Bureau personnel.

Lastly, he said that the Executive Committee's proposal concerning Article 14 of the Constitution would be submitted to the Council in plenary session.

Dr. PRIETO (Paraguay) remarked that, in the text proposed for Articles 7-D and 12-B by the Delegation of Ecuador at the previous meeting, it had not been made clear whether the personnel mentioned was that of the Representative or of the Bureau. That point should be clarified.

Dr. YÉPEZ (Ecuador) explained that the proposed amendment referred to the personnel of the Bureau.

Mr. PHILIPPEAUX (Haiti) supported the President's suggestion that the amended text of Article 7-D should be adopted as it stood and that the Director of the Bureau should be authorized to make the appropriate recommendations to the Governments.

The PRESIDENT, replying to the remark of the Representative of Paraguay, pointed out that Article 12-B of the Constitution specified, with regard to meetings, that each Government would pay the expenses of its representatives and the Bureau the costs of its personnel, so that there was no reason for confusion.

[1] See p. 175.

[2] See Annex 11, p. 409.

Mr. CASTELLS (Uruguay) proposed the following wording: "The Bureau shall pay the expenses of the chief delegate or sole delegate to the Conference, as well as the expenses to the Bureau personnel."

Dr. CALVO (Panama) said that, since the amendment referred to the "chief delegate" or "sole delegate" indiscriminately and its meaning was therefore unclear, it might be construed to mean that, when a country sent more than one delegate, the Bureau would pay nothing. That interpretation had not been the sponsors' intention.

The PRESIDENT pointed out that for all official intents and purposes the Pan American Sanitary Bureau recognized only one delegate. A country could send a very large delegation composed of several advisers, but only the chief delegate was the official representative, so that, for the purposes of the amendment, the terms "chief delegate" and "sole delegate" were equivalent.

Dr. CALVO (Panama) said that the proposed wording did not convey the spirit of the Executive Committee's two recommendations to the effect that the Bureau should defray the expenses of a delegate who was a high-ranking technician, the implication being that the Minister could rest assured that his travel expenses would be covered in the normal course of events. The only purpose had been to ensure that a delegate with high technical qualifications participated in those meetings.

Mr. PHILIPPEAUX (Haiti) stated that he appreciated the significance of the Panamanian Representative's observation but thought that, in the light of the recommendation just made by the President, if the text of the amendment was adopted as it stood and the Director of the Bureau was authorized to clarify the meaning of the amendment for the information of Governments, all the difficulties would be solved. He added that it should not be forgotten that each Government was interested in ensuring that its representatives enjoyed the maximum technical prestige, but sometimes the Minister was not a technician in public health but in some other field connected with health, which was why the Governments should be interested in including technicians in their delegations. However, only the travel expenses of one member or the head of each delegation, whether or not he was a technician, should be paid by the Organization and each Government was free to inform the Bureau of the person designated. In that connection the text of the amendment should be brief and precise.

Mr. BURKE (Jamaica) felt that the purpose of the proposed amendment to Article 7-D became clear if one looked at Article 5-B, which stated that: "Each Government shall be represented by not more than three delegates, one of whom shall be designated by the respective Government as chief delegate. Delegates may be accompanied by one or more alternates and advisers. Delegates selected by the respective Governments should include specialists in public health, preferably officials of national public health services."

The intention of the amendment was that the Bureau should pay the expenses of one delegate only, and that if a delegation consisted of three people, the Bureau would pay the expenses of one of them. The expenses of a sole delegate would likewise be met. That, however, need not prevent a country from sending a number of advisers also.

The PRESIDENT suggested the following new wording for the proposed text:

Article 7-D: The Bureau shall pay the expenses of one delegate to the Conference, as well as those of the Bureau personnel.

Dr. SALDAÑA (El Salvador) proposed that the text should be shortened to read: "The Bureau shall pay the expenses of one representative of each Government."

The PRESIDENT thought that, in order to conform to the language of the Constitution, it would be necessary to say: "The Bureau shall pay the expenses of one delegate to the Conference."

Dr. ALONSO MENÉNDEZ (Cuba) felt that the text should specifically mention who was to pay for the personnel of the Bureau.

The PRESIDENT put to the vote the amendment to Article 7-D of the Constitution, worded as follows:

The Bureau shall pay the expenses of one delegate of each Government to the Conference, as well as the expenses of the Bureau personnel.

The result of the voting was as follows: 14 votes in favor, 1 against, and 3 abstentions.

The PRESIDENT declared the amendment rejected since it had not obtained the two-thirds vote of the representatives of all Member Governments. He then announced that the amendment proposed to Article 12-B was similar but referred to delegates to meetings of the Directing Council and not to delegates to the Conference.

Dr. BONICHE VÁSQUEZ (Nicaragua) said that there might be some misunderstanding with regard to the previous vote so that, if maintained, it might not reflect the Council's intentions. He therefore proposed that there should be a second vote. The amendment proposed to Article 7-D was a welcome improvement, because countries usually found it difficult to send a delegation of more than one representative. It was advisable for the Minister to attend, since he participated in his Government's decisions, but it was also necessary for one or two technicians to participate, and it would be an advantage if the travel expenses of one of those representatives were to be defrayed by the Bureau.

Dr. SALDAÑA (El Salvador) agreed with the view expressed by the Representative of Nicaragua.

Dr. HORWITZ (Director, PASB) thought that the reason why the result of the vote had attracted attention might be a fact that had been overlooked, namely that, under Article 28 of PAHO's Constitution, constitutional amendments must be adopted by the Conference or the Council by a two-thirds majority of the representatives of all the Member Governments. Moreover, in order to reopen the debate, it would be necessary to apply Rule 35 of the Rules of Procedure of the Directing Council, which stated that "When a proposal has been adopted or rejected, it may not be reconsidered at the same meeting unless the Council, by a vote of two thirds of the Governments present and voting, so decides. Permission to speak on a motion to reconsider shall be accorded only to two speakers opposing the matter, after which it shall be immediately put to the vote."

Dr. VALDIVIESO (Chile) said that he was afraid that the Council might be setting an unfortunate precedent if it reopened the debate merely because a decision might be misinterpreted. He felt that it had not been clearly explained where the mistake lay and he opposed a second vote.

The PRESIDENT put to the vote the proposal to reopen the debate on the amendment to Article 7-D.

The proposal was rejected by 13 votes against, 2 in favor, and 3 abstentions.

The PRESIDENT submitted for the Council's consideration the following text of the proposed amendment to Article 12-B, referring to representatives to meetings of the Directing Council: "The Bureau shall pay the expenses of one Representative of each Government, as well as the expenses of the Bureau personnel."

The result of the voting was as follows: 14 in favor, 1 against, and 3 abstentions.

The PRESIDENT declared the amendment rejected. He then recalled that the Executive Committee, at its 52nd Meeting,[3] had expressed the opinion that the functions assigned to the Committee by Article 14 of the Constitution, particularly paragraphs D and E, were so broad that the constitutional amendment to that article proposed [4] at the XV Meeting of the Council was unnecessary. Hence it was in order to consider that draft amendment withdrawn.

It was so agreed.

Dr. CALVO (Panama) then submitted the following draft resolution:

THE DIRECTING COUNCIL,

Having considered Resolution VIII of the 52nd Meeting of the Executive Committee concerning the organization of the Pan American Sanitary Conference;

Having considered the report of the working party of the Executive Committee in the Addendum to *Official Document 62,* which recommends "that the Executive Committee be officially represented at the meetings of the Directing Council and the Conference by its Chairman or by any other member appointed by the Committee"; and

Bearing in mind the desirability of the Executive Committee being officially represented at those meetings,

RESOLVES:

1. To provide that the Executive Committee shall be officially represented by its Chairman, or any other member designated by the Committee, at the meetings of the Directing Council of the Pan American Health Organization and of the Pan American Sanitary Conference.

2. To provide that the travel and subsistence expenses of the Official Representative of the Executive Committee at the meeting shall be borne by the Organization.

The PRESIDENT announced that the draft resolution proposed by the Representative of Panama and the draft resolution on the organization of the Pan American Sanitary Conference would be distributed so that the Council could vote thereon at the session of the following day.[5]

Item 17: Place of the XVII Pan American Sanitary Conference, XVIII Meeting of the Regional Committee of WHO for the Americas and Amendments to Articles 7-A, B, and C of the Constitution and Rule 1 of the Rules of Procedure of the Directing Council

[3] *Official Document PAHO* **62,** 43.
[4] *Official Document PAHO* **60,** 185.
[5] See thirteenth plenary session, p. 176.

Dr. SUTTER (Assistant Director, PASB) introduced CD16/23,[6] supplemented by the report of the working party, established at the 52nd Meeting of the Executive Committee,[7] on the organization of the Pan American Sanitary Conference. Paragraphs 3 and 4 of the report reproduced the proposals unanimously adopted by the Executive Committee.

He added that the two reports prepared by the Director had also to be taken into account. The first (Document CD15/26, Addendum),[8] paragraph VI of which referred to the meeting place of the Pan American Sanitary Conference, had been transmitted to the XV Meeting of the Directing Council, and the second (Document CE52/13),[9] submitted to the 52nd Meeting of the Executive Committee dealt, under a separate heading, with the place of the XVII Pan American Sanitary Conference.

The three reports mentioned were contained in appendixes 1 and 2 of Document CD16/22.[10]

As the Chairman of the Executive Committee stated in his Annual Report (Document CD16/28)[11] already submitted to the Council: "The Committee decided to recommend to the Directing Council that the next Pan American Sanitary Conference should be held at the Headquarters of the Bureau, in Washington, D.C., and that Articles 7-A, B, and C of the Constitution be modified accordingly. It also proposed that the Council modify Rule 1 of its own Rules of Procedure to the effect that its meetings should be held at the Headquarters of the Organization or at a place chosen by the Conference or the Council, and not alternately as was currently stipulated."

Dr. FERREIRA (Brazil) announced that he would submit the following two draft resolutions on the subject under discussion and asked the Representatives to bear in mind that, notwithstanding the technical details that had to be included therein, the purpose was simply to enable the next Pan American Sanitary Conference to be held in Washington, D.C., in the new Headquarters which had recently been inaugurated:

THE DIRECTING COUNCIL,

Bearing in mind the report approved by the Executive Committee at its 52nd Meeting (Resolution VIII) and the proposed amendments to the Constitution relating to the place of the Pan American Sanitary Conference formulated therein; and

Bearing in mind Article 28 of the Constitution of the Pan American Health Organization,

RESOLVES:

To approve the following constitutional changes:

"Article 7-A. The Conference shall meet every four years at the Headquarters of the Organization on a date fixed by the Director of the Bureau in consultation with the Executive Committee.

Article 7-B. Notwithstanding the provision of the immediately foregoing paragraph, the Conference may meet in any Member Country of the Organization provided that the Government concerned invites it, and the Conference itself or the Directing Council at its meeting held one year before that appointed for the Conference accepts the invitation.

Article 7-C. Whenever the provisions of the immediately foregoing paragraph apply, the Government of the country in which the Conference is to be held shall appoint a Committee to cooperate with the Bureau in organizing the Conference."

The present paragraphs C to G of Article 7 will become paragraphs D to H of the amended text of the new Article.

THE DIRECTING COUNCIL,

Bearing in mind the report approved by the Executive Committee at its 52nd Meeting (Resolution VIII) and the proposed amendment to the Rules of Procedure of the Directing Council formulated therein; and

Bearing in mind Article 58 of the Rules of Procedure of the Directing Council,

RESOLVES:

To amend Rule 1 of the Rules of Procedure of the Directing Council to read as follows:

"Rule 1. The Director of the Bureau shall convene the Council to meet in conformity with Article 12, paragraph A, of the Constitution and pursuant to a resolution of the Executive Committee. The meeting shall be held at the Headquarters of the Organization or at a place chosen by the Conference or the Council. Whenever the meeting is not held at the Headquarters of the Organization, the Director shall fix the date of the meeting in consultation with the Host Government."

Mr. CASTELLS (Uruguay) said that, at the XVI Pan American Sanitary Conference, Uruguay had offered to serve as the site of the XVII Conference but that, in view of the recent inauguration of the Headquarters of the Organization, his Delegation would not press its invitation and would vote in

[6] Mimeographed document.
[7] *Official Document PAHO* **62**, 41-43.
[8] See Annex 11, Appendix 2, p. 414.
[9] *Ibid.*, Appendix 1, p. 412.
[10] See Annex 11, pp. 412–415.
[11] See Annex 1, p. 214.

favor of holding the next Conference in Washington, in PAHO's new building, if that was the wish of the majority.

Dr. ALONSO MENÉNDEZ (Cuba) stated that his Delegation, like the others, had already expressed its great pleasure at the fact that the regional body had such magnificent Headquarters at its disposal. In addition to the material advantages involved, the building would also serve to strengthen further the principles underlying the Organization which were based on forging even closer links of interrelationship, intercommunication, and solidarity between countries so as to solve the health problems of the peoples of the Americas. He nevertheless felt that to amend the Organization's Constitution just because there was a Headquarters which met the desired conditions might prove detrimental to the aforesaid principles. His Delegation was therefore opposed to amending the Constitution and would vote against the change.

Dr. FERREIRA (Brazil) remarked that the proposed amendment was not designed to ensure that the Conference was always held in the headquarters building but merely to lift the constitutional ban on convening two consecutive meetings in it.

The PRESIDENT announced that the draft resolutions submitted by the Representative of Brazil would be circulated and that they would be put to the vote at the next plenary session.[12]

Item 12: Planning of Hospitals and Health Facilities

Dr. FLISFISCH (Special Adviser, PASB) introduced Document CD16/24[13] and stated that the Pan American Health Organization had been promoting the orderly incorporation of medical care in local or national health programs under a regional system capable of offering adequate coverage to the people concerned.

He pointed out that the Meeting of the Task Force on Health, held in April 1963, and recommended[14] that the extension of health facilities, especially medical care services, should be planned and that consideration should be given not only to the costs of investing in buildings and equipment but also to staff requirements, in terms of both quantity and quality, and operational costs, and that full use should be made of existing resources.

The Inter-American Economic and Social Council had recommended, at its Second Annual Meeting at the Ministerial Level, that the Governments should plan medical care in graded systems of services which would enable better advantage to be taken of existing hospital facilities through the extension of outpatient service and the use of other technical and administrative methods.

In that connection, the Pan American Sanitary Bureau had considered and maintained that the construction and staffing of hospitals was primarily a technical problem with major financial implications. Owing to the volume of the investments being made by the Latin American countries, international collaboration could play a more active role, using regional machinery which should be studied in detail.

The XV Meeting of the Directing Council had requested[15] that the Director of the PASB, through an Advisory Committee, should study the planning aspects of hospitals and health facilities within the national health planning process, and that he should report to the Governing Bodies on how the Bureau could best participate in the planning for the construction, staffing, and operation of integrated hospitals and related health facilities designed to serve the community in the various countries.

An analysis of the resolution revealed that consideration must be given to its following implications:[16]

(a) Orderly incorporation of medical care into the national and local plans for social and economic development; improvement of health services, hospitals, and outpatient clinics as a result of the technical integration of prevention and curative activities.

(b) Construction of new health facilities and remodeling of existing ones so as to increase population coverage on a continental, national, and local level; improving their organization and administration through adequate coordination of the institutions involved, so that better use can be made of available resources.

(c) Planning of health services with a better understanding of the present and the future, de-

[12] See thirteenth plenary session, p. 176.
[13] See *Scientific Publication PAHO* **129.**
[14] *Official Document PAHO* **51,** 37.
[15] Resolution XXV. *Official Document PAHO* **58,** 78-79.
[16] *Scientific Publication PAHO* **129,** 71.

termining the initial investment required for buildings and installations, operating budgets, and personnel needs.

(d) A meeeting of an advisory committee for a comprehensive study of the problem, with a view to finding how best to strengthen the technical assistance the Pan American Sanitary Bureau can give in this field and how to put it on a permanent basis.

In order to derive the maximum benefit from the Advisory Committee's work, a Special Adviser had been appointed to prepare a working document[17] containing supplementary information which had been collected during the visit to eight countries of Latin America and made in accordance with the guidelines given by Headquarters and its competent branches and units.

In April 1965, at the 52nd Meeting of the Executive Committee, note had been taken[18] of the progress achieved in implementing Resolution XXV, and the efforts made to prepare such a sound and comprehensive plan of operations had been noted, emphasis being placed on the need for the study to be undertaken by the Advisory Committee to cover all the subsectors providing medical care services. At the same time, the Executive Committee had stressed, in the above-cited resolution, the importance of social security services in medical care, for which purpose it had suggested that the Governments should include representatives of those services in their delegations.

The Advisory Committee had met from 26-30 July 1965 and had carefully analyzed the background related to Resolution XXV. Representatives of the Inter-American Development Bank had played an active part in its work. The Advisory Committee had taken the view that the working document dealt adequately with the main aspects of the problem under discussion, despite the incompleteness of the existing information, and it had become apparent that, while several countries were registering major improvements in their health levels, the situation as a whole was eminently unsatisfactory owing to the existence of high indices of morbidity, of mortality, and of others which were incompatible with the minimum levels desired by present-day society. It had also recognized that the situation was the result of various historical, cultural, and economic factors of the policy of national Governments, and of attitudes and habits of diverse population groups, either organized or unorganized, of a country or region, for which reason it was becoming necessary to make intense and sustained efforts to overcome that whole spectrum of factors.

As a conceptual delimitation and without diverging from the substance of Resolution XXV, the Advisory Committee had expressed its conviction that curative and preventive activities should be unified, emphasizing that everything that was done in that connection should aim at doing away with the traditional separation of the activities still persisting in Latin America, although a marked trend towards unity was observed in most countries.

The Committee had also pointed out that the lack of cooperation and understanding between the different subsectors of the health sector was leading to the latter's disintegration and to the defective planning of field activities, so that it was vital to coordinate the various health systems and services to the fullest extent, including autonomous and semiofficial services.

It had also thought that, in the various countries, the available personnel was in short supply and poorly distributed. It had therefore urged that existing personnel requirements should be studied as well as the training problems involved, the optimum proportion that should exist between the various groups and ways and means of deriving greater benefit from the staff available.

Given the shortage and distribution of material resources, the Committee agreed on the urgent need to have periodic surveys conducted by national and international specialized personnel in accordance with previously established standards. The surveys would cover both quantity and quality. It had also stressed the importance to the development of programs of the countries' economic ability to bear the costs of their execution.

In order to make good use of existing resources, it had recommended that the methods and modern techniques of management should be applied to health facilities, because it was highly important to organize and administer them on the basis of specific indices to show the yield and efficiency of the programs. It had drawn attention to hospital care, outpatient clinics, and home care as basic factors in the more rational utilization of these resources.

The Committee had emphasized with regard to the construction of hospital facilities, that all con-

[17] *Scientific Publication PAHO* **129**, 68-123.

[18] Resolution XVI. *Official Document PAHO* **62**, 38-39.

struction should form part of a national building plan designed to provide or improve the quality and quantity of medical care for the community; that attention should be given to the significance of commercial external advisory services and to the contractual obligations they implied; that it was imperative to attain standardization to reduce the costs of purchasing equipment and supplies and, where possible, building costs, so that the best use could be made of resources in that connection.

In the light of the various considerations outlined above, the Committee had adopted several conclusions and recommendations for expanding and strengthening the technical advisory services with which the Organization was providing Governments. The purpose of those recommendations was to strengthen the Bureau's role as regards providing study and advisory facilities to countries and international organizations; the planning and organization of national health services based on regional systems, in which provision was made for putting to better use resources by determining costs and priorities for expenditure and investment; improving the administration of hospitals and other health services; studying needs in terms of human resources with the participation of medical schools, universities, and other educational centers; the costs and financing of the various systems including autonomous and semiofficial systems; and use of the international resources not only to service direct purposes but also to help promote the expansion of national resources for the same objectives.

Lastly, the Committee had recommended that, for the attainment of those objectives, the Organization should establish adequate structures and also utilize the resources currently available for functions related to those activities.

Dr. OÑATIVIA (Argentina) agreed with the views expressed in the document and stated that his country was pursuing a policy aimed at converting the hospitals from purely curative establishment into centers which also provided medical preventive and social services. He also thought that it was necessary to give the communities an active and continuing part to play in hospital management.

He stressed that in Argentina the shortage was not of general but of specialized hospitals, particularly those catering to the mentally ill. Actually there was a lack not of resources but of coordination between all the material and human resources employed in that specific field of medical care. In his opinion, the multiplicity of efforts and the overlapping of the jurisdictions, at the national, provincial, or community level, of private and semiofficial entities engaged in similar health activities was obvious and jeopardized the resources used and the efficiency of medical care.

His Government hoped that the Bureau would forge ahead in the field of medical care by providing technical advisory services and duly channeling international assistance with a view of solving that problem, one of whose most serious aspects was the training and instruction of personnel in accordance with the modern concept of hospital organization.

He announced that he would submit a draft resolution on the subject, based on the points he had outlined, for the Council's consideration.[19]

Dr. VALDIVIESO (Chile) said that the utilization of the funds earmarked for hospitals was, at least in his country, unsatisfactory. There was a shortage of medical personnel and sometimes an even greater shortage of auxiliary personnel, so that doctors were forced to perform subsidiary duties which could be delegated to nurses or some other kind of auxiliary whose training was less costly for the State. In other cases, inadequate use was made of human resources, which jeopardized efficiency.

He agreed with the opinion expressed by the Representative of Argentina that the community must be more closely associated with hospital management, because the hospitals were intended to serve the population and yet the latter had no part in their organization and operation. He therefore suggested that the populations should be represented in the advisory councils of hospital directors.

He was gratified to note that the Bureau was concerned with that kind of problem, because it was highly important for the Organization to provide technical advisory services on the different aspects of hospital services in order to improve them. He added that a hospital construction program should form part of any health plan and the latter should, in turn, be integrated in an economic development plan. He underlined the importance of properly planning the organization of hospitals right from the time of their construction and stated that a hospital's action program should be based on the conditions in which the population lived—

[19] See thirteenth plenary session, p. 177.

its density, the prevalence of certain diseases, the economic situation, among others. He therefore reiterated his opinion that it was essential to provide the countries with an increasing amount of advisory services for the proper planning and management of their hospitals. Chile was currently formulating such a long-term program for which adequate advisory services would be required.

Mr. BURKE (Jamaica) congratulated those responsible for the preparation of what was, in his opinion, an excellent report. His Delegation wished to support its conclusions and recommendations, especially Nos. 2, 3, and 4.[20] If a special department were established, he hoped it would promote the incorporation of similar concepts in the curricula of medical schools, foster research, and study the cost of financing the various systems, including those envisaging the participation of social insurance institutions.

From Recommendation 5-e, it appeared that "technical integration of preventive and curative activities and administrative coordination of the various health institutions" would be a prerequisite to making a recommendation to an international organization. While administrative coordination of the different health institutions might not be difficult to achieve, he felt that technical integration of the preventive and curative activities would be extremely difficult, indeed the kind of thing for which one might seek help from the international organizations. Perhaps this point could be clarified.

Dr. CASTILLO REY (Venezuela) pointed out that programs designed to restore health were becoming steadily costlier for every public health administration. Owing to the need for increasingly more highly-skilled teams and increasingly better-trained and diversified medical and technical personnel and to the pressure of work which was the result of legitimate ambition, those costs accounted for a larger part of the over-all investment of countries in the execution of their public health plans as a whole. The results might be contrary to those desired if that had an unfavorable impact on other programs that might show quicker results in terms of reducing mortality, increasing life expectancy, and other factors of that kind.

It might be thought that one of the possible solutions to the problem would be to move the center of gravity of the hospital organizations from hospitalization proper to outpatient clinics and ambulatory services. Another solution might be for a good graded structure, within the general network of services, to lay down definite levels depending on the complexity of the organization and operation of such services, so that all possible cases were dealt with externally and only those cases whose treatment was more complex and who really had to be attended to at that level reached the hospitals. He concluded by saying that collection of funds for services rendered might have to be expanded within the State health services. Although all the income of the State services went into the public treasury, some recommendation should be made to the effect that what the medical services received under that heading should be returned to them in one way or another.

The session was suspended at 5:25 p.m. and resumed at 5:55 p.m.

Item 11-A: Report on the Status of Malaria Eradication in the Americas (*continuation*)
11-B: Financing of the Malaria Eradication Program in the Americas (*continuation*)
11-C: Estimated Requirements for Malaria Eradication in the Americas (*continuation*)

Report of the Working Party

The PRESIDENT announced that the working party established to prepare draft resolutions on Items 11-A, 11-B, and 11-C on malaria had prepared a report and the resolutions, which would be voted on by the Council at its next session.[21] He called upon the Rapporteur of the working party, Dr. Blaksley (Argentina) to read the document in question.

Dr. BLAKSLEY (Argentina) read the following document:

The working party appointed by the Directing Council at its eighth plenary session, composed of Dr. Julio C. Blaksley (Argentina), Dr. Achiles Scorzelli, Jr. (Brazil), Dr. Miguel E. Yépez Aschieri (Ecuador), Dr. Alberto Aguilar Rivas (El Salvador), Dr. Manuel B. Márquez Escobedo (Mexico), Mr. Leonard M. Board (United States of America), and Dr. Francisco Castillo Rey and Dr. José Luis Aponte-Villegas (Venezuela), met in Room "C" on 5 October 1965 at 2 p.m.

Dr. Miguel E. Yépez Aschieri (Ecuador) was elected Chairman, and Dr. Julio C. Blaksley (Argentina) Rapporteur.

[20] *Ibid.*, p. 130.

[21] See thirteenth plenary session, p. 171.

After studying the relevant documents and the comments made during the discussion, the working party agreed to submit the following draft resolutions to the Council for consideration:

THE DIRECTING COUNCIL,

Having examined the XIII Report of the Director of the Pan American Sanitary Bureau on the status of malaria eradication in the Americas (Document CD16/13);

Bearing in mind the progress made, especially in plans for the adequate financing of various campaigns after 1965;

Bearing in mind the plans of the international organizations and of the Government of the United States of America to continue their collaboration to enable the national malaria eradication campaigns to proceed without stoppages until the final objective is attained;

Considering the importance for the Hemisphere of the coordination of antimalaria activities which are being carried out by the Governments of Central America and Panama, in recognition of the regional epidemiological nature of the problem;

Bearing in mind the conclusions of the Seminars on "The Role of the General Health Services in the Eradication of Malaria"; and

Considering the Report of the First Meeting of the PAHO Advisory Committee on Malaria Eradication,

RESOLVES:

1. To take note of the XIII Report on the status of malaria eradication in the Americas (Document CD16/13).

2. To express satisfaction with the continued interest of the Governments in eradicating malaria from their territories by means of the more adequate financing of their campaigns.

3. To reiterate the need for increased international assistance, both technical and financial, as well as bilateral aid, in solving the biological problems that have arisen.

4. To congratulate the Governments of Central America and Panama on the results of the Meeting of Ministers of Health of Central America and Panama.

5. To take note of the observations and conclusions formulated at the Seminars on "The Role of the General Health Services in the Eradication of Malaria" and to recommend that they be put into practice as soon as possible.

6. To take note of the Report of the First Meeting of the PAHO Advisory Committee on Malaria Eradication, and to urge that the research recommended in that document be intensified.

7. To express thanks for the assistance rendered to the Governments by the Pan American Health Organization, the World Health Organization, the United Nations Children's Fund (UNICEF), and the Government of the United States of America, through its Agency for International Development, in the 1964 campaigns.

THE DIRECTING COUNCIL,

Having considered the report on the future financing of the malaria eradication program in the Americas (Document CD16/7), as well as Resolution III of the 52nd Meeting of the Executive Committee;

Bearing in mind the great importance of both the PAHO Special Fund and the WHO Special Account, as well as the regular budgets of the two Organizations, in financing the malaria eradication program; and

Bearing in mind that continuing support in the form of voluntary contributions is of the utmost importance in maintaining the advisory services which the countries at present need in order to protect the financial investments they have already made and ensure the satisfactory prosecution of the above-mentioned program,

RESOLVES:

1. To take note of Resolution III of the 52nd Meeting of the Executive Committee and of the report of the Director on the future financing of the malaria eradication program in the Americas (Document CD16/7).

2. To stress the importance of voluntary contributions to the PAHO Special Malaria Fund and WHO Malaria Eradication Special Account, as well as of strengthening the regular budgets of both Organizations in continuing the malaria eradication program in the Americas.

3. To urge the Governments to continue their contributions at the level necessary to achieve the objectives of the program.

THE DIRECTING COUNCIL,

Having considered Document CD16/14 on the estimated requirements for the PAHO Special Malaria Fund;

Bearing in mind the increasing efforts of Governments to eradicate malaria from their territories, and the fact that some Governments have decided to negotiate foreign loans for this purpose;

Noting that the PAHO Advisory Committee on Malaria Eradication considered the estimates of the requirements to be minimal, in the light of available information; and

Considering the need of the Pan American Sanitary Bureau to have more specialists available for providing the campaigns with appropriate assistance and for intensifying research on current problems,

RESOLVES:

1. To take note of the estimated requirements for the PAHO Special Malaria Fund.

2. To express to the Governments its deep satisfaction with the financial efforts they are making to provide the campaigns with the funds necessary to continue the campaigns.

3. To commend the Government of the United States of America for the facilities offered through the program of the Alliance for Progress in the granting of loans, under very favorable conditions, for the Governments requesting them in order to continue their campaigns.

4. To recommend to the Governments that they bear in mind the Declaration of the Ministers of Health of Central America and Panama, approved at the Meeting held in Washington, D. C., on 28 and 29 April 1965, insofar as it applies to all the malaria eradication campaigns.

5. To recommend that the Governments cooperate with the Pan American Sanitary Bureau in providing the specialists required by the Bureau in order to intensify its technical assistance to the malaria eradication program in the Hemisphere.

6. To recommend to the Bureau that it continue its negotiations with international credit institutions with a view to having them include in their policy the financing of malaria eradication programs through long-term low-interest loans.

The PRESIDENT announced that the report submitted would be distributed so that it could be put to the vote at the next session.[22] He then announced that the working party established to study the draft resolution relating to Item 26 (Study of the Relationship between Social Security Medical Programs and Those of Ministries of Health or Other Official Health Agencies) had also completed a report but that, since the Rapporteur was absent, the report would be submitted to the Council for its consideration at the next session, as would the report of the working party set up to study the draft resolution on smallpox eradication (Item 27).

Item 12: Planning of Hospitals and Health Facilities (*continuation*)

The PRESIDENT asked Dr. Flisfisch to answer the Representative of Jamaica with reference to some details in the document relating to Item 12, so that the clarification would be placed on record.

Dr. FLISFISCH (Special Adviser, PASB), said that the misgiving expressed by the Representative of Jamaica referred to paragraph 5-e of the Advisory Committee's conclusions.[23] Paragraph 5 enumerated the minimum requisites for recommending priority standards for the approval of requests from countries, and sub-paragraph (e) referred to technical integration of the preventive and curative activities and administration coordination of the different health institutions. He added that, when the English text had been revised, the word "will" had been substituted for the words "might be," which he believed, was the reason for the Jamaican Representative's confusion.

Item 14: Report on Buildings and Installations for Headquarters

Dr. PORTNER (Chief of Administration, PASB) indicated the Bureau's gratitude to the Permanent Subcommittee on Buildings and Installations for its very valuable help and guidance during the construction phase of the new headquarters building. He requested that, as had been customary at previous meetings of the Directing Council, the Chairman of the Permanent Subcommittee, Mr. Paul J. Byrnes (United States of America), submit this report prior to the presentation of Document CD16/21.

Mr. BYRNES (Chairman, Permanent Subcommittee on Buildings and Installations) said that during the Council meeting he had been pleased to hear much praise directed at those responsible for the new headquarters building, but that he had been associated with the Subcommittee for only a very short period. Over many years, his predecessors had suffered valiantly, together with the Secretariat, the daily frustration involved in completing a building of this type. As the last man in the race, crossing the finishing line with the baton in his hand, he was grateful to those who had gone before.

He also expressed his appreciation to his colleagues on the Subcommittee, Mr. Regis Novaes de Oliveira of Brazil, who was unable to be present at the meeting, and Mr. Francisco Borrego of Mexico, who had recently been assigned to a post outside of the United States of America. A replacement for Mr. Borrego was expected shortly.

After Dr. Portner had concluded his detailed report, he would take off his building hat and put on his hat as Representative of his Government to propose a resolution regarding the disposal of surplus building funds.

The Subcommittee was a permanent one and he looked forward to working with the Director and his very capable staff in meeting any problems that might be encountered in the future use of their new building.

Dr. PORTNER (Chief of Administration, PASB) presented Document CD16/21.[24] He indicated that

[22] See thirteenth plenary session, p. 171.

[23] *Scientific Publication PAHO* **129**, 130.

[24] See Annex 14, pp. 434–437.

since that was the first time the meeting of the Directing Council was held in the new headquarters building, the representatives had had an opportunity to gain a better appreciation of the characteristics of the building, its structure, and other facilities.

Sixty-three years of effort and planning for a permanent headquarters building for the Pan American Health Organization had culminated in August with the occupancy of the new headquarters building by the Bureau's staff members, and its dedication at the ceremony of the previous week.

He said that after a decade of negotiations a bill had been signed by the President of the United States of America authorizing the donation of the present site. In addition, loans had been obtained from the W. K. Kellogg Foundation and those, together with the proceeds from the Building Fund and those from the sale of the two buildings at 1501 and 1515 New Hampshire Avenue, N. W., had made possible the construction of the building.

Of the $6.6 million made up by the grant from the Kellogg Foundation, the proceeds of the sale of their two buildings to the American Council on Education and the money originally in the Building Fund, it appeared that between $300,000 and $350,000 would remain when final obligations had been met. It was thus appropriate to plan the utilization of those monies in the substantive program of the Organization.

The structure of the new building had, of course, been based upon a design by Mr. Román Fresnedo Siri of Uruguay, who had been awarded first prize in a hemisphere-wide competition, and his aid had been enlisted in deciding what sculptures, paintings, and tapestries might be donated by the Governments to be used in the beautification of its interior. A circular letter had been sent on 7 June 1965 indicating the specifications agreed upon and eight Governments, a private individual, and a commercial firm had extended offers of objects of art. Those and all future offers would be considered by the Permanent Subcommittee and the Director, assisted by expert counsel.

In closing, Dr. Portner gave a brief account of property transactions that had taken place in four of the Bureau's field installations.

Mr. LUTCHMAN (Trinidad and Tobago) thanked the Bureau for its report. The Representatives would agree that their meeting had been dominated physically by the new PAHO headquarters building and that it had been a great pleasure to attend daily and appreciate its functional beauties.

If economists could say that prosperity was indivisible, how much more so was that true of health. Disease and suffering did not recognize national frontiers. The headquarters building, because of the field with which it was related, therefore belonged in a very special way to all the inhabitants of the Hemisphere. He was happy to announce that the Cabinet of Trinidad and Tobago had appointed a group to select a work of art that would help beautify the building, if, indeed, that were possible, and he hoped that soon it would take its place alongside those from other countries of the Hemisphere, as a token of his country's pride in the new Headquarters, and in its membership of the Organization. He then stated that his Delegation wished to propose the following draft resolution:

THE DIRECTING COUNCIL,

Considering the report of the Director on the construction of the new building, and the sale of the property owned by the Organization (Document CD16/21); and

Noting that the Governments have been approached for donations of objects of fine art,

RESOLVES:

1. To express its appreciation to the Government of the United States of America for its gift of land and to the W. K. Kellogg Foundation for the grant of money which permitted the construction of the new headquarters building.

2. To express its appreciation to the Chairman and members of the Permanent Subcommittee on Buildings and Installations for their valuable assistance in the prosecution of all activities related to the construction of the new headquarters building and to the sale of the buildings at 1501 and 1515 New Hampshire Avenue, N. W., Washington, D. C.

3. To thank the Director and the staff of the Bureau for their effort in the construction of the new building and the sale of the buildings at 1501 and 1515 New Hampshire Avenue, N. W.

4. To take note of the status of property purchased or rented for the field installations.

5. To request the Director to keep the Executive Committee and the Directing Council informed at future meetings of donations of objects of art made to the Organization for its new Headquarters.

6. To request the Permanent Subcommittee to continue assisting the Director on all matters concerning the headquarters establishment.

Mr. BYRNES (United States of America), referring to Dr. Portner's statement that the Building Fund surplus would be between $300,000 and $350,000,

said all would agree that that should not be permitted to remain unused when needs were so great and other funds were so limited. His Delegation wished to suggest that the Executive Committee be authorized to transfer that money to the Special Fund for Health Promotion and therefore proposed the following draft resolution:

THE DIRECTING COUNCIL,

Considering that both the agreement with the W. K. Kellogg Foundation and the authorization by the XIII Meeting of the Directing Council in Resolution XVI for the establishment of the Special Fund for Health Promotion envisaged the possibility of allocating a larger amount of funds to the Special Fund for Health Promotion than the minimum required under that agreement; and

Taking into account that a balance which could be used for program activities undoubtedly will remain in the Building Fund,

RESOLVES:

To authorize contributions from the Building Fund of the Pan American Health Organization to the Special Fund for Health Promotion under such conditions and in such amounts as may be authorized by the Executive Committee.

The PRESIDENT announced that the draft resolutions of Trinidad and Tobago and the United States of America would be circulated and voted upon at the next session.[25]

Dr. AGUILAR HERRERA (Guatemala) congratulated the Permanent Subcommittee on Buildings and Installations on its efforts which had culminated in the completion of the building of the Organization. He would vote for the draft resolutions submitted by the Representatives of Trinidad and Tobago and of the United States of America. The Guatemalan Government intended to offer a work of art which, together with those donated by other countries of the Continent, would serve to decorate the new building.

Item 21: Selection of Topics for the Technical Discussions during the XVII Pan American Sanitary Conference, XVIII Meeting of the Regional Committee of WHO for the Americas

Dr. SUTTER (Assistant Director, PASB) introduced Document CD16/4 [26] and pointed out that Article 7 of the Rules for Technical Discussions at meetings of the Pan American Sanitary Conference and of the Directing Council provided that: "The Conference or the Council, as the case may be, shall each year select the topic or topics for the Technical Discussions to be held during the ensuing meeting of either of these two governing bodies. The Member Governments and the Director of the Bureau may propose topics prior to those meetings or in the course of them. The Conference or the Council may delegate the selection of topics to the Executive Committee."

Document CD16/4 also supplied information on the topics selected for the Technical Discussions held since 1951 at the meetings of the Pan American Sanitary Conference, the Directing Council, and the World Health Assembly, which appeared in annexes thereto.

Since neither Article 7 nor any other of the Rules for Technical Discussions laid down the procedure for selecting the topics for discussion, the Director had proposed to the General Committee that it should decide what procedure should be followed in selecting the topic for the next Conference, as some delegations had already informally expressed the view that the procedure followed in prior years had resulted in not giving proper consideration to all the topics. The General Committee had decided that, on the present occasion, a working group should be established to study all the topics and to choose three of them for submission to the Council which would then select one of them by a single simple majority vote. The Secretariat had already received official proposals for topics from one delegation. Those and the other topics presented would be transmitted to the members of the working group if established.

The PRESIDENT explained that, if there were more than three different proposals or topics put forward by the representatives, a working group would be appointed to reduce the number to three, on which the Council would vote. If there were three or less than three, they would be voted on directly without a working group. The one receiving most votes would thus be the topic chosen for the next meeting.

The session rose at 6:25 p.m.

[25] See thirteenth plenary session, p. 178.

[26] Mimeographed document.

THIRTEENTH PLENARY SESSION

Wednesday, 6 October 1965, at 9:30 a.m.

President: Dr. RAYMUNDO DE BRITTO (Brazil)

Item 11-A: Report on the Status of Malaria Eradication in the Americas (*conclusion*)

11-B: Financing of the Malaria Eradication Program in the Americas (*conclusion*)

11-C: Estimated Requirements for Malaria Eradication in the Americas (*conclusion*)

Report of the Working Party

The PRESIDENT called the session to order and announced that, since the report of the working party on malaria eradication had already been read at the twelfth plenary session,[1] he would put it to the vote.

Decision: By 18 votes in favor, none against, and 6 abstentions, the report of the working party on Items 11-A, 11-B, and 11-C with the three resolutions contained therein, was approved.[2]

Item 27: Status of Smallpox Eradication in the Americas (*continuation*)

Report of the Working Party

Dr. BLAKSLEY (Argentina) read the report of the working party on the status of smallpox eradication in the Americas, as follows:

At 6:00 p.m. on 4 October 1965, the working party appointed by the Directing Council at its ninth plenary session met in Committee Room "D." It was composed of Dr. Julio C. Blaksley (Argentina); Dr. Daniel Alonso Menéndez (Cuba); Dr. Alfonso Boniche Vásquez (Nicaragua); Dr. Claudio L. Prieto (Paraguay); Dr. Carlos Quirós Salinas (Peru); and Dr. Charles L. Williams, Jr., and Mr. Leonard M. Board (United States of America).

The working party elected Dr. Claudio L. Prieto (Paraguay), Chairman, and Dr. Julio C. Blaksley (Argentina), Rapporteur.

After studying the report of the Director on the item, the draft resolutions submitted by the Delegations of Argentina, Panama, Paraguay, and the United States of America, and the statements made during the discussions, the working party decided to propose the following draft resolution:

THE DIRECTING COUNCIL,

Having considered the report of the Director on the status of the smallpox eradication program in the Americas (Document CD16/29);

Bearing in mind the resolutions of the XIII, XIV, XV, and XVI Pan American Sanitary Conferences on the eradication of smallpox, as well as its own previous resolutions, especially Resolution XLI approved at the XV Meeting;

Considering that smallpox is an eradicable disease and that effective techniques and means are available for that purpose; and

Bearing in mind Resolution XHA18.38 which declares the worldwide eradication of smallpox to be one of the major objectives of WHO,

RESOLVES:

1. To declare smallpox eradication in the Americas to be one of the major objectives of the Pan American Health Organization.

2. To reiterate and confirm the previous resolutions of the Governing Bodies of the Organization to the effect that smallpox must be eradicated from the Hemisphere as soon as possible.

3. To remind the Governments that the organization and execution of national smallpox vaccination programs is a specific obligation incumbent upon them.

4. To recommend to the Governments that, side by side with intensive vaccination programs, they organize activities aimed at maintaining a high level of immunity among the population and that in countries where the eradication campaign has been completed but where the corresponding maintenance operations have not yet been initiated, they begin them as soon as possible.

5. To urge the Governments of countries in which there is no smallpox and in which the level of immunity of the general population is low to institute, by such means as they deem appropriate, a program for progressively increasing the vaccinated proportion of the population.

6. To urge the Governments to organize epidemiological surveillance services for the early detection of suspect cases of smallpox and for the prevention of the spread of the disease, and to recommend that to that end, the Governments take special measures for the clinical, laboratory, and epidemiological confirmation of suspect cases of smallpox occurring in their territories.

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[1] See pp. 166–168.

[2] Resolutions XVI, XVII, XVIII. *Official Document PAHO* **66**, 68-71.

7. To request the Director of the Bureau to prepare an estimate of the financial and other resources which the countries and the Organization require for the eradication of smallpox and to submit that estimate to the 54th Meeting of the Executive Committee and the XVII Pan American Sanitary Conference.

8. To emphasize the need for the Pan American Sanitary Bureau to continue to coordinate the national smallpox vaccination campaigns and to provide those campaigns with the help they need, including technical assistance in planning, operation, research, and personnel training, as well as vaccine, supplies and equipment, and certain local costs, whenever necessary.

9. To urge the Director of the Bureau to assist the Governments in obtaining financial and material resources for their national programs.

10. To urge the Governments to supply the national programs of other countries of the Continent that need them, not only with smallpox vaccine but also with financial and material resources and specialist services, either directly or through the Pan American Sanitary Bureau.

11. To express its thanks to the countries of the Continent that have so generously donated smallpox vaccine to countries that need it or do not produce enough of it.

Dr. WILLIAMS (United States of America) called attention to the fact that in the English text, the last paragraph of the preamble of the proposed resolution read "Resolution XHA18.38" instead of "Resolution WHA18.38." Furthermore, the words "of the Eighteenth World Health Assembly" had been omitted, although they did appear in the Spanish text.

Dr. CASTILLO REY (Venezuela) praised the document submitted and the efforts of the working party. In operative paragraph 6, the phrase "To urge the Governments to organize epidemiological surveillance services" might give the impression that such services should be organized in connection with specific programs and that there should be as many services as there were programs of that kind in a given country. The first thing any health administration had to do was to organize an epidemiological information service. He therefore suggested that paragraph 6 should be reworded to read "To urge the Governments to intensify their epidemiological surveillance services for the early detection and investigation of suspect cases of smallpox and for the prevention of the spread of the disease." The remainder of the paragraph could stand unamended.

Dr. NICHOLSON (United Kingdom) proposed redrafting operative paragraph 10 of the proposed resolution, so that the statement "To urge the Governments to supply the national programs . . ." be replaced by the following: "To urge the Governments that are in a position to do so to supply the national programs of other countries . . ."

Dr. QUIRÓS (Peru) thought that the observation made by Dr. Castillo Rey was very pertinent, adding that his country's Delegation accepted the proposed amendment without reservation.

Dr. BLAKSLEY (Argentina) likewise accepted the Venezuelan Representative's suggestion.

The PRESIDENT announced that the proposed amendments would be submitted in writing, so that the final text could be put to the vote.[3]

Item 26: Study of the Relationship between Social Security Medical Programs and Those of Ministries of Health or Other Official Health Agencies (*conclusion*)

Report of the Working Party

Dr. FERREIRA (Brazil) read the report of the working party on the item, as follows:

Pursuant to the decision of the Directing Council at its eighth plenary session held on Saturday, 2 October, a meeting of a working party composed of the following members was held in Committee Room "B" on 5 October at 2:00 p.m.: Dr. Manoel José Ferreira (Brazil); Dr. Ramón Valdivieso (Chile); Mr. Edison Rivera (Costa Rica); Dr. Pedro Daniel Martínez (Mexico); and Dr. Alberto E. Calvo (Panama).

The Representatives of Chile and Costa Rica, who were unfortunately unable to attend, made their opinions known through other members of the working party. Dr. Pedro Daniel Martínez (Mexico) was elected Chairman and Dr. Manoel José Ferreira (Brazil) Rapporteur.

The working party carefully studied the draft resolution proposed by the Delegation of Panama[4] and, after introducing numerous changes, decided unanimously to propose the following draft resolution for the Council's consideration:

THE DIRECTING COUNCIL,

Having considered the Final Report of the Study Group on Coordination of Medical Care in Latin America, with special reference to the relationship between social security medical programs and those of ministries of health or other official health agencies (Document CD16/25);

Bearing in mind that the enjoyment of the highest attainable standard of health is the right of all human

[3] See fifteenth plenary session, p. 193.

[4] See eighth plenary session, p. 108.

beings without distinction, a right which should be ensured by the State through the organization or promotion of a system of services for the protection, promotion, and restoration of health;

Recognizing that government health services and social security medical services complement each other; and

Recognizing that the planning of economic development and social progress requires that the countries make rational use of existing installations and program the development of their human and material resources in a methodical and coordinated manner,

RESOLVES:

1. To take note of the Final Report of the Study Group.

2. To thank the Director of the Bureau and the members of the Study Group for their profound analysis of the problem, and the Organization of American States for its efficient cooperation.

3. To reiterate its previous resolution to the effect that the above-mentioned Report be transmitted to the Governments together with an invitation to progressively apply the recommendations in it concerning machinery for coordination between ministries of health and social security institutions, especially that which refers to the need for a survey to measure the real magnitude of the problem and to ascertain its characteristics.

4. To recommend to the Governments that social security institutions and all public or private agencies that engage in health activities participate in the national planning of the health sector.

5. To recommend to the Director of the Bureau that:

a) He make studies, diffuse knowledge, and offer advisory services to the Governments on how to achieve the maximum degree of coordination between ministries of health and the autonomous, semiautonomous, and private institutions that engage in health activities.

b) He sponsor and promote, in collaboration with national and international agencies concerned, educational programs designed to lead to the development of a common doctrine on the administration of medical care.

c) Through the Governments concerned, to help spread modern concepts of health care among trade unions and the local communities, in order to secure the adoption of a favorable attitude toward coordination.

d) To promote joint meetings of medical authorities and other high officials of the ministries of health and of the social security institutions of the Member Countries in order to encourage the above-mentioned coordination.

Dr. WILLIAMS (United States of America) suggested two minor changes in the second paragraph of the English text of the preamble that might bring the resolutions more in line with some of the practicalities. Instead of "Bearing in mind that the enjoyment of the highest attainable standard of health is the right of all human beings without distinction," the first line could read: "Bearing in mind that the opportunity to enjoy the highest attainable standard of health is a right . . . ." In his opinion, the right to enjoy the highest attainable standard of health was something that could not be guaranteed since there were too many factors—physical, medical, and others—that were related.

The PRESIDENT put to a vote the amendment to the English text proposed by the Representative of the United States of America.

Decision: The amendment proposed was unanimously approved.

The PRESIDENT announced that he would put the draft resolution, as amended, to the vote.

Decision: The draft resolution, with the amendment proposed by the Representative of the United States of America, was unanimously approved.[5]

Dr. HORWITZ (Director, PASB) remarked that operative paragraph 3 referred to the need for a survey to measure the real magnitude of the problem and to ascertain its characteristics. Since the Bureau intended to transmit a communication on the survey to the Governments very shortly, he invited the latter to make the requisite facilities available so that PASB could carry out its work along the lines laid down by the working party in the report serving as a basis for the current discussion. For the survey in question to be properly organized, it was desirable to know how many Governments intended to cooperate so that the Bureau might make the necessary arrangements.

Dr. ESQUIVEL (Panama) said that his country would extend the collaboration required for Panama to be the first country in which the survey was conducted. He pointed out that the Delegation of Panama had been the only one to include a member of the social security service, an institution which was prepared to have the survey carried out as quickly as possible. He added that, if the first survey was successful, the other countries would follow suit immediately.

Dr. MARTÍNEZ (Mexico) suggested to the Director that, whenever the collaboration of the social security systems was needed, it should explicitly be

[5] Resolution XIX. *Official Document PAHO* **66**, 71-72.

requested through the normal channel of the ministries of health. The Delegation of Mexico had not included a representative of the social security institutions simply because the latter had never been invited by the Bureau. An invitation had been extended to the social security services by his country's Ministry of Health and Welfare, but independently of the Bureau. Hence the invitation had not been given the best reception and that was why the services in question had not appointed representatives.

Dr. QUIRÓS (Peru) requested that priority be given to studying the financing of social security systems, taking into account their desirability or undesirability, with a view to remedying a series of untoward situations to which he had referred in the discussion on the item.

Item 13: Status of National Health Planning (*conclusion*)

Report of the Working Party

Dr. AGUILAR HERRERA (Guatemala) read the following report of the working party on the item:

The working party on planning, composed of the Representatives of Chile, El Salvador, Guatemala, and Haiti, met on 5 October 1965 under the chairmanship of Dr. Orlando Aguilar Herrera (Guatemala).

The working party submits the following resolution for consideration by the Directing Council:

THE DIRECTING COUNCIL,

Having considered the report of the Director on the status of national health planning (Document CD16/15), the Final Report of the Study Group on Health Planning, and the Report of the Technical Discussions on Health Planning at the Eighteenth World Health Assembly annexed to the report of the Director;

Recognizing the importance of systematic planning in the health field within the framework of national plans for economic and social development; and

Recognizing the need, outlined in the Final Report of the Study Group on Health Planning, for a firm institutional base for the assistance which the Organization provides the Governments in the field of national health planning,

RESOLVES:

1. To commend the Director for the detailed report which shows in general terms the progress made in the field of health planning since the XV Meeting of the Directing Council.

2. To recommend to the Director:

a) That the Organization continue and intensify its assistance to the Governments in those activities which in each particular case are deemed necessary for the prosecution of health planning.

b) That the Organization continue to promote research for the improvement of planning theory and practice and the international exchange of research findings.

c) That he study the advantages that would accrue from the establishment of a Pan American Center for Health Planning, which would act as a focal point for health planning activity in the Hemisphere, and that he explore all possible sources of financial assistance for the Center.

d) That, depending on the situation in each country, he request the Governments to give full support to national health plans.

e) That he report next year to the Pan American Sanitary Conference on the results of his efforts and the progress made in the planning field.

Decision: The draft resolution proposed by the working party was unanimously approved.[6]

Mr. RIVERA (Costa Rica), referring to operative paragraph 2-e of the resolution just approved, stated that it was desirable for the report which the Bureau was to transmit to the next Conference to be rather detailed and more comprehensive than planned and that it should, if possible, provide some evaluation of the actual planning undertaken so as to show what headway the process was making, which was actually the most important aspect.

Dr. QUIRÓS (Peru), referring to operative paragraph 2-c concerning the establishment of a Pan American Center for Health Planning, announced that his country would welcome a decision by the Center to set up its headquarters in Lima, Peru, for which purpose it would offer facilities of every kind.

Item 22: Research Policy and Program of the Pan American Health Organization (*conclusion*)

Draft Resolution Presented by the Delegation of the United States of America

Dr. SUTTER (Assistant Director, PASB) read the following draft resolution on the item, presented by the Delegation of the United States of America:

THE DIRECTING COUNCIL,

Having considered the report of the Director on the research policy and program of PAHO (Document CD16/20), the report of the Fourth Meeting of the PAHO Advisory Committee on Medical Research (Document CD16/20, Annex I), and the Current PAHO Collaborative Research Program (Sources of Financing) (Document CD16/20, Annex II);

Noting the progress made in the Inter-American Investigation of Mortality; in studies on Chagas' disease, epidemic typhus, endemic goiter, nutritional anemias,

[6] Resolution XX. *Official Document PAHO* **66, 72-73.**

malaria, mosquito resistance to insecticides, and the radiation and isotopes projects; and in the research activities of the Institute of Nutrition of Central America and Panama (INCAP), the Pan American Foot-and-Mouth Disease Center, and the Pan American Zoonoses Center;

Noting that new work includes major studies in biomedical research policy for the Region, public health research in Argentina, population dynamics and medical demography, faculty and research training centers, environmental determinants of community well-being, malnutrition in mental development, deprivation in psychobiological development, and, as part of a broad effort to improve medical library resources of the Region, a regional medical library center;

Recalling that the entire program is following the policy guidelines of Resolution XXVI of the XVI Pan American Sanitary Conference;

Noting with gratitude that the Advisory Committee on Medical Research continues its dedicated interest in the research program of PAHO, providing timely and informed advice on specific projects and on the program as a whole, including the priorities to be devoted to biomedical, biosocial and biosanitary research and to major regional, community, and individual health problems; and

Noting with appreciation the increase in both the amount and the sources of voluntary and public support and the administrative efficiency of the PAHO research planning and coordination, as exemplified by the fact that although there has been a marked expansion in the program since the XVI Pan American Sanitary Conference, there has been no increase in the administrative budget,

RESOLVES:

1. To commend the Director, the Advisory Committee on Medical Research, and the staff for the breadth, balance, and vitality of the research program.

2. To record its satisfaction with the fact that, in the field of research and training in population dynamics, as in other subject fields, PAHO and WHO are collaborating in developing a coordinated program for the Americas (under Resolution XXXI of the XV Meeting of the Directing Council and Resolution WHA18.49 of the Eighteenth World Health Assembly) aimed at achieving a harmonious integration of health, population growth, and community development components of national efforts to raise the standard of living of populations throughout the Region.

3. To endorse the emerging emphasis on (a) programs and research studies for measuring present and future requirements in the Americas, of physicians and other professional, paramedical and auxiliary personnel; and (b) the program for Pan American Faculty and Research Training Centers which are intended to assist in meeting the severe shortage of qualified teachers and researchers in various medical sciences and in related professions, and of paramedical and auxiliary personnel in the fields of industrial, occupational, and environmental health.

4. To note with satisfaction the recommendations made by the Advisory Committee on Medical Research to the Director on the subject of biomedical research policy for the Region, which emphasize that universities should foster "a climate of opinion which recognizes that scientific research is part of the cultural life of the community" and that the ministries of health, like the ministries of education, should promote and support research and advanced educational programs calculated to assist in solving health and community development problems.

5. To reaffirm paragraph 5 of Resolution XXXI of the XV Meeting of the Directing Council (1964), to urge individual Governments, insofar as their resources permit, to consider the possibility of establishing a permanent national fund for research on public health problems, and to commend Argentina for its initiative in this respect.

Dr. QUIRÓS (Peru), referring to the training of personnel specialized in occupational health, said that for many years his country had had an Occupational Health Institute in which many of the Hemisphere's specialists had been trained. He sincerely hoped that advantage would continue to be taken of the Institute's services.

In addition, he proposed that a sixth paragraph should be added to the operative part, as follows: "To request the Director of the Bureau to provide Governments that request it with technical assistance in the organization of National Scientific and Technical Research Councils."

The PRESIDENT put to the vote the addition proposed by the Delegation of Peru.

Decision: The amendment proposed by the Peruvian Delegation was unanimously approved.

The PRESIDENT put to the vote the draft resolution submitted by the Delegation of the United States of America, with the proposed addition.

Decision: The draft resolution was unanimously approved.[7]

Item 16: Organization of the Pan American Sanitary Conference (*conclusion*)

Draft Resolution Presented by the Delegation of Ecuador

Dr. SUTTER (Assistant Director, PASB) after referring to the previous discussion on this item,[8] read the following draft resolution:

[7] Resolution XXI. *Official Document PAHO* **66**, 73-75.

[8] See eleventh and twelfth plenary sessions, pp. 152 and 159.

THE DIRECTING COUNCIL,

Bearing in mind the preliminary report submitted to the Executive Committee (Document CE52/13) and the Addendum thereto, "Study of the Organization of the Pan American Sanitary Conference" (Document CD15/26), to which were annexed the replies of the Governments on this subject; and

Bearing in mind the recommendation of the Executive Committee in its report (Document CE52/22),

RESOLVES:

1. To recommend that for the XVII Pan American Sanitary Conference the Director retain the same general structure as in earlier Conferences, due regard being had to the suggestions made by the Governments about the organization and work of the main committees.

2. To invite the Director to study the cost of the XVIII Pan American Sanitary Conference from the standpoint of its organization, with a view to ensuring that future meetings of the Conference have the most appropriate structure at the lowest cost.

Decision: The draft resolution was unanimously approved.[9]

Mr. LUTCHMAN (Trinidad and Tobago) suggested that in the English text of the second operative paragraph of the resolution presented by the Delegation of Ecuador, which the Directing Council had just approved, the words "XVIII Pan American Sanitary Conference" be corrected to read "XVII Pan American Sanitary Conference."

It was so agreed.

Representation of the Executive Committee at Meetings of the Directing Council and the Pan American Sanitary Conference

Draft Resolution Presented by the Delegation of Panama

Dr. SUTTER (Assistant Director, PASB), after referring to the discussion on this subject,[10] read the following draft resolution on the representation of the Executive Committee at meetings of the Directing Council and the Pan American Sanitary Conference:

THE DIRECTING COUNCIL,

Having considered Resolution VIII of the 52nd Meeting of the Executive Committee concerning the organization of the Pan American Sanitary Conference;

Having considered the report of the working party of the Executive Committee in the Addendum to *Official Document 62*, which recommends "that the Executive Committee be officially represented at the meetings of the Directing Council and the Conference by its Chairman or by any other member appointed by the Committee"; and

Bearing in mind the desirability of the Executive Committee being officially represented at those meetings,

RESOLVES:

1. To provide that the Executive Committee shall be officially represented by its Chairman, or any other member designated by the Committee, at the meetings of the Directing Council of the Pan American Health Organization and of the Pan American Sanitary Conference.

2. To provide that the travel and subsistence expenses of the Official Representative of the Executive Committee at the meeting shall be borne by the Organization.

Decision: The draft resolution was unanimously approved.[11]

Item 17: Amendments to Article 7 of the Constitution of the Pan American Health Organization (*continuation*)

Draft Resolution Presented by the Delegation of Brazil

Dr. SUTTER (Assistant Director, PASB), after referring to the previous discussion on this subject,[12] read the following draft resolutions:

THE DIRECTING COUNCIL,

Bearing in mind the report approved by the Executive Committee at its 52nd Meeting (Resolution VIII) and the proposed amendments to the Constitution relating to the place of the Pan American Sanitary Conference formulated therein; and

Bearing in mind Article 28 of the Constitution of the Pan American Health Organization,

RESOLVES:

To approve the following constitutional changes:

"Article 7-A. The Conference shall meet every four years at the Headquarters of the Organization on a date fixed by the Director of the Bureau in consultation with the Executive Committee.

"Article 7-B. Notwithstanding the provision of the immediately foregoing paragraph, the Conference may meet in any Member Country of the Organization provided that the Government concerned invites it, and the Conference itself or the Directing Council at its meeting held one year before that appointed for the Conference accepts the invitation.

"Article 7-C. Whenever the provisions of the immediately foregoing paragraph apply, the

[9] Resolution XXII. *Official Document PAHO* **66**, 75-76.
[10] See twelfth plenary session, p. 161.
[11] Resolution XXIII. *Official Document PAHO* **66**, 76-77.
[12] See twelfth plenary session, p. 162.

Government of the country in which the Conference is to be held shall appoint a Committee to cooperate with the Bureau in organizing the Conference."

The present paragraphs C to G of Article 7 will become paragraphs D to H of the amended text of the new Article.

Dr. ALONSO MENÉNDEZ (Cuba) recalled that on the previous day his Delegation had expressed its opinion on the amendments proposed to Article 7 of the Constitution of the Pan American Health Organization. In its view, Article 7-B in the draft resolution just read by Dr. Sutter did not constitute an amendment to the relevant constitutional provision in force at present, because it would leave open the possibility of holding the Conference in any Member Country of the Organization. He recalled that the present text of Article 7 of the Constitution provided that "The Conference shall normally meet every four years in the country determined by its immediately preceding meeting." The text proposed for that article, namely, that the Conference should meet every four years at the Headquarters of the Organization, was, in the view of the Cuban Delegation, a substantive amendment, whereas Article 7-B kept open the possibility that the Conference might meet in one of the Member Countries, provided that the Conference or the Council agreed at its meeting held one year before, so that something which had hitherto been a permanent feature of the Constitution would become an exception. For those reasons, his Delegation objected to the constitutional amendment and repeated the offer it had extended at the previous Conference inviting the next Conference to the Cuban capital which, as was common knowledge, enjoyed a very pleasant climate in September.

Dr. QUIRÓS (Peru) said that his Government, which had already offered Lima as the site for the next Pan American Sanitary Conference, wished its offer to stand until the Directing Council considered it appropriate to take it up.

Decision: By 21 votes in favor, 1 against, and no abstentions, the draft resolution proposed by the Delegation of Brazil on amendments to Article 7 of the Constitution, was approved.[13]

Item 17: Amendment to Rule 1 of the Rules of Procedure of the Directing Council (*conclusion*)

Draft Resolution Presented by the Delegation of Brazil

Dr. SUTTER (Assistant Director, PASB), after referring to the previous discussion on this subject,[14] read the following draft resolution:

THE DIRECTING COUNCIL,

Bearing in mind the report approved by the Executive Committee at its 52nd Meeting (Resolution VIII) and the proposed amendment to the Rules of Procedure of the Directing Council formulated therein; and

Bearing in mind Article 58 of the Rules of Procedure of the Directing Council,

RESOLVES:

To amend Rule 1 of the Rules of Procedure of the Directing Council to read as follows:

"Rule 1. The Director of the Bureau shall convene the Council to meet in conformity with Article 12, paragraph A, of the Constitution and pursuant to a resolution of the Executive Committee. The meeting shall be held at the Headquarters of the Organization or at a place chosen by the Conference or the Council. Whenever the meeting is not held at the Headquarters of the Organization, the Director shall fix the date of the meeting in consultation with the Host Government."

Decision: The draft resolution proposed by the Delegation of Brazil on the amendment to Rule 1 of the Rules of Procedure of the Directing Council was unanimously approved.[15]

Item 12: Planning of Hospitals and Health Facilities (*continuation*)

Draft Resolution Presented by the Delegation of Argentina

The PRESIDENT announced that, since two modifications had been proposed in the draft resolution on the item, the voting would be postponed.[16]

Dr. HORWITZ (Director, PASB) said that he thought he would have been referring to an approved resolution, but in any event he was very pleased to inform the Directing Council that, in the course of talks with the President of the Inter-American Development Bank, the President had expressed his interest in the general problem of hospital planning, in the broad meaning given to the term by the Organization on the basis of the Ad-

[13] Resolution XXIV. *Official Document PAHO* **66**, 77.

[14] See twelfth plenary session, p. 162.

[15] Resolution XXV. *Official Document PAHO* **66**, 78.

[16] See fifteenth plenary session, p. 200.

visory Committee's report, i.e., including hospital services in the over-all process of promoting and restoring health, and also in each country's over-all development plan. The President of the Bank had also expressed interest in the Organization's collaboration in determining the criteria which the Bank would have to study in due course, in the event that it decided to extend its credit policy to the granting of loans for health establishments. In that connection the credit agencies should proceed with due caution and lay down clearly the principles of a lending policy for that purpose, because the matter was of vital importance in the American Continent. The fact that the Inter-American Development Bank—which had quickly become the banking institution most typical of Latin America's development and progress—was thinking of extending its activities to a field of interest to all was extremely important and made it possible for the draft resolution, once approved by the Council, to be put into effect immediately, for which purpose the Bureau would cooperate to the fullest possible extent. He announced that the Executive Committee and the Conference would, of course, be kept informed of the result of the negotiations.

Item 14: Report on Buildings and Installations for Headquarters (*conclusion*)

Draft Resolution Presented by the Delegation of Trinidad and Tobago

The PRESIDENT put to a vote the draft resolution on the item proposed by the Delegation of Trinidad and Tobago at the twelfth plenary session.[17]

Decision: The draft resolution was unanimously approved.[18]

Building Fund and Special Fund for Health Promotion

Draft Resolution Presented by the Delegation of the United States of America [19]

Dr. SUTTER (Assistant Director, PASB) read the following draft resolution on the subject.

THE DIRECTING COUNCIL,

Considering that both the agreement with the W. K. Kellogg Foundation and the authorization by the XIII Meeting of the Directing Council in Resolution XVI for the establishment of the Special Fund for Health Promotion envisaged the possibility of allocating a larger amount of funds to the Special Fund for Health Promotion than the minimum required under that agreement; and

Taking into account that a balance which could be used for program activities undoubtedly will remain in the Building Fund,

RESOLVES:

To authorize contributions from the Building Fund of the Pan American Health Organization to the Special Fund for Health Promotion under such conditions and in such amounts as may be authorized by the Executive Committee.

Decision: The draft resolution was unanimously approved.[20]

Eradication of *Aedes aegypti* in Argentina (*conclusion*)

Draft Resolution on the Eradication of Aedes aegypti in Argentina

Dr. PRIETO (Paraguay) said that it was an honor for his Delegation to present the following draft resolution announcing that Argentina had succeeded in eradicating *Aedes aegypti:*

THE DIRECTING COUNCIL,

Considering the final report on the eradication of *Aedes aegypti* presented by Argentina, which declared that the country is free of the mosquito and that the standards and criteria for eradication established by the Pan American Sanitary Bureau have been met; and

Bearing in mind that the special confirmatory verification was carried out with the participation of officials of the Pan American Sanitary Bureau,

RESOLVES:

1. To accept the report presented by Argentina, to congratulate that country on the work accomplished, and to declare its territory free of *Aedes aegypti.*

2. To urge the Governments of countries and areas still infested by *Aedes aegypti* to give the highest priority to the provision of the funds, personnel, and supplies needed for the completion of their eradication campaigns.

3. To recommend to the Governments of countries and areas from which the vector has been eradicated that they maintain active surveillance programs to prevent reinfestation.

4. To urge the Director to adopt appropriate measures to intensify and accelerate *Aedes aegypti* eradication campaigns so that the goal of eradication in the Americas can be achieved as soon as possible.

[17] See p. 169.

[18] Resolution XXVI. *Official Document PAHO* **66, 78-79.**

[19] See twelfth plenary session, p. 170.

[20] Resolution XXVII. *Official Document PAHO* **66, 79.**

Decision: The draft resolution was approved unanimously.[21]

Dr. MARTÍNEZ (Mexico) called upon the members of the Directing Council to join in a round of applause to the Government of Argentina for having successfully eradicated *Aedes aegypti,* a vector which was a serious danger to health and still constituted a threat in America.

The PRESIDENT associated himself with the proposal of the Representative of Mexico and called upon all the members of the Directing Council and other participants to pay to the Government of Argentina the tribute proposed by Dr. Martínez.

The participants in the meeting rose and gave a round of applause to the Government of Argentina.

The session was suspended at 10:45 a.m. and resumed at 11:20 a.m.

Proposed Amendments to the Rules of Procedure of the Pan American Sanitary Conference

The PRESIDENT referred to the 52nd Executive Committee's recommendation[22] that the Council should be requested to bring to the Conference's attention the changes proposed by the Delegation of the United States of America to the existing Rules of Procedure of the Conference, which it considered would improve the text in substance and in principle. He proposed that the Secretariat prepare a new text of the Rules and submit it to the 54th Meeting of the Committee for study and transmittal to the Conference, which was responsible for approving its own Rules.

Dr. WILLIAMS (United States of America) stated that the original suggestion with regard to that matter had been made by his country's Delegation at the 47th Meeting of the Executive Committee[23] held immediately after the XVI Pan American Sanitary Conference in Minneapolis, Minnesota, in 1962. On that occasion the United States Representative suggested that a study be made of the Rules of Procedure of the Pan American Sanitary Conference with the view to effecting certain economies and, perhaps, to increasing the efficiency of the proceedings of the Conference. Those had been discussed on several opportunities, most recently at the 52nd Meeting of the Executive Committee. The report to which the President had referred pointed out the need to study the suggestions made by the United States Representative, a course of action that, in the opinion of the Executive Committee, might well affect favorably the proceedings of the Conference.

The speaker added that, as the Directing Council knew, the suggested changes in the Rules of Procedure of the Conference would be adopted by the Conference itself. In his opinion, the President's proposal that the suggestions be referred to the Executive Committee for its recommendation to the Conference was most appropriate.

Decision: The President's proposal was unanimously approved.

Item 25: Training of Auxiliary Personnel

Dr. DÍAZ-COLLER (Chief, Professional Education Branch, PASB), in introducing Document CD16/11,[24] stated that during the 50th Meeting of the Executive Committee the Mexican Delegation had pointed out[25] that the more developed countries used auxiliary personnel, under adequate professional supervision, on a much larger scale than the developing countries. That made it possible to increase that personnel and adequately cover many health activities which otherwise it would be impossible to carry out.

Latin America had continued to increase its public health programs, hence the scarcity of workers at all levels constituted a serious problem.

The Executive Committee had made a recommendation[26] to the XV Meeting of the Directing Council in Mexico in 1964, and it, in turn, had adopted Resolution XXIX[27] in which it recommended that the Director prepare a study on the training of auxiliary workers as the basis for discussion at a meeting of national authorities on the subject. That meeting would be convoked for the purpose of presenting for the Organization's consideration a policy for the training of auxiliary personnel that would satisfy the needs of the countries of the Hemisphere.

Certain measures were taken pursuant to that resolution, among them, a request to official agen-

[21] Resolution XXVIII. *Official Document PAHO* **66,** 80.
[22] *Official Document PAHO* **62,** 42.
[23] *Official Document PAHO* **49,** 309-310.
[24] Mimeographed document.
[25] *Official Document PAHO* **60,** 226.
[26] Resolution X. *Official Document PAHO* **57,** 25-26.
[27] *Official Document PAHO* **58,** 81-82.

cies of the different countries to furnish information on the matter, and the services of an expert in the training of public health auxiliaries were obtained for the study. The consultant was Dr. Branko Kesić, Director of the "Andrija Stampar" School of Public Health at Zagreb, Yugoslavia, who had visited several countries of the Americas that year, including Brazil, El Salvador, Mexico, Peru, and Venezuela.

With the data obtained from the different Governments, Dr. Kesić had prepared a report[28] that would serve as a basis for the aforementioned meeting of experts. It was being translated and contained the basic facts required for the training and utilization of auxiliaries. Mention was also made of the rapid migration of the rural population toward the large urban centers, which was the cause of serious social, educational, and public health problems. With the decrease in the density of the rural population, communication problems were created in sparcely populated areas, where auxiliaries were very much needed.

The report also called attention to what had been discussed at length by the XIV Meeting of the Council, i.e., that the definition of "auxiliary" varied from one country to another, as did the type and duration of training according to the requirements of each country. Information was also given on courses currently being given in Latin America to train auxiliaries in the fields of nursing, statistics, nutrition, laboratory work, X-ray techniques, dentistry, environmental sanitation inspection, community development, and health education. The report also posed some challenging questions concerning factors essential to the training and utilization of public health auxiliaries—factors that were of key importance to the development of health of the peoples of the Americas.

The Director would report to the Governing Bodies in due course on the conclusions reached at that meeting of experts.

Dr. QUIRÓS (Peru) considered the item on the training of auxiliary personnel to be one of the most important and hoped that the report mentioned by Dr. Díaz-Coller would be available as soon as possible.

[28] "Training and Utilization of Auxiliary Health Workers in Latin America" (mimeographed document).

A vast training program for auxiliary personnel had been carried out in Peru in the last few years, especially for the 15 hospitals established in the past three years. The personnel of the old hospitals had not received the necessary training.

His country had enjoyed the valuable cooperation of UNICEF and PAHO in the form of local fellowships for the training of such personnel. It should be borne in mind that each country had its own peculiar problems and required its own kind of auxiliary personnel.

The Delegation of Peru was especially interested in the training of lower-grade auxiliary personnel, i.e., at the elementary level, and for that purpose it would be useful to study the program of simplified medicine that had been organized in Venezuela and the way in which it might be applied to other countries.

Lastly, he suggested that the proposed meeting of experts should include representatives of the greatest possible number of countries so that they could relate their experiences. In that connection he pointed out that, while the group of experts in hospital planning had consisted of highly-qualified people, it had, in a certain sense, lacked the necessary variety, since there had been no representatives either from his own country or from Venezuela, both of which had very valuable experience in the training of auxiliary personnel.

Dr. CASTILLO REY (Venezuela) referred mainly to the statement in the report by Dr. Díaz-Coller that the more developed countries were using the services of auxiliary personnel much more intensively and extensively than the developing countries. That seeming paradox showed that the Latin American countries were making insufficient use of a vast human resource as regards improving its capacity to render service, and also that employment opportunities were not being given to people who, owing to different circumstances, were denied access to the higher levels of education.

Auxiliary workers had been employed in Venezuela since the start of the programs and had been trained as the need arose in each case. He thought that the time had come to define what was meant by "auxiliary workers," the degree of basic schooling they required and the kind of training they should have, in accordance with the work that was to be done, in order to be, in a sense, multi-purpose and not unreasonably numerous. It was therefore essential to make the training of auxiliary workers

more uniform and to build it on sounder foundations so that they could be effectively employed in the extension of programs and, specifically in the case of Venezuela, in simplified medicine.

He remarked that the simplified medicine program had enjoyed the support and encouragement of the country's medical associations, which was an important factor since doctors had reservations about certain medical activities being assigned to personnel without university training. For that type of program local workers were required with enough training to enable them, using simple techniques, to help improve the health conditions of the inhabitants of vast rural areas whose problems were difficult to solve because of the lack of funds, the dispersal of population centers, and poor communications. He was confident that such well-trained personnel would be used, that they would understand their duties, and that they would be under the necessary supervision.

In conclusion, he thought that the time had come for the Pan American Sanitary Bureau to extend its activities in the matter of training auxiliary personnel and to consult Governments and experts, as it saw fit, in order to define the term.

Dr. ESQUIVEL (Panama) stated that the lack of trained auxiliary personnel constituted a major problem and that high priority was given in his country to its solution. Such training should be seen in the light of certain conditions which were very prevalent in the Latin American countries, *inter alia,* the lack of adequate remuneration, the instability of posts of the lower-grade employees, and the poor administrative discipline in some public health agencies and local training services. The low wages made it difficult to recruit personnel capable of undergoing the necessary training, and that was why the trained workers went to work in institutions which offered better pay and why they often went abroad.

In Panama, owing to the discrepancy in wages between governmental institutions proper and social security agencies, the best-trained personnel sought employment in the latter which, moreover, offered them better security of tenure.

In an institution where iron discipline prevailed, it might be possible to work efficiently and train and retain personnel of any category. Organizations which lacked trained auxiliary personnel showed thereby that they were incapable of training personnel or introducing training systems. Again, at the various levels and in different institutions in the various countries, workers were trained to undertake certain functions in the training of other personnel.

The possibility of using the hospital of the Social Security Fund of Panama for the training of auxiliary personnel for hospital cleaning had been carefully explored, because good discipline was maintained in that hospital and it had been possible to reach a high level of performance even with personnel of low intellectual caliber.

Where there were no such institutions, it would be advisable to initiate a system of exchange with the more developed countries or to obtain assistance from them, rather than have the Pan American Sanitary Bureau organize training centers. His country, for instance, had thought of building several hospitals but, fearing that it would not obtain trained personnel, it had introduced a system of exchanges with United States university hospitals in order to send to the latter lower-grade personnel, including cleaners, maintenance workers, X-ray assistants, etc., for work and training in the operation of a well-organized hospital. That procedure had been found to be the most effective and productive. The Government of Panama paid the wages of the trainees in those university hospitals, and he lauded the excellent cooperation which his country had received from the United States universities and the great enthusiasm with which they took part in the exchange.

Dr. RISTORI (Chile) said that the problem of training nursing auxiliaries had been a source of concern to the authorities of his country's National Health Service since its foundation. In 1958, a three-year agreement had been signed between the National Health Service, the Pan American Health Organization, and UNICEF for the purpose of training nursing auxiliaries for field activities, and in 1962 a further agreement had been concluded concerning the nursing auxiliaries program. For the purpose of regulating and supervising the formulation of training programs, the necessary action had been taken as regards determining the educational qualifications of such auxiliaries, approval by the Ministry of Public Education of the equivalent of the present course conducted by the National Health Service, the awarding of an official certificate, the institution of a national register of nurs-

ing auxiliaries, and the recognition of particular courses.

Special regulations were being drafted for improving and extending the operation of the courses throughout the country. Some 1,000 auxiliaries were trained at those courses each year and it was hoped that, in less than five years, all the untrained personnel serving in the field and in hospitals would be renewed. Such auxiliary workers would not replace but supplement the university-trained nurses.

In Chile there was only one nurse for every two physicians and the high-level training required for nurses was a slow process because four years of university studies were required after high school. It was therefore necessary to supplement that personnel with auxiliaries working under the supervision of a professional nurse, the university-trained nurse.

Dr. ALONSO MENÉNDEZ (Cuba) recalled that, in order to develop its four-year plan (1962-1965), prepared in 1960-1961, Cuba had had to increase its auxiliary personnel substantially and that, once it had taken possession of the national wealth, the training plan had begun. The plan had started with a primary-school qualification. In those years, more than 11,500 people had been successfully trained and, in 1964, 2,404 auxiliaries had graduated. Currently there were more than 3,000 trainees.

One of the main problems that had arisen was supervision, but it had been improving with the establishment of schools and faculties of medical auxiliaries.

He stressed the possibility of setting up training centers close to places of work, as had been done in Cuba. While not every problem had been solved, great headway had been made, and the problems connected with wage difficulties and political changes, mentioned during the Council meeting, might well not arise in his country.

Dr. AGUILAR RIVAS (El Salvador) observed that the great importance of the item had been rightly emphasized. The training and improvement of auxiliary personnel were the very factors which would lead to better medical care in the Latin American communities. In view of those considerations and of the fact that the Pan American Sanitary Bureau apparently had further funds for health promotion, its assistance would be very valuable in developing the program under discussion.

As a result of the activities in the health demonstration area, a Training School had been founded in El Salvador, with very good results, in 1951 and provided the necessary training for local and regional personnel. The School had made it possible to promote the training not only of auxiliaries whose services had formerly been limited to health services but also of new auxiliary workers for hospitals. It had also been used for the training of sanitary inspectors, auxiliary statisticians, dieticians, and instructors in public health. Hence it represented, in his opinion, perhaps one of the quickest and cheapest ways of training that type of personnel, as compared, in terms of time and cost, with the training of professionals. Training was the backbone of any health plan and his country's Training School was directing and carrying out the central, regional, and local in-service training programs.

The above-mentioned training program was also a source of employment because, even though in his country too it was the social security institutions which, by offering better employment conditions and wages, attracted most of the personnel, it was always the community which used its services. In addition, there was another training plan under which people whom it was not practical to train locally were sent abroad for special study courses.

Dr. MARTÍNEZ (Mexico) said that he was gratified at the interest shown by all members of the Council in an item that was of such great importance for public health programs. The Delegation of Mexico had followed the debate with particular satisfaction because it had had the honor of expressing that concern by suggesting, at the meetings in 1964, that it would be advisable to take up such an important question.

He thought that the root of the problem of auxiliary workers lay in a certain inability of professional staff to understand them and to utilize their sources properly. As the professional worker developed his personality, his capacity to confront new situations and to adapt to any circumstances increased. The auxiliary workers, on the other hand, lacked that adaptability because they were usually people with little education who found it difficult to accustom themselves to cultural conditions different from their own and to unknown problems. It would therefore be dangerous to study the item if

there was even a suggestion that rules ought to be established. There was no disputing the fact that, since the auxiliary worker's personality could not be adapted to any but his own cultural environment, there was no point in laying down regulations. He therefore thought that it would be more profitable to state some general principles that would serve as a guide to professionals in formulating training programs for auxiliary personnel. He also suggested that it would be advisable for the proposed study group to include one or more auxiliary workers; otherwise the discussion would be academic and lead to no practical result.

He then submitted for the consideration of the representatives a draft resolution proposing that the Council should take note of the fact that the recommendation adopted at its XV Meeting, to the effect that a study should be made concerning the training of auxiliary personnel, had been complied with, and requesting the Director to report in due course to the Governing Bodies of the Organization on the conclusions reached at the proposed meeting of national authorities experienced or interested in the subject, with a view to framing a policy for the training of such personnel.

The PRESIDENT announced that the draft resolution presented by the Representative of Mexico would be circulated and put to the vote at a later session.[29]

Dr. FERREIRA (Brazil) congratulated the Director and Dr. Díaz-Coller on their excellent exposition of a problem which had aroused such lively interest in the Council. He stressed the remarks made by the Representatives of Venezuela and Cuba concerning the need for the training of auxiliary personnel to be supervised by superior and more highly skilled organizations, because the problem was of the utmost importance, especially in such a vast country as Brazil, where there was a natural tendency to train auxiliary workers on such a scale that it was impossible to supervise them adequately. In such circumstances they became too independent and failed to do their work properly or adopted a hostile attitude to the objective pursued.

He also drew attention to the need for such workers to be locally recruited in order to avoid problems of adaptation. In Brazil's experience, one of the major problems involved in obtaining such auxiliary workers was insecurity of tenure. It was imperative to pay adequate wages if security of tenure was to be achieved. In conclusion, he remarked that, while the training of such personnel was a great public health problem, it was imperative to avoid the easy way out, namely, to train a large number of auxiliaries quickly without adequate supervision or remuneration.

Dr. PINEDA (Honduras) said that eight courses for nursing auxiliaries had been organized in his country with the assistance of PASB and UNICEF: seven for auxiliaries in environmental sanitation; one for laboratory auxiliaries; and, recently, an intensive course for statistics auxiliaries.

Honduras was also experiencing serious difficulties in the matter of auxiliary workers; not only was there a lack of supervision but approximately 50 per cent of them looked for work in the social security institutions. Unfortunately there were few nursing graduates in his country, so that special importance had been attributed to the training of auxiliary workers, not only in public health but also for hospitals, since most of the 18 existing in the country had no trained staff. Hence it was necessary for Honduras to continue organizing courses of that type and to continue receiving the technical collaboration of the Pan American Sanitary Bureau and material assistance from UNICEF, with a view to completing the training of auxiliaries in nursing, environmental sanitation, and laboratory work.

Mr. RIVERA (Costa Rica) said that, owing to the population explosion in Latin America, the training of medical and paramedical professionals had to be intensified. The lack of personnel and the time it took to train professionals of high caliber, together with the large increase in population, made it necessary, generally speaking, to lower the level of medical services rendered to the population. In that connection, auxiliary workers were indispensable. The universities had not contributed to the training of any given class of professionals or subprofessionals and had concentrated mainly on training the highest level of personnel. Only the respective ministries of health and sometimes other organizations concerned themselves with the subprofessional class. He therefore thought that, in the next few years, a large number of auxiliary workers of the various levels should be trained in order to meet

[29] See fifteenth plenary session, p. 194.

the vital needs of the population, especially in rural areas.

He was confident that the report referred to by Dr. Díaz-Coller could be thoroughly scrutinized at one of the meetings and urged that attention should be paid not only to the need for auxiliary personnel as a whole but also to the different levels of professional training.

Dr. CASTILLO REY (Venezuela) considered that reservations and provisos were out of place when dealing with a category of personnel which was necessary and would become even more so in the future. He repeated that agreement should be reached on the meaning of the term "auxiliary workers" in connection with general public health programs, their fields of action, and the level of multi-purpose training which they could be given, and on the scope of its application.

The multi-purpose aspect seemed to him indispensable because, since the population of the countries of the Americas was so widely scattered, they could scarcely afford the luxury of training a host of people to perform as many functions as the programs required, i.e., one person for each activity. It would be logical for them to be able to undertake a series of activities.

The program of simplified medicine being carried out in his country involved the use of selected techniques which were simply to apply, even when they were to be utilized by physicians. To the extent that the limited number of professionals available and the relative shortage of resources and communications allowed, duly trained auxiliary workers could be trusted to apply those techniques for the purpose of attending to the inhabitants of the more remote communities. Lastly, it was essential to lay down clearly a series of concepts, so that the process could develop homogeneously, without overlooking the particular features of each country but remembering that most of them had similar socioeconomic or political characteristics.

Dr. PICHARDO (Dominican Republic) said that the problem in his country was similar to that prevailing in the rest of the Region, but he wished to emphasize three fundamental aspects: international assistance for the training of auxiliary personnel; the multi-purpose aspect that such training should have—a point on which he fully agreed with the Representative of Venezuela; and the astonishing desertion of such workers and the steps which should be taken to remedy the situation. It was essential to think of the organization of the community, because it was the community which would benefit directly from the services of the auxiliaries. Even in the matter of adequate remuneration, the community could help to solve the problem if the Department of Public Health was unable to offer an appropriate wage. It might thus be possible to avoid the desertion of public health workers and their recruitment in other activities which offered them better terms.

Dr. HORWITZ (Director, PASB) congratulated the Council on its discussion which had been extremely instructive and whose substance would be transmitted to the group which would analyze the problem in detail on the basis of Dr. Kesić's report, as mentioned by Dr. Díaz-Coller. The observations made in the Council were, to his mind, as valuable as those in the information obtained by the Bureau's consultant during his visits to some countries.

The problem would obviously have to be analyzed from the point of view of the existing number of auxiliaries, their function, and the quality of their training—three aspects which could not be separated from one another. As some representatives had pointed out, the subject should be examined in its correlationship with the professionals who would have to supervise the auxiliary personnel. Further analysis of the correlationships led to the concept of the over-all or partial programming of the health function. In his view, the aforesaid group would have to study all those aspects in order to offer each Government suggestions in line with its own particular situation. The progress made in the matter had been tremendous although, generally speaking, there was a tendency to give prominence to the negative factors and to forget the positive ones. It was sufficient to look at Table 25 in the Annual Report for 1964 [30] to appreciate the great headway made in the nursing field between 1954 and 1964 in Guatemala. It had also been pointed out that 1,000 auxiliaries were being trained every year in several countries as part of their normal programs, and the fact that the Delegation of Mexico had chosen to raise the subject meant

[30] *Official Document PAHO* **63**, 73.

that there already existed a rather solid fund of experience in the Continent. Some rather archaic traditions bearing on the responsibilities that could be assigned to such employees had been revised, and that very fact revealed the stage of maturity that the countries had reached in adopting a logical approach to a complex problem. Reference had also been made during the debate to university tradition and to the picture that university-trained professionals had formed of the extent of their functions, which did not always take into account the urgent needs of the rural environment and the more deprived communities.

The substance of the debate, in all its depth, would form part of the material to be scrutinized by the study group, and he was confident that as comprehensive a report as possible would be presented at the forthcoming Pan American Sanitary Conference, a report that would embody the recommendations made during the discussion and serve as a basis for the policy to be followed by the Organization in a field in which it had already provided advisory services.

With regard to the presence or absence of certain advisers in the expert committees, he stated that the Organization had been honored by the collaboration, in the Advisory Committee on Planning of Hospitals and Other Health Services, of Dr. Agustín La Corte, Chief of the Programming, Personnel, and Equipment Office, Planning Unit, Ministry of Health and Social Welfare of Venezuela and in the Study Group on the Coordination of Medical Care in Latin America, by the presence of Dr. Arturo Vasi Páes, Director of the Programming Office of the National Social Security Fund of Peru.

Item 21: Selection of Topics for the Technical Discussions during the XVII Pan American Sanitary Conference, XVIII Meeting of the Regional Committee of WHO for the Americas (*continuation*)

Establishment of a Working Party

The PRESIDENT announced that, since more than three topics had been proposed for the Technical Discussions, he would follow the procedure approved by the Council and appoint a working party to make the selection. He proposed that the party should consist of the Representatives of Brazil, Colombia, Mexico, Panama, and Peru and that it should meet as soon as possible with a view to submitting the topic selected to the Council for consideration at the next plenary session.

It was so agreed.

The session rose at 12:40 p.m.

FOURTEENTH PLENARY SESSION

Wednesday, 6 October 1965, at 3:25 p.m.

President: Dr. RAYMUNDO DE BRITTO (Brazil)

Item 21: Selection of Topics for the Technical Discussions during the XVII Pan American Sanitary Conference, XVIII Meeting of the Regional Committee of WHO for the Americas (*continuation*)

Report of the Working Party

The PRESIDENT called the session to order and announced that the report of the working party on the selection of topics for the Technical Discussions during the XVII Pan American Sanitary Conference would be presented to the Council for its consideration.

Dr. FERREIRA (Brazil) read the report, in which the following three topics were proposed for the Technical Discussions: (1) Means for Promoting and Making Effective the Coordination between the Services and Programs of Ministries of Health,

Social Security Institutes, and Other Institutions That Conduct Activities Related to Health; (2) How to Extend the Provision of Health Services to the Rural Population; and (3) Eradication of Diseases.

The PRESIDENT suggested that consideration of the item should be deferred until the next session.[1]

Item 19: Technical Discussions: Methods of Improving Vital and Health Statistics (*continuation*)

Report of the Rapporteur

Dr. RISTORI (Chile) thanked the Directing Council for the confidence placed in him by appointing him to act as Rapporteur of the Technical Discussions. He was also grateful for the cooperation afforded to him by the rapporteurs of the three working parties and the Bureau personnel. He then read the report of the Technical Discussions contained in Document CD16/DT/9 [2] and presented the following draft resolution:

THE DIRECTING COUNCIL,

Having considered the Final Report of the Technical Discussions on "Methods of Improving Vital and Health Statistics";

Considering that this report provides a summary of the seven working documents and the views expressed by the participants; and

Considering the urgent need for the institution of the methods recommended to provide the basic data needed for planning and administration of health programs,

RESOLVES:

1. To take note of the Final Report and the recommendations made in the Technical Discussions on "Methods of Improving Vital and Health Statistics."

2. To recommend to the Organization and to the Governments that efforts be made immediately to implement the recommendations for actions to rapidly develop satisfactory statistics for planning and administration of health programs.

3. To request the Director to publish the working documents and the Final Report of the Technical Discussions and to give them wide distribution.

Mr. RIVERA (Costa Rica) observed that, although the report was, in his opinion, sufficiently comprehensive, it did not attribute enough importance to the statistical offices and systems in the ministries of health. Actually those units should be the agencies that processed the basic information which the ministries required and which were often scattered throughout the country.

Dr. AGUILAR RIVAS (El Salvador) thought that the functions of the services responsible for the simple preparation of statistics should be properly laid down so as to prevent them from being given assignments, such as the determination or computation of percentages in connection with a given activity, which should be the responsibility of the research services.

Mr. LUTCHMAN (Trinidad and Tobago), referring to Section 3 [3] of the report, stated that in his country the Ministry of Health was not responsible for the registration of births and deaths. Which Ministry should be charged with that was a matter for the individual countries to decide. However, he felt that more emphasis might be given to the role to be played by law, in placing an obligation to report vital events not only on the individuals concerned, such as parents or relatives, but also on the various professionals involved, such as midwives, qualified or unqualified, persons in charge of health offices where children went to be vaccinated, and the clergy. The latter could help especially in the rural areas, where the gathering of statistics was difficult but the people did come from time to time in contact with members of the church.

The PRESIDENT announced that the draft resolution proposed by the Representative of Chile would be voted on at the next session.[4]

Item 31: Procedure for the Presentation of Reports to the Directing Council

Dr. DROZNY (Chief, Office of Evaluation and Reports, PASB) referring to Document CD16/9 [5] on the item, said that the 52nd Meeting of the Executive Committee had analyzed [6] the procedure to be followed for the presentation of reports to the Directing Council on the basis of a document [7] which had specified the nature and purpose of each of the regular reports.

On that occasion, several Committee members had expressed their satisfaction with the manner in which the information was presented on the activities undertaken and with the progress achieved by the Bureau in that field and had remarked that the system of program budgeting and evaluating

[1] See fifteenth plenary session, p. 192.
[2] *Scientific Publication PAHO* **128.**
[3] *Ibid.*, p. 6.
[4] See fifteenth plenary session, p. 194.
[5] Mimeographed document.
[6] *Official Document PAHO* **64,** 134-145.
[7] Document CE52/15 (mimeographed).

the results of each of the projects should be continued.

He then referred to the progress registered in project evaluation, which was evident from the description of the work accomplished in each project and recorded in the Director's last Annual Report.[8] He added that, although complete information was not yet available, very satisfactory headway had been made. The system of reporting and evaluation followed in 1965 held out certain promise of rapid improvement in the years to come.

Lastly, he stated that consideration was being given to the possibility of applying modern techniques for channeling the information received concerning projects in such a way that it could be used not only for evaluating performance and requirements but also for reformulating the programs.

Dr. QUIRÓS (Peru) recalled that, when examining the program and budget, the Directing Council had expressed the view that the item had not been given sufficient attention. He had been deeply interested in it both at the XV Meeting of the Council and subsequently at the 52nd Meeting of the Executive Committee in April 1965, since he believed that some necessary improvements should be made in the presentation of the program and budget.

He pointed out that only in Table 6 of *Official Document 61* (*Proposed Program and Budget*) was the functional or program budget presented in a comprehensive form, which included all the funds—not just those of the Pan American Health Organization and the special accounts—and an analysis of each project as a whole but not by countries. In each of those projects, for example the one on zoonoses, the amount budgeted was given together with the relevant percentage of the total budget, but another part of the document (from page 119 onward) contained the detailed tables showing the implementation of the budget, which followed the traditional procedure. If the budget was to be given the operational character which, in his opinion, it should have, it should follow the sequence of Table 6. In support of his argument, he cited a few examples, adding that he had earlier asked certain questions but that the answers had not satisfied him. Thus, when he had said that it was impossible to have withdrawn the appropriation for a plague control project in Ecuador, itemized in Annex 7 concerning projects desired by Governments and not included within the PAHO/WHO program and budget estimates for 1967 (p. 245), as had also been other funds intended for smallpox control, he had been told to note that the items in question were marked with an asterisk which indicated (page 249, footnote) part of a project which exceeded the budget. Reference to Table 6 would show that no provision was made for plague control, although it was probably included under the section for zoonoses.

Limiting himself to the specific project of the two countries interested in the matter, he remarked that he had found no reference on page 73 to the funds earmarked for plague control in Ecuador but had finally found the item on page 176 and verified that the amounts provided for that purpose were $2,796 in 1965, $14,076 in 1966, and $22,865 for 1967, and that the figures for the same activity in Peru appeared on page 178. As he had stated at a previous session, the world's largest focus of plague was in Ecuador and Peru and the amounts earmarked for controlling it could not be regarded as adequate. The budget should be prepared by functions or programs in order to avoid any confusion, and the items should be arranged in the same way. The representatives would thus be able to understand the itemized investment of resources more easily.

Dr. AGUILAR HERRERA (Guatemala) said that, notwithstanding the remarks made by the Representative of Peru, the mere perusal of the documents before the Council showed that striking headway had been made in the presentation of reports. It was to be hoped that their preparation would be gradually improved, which would facilitate the work of the Directing Council and of the Executive Committee. Those bodies could carry out their analytical work more thoroughly if they had clear and precise documents.

The work of evaluation was complex in view of the multiplicity of factors to be taken into account and the number of figures to be compared. The Bureau had managed to improve that machinery in recent times. He therefore suggested that the Council should express its satisfaction at the results achieved and formulate a recommendation to the Director requesting him to continue the efforts already begun. He announced that he intended to submit a draft resolution on the subject to the Council.

[8] *Official Document PAHO* **63**, 121-236.

Dr. WILLIAMS (United States of America) said that his Delegation admitted to a certain frustration at times in considering what, after all, were complex program and budget proposals, requiring careful analysis to determine what the position of one's country should be on particular aspects. However, he felt sure that the staff must have experienced an even greater degree of frustration in the preparation of the budget, because that was certainly more difficult than reading and reviewing it.

He had been interested to hear the references to the increasing use of computer techniques. Such techniques might provide an opportunity to give the Governments much useful information. Budgetary data could, of course, be put on magnetic tape so as to permit every conceivable breakdown to be made rapidly and economically. It might not be practicable to include all of the resultant tables in a volume that was already about two centimeters thick, but they might be provided, *in extenso*, at the request of a particular ministry of health. He would be glad to have the opinion of the staff on whether that was a feasible solution to the problem under discussion.

Dr. HORWITZ (Director, PASB) considered that the Bureau had made great strides in the form of presentation of its budget and remarked that it was impossible to summarize in a single document what had happened the year before, i.e., what the auditors believed to have been the financial mechanism for disbursing funds, and what it was proposed to achieve during the two following years. Such a document would be, to say the least, extremely complex and would not help to clarify the question.

What was apparently troubling the Representative of Peru was his belief that the Bureau's program was not being executed in accordance with the so-called functional budgeting technique. He recalled that the Governments had repeatedly expressed their wish to know as accurately as possible how much of the total budget was going to be invested in each country, in a given period, and for what project. The budget was therefore presented by programs and the policy to be followed for each function was described; each program was then classified by countries, as the Council had agreed should be done. If, in compliance with the Peruvian Representative's comments, the Council wished the whole document to be presented in terms of activities by programs, the Bureau would abide by its instructions.

He felt, however, that the present system fulfilled the two objectives and was much more explanatory. In addition, if the budget, in its current presentation, was carefully correlated with the Annual Report and the form in which the resources were disbursed, as appeared in the Report of the External Auditor, the necessary material would be available for evaluating or criticizing the work done in a given year.

The procedure adopted was a dynamic one and, as Dr. Drobny had mentioned in presenting the document under consideration, the possibility was being explored of using electronic techniques for data analysis; those techniques would be feasible only if the existing budget structure were retained.

The use of computers would make it possible to correlate a larger number of variables. He doubted whether, in order to gain a clear idea of the percentage distribution of activities by function, very elaborate calculations should be made which might complicate the situation as a whole.

As regards the problem of plague, concerning which the Representative of Peru had expressed such concern, he stated that the Bureau would proceed to increase the resources earmarked for that purpose, as specified in the projects to which that Representative had referred. It should be borne in mind that the focus on the border between Peru and Ecuador had been in existence for years. There were many unknown epidemiological factors, especially as regards the jungle carriers of plague. The Bureau had been making arrangements to carry out, with the collaboration of an institution of the United States of America, the detailed study of the dynamics of selvatic plague in that region, but so far the arrangements had not yielded the results anticipated. Only the conventional control methods were therefore being applied and the epidemic foci or outbreaks still occurring in that zone were being eliminated to a certain extent. He announced that the Bureau would endeavor in 1966 to intensify its economic aid, if possible on a larger scale than provided for in the proposed program and budget estimates.

Lastly, he thought that the Council should take a definitive decision on the system that should be followed in the future for the presentation of the program and budget estimates, i.e., whether they

were to be prepared in terms of functions or in the mixed form, as was done currently. He stated that he would continue to improve the presentation so that the data improved in both quantity and quality and so that the Council could form an increasingly sounder opinion of the programs, budget estimates, and performance for each period.

The PRESIDENT announced that the draft resolution submitted by the Representative of Guatemala would be circulated and voted on at the next session.[9]

The session was suspended at 4:30 p.m. and resumed at 5:00 p.m.

Dr. QUIRÓS (Peru) thanked the Director of the Bureau for his explanations and stated that the budget estimates had to be evaluated in terms of numbers. He then referred to the budget structure and to the headings of Table 6 of *Official Document 61*, remarking that, up to page 34 of the document, the same sequence had been followed in describing the situation for each item and the amounts allocated. He suggested that, instead of the description by headings, the first part could be broken down and classified by projects, specifying the project and country to which each applied. The Governments would thus understand more easily and clearly what was being done in their own countries, what was being accomplished in the intercountry programs, and all the other information.

He also thought that, if the same procedure was followed in the last part, where the projects were described and the objective, probable duration of the programs, assistance provided, and the work done were specified, it would be easy to make comparisons.

He then referred to the Report of the External Auditor and stated that it contained an analysis by headings rather than programs, since there was a great difference between transferring resources allocated for field activities to commitments of the Governing Bodies, for example, and transferring funds for communicable diseases to health care. He recognized that great progress had been made in the process of preparing such documents and agreed that they should recommend that the Director provide increasingly more comprehensive and detailed documentation so as to facilitate a better evaluation of the way in which the projects were developing. He suggested that the draft resolution to be submitted to the Council should include a specific reference to the presentation of the budget.

Mr. RIVERA (Costa Rica) stated that in his country program budgeting had led, in the first year the system had been applied, to such administrative rigidity that it had impeded the development of certain activities. The system had therefore been changed in the course of time and the programs had been given more or less specific headings which made it possible to control expenditure. The funds were administered on the basis of more general headings which allowed greater operational flexibility when circumstances so required.

To his mind, the Bureau had prepared a detailed budget by countries while managing to retain the flexibility required in order to operate efficiently. While the procedure applied was not perfect, noteworthy progress had been made.

Dr. AGUILAR HERRERA (Guatemala) explained that the draft resolution submitted was designed to support the Executive Committee's view that continuing efforts should be made to improve the procedures and to continue program evaluation which, moreover, coincided with the wishes of the Representative of Peru.

Item 33: Air and Water Pollution in Latin America

Dr. HOLLIS (Chief, Environmental Sanitation Branch, PASB), in presenting the report on the item (Document CD16/17),[10] stated that it had been prepared in response to proposals [11] made at the 51st Meeting of the Executive Committee in September 1964. The report attempted to outline the status and trends of air and water pollution—including suggested program activities to assist and support the Governments.

The report stressed the rural-urban migration trend, the expanding industrialization, and technological advancements as the major factors influencing air and water pollution. It was expected that urban population densities would increase, as would the types and volumes of industrial wastes. Hence, air and water pollution would broaden, would become more pronounced, and would be of greater significance to the health and well-being of urban peoples.

[9] See fifteenth plenary session, p. 194.

[10] See Annex 8, pp. 396–399.

[11] *Official Document PAHO* **60**, 242.

Also included in the report were the health-related problems of air and water pollution, which stressed the need for being realistic in developing regulatory controls so as not to restrict industrial and economic growth, and pointed out the importance of developing scientific intelligence as a guide in determining when and how to apply corrective actions and remedial measures.

The speaker went on to state that the report described the Organization's current activities in air and water pollution and suggested broader plans of action. A continental network of air sampling stations was proposed, which would include, initially, 10 cities in Latin America. As for water pollution, consultant missions had been suggested to assist Governments in analyzing the status and trends of such pollution and in establishing the necessary surveillance to determine the type and extent of essential regulatory controls. The report suggested that the Organization might also extend its system for the collection and dissemination of technical information as a means of keeping the Governments apprised of research findings and to assist them in making full use of education and training programs to provide competent technical manpower, so essential for air and water pollution work.

The summary of the report outlined the problem, the trends, and the needs. Air and water pollution was a by-product of industrialization and economic growth. In Latin America, air and water pollution was already a significant health-related problem in a number of metropolitan centers, and was increasing in the majority of the Latin American countries. The health and well-being of the populations required that air and water pollution be kept within reasonable limits. Necessary control measures should therefore be developed on a practical basis and should be applied to maintain a proper balance in protecting the health and well-being of the peoples and to support the orderly industrial and economic growth of communities. To assist the Governments with that difficult task should be an objective and a program mission of the Pan American Health Organization.

Mr. RIVERA (Costa Rica) congratulated the Director and the Bureau for submitting the item for the Council's consideration and observed that the growth of Latin America made the problem of wastes daily more acute and that even the industrialization plans provided for the use of the most up-to-date industrial processes for treating waste material. It was becoming increasingly difficult to treat wastes by the conventional methods. For that reason, the advisory services of highly-trained personnel were imperative. In that connection he recalled the prompt, timely, and efficient advisory services provided by the Bureau to his country in the particular case of a chemical industry which had been established in Costa Rica as a regional enterprise and which had threatened—or at least, it was feared, might have threatened—to destroy the fishery resources of the Pacific coast which provided a large part of the sea products used to supplement the population's low consumption of animal protein.

The document submitted dealt in general terms with a problem which required adequate technical assistance, as far as many Latin American countries were concerned. He would therefore present a draft resolution on the subject. The large-scale industrial and demographic growth of Latin America was leading the countries of the Hemisphere into a situation through which the most developed countries such as the United States of America had already passed. The solution had required vast investments and efforts. Little had so far been done in the developing countries to cope with the problem. Since each country had its own peculiar characteristics, the advisory services required would also have to vary, and the needs and economic possibilities of each country would also have to be taken into account with a view to raising the living levels of their respective populations.

Dr. RISTORI (Chile) joined the Representative of Costa Rica in praising the Director of the Bureau and his colleagues for the attention given to a problem to which in the past the Latin American countries had not ascribed the importance it deserved. As the industrialization of the Americas progressed, such problems increased in scope and magnitude. In recent years they had taken on serious aspects in Chile as regards both water and air pollution.

So far as the quality of water was concerned, the regulations in force in Chile were very similar to those existing in the United States of America since 1946. The urban population supplied with water amounted to four and a half million people, or 75 per cent of the total population. The Department of Sanitary Works was responsible for water control and had a central laboratory with installations at Santiago and eight laboratories distributed

over the various zones, with sufficient capacity for carrying out the necessary physical, chemical, and bacteriological tests. The National Health Service, acting through the Bacteriological Institute and some zone laboratories, kept a check on the quality of the water in the drinking water systems. In the near future some 400 rural drinking water systems would be put into operation and would be under the surveillance of the general health service, pursuant to an agreement with the Inter-American Development Bank. Chile would continue to enlarge the public and private drinking water systems. In order to cope with the further demand for control and to enable the National Health Service to exercise direct jurisdiction over the rural drinking water systems, that responsibility would be delegated to the zone laboratories whose resources would be augmented accordingly.

A start had been made in the direction of standardizing the presentation of data, for the purpose of facilitating the bacteriological, physical, and chemical control of water. Standard forms were available and were being distributed. A review of sampling techniques would make it possible to improve all the water services.

As regards the pollution of watercourses by sewage and industrial wastes, the National Health Service would be responsible for reviewing the plans of new factory installations and drainage and would lay down regulations to prohibit the pollution of watercourses. Those efforts had been strengthened since mid-1961 when an agreement had been signed between the National Health Service and the University of Chile for the use of the physical and chemical laboratory of the School of Health in Santiago. Studies carried out in that laboratory had formed the basis for certain mandatory conditions imposed on particular industries. The tanning, iron and steel, and chemical industries, factories, manufacturing stoves, and sugar refineries were subject to particularly strict control. He also mentioned the control exercised over the pulp plants in the Concepción area which discharged their wastes into large watercourses and which produced an annual total of 200,000 tons of pulp. Those factories had been responsible for the large-scale pollution of water.

In order to improve the existing situation and to avoid problems created by the large-scale disposal of sewage and industrial wastes by big complexes, Chile had drawn up the following plan: it intended to set up a national commission for the prevention of water pollution and to provide the provinces with an adequate number of engineers and technical staff with the relevant specialized training and the resources necessary for them to perform their duties. In addition to their functions in that field, they would collaborate in sanitation programs. The authorities also intended to increase the allocations to the physical and chemical laboratory of the School of Health, which was equipped to study the controls and apply the most suitable schemes for preventing water pollution. Lastly, the construction of waste-water treatment plants would be promoted to the extent that available resources allowed.

As regards air pollution, a serious problem might arise in three cities: Santiago, Valparaíso, and Concepción, but the weather conditions in Valparaíso and Concepción and their relatively low industrial density reduced the magnitude of the problem. Nevertheless, the matter was more serious in Santiago, which had two million inhabitants and 60 per cent of the country's industries in its urban areas, not to speak of approximately 150,000 motor vehicles. Santiago was situated at the bottom of a valley, surrounded by mountains of over 2,000 meters; the total rainfall was of the order of 300 mm per year; average wind velocity was less than two kilometers per hour; vertical ventilation was very poor owing to the existence of pollution elements which remained in the air in concentrations sufficient to constitute a serious threat.

The National Health Service had been dealing with the problem for several years and had focused attention on the excessive production of smoke which could be determined even without specialized equipment. Whereas the first measurements of sedimentary dust made in 1962 had resulted in a figure of 20 tons per Km^2 per month in the central part of the city, the figure was now only 5 tons per Km^2 per month, so that it could be said that the problem in Santiago was only one fourth as serious as it had been before.

The program had assumed new dimensions with the installation in Chile of the Institute of Occupational Health and Air Pollution Research, which had begun its operations in 1964 with the technical advisory services of the Bureau and the financial assistance of the United Nations Special Fund

which had contributed $400,000 for the purpose. The main functions of the Institute were research and teaching. It also acted as the central laboratory of the National Health Service for those purposes. The financial assistance had made it possible to purchase specialized equipment and to recruit an expert in the meteorological aspects of the problem. As a result, more comprehensive measuring of better quality had begun, the results of which might be known in a few months' time. The first course for experts in the prevention of occupational hazards and air pollution was in progress and would last five months. It was being attended by 14 Chileans and two foreign students who had been awarded fellowships by the Pan American Sanitary Bureau.

In conclusion, he stated that the Bureau had proposed that Santiago should participate in an air pollution measurement program that would cover 10 Latin American cities. That extremely valuable initiative deserved every support and constituted an obligation for Chile which it gladly accepted.

The session rose at 5:40 p.m.

FIFTEENTH PLENARY SESSION

Thursday, 7 October 1965, at 9:20 a.m.

President: Dr. Raymundo de Britto (Brazil)

Later: Dr. Roderick Esquivel (Panama)

Item 21: Selection of Topics for the Technical Discussions during the XVII Pan American Sanitary Conference, XVIII Meeting of the Regional Committee of WHO for the Americas (*conclusion*)

Topics Selected by the Working Party

The President opened the session and announced that the working party on the selection of topics for the Technical Discussions during the XVII Pan American Sanitary Conference, XVIII Meeting of the Regional Committee of WHO for the Americas, had selected the following three topics, from which it was necessary to choose one:

1. Means for Promoting and Making Effective the Coordination between the Services and Programs of Ministries of Health, Social Security Institutes, and Other Institutions That Conduct Activities Related to Health.
2. How to Expand the Provision of Health Services to the Rural Population.
3. Eradication of Diseases.

Dr. Blaksley (Argentina) observed, with reference to the third topic, that, in the interest of clarity, it would be better to replace the expression "Eradication of Diseases" by "Eradicable Diseases." He recalled that in Dr. Fred L. Soper's time, the terms "control" and "eradication" had given the Bureau a great deal of difficulty and that the programs to combat malaria and *A. aegypti* had made and continued to make heavy demands on funds. He declared that his country's Delegation would not object to voting for the topic "Eradicable Diseases."

Dr. Esquivel (Panama) observed that, as the third topic had been suggested by the Delegation of the United States of America, Dr. Williams might possibly wish to provide some explanation.

Dr. Williams (United States of America) stated that the intention had been to suggest inclusion of an item of a general nature as a subject for the Technical Discussions. It was thought that the epidemiological aspects of programs for the eradication of diseases in general, but not of any particular or special one, met that requirement. It had not been anticipated that the discussion would revolve around the eradication of smallpox or malaria or any other disease, but rather on the basic principles

of epidemiology and of program organization, planning, and execution which applied to the eradication of any disease.

Dr. FERREIRA (Brazil) thought that the doubt felt by the Representative of Argentina was largely confined to the epidemiological significance of the topic. He considered that Dr. Williams' explanation had been very timely and that the proposal to include a survey of eradication as a topic for the Technical Discussions was an extremely important one because it would in fact provide a new approach to public health activities and help reverse the growing tendency to attempt to eradicate what was ineradicable and to employ eradication methods which were in fact not eradication methods at all. In the view of the Delegation of Brazil that trend would in itself provide sufficient justification for the presentation of the topic at the Technical Discussions, a topic that would give rise to ample discussion on the general aspects of the principle of eradication.

The PRESIDENT announced that the vote on the selection of the topic for the Technical Discussions would be by ballot. He accordingly appointed Dr. Esquivel (Panama) and Dr. Williams (United States of America) as tellers.

The vote was held and subsequently Dr. SUTTER (Assistant Director, PASB) announced that, according to the tellers, 21 votes had been cast, so that 11 votes would give the required majority.

Decision: By 13 votes in favor the topic "Means for Promoting and Making Effective the Coordination between the Services and Programs of Ministries of Health, Social Security Institutes, and Other Institutions That Conduct Activities Related to Health" was selected for the Technical Discussions to be held during the XVII Pan American Sanitary Conference, XVIII Meeting of the Regional Committee of WHO for the Americas.[1]

Item 27: Status of Smallpox Eradication in the Americas (*conclusion*)

Draft Resolution Presented by the Working Party

Dr. SUTTER (Assistant Director, PASB) read the new draft resolution presented by the working party, with the amendments proposed at the thirteenth plenary session, the text of which was as follows:

THE DIRECTING COUNCIL,

Having considered the report of the Director on the status of the smallpox eradication program in the Americas (Document CD16/29);

Bearing in mind the resolutions of the XIII, XIV, XV, and XVI Pan American Sanitary Conferences on the eradication of smallpox, as well as its own previous resolutions, especially Resolution XLI approved at the XV Meeting;

Considering that smallpox is an eradicable disease and that effective techniques and means are available for that purpose; and

Bearing in mind Resolution WHA18.38, which declares the world-wide eradication of smallpox to be one of the major objectives of WHO,

RESOLVES:

1. To declare smallpox eradication in the Americas to be one of the major objectives of the Pan American Health Organization.

2. To reiterate and confirm the previous resolutions of the Governing Bodies of the Organization to the effect that smallpox must be eradicated from the Hemisphere as soon as possible.

3. To remind the Governments that the organization and execution of national smallpox vaccination programs is a specific obligation incumbent upon them.

4. To recommend to the Governments that, side by side with intensive vaccination programs, they organize activities aimed at maintaining a high level of immunity among the population and that in countries where the eradication campaign has been completed but where the corresponding maintenance operations have not yet been initiated, they begin them as soon as possible.

5. To urge the Governments of countries in which there is no smallpox and in which the level of immunity of the general population is low to institute, by such means as they deem appropriate, a program for progressively increasing the vaccinated proportion of the population.

6. To urge the Governments to intensify their epidemiological surveillance services for the early detection and investigation of suspect cases of smallpox and for the prevention of the spread of the disease, and to recommend that to that end, the Governments take special measures for the clinical, laboratory, and epidemiological confirmation of suspect cases of smallpox occurring in their territories.

7. To request the Director of the Bureau to prepare an estimate of the financial and other resources which the countries and the Organization require for the eradication of smallpox and to submit that estimate to the 54th Meeting of the Executive Committee and the XVII Pan American Sanitary Conference.

8. To emphasize the need for the Pan American Sanitary Bureau to continue to coordinate the national smallpox vaccination campaigns and to provide those

[1] Resolution XXIX. *Official Document PAHO* **66**, 80-81.

campaigns with the help they need, including technical assistance in planning, operation, research, and personnel training, as well as vaccine, supplies and equipment, and certain local costs, whenever necessary.

9. To urge the Director of the Bureau to assist the Governments in obtaining financial and material resources for their national programs.

10. To urge the Governments that are in a position to do so to supply the national programs of other countries of the Continent that need them, not only with smallpox vaccine but also with financial and material resources and specialist services, either directly or through the Pan American Sanitary Bureau.

11. To express its thanks to the countries of the Continent that have so generously donated smallpox vaccine to countries that need it or do not produce enough of it.

Decision: The draft resolution was unanimously approved.[2]

Item 25: Training of Auxiliary Personnel (*conclusion*)

Draft Resolution Presented by the Delegation of Mexico

Dr. SUTTER (Assistant Director, PASB) read the following draft resolution:

THE DIRECTING COUNCIL,

Having considered the report of the Director on the preparations for holding a meeting to formulate a policy for the training of auxiliary workers based on the needs of the countries of the Americas (Document CD16/11),

RESOLVES:

To take note that the recommendation of the Council at its XV Meeting that a study be made of the training of auxiliary personnel has been carried out, and to request the Director to inform the Governing Bodies of the Organization in due course of the conclusions reached at the proposed meeting of national authorities with experience or interest in the matter, in order to establish a policy for the training of such personnel.

Decision: The draft resolution was unanimously approved.[3]

Item 31: Procedure for the Presentation of Reports to the Directing Council (*conclusion*)

Draft Resolution Presented by the Delegation of Guatemala

Dr. SUTTER (Assistant Director, PASB) read the following draft resolution:

THE DIRECTING COUNCIL,

Having considered the report of the Director (Document CD16/9) on the procedure for the presentation of reports to the Directing Council; and

Bearing in mind the discussions of the 52nd Meeting of the Executive Committee on this matter and its Resolution XVII,

RESOLVES:

1. To take note of the report of the Director on the procedure for the presentation of reports to the Directing Council, and to express its satisfaction with the manner in which these reports are presented, especially with the progress achieved in recent years.

2. To recommend to the Director that he continue the evaluation begun in the last two years so as to provide the Governing Bodies with an ever clearer account of the progress made in the development of the programs in which the Organization is collaborating with the Governments.

Decision: The draft resolution was approved by 18 votes in favor, 1 against, and no abstentions.[4]

Item 19: Technical Discussions: Methods of Improving Vital and Health Statistics (*conclusion*)

Draft Resolution Presented by the Delegation of Chile

Dr. SUTTER (Assistant Director, PASB) read the following draft resolution presented by the Delegation of Chile:

THE DIRECTING COUNCIL,

Having considered the Final Report of the Technical Discussions on "Methods of Improving Vital and Health Statistics";

Considering that this report provides a summary of the seven working documents and the views expressed by the participants; and

Considering the urgent need for the institution of the methods recommended to provide the basic data needed for planning and administration of health programs,

RESOLVES:

1. To take note of the Final Report and the recommendations made in the Technical Discussions on "Methods of Improving Vital and Health Statistics."

2. To recommend to the Organization and to the Governments that efforts be made immediately to implement the recommendations for actions to rapidly develop satisfactory statistics for planning and administration of health programs.

3. To request the Director to publish the working documents and the Final Report of the Technical Discussions and to give them wide distribution.

Decision: The draft resolution was unanimously approved.[5]

[2] Resolution XXX. *Official Document PAHO* **66**, 81-82.
[3] Resolution XXXI. *Official Document PAHO* **66**, 82-83.
[4] Resolution XXXII. *Official Document PAHO* **66**, 83.
[5] Resolution XXXIII. *Official Document PAHO* **66**, 84.

Item 24: Resolutions of the WHO Executive Board and the World Health Assembly of Interest to the Regional Committee (*conclusion*)

Dr. SUTTER (Assistant Director, PASB) read the following draft resolution on the item:

THE DIRECTING COUNCIL,

Having examined Document CD16/19 and Addenda I and II, in which the Director brought to the attention of the Regional Committee for the Americas a number of resolutions adopted by the Eighteenth World Health Assembly and by the Thirty-Fifth and Thirty-Sixth Sessions of the WHO Executive Board; and

Bearing in mind that the Pan American Sanitary Bureau is already dealing with the matters covered by the resolutions of the World Health Assembly and the Executive Board,

RESOLVES:

To take note of the following resolutions in Document CD16/19 and Addenda I and II: WHA18.33 and EB35.R45, Fourth General Program of Work covering a Specific Period (1967-1971); WHA18.37, Organizational Study of the Executive Board: Methods of Planning and Execution of Projects; and WHA18.48, Amendments to Article 7 of the Constitution.

Decision: The draft resolution was unanimously approved.[6]

Item 33: Air and Water Pollution in Latin America (*conclusion*)

Draft Resolution Presented by the Delegation of Costa Rica

Dr. SUTTER (Assistant Director, PASB) read the following draft resolution presented by the Delegation of Costa Rica:

THE DIRECTING COUNCIL,

Having considered the report of the Director on the growing significance of air and water pollution problems (Document CD16/17);

Considering that increasing demographic expansion is causing unprecedented urban and industrial concentrations that create a large volume of waste discharges;

Bearing in mind that uncontrolled waste discharges from urban centers and industrial installations pollute air and water resources and, if excessive, such pollution is detrimental to the health and well-being of people, restricts industrial expansion, and limits water and land use;

Recognizing that problems of air and water pollution are further complicated by accelerating technological changes affecting the production and use of industrial products and the types and volumes of polluting wastes;

Noting with satisfaction that the report emphasizes the importance and urgency of industrial development and the need for Governments to be realistic and practical in the development and application of regulatory measures, and to give due consideration to the capacity of air and water resources to assimilate, with safety, reasonable volumes of polluting materials; and

Noting the grave implications of excessive and uncontrolled air and water pollution for the health and the social and economic well-being of people and that Governments must take prompt action to analyze problem areas and, where necessary, apply the proper measures to remedy the situation,

RESOLVES:

1. To endorse the courses of action proposed in the Director's report (Document CD16/17) in order to provide the Governments that request it with all the technical assistance they need on all aspects of air and water pollution, including appropriate measures, as required, for monitoring trends in air and water pollution, for appraising special problems, and for developing practical control methods.

2. To recommend to the Governments that they give proper attention to problems of air and water pollution and, where appropriate, expand their technical staff and related facilities to provide for practical and effective regulatory controls to prevent excessive pollution of air and water resources, taking into account the economic importance of industrial development.

3. To urge the Director to make studies on the cost of control practices and to use the resources of the Organization to determine more feasible and practical methods of water treatment that will be within the economic and operational reach of the people to be protected and within the financial and administrative capacity of the Governments concerned.

4. To request the Director to give appropriate attention to the expanding problems of air and water pollution in the Organization's programs of assistance in the fields of education, training, and research, and to provide for the collection and dissemination to Governments of such scientific information as might be helpful on the health and economic implications of air and water pollution and on remedial practices.

Dr. QUIRÓS (Peru) stated that his Government considered that the activities to which the report referred should be developed to the fullest possible extent. His experience in that respect had been very salutary.

In Peru the fish meal industry had grown very rapidly and, in the course of a few years, had achieved world primacy; it had nevertheless given rise to serious health problems: the pollution of beaches and watercourses through the discharge of its industrial waste, as well as air pollution.

The city of Lima was surrounded by hills and was subject to very unusual climatic conditions.

[6] Resolution XXXIV. *Official Document PAHO* **66**, 84-85.

As Dr. Ristori had pointed out in connection with his country, air pollution in Lima posed a very serious problem, especially those forms of pollution attributable to the defective combustion systems of automobile engines. In one part of the city the Institute of Occupational Health had confirmed the existence of harmful concentrations of carbon monoxide. The problem was complicated by the narrowness of the streets and the large number of vehicles using them, many of which were in poor operational conditions. His Delegation regarded the subject of air and water pollution as deserving of the closest attention.

In conclusion he stated that his country's Institute of Occupational Health was prepared to place its services at the disposal of any country that wished to avail themselves of them, either for the training of personnel or for any form of technical guidance.

Mr. BOARD (United States of America) stated that his country's Delegation shared the sentiments expressed by previous speakers in commending the Organization and its staff for taking the initiative in recognizing the potential seriousness of the problems under debate, and for undertaking studies and research in order to make technical assistance available, on request, to deal with them. Especially noteworthy was the fact that plans were being made by the Organization to initiate comprehensive studies to make it possible to institute measures to prevent the development of serious conditions such as were currently being faced in those countries. The United States Delegation was confident that the national ministries of health, particularly those interested in formulating long-range program plans, would recognize and take advantage of the opportunity to make dramatic and important contributions to the development of their countries by giving early and effective attention to those problems.

The speaker added that he heartily endorsed the draft resolution presented by the Delegation of Costa Rica, but wished to propose a minor addition in operative paragraph 2, to read as follows: "2. To recommend to the Governments that, through their ministries of health, they give proper attention to problems of air and water pollution. . . ." Experience had shown that as those problems became more acute and more in the public interest, various agencies became involved in a struggle for sharing the responsibility to deal with them. Early identification of the responsibilities, and interest of the national departments of health, might well prevent such confusion.

Mr. Board was gratified to note that the staff of the engineering programs, and particularly the Chief of the Bureau's Environmental Sanitation Branch, had not lost their enthusiasm and zeal for advocating action in that problem area. He had, in fact, called attention to that situation in the United States of America when it was a very unpopular subject. Since there was now considerable interest in it, the Organization was undoubtedly in an excellent position to provide the leadership needed to prevent the Latin American countries from delaying their approach to those problems.

Mr. BURKE (Jamaica) thanked the Director for a very useful report. The Delegation of Jamaica realized that as a developing country, Jamaica would have to pay a price for industrial development. However, the Government of his country considered that careful attention to the control of air and water pollution, at the present stage of development, might avoid paying the high price in human suffering and even human life that the developed countries had had to pay and might have to continue to pay. His Delegation therefore welcomed the initiative taken by the Pan American Health Organization on the matter.

So far as water pollution was concerned, it seemed to him that apart from the fact that treatment of wastes and water itself prevented or controlled the spread of disease, it would also prevent a country from having to choose between one or two industries, since with proper control there could be two and not only one industry. It was a great pity, for instance, that sugar factories should have contributed to destroying the fishing industry, when proper control of water pollution could make both industries possible. With regard to air pollution, his Delegation shared the view expressed in the document that prevention was better than cure.

There was another aspect to the matter which he considered of general importance. Broadly speaking, the Region was concerned with the disease of the young, and the measures taken for their alleviation were beginning to bear fruit. As the expectation of life increased, they should also become increasingly concerned with the illnesses of the middle-aged and the aged. In his opinion, the attention that was being focused on water and,

especially, air pollution would facilitate their task in the coming years.

Finally, Mr. Burke stated that his country's Delegation strongly supported the Organization's initiative on that matter, and expressed the hope that close attention would be given to the problems of industrial health, industrial waste, and water pollution to which he had referred.

Dr. FERREIRA (Brazil) supported Mr. Board's amendment proposing the addition of the words "through their ministries of health" in paragraph two of the operative part of the draft resolution. He expressed the fear that in the developing countries occupational health activities and, more especially, those related to air and water pollution, would tend to remain the responsibility of other institutions, often through lack of initiative on the part of health agencies. As a typical example he referred to what had happened in Brazil in connection with the visit of Mr. Bloomfield, an outstanding expert in occupational health. As a result of his efforts a laboratory of industrial hygiene had been established in the State of Rio de Janeiro, responsible to the State Health Service, the School of Medicine, and the Special Public Health Service Foundation. That laboratory functioned for some time with excellent results but had later been more or less abandoned through indifference, even though, at a subsequent stage, the Ministry of Labor had begun to show an interest in it.

If a special effort were not made to ensure that matters of air and water pollution and, in more general terms, the activities of occupational medicine, were made the responsibility of public health agencies, within a few years there would be a repetition of what had happened with social security and the outcome would be that occupational health would fall within the competence of a number of organizations, so that when health institutions wished to enter the field they would find it was already occupied by others, a situation that, from their standpoint, would complicate the problem still further. For all those reasons he wished to associate himself with the statements made by the Representatives of the United States of America and of Jamaica, whose words should encourage public health agencies, especially those in the industrial sector in the developing countries, not to pay the price that the more advanced countries had had to pay for not having attached a sufficiently high priority to such activities of the health sector.

Dr. HYRONIMUS (France), after expressing his satisfaction at the Council's interest in the item, said that the problem of water and air pollution also existed in the French Departments in America, particularly because of the existence of sugar distilleries and sugar mills. A serious situation had arisen as a result of having required manufacturers to take measures to prevent pollution caused by the effluents of sugar mills, as the necessary improvements to the mills had imposed a considerable financial strain on them at a time when they had been experiencing difficulties in marketing their sugar.

He also referred to the problem created by the increasing use of certain kinds of detergents, which seriously impaired the operation of water purification plants; the use of some of those detergents would, he thought, have to be prohibited or others that were less harmful would have to be used.

Lastly, he referred to the use of atomic energy in the industrial sector and stated that regular inspections of air and water and also of pastureland and of milk were being undertaken in the French Departments, with a view to determining the degree of contamination caused by the presence of certain industries using atomic power. Although the problem barely fell within the subject under discussion, there was no doubt that the Council and the Conference would have to take an increasing interest in its examination in the future.

Dr. ACOSTA (Colombia) said that he was in full agreement with the statements that had been made by the various Representatives who had spoken before him and observed that the discussion had centered largely around those aspects of the subject that related to industrial development in urban areas. He noted that the Directing Council appeared to be primarily interested in those forms of air pollution that would be one of the future consequences of the growth of manufacturing activity in the cities. Although industry in the Latin American countries had made notable progress, the rural and agricultural sector continued to constitute the principal source of revenues for their economies. It was therefore also necessary to take account of developments in the agricultural sector in Latin America and of the problems to which they would give rise and he therefore suggested that in the draft resolution presented by the Delegation

of Costa Rica a sentence be added that stressed the importance that should be attached to the pollution, temporary in character but nevertheless severe and widespread, which occurred in rural areas as a result of crop control activities. As an illustration he observed that cotton growing had been extensively developed in Peru and Colombia and, at the same time, there had been a very marked increase in the indiscriminate use of pesticides to control the diseases that attacked the cotton plant. The use of such pesticides resulted in air pollution as well as contamination of the cotton plants themselves to an extent that might give rise to serious health problems for human beings and animals that lived in the areas affected.

Mr. RIVERA (Costa Rica) said that he regarded the observations on the draft resolution made by the Representatives of the United States of America and of Colombia as very pertinent and observed that, if the first objection could be met by the addition of the phrase "through their ministries of health," the second might be overcome by the addition of the words "and agricultural" before the word "development" at the end of operative paragraph 2 so that it would read ". . . of industrial and agricultural development," and incorporate the point made by the Representative of Colombia.

Dr. QUIRÓS (Peru) supported the amendments proposed by Mr. Board and Dr. Acosta and added that, besides the problem in the agricultural sector to which the latter speaker had referred, it was also necessary to consider the serious problems created by the waste products of certain factories located in the rural sector such as, for instance, sugar mills. Apparently very complex measures were necessary to eliminate certain of the substances produced at such mills so that the question was not so simple as might at first appear; he therefore believed that it would be worthwhile to intensify research into the matter.

The PRESIDENT called for a vote on the draft resolution presented by the Delegation of Costa Rica with the two amendments proposed. Accordingly, operative paragraph 2 would begin with the words: "To recommend to the Governments that, through their ministries of health, they give proper attention . . ." and concluded with the phrase "the economic importance of industrial and agricultural development."

Decision: The draft resolution presented by the Delegation of Costa Rica on air and water pollution in Latin America, with the amendments proposed by the Representative of the United States of America and of Colombia, was unanimously approved.[7]

Item 32: International Transportation of Human Remains

Dr. CUTLER (Deputy Director, PASB), in presenting this item, explained that Document CD16/27 [8] submitted to the Directing Council for consideration, had two appendices. The first presented a summary of the legislation on the international transportation of human remains enforced in 31 countries and political entities of the Hemisphere. The information was contained in Document CE52/17 [9] which was presented to the 52nd Meeting of the Executive Committee and had been updated for the current meeting of the Council by the addition of replies received from the Governments after the Executive Committee meeting. The second appendix was a report of the Study Group which the Director had organized in compliance with Resolution XVIII [10] of the 52nd Meeting of the Executive Committee. In addition to the report on their findings, the Study Group had prepared a draft proposal for general standards for the Americas on the subject. Those followed generally the provisions proposed in the Berlin Convention of 1937 on the Shipment of Dead Bodies, which never went into effect because it was not ratified, but were simplified and updated on the basis of the experience gained during World War II and afterwards.

The speaker stated that—in his opinion—it was safe to say that the legislation on the international transport of human remains was rather confused and conflicting. Many Governments had no legislation whatsoever while others had legislation of varying degrees of strictness, such as the requirements by some that an entire baggage car or freight car should be destined to the transportation of human remains, or that an individual compartment or airplane be set aside for them. The cost to the family or to

[7] Resolution XXXV. *Official Document PAHO* **66**, 85-86.
[8] See Annex 10, pp. 402-408.
[9] *Ibid.*, p. 403.
[10] *Official Document PAHO* **62**, 40.

the Government or organization involved could therefore be very substantial.

The element common to whatever legislation or regulation existed on the matter was the concern from the health point of view, to prevent the transmission of epidemic or infectious disease from the body, to anyone who might be involved in handling it at any stage of the process.

Dr. Cutler added that the report prepared by the Study Group offered the Directing Council some alternatives as to the procedure to be followed in the handling of the problem. They all pursued, as an ultimate objective, the achievement of uniformity in the Americas in regard to the international transportation of human remains. As a final remark, he stated that the Director of the Bureau would gladly comply with whatever recommendations were deemed appropriate by the Directing Council on that matter.

Dr. WILLIAMS (United States of America) pointed out that since the Delegation of the United States of America had been the one to request that the item under discussion be placed on the agenda of the 52nd Meeting of the Executive Committee, he thought it appropriate to make some comments.

He described the manner in which the problem of transportation of human remains had come to their attention when some representatives of the mortuary industry in the United States had approached them some years ago and described the problems they had in preparing bodies for shipment, both from the country to other places of the world and from other countries to the United States of America. He emphasized the fact that in the United States there was no single national law governing the method of preparation of human remains for shipment; there were, however, at least 50 separate state laws and that caused considerable confusion since there was no national standardization or uniformity.

As the pertinent report revealed, the same lack of uniformity existed in an international sense. He thought the Study Group had done a very good job in setting down draft standards and believed that they merited careful study and consideration. He stressed the desirability of finding ways and means of arriving at standardization in that regard in the Western Hemisphere and, hopefully, in the entire world.

Dr. Williams felt that with modern embalming techniques and with air transportation, it was possible to ship bodies for long distances with relatively minor health implications. On the other hand, even when death was due to infectious disease, there were currently less possibilities of their being transmitted by a properly prepared body. Since there seemed to be no other professional group available to take leadership, it was appropriate that PAHO attempted to bring some order to what clearly was an important problem in this Hemisphere.

He stated that his country's Delegation was completely in agreement with the report of the Study Group, which was considered excellent, as well as with the suggestions made by Dr. Cutler. Therefore, later on he would propose a draft resolution, asking the Director to give final form to the proposed regulations and to transmit them to the Governments of the Pan American Health Organization and to the Director-General of WHO for comments, and expressing the hope that the next Executive Committee might have both the final draft on the proposed regulations, as well as the comments of the Governments as the basis for careful and intensive study by the Executive Committee.

Dr. Esquivel (Panama) took the Chair.

Dr. RISTORI (Chile) considered that the item under discussion was assuming increasing importance in view of the various regulations in force, which, in his view, went beyond what was justified on health grounds. There could be no doubt that there was a tendency to misjudge the risks to which the transportation of human remains gave rise and that it was, in fact, a throwback to those periods in which there were serious epidemics of plague and smallpox when such dangers had clearly existed. In Chile the requirements imposed were minimal and, in point of fact, were usually limited to approval of the transfer by local health agencies subject to the grant of the necessary visa by the diplomatic representative of the country to which it was desired to make the shipment. It was therefore essential to submit a copy of the death certificate authorized by the National Health Service. The legal provisions governing the transportation of human remains were included in the Chilean Health Code, although that Code did not even impose the requirement proposed by the experts on

forensic medicine that only the transportation of human remains that had been embalmed or reduced to skeletons should be authorized. Nevertheless, in practice, the air and sea transport companies required a series of further formalities which went well beyond those laid down in the corresponding health legislation. He said that if it was the Council's intention to approve a resolution that would simplify the formalities and reduce the requirements affecting the transportation of human remains to those essential to ensure that no threat to health was involved, then the conclusions reached after the necessary amendments had been made in the legislation of each country should be communicated to the air and sea transport companies with a view to an easing of their own requirements.

The session was suspended at 10:30 a.m. and resumed at 11:15 a.m.

Dr. QUIRÓS (Peru) expressed his agreement with Dr. Ristori's very pertinent suggestion that not only health authorities but also other agencies, such as air transportation companies, should be requested to simplify the formalities governing the international transportation of human remains. He emphasized that frequently even the customs authorities created difficulties with respect to such shipments.

The PRESIDENT announced that the Delegation of the United States of America had presented a draft resolution on the item, which would be distributed immediately so that it could be put to the vote later in the session.[11]

Item 12: Planning of Hospitals and Health Facilities (*conclusion*)

Draft Resolution Presented by the Delegation of Argentina

Dr. SUTTER (Assistant Director, PASB) read the following draft resolution:

THE DIRECTING COUNCIL,

Having considered the Final Report of the Advisory Committee on Planning of Hospitals and Other Health Facilities (Document CD16/24) prepared pursuant to Resolution XXV of the XV Meeting of the Directing Council;

Bearing in mind that one of the basic health services is the provision of medical care and that, because of its importance and the financial burden it represents for the economic development of the countries, measures will have to be taken on a continental scale to strengthen medical care services in the countries and to coordinate their activities for the sake of timely provision of services, reduction of costs, and efficiency; and

Considering that the construction of new health facilities and the remodeling of existing ones, including hospitals, and the improvement of their organization and administration, are an indispensable part of any continental, national, or local policy,

RESOLVES:

1. To approve the Final Report of the Advisory Committee on Planning of Hospitals and Other Health Facilities (Document CD16/24) and to thank the Director of the Bureau and the members of the Committee for the work accomplished.

2. To recommend that the Pan American Sanitary Bureau expand its present resources for this purpose so that it can cooperate in studies and provide countries and international agencies with advisory services in the following fields:

(a) The planning and organization of national health services, which should be based on appropriate regional systems with a view to achieving optimum utilization of resources by establishing costs and priorities in expenditures and investments.

(b) The administration of hospitals and other health services with a view to increasing their efficiency and performance.

(c) The assessment of the need for various types of personnel and for facilities for their education and training.

(d) The incorporation of these above-mentioned concepts into the teaching programs of medical schools and the encouragement of research on these subjects by universities and other educational centers.

(e) The costing and financing of various medical care systems, including independent and semi-independent services, and of the construction and equipping of hospitals.

(f) The utilization of international resources so that, in addition to meeting the purposes for which they are intended, they stimulate the increase of national resources for the same purposes as well as better use of those resources.

3. To request the Director of the Bureau to establish suitable machinery for putting these objectives into practice, and to avail himself for that purpose of the currently available resources connected with this type of activity.

4. To recommend that the Pan American Sanitary Bureau strengthen its working relations with public and private international agencies active in this field, with a view to ensuring that the planning of hospitals and other health facilities occupies its appropriate place in medical care programs and, consequently, in national health programs.

Dr. WILLIAMS (United States of America) proposed that in the second operative paragraph the

[11] See p. 203.

statement "expand its present resources for this purpose so that it can . . .," should read: "to the extent possible without detriment to its existing program priorities."

Dr. FERREIRA (Brazil) requested clarification on this point from the Representative of the United States of America. In his opinion, the matter was only a question of editorial writing, since in no way did it endanger or change the programs already accepted and approved. He thought, therefore, that the proposed amendment should be limited to state "to the extent of the possibilities."

Dr. MARTÍNEZ (Mexico) suggested that, in paragraph 1 of the operative part of the draft resolution, the words "To take note of the Final Report. . . ." should replace the words "To approve the Final Report. . . ."

The wording of operative paragraph 2-d was also, he thought, inconsistent. With respect to the administration of hospitals it appeared out of place to refer to concepts rather than to realities, such as the assessment of the need for various types of personnel to which paragraph 2-c referred. He therefore suggested that subparagraph (d) be reworded as follows: "The incorporation of the above-mentioned subjects into the teaching programs. . . ."

Dr. RISTORI (Chile) considered that the amendment proposed by the Representative of the United States of America tended to restrict the draft resolution, insofar as the projected program was concerned. In view of the immense importance of the latter, the Delegation of Chile did not support that amendment and would prefer to retain the original text, as it had been presented by the Delegation of Argentina.

Mr. RIVERA (Costa Rica) said that he did not agree to the distinction that appeared to be made in the draft resolution under consideration between hospitals and other health services, as, according to paragraph 2-d, the objective was to ensure that the universities and the physicians of the future should be fully aware of the problems that existed in the health sector. The goal of the planning of hospitals and other services should be to resolve those problems as a whole and future physicians should be encouraged to realize that the hospital had ceased to be something rather like a medieval castle and to regard it rather as an institution with a staff that was fully integrated with the other educational and health services of the community.

The PRESIDENT indicated to the Council that the Director had informed him that the report of the Advisory Committee was based on just such principles as had been set forth by Mr. Rivera.

Dr. AGUILAR RIVAS (El Salvador) observed that, in his view, the recommendation made to the Pan American Sanitary Bureau was too broad and difficult to apply. For instance, he could not see what was the connection between subparagraph (e), which referred to "the costing and financing of various medical care systems including independent and semi-independent services, and of the construction and equipping of hospitals" and the subject of the study, which was the planning of hospitals and other health services. He said that he would like to have the Director's views on that point.

Dr. HORWITZ (Director, PASB) explained that the subparagraph to which the Representative of El Salvador had referred should be read in association with paragraph 2 as a whole, for what was being recommended that the Bureau do, whatever might be the final wording of the text of that paragraph, was to cooperate in studies and advise the countries on how to determine costs, which was what subparagraph (e) in effect stated. As the Representative of El Salvador was no doubt aware, the Bureau had already given advice on and determined the costs and methods of financing for systems of medical care and in connection with the building and equipping of hospitals, as the result of a research project that the World Health Organization had undertaken in association with some of the countries of the Americas. The function was an advisory one whether the advice was given directly to Governments or to international financing and other agencies that were contributing to the solution of the problem. The Bureau could therefore perform such an advisory service and had in fact been so doing in some countries over a considerable period.

Dr. AGUILAR HERRERA (Guatemala) said that he would prefer to see the original text of operative paragraph 2 retained in which, as he understood it, the Bureau was being asked to seek sources of financing to carry out the program in question. On the other hand, the aim of the amendment proposed by the Representative of the United States of

America appeared to be to keep the recommendation within the limits of the existing budgetary resources of the Bureau without recourse to new sources of financing.

Dr. WILLIAMS (United States of America) thanked Dr. Ferreira for his remarks and explained that he would like the recommendation to read: "within the limitations of existing program priorities."

The PRESIDENT declared the discussion closed and put to the vote the draft resolution presented by the Delegation of Argentina with the amendments proposed by the Representatives of the United States of America and of Mexico.

Decision: The draft resolution presented by the Delegation of Argentina, with the amendments proposed by the Representatives of the United States of America and Mexico, was unanimously approved.[12]

Item 30: Establishment of Official Relations with the Pan American Federation of Associations of Medical Schools

Dr. VILLARREAL (Medical Education and Research Training Unit, PASB), in presenting Document CD16/6 [13] on the item, stated that the Pan American Federation of Associations of Medical Schools was a nongovernmental organization, entirely educational and scientific in character, whose objective, under the terms of its Statutes, was to contribute systematically and progressively to the improvement of medical education in the Americas. It was formed on 29 November 1962, when its statutes were approved at the Third Latin American Conference of Medical Schools held in Viña del Mar, Chile. The Federation had sought to encourage those countries with three or more medical schools to form national associations, such as the Association of Medical Schools of Peru, constituted a few months previously, and the Association of Medical Schools of Venezuela, whose act of incorporation had been recently approved. The Federation's activities were financed with contributions from associations or schools and by grants from philanthropic foundations interested in education in the Americas. From the outset the Federation had sought advice from the Pan American Health Organization and had expressed its wish to engage in joint activities.

The Federation could form an important link between the Pan American Health Organization, as an intergovernmental agency, and the institutions of higher education responsible for the training of physicians and it therefore appeared to be an advantageous and useful step to establish close relations between the Federation and the Organization to pursue the common purpose of the improvement of medical education in the Americas. There were various cooperative activities of mutual interest that PAHO and the Federation could undertake jointly with a view to the strengthening of medical education in the Continent. He submitted the following draft resolution for consideration by the Council.

THE DIRECTING COUNCIL,

Having considered Document CE52/6 on the Pan American Federation of Associations of Medical Schools, and bearing in mind the considerations contained therein;

Having examined the statutes of the Pan American Federation of Associations of Medical Schools;

Bearing in mind the provisions of Article 26 of the Constitution of the Pan American Health Organization and Resolution XXVIII of the XIV Pan American Sanitary Conference; and

Considering Resolution XV adopted by the Executive Committee at its 52nd Meeting,

RESOLVES:

1. To establish official relations with the Pan American Federation of Associations of Medical Schools as a nongovernmental organization representing the medical schools in the Americas.

2. To authorize the Director to develop with the Federation, to the extent financial and budgetary limitations allow, cooperative activities of mutual interest aimed at strengthening medical education programs in the Americas.

Dr. FERREIRA (Brazil) expressed his conviction that the draft resolution just read would be supported by the representatives on the Council, especially since on previous occasions stress had been laid on the importance of establishing relations between health agencies and the universities and institutions of medical education. Besides the Federations of Venezuela and of Peru, there existed a third in Brazil, whose Statutes had already been approved. It was presided over by Dr. Amador Neghme and its Executive Director was Dr. Ernani Braga; it was functioning from provisional head-

[12] Resolution XXXVII. *Official Document PAHO* **66**, 87-89.

[13] Mimeographed document.

quarters that had been provided through the kindness of the Zone V Office of PASB at Rio de Janeiro.

What was important was that the action proposed would help to ensure that all medical schools in the Americas would take into consideration, in education, research, and in the training and preparation of personnel, those objectives that were vital if public health activities were to be effectively continued and expanded. He declared that he supported the draft resolution.

Decision: By 16 votes in favor, none against, and one abstention, the draft resolution on the establishment of official relations with the Pan American Federation of Associations of Medical Schools was approved.[14]

Item 18: Amendments to the Staff Rules of the Pan American Sanitary Bureau

Dr. PORTNER (Chief of Administration, PASB) presented Document CD16/5 [15] on the item. The amendments introduced by the Director in the Staff Rules were confirmed [16] by the Executive Committee at its 52nd Meeting in accordance with the provisions of Staff Rule 030. The Director-General of the World Health Organization had introduced similar changes in the WHO Rules and those had been confirmed by the Executive Board at its Thirty-fifth Session (EB35.R21).[17]

Dr. Portner commented on the pattern of uniformity that existed in matters of conditions of employment. The Pan American Sanitary Bureau followed as closely as possible the action taken by WHO, which in turn was guided by decisions of the United Nations.

He then explained in detail the changes introduced in Staff Rules 210.1, 430.2, 640.4, 730.3, 870, 1110.4, and 1110.6. The changes introduced reflected minor adjustments and in some cases were merely editorial corrections, except for Staff Rule 730.3 which contained a more significant proposal.

Dr. Portner explained that that change affected the reported remuneration of a staff member for purposes of computation of Pension Fund contributions and benefits.

The reason for the change was based upon a recommendation presented by a group of experts who met in 1960 to review the functioning of the Joint Staff Pension Fund. It was their recommendation that pensions in international organizations should be based upon the gross salary level as in other normal employment, rather than the net salary after tax. For a number of reasons the group did not feel that it was possible at that stage to move immediately from net to full gross. As an initial step they recommended that pension be calculated on an assumed figure and halfway between net and gross. That was adopted by the legislative authorities of the various organizations and was reflected in an amendment to PASB Rule 210.2 (now Rule 730.3), confirmed by the Executive Committee at its 43rd Meeting. It was now felt that the organizations might proceed with the second step of implementation of the Pension Review Group's recommendation, i.e., to move to a full gross effective as of 1 March 1965. The revised rule also took into consideration that portion of staff remuneration given in the form of cost-of-living adjustment as the basis for calculating pension fund contributions and benefits.

Decision: It was unanimously agreed to take note of the amendments to the Staff Rules of the Pan American Sanitary Bureau presented by the Director in the Annex to Document CE52/14, and confirmed by the Executive Committee at its 52nd Meeting.[18]

Item 32: International Transportation of Human Remains (*conclusion*)

Draft Resolution Presented by the Delegation of the United States of America

Dr. SUTTER (Assistant Director, PASB) read the following draft resolution:

THE DIRECTING COUNCIL,

Having considered Document CD16/27 on the international transportation of human remains, and its Annexes I and II, which contain information on the legislation in force in 31 countries and political entities of the Americas, and Annex III, containing the report of the Study Group on the subject;

Bearing in mind the points of view expressed by the representatives at the 52nd Executive Committee and

[14] Resolution XXXVIII. *Official Document PAHO* **66**, 89.

[15] Mimeographed document.

[16] Resolution VII. *Official Document PAHO* **62**, 32-33.

[17] *Off. Rec. Wld Hlth Org.* **140**, 17.

[18] Resolution XXXIX. *Official Document PAHO* **66**, 90.

during the discussion of this subject in the Directing Council; and

Considering Resolution XVIII of the 52nd Meeting of the Executive Committee,

RESOLVES:

1. To take note of the report of the Director and documents annexed to it concerning the international transportation of human remains (Document CD16/27).

2. To express its appreciation to the Director for the report and for the draft proposal for the establishment of general standards for the Americas in the international transportation of human remains.

3. To request the Director to prepare a final draft on standards for the Americas on the international transportation of human remains, to transmit them to the Governments for review and comment at the earliest practicable time, and to submit them to the Executive Committee for its consideration and its recommendations for action.

4. To request the Director to transmit a copy of this resolution, together with the draft proposal for the establishment of general standards for the Americas on the international transportation of human remains, to the Director-General of the World Health Organization.

Decision: The draft resolution was unanimously approved.[19]

Item 28: Epilepsy in the Americas

Dr. González (Regional Adviser on Mental Health, PASB), in presenting Document CD16/18,[20] stated that the importance of epilepsy as a medicosocial problem in the Americas had been pointed out on several occasions by scientists in the Region, who had drawn attention to its magnitude and to the need to take action to find a solution.

At various times it had been observed that it was likely that in those sectors of the population that were economically weak and in regions where the infectious diseases were highly prevalent and maternal and child health care was inadequate, the incidence and prevalence of epilepsy were very high, although in the majority of cases such statements had no validity other than that of assumptions or estimates that required confirmation by more exacting epidemiological methods. On the basis of the results achieved by the use of such methods, action could be taken in the areas of prevention and care.

So far as the legal and social aspects of the disease were concerned, it was well known that discrimination did in fact exist in a number of countries and was of such a nature as to restrict the freedom of action of the epileptic patient and deprive him of certain rights as a citizen, on no other basis than that of the accumulated prejudice of centuries against persons suffering from the disease. In some countries legal discrimination existed and it would be possible to review the situation of the patient in that respect by a study of the legal texts and of the application of the law in each country. Such an investigation would be extensive and would require a substantial investment of funds in view of the dispersed character of the legal documentation available. It had also been pointed out on a number of occasions that discrimination of a non-legal character also existed and, to make a proper study of the forms that it took, it would be necessary to set up working parties that should include sociologists and cultural anthropologists.

He recalled that the Directing Council, at its XV Meeting held in Mexico in 1964, had approved Resolution III [21] in which it had been recommended to the Director that a study of the incidence and distribution of epilepsy in the Americas should be made as well as of the legal and other types of discrimination to which patients suffering from that disease were subject.

As a first step under the terms of that mandate, the Pan American Sanitary Bureau had convened in May of 1965 a meeting on the epidemiology of the mental diseases in Latin America which had, at the same time, undertaken a specific examination of the question of what epidemiological research into epilepsy could be undertaken in the Region and had also made various recommendations. In one of the countries an investigation of that nature had already been initiated in accordance with the recommendations made.

As for the legal aspects, the Mental Health Information Center on Latin America had begun to collect legal texts and to prepare a bibliography of the information available. In conclusion, he indicated that the document presented provided a more detailed account of what had been achieved.

Dr. Hyronimus (France) congratulated Dr. González on the excellent report he had presented, which was clear, brief, and to the point. He stressed

[19] Resolution XXXVI. *Official Document PAHO* **66**, 86-87.

[20] See Annex 9, pp. 400-401.

[21] *Official Document PAHO* **58**, 58-59.

the continental scope of the problem and its special importance in the case of some of the countries of the Caribbean area, and referred to the congresses held at Curaçao, Jamaica and, a short-while previously, at Martinique (the French Government having met the cost of the latter) to examine mental health problems in general and epilepsy in particular.

He thanked the Bureau for having given the problem the full attention it deserved, and he submitted for consideration by the Council the following draft resolution:

THE DIRECTING COUNCIL,

Having considered the report of the Director (Document CD16/18) on the work done on the study of the incidence and distribution of epilepsy in the Americas, in implementation of Resolution III adopted by the Council at its XV Meeting,

RESOLVES:

To recommend to the Director of the Bureau that, in cooperation with the Governments, he develop a program of epidemiological research on epilepsy and continue the study of the legal aspects of the disease.

Dr. QUIRÓS (Peru) expressed his satisfaction at the manner in which the subject had been presented, as it was an extremely important one to which, he believed, psychiatrists had given scant attention. He added that there was a great aversion to epileptics because of the dramatic form the seizure assumed and he referred to the neglect from which they suffered as a result of the widespread objections to employing them. Moreover, in some countries legislation existed which restricted their employment. It was therefore of fundamental importance to seek their rehabilitation so as to provide them with security and contribute to the treatment of the disease.

In Peru the problem had been ignored not only by psychiatrists but also by the health services; there was only one voluntary association to combat epilepsy, which operated a center to provide for the training of epileptic patients in work they could undertake. The Delegation of Peru therefore attached great importance to the projected epidemiological survey, as the problem was deserving of special attention.

Dr. CASTILLO REY (Venezuela) said that his country's Delegation also wished to praise the report presented, which brought into focus the medical, epidemiological, social, and legal aspects of the problem in the Americas. It was clearly necessary to continue and intensify such studies. The legal and social restrictions imposed on those suffering from epilepsy should be examined with extreme care, as they were throwbacks to the past and had no validity in modern societies. The only restriction that could be justified, in his view, was in the labor field, but should apply solely in the sense that certain forms of work might involve risks that could jeopardize the lives of those suffering from the disease. With that exception there could be no other valid reason for imposing social or legal impediments on epileptics.

Mr. PHILIPPEAUX (Haiti) supported the draft resolution and expressed his agreement with the comments that had been made. He drew attention to the need to study the disease not merely in its legal aspects but also from a social standpoint. He therefore proposed that the final words of the operative part should read: ". . . . the legal and social aspects of the disease."

Decision: The draft resolution, with the amendment proposed by the Representative of Haiti, was unanimously approved.[22]

Convocation of the 53rd Meeting of the Executive Committee

Dr. SUTTER (Assistant Director, PASB) announced that the Executive Committee would meet on the following day to proceed with the election of the Chairman and the Vice-Chairman and the examination of those resolutions of the Directing Council that were of interest to the Committee, and also to decide on the date of its next meeting.

The session rose at 12:20 p.m.

[22] Resolution XL. *Official Document PAHO* **66**, 90.

CLOSING SESSION

Friday, 8 October 1965, at 11:15 a.m.

President: Dr. Raymundo de Britto (Brazil)

The President opened the session and said that the Final Report of the XVI Meeting of the Directing Council would be presented to the representatives for consideration.

Illness of the President of the United States of America: Expression of Sympathy and Best Wishes

Dr. Ristori (Chile) proposed that the Directing Council, through the Director of the Bureau, extend to the President of the United States of America, Lyndon B. Johnson, the Organization's sympathy on the occasion of his illness and scheduled surgery, and the unanimous desire of all for his speedy recovery.

It was so agreed.

Approval and Signature of the Final Report

Dr. Sutter (Assistant Director, PASB) presented the Final Report and the 40 approved resolutions contained in it.

The President submitted the Final Report of the meeting to the Directing Council for approval.

Decision: The Final Report and Resolutions I to XL contained therein were unanimously approved without change.[1]

The Final Report was then signed by Dr. Raymundo de Britto, President of the XVI Meeting of the Directing Council, and by Dr. Abraham Horwitz, Director of the Pan American Sanitary Bureau and Secretary ex officio of the Council.

Tribute to the Memory of Dr. Guillermo Rojas Sucre of Panama

Dr. Quirós (Peru) invited the Council to pay tribute to the memory of Dr. Guillermo Rojas Sucre, Representative of Panama at the XV Meeting of the Directing Council, who had recently passed away, and to officially record the sympathy of the Organization. He proposed that the Council observe one minute of silence.

All participants rose and observed one minute of silence in tribute to the memory of Dr. Guillermo Rojas Sucre.

Closing of the XVI Meeting of the Directing Council

The President expressed his appreciation for the honor of having been chosen to serve as President of the meeting, which he regarded as a testimony of the fraternal feelings of the nations of the Hemisphere and of the friendship with which Brazil was regarded.

He also expressed his gratitude to all the representatives for the assistance they had so sincerely given him and for the understanding and discernment with which they had examined the problems. He extended his thanks to Dr. Abraham Horwitz, Director of the Bureau, for his valuable cooperation and to the technical and secretariat personnel for having achieved such a high standard of excellence in the discharge of their various responsibilities.

He then praised the Annual Report of the Director, the Report of the External Auditor, and the proposed program and budget of the Organization. He also expressed his satisfaction with the course the meeting had taken and with the important resolutions that had been adopted, such as those relating to malaria, smallpox, the relationship between the medical programs of social security institutions and the health ministries (a problem of major significance in the Americas), water and air pollution, and others. He emphasized the importance of the Organization's work, which was inspired by the universal ideal of doing good to humanity.

He pointed out that, at a time when all their efforts and aspirations were united in a common desire to raise the economic status of the Hemisphere, only health and education could ensure that its peoples were fit and able to perform productive and rational functions. The objective of the Governments of the Americas was to secure the great-

[1] The complete text of the Final Report appears in *Official Document PAHO* 66 (1966).

ness of the peoples of the Hemisphere, and in that aspiration and in their struggle for continuing progress they were united by bonds of enduring friendship and kinship. Finally, he said that he again wished to express his gratitude, both on his own behalf and on that of Brazil, for the trust placed in him and the honor shown to him. He then declared the XVI Meeting of the Directing Council closed.

The session rose at 11:50 a.m.

3. ANNEXES

Annex 1

ANNUAL REPORT OF THE CHAIRMAN OF THE EXECUTIVE COMMITTEE [1]

Submitted by Dr. Charles L. Williams, Jr. (United States of America) Chairman of the 51st and 52nd Meetings of the Executive Committee

I have the honor to submit to the Directing Council, pursuant to Article 9-C of the Constitution, this report on the work of the Executive Committee between September 1964 and September 1965, the period during which it held its 51st and 52nd Meetings.

The 51st Meeting was held in Mexico City on 11 September 1964, after the close of the XV Meeting of the Directing Council. On that occasion, Dr. Charles C. Wedderburn (Jamaica), Dr. Guillermo Rojas Sucre (Panama), and Dr. Juan Motezuma Ginnari (Venezuela), the representatives of the three countries which the Directing Council had elected to the Executive Committee, took office. The following representatives were also present: Dr. Manoel José Ferreira (Brazil); Mr. Carlos A. Moreno Velázquez (Costa Rica); Dr. Miguel E. Bustamante (Mexico); and Dr. Charles L. Williams, Jr. (United States of America). Dr. Carlos Quirós Salinas (Peru) attended as an Observer.

At the 51st Meeting I had the honor to be elected Chairman of the Executive Committee for the period covered by this report, and therefore presided over the 51st and 52nd Meetings. Dr. Manoel José Ferreira, the Representative of Brazil, was elected Vice-Chairman.

The 52nd Meeting, held in Washington, D.C., from 19 to 23 April 1965, was attended by the following representatives, alternates, and advisers: Dr. Manoel José Ferreira (Brazil); Mr. Francisco Castro Víquez (Costa Rica); Dr. Charles C. Wedderburn (Jamaica); Dr. Manuel B. Márquez Escobedo (Mexico); Dr. Alberto E. Calvo (Panama); Dr. Charles L. Williams, Jr., Dr. Benjamin D. Blood, Mr. Leonard M. Board, Mr. Howard B. Calderwood, Mr. Paul J. Byrnes, Dr. Jacques M. May, and Mr. Simon H. Wilson (United States of America); and Dr. Daniel Orellana (Venezuela). Mr. Milton P. Siegel, Assistant Director-General of the World Health Organization, and the following Observers were also present: Dr. Pedro Alvarez Tabío (Cuba); Dr. Carlos Quirós Salinas (Peru); Miss Christine Yvonne Henny and Mr. A. G. O. Smit (Kingdom of the Netherlands); and Mr. Armando Cassorla, Mrs. Alzora H. Eldridge, and Mr. Beryl Frank (Organization of American States).

Pursuant to Rule 12 of the Rules of Procedure, the Director of the Pan American Sanitary Bureau, Dr. Abraham Horwitz, acted as Secretary ex officio of the Committee.

The 51st Meeting considered the following agenda items:

Review of the Items Referred to the Committee by the Directing Council

The Director of the Bureau reviewed the resolutions approved by the Directing Council that specifically called for action by the Executive Committee. They referred to the proposed program and budget of the Pan American Health Organization for 1966, payment of arrears, financing of the malaria eradication program, planning of hospitals and other health facilities, organization of the Pan American Sanitary Conference, and the relationship between social security medical programs and those of ministries of health or other official health agencies. The Director explained in detail what steps would be taken to fulfill the instructions given by the Council.

[1] Document CD16/28 (10 September 1965). The Final Reports of the 51st and 52nd Meetings of the Executive Committee appear in *Official Documents PAHO* 60 and 62, respectively.

The Representative of Mexico suggested that a study be made of the health hazards of water and air pollution, a suggestion supported by the Representative of Jamaica. The Director mentioned the work being done at the Latin American Institute of Occupational Health and Air Pollution Research in Santiago, Chile, which was engaged in studying the problem of air pollution.

Date of the 52nd Meeting of the Executive Committee

The Committee resolved to authorize the Chairman of the Executive Committee to fix the date of the 52nd Meeting in agreement with the Director of the Bureau.

Organization of the XVI Meeting of the Directing Council of PAHO, XVII Meeting of the WHO Regional Committee for the Americas

The Director indicated that, except for unforeseen circumstances, the next meeting of the Directing Council could be held in the new headquarters building of the Organization. In view of the significance of the event, there could be no better way of commemorating it than to devote the meeting to an analysis of the major problems afflicting the peoples of the Americas, and to organize the meeting at a very high level, possibly with the ministers of health of the Hemisphere attending.

The 52nd Meeting considered the following agenda items:

Financial Report of the Director and Report of the External Auditor for 1964

After a detailed study of the reports, the Committee resolved to transmit them to the Directing Council at its XVI Meeting. It also agreed to urge that the Governments having outstanding quotas pay them as soon as possible and that those in arrears two or more years adopt a financial plan for the payment of outstanding quotas within a definite period. The Committee also commended the policy of prudent management followed by the Director over the years in maintaining budgetary expenditures within income, in building up the Working Capital Fund, and in creating reserves for termination costs.

Proposed Program and Budget of the Pan American Health Organization for 1966

The Committee made a careful study, item by item, of the figures of the proposed program and budget for 1966 presented by the Director. Several items were discussed in that connection, such as the distribution of the budget among the various countries, the Pan American Zoonoses Center, medical care and hospital administration, the number of posts and duty travel allocations, Chagas' disease, food and drug service, chronic diseases, seminar on venereal diseases, teaching of medicine, and others.

Finally, the Committee agreed to submit to the XVI Meeting of the Directing Council the proposed program and budget of PAHO for 1966 and to recommend to the Council that it establish the level of the budget for that year at $8,080,000.

Financing of the Malaria Eradication Program in the Americas

In compliance with a resolution adopted by the Directing Council at its XV Meeting, the Director submitted to the Committee a report on the future financing of the malaria eradication program. After a detailed examination of that report, the Committee resolved to take note of it and to transmit it to the XVI Meeting of the Council, together with such additional information as may be available on the matter.

Report on the Collection of Quota Contributions

After making a detailed examination of the report on the collection of quota contributions presented by the Director, the Committee took note of the report and commended the Director on his efforts to obtain settlement of the outstanding arrearages; it expressed its concern, nevertheless, over the continuing serious quota situation, especially the arrearages of more than two years' standing; it recommended that the Director instruct the PAHO Zone Chiefs and PAHO Representatives in the respective countries to maintain continuous efforts to have the payment of quotas effected on a current basis and to have arrearages paid as soon as possible. The Committee further requested the Director to continue his efforts to keep the Governments amply informed of the status of quota payments and of the implications of non-payment on the prosecution of the program of the Organization.

It also urged the Governments whose arrearages would bring them within the loss-of-vote provision of Article 6-B of the Constitution, to pay their quota arrears as soon as possible, in order to ensure the full participation of all the Governments, which is so vital to the work of the Organization.

Nongovernmental Financial Support for Health Activities

The Committee examined the report on nongovernmental financial support for health activities, which mentioned the establishment of the World Health Foundation of the United States of America and the plan for the establishment of similar national foundations in other countries. The Committee also learned of the agreement concluded between the World Health Organization and PAHO and signed on 15 October 1964 in Washington, D. C., by the Director-General of WHO and the Director of PASB, regarding the manner in which relations would be conducted with the World Health Foundation of the United States.

The Committee recommended to the Directing Council that it take note of the agreement, and that it invite the Director of the Bureau to continue to cooperate in the plan with regard to world health foundations, and to take such steps as he deemed necessary to further the fundamental purposes set forth in the Constitutions of the Pan American Health Organization and the World Health Organization.

Report on Administrative Rationalization in the Pan American Sanitary Bureau

The Committee took note of the report of the Director on administrative rationalization in the Pan American Sanitary Bureau and commended the Director and the staff of PASB on their efforts to date in effecting economies in administration. It also requested the Director to continue the program of rationalization and to report progress to the 54th Meeting of the Executive Committee, and to transmit Resolution VI and the report of the Director to the XVI Meeting of the Directing Council.

Amendments to the Staff Rules of the Pan American Sanitary Bureau

The Committee confirmed the amendments to the Staff Rules of the Pan American Sanitary Bureau presented by the Director, which were similar to those adopted by the WHO, with small adjustments and changes of an editorial nature in Articles 210.1, 430.2, 640.4, 870, 1110.4, and 1110.6, and a basic change in Article 730.3, on "pensionable remuneration" of staff members, which would hence forward be based on the gross salary level, including cost-of-living adjustment.

Organization of the Pan American Sanitary Conference and Constitutional Amendments

The Committee examined the report of the Director on the organization and structure of the Pan American Sanitary Conference, the proposed constitutional amendments submitted by various Governments in that regard, and the meeting place of the next Conference.

The Directing Council, in Resolution XXXIX of its XV Meeting held in Mexico City in September 1964, had instructed the Executive Committee to submit a report to the XVI Meeting of the Council on the organization, structure, and place of the meetings of the Governing Bodies of PAHO.

The Committee examined this matter in depth, bearing in mind the antecedents and the documentation presented. At the conclusion of deliberations, it established a working party composed of the Representative of Panama, Dr. Alberto E. Calvo, and the Representative of Venezuela, Dr. Daniel Orellana, to draw up a draft report on the opinions expressed during the discussions which would then be submitted to the Council. This draft report was examined and modified by the Committee in plenary session, and the definitive text was included as an Addendum to the Final Report of the Meeting.[2] Among other recommendations, the Committee decided to submit to the consideration of the Council the proposed amendments to Articles 7-D and 12-B, formulated by the Representative of Ecuador at the last meeting of the Council, to the effect that the Organization should pay the travel expenses of one Representative of each Government to the meetings of the Conference and the Directing Council. The Committee proposed to the Council that it request the Director to report on the practice of other organizations in the Inter-American System and the United Nations regarding payment of travel or expenses, and attendance records of members where travel is paid by the Organization or by the Member States. The Representative of Peru at the XV Meeting of the Council proposed that: "The Execu-

[2] *Official Document PAHO* **58**, 41-43.

tive Committee shall be responsible for the direct surveillance of the work of the Organization, fiscalizing the execution of its programs and its finances, and shall submit to the Directing Council or the Conference for its approval a detailed report thereon. This report shall be one of the main items of business of those bodies." [3] The Committee decided to inform the Council that the Executive Committee had decided unanimously, with the concurrence of the Observer of Peru, that the functions assigned to the Committee by Article 14 of the Constitution, especially in paragraphs D and E, were broad enough to preclude the need for the constitutional amendment proposed at the XV Meeting of the Council by the Representative of Peru. Further, the Committee unanimously accepted the proposal of the Observer of Peru that the Executive Committee should be officially represented at the meetings of the Directing Council and of the Conference by its Chairman or by any other member appointed by the Committee, and that the Organization should pay the transportation and subsistence of that representative.

Moreover, the Committee decided to recommend to the Directing Council that the next Pan American Sanitary Conference should be held at the new Headquarters of the Bureau in Washington, D. C., and that Articles 7-A, B, and C of the Constitution be modified accordingly. It also proposed that the Council modify Rule 1 of its own Rules of Procedure to the effect that its meetings should be held at the Headquarters of the Organization or at a place chosen by the Conference or the Council, and not alternately as was currently stipulated.

In the pertinent resolution, the Committee approved the report of the working party as amended in plenary session, and decided to transmit it as its own to the Council, together with the report submitted by the Director, so that the Council might adopt such measures as it deemed advisable.

Emergency Revolving Fund

The Committee took note of the report of the Director on the status of the Emergency Revolving Fund, and instructed him to include the subject as a specific agenda item for meetings of the Governing Bodies only when the status of the Fund was such as to require consideration separately from the Financial Report.

[3] *Official Document PAHO* **60**, 185.

Report on Buildings and Installations for Headquarters

The Committee expressed its appreciation to the Chairman and the members of the Permanent Subcommittee on Buildings and Installations for their valuable assistance in the prosecution of all activities related to the construction of the new headquarters building, and particularly in the sale of the buildings at 1501 and 1515 New Hampshire Avenue, N. W. It also requested the Director to inform the Governments concerning contributions to the headquarters building by the donation of works of art.

In another resolution on the same item, the Committee authorized the Director to advance funds from internal reserves or to borrow from external sources, as necessary, in an amount not to exceed $900,000, for the purpose of financing the construction and installation of the new headquarters building until receipt of the full proceeds from the sale of the buildings located at 1501 and 1515 New Hampshire Avenue, N. W., Washington, D. C.

Third Annual Meetings of the Inter-American Economic and Social Council

The Committee noted with satisfaction and interest the report of the Director on the Third Annual Meetings of the IA-ECOSOC at the Expert and the Ministerial Levels, held in Lima, Peru, from 30 November to 11 December 1964. It decided to transmit the above-mentioned report to the XVI Meeting of the Directing Council, to invite the latter to express its satisfaction with the interest shown by these Meetings in health in the Americas, and especially with the resolutions approved at the Expert Level on foot-and-mouth disease, rural and urban water supply, inclusion of proposals for health investments in requests for international loans for land settlement, road building, urbanization, and other programs.

It also agreed to recommend to the Directing Council that it instruct the Director of the Bureau to continue to develop and strengthen relations between the Organization, IA-ECOSOC, and the Inter-American Committee on the Alliance for Progress (CIAP), in order to bring about the integration of health activities in economic and social development programs; and to recommend to the Council that it urge the Governments of the Or-

ganization to include representatives of ministries of health in their delegations to the Annual Meetings of the IA-ECOSOC, and that they also endeavor to have included in the agenda of those meetings specific items concerning the participation of the health sector in the dynamic process of development of the countries of the Americas.

Arrangements for the XVI Meeting of the Directing Council of PAHO, XVII Meeting of the Regional Committee of WHO for the Americas

The Committee approved, with a slight change, the provisional agenda prepared by the Director for the XVI Meeting of the Directing Council, and authorized him to include in it such additional items as might be proposed in due time by the Governments and by those organizations entitled to propose agenda items.

The Committee also took note of the report of the Director concerning the arrangements for the aforesaid Meeting, and authorized him to convoke it from 27 September to 8 October 1965.

Establishment of Official Relations with the Pan American Federation of Associations of Medical Schools

In view of the request made by the afore-mentioned Federation, the Committee decided to recommend to the XVI Meeting of the Directing Council that the PAHO establish official relations with the Pan American Federation of Associations of Medical Schools as a nongovernmental organization representing the medical schools of the Americas and, at the same time, that it authorize the Director to develop with the Federation, to the extent financial and budgetary limitations allowed, cooperative activities of mutual interest aimed at strengthening medical education programs in the Americas.

Planning of Hospitals and Health Facilities

The Committee studied a report on this item, submitted pursuant to Resolution XXV of the XV Meeting of the Directing Council. In taking note of the report, it emphasized the need for the plan of operations outlined therein to be supplemented by the work of an Advisory Committee that would be appointed to make a study of the medical care problem in the Hemisphere, covering all the subsectors that provide medical care services. It also emphasized the importance of having senior officials responsible for the medical care benefits of social security services take part in the discussion of the problem at the XVI Meeting of the Council, and requested that the Director, when convening that meeting of the Council, suggest to the Governments that they include such officials in their delegations.

It also recommended to the Directing Council that it support the proposed plans and induce the Governments to do so; and invited the Director to submit a report to the 54th Meeting of the Executive Committee and the XVII Pan American Sanitary Conference on the progress made in the planning of medical care services incorporated into the general health services or coordinated with them.

Procedure for the Presentation of Reports to the Directing Council

The Committee carefully considered the report of the Director on the main administrative documents that are presented to the Directing Council. It decided to transmit that report to the XVI Meeting of the Council, and recommended to the Director that he continue the process initiated in recent years of providing the Governing Bodies with the kind of documentation that would facilitate the evaluation of program development.

International Transportation of Human Remains

Finally, the Committee examined a document on the international transportation of human remains, which contained information on the legislation currently in force in countries and political entities of the Americas. The Committee took note of the report and requested the Director to entrust to an advisory group the continuing study of the matter, including the advisability of preparing a set of general standards for the Americas on the international transportation of human remains. It also requested the Director to transmit the document submitted to the Committee, together with the report of the advisory group, to the XVI Meeting of the Directing Council.

In concluding this report, in which I have tried to set forth objectively and concisely the most im-

portant decisions taken at both meetings, I should like to thank the members of the Executive Committee for the confidence they placed in me by electing me Chairman, and to acknowledge the assistance I received in the course of the meetings from the Vice-Chairman and from all the members of the Committee. I should also like to thank the Director of the Pan American Sanitary Bureau and the staff of the Bureau for their efficient work in organizing and conducting the meetings.

Annex 2

XIII REPORT ON THE STATUS OF MALARIA ERADICATION IN THE AMERICAS [1]

Introduction

The Director of the Pan American Sanitary Bureau has the honor to present to the XVI Meeting of the Directing Council the XIII Report on the status of malaria eradication in the Americas.

The report consists of four chapters: status of the program in general and country-by-country summaries of progress, depicting the history and present status of each program in tables and graphs; special technical problems that have arisen; research in malaria currently in progress; and international cooperation in the malaria eradication program.

The data have been taken from the replies from each country to a detailed annual questionnaire and from monthly and quarterly statistical reports submitted to the Pan American Sanitary Bureau by most of the programs, supplemented by data from plans of operation. Special technical reports concerning research projects are also presented when appropriate.

I. STATUS OF THE MALARIA ERADICATION PROGRAM

General Picture

The progress made in 1964 toward eradicating malaria from the Hemisphere cannot be summarized and expressed in a global figure; the situation was complex, with different trends in different regions. Satisfactory progress was made in most programs, but in several of those in Central America and in Mexico, the situation remained stationary or deteriorated. Maps 1 and 2 and the summary presented in Table 1 [2] permit comparison of the overall status at the end of 1964 with that at the end of 1963.

During 1964 two countries (Jamaica and Trinidad and Tobago) completed their consolidation phase and are in process of receiving certification of the eradication of malaria.

The population of consolidation areas shows a decrease compared with December 1963, from 33.9 million persons to 32.3 million. This change is the combined result of the progression of many relatively small areas in various programs from the attack to the consolidation phase, and the regression of areas with about 3.4 million persons from the consolidation to the attack phase in Mexico, where persistent transmission has resisted attack measures in problem areas and reinfection of previously clean regions has occurred. The countries showing the greatest numbers of persons in areas placed in consolidation during 1964 are Colombia, Honduras, Ecuador, and the State of São Paulo in Brazil; a number of other programs shifted areas with smaller populations. In addition to Mexico, programs which were forced to return areas from consolidation to attack included those in Guatemala, Nicaragua, and Venezuela (Nicaragua also shifted some attack areas into consolidation, with a net gain in population and loss in area in the consolidation phase).

At the end of 1964, the increase in population in the attack phase reflects primarily the shift in Mexico mentioned above and movements in the Brazilian and Guatemalan programs. In the federal program in Brazil, areas inhabited by some 660,000 persons were brought from the preparatory stage to the attack phase; in São Paulo areas with over 900,000 moved from attack to consolidation. In Colombia some areas were advanced to consolidation (and attack was actually suspended in others with a population of 1.2 million, although these areas have not officially been placed in consolidation); at the same time, a large but sparsely-populated area was withdrawn from attack and the

[1] Document CD16/13 (12 July 1965).

[2] All maps and tables mentioned in the text appear at the end of this Annex.

program's activities were suspended there to concentrate resources on more populous areas. As has been mentioned, considerable areas of Guatemala returned from consolidation to the attack phase.

For some programs, part of the areas listed in Tables 3 and 4 as being in the attack phase were actually "in recess," with no active attack measures in progress for lack of funds. Such areas existed in El Salvador, Haiti, Nicaragua, and Colombia.

In Haiti spraying was stopped in large areas which included 2,000,000 persons, and these were placed under intensified surveillance but were not formally classified as being in the consolidation phase.

The area in the preparatory phase, or with no program in operation, has increased through the addition of some areas in southeastern Colombia where attack measures have been discontinued. Paraguay still remained entirely in this phase at the end of the year, and it is expected that attack operations will begin there in the last quarter of 1966. In Argentina the Provinces of El Chaco and Formosa also continued in the preparatory phase.

During 1964 administrative problems continued to be the primary obstacle to better progress; technically adequate methods are known for interrupting transmission in most of the areas where malaria persists, but funds, personnel, and efficient administration were frequently lacking. The progress made in improving administration in the Dominican Republic and Colombia continued. The program in Brazil is striving to improve its organization, although much remains to be accomplished in this respect. The campaigns in Panama, Central America, and Mexico suffered seriously from the lack of adequate financial resources.

In view of their proximity and common problems, closer coordination of the various campaigns in Central America and Panama is necessary; the Pan American Health Organization is strengthening its malaria eradication advisory services in Zone III in order to work more effectively in this sphere. Consultations were held during the year to determine the varying legal frameworks of the different countries within which coordinating activities must operate.

Extent of the Problem

The deterioration which occurred during 1964 in the problem areas of Central America and Mexico can be seen in Tables 1 and 2. The advances made by other programs are masked by the large number of persons involved in this one large problem area, but they can be seen in the country by country details which are shown in Tables 3 and 4.

In addition to Jamaica and Trinidad and Tobago, which achieved eradication and will receive certification during 1965, the program in Dominica is successfully completing its consolidation phase. Bolivia, British Honduras, Costa Rica, Cuba, the Dominican Republic, Ecuador, Honduras, Peru, and Venezuela are making good progress with their campaigns, despite existing problems and setbacks in some areas during the year.

Other programs face more serious technical or administrative problems still to be overcome. The areas with technical problems are listed in Table 5, which shows the extent of the area and population involved in each country, causes so far discovered for the existence of the problem, measures which had been applied up to the end of 1964, and the results achieved as of that date.

In studying Table 5 it should be noted that in many programs, the remedial measures being applied are less than what is known to be required. In El Salvador, for example, a collective treatment program for the population of 166,000 in the Departments of Usulután, San Miguel, and La Unión was planned for 1964 but was not instituted because of lack of funds. In Costa Rica, budgetary difficulties prevented the initiation of semiannual cycles of dieldrin during 1964 in areas of persistent transmission where excito-repellency of the vector toward DDT is considered an important cause, and also interrupted the normal progress of the campaign in both problem and non-problem areas. In Guatemala, supplementary attack with drugs was scheduled for 1964 for 195,000 permanent residents and 154,000 temporary residents in areas of high vector resistance to insecticides, but was carried out only among 20,000 persons in normal collective-treatment programs; 19,600 additional persons were also treated by personnel of cotton plantations where they were employed, in a cooperative program between the plantations and the malaria service. During this year of inadequate attack measures, cotton cultivation and the area with DDT-resistant vectors expanded continuously. The adverse effects on the malaria eradication program can be seen in the country tables for Guate-

mala relating to epidemiological evaluation operations (see pp. 279–281).

In Haiti, an evaluation was made in July 1964 after five cycles of spraying. The conclusion was reached that transmission had been interrupted over considerable areas but that it persisted despite normal DDT intradomiciliary spraying operations in other large territories. The habit of the population to remain outdoors during peak biting hours of the vector, *Anopheles albimanus*, is considered a main cause of this persistence. In the area (of about 2,000,000 inhabitants) in which transmission had apparently been successfully interrupted, spraying was stopped in mid-1964 in order to conserve resources for a trial of quarterly cycles of DDT in areas with persistent malaria; this measure proved inadequate in high-transmission areas. In October 1964 a trial of collective treatment using chloroquine-pyrimethamine combined tablets on a three-week cycle was initiated in Petit Goâve with promising results (see Table 6). It is planned to expand the program of collective treatment to cover 574,000 persons during 1965. The region of presumed interruption of transmission remains under a passive type of surveillance with focal attack to be used where indicated. DDT is being sprayed in an annual cycle in an area of some 930,000, and surveillance measures with focal attack will be maintained in these areas.

Mexico still faces problems of persistent transmission in areas with over 4,300,000 persons. Transmission is at low levels but has not decreased beyond those levels. Experiments were made during the year with larviciding and varying spraying schedules with some success. A program of attack integrating intensified DDT spraying and case-finding with radical treatment of all cases was initiated in the problem areas of the State of Oaxaca on the south coast with financial support from WHO. Complete attack on the problem areas during 1964 was prevented by inadequate financing; it is expected that in 1966 the Government will be able to provide the substantially increased budget required.

In British Guiana chloroquine resistant strains of *Plasmodium falciparum* caused adoption of DDT spraying in 1962 in an area of the interior, supplementing the chloroquinized-salt program which was the main attack measure. This program achieved good results after an interruption early in 1963, and cases are now confined to a few foci.

A summary of programs of collective treatment with antimalaria drugs is presented in Table 6. This attack measure has increased in importance and will undoubtedly play a large role as a complementary method in the future in problem areas where there are resistant or excitable vectors or where outdoor biting occurs to a considerable degree.

In general, events during 1964 have shown that satisfactory results are obtained in places where technical measures properly adapted to the existing situation are thoroughly applied; however, in the absence of adequate attack covering all the areas where transmission persists, combined with good surveillance in all cleared areas, transmission may rise and the eradication work may have to be extended and become more difficult.

Field Operations

Personnel engaged in national malaria eradication programs is shown by category of operations and by type of work in Table 7. Tables 8 to 11 present available details on personnel, by country.

Spraying operations personnel were slightly more numerous at the end of 1964 than they had been at the end of the previous year. The increase occurred mainly in Brazil's federal program, where additional areas were brought into the attack phase. Honduras also employed more spraying operations personnel at the end of 1964 than at the end of the preceding year, but the drop reflected in 1963 was due to financial difficulties. Spraying cycles in El Salvador were timed so as to take place in only six months of the year; there were therefore no spraying personnel at 31 December. Spraying was carried on in 1964 and will be continued in 1965. In Haiti the drop in personnel stems from the discontinuance of spraying in large areas, as discussed above. The decrease in Surinam is an indication of difficulties experienced during the year by the program in the interior of the country, where refusals by the population to permit spraying increased for various social reasons. Operational changes were attempted in order to overcome some of the objections and obtain the cooperation of the people. The most promising one was to hire spraymen in every village among members of each family group, train them in spraying techniques, supervise their work closely, and pay each one according to the number of houses sprayed. The approach is

unorthodox, but special approaches must be devised when dealing with special populations.

The number of persons employed in epidemiological evaluation was also somewhat higher at the end of 1964 than a year earlier. The over-all total reflects the increases in a number of programs: in Jamaica which was in the final year of its consolidation phase; in Honduras, again showing in part the unusually low number employed in December 1963 and in part increased evaluation activities in areas newly added to the consolidation phase, together with preparations for a projected collective treatment program in the southern problem area; and in Haiti, where both drug distribution and intensive surveillance required additional evaluation personnel. An increase occurred in El Salvador partly as a result of seasonal incorporation into evaluation activities or drug distribution in programs of collective treatment. Venezuela nearly doubled the number of personnel in this category, owing to its programs of collective treatment for over 115,000 persons. Cuba and the Dominican Republic also experienced increases. Four programs had significant decreases in evaluation personnel: Bolivia and Costa Rica, where personnel reduction was caused by budgetary reasons; Mexico, where the number of physicians increased but that of evaluators fell; and Trinidad and Tobago, which concluded its consolidation phase in the last half of 1964.

Some increase occurred in the total number of persons in administrative and related activities because in Brazil the federal program increased its personnel in this category by several hundred. A number of programs experienced decreases, some of which, as in Peru, were related to restructuring of zone divisions to meet the current needs of the campaign more economically without hampering its efficiency.

With regard to transport operations, the greatest increase in personnel was in the Brazilian federal program. In Peru, increased attention to activities in the Amazon basin region is reflected in the increase in motorboat operators. Venezuela increased the number of operators of insecticidal fogging machines. Decreases occurred in the transport category in São Paulo, El Salvador, and Guatemala, and smaller changes occurred in other programs.

Table 12 details the means of transportation used in the various programs and shows the increasing use of motorcycles, which have more than doubled in number, and of bicycles which also doubled. These changes result from increased evaluation operations and drug distribution programs, which require one-man transport. An increase of almost 20 per cent occurred in the number of motorboats used in the campaigns, while the number of boats without motor, already low, decreased further. Venezuela increased the number of fogging machines used for peridomiciliary fogging of vegetation. Means of transport—two-wheeled, four-wheeled, and fluvial—have as usual been provided promptly by the United Nations Children's Fund (UNICEF) in the kinds and quantities recommended by PAHO.

The country by country figures for national budgets for malaria eradication in 1963 and 1964 and amounts committed for 1965 are shown in Table 13. By comparing the amounts actually provided to the programs in 1964 with the amounts committed for that year (shown in the XII Report on the status of malaria eradication in the Americas [3]), it can be seen that five countries provided more than was originally planned; these were Argentina, Bolivia, Costa Rica, Honduras, and Venezuela, all of which were experiencing some difficulty either in financing or in technical matters. Although four of these had increased their financing above the committed level, they were still considered underfinanced. Four programs provided exactly the amount committed; and seven provided very nearly the committed amount, although of the seven, six fell slightly short. Among the territories, British Guiana increased the amount of the national malaria budget significantly, while British Honduras and Dominica reduced theirs as a result of progress in their programs. The programs in Grenada and Surinam received what had been committed.

If commitments for 1965 are compared with amounts provided in 1964, a slight decrease can be noted. This decrease is more than accounted for by the reduction in the national budget of the Brazilian federal program, for which a new plan of operations has been prepared calling for extended activities over a somewhat longer period than had been previously anticipated. This extension was required for financial reasons, and within a true eradication program, is possible only because the great size of the country permits eradication to be carried out successively region by region.

[3] Document CD15/5 (mimeographed).

Programs in South America which made a sizeable increase in their budget commitments in 1965 include Argentina, Bolivia (this would merely restore the total budget to its 1963 level), Colombia, Ecuador, Paraguay, and Venezuela. Of these programs four were underfinanced in 1964 and three are still considered underfinanced. In the Isthmus of Panama and the Central American region, Guatemala and Panama have increased their commitments greatly compared with 1964. Guatemala had also increased its budget in 1964 and the 1965 commitment is double the 1963 budget. In Panama the 1965 budget will restore the program's funds to the level planned but not actually met in 1964, plus an increase of some 7 per cent. In the Caribbean, Haiti has doubled its commitment (this program, like that of Bolivia in prior years, is financed primarily by external funds from the U.S. Agency for International Development (AID)), Cuba has increased its budget slightly, the Dominican Republic planned an increase of about 14 per cent, while Jamaica and Trinidad and Tobago, both now finished with their consolidation phase, have reduced their commitments.

Among the territories, Dominica has scheduled a restoration of the budget to the level projected but not met in 1964; St. Lucia, which is in maintenance phase, has restored part of the decrease which occurred in 1964; and the remaining programs will continue at approximately the same level as last year.

The Central American countries whose malaria campaigns face serious technical problems, and Costa Rica, where some problem areas also remain, are taking steps to provide considerably higher budgets over the next three years in order to permit their programs to attack the existing problems with thorough, technically adequate, and coordinated campaigns throughout Central America.

Table 14 presents data on active and passive case search in each program. If a comparison is made between the columns showing the percentage of positive smears taken in active search and those taken by the passive network, it can be seen that more cases are found by the latter method. This is to be expected since the persons from whom blood samples are taken by passive search are self-selected as possible malaria cases.

A summary of the results of case-detection activities from 1958 through 1964 appears in Table 15. Both the number of smears examined and the number of positives found increased in 1964 as compared to 1963, and on the average the percentage of positives increased. Analysis of these figures by country shows that the increase is mainly accounted for by increasing levels of positivity in Bolivia, Costa Rica, Guatemala, Haiti, Paraguay, and Venezuela. In some of these cases heavy sampling in problem areas accounted for a great part of the increase. In Bolivia and Paraguay this was due to outbreaks in localized areas. In Haiti, the rise in incidence was largely the result of house damage and floods which followed the hurricane late in 1963. In El Salvador there was a marked increase in 1964 in the total number of cases, especially in the eastern coastal section where the planned collective treatment program could not be carried out for lack of funds. In Guatemala there was a marked rise in both the number of cases and slide positivity owing to increased transmission in the western half of the Pacific coastal zone where vector resistance to DDT has been rising rapidly, following accelerated cotton cultivation in the last two years. Increases occurred in Venezuela both in the number of cases imported from Colombia and in those infected locally. In Costa Rica, cases of malaria showed a sharp increase in one portion of the consolidation area; because of this, the total number of positive slides remained the same as in the previous year, despite a drop of 50 per cent in the number of slides examined.

II. SPECIAL TECHNICAL PROBLEMS

General

The technical problems which are currently impeding progress toward eradication and increasing the cost of success have been fully described in preceding annual reports. The known technical problems have not changed in any country, except in degree or extent in a few. These problems are: physiological resistance of the vector to insecticides, excito-repellency, sorption of insecticides into mud walls, repairs in houses and the construction of new ones between spraying cycles, outdoor biting habits of the vector, migration of population, and drug resistance of parasites. Since the distribution and impact of these problems have already been described both in this and prior reports, only the significant changes will be mentioned here.

The most marked deterioration occurred in the western half of the Pacific coastal area of Guatemala and adjacent portions of the State of Chiapas

in Mexico, where cotton cultivation and DDT resistance have been increasing rapidly in recent years.

There were proved cases of chloroquine resistant *P. falciparum* report for the first time from Belém and Santarém in Brazil, but the location where these infections were acquired is not known. An outbreak of cases with many deaths was reported among Indian tribes in the interior of Venezuela near the Brazilian border, and suspected cases of chloroquine resistant *P. falciparum* infections were reported during the year in Bolivia and Peru along their borders with Brazil, but not elsewhere.

Apparently the *P. falciparum* strains resistant to chloroquine are spreading in Brazil along the road between Belém and Brasilia. Outbreaks of malaria with deaths have been reported along the road; cases (*P. falciparum*) did not respond to chloroquine treatment so that quinine had to be used. A branch road to Manaus is now to be constructed, which probably will be plagued with the same difficulty.

Evaluation of Methods for Solving Problems of Continuing Transmission

1. *Change to an alternate insecticide*

During 1964 malathion remained the only new insecticide currently available for substitution on an operational scale when resistance exists to both DDT and dieldrin. A purified grade was tried early in the year to see if house spraying refusals could thereby be reduced. The disagreeable odor of technical grade malathion was appreciably less and lasted a shorter period so that complaints were greatly reduced; the actual number of outright refusals, however, was not altered a great deal. Nevertheless, there were fewer absences (hidden refusals).

Malathion continued to be used in the city of Estelí, Nicaragua, apparently with success. A low level of cases continued, but on investigation nearly all proved to have contracted the infection outside the city. In the sugar estates of Nicaragua, malathion was used for the second full year. Cases persisted at about the 1963 level (5-6 per cent of positive smears) in the estates as a whole, although these cases appeared concentrated in certain parts of two estates. This made the application of mass drug treatment there more economical during the second half of the year. This combination was used in five of the country's worst localities in the second half of the year with very good results.

Malathion, at the rate of 2 g/m² every three months was used in the entire southern problem areas of Honduras, without regard to type of houses, starting in July 1963. Two rather irregular cycles were completed when a financial crisis halted the operation during the first four months of 1964. It was resumed on 23 April 1964, but the first cycle was not completed until mid-August, after two and a half months of extraordinarily high rainfall. This, together with a high migration of infected persons from adjacent parts of El Salvador, which were suffering the worst malaria outbreak in many years, prevented a valid comparison with former years. Nevertheless it was obvious that, given the combination of circumstances in the problem areas of Honduras, malathion alone could not halt transmission. Perhaps an ideal indoor residual insecticide might fail under those conditions. Because of the urgent but relatively small problem, it has been decided to use the more certain though costlier method of mass drug distribution, which protects against both outdoor and indoor biting.

Field trials of dieldrin at 0.3 mg twice a year in Panama have not halted transmission; the exact cause of failure is not yet known, but defective spraying coverage has been a contributing factor. Necessary entomological studies have been started. In Mexico a field trial of BHC, at the rate of 0.5 g/m², will be made in an area of the Costa Chica (Guerrero) where irritability of the mosquito to DDT is considered a major factor and the vector is susceptible to dieldrin.

The two-year DDVP study in Haiti, carried out in cooperation with AID and the Communicable Disease Center (USPHS) was completed in July 1964. An epidemiological analysis was made by PAHO advisory staff indicating that DDVP and DDT, in the area chosen, produced about the same degree of partial control and neither was interrupting transmission. Outdoor biting was considered the major cause of failure.

2. *Rescheduling or increasing DDT cycles*

In the problem area of the Costa Chica (Mexico), the trial of DDT in four-month cycles with three different dosage schedules was continued: one area used 2 g/m² for each cycle, one used 1 g, then 2 g, then 1 g, and one area used 1 g in all three cycles. These have now all been compared with 2 cycles per year at 2 g and only the 2, 2, 2 g dose was con-

sidered worthy of continuing in trial form. While this application did not successfully halt transmission in many localities, there were some differences suggesting that a greater effect had been achieved. This study is being combined in part with increased search for cases and radical treatment.

Owing to the lack of adequate resources in El Salvador, an attempt was made in 1964 to conserve funds by limiting DDT spraying to altitudes of 0-200 meters, considered as the hard-core malarious area. The decision to conserve funds was dictated by the urgent need to extend collective treatment to the rest of the area between 0 and 100 meters, where about 70 per cent of the cases occurred. However, because of shortage of funds, this program was not carried out in the three eastern Departments of Usulután, San Miguel, and La Unión. In order to improve the efficacy of spraying, the two cycles were rescheduled at three-month intervals in such a way as: (1) to concentrate the insecticide during the rainy season, and (2) to spray late in the first semester after the usual prerainy season house alterations had been made. The first spraying cycle was programmed for May, June, and July, but was actually completed on 14 August. The months of June, July, and August were abnormally rainy, and the worst malaria outbreak in years occurred in the three eastern departments which depended on this measure alone. The aim of having a fresh deposit of DDT throughout the rainy season becomes very difficult to achieve. Nevertheless, it was also shown, as has long been recognized, that in high resistance problem areas DDT alone cannot prevent all the transmission. The actual value of DDT is seen only where similar areas are compared with and without DDT. An earlier observation in a resistant area of Nicaragua was terminated when one of the areas where DDT was suspended developed such a high malaria incidence that malathion and mass drug treatment were used to protect the population. In Guatemala, one area with about 5,000 population where malaria persisted was divided in half. In one half, DDT was suspended in May 1963. This area showed an increase of 28 per cent in incidence in 1964 over 1963, while the other showed a decrease of 52 per cent. In July 1964 (near the peak of transmission) a large survey was made in both areas. The one where DDT was continued showed 2.9 per cent positive, while the one where it was suspended showed 9.6 per cent. Comparable figures of slide positivity for the entire year were 8.0 per cent and 18.4, although in 1963 the figures were 18.5 for the first half and 14.4 for the second. DDT resistance in this area was about 95 per cent when measured in 1961, at a point halfway between the major population centers of the two areas.

Antilarval Measures

During 1964, after one year of mass drug distribution in the problem areas of the Departments of Madriz and Estelí (Nicaragua), transmission persisted at medium to high levels so that additional methods were required. In and near the town of Condega, where acceptance of medication had fallen below 50 per cent and cases reached 500 per year, breeding places were limited to river bottoms and shallow wells. Larviciding with fenthion was tried in June 1964, and after adjusting the dose to local conditions, the results were so good that mass drug distribution was stopped and radical treatment of known cases was instituted instead. In other localities with better acceptance but continuing transmission, larviciding was used to supplement the drug program. Some difficulties were encountered with aquatic vegetation. While larviciding was not perfect, the combination was effective.

Antilarval measures were first used in the Sanarate River valley of Guatemala from November 1961 to August 1963. Both *A. albimanus* and *A. pseudopunctipennis* disappeared completely. The latter returned promptly in large numbers after larviciding was suspended, while *A. albimanus* was not seen until November 1964. Imported malaria cases were plentiful during all of 1964, but autochthonous cases appeared in large numbers in the second half of the year. This area was the worst problem area in the country in 1959 and 1960 and larviciding will doubtless have to be used again. The lesson to be learned from this field observation is that larviciding should be reinitiated at the time the first autochthonous case appears, or sooner.

Antilarval measures using fenthion were field tested in 1964 in two areas of persistent transmission in the northwestern part of Mexico. The entomological results were very encouraging; in these latitudes, the measure may be successful when used only from June to November. Trials will be continued. It is clear that this measure is practicable only where breeding places appear constantly and where they are not too extensive in proportion to the population protected.

Mass Drug Distribution

A great deal of additional field experience was acquired in the use of this measure during 1964. This has demonstrated the need to start intensive vigilance immediately after mass treatment is suspended in any area or locality. Zone I of El Salvador, with 59,000 inhabitants, was treated in 1963 (see Map 3). Area A, with 14,500 inhabitants and the lowest transmission potential, was placed under vigilance after only 12 cycles of drugs given every two weeks. This area has remained free of autochthonous cases, but occasional imported cases have been discovered and given radical treatment.

Area B, with 27,500 inhabitants in a coastal area, underwent 15 cycles from April through November 1963, and was kept under vigilance without treatment during the following four months of the dry season (December 1963-March 1964). During this period, there were 18 imported cases, 18 autochthonous cases (in very few foci), 9 relapses, and 5 lost cases. This is considered a very satisfactory record in view of the tremendous migration from infested areas and lack of experience in vigilance during this first field trial.

Area C continued under treatment during 23 cycles, but the prolongation wearied the population considerably.

In April 1964, all of Area A, 14,500 of the Area B population, and 7,000 in Area C were continued under vigilance, and 24,000 in Areas B and C were placed in the second "year" of treatment. Transmission was reestablished subsequently in two localities of Area B under vigilance, and these were placed again under attack with drugs. There were imported cases present which may have initiated the transmission.

Results during the rest of the year were excellent. Cases, mainly imported, remained at a rather consistently low level during June to September (the period of high transmission in the rest of the country) and dropped to zero in October. Importation of cases continues to be a risk, however, and only the strictest vigilance plus rapid reinitiation of focal mass drug distribution can maintain these gains until the rest of the country, and doubtless all of Central America, are equally clean.

It should be noted that these 59,000 people were under the protection of DDT spraying, and that part of the area had susceptible vectors, while resistance was partial in the rest of the area.

In Zone II, treatment was started in February 1964 in localities from 0 to 100 meters of altitude in accordance with an emergency plan prepared the previous October on the basis of a limited budget. The response was less rapid and complete than in Zone I mainly because of the larger amount of migrant labor entering from the highly malarious untreated areas to the east. Nevertheless, about 12,000 persons were dropped from the program in this Zone because very few cases of malaria were discovered among them, and new localities above 100 meters of altitude were placed under treatment because of high transmission which existed there. Before the year's end, it was only too clear that this program could not succeed until transmission was effectively attacked in the remainder of the problem areas.

Treatment was not initiated in Zone III because of lack of funds.

In Nicaragua a contrary experience occurred. Treatment was not as well done and a lower percentage of acceptance was achieved. Treatment was terminated after 18 to 26 cycles in many localities of the Madriz-Estelí program (an area of high DDT resistance with no insecticide protection at all), wherever epidemiological evidence seemed to permit this. Some of these localities remained malaria free, but because of overall lack of personnel and the removal of too many workers to perform mass drug distribution in other areas, case finding and remedial measures were too slow, and rarely was a locality placed again under mass treatment. Therefore, transmission was reestablished in the majority in 6 to 8 months, sometimes at high levels. In addition, inadequate laboratory staff and a backlog of unexamined smears prevented prompt institution of focal attack measures when these might have been successful.

In October 1963 mass drug distribution was abandoned in the Nueva Concepción area of Guatemala (35,000 people), a failure resulting from the low percentage acceptance of the drug and the high importation of cases from surrounding untreated areas. In August 1964 this high transmission area became so highly malarious that an emergency distribution of drugs for radical treatment was made to all persons with symptoms on a presumptive basis.

Two house-to-house drug programs were instituted in Guatemala along the frontiers with Mexico and El Salvador. These were of only 8 to 12 cycles

and no lasting change is anticipated because vigilance is not being maintained. A field trial was also made of drug distribution using personnel of the major plantations to carry out the actual work of drug distribution. The epidemiological results were in proportion to the percentage treated—94 per cent reduction to 90 per cent or more treated, 32 per cent reduction to 70 per cent treated, and an increase over the preceding year where none were treated (controls).

A field trial (or pilot project) of mass drug administration was started in Haiti in October 1964 in order to determine the acceptability and effectiveness of a proposed mass drug distribution schedule there. Since 98 per cent of the cases are *P. falciparum* malaria and since nearly 100 per cent of the population is of the negro race, in which primaquine sensitivity is a more common occurrence, a combination of chloroquine and pyrimethamine was chosen. The pyrimethamine has two advantages over primaquine when used against *P. falciparum;* its anti-gametocyte action lasts much longer and it is causually prophylactic, that is, it prevents *P. falciparum* from developing in the liver. The dosage of chloroquine was increased to 600 mg for everyone over 12 years of age in order to try for protection for three weeks instead of two, and undoubtedly reactions and complaints will be more frequent. In the first five cycles, acceptance dropped from 99 to 90 per cent. The incidence dropped from 15 per cent positive slides to 1 per cent positive. And, as expected, the complaints rose rapidly. Nevertheless, it is planned to extend the measure to all of the problem area (570,000 persons), since outdoor biting appears to be the major cause of persistence and is likely to block an adequate result using any residual spray alone in areas of high mosquito density. Preliminary tests for drug resistance of plasmodia have shown that there is at present no problem of resistance to either pyrimethamine or chloroquine in Haiti.

Chloroquinized Salt Programs

The British Guiana chloroquinized salt program completed its fourth year. Two districts with 28,000 people have remained negative since the third month, except for two cases in 1963. The program is to be terminated in these districts. In the Rupununi area, where chloroquine resistant strains of *P. falciparum* have created the major problem, the use of treated salt is being continued, since some *P. vivax* remains and some protection against infections with *P. falciparum* is probably obtained, although certainly not against all. House spraying efforts are being intensified as more and more temporary shelters are found deep in the forest.

Long-acting Repository Drugs

Plans for a field trial of cycloguanil pamoate (trade name "Camolar," formerly known as CI-501) were drawn up and a site tentatively selected. Early in 1965 it was learned that field trials of this drug in Africa had revealed that the 5 mg/Kg dose was insufficient for small children. Further action has been suspended until a new dosage schedule is worked out and tested for safety and absence of reactions. Dr. G. Robert Coatney, of the U.S. National Institutes of Health, who is carrying on the studies, is now testing revised dosages for their suitability in children.

Field Test of Disc Flow Regulators for Spraying

A satisfactory material has been developed for the regulator disc, and field tests indicate good flow control during the three-month period of the tests; it is expected that the present disc will give the same good control over a much longer period.

These discs have been recommended for field use, and they are being used exclusively in a number of programs and are being introduced in stages in others. The advantages of constant flow are numerous but the principal one is a more uniform deposit of insecticide.

Experimental work continues in an effort to produce a nozzle tip which will further improve the distribution of the insecticide.

Poor Suspensibility of DDT

During 1964 many programs encountered the problem of poor suspensibility of DDT. Many tests were run to define the extent of the problem and investigations were made to determine the cause and the effects. The material had been in satisfactory condition at the time of shipment, but a large number of lots suffered from a latent defect which produced poor suspensibility after storage. The cause is still not definitely known, but one of the effects is to increase the concentration of insecticide during the first several minutes of spraying,

with consequent reduction of concentration later.

It has been found that this condition can be corrected by the addition of a small amount of a detergent, which restores normal suspensibility. Suitable detergents are available locally in most countries. The killing power of the residual DDT is not adversely affected by this additional detergent; bioassays have been made to confirm the lethal action. It is thus possible to utilize existing supplies of DDT even when these are defective in suspensibility; meanwhile, efforts are being made to eliminate the problem at the manufacturing level.

Stimulation and Coordination of Operational Research

Field trials and investigations such as those described in this section are of major operational significance for future planning. In addition, various meetings and visits to the field have been made with representatives of AID and the Communicable Disease Center (USPHS) to discuss ways in which these agencies can assist, participate, and cooperate in more intensive operational research of this type.

III. RESEARCH ON MALARIA

Malaria Eradication Epidemiology Team—AMRO-0210

The Synoptic Studies of this team in El Salvador were written up in final form in 1964, and accepted for publication.[4] The main points were described in the XII Report on the status of malaria eradication in the Americas.[5]

Extensive work was continued during 1964 by the staff in redrafting and condensing the final report on the Intensive Studies of two representative localities of El Salvador, left unfinished by Dr. René G. Rachou at the time of his untimely death.

The Epidemiology Team is being reconstituted in Mexico. The operation is being carried out in the State of Oaxaca, with headquarters at Pinotepa Nacional, and consists of an operational study and the evaluation of methods of overcoming the problem of persistence of transmission. At present it is devoted to the largest problem area in Mexico where there is a low level persistence of transmission in areas of susceptible but irritable vectors, both *A. albimanus* and *A. pseudopunctipennis*. The first aim is to evaluate the effectiveness of an integrated attack using the best spraying routine possible, plus intensive case-finding and radical treatment. Other attack methods will be evaluated later, wherever the first proves insufficient.

Insecticide Testing Team—AMRO-0209

The Insecticide Testing Team continued its work in El Salvador and concentrated on the evaluation of new insecticides, improving the Excito-Repellency Test equipment, and evaluating and perfecting the method. Extensive field reconnaissance and epidemiological and entomological studies were also made to select suitable areas for large-scale trials of one or more new insecticides when they have passed the hut and village scale of testing. A great many useful observations were obtained in the latter operation which permit correlation of rainfall, productivity of breeding places of various types, adult anopheline density (*A. albimanus*), and malaria transmission. These data should be useful both in future research and in guiding focal attack on malaria transmission.

The evaluation of new insecticides included a very large series of observations of their duration on all common types of wall surfaces, with and without sealers; their inherent excito-repellency; and their ability to overcome or neutralize the excito-repellent effect of an underlying coat of DDT which will be found in the houses whenever a new insecticide is first used and for some time thereafter.

Achievements include the design of a smaller, lighter, more easily transported excito-repellency test box, now identified as PASB Mod. MLW; comparison-testing the new box with the old; and preparing instructions for its use. WHO has shown an interest in having this model tried in various parts of the world.

Two of the new insecticides tested in 1963 were carried forward into 1964 and seven more added to the group being evaluated. All are compared with DDT and with malathion. As for duration on various surfaces, none is as long lasting as DDT, but several are better than malathion. Furthermore, the E-R tests of combinations with DDT show that they exert their lethal action so fast that

[4] Rachou, R. G., Lyons, G., Moura-Lima, M., and Kerr, J. A.: "Synoptic Epidemiological Studies of Malaria in El Salvador." *Amer J Trop Med* **14**:1-62, 1965.

[5] Document CD15/5 (mimeographed).

the mosquito is knocked down before becoming irritated enough by DDT to escape a lethal dose, even when the amount of DDT is 10 times the amount of the new insecticide. OMS-33 is the most promising in this respect. On sorptive muds, however, even the best—OMS-33 (Bayer 39007)—is not able to produce satisfactory mortality beyond six weeks at a 1 g/m^2 dose and 30 minute contact. Longer exposure may improve this somewhat, and fortunately some of these new insecticides are non-irritating. Several others tested less extensively are also promising enough for further study and it is part of the overall plans of WHO to have several insecticides available in the event resistance develops to the first one used.

Extensive tests done by AMRO-0209 with mosquitoes from different sources showed that mosquito populations which have had the most contact (over the years) with cotton cultivation have the highest tolerance for malathion, four to five times that of DDT-susceptible strains taken from areas where cotton was never grown.

The pattern of "resistance" to malathion is not well known, but it appears to be a type of progressive tolerance. It is now appearing in some of the mosquitoes found in the cotton-growing parts of Nicaragua and El Salvador. It undoubtedly lowers the effectiveness of malathion in the sugar estates (which also grow cotton), and may have been operative in Honduras also, although there were not enough tests to demonstrate its effectiveness there. These changes are probably the result of heavy selection by methyl parathion, one of the most widely used insecticides in the control of cotton pests.

Resistance of Malaria Plasmodia Strains to Drugs—AMRO-0212

The Screening Center for the study of this problem was very active throughout 1964, and confirmed resistance in additional strains from Brazil and Colombia as well as a new area in Venezuela, near the Brazilian border. Resistance to varying combinations of different drugs was demonstrated.

The most important contribution, however, was the study of different dosage schedules of pyrimethamine and sulfonamides, which proved to be curative for all strains, even those resistant to pyrimethamine alone. After more than 30 treatments had been given with pyrimethamine at a dosage of 100 mg daily for three or four days without trouble, five cases in close succession, out of 16 who were receiving 50 mg daily for four days plus a total of 2.5 mg of long acting sulfonamide in four days, showed bonemarrow depression, and four of these cases received transfusions. All recovered promptly, and leucovorin alone was shown to be sufficient in most such cases. However, these reactions prevented this method from being recommended for the treating of chloroquine resistant cases in the field. Nevertheless, this combination, or quinine, is the only medication certain to cure cases at present of chloroquine resistant malaria. An increase in tolerance to quinine is beginning to appear.

There is urgent need for more research in this field, but as the Screening Center was closed at the end of March 1965 this research must be carried out elsewhere.

IV. INTERNATIONAL COOPERATION

The distribution of PAHO personnel assigned to malaria eradication projects in the past three years and projected for assignment in 1965 is shown in Table 16, by program and by type of consultant.

The number of training centers giving instruction in malaria eradication theory and techniques in this Hemisphere has been reduced to two: the courses given at the School of Hygiene and Public Health of the University of São Paulo and those given by the School of Malariology and Environmental Sanitation in Maracay, Venezuela. Two courses were given, in São Paulo as usual, one in medical entomology with emphasis on malaria, the other in malaria eradication. One PAHO fellow from El Salvador attended the medical entomology course; no fellows were sent this year to the malaria eradication course. In addition to the PAHO fellow, 10 Brazilians were trained in the malaria eradication course in São Paulo. One course was presented in Maracay, attended by 32 trainees, of whom 25 were Venezuelans, two PAHO fellows, and five foreign recipients of fellowships from the Venezuelan Government; PAHO assisted with payment of transportation expenses. The foreign students included two Colombians, two Ecuadorians, one Costa Rican, one Brazilian, and one Guatemalan.

The fellowships awarded by PAHO for study travel in malaria eradication decreased sharply in 1964, from 20 in 1963 to nine in 1964. Five of the

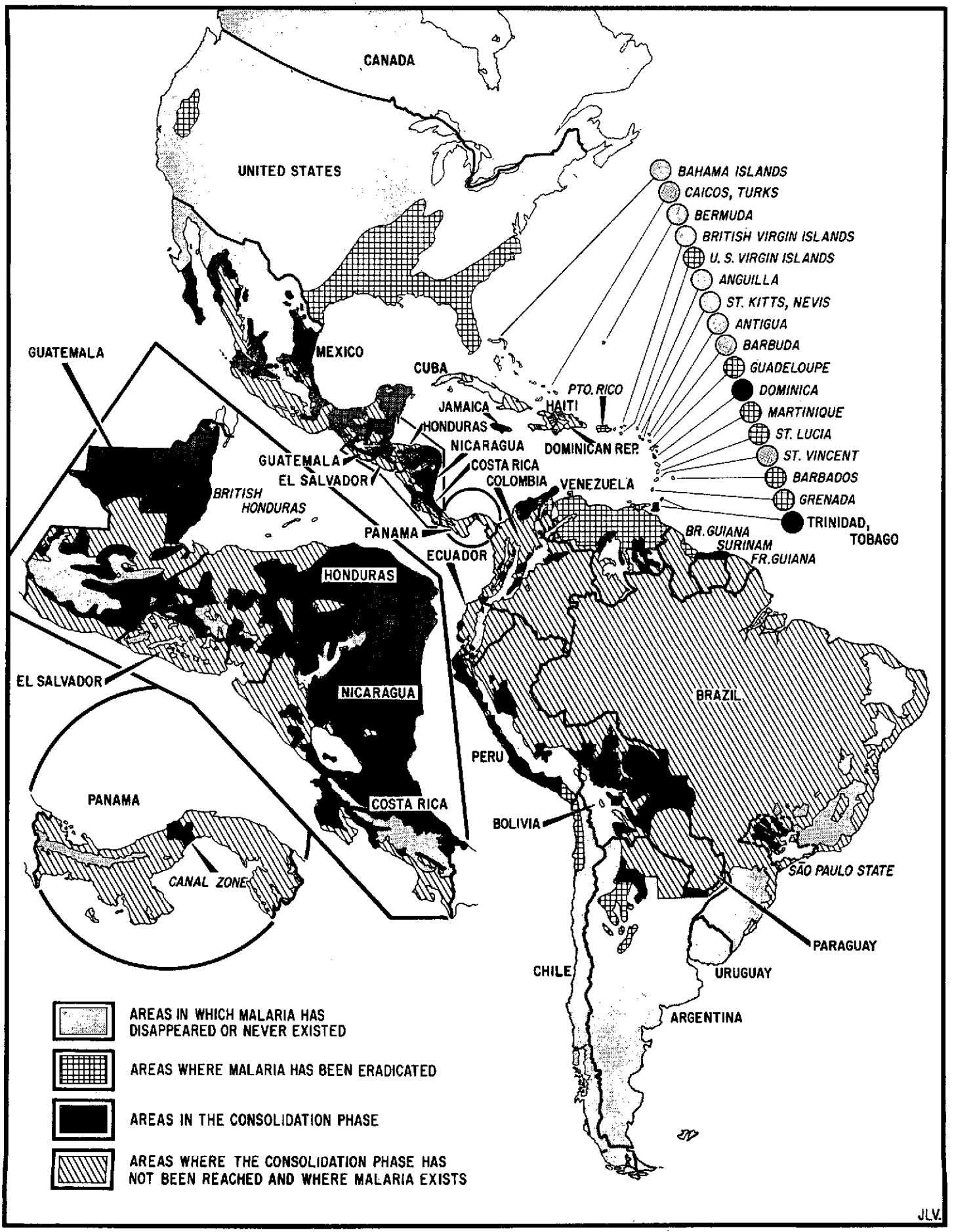
nine were doctors, three engineers, and one an entomologist. The trainees came from Brazil, Colombia, Ecuador, Costa Rica, El Salvador, and Guatemala.

Table 18 shows the amounts of equipment and supplies, excluding drugs, furnished to the various countries by PAHO to support the malaria eradication campaigns. These are essential items and cannot be obtained from local sources or UNICEF.

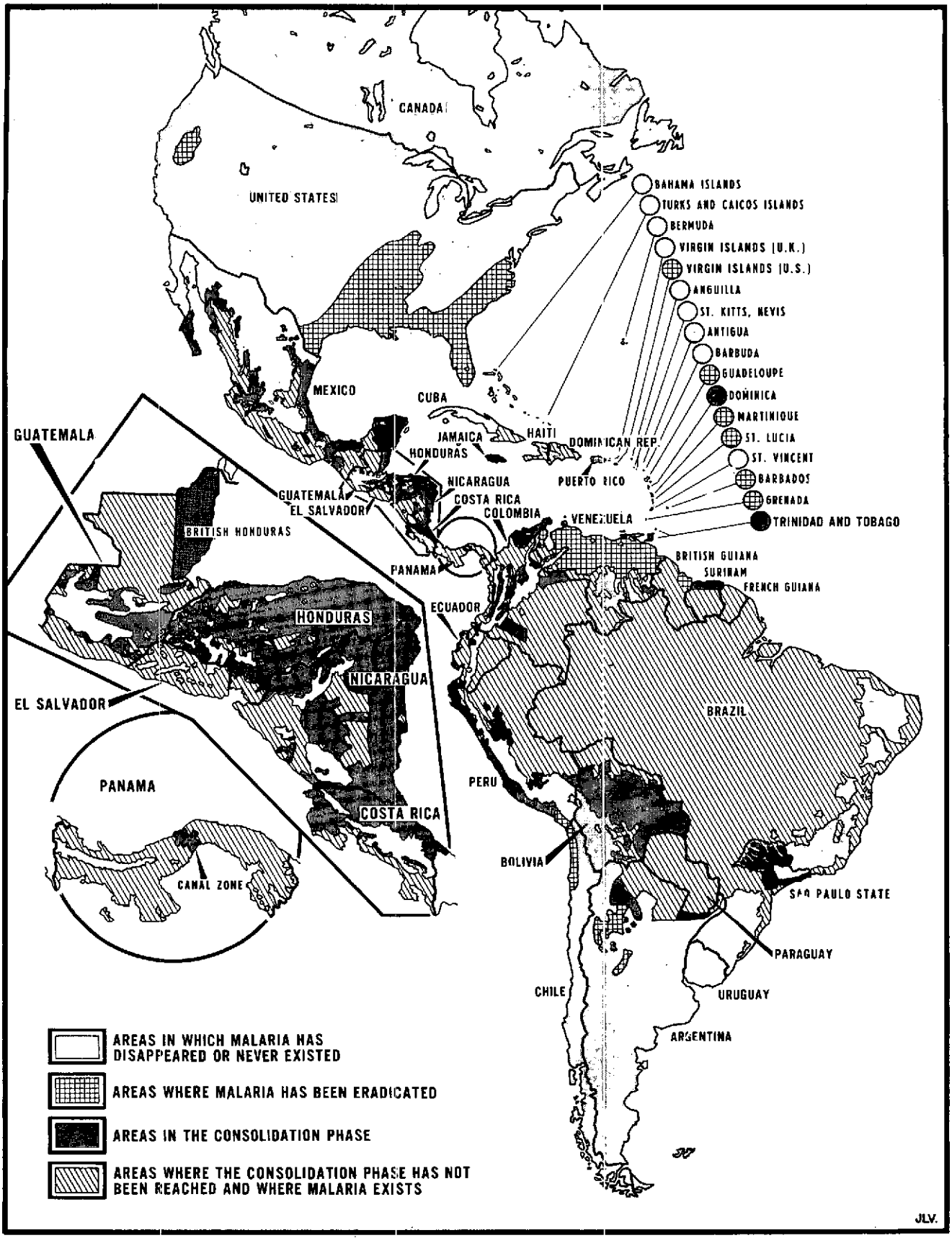
Table 19 shows the drugs provided by PAHO to the several campaigns for the period 1958-1963 and during 1964. PAHO furnishes drugs for administration as presumptive treatment or in radical cures of malaria cases; UNICEF provides drugs to be used in collective treatment programs when these are employed as an attack measure.

The amount of international contributions made to each malaria eradication program by the four international or bilateral agencies during 1964 and projected to be given during 1965 is shown in Table 20. The total PAHO/WHO contributions remained essentially unchanged from 1963 to 1964, the apparent decrease stemming from the noninclusion for 1964 of expenditures financed from the regular budget. An increase is projected in 1965. UNICEF increased its support by about 10 per cent between 1963 and 1964, mainly in the form of materials supplied to the large Mexican program. AID decreased the level of grants made to malaria eradication programs drastically in 1964, in line with its policy of substituting long-term loans to Governments to finance deficits in local costs. The projected 1965 level of AID grants is about 15 per cent below the level of 1964. In addition to grants, AID contributed $2,000,000 to the PAHO Special Malaria Fund and in 1965 its contribution is projected at $1,800,000.

The contributions of the international and bilateral agencies to malaria eradication are not entirely measurable in dollars, as they provide elements essential to the progress of the campaigns and unobtainable from any other source. They act as catalysts without which much of the achievements of the eradication programs in the Americas would be impossible.

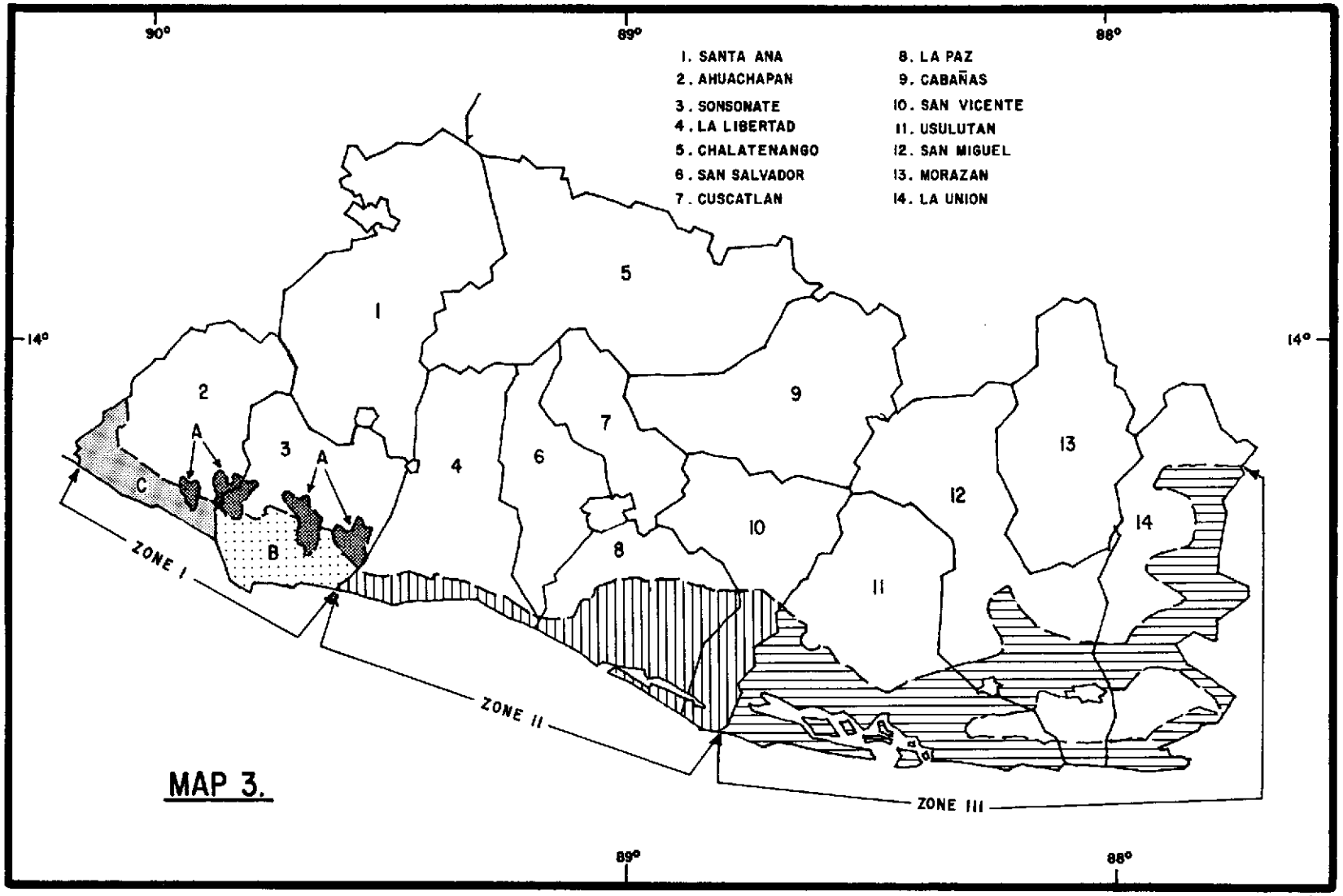


STATUS OF THE MALARIA ERADICATION PROGRAM IN THE AMERICAS, 31 DECEMBER 1963.



STATUS OF THE MALARIA ERADICATION PROGRAM IN THE AMERICAS, 31 DECEMBER 1964.

MASS DRUG PROGRAM IN EL SALVADOR



MAP 3.

jlv.

Table 1

COMPARISON OF 1963 AND 1964 POPULATION AND AREA IN VARIOUS PHASES OF THE MALARIA ERADICATION PROGRAMS IN THE AMERICAS, AND PERCENTAGES OF CHANGE BY PHASE

Phase	1963	1964	Percentage change
A. Population in thousands:			
1. Malaria eradication claimed or registered ...	56 546	57 414	+ 1.5
2. Consolidation phase	33 901	32 277	- 4.8
3. Attack phase	31 910	34 426	+ 7.9
4. Preparatory phase or not yet started	29 664	34 525	+ 16.4
B. Area in km^2			
1. Malaria eradication claimed or registered ...	2 874 214	2 874 313	+ 0.003
2. Consolidation phase	2 411 815	2 109 589	- 12.5
3. Attack phase	3 378 932	3 219 017	- 4.7
4. Preparatory phase or not yet started	7 663 009	7 852 697	+ 2.5

Table 2

Year	Population in thousands			
	Malaria eradication claimed or achieved	Consolidation phase	Annual % of increase	
			Malaria eradication claimed	Consolidation phase
1960	50 741	1 991	-	-
1961	53 357	13 879	5.2	597.1
1962	55 397	25 914	3.8	86.7
1963	56 546	33 901	2.1	30.8
1964	57 414	32 277	1.5	4.8

Table 3

STATUS OF MALARIA ERADICATION IN THE AMERICAS, BY POPULATION, 1964

(Population in thousands)

Country or other political unit	Total population[a]	Population of originally malarious areas				
		Total	Malaria eradication claimed (maintenance phase)	Consolidation phase	Attack phase	Prep. phase or program not yet started
Argentina	21 480	2 738	1 021	627	329	761
Bolivia	4 266	1 353	-	1 141	212	-
Brazil	80 332	40 291	-	2 183	6 289	31 819[b]
Canada	19 272	-	-	-	-	-
Chile	8 369	134	134	-	-	-
Colombia	17 505	9 569	-	6 053	3 154[c]	362
Costa Rica	1 387	423	-	294	129	-
Cuba	7 256	2 239	-	-	2 239	-
Dominican Republic	3 452	2 830	-	-	2 830	-
Ecuador	4 813	2 652	-	1 053	1 599	-
El Salvador	2 828	1 900	-	-	1 900[d]	-
Guatemala	4 278	1 919	-	1 057	862	-
Haiti	4 494	3 533	-	-	3 533[e]	-
Honduras	2 030	1 900	-	1 631	269	-
Jamaica	1 706	1 365	-	1 365	-	-
Mexico	39 494	20 212	-	12 740	7 472	-
Nicaragua	1 740	1 671	-	695	976[f]	-
Panama	1 210	1 165	-	-	1 165	-
Paraguay	1 900	1 579	-	-	-	1 579
Peru	10 794	3 292	43	2 204	1 045	-
Trinidad and Tobago	962	822	-	822	-	-
United States	191 300	46 400	46 400	-	-	-
Uruguay	2 996	-	-	-	-	-
Venezuela	8 336	6 225	5 822	116	287	-
Antigua	60	-	-	-	-	-
Bahamas	133	-	-	-	-	-
Barbados	235	231	231	-	-	-
Bermuda	48	-	-	-	-	-
British Guiana	631	631	589	-	42	-
British Honduras	104	104	-	104	-	-
Dominica	60	14	-	14	-	-
Falkland Islands	2	-	-	-	-	-
French Guiana	35	35	-	-	31	4
Grenada and Carriacou	93	39	39	-	-	-
Guadeloupe	298	266	266	-	-	-
Martinique	309	192	192	-	-	-
Montserrat	13	-	-	-	-	-
Netherlands Antilles	206	-	-	-	-	-
Panama Canal Zone	51	51	-	50	1	-
Puerto Rico	2 572	2 556	2 556	-	-	-
St. Kitts-Nevis-Anguilla	62	-	-	-	-	-
St. Lucia	99	84	84	-	-	-
St. Pierre-Miquelon	5	-	-	-	-	-
St. Vincent	86	-	-	-	-	-
Surinam	315	190	-	128	62	-
Virgin Islands (U. K.)	8	-	-	-	-	-
Virgin Islands (U. S.)	41	37	37	-	-	-
Total	447 666	158 642	57 414	32 277	34 426	34 525

- None

(a) Latest available official figures. (b) Part of this population is partially protected by irregular spraying. (c) Includes an area with 1 214 535 inhabitants in which spraying has been suspended, but which has not been declared in consolidation phase. (d) Includes an area of 1 204 350 inhabitants where spraying is suspended for technical reasons. (e) Includes an area with 2 072 588 inhabitants in which spraying has been suspended, but which has not been declared in consolidation phase. (f) Includes inhabitants in areas in recess from spraying. (g) 4 386 027 inhabitants in areas for which malaria has been registered by PAHO.

Table 4

STATUS OF MALARIA ERADICATION IN THE AMERICAS, BY AREA, 1964

(Area in km^2)

Country or other political unit	Total area	Originally malarious areas				
		Total	Malaria eradication claimed (maintenance phase)	Consolidation phase	Attack phase	Prep. phase or program not yet started
Argentina	4 024 458	349 051	40 100	66 963	85 922	156 066
Bolivia	1 098 581	824 260	-	619 540	204 720	-
Brazil	8 513 861	7 445 757	-	190 675	363 205	6 891 877 [a]
Canada	9 974 375	-	-	-	-	-
Chile	741 767	55 287	55 287	-	-	-
Colombia	1 138 338	946 222	-	120 777	427 281 [b]	398 164
Costa Rica	51 011	31 526	-	23 281	8 245	-
Cuba	114 524	37 502	-	-	37 502	-
Dominican Republic	48 442	39 000	-	-	39 000	-
Ecuador	291 906	175 462	-	19 198	156 264	-
El Salvador	21 146	19 300	-	-	19 300 [c]	-
Guatemala	108 889	80 350	-	19 282	61 068	-
Haiti	27 750	19 100	-	-	19 100 [d]	-
Honduras	112 088	106 969	-	97 100	9 869	-
Jamaica	11 428	10 028	-	10 028	-	-
Mexico	1 969 367	1 054 775	-	539 731	515 044	-
Nicaragua	139 000	132 385	-	91 799	40 586 [e]	-
Panama	75 650	69 844	-	-	69 844	-
Paraguay	406 752	406 590	-	-	-	406 590
Perú	1 381 800	943 200	31 040	268 210	643 950	-
Trinidad and Tobago	5 605	5 444	-	5 444	-	-
United States	9 339 900	2 255 890	2 255 890	-	-	-
Uruguay	186 926	-	-	-	-	-
Venezuela	912 050	600 000	469 552 [f]	7 681	122 767	-
Antigua	280	-	-	-	-	-
Bahamas	11 396	-	-	-	-	-
Barbados	431	430	430	-	-	-
Bermuda	53	-	-	-	-	-
British Guiana	215 800	215 800	10 600	-	205 200	-
British Honduras	22 696	22 696	-	22 696	-	-
Dominica	790	152	-	152	-	-
Falkland Islands	11 961	-	-	-	-	-
French Guiana	86 000	32 000	-	-	32 000	-
Grenada and Carriacou	344	230	230	-	-	-
Guadeloupe	1 779	1 136	1 136	-	-	-
Martinique	1 102	300	300	-	-	-
Montserrat	84	-	-	-	-	-
Netherlands Antilles	961	-	-	-	-	-
Panama Canal Zone	1 432	1 432	-	1 432 [g]	(g)	-
Puerto Rico	8 896	8 896	8 896	-	-	-
St. Kitts-Nevis-Angilla	396	-	-	-	-	-
St. Lucia	603	510	510	-	-	-
St. Pierre-Miquelon	240	-	-	-	-	-
St. Vincent	389	-	-	-	-	-
Surinam	163 820	163 750	-	5 600	158 150	-
Virgin Islands (U. K.)	174	-	-	-	-	-
Virgin Islands (U. S.)	342	342	342	-	-	-
Total	41 225 583	16 055 616	2 874 313	2 109 589	3 219 017	7 852 697

- None.

(a) Part of this area is irregularly sprayed. (b) Includes an area of 160 888 km^2 in which spraying has been suspended, but which has not been declared in consolidation phase. (c) Includes an area of 10 375 km^2 where spraying is suspended for technical reasons. (d) Includes an area of 9 031 km^2 in which spraying has been suspended, but which has not been declared in consolidation phase. (e) Includes areas in recess from spraying. (f) Includes an area of 407 945 km^2 for which malaria eradication has been registered by PAHO. (g) Spraying is continued in limited areas shown as in consolidation phase.

Table 5

THE EXTENT AND NATURE OF PROBLEM AREAS AND REMEDIAL MEASURES TAKEN AND PLANNED, AS OF DECEMBER 1964

Country and name of area	Population	Area (km^2)	Insecticide		Vector	Causes of Problem	Remedial Measures		
			Kind	Years of coverage			In operation in 1964	Planned for 1965	Results
British Guiana									
Rupununi	8 750	6 000	(a)	4	A. darlingi	Chloroquine-resistant P. falciparum	DDT spraying, 2 1/2 Yr. Rad. treatment, Pyrimethamine or quinine for relapses.	Continue	Good
Costa Rica									
Jicaral-Puntarenas	2 251	223	DDT	7	Known:	Excito-repellency to DDT; peri-domiciliary biting; open construction of houses; internal migration of population.	Mass treatment with chloroquine-primaquine bi-weekly; DDT spraying intra and peri-domiciliarly. Radical Treat. of cases and contacts	Substitute DLN spraying semi-annually for DDT; Continue Mass and Radical Treat.	Good results in Mass Treatment areas but not all areas requiring Treat. included for lack of funds.
Matapalo-Aguirre	2 684	266	"	"	A. albimanus				
Puerto Cortés-Osa	1 709	169	"	"	A. punctimacula				
Sierpe-Osa	1 321	130	"	"	Suspected:				
Tinoco-Osa	1 781	176	"	"	A. pseudo-punctipennis				
Golfito	1 482	146	"	"					
Colorado-Golfito	846	82	"	"					
Sámara-Nicoya	906	89	"	"					
	12 980	1 281							
El Salvador									
Coast 0 to 100 m. of Depts. of Usulután, San Miguel and La Unión	166 000	1 807	DLN DDT	1 8	A. albimanus	Resistance to DDT; Excito-repellency to DDT; migration of Pop. aggressions to spraying; new houses.	DDT spraying	Mass treatment	No progress in recent years
Coast, 0 to 100 m. of Depts of Ahuachapán, Sonsonate, La Libertad, La Paz, San Vicente	130 000	2 200	DLN DDT	1 8	"	"	DDT spraying; Mass Treatment with Chloroquine-Primaquine bi-weekly	Continue	Good
	296 000	4 007							

General Note: Unless otherwise noted, DDT and DLN sprayings are at standard doses and intervals.

(a) The main attack measure used was chloroquinized salt; after resistance of P. falciparum to chloroquine was discovered, DDT spraying was adopted as a supplementary attack measure.

Table 5 (Cont.)

THE EXTENT AND NATURE OF PROBLEM AREAS AND REMEDIAL MEASURES TAKEN AND PLANNED AS OF DECEMBER 1964

Country and name of area	Population	Area (km^2)	Insecticide		Vector	Causes of Problem	Remedial Measures		
			Kind	Years of coverage			In operation in 1964	Planned for 1965	Results
Guatemala									
Pacific coast (western 2/3)	329 358	6 109	DLN DDT	2 6	A. albimanus A. pseudopunctipennis (rarely)	Resistance to DDT and DLN; excito-repellency; migration; new houses	Mass treatment in cotton plantations	Mass Treatment	Poor
Moyutla	12 066	310	"	"	"	Excito-repellency; migration, new houses	DDT; Radical Treat.; mass Treat. 4 months bi-weekly		Good
Jalapa	71 069	1 324	"	"	"	Resistance to DDT and DLN, internal migration	Larviciding in Capital Distirct	Larvicides	Insufficient
Baja Verapaz	27 870	675	"	"	"	Resistance to DDT and DLN, internal migration	None	Larvicides	None
Alta Verapaz	78 025	2 112	"	"	"	Internal migration; open construction of houses	Improved spraying		Insufficient
	518 388	10 530							
Haiti									
Petit-Goâve	44 091	200	DDT	2 1/2	A. albimanus	Aggresions to spraying; habits of population	Mass treatment, Chloro-Pyrimethamine 3 week schedule	Cont. Mass treat.	Too soon to tell
Honduras									
Southern area	132 517	3 682	DDT Mal.	4 1 1/2	A. albimanus	Resistance to DDT and DLN	Malathion in quarterly cycles, but interrupted and delayed by lack of funds	Mass treatment; malathion in limited foci	Insufficient
Mexico									
Tapachula-Suchiate	41 648	1 204	DDT	4	A. albimanus	Partial resistance to DDT and DLN	DDT; Radical treatment.	Mass treatment	Transmission persists
Basin middle Grijalva river	40 596	3 078	"	"	A. pseudopunct. A. albimanus	Internal migration; open houses	Prompt spraying; Radical treatment		"

Table 5 (Cont.)

THE EXTENT AND NATURE OF PROBLEM AREAS AND REMEDIAL MEASURES TAKEN AND PLANNED AS OF DECEMBER 1964

Country and name of area	Population	Area (km^2)	Insecticide		Vector	Causes of Problem	Remedial Measures		
			Kind	Years of coverage			In operation in 1964	Planned for 1965	Results
Mexico (Cont.)									
North Slope, Sierra Chiapaneca	238 138	10 495	DDT	4	A. albimanus A. pseudopunct.	Not yet determined	---	(a)	Transmission persists
Isthmus, Gulf slope	156 662	13 467	"	"	"	Excito-repellency to DDT, exophagy; new houses	Radical treatment		"
Ravine Miguel Alemán Dam	117 736	3 562	"	"	A. albimanus	Population movements	Prompt spraying and radical treatment		Problem disappearing
Upper basin of Papaloapan river	18 749	1 757	"	"	A. pseudopunct.	Exophagy; new houses	"		
Huastecas	579 035	12 307	"	"	A. albimanus	Aggressions; new houses	"		Improving
Upper basin of Sta. Maria river	23 153	1 608	"	"	A. pseudopunct.	Aggressions because of bed-bugs	Added BHC to DDT		Transmission persists
Southern Pacific Coast	950 723	72 757	"	"	A. albimanus A. pseudopunct.	Excito-repellency, aggressions; new houses	4-month spraying cycles		"
Basin of the Balsas river and tributaries	1 349 733	68 894	"	"	A. pseudopunct.	Aggressions (studies in progress)	---		"
Morelos Valley	205 548	2 853	"	"	A. pseudopunct.	New houses	Prompt spraying	All purpose functionaries	"
Coast of Colima and Pihuamo	58 426	4 723	"	"	A. pseudopunct.	Not yet determined	---	Larvicides	"
Coast of Nayarit	94 636	6 130	"	"	A. pseudopunct.	Not yet determined	---		"
Basin of the Santiago river and tributaries	96 929	19 810	"	"	A. pseudopunct.	Population movements; new houses	Prompt spraying; Radical treatment		"
Basin rivers and Pacific coast	220 160	40 108	"	"	A. albimanus A. pseudopunct.	Excito-repellency; exophagy; new houses	Radical treatment		"

(a) A pilot Plan of Integrated Attack including DDT thrice a year, intensive case-detection and 5-day radical treatment with additional measures if necessary, began in October 1964 on the south coast of the Pacific area and will continue. Larviciding and other current measures will be continued.

Table 5 (Cont.)

THE EXTENT AND NATURE OF PROBLEM AREAS AND REMEDIAL MEASURES TAKEN AND PLANNED AS OF DECEMBER 1965

Country and name of area	Population	Area (Km^2)	Insecticide		Vector	Causes of Problem	Remedial Measures		
			Kind	Years of coverage			In operation in 1964	Planned for 1965	Results
Mexico (Cont.)									
Basins of Fuerte and Mayo rivers	132 908 4 324 780	27 693 290 446	DDT	4	A. pseudopunct.	People sleep outdoors	Radical treatment		Transmission persists
Nicaragua									
Departments of:	767 051	19 021	DDT	3 or 4	Known:	Resistance of A. albimanus to DDT and DLN	Malathion; mass treatment with chloroquine-pimaquine bi-weekly	Continue	Good
Managua			Mal.		A. albimanus				
León			"	"	Suspected:				
Chinandega			"	"	A. pseudopunct.				
Madriz			"	"	occasionally				
Estelí			"	"					
Surinam									
Upper Surinam	14 138	...	DLN	2 or 3	A. darlingi	Refusal of spraying for social and religious reasons; refusals because of DDT-resistance of cockroachs	Health education; substitution of DLN for DDT	Medicated salt beginning in 1966	Insufficient
Marowijne	2 954	...	DDT	2					
Tapanahony	5 956	...							
Lawa	2 356	...							
	25 404								

Table 6

MASS DRUG PROGRAMS IN THE AMERICAS, 1964

Country	Population treated	Area (Km^2)	Location	Drug	Cycle	Planned for 1965 *	Other measures in use
Bolivia	308	770	Quebrada de Tonina Depto. de Chuquisaca	Chloroquine-primaquine	2 weeks	C	DDT spraying
El Salvador	130 000	2 200	Coast of: Ahuachapán, Sonsonate, La Libertad, San Salvador, La Paz, San Vicente	"	"	E [a]	DDR spraying, larviciding
Guatemala	68 866	...	Nueva Concepción, Ocós, Moyutla, cotton plantations	"	"	E [b]	DDT spraying
Haiti	44 091	200	Petit Goâve	Chloroquine-pyrimethamine	3 weeks	E	--
Nicaragua	28 056	1 477	Some localities in Depts. Madriz, Managua, Chinandega	Chloroquine-primaquine	2 weeks	E	Malathion spraying; larviciding
Venezuela	116 614	...	Oriental and occidental	"	1 week: 85 922 pers. 2 weeks: 29 094 pers. 1 month: 1 598 pers.	C	Spray; peri-domiciliary; fogging

* C = To be continued
E = To be expanded

(a) Treatment terminated and vigilance instituted for 44 000 persons

(b) 1964 treatment terminated.

Table 7

PERSONNEL EMPLOYED IN MALARIA ERADICATION PROGRAMS IN THE AMERICAS
31 DECEMBER 1963 AND 1964, BY CATEGORY

(Part-time personnel in parentheses)

	Title	1963	1964
SPRAYING OPERATIONS	Engineers	119 (1)	117 (1)
	Spraying Chiefs (non-professionals)	166 (2)	208 (2)
	Sector Chiefs	646 (2)	662 (2)
	Squad Chiefs	1 923 (2)	2 082 (2)
	Spraymen	9 584 (20)	10 036 (20)
	Draftsmen	133	141
	SUB-TOTAL	12 571 (27)	13 246 (27)
EPIDEMIOLOGICAL OPERATIONS	Physicians	278 (18)	271 (13)
	Entomologists	31 (1)	21 (1)
	Entomologist Assistants	262 (12)	247 (12)
	Statisticians and Statistician Assistants	119	139
	Evaluation Inspectors	507 (2)	770 (5) a
	Evaluators	3 693 (7)	4 188 (9) a
	Microscopists	756 (14)	747 (15)
	SUB-TOTAL	5 646 (54)	6 383 (55)
ADMINISTRATION AND OTHERS	Administrators	317 (1)	347 (1)
	Administrative Assistants	947	1 123
	Accountants	34	38
	Disbursing Officers	51	50
	Storekeepers	96	106
	Assistant Storekeepers	104 (1)	93 (1)
	Secretaries	351 (1)	351 (1)
	Others	1 852 (56)	1 645 (32)
	SUB-TOTAL	3 752 (59)	3 753 (35)
TRANSPORT	Transport Chiefs, Mechanics and Assistant Mechanics	507	579
	Drivers	1 464 (2)	1 557 (2)
	Motorboat Operators	223 (2)	229 (2)
	Boatmen	36	28
	SUB-TOTAL	2 230 (4)	2 393 (4)
	GRAND TOTAL	24 199 (144)	25 775 (121)

(a) Includes personnel engaged in mass drug treatment and larviciding.

Table 8

PERSONNEL EMPLOYED IN SPRAYING OPERATIONS IN MALARIA ERADICATION PROGRAMS IN THE AMERICAS - 31 DECEMBER 1964

(Part-time personnel in parentheses)

Country or other political unit	Total	Engineers	Sanitarians or Spraying Chiefs	Sector Chiefs	Squad Chiefs	Spraymen	Draftsmen
Argentina	148	2	6	11	28	96	5
Bolivia[a]	34	1	7	3	3	20	-
Brazil (Excl.São Paulo)[b]	5 334	29	56[c]	229	800	4 183	37
Brazil (São Paulo)	606	9	-	33	128	418	18
Colombia	706	3	16	54	132[d]	487	14
Costa Rica	46	1	1	7	8	28	1
Cuba	515	1	4	15	74	419 e	2
Dominican Republic	527	3	-	14	75	434	1
Ecuador[b]	570	6	-	36	96	431	1
El Salvador	3	1	-	-	-	-	2
Guatemala	335	1	22f	8	46	254	4
Haiti	661	6	8	22	96	524	5
Honduras	113	-	3	3	16	91	-
Mexico	2446	45	58	117	385	1 818	23
Nicaragua	126	-	4	28	15	77	2
Panama	257	-	6	10	43	197	1
Paraguay	34	2	6	2	18	-	6
Peru	303	5	9	34	51	198	6
Trinidad and Tobago	30	-	-	8	7	12	3
Venezuela	331	1	-	20	33	269	8
British Guiana	9	1	-	-	1	7	-
French Guiana	29	-	-	2	7	20	-
Guadeloupe	37	-	-	1	6	30	-
Panama Canal Zone	(27)	(1)	(2)	(2)	(2)	(20)	-
Surinam	46	-	2	5	14	23	2
Total	13 246 (27)	117 (1)	208 (2)	662 (2)	2 082 (2)	10 036 (20)	141

- None

(a) June. (b) November. (c) Statistical aides for spraying operations. (d) Includes 107 squad chiefs, spraymen. (e) Includes 13 squad auxiliaries. (f) Includes chiefs of mass drug treatment and larviciding.

Table 9

PERSONNEL EMPLOYED IN EPIDEMIOLOGICAL EVALUATION IN MALARIA ERADICATION PROGRAMS IN THE AMERICAS - 31 DECEMBER 1964

(Part-time personnel in parentheses)

Country or other political unit	Total	Physicians	Entomologists	Assistant Entomologists	Statisticians and Statisticians' Assistants	Evaluation Inspectors	Evaluators	Microscopists and Laboratory personnel
Argentina	164	9	1	4	2	25	99	24
Bolivia [a]	123	8	1	4	6	28	61	15
Brazil (excl. São Paulo) [b]	1782	57	3	24	51	297	1185	165
Brazil (São Paulo)	239	12	1	12	1	32	124	57
Colombia	496	16	-	7	4	55	377	37
Costa Rica	91	1	-	-	2	3	72	13
Cuba	42	7	1	2	4	3	9	16
Dominican Republic	61	2	1	4	6	4	27	17
Ecuador [b]	161	9	1	5	1	-	111	34
El Salvador	216	5	-	7	4	10	170 [c]	20
Guatemala	144	3	1	19	6	16 [c]	77 [c]	22
Haiti	197	8	3	11	9	15 [c]	109 [c]	42
Honduras	121	2	-	2	1	12	82	22
Jamaica	105	2	-	7	-	4	77	15
Mexico	988	81	1	33	2	70	706 [c]	95
Nicaragua	224	5	1	6	7	91 [c]	98 [c]	16
Panama	43	2	1	3	4	-	23	10
Paraguay	66	5	1	13	10	2	23	12
Peru	209	16	1	6	15	3	126	42
Trinidad and Tobago	125	1	-	40	-	1	75	8
Venezuela	661	17	2	25	-	71 [c]	497 [c]	49
British Guiana	24 (1)	(1)	-	-	3	-	16	5
British Honduras	12	1	-	-	-	2	7	2
Dominica	7 (1)	(1)	-	-	-	1	5	1
French Guiana	4	1	-	1	-	-	-	2
Grenada	25 (2)	-	-	10	-	14	1	(2)
Guadeloupe	12 (8)	1	1	1	-	3 (2)	6 (6)	-
Panama Canal Zone	(40)	(10)	(1)	(12)	-	(2)	(3)	(12)
St. Lucia	7 (3)	(1)	-	-	-	4 (1)	3	(1)
Surinam	34	-	-	1	1	4	22	6
Total	6383 (55)	271 (13)	21 (1)	247 (12)	139	770 (5)	4188 (9)	747 (15)

- None

(a) June. (b) November. (c) Includes personnel with same category from the mass drug treatment and larviciding programs.

Table 10

PERSONNEL EMPLOYED IN ADMINISTRATIVE AND OTHER SERVICES IN MALARIA ERADICATION PROGRAMS IN THE AMERICAS - 31 DECEMBER 1964

(Part-time personnel in parentheses)

Country or other political unit	Total	Administrators	Administrative Assistants	Accountants	Disbursing Officers	Storekeepers	Storekeepers' Assistants	Secretaries	Others
Argentina	130	4	64	-	-	4	8	3	47
Bolivia [a]	35	9	5	5	-	-	-	8	8
Brazil (excl. São Paulo) [b]	1596	274	564	23	-	29	-	20	686
Brazil (São Paulo)	408	15	85	-	9	7	13	-	279 [c]
Colombia	235	2	7	-	15	14	8	60	129
Costa Rica	17	1	7	-	-	2	1	1	5
Cuba	28	1	4	1	-	2	-	5	15
Dominican Republic	22	1	3	-	-	1	1	5	11
Ecuador [b]	105	5	13	-	4	6	-	20	57
El Salvador	38	1	1	-	1	1	4	8	22
Guatemala	36	1	8	-	-	3	-	4	20
Haiti	109	6	5	3	3	5	3	18	66
Honduras	51	1	5	2	-	1	-	15	27
Jamaica	9 (1)	2	-	-	-	1	3	3	(1)
Mexico	555	15	236	-	16	15	25	138	110
Nicaragua	40	-	5	-	-	1	7	8	19
Panama	31	1	4	-	-	2	9	4	11
Paraguay	51	1	25	-	-	1	1	7	16
Peru	180	1	65	4	1	5	5	15	84
Trinidad and Tobago	24	2	15	-	-	3	1	2	1
Venezuela	...	...	...	...	...	...	...	...	...
British Guiana	10	-	-	-	-	1	1	1	7
British Honduras	4	1	-	-	-	-	-	2	1
Dominica	1 (1)	(1)	-	-	-	-	-	1	-
French Guiana	3	-	-	-	-	-	-	1	2
Grenada	1 (1)	1	-	-	-	-	(1)	-	-
Guadeloupe	3 (26)	1	-	-	-	-	-	-	2 (26)
Panama Canal Zone	(2)	-	-	-	-	-	-	-	(2)
St. Lucia	(4)	-	-	-	-	-	-	(1)	(3) [d]
Surinam	31	1	2	-	1	2	3	2	20
Total	3753 (35)	347 (1)	1123	38	50	106	93 (1)	351 (1)	1645 (32)

... No information.
- None
(a) June. (b) November. (c) Includes personnel of Chagas disease control. (d) Spraymen.

Table 11

PERSONNEL EMPLOYED IN TRANSPORT SERVICES IN MALARIA ERADICATION PROGRAMS IN THE AMERICAS - 31 DECEMBER 1964

(Part-time personnel in parentheses)

Country or other political unit	Total	Transport Chiefs, Mechanics and Assistant Mechanics	Drivers	Motorboat operators	Boatmen
Argentina	59	27	32	-	-
Bolivia[a]	43	8	21	14	-
Brazil (excl. São Paulo)[b]	1 032	246	742[c]	38	6
Brazil (São Paulo)	250	19	228	3	-
Colombia	237	56	63	101	17
Costa Rica	11	2	9	-	-
Cuba	13	6	7	-	-
Dominican Republic	73	17	56	-	-
Ecuador[b]	74	12	62	-	-
El Salvador	41	15	25	1	-
Guatemala	30	1	29	-	-
Haiti	70	30	39	1	-
Honduras	40	8	32	-	-
Mexico	126	85	25	16	-
Nicaragua	61	2	51	8	-
Panama	9	5	4	-	-
Paraguay	21	1	18	-	2
Peru	70	18	29	23	-
Trinidad and Tobago	30	3	27	-	-
Venezuela	35	...	31[d]	4	-
British Guiana	12	-	6	3	3
British Honduras	3	2	1	-	-
Dominica	1	-	1	-	-
French Guiana	6	1	4	1	-
Guadeloupe	6	2	4	-	-
Panama Canal Zone	(4)	-	(2)	(2)	-
Surinam	40	13	11	16	-
Total	2 393 (4)	579	1 557 (2)	229 (2)	28

... No information
- None.
(a) June. (b) November. (c) Includes two airplane pilots. (d) 23 fogging machine operators.

Table 12

MEANS OF TRANSPORT IN MALARIA ERADICATION PROGRAMS IN THE AMERICAS - 1964

Country or other political unit	Trucks (3 tons or more)	Trucks and "Pick-up" (less than 3 tons)	Jeeps	Automobiles and station wagons	Motorcycles	Bicycles	Motor boats	Boats without motor	Saddle and pack animals	Other
Argentina	10	106	17	13	1	21	-	-	-	-
Bolivia	-	23	37	2	18	54	35	-	95	-
Brazil (Excl. São Paulo)	54	354	807	34	-	232	150	9	787	2[a]
Brazil (São Paulo)	11	158	58	13	-	1	11	-	-	2
Colombia	16	143	122	37	2	77	153	-	867	-
Costa Rica	1	8	14	3	-	80	11	-	(b)	-
Cuba	-	36	29	14	-	-	-	-	158	-
Dominican Republic	1	64	15	3	5[c]	14	-	-	6	-
Ecuador	4	50	37	12	30	10	16	21	326	-
El Salvador	2	49	13	8	48	1	1	-	-	-
Guatemala	1	42	14	22	51	40	9	1	-	-
Haiti	5	69	13	22	-	2	1	-	16	-
Honduras	2	35	30	7	20	50	1	-	157	-
Jamaica	-	14	16	8	-	-	-	-	-	-
Mexico	15	436	347	2	-	-	9	-	2 394[d]	-
Nicaragua	2	17	34	10	-	-	11	-	-	-
Panama	-	52	20	8	11	-	20	-	(b)	-
Paraguay	-	10	15	2	3	2	15	1	12	-
Peru	3	108	66	-	-	1	48	13	-	-
Trinidad and Tobago	9	9	9	2	-	-	-	1	-	-
Venezuela	3	92	72	27	19	314	122	-	560	62[e]
British Guiana	-	2	5	-	-	-	4	-	1	-
British Honduras	-	2	8	1	-	3	7	4	-	-
Dominica	-	-	3	-	4	-	-	-	-	-
French Guiana	...	...	...	...	...	...	...	...	...	...
Guadeloupe	1	4	6	-	-	-	-	-	-	-
Panama Canal Zone	-	2[f]	-	-	-	-	-	2[f]	-	-
St. Lucia	-	-	-	-	3	-	-	-	-	-
Surinam	1	2	5	1	4	6	24	-	-	-

- None. ... No information.
(a) Airplanes. (b) Rented as needed. (c) In addition, 10 motorcycles belonging to the evaluators are utilized. (d) Rented. (e) Fogging machines and tractors.
(f) Part-time.

Table 13

NATIONAL BUDGETS FOR MALARIA ERADICATION IN THE AMERICAS, 1963-1965

(in thousands of U. S. dollars)

Country or other political unit	National Budget 1963	National Budget 1964	National Commitments 1965
Argentina	520	951	1 392
Bolivia	-	83	160 *
Brazil (Excl. São Paulo)	3 395	11 277	8 900
Brazil (São Paulo)	1 123	1 242	2 241
Colombia	2 333	2 333	2 778 *
Costa Rica	270	264	264 *
Cuba	1 684	1 778	1 861
Dominican Republic	772	1 127	1 284
Ecuador	685	715	1 045
El Salvador	366	732	... *
Guatemala	452	738	990 *
Haiti	50	50	100
Honduras	300	300	300 *
Jamaica	267	249	167
Mexico	5 675	6 322	5 974 *
Nicaragua [a]	453	453	443 *
Panama	589	518	690 *
Paraguay	256	258	294 *
Peru	937	950	...
Trinidad and Tobago	473	470	426
Venezuela	3 593	3 947	4 296
British Guiana	39	67	...
British Honduras	33	24	25
Dominica	9	9	10
French Guiana	...	...	...
Grenada	1	1	1
Guadeloupe	147	186	192
Panama Canal Zone	50	50	50
St. Lucia	5	3	4
Surinam	288	301	298
Total	24 765	35 398	34 185

- None
... No information

(a) National budget from July to June.

* Projects considered under-financed

Table 14

COMPARATIVE RESULTS OF ACTIVE AND PASSIVE CASE DETECTION IN MALARIA ERADICATION PROGRAMS IN THE AMERICAS, 1964

Country or other political unit	Active case detection				Passive case detection				
	Average number of evaluators	Blood slides		Average production per evaluator per month	Average number of notification posts	Average of notification post producing slides per month	Blood slides		Average of slides per month per productive notification post
		Number examined	Per cent positive				Number examined	Per cent positive	
Argentina	102	152 934	0.1	124.9	1 299	232	28 788	1.4	10.3
Bolivia	87	108 097	2.0	103.5	2 545	581	47 443	2.8	6.8
Brazil (excl. São Paulo)	1 167	643 911	4.4	46.0	18 829	7 112	597 331	13.5	7.0
Brazil (São Paulo)	229	454 406	0.1	165.4	4 949	1 768	80 216	1.7	3.8
Colombia	302	289 152	1.4	79.8	7 889	4 138	210 371	5.0	4.2
Costa Rica	67	111 721	0.5	138.9	654	141	11 564	5.5	6.8
Cuba	9	38 995	0.2	361.1	548	266	237 475	0.2	74.4
Dominican Republic	29	87 552	0.2	251.6	1 192	352	33 659	0.4	8.0
Ecuador	113	66 181	0.3	48.8	4 443	2 280	248 519	1.8	9.1
El Salvador	59	95 784	1.9	135.3	2 000	1 656	255 059	9.4	12.8
Guatemala	126	178 619	3.0	134.8	2 244	1 104	110 439	13.7	8.3
Haiti	63	281 601	3.0	372.5	2 051	978	191 696	5.5	16.3
Honduras	64	75 769	2.0	98.7	2 238	1 101	131 231	3.9	9.9
Jamaica	62	55 249	0	74.3	711	82	79 575	0.0	80.9
Mexico	323	1 216 462	0.7	313.8	25 755	3 977	378 861	1.4	7.9
Nicaragua	65	153 836	3.4	197.2	1 692	919	93 775	8.3	8.5
Panama	20	55 156	1.1	229.8	1 105	261	76 731	1.6	24.5
Paraguay	37	31 072	3.6	70.0	2 605 [a]	836 [a]	72 097	10.7	7.2
Peru	119	383 820	0.4	268.8	8 821	1 184	110 199	0.5	7.8
United States [b]	...	16	0	....	...	...	90	86.7	...
Trinidad and Tobago	75	28 583	0	31.8	82	82	53 455	0.006	54.3
Venezuela [c]	499	248 602	1.1	55.4	2 331	413	125 508	1.5	33.8
British Guiana	16 [b]	50 253	0.4	261.8	78 [b]	23 [b]	4 932	0.3	17.9
British Honduras	8	5 255	0.2	54.7	127	71 [d]	6 571	0.3	7.7
Dominica	6	8 026	0	111.5	26	21	8 128	0	32.3
French Guiana	-	-	-	-	16	10	3 025	1.6	25.2
Grenada	1	517	0	43.1	-	-	-	-	-
Guadeloupe	9	21 810	0	201.9	...	...	21	0	...
Panamá Canal Zone	3 [e]	1 147	0	63.7	...	...	25 081	0.1	...
St. Lucia	3	13 368	0.03	371.3	-	-	-	-	-
Surinam	24	72 115	0.6	250.4	54	9	4 441	28.9	41.1

... No information
- None
(a) Last quarters' average. (b) January-November. (c) January-September. (d) 11 months' average. (e) Part-time.

Table 15

SUMMARY OF CASE DETECTION IN THE AMERICAS, 1958-1964

Year	Number of slides examined	Number of slides found positive	Per cent positive
1958	1 716 103	56 705	3.3
1959	2 749 117	75 612	2.8
1960	3 955 149	79 998	2.0
1961	5 341 004	99 539	1.9
1962	7 221 367	177 089	2.4
1963	7 903 156	227 026	2.9
1964	8 156 290	254 572	3.1

Country: ARGENTINA

Date attack phase began: 1 August 1959

STATUS OF MALARIA PROGRAM AT DECEMBER 1964

	Population (thousands)	Area km^2
TOTAL COUNTRY	21 480	4 024 458
Non malarious areas	18 742	3 675 407
Originally malarious areas		
Maintenance phase	1 021	40 100
Consolidation phase	627	66 963
Attack phase	329	85 922
Preparatory phase	761	156 066
Total originally malarious areas	2 738	349 051

PERSONNEL

Activity	Professional	Non professional	Total
Spraying operations	2	146	148
Evaluation operations	11	153	164
Administrative and other	-	130	130
Transport	-	59	59
Total	13	488	501

TRANSPORT FACILITIES

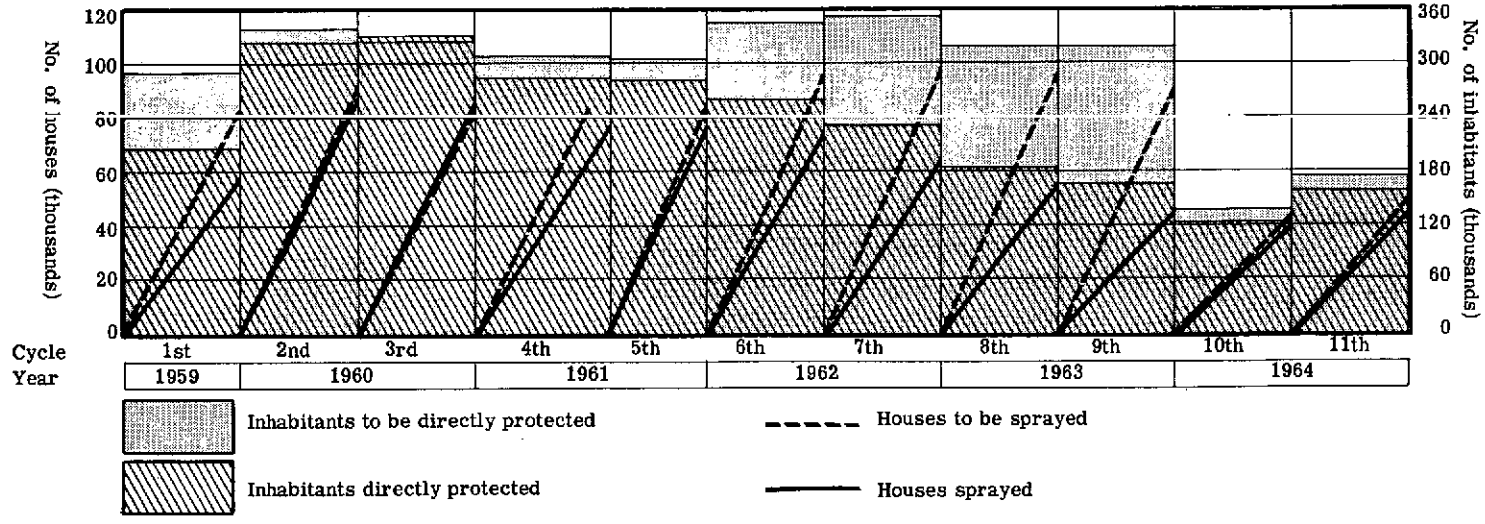
Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four wheel vehicles	53	50	43	146
Two wheel vehicles	-	18	4	22
Boats	-	-	-	-
Animals	-	-	-	-
Other	-	-	-	-
Total	53	68	47	168

ARGENTINA (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Cycle DDT	Houses sprayed		Inhabitants directly protected		Insecticide used per house (g. technical) DDT	Average houses sprayed per spray-man/day
			Planned	Sprayed	Planned	Protected		
1st	Aug. 59-Jun. 60	1st	81 619	55 849 [a] 2 146 [b]	288 768	205 189	263	...
		2nd	92 438	81 170 [a] 6 909 [b]	347 012	330 733	255	
2nd	Jul. 60-Jul. 61	3rd	84 011	78 487 [a] 6 442 [b]	323 610	327 209	305	...
		4th	84 077	74 188 [a] 2 803 [b]	308 142	282 178	334	
3rd	Aug. 61-Jun. 62	5th	81 906	73 682 [a] 2 052 [b]	303 290	280 425	383	...
		6th	96 249	73 027 [a]	341 780	259 379	349	
4th	Jul. 62-Jun. 63	7th	97 908	63 967 [a]	351 096	229 432	353	...
		8th	95 552	54 392 [a] 350 [b]	318 288	182 273	329	
5th	Jul. 63-Jun. 64	9th	90 333	46 627 [a]	317 972	164 420	320	...
		10th	43 572	39 430 [a]	135 574	122 685	324	
6th	Jul. 64-Dec. 64	11th	50 322	44 972 [a]	172 313	153 995	302	...

(a) Sprayed twice a year. (b) Sprayed once a year.



EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st[a]	Aug. 59-Jun. 60	70700	2497	3.53	6	2491	-
2nd[b]	Jul. 60-Jul. 61	96991	3880	4.00	4	3876	-
3rd	Aug. 61-Jun. 62	107926	5081	4.71	1	5080	-
4th	Jul. 62-Jun. 63	100342	1572	1.56	-	1571	1
5th	Jul. 63-Jun. 64	93850	549	0.58	-	549	-
6th	Jul. 64-Dec. 64	53980	140	0.26	-	140	-

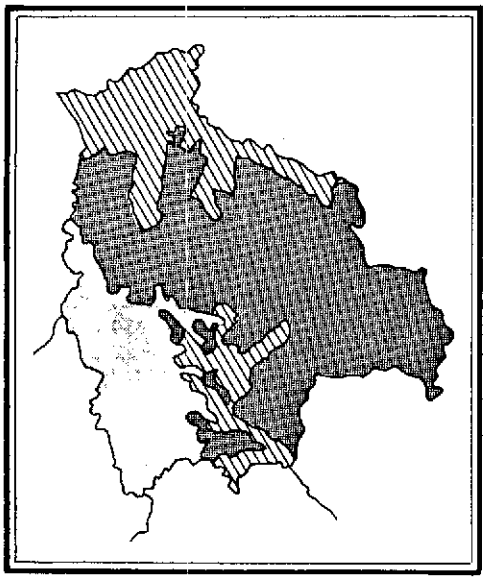
CONSOLIDATION AND MAINTENANCE PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
						Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
Year	Quarter							from abroad	from areas within country						
1959	1 - 4	911	9491	1.0	51	-	-	-	32	-	19	-	...	19	...
1960	1 - 4	929	14438	1.5	26	-	-	-	14	-	12	-	-	26	-
1961	1 - 4	1278	44305	3.5	17	-	2	-	5	-	10	-	-	17	-
1962	1o.	1542	9011	2.3	1	-	1	-	-	-	-	-	-	-	1
	2o.		8034	2.1	11	-	1	-	3	1	6	-	-	10	1
	3o.		6545	1.7	4	-	4	-	-	-	-	-	-	3	1
	4o.		16085	4.2	7	-	4	-	2	-	1	-	-	7	-
1963	1o.	1584	13371	3.4	7	2	-	-	4	1	-	-	-	6	1
	2o.		17759	4.5	2	-	-	-	1	1	-	-	-	1	1
	3o.		12367	3.1	2	-	-	-	1	-	-	1	-	2	-
	4o.		17245	4.3	-	-	-	-	-	-	-	-	-	-	-
1964	1o.	1648	20144	4.9	5	-	-	-	5	-	-	-	-	5	-
	2o.		21782	5.3	5	1	-	-	2	-	2	-	-	5	-
	3o.		14703	3.6	-	-	-	-	-	-	-	-	-	-	-
	4o.		22410	5.4	1	1	-	-	-	-	-	-	-	1	-

(a) Data for entire country; not separated by attack or consolidation phases. (b) Data for attack and consolidation phases, July to December 1960; attack phase only, January to July 1961.

Country: BOLIVIA Date attack phase began: 1 September 1958

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	4 266	1 098 581
Non malarious areas	2 913	274 321
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	1 141	619 540
Attack phase	212	204 720
Preparatory phase	0	0
Total originally malarious areas	1 353	824 260

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	-	34	34
Evaluation operations	11	112	123
Administrative and other	-	35	35
Transport	-	43	43
Total	11	224	235

TRANSPORT FACILITIES

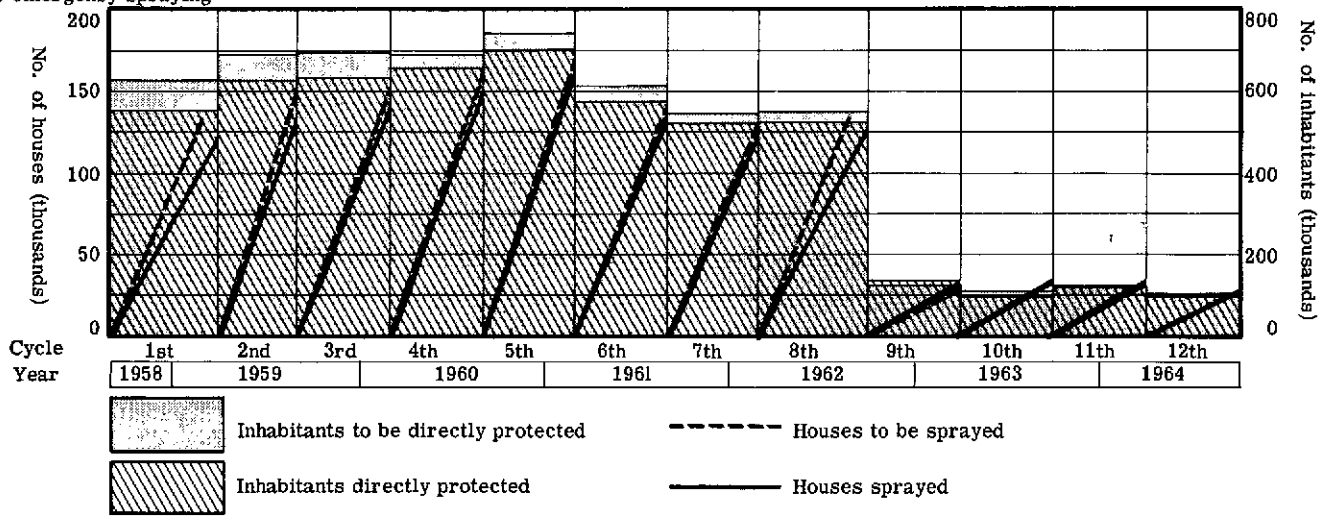
Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	23	34	5	62
Two-wheel vehicles	-	51	21	72
Boats	12	22	1	35
Animals	60	35	-	95
Other	-	-	-	-
Total	95	142	27	264

BOLIVIA (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Houses sprayed						Inhabitants directly protected		Insecticide used per house (g. technical)		Average houses sprayed per spray-man/day
		DDT			Dieldrin							
		Cycle	Planned	Sprayed	Cycle	Planned	Sprayed	Planned	Protected	DDT	Dieldrin	
1st	Sep. 58-Aug. 59	1st 2nd	131 444 148 200	116 572 129 119	1st	6 365	10 910	627 362 691 820	556 190 627 210	362 331	115	8.3 7.0
2nd	Sep. 59-Aug. 60	3rd 4th	147 263 153 514	136 601 142 536	2nd	11 331	12 268	695 521 692 274	634 859 660 185	319 309	118	7.6 7.2
3rd	Sep. 60-Aug. 61	5th 6th	169 690 142 210	159 952 134 173	-	-	-	742 902 612 356	700 295 577 743	331 329	-	7.6 7.5
4th	Sep. 61-Sep. 62	7th 8th	129 600 135 474	124 623 128 898	-	-	-	546 005 551 785	524 986 525 005	353 359	-	7.9 8.6
5th	Oct. 62-Sep. 63	9th 10th	32 561 32 361	34 469 28 893	-	-	-	124 643 110 578	131 962 98 727	408 428	-	6.0 5.9
6th[a]	Oct. 63-Sep. 64	11th 12th	32 361 28 536	32 160 27 509	-	-	-	123 923 101 503	123 152 97 855	533 547	-	5.3 5.6

- None
(a) Includes emergency spraying



BOLIVIA (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Sep. 58-Aug. 59	50 980	1 843	3.62	273	1 268	302
2nd	Sep. 59-Aug. 60	99 241	1 106	1.12	124	803	179
3rd [a]	Sep. 60-Aug. 61	126 384	735	0.58	90	615	30
4th [a]	Sep. 61-Sep. 62	174 800	982	0.56	214	758	10
5th [a]	Oct. 62-Sep. 63	165 200	2 026	1.23	803	1 222	1
6th [a]	Oct. 63-Dec. 63	64 913	679	1.05	281	398	-
6th - 7th [b]	Jan. 64-Dec. 64	88 368	3 315	3.75	477	2 838	-

CONSOLIDATION PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified and not Investigated	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1961	1 - 4	461	11 975	2.6	14	1	1	5	7	-	-	-	-	14	-
1962	1 - 3	759	18 131	3.2	21	-	-	2	19	-	-	-	-	21	-
1963	1 - 3	1 179	58 587	7.4	104	18	1	-	73	-	2	10	4	100	-
1964	1 - 4	1 141	67 172	5.9	139	19	2	4	77	-	16	21	16	121	2

(a) Data for the entire country, not separated by attack or consolidation phase. (b) Includes last 9 months of 6th year and first 3 of 7th year of total coverage.

Country: BRAZIL (Excl. São Paulo) Date attack phase began: August 1959

STATUS OF MALARIA PROGRAM AT DECEMBER 1964

	Population (thousands)	Area km^2
TOTAL COUNTRY	65 332	8 266 622
Non malarious areas	27 801	1 048 880
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	0	0
Attack phase	5 712	325 865
Preparatory phase	31 819	6 891 877
Total originally malarious areas	37 531	7 217 742

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	29	5 305	5 334
Evaluation operations	66	1 716	1 782
Administrative and other	61	1 535	1 596
Transport	-	1 032	1 032
Total	156	9 588	9 744

TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	717	276	256	1 249
Two-wheel vehicles	-	232	-	232
Boats	102	48	9	159
Animals	664	123	-	787
Other	-	-	2[a]	2
Total	1 483	679	267	2 429

(a) Airplanes

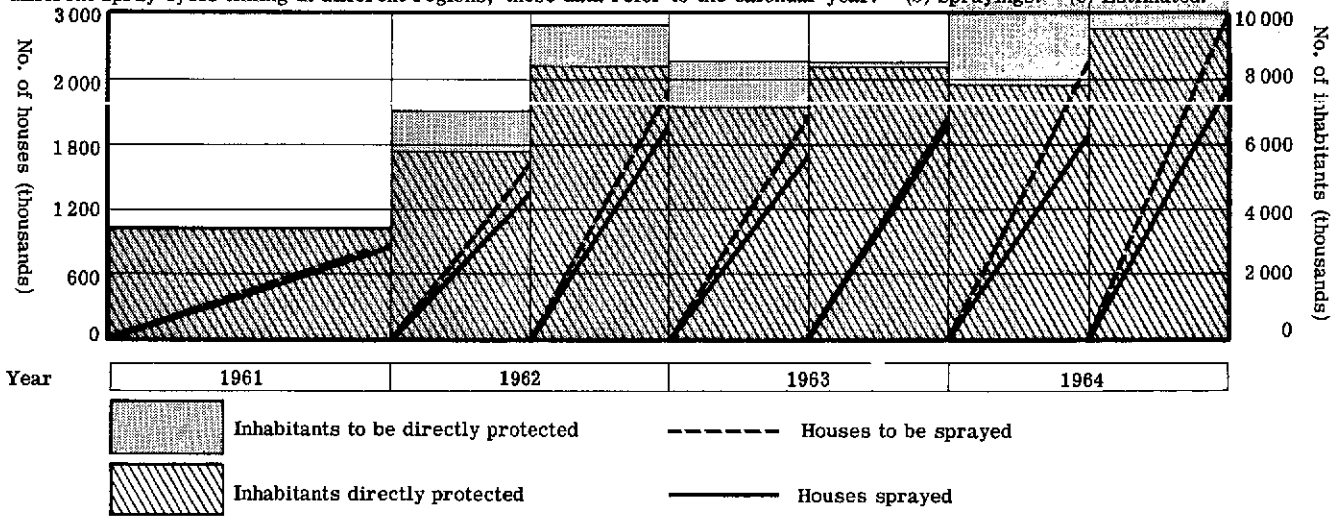
BRAZIL (Excl. São Paulo) (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Cycle DDT	Houses sprayed		Inhabitants directly protected		Insecticide used per house (g. technical) DDT	Average houses sprayed per spray-man/day
			Planned	Sprayed	Planned	Protected		
(a)	Jan. 61-Nov. 61	(a)	820 095	814 475 [b]	3 399 300 [c]	3 380 000 [c]	...	...
(a)	Jan. 62-Jun. 62	...	1 622 052	1 350 566	7 016 997	5 843 075	424	...
	Jul. 62-Dec. 62	...	2 292 000	1 960 358	9 724 956	8 317 433	420	...
(a)	Jan. 63-Jun. 63	...	2 062 265	1 726 289	8 574 898	7 178 751	407	...
	Jul. 63-Dec. 63	...	2 045 534	2 010 035	8 524 558	8 376 676	414	7.5
(a)	Jan. 64-Jun. 64	...	2 532 153	1 899 065	10 502 357	7 876 719	412	7.9
	Jul. 64-Dec. 64	...	2 993 954	2 350 055	12 310 241	9 662 834	419	7.7

... No information.

(a) Owing to different spray cycle timing in different regions, these data refer to the calendar year. (b) Sprayings. (c) Estimated.



BRAZIL (Excl. São Paulo) (Cont.)

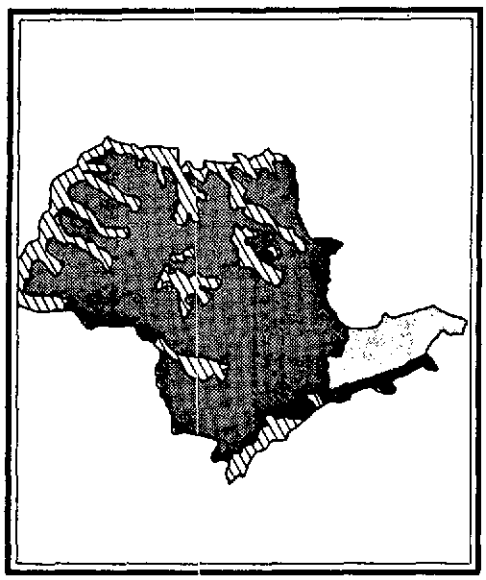
EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
(a)	Jan. 61-Dec. 61	230 205	36 912[b]	16.03	3.620	32 285	2
(a)	Jan. 62-Dec. 62	513 767	68 371	13.31	22 683	45 683	5
(a)	Jan. 63-Dec. 63	860 681	109 210	12.69	37 502	71 610	98
(a)	Jan. 64-Dec. 64	1 241 242	109 507	8.82	41 737	67 713	57

(a) Owing to different spray cycle timing in different regions, these data refer to the calendar year.
(b) Includes 1,005 undifferentiated mixed infections from Espiritu Santo Sector.

Country: BRAZIL (São Paulo) Date attack phase began: 4 January 1960

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	15 000	247 239
Non malarious areas	12 240	19 224
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	2 183	190 675
Attack phase	577	37 340
Preparatory phase	0	0
Total originally malarious areas	2 760	228 015

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	9	597	606
Evaluation operations	13	226	239
Administrative and other	-	408	408
Transport	-	250	250
Total	22	1 481	1 503

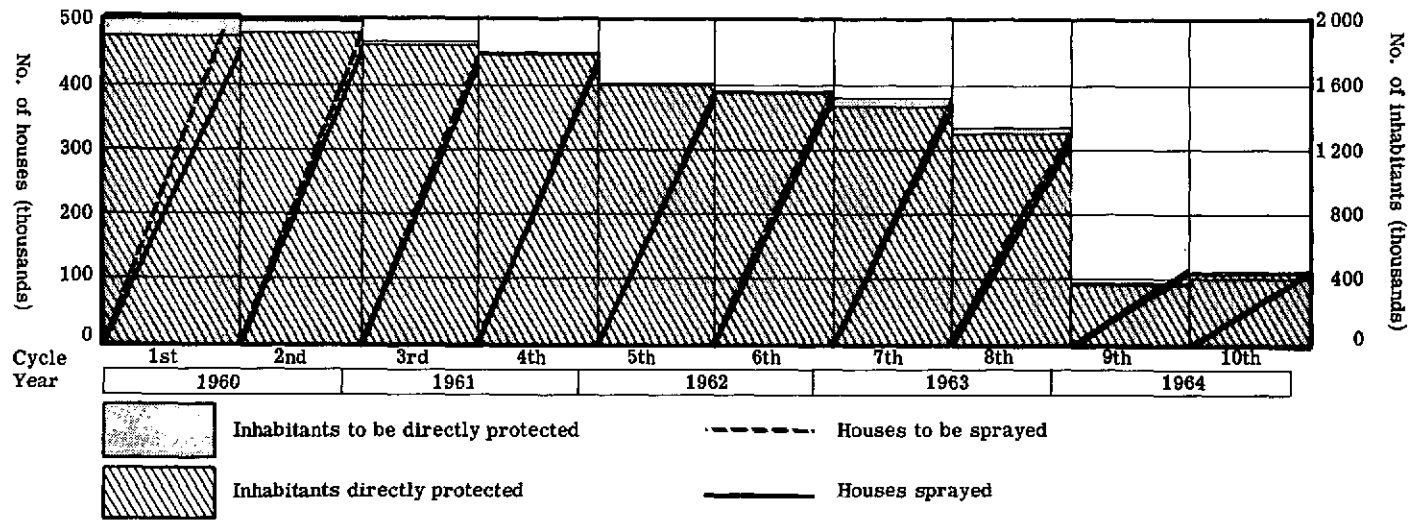
TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	59	156	25	240
Two-wheel vehicles	-	-	1	1
Boats	5	6	-	11
Animals	-	-	-	-
Other	-	-	2	2
Total	64	162	28	254

BRAZIL (São Paulo) (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Cycle DDT	Houses sprayed		Inhabitants directly protected		Insecticide used per house (g. technical) DDT	Average houses sprayed per spray-man/day
			Planned	Sprayed	Planned	Protected		
1st	Jan. 60-Jan. 61	1st. 2nd	481 533 475 121	455 219 458 926	2 002 214 1 992 182	1 892 679 1 924 405	433 404	8.4 9.8
2nd	Feb. 61-Jan. 62	3rd 4th	441 104 436 057	436 048 431 473	1 870 722 1 807 892	1 849 398 1 789 051	416 412	9.4 9.7
3rd	Feb. 62-Jan. 63	5th 6th	381 254 385 555	380 623 383 717	1 605 079 1 558 413	1 602 444 1 550 975	419 420	9.7 9.8
4th	Feb. 63-Jan. 64	7th 8th	378 922 324 556	366 817 316 221	1 525 540 1 346 907	1 477 021 1 312 405	424 433	9.7 9.5
5th	Feb. 64-Jan. 65	9th 10th	113 293 113 257	110 114 109 480	379 362 449 981	368 721 434 974	444 440	8.1 8.3



BRAZIL (São Paulo) (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

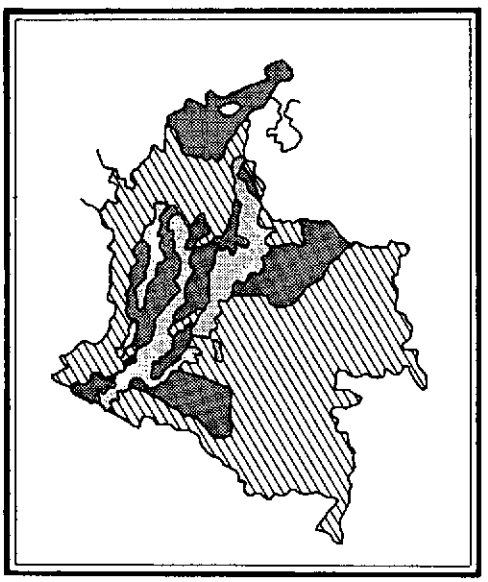
Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Jan. 60-Jan. 61	124 525	9 078	7.29	72	9 005	1
2nd	Feb.61-Jan. 62	219 841	7 082	3.22	262	6 817	3
3rd[a]	Feb.62-Jan. 63	381 413	3 314	0.87	228	3 082	4
4th[a]	Feb.63-Feb.64	419 401	2 267	0.54	433	1 833	1
5th[a]	Mar.64-Jan.65	484 503	1 664	0.34	314	1 350	0

(a) Data for entire State, not separated by attack or consolidation phase.

Country: COLOMBIA

Date attack phase began: 20 September 1958

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	17 505	1 138 338
Non malarious areas	7 936	192 116
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	6 053	120 777
Attack phase	3 154	427 281
Preparatory phase	362	398 164
Total originally malarious areas	9 569	946 222

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	3	703	706
Evaluation operations	16	480	496
Administrative and other	4	231	235
Transport	-	237	237
Total	23	1 651	1 674

TRANSPORT FACILITIES

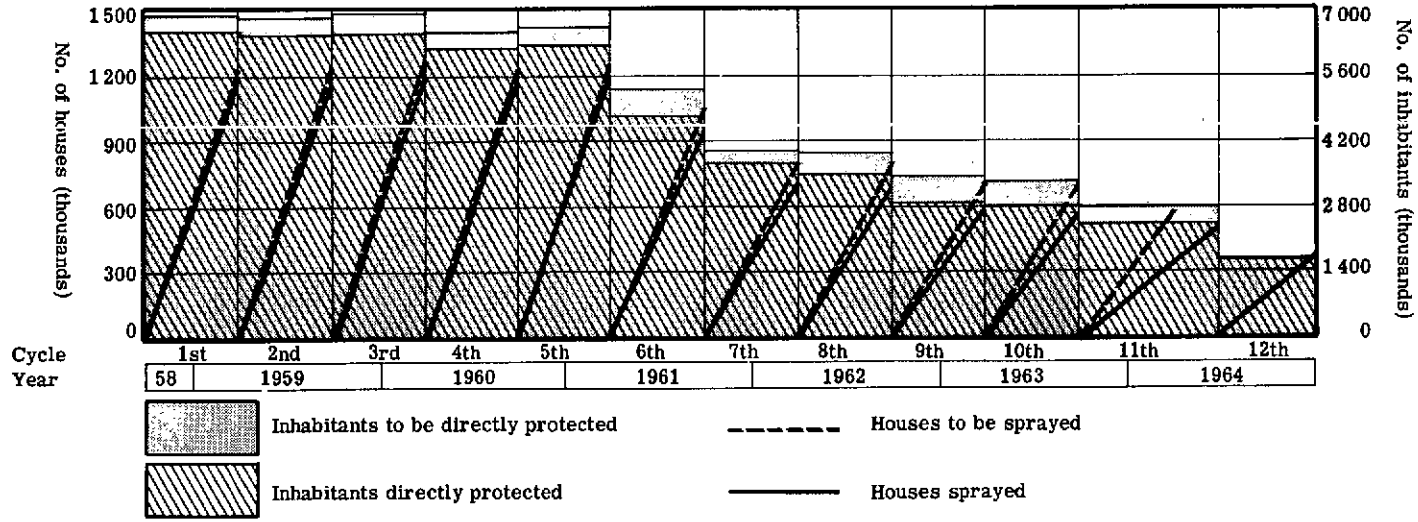
Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	106	88	124	318
Two-wheel vehicles	-	79	-	79
Boats	38	42	73	153
Animals	457	215	195	867
Other	-	-	-	-
Total	601	424	392	1 417

COLOMBIA (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Cycle DDT	Houses sprayed		Inhabitants directly protected		Insecticide used per house (g. technical) DDT	Average houses sprayed per spray-man/day
			Planned	Sprayed	Planned	Protected		
1st	Oct. 58-Sep. 59	1st 2nd	1 235 473 1 240 810	1 181 235 1 176 392	6 900 118 6 848 030	6 597 002 6 492 119	466 425	6.6 8.9
2nd	Oct. 59-Sep. 60	3rd 4th	1 273 295 1 228 550	1 196 930 1 162 059	6 915 265 6 556 771	6 500 325 6 201 358	409 309	9.4 8.7
3rd	Oct. 60-Sep. 61	5th 6th	1 253 594 1 050 556	1 181 557 945 501 [a]	6 642 794 5 320 016	6 261 680 4 788 305	394 402	9.7 9.3
4th	Oct. 61-Sep. 62	7th 8th	796 056 789 399	738 459 [a] 693 315 [a]	3 997 793 3 928 049	3 708 400 3 449 630	408 421	8.9 8.8
5th	Oct. 62-Sep. 63	9th 10th	701 762 690 726	586 740 [b] 576 540 [b]	3 440 739 3 363 145	2 876 514 2 806 950	435 459	8.4 7.9
6th	Oct. 63-Dec. 64	11th 12th	582 580 365 843	508 501 [b] 362 793	2 801 627 1 710 645	2 445 856 1 696 396	437 602	7.9 6.0

(a) Some houses were sprayed in 1-year cycles. (b) Some houses were sprayed in cycles of one, three and four times a year.



EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Oct. 58-Sep. 59	205 343	2 626	1.28	731	1 877	18
2nd	Oct. 59-Sep. 60	542 570	8 529	1.57	3 564	4 923	42
3rd	Oct. 60-Sep. 61	515 395	14 591	2.83	8 730	5 822	39
4th	Oct. 61-Sep. 62	640 720	17 623	2.75	9 873	7 716	34
5th	Oct. 62-Sep. 63	519 600	18 380	3.54	9 809	8 545	26
6th	Oct. 63-Dec. 64	390 362	16 136	4.13	9 283	6 826	27

CONSOLIDATION PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified and not Investigated	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1962	2nd	3 027	16 345	2.2	14	1	-	-	10	1	-	2	3	11	-
	3rd	3 027	17 636	2.3	36	1	2	-	29	-	-	4	21	15	-
	4th	3 027	36 269	4.8	97	46	2	-	33	4	-	12	75	22	-
1963	1st	3 874	28 193	2.9	129	26	-	-	61	1	6	35	82	47	-
	2nd	3 874	26 694	2.8	85	6	-	-	52	5	-	22	46	39	-
	3rd	3 874	24 844	2.6	89	4	-	-	78	-	-	7	46	43	-
	4th	5 305	41 083	3.1	147	47	1	-	88	1	1	9	88	59	-
1964	1st	6 053	41 501	2.7	257	30	-	1	197	-	5	24	111	146	-
	2nd		40 571	2.7	226	25	-	-	165	-	5	31	132	94	-
	3rd		50 135	3.3	356	39	-	-	240	-	9	68	170	186	-
	4th		46 072	3.0	375	130	-	-	172	-	8	65	165	209	1

Country: COSTA RICA Date attack phase began: 15 July 1957

STATUS OF MALARIA PROGRAM AT DECEMBER 1964

	Population (thousands)	Area km^2
TOTAL COUNTRY	1 387	51 011
Non malarious areas	964	19 485
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	294	23 281
Attack phase	129	8 245
Preparatory phase	0	0
Total originally malarious areas	423	31 526

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	1	45	46
Evaluation operations	2	89	91
Administrative and other	1	16	17
Transport	-	11	11
Total	4	161	165

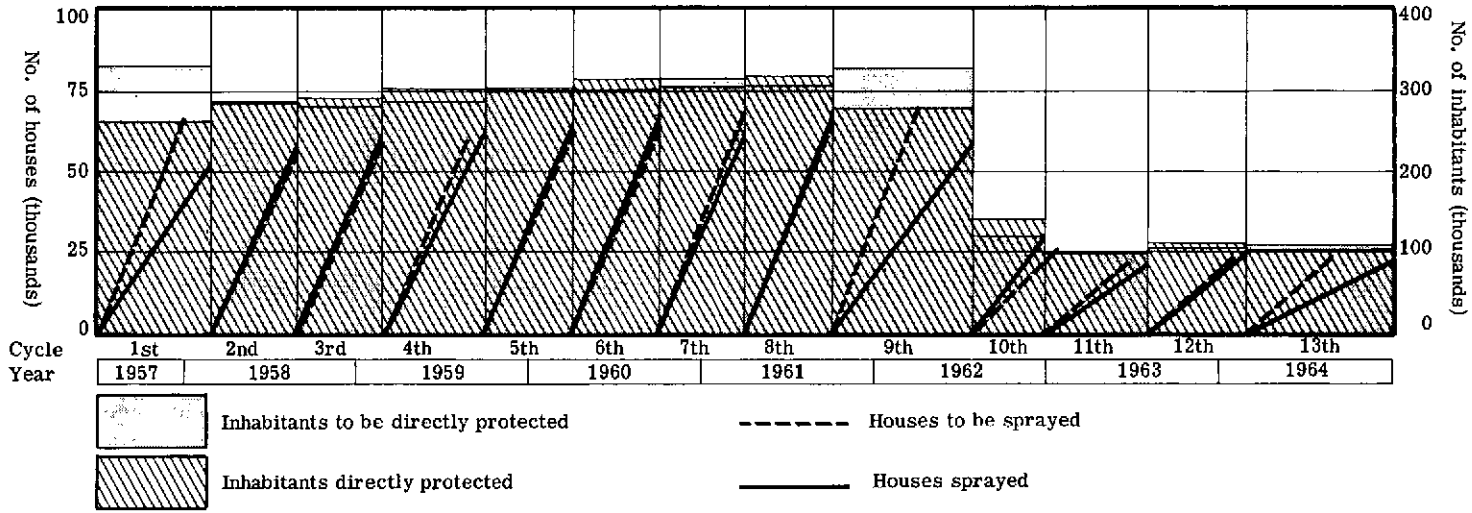
TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	8	14	4	26
Two-wheel vehicles	-	80	-	80
Boats	2	9	-	11
Animals	-	-	-	-
Other	-	-	-	-
Total	10	103	4	117

COSTA RICA (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Cycle DDT	Houses sprayed		Inhabitants directly protected		Insecticide used per house (g. technical) DDT	Average houses sprayed per spray-man/day
			Planned	Sprayed	Planned	Protected		
1st	Jul. 57-Aug. 58	1st 2nd	67 059 58 641	53 297 58 624	331 070 287 634	263 123 287 537	464 419	5.1 7.4
2nd	Sep. 58-Sep. 59	3rd 4th	58 858 60 413	60 800 63 063	282 930 290 405	292 856 303 151	465 531	6.9 7.1
3rd	Oct. 59-Sep. 60	5th 6th	63 259 64 057	63 884 66 961	302 568 302 926	305 586 316 629	512 475	8.6 9.3
4th	Oct. 60-Sep. 61	7th 8th	68 300 65 567	66 242 68 277	317 185 307 903	307 601 320 603	473 485	9.4 9.2
5th	Oct. 61-Dec. 62	9th 10th	69 643 26 075	58 910 30 684	332 545 120 753	281 295 142 102	492 508	8.8 9.6
6th	Jan. 63-Feb. 64	11th 12th	21 582 22 764	21 443 24 003	99 300 105 260	99 083 110 988	509 526	8.6 8.2
7th	Mar. 64-Dec. 64	13th	23 046	22 098	107 413	102 996	610	8.0



COSTA RICA (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Jul. 57-Aug.58	24773	1786	7.21	115	1661	10
2nd	Sep. 58-Sep. 59	52697	2222	4.22	135	2081	6
3rd	Oct. 59-Sep. 60	66721	1980	2.96	91	1888	1
4th	Oct. 60-Sep. 61	81977	1830	2.23	32	1798	-
5th	Oct. 61-Dec.62	155909	1779	1.14	6	1772	1
6th	Jan. 63-Feb.64	137749	912	0.66	7	905	-
7th	Mar.64-Dec.64	34666	511	1.47	-	511	-

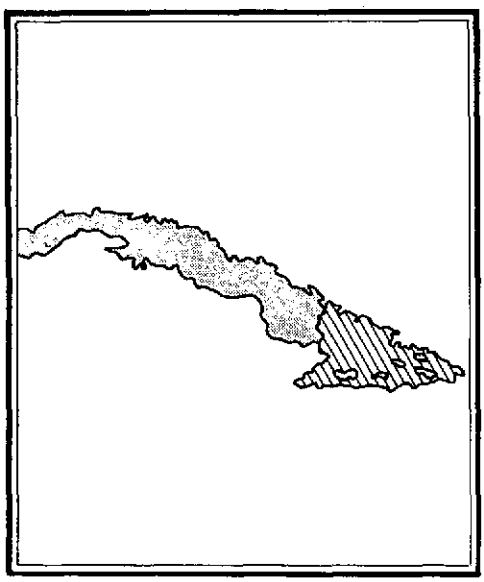
CONSOLIDATION PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1962	3rd	230	22765	39.6	37	-	6	2	9	-	17	3	-	37	-
	4th	230	29829	51.9	64	-	9	2	3	-	34	16	-	64	-
1963	1st	255	35311	55.4	62	33	13	-	-	-	8	8	-	62	-
	2nd	255	35946	56.4	59	40	11	-	4	-	-	4	-	59	-
	3rd	255	26855	42.1	135	101	11	-	3	-	-	20	-	135	-
	4th	262	35233	53.8	115	70	10	-	-	-	2	33	-	115	-
1964	1st	263	23761	36.1	93	41	7	-	4	-	-	41	-	93	-
	2nd	263	15471	23.5	34	30	2	-	-	-	-	2	-	34	-
	3rd	283	19262	27.2	192	116	10	2	12	-	1	51	4	188	-
	4th	294	16851	22.9	327	164	-	-	-	-	-	163	6	321	-

Country: CUBA

Date attack phase began: 1 January 1962

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	7 256	114 524
Non malarious areas	5 017	77 022
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	0	0
Attack phase	2 239	37 502
Preparatory phase	0	0
Total originally malarious areas	2 239	37 502

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	1	514	515
Evaluation operations	8	34	42
Administrative and other	-	28	28
Transport	-	13	13
Total	9	589	598

TRANSPORT FACILITIES

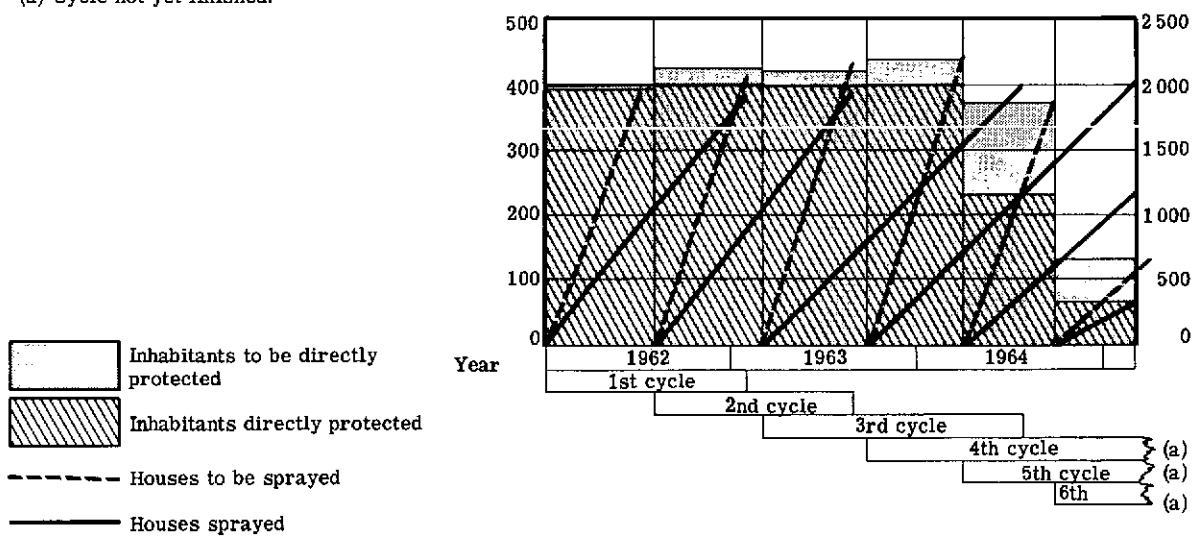
Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	65	10	4	79
Two-wheel vehicles	-	-	-	-
Boats	-	-	-	-
Animals	150	8	-	158
Other	-	-	-	-
Total	215	18	4	237

CUBA (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Cycle DDT	Houses sprayed		Inhabitants directly protected		Insecticide used per house (g. technical) DDT	Average houses sprayed per spray-man/day
			Planned	Sprayed	Planned	Protected		
1st	Jan. 62-Jan. 63	1st	391 155	385 020	2 007 000	1 975 528	210	9.7
	Jul. 62-Aug. 63	2nd	411 773	389 914	2 125 572	2 012 831	209	10.0
2nd	Mar. 63-Jul. 64	3rd	432 891	398 940	2 110 456	1 944 936	222	9.1
	Oct. 63-Feb. 65	4th [a]	440 285	402 792	1 201 425	2 013 975	271	8.5
3rd	Apr. 64-Feb. 65	5th [a]	375 203	230 382	1 876 015	1 151 930	246	8.6
	Oct. 64-Feb. 65	6th [a]	127 673	65 570	651 132	334 045	222	8.6

(a) Cycle not yet finished.



CUBA (Cont.)

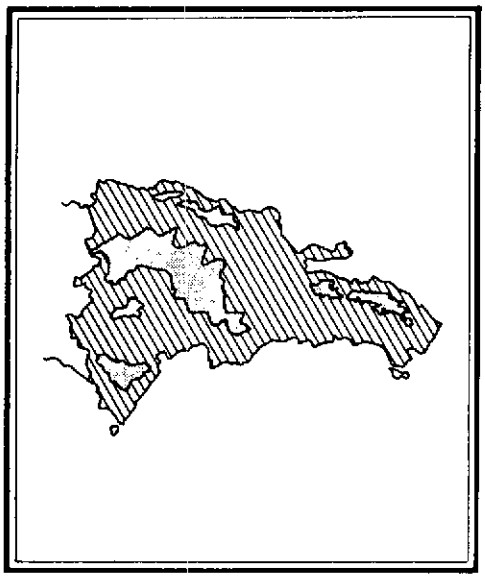
EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
(a)	Jan. 60-Dec. 60	28 791	1 325	4.60	197	1 128	-
(a)	Jan. 61-Dec. 61	91 181	3 230	3.54	128	3 102	-
1st	Jan. 62-Dec. 62	100 247	3 515	3.51	31	3 484	-
2nd	Jan. 63-Dec. 63	126 334	833	0.66	6	827	-
3rd	Jan. 64-Dec. 64	276 470	624	0.23	-	623	1

(a) Pre-eradication survey

Country: DOMINICAN REPUBLIC Date attack phase began: 16 June 1958

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	3452	48442
Non malarious areas	622	9442
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	0	0
Attack phase	2830	39000
Preparatory phase	0	0
Total originally malarious areas	2830	39000

PERSONNEL

Activity	Professional	Non professional	Total
Spraying operations	3	524	527
Evaluation operations	3	58	61
Administrative and other	-	22	22
Transport	-	73	73
Total	6	677	683

TRANSPORT FACILITIES

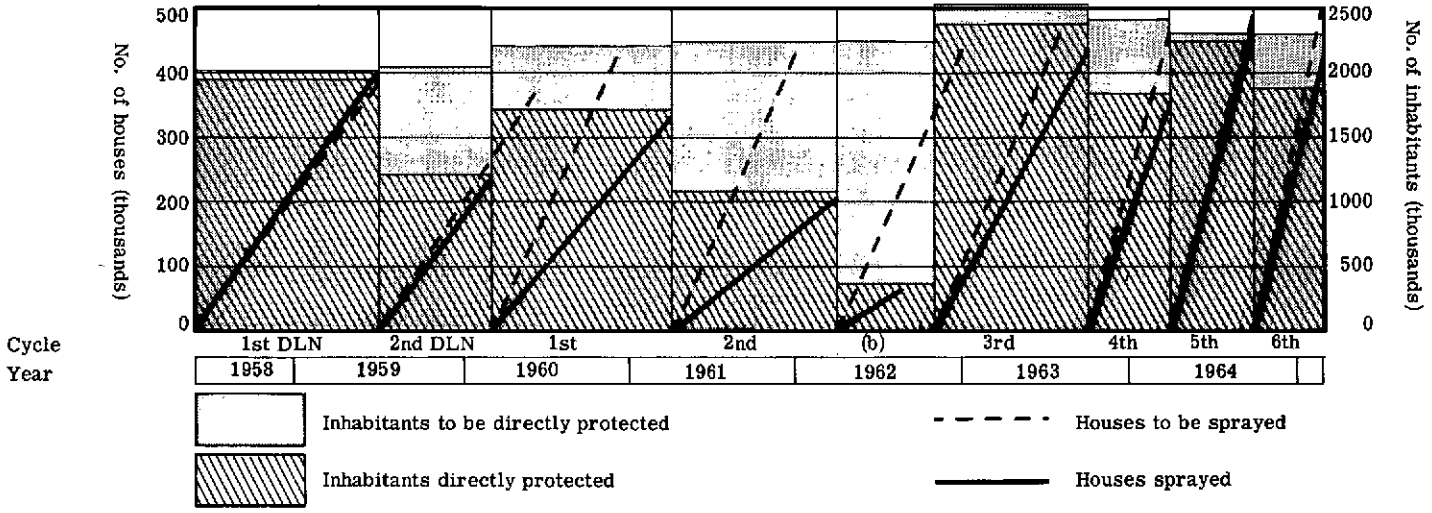
Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four wheel vehicles	67	15	1	83
Two wheel vehicles	-	19	-	19
Boats	-	-	-	-
Animals	-	6	-	6
Other	-	-	-	-
Total	67	40	1	108

DOMINICAN REPUBLIC (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Houses sprayed						Inhabitants directly protected		Insecticide used per house (g. technical)		Average houses sprayed per spray-man/day
		DDT			Dieldrin							
		Cycle	Planned	Sprayed	Cycle	Planned	Sprayed	Planned	Protected	DDT	Dieldrin	
1st	Jun. 58-Jun. 59	-	-	-	1st	386 120	395 597	1 966 895	2 015 214	-	102	11.4
2nd	Jul. 59-Feb. 60	-	-	-	2nd[a]	400 000	236 597	2 032 800	1 202 301	-	119	10.5
3rd	Mar.60-Mar.62	1st	428 615	332 944	-	-	-	2 206 080	1 713 612	495	-	9.0
		2nd	428 615	204 531				2 241 656	1 083 459	472		8.4
(b)	Apr. 62-Oct. 62	(b)	428 615	72 499	-	-	-	2 241 656	368 201	424	-	8.4
4th	Nov. 62-Mar.64	3rd	462 900	438 706	-	-	-	2 530 674	2 398 328	468	-	8.2
		4th	472 000	359 653				2 428 110	1 850 166	475		8.4
5th	Apr. 64-Feb. 65	5th	490 000	480 537	-	-	-	2 316 181	2 271 494	449	-	9.8
		6th[c]	510 575	417 855				2 311 680	1 891 904	449		10.5

(a) Cycle suspended due to shift of insecticide. (b) Cycle suspended. (c) Cycle not yet finished.



DOMINICAN REPUBLIC (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

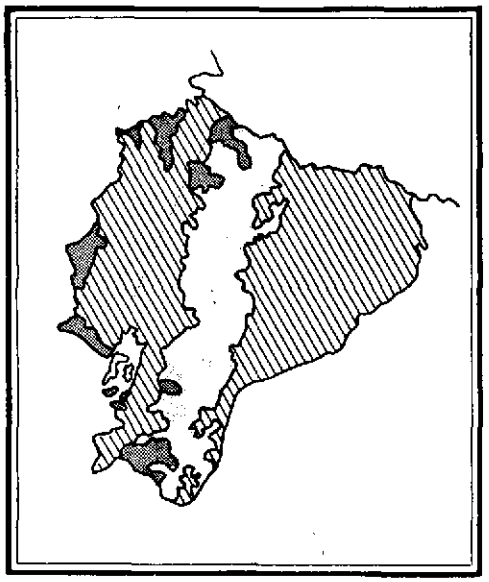
Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Jun. 58-Jun. 59	29 718	3 060	10.30	1 522	1 537	1
(a)	Jul. 59-Dec. 59	14 516	2 788	19.21	1 515	1 265	8
(a)	Jan. 60-Dec. 60	20 337	5 540	27.24	3 583	1 949	8
(a)	Jan. 61-Dec. 61	21 946	2 523	11.50	1 164	1 358	1
(a)	Jan. 62-Dec. 62	19 742	548	2.78	275	271	2
(a)	Jan. 63-Dec. 63	73 352	386	0.53	129	256	1
(a)	Jan. 64-Dec. 64	121 211	321	0.26	103	201	17

(a) Due to the irregularity of the spraying cycles, these data refer to calendar year.

Country: ECUADOR

Date attack phase began: 28 March 1957

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	4 813	291 906
Non malarious areas	2 161	116 444
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	1 053	19 198
Attack phase	1 599	156 264
Preparatory phase	0	0
Total originally malarious areas	2 652	175 462

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	6	564	570
Evaluation operations	11	150	161
Administrative and other	3	102	105
Transport	-	74	74
Total	20	890	910

TRANSPORT FACILITIES

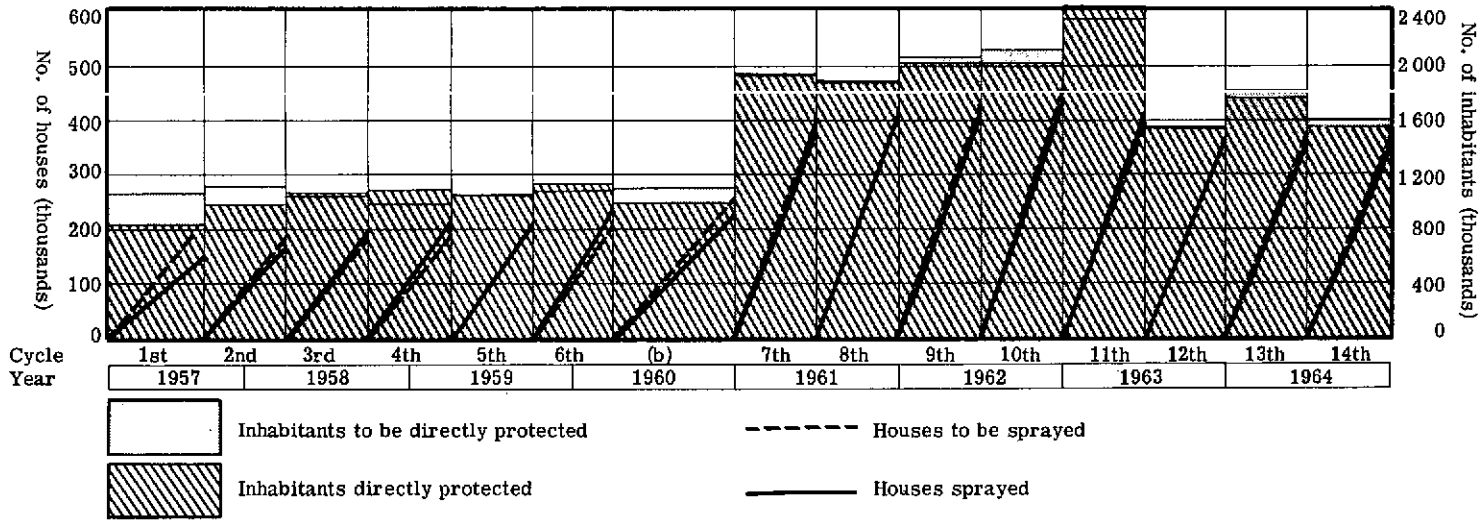
Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	67	25	11	103
Two-wheel vehicles	-	38	2	40
Boats	29	8	-	37
Animals	294	32	-	326
Other	-	-	-	-
Total	390	103	13	506

ECUADOR (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Houses sprayed						Inhabitants directly protected		Insecticide used per house (g. technical)		Average houses sprayed per spray-man/day
		DDT			Dieldrin							
		Cycle	Planned	Sprayed	Cycle	Planned	Sprayed	Planned	Protected	DDT	Dieldrin	
1st	Mar. 57-Mar. 58	1st + 2nd	42 418	63 284	1st	244 304	257 697	1 587 866	1 777 566	590	114	8.0
2nd	Apr. 58-Mar. 59	3rd 4th	48 104 48 391	50 089 83 018	2nd	280 832	144 069 127 348	1 047 229 980 474	1 078 629 1 092 450	490 436	123.5 169	6.9 8.5
3rd	Apr. 59-Mar. 60	5th 6th	76 577 76 577	72 370 97 790[a]	3rd[a]	260 539	135 187 136 542[a]	949 386 995 761	952 664 1 128 111	399 403	119 122	9.3 8.8
(b)	Apr. 60-Dec. 60	(b)	251 768	227 411	-	-	-	1 016 387	918 151	424	-	8.9
4th	Jan. 61-Dec. 61	7th 8th	403 989 413 951	394 246 412 008	-	-	-	1 954 095 1 897 137	1 907 065 1 888 183	446 502	-	8.4 8.5
5th	Jan. 62-Dec. 62	9th 10th	438 027 448 716	428 269 428 329	-	-	-	2 069 240 2 119 734	2 023 097 2 023 430[c]	529 557	-	8.4 8.2
6th	Jan. 63-Dec. 63	11th 12th	400 362 363 437	409 722 363 304	-	-	-	2 360 935 1 553 330	2 416 436 1 552 883	581 602	-	8.2 8.2
7th	Jan. 64-Dec. 64	13th 14th	374 284 367 377	362 930 357 206	-	-	-	1 829 500 1 606 760	1 774 020 1 562 305	620 630	-	7.8 7.9

(a) Cycle suspended. (b) Emergency spraying. (c) Estimated.



ECUADOR (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Mar.57-Mar. 58	47 993	2 258	4.70	1 169	1 086	3
2nd	Apr. 58-Mar. 59	69 085	4 802	6.95	2 361	2 437	4
3rd	Apr. 59-Mar. 60	108 041	6 291	5.82	2 454	3 833	4
(a)	Apr. 60-Dec. 60	92 510	7 692	8.31	2 761	4 912	19
4th	Jan. 61-Dec. 61	213 169	9 733	4.57	1 489	8 243	1
5th	Jan. 62-Dec. 62	269 004	5 531	2.06	658	4 868	5
6th	Jan. 63-Dec. 63	199 673	3 760	1.88	231	3 510	19
7th	Jan. 64-Dec. 64	174 203	4 246	2.44	251	3 994	1

CONSOLIDATION PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified and not Investigated	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1963	1st	625	17 734	11.3	6	-	-	-	6	-	-	-	-	5	1
	2nd	625	19 286	12.3	15	-	-	-	15	-	-	-	1	14	-
	3rd	806	25 488	12.6	29	-	-	-	29	-	-	-	1	28	-
	4th	927	24 270	9.6	47	-	-	-	39	-	-	8	4	43	-
1964	1st	927	23 820	10.3	51	-	1	-	20	-	-	31	4	47	-
	2nd	938	39 275	16.7	118	1	1	-	58	-	2	56	7	111	-
	3rd	1 016	41 398	16.3	129	32	2	-	65	-	7	23	1	128	-
	4th	1 053	36 004	13.7	84	3	-	-	55	-	-	26	1	83	-

(a) Emergency spraying.

Country: EL SALVADOR Date attack phase began: 1 July 1956

STATUS OF MALARIA PROGRAM AT DECEMBER 1964

	Population (thousands)	Area km^2
TOTAL COUNTRY	2828	21146
Non malarious areas	928	1846
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	0	0
Attack phase	1900	19300
Preparatory phase	0	0
Total originally malarious areas	1900	19300

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	1	2	3
Evaluation operations	7	209	216
Administrative and other	3	35	38
Transport	-	41	41
Total	11	287	298

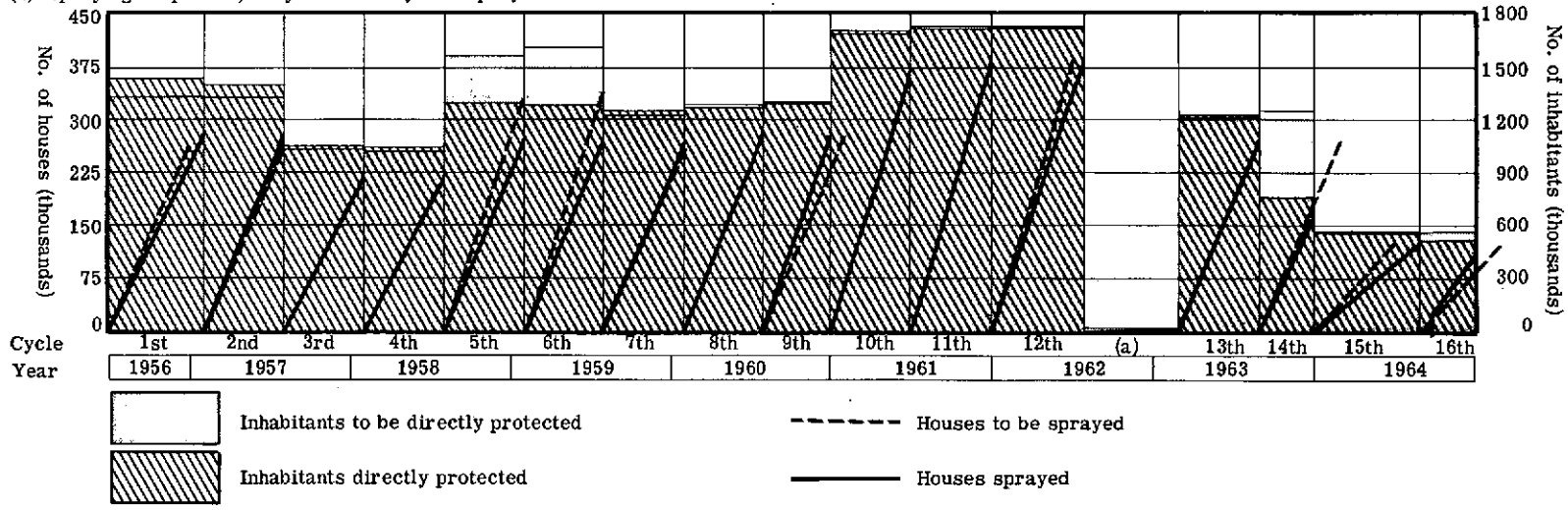
TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	17	11	44	72
Two-wheel vehicles	-	-	49	49
Boats	1	-	-	1
Animals	-	-	-	-
Other	-	-	-	-
Total	18	11	93	122

SPRAYING OPERATIONS

Year of total coverage	Date	Houses sprayed						Inhabitants directly protected		Insecticide used per house (g. technical)		Average houses sprayed per spray-man/day
		DDT			Dieldrin							
		Cycle	Planned	Sprayed	Cycle	Planned	Sprayed	Planned	Protected	DDT	Dieldrin	
1st	Jul. 56-Jul. 57	1st	177 035	260 035	1st	88 788	21 699	1 330 975	1 440 038	454	158	8.5
		2nd	177 035	173 537		88 788	107 140	1 329 115	1 405 530	621		8.8
2nd	Aug.57-Jul. 58	3rd	105 983	126 329	2nd	111 620	93 931	1 044 500	1 057 339	469	162	9.4
		4th	111 613	111 726		104 983	108 797	1 026 448	1 045 164	450		9.3
3rd	Aug.58-Jul. 59	5th	331 975	273 788	-	-	-	1 575 885	1 299 671	493	-	8.6
		6th	341 277	270 719				1 620 050	1 285 197	527		8.9
4th	Aug.59-Jul. 60	7th	261 102	265 361	-	-	-	1 237 362	1 257 537	573	-	7.7
		8th	278 991	276 050				1 289 775	1 277 428	545		7.7
5th	Aug.60-Jun. 61	9th	281 430	279 481	-	-	-	1 306 400	1 297 262	528	-	7.6
		10th	368 841	371 715				1 700 000	1 713 252	526		8.9
6th	Jul. 61-Jul. 62	11th	380 283	377 551	-	-	-	1 748 922	1 736 431	546	-	9.2
		12th	387 944	386 094				1 742 645	1 734 366	562		9.5
(a)	Ago.62-Feb.63	(a)	3 901	3 816	-	-	-	20 117	19 680	809	-	6.7
7th	Mar.63-Dec.63	13th	267 239	270 703	-	-	-	1 206 851	1 222 430	559	-	9.3
		14th	273 344	165 666				1 255 742	761 151	506		9.3
8th	Jan. 64-Nov.64	15th	127 000	125 854	-	-	-	581 745	576 496	536	-	8.4
		16th	125 806	114 441				577 568	525 392	533		9.4

(a) Spraying suspended, only one locality was sprayed.



EL SALVADOR (Cont.)

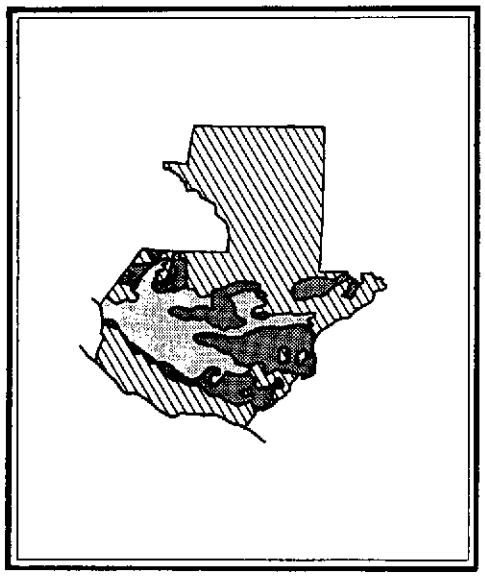
EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Jul. 56-Jul. 57	11 829	2 284	19.31	774	1 510	-
2nd	Aug. 57-Jul. 58	42 216	9 108	21.57	4 212	4 891	5
3rd	Aug. 58-Jul. 59	59 463	13 520	22.74	4 384	9 136	-
4th	Aug. 59-Jul. 60	75 177	12 627	16.80	3 061	9 566	-
5th	Aug. 60-Jun. 61	75 053	10 791	14.38	3 168	7 620	3
6th	Jul. 61-Jun. 62	145 501	12 004	8.25	2 343	9 655	6
(a)	Jul. 62-Feb. 63	163 331	14 104	8.63	2 581	11 520	3
7th	Mar. 63-Dec. 63	215 105	14 949	6.95	1 295	13 652	2
8th	Jan. 64-Nov. 64	328 332	24 491	7.46	2 441	22 049	1

(a) Spraying discontinued due to economic reasons.

Country: GUATEMALA Date attack phase began: 1 August 1956

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	4 278	108 889
Non malarious areas	2 359	28 539
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	1 057	19 282
Attack phase	862	61 068
Preparatory phase	0	0
Total originally malarious areas	1 919	80 350

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	1	334	335
Evaluation operations	4	140	144
Administrative and other	2	34	36
Transport	-	30	30
Total	7	538	545

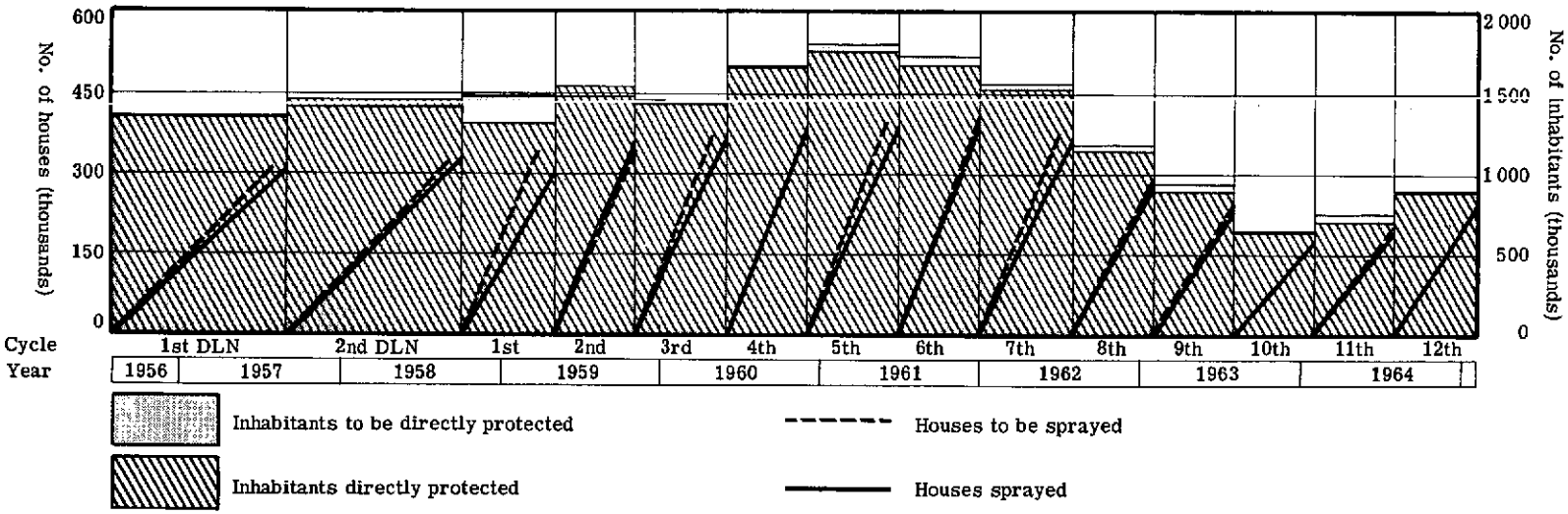
TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	33	13	33	79
Two-wheel vehicles	-	23	68	91
Boats	8	2	-	10
Animals	-	-	-	-
Other	-	-	-	-
Total	41	38	101	180

GUATEMALA (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Houses sprayed						Inhabitants directly protected		Insecticide used per house (g. technical)		Average houses sprayed per spray-man/day
		DDT			Dieldrin							
		Cycle	Planned	Sprayed	Cycle	Planned	Sprayed	Planned	Protected	DDT	Dieldrin	
1st	Aug. 56-Aug. 57	-	-	-	1st	308 097	306 306	1 361 175	1 353 121	-	117	8.4
2nd	Sep. 57-Sep. 58	-	-	-	2nd	321 975	331 090	1 422 165	1 462 510	-	117	8.5
3rd	Oct. 58-Oct. 59	1st 2nd	341 000 342 586	301 329 357 104	-	-	-	1 482 670 1 481 342	1 310 317 1 544 144	427 542	-	8.8 7.5
4th	Nov. 59-Nov. 60	3rd 4th	373 641 377 381	368 269 378 636	-	-	-	1 460 936 1 654 816	1 439 781 1 660 207	541 560	-	7.1 8.1
5th	Dec. 60-Dec. 61	5th 6th	396 588 406 807	386 737 393 090	-	-	-	1 815 183 1 737 473	1 769 971 1 678 906	588 557	-	7.8 7.9
6th	Jan. 62-Jan. 63	7th 8th	375 000 291 490	368 135 280 687	-	-	-	1 562 625 1 185 781	1 534 089 1 141 867	553 589	-	7.5 7.5
7th	Feb. 63-Jan. 64	9th 10th	243 511 175 000	231 824 171 061	-	-	-	949 936 642 950	904 382 628 563	537 502	-	7.6 8.0
8th	Feb. 64-Jan. 65	11th 12th	205 686 239 819	193 780 236 069	-	-	-	748 945 905 667	705 594 891 507	510 506	-	8.1 8.0



EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage[a]	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Aug.56-Aug.57	22 965	5 116	22.28	1 255	3 858	3
2nd	Sep. 57-Sep. 58	47 945	10 084	21.03	3 909	6 174	1
3rd	Oct. 58-Oct. 59	124 519	13 034	10.47	3 734	9 300	-
4th	Nov.59-Nov.60	126 667	3 367	2.66	400	2 967	-
5th	Dec.60-Dec.61	230 702	4 356	1.89	865	3 485	6
6th	Jan. 62-Dec.62	275 003	5 783	2.10	1 539	4 224	20
7th	Jan. 63-Dec.63	216 717	12 270	5.66	4 660	7 565	45
8th	Jan. 64-Dec.64	167 261	17 241	10.31	4 293	12 914	34

CONSOLIDATION PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified and not Investigated	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1962	1st	175	2 399	5.5	2	-	-	2		-	-	-	1	1	-
	2nd	175	5 457	12.5	1	-	-	1		-	-	-	1	-	-
	3rd	498	20 655	16.6	93	1	-	26		-	-	66	18	75	-
	4th	581	19 859	13.7	117	1	-	71		-	-	45	42	75	-
1963	1st	890	20 834	9.4	297	-	2	144		-	-	151	68	229	-
	2nd	890	25 543	11.5	413	17	18	168		-	2	208	117	294	2
	3rd	1 234	40 400	13.1	1 082	89	64	169		-	-	760	359	723	-
	4th	1 234	45 372	14.7	1 054	72	58	73		-	-	851	353	699	2
1964	1st	1 009	26 989	10.7	454	64	122	-	134	-	-	134	67	385	2
	2nd	1 025	28 439	11.1	790	49	157	-	250	-	1	333	110	678	2
	3rd	1 025	30 529	11.9	941	-	-	-	-	-	-	941	180	759	2
	4th	1 057	35 840	13.6	975	41 [b]	56 [b]	-	127 [b]	-	-	...	353	622	-

(a) Beginning in 1962, data are for calendar year. (b) Data incomplete.

Country: HAITI Date attack phase began: 1 January 1962

STATUS OF MALARIA PROGRAM AT DECEMBER 1964

	Population (thousands)	Area km^2
TOTAL COUNTRY	4 494	27 750
Non malarious areas	961	8 650
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	0	0
Attack phase	3 533	19 100
Preparatory phase	0	0
Total originally malarious areas	3 533	19 100

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	6	655	661
Evaluation operations	10	187	197
Administrative and other	1	108	109
Transport	-	70	70
Total	17	1 020	1 037

TRANSPORT FACILITIES

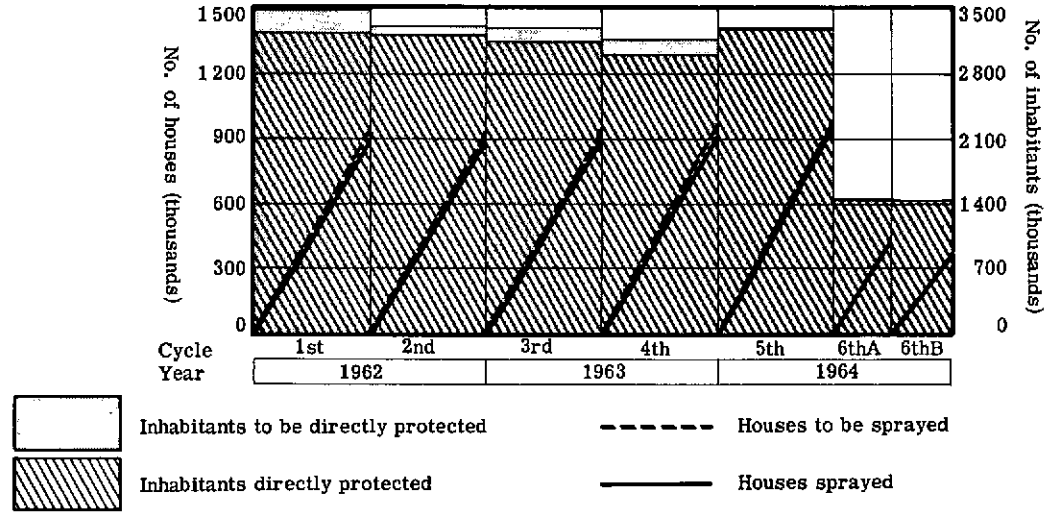
Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	46	29	34	109
Two-wheel vehicles	-	-	2	2
Boats	1	-	-	1
Animals	16	-	-	16
Other	-	-	-	-
Total	63	29	36	128

HAITI (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Cycle DDT	Houses sprayed		Inhabitants directly protected		Insecticide used per house (g. technical) DDT	Average houses sprayed per spray-man/day
			Planned	Sprayed	Planned	Protected		
1st	Jan. 62-Dec. 62	1st	952 301	885 549 [a]	3 490 183	3 245 821	220	14.3
		2nd	929 415	906 846	3 311 505	3 231 438	196	16.6
2nd	Jan. 63-Dec. 63	3rd	940 397	902 687	3 297 032	3 165 209	217	15.4
		4th	964 942	914 340	3 186 238	3 019 259	235	16.2
3rd	Jan. 64-Dec. 64	5th	984 853	974 136	3 317 674	3 281 609	243	16.1
		6th-A [b]	457 066	454 029	1 459 549	1 449 893	127	16.8
		6th-B [b]	465 260	455 353	1 446 450	1 446 458	122	17.5

(a) 10 016 houses sprayed with dieldrin. (b) Quarterly cycles, using DDT 1 g/m^2.



HAITI (Cont.)

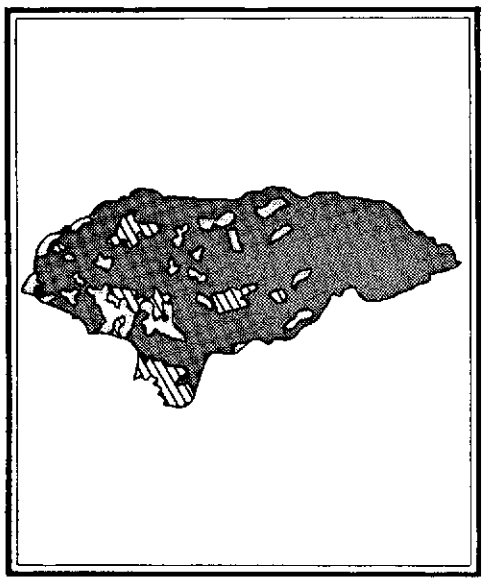
EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Jan. 62-Dec. 62	111 142	4 033	3.63	3 441	20	572
2nd	Jan. 63-Dec. 63	386 657	6 662	1.72	5 464	12	1 186
3rd	Jan. 64-Dec. 64	473 297	19 170	4.05	18 422	24	724

Country: HONDURAS

Date attack phase began: 15 July 1959

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	2 030	112 088
Non malarious areas	130	5 119
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	1 631	97 100
Attack phase	269	9 869
Preparatory phase	0	0
Total originally malarious areas	1 900	106 969

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	-	113	113
Evaluation operations	4	117	121
Administrative and other	1	50	51
Transport	-	40	40
Total	5	320	325

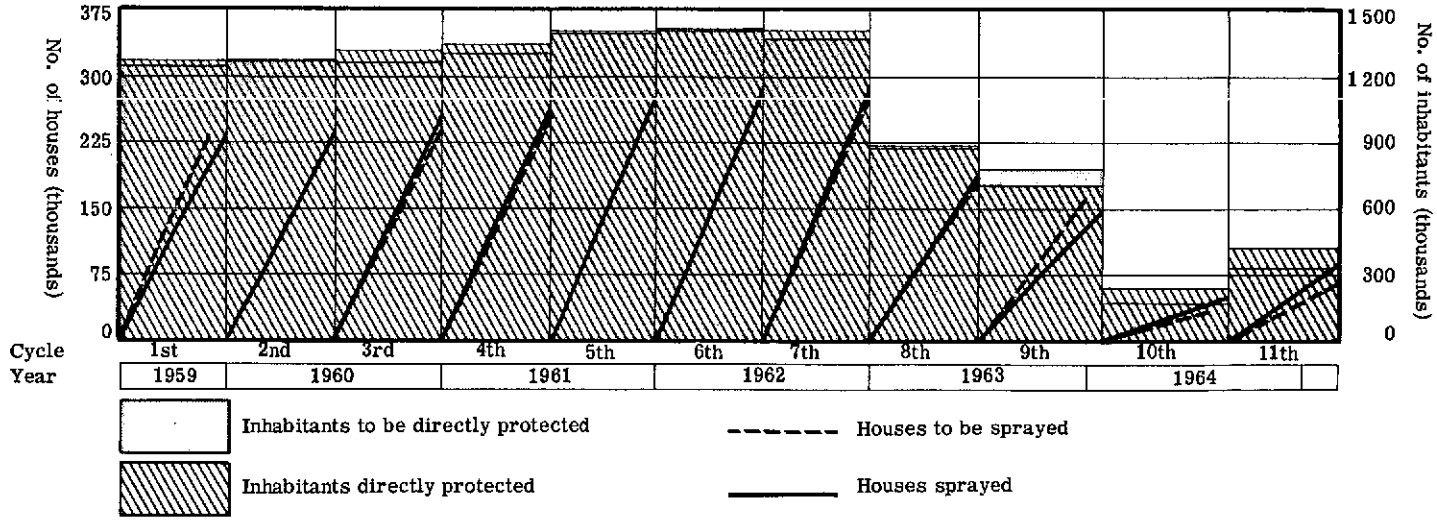
TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	20	15	39	74
Two-wheel vehicles	-	70	-	70
Boats	-	-	1	1
Animals	-	117	40	157
Other				
Total	20	202	80	302

HONDURAS (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Houses sprayed						Inhabitants directly protected		Insecticide used per house (g. technical)		Average houses sprayed per spray-man/day
		DDT			Malathion							
		Cycle	Planned	Sprayed	Cycle	Planned	Sprayed	Planned	Protected	DDT	Malathion	
1st	Jul. 59-Jun. 60	1st 2nd	232 771 241 726	236 963 242 059	-	-	-	1 252 773 1 277 280	1 275 237 1 279 148	406 368	-	9.8 11.4
2nd	Jul. 60-Jun. 61	3rd 4th	245 572 258 519	254 699 265 825	-	-	-	1 274 028 1 314 052	1 321 450 1 351 212	369 419	-	11.8 10.9
3rd	Jul. 61-Jun. 62	5th 6th	276 458 287 516	277 941 285 394	-	-	-	1 401 919 1 421 192	1 409 325 1 410 773	360 262	-	11.1 11.3
4th	Jul. 62-Jun. 63	7th 8th	282 186 187 905	290 056 191 321	-	-	-	1 376 785 877 892	1 415 286 893 861	373 377	-	11.1 11.0
5th	Jul. 63-Aug. 64	9th 10th	126 499 14 851	110 612 27 719	1st 2nd 3rd	19 776 17 471 21 499	20 440 18 286 23 066	781 085 171 805	712 355 240 031	404 505	440 343 575	10.5 9.0
6th	Sep. 64-Feb. 65	11th	21 502	37 818	4th 5th	23 274 22 039	23 614 24 997	328 950	425 513	567	550 411	8.4



EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Jul. 59-Jun. 60	82 673	6 575	7.95	2 925	3 649	1
2nd	Jul. 60-Jun. 61	137 025	5 223	3.81	1 506	3 716	1
3rd	Jul. 61-Jun. 62	190 209	3 679	1.93	481	3 198	-
4th	Jul. 62-Jun. 63	216 940	7 556	3.48	884	6 672	-
5th [a]	Jul. 63-Sep. 64	136 253	6 510	4.78	452	6 058	-
6th [a]	Oct. 64-Dec. 64	25 088	2 460	9.81	380	2 080	-

CONSOLIDATION PHASE AREAS

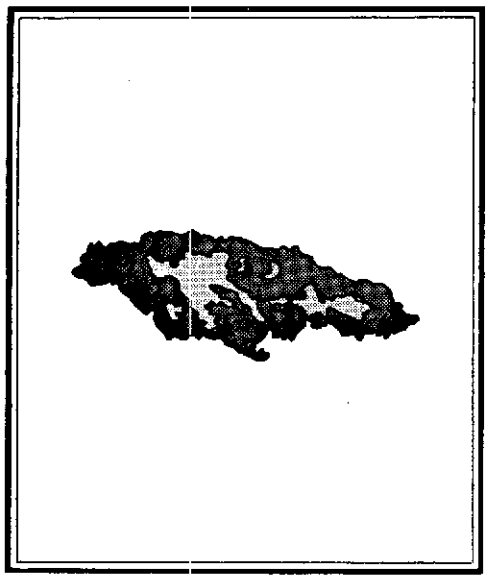
Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
						Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified and not Investigated	P. falciparum	P. vivax	P. malariae
Year	Quarter							from abroad	from areas within country						
1962	3rd	46	6 992	60.8	1	-	1	-	-	-	-	-	-	1	-
	4th	46	2 997	26.0	2	-	-	-	2	-	-	-	-	2	-
1963	1st	526	19 133	14.5	69	23	-	-	36	-	-	10	11	58	-
	2nd	526	19 790	15.0	41	12	6	-	21	-	-	2	3	38	-
	3rd	765	32 869	17.2	89	50	13	-	15	-	-	11	4	85	-
	4th	941	23 702	10.1	157	92	32	1	12	-	-	20	1	156	-
1964	1st	1 631	20 253	5.0	122	61	41	-	12	-	-	8	4	118	-
	2nd		29 169	7.2	161	84	49	-	18	-	-	10	-	161	-
	3rd		37 962	9.3	474	294	86	-	36	-	-	58	5	469	-
	4th		44 330	10.9	524	272	82	-	77	-	-	93	28	496	-

(a) This period does not coincide with year of total coverage.

Country: JAMAICA

Date attack phase began: 2 January 1958

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	1 706	11 428
Non malarious areas	341	1 400
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	1 365	10 028
Attack phase	0	0
Preparatory phase	0	0
Total originally malarious areas	1 365	10 028

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	-	-	-
Evaluation operations	2	103	105
Administrative and other	(1)	9	9 (1)
Transport	-	-	-
Total	2 (1)	112	114 (1)

Part-time personnel in parentheses

TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	-	37	2 [a]	39
Two-wheel vehicles	-	-	-	-
Boats	-	-	-	-
Animals	-	-	-	-
Other	-	-	-	-
Total	-	37	2 [a]	39

(a) One vehicle is used for Aedes aegypti survey

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Jan. 58-Dec. 58	56 266	205	0.36	199	-	6
2nd	Jan. 59-Sep. 59	27 953	295	1.06	280	-	15
3rd	Oct. 59-Sep. 60	111 039	194	0.17	180	-	14
4th	Oct. 60-Dec. 61	190 094	38	0.02	30	-	8

CONSOLIDATION PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1960	3-4	337	48 411	28.7	2	-	2	-	-	-	-	-	-	-	2
1961	1-4	337	139 664	41.4	8	1	7	-	-	-	-	-	-	-	8
1962	1st	1 282	63 426	19.8	-	-	-	-	-	-	-	-	-	-	-
	2nd		75 804	23.6	-	-	-	-	-	-	-	-	-	-	-
	3rd		59 089	18.4	1	-	-	1	-	-	-	-	-	1	-
	4th		48 273	15.1	1	-	-	-	-	-	-	1	-	-	1
1963	1st	1 309	43 398	13.3	2	-	2	-	-	-	-	-	-	-	2
	2nd		47 929	14.6	-	-	-	-	-	-	-	-	-	-	-
	3rd		54 264	16.6	1	-	1	-	-	-	-	-	-	-	1
	4th		39 868	12.2	-	-	-	-	-	-	-	-	-	-	-
1964	1st	1 365	36 054	10.6	-	-	-	-	-	-	-	-	-	-	-
	2nd		35 955	10.5	-	-	-	-	-	-	-	-	-	-	-
	3rd		34 498	10.1	1	-	1	-	-	-	-	-	-	-	1
	4th		28 317	8.3	-	-	-	-	-	-	-	-	-	-	-
1965	1st	1 365	24 443	7.2	1	1	-	-	-	-	-	-	-	-	1

Country: MEXICO

Date attack phase began: 2 January 1957

STATUS OF MALARIA PROGRAM AT DECEMBER 1964

	Population (thousands)	Area km^2
TOTAL COUNTRY	39 494	1 969 367
Non malarious areas	19 282	914 592
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	12 740	539 731
Attack phase	7 472	515 044
Preparatory phase	0	0
Total originally malarious areas	20 212	1 054 775

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	45	2 401	2 446
Evaluation operations	84	904	988
Administrative and other	16	539	555
Transport	-	126	126
Total	145	3 970	4 115

TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	458	317	25	800
Two-wheel vehicles	-	-	-	-
Boats	2	7	-	9
Animals	1 970 [a]	424 [a]	-	2 394 [a]
Other	-	-	-	-
Total	2 430	748	25	3 203

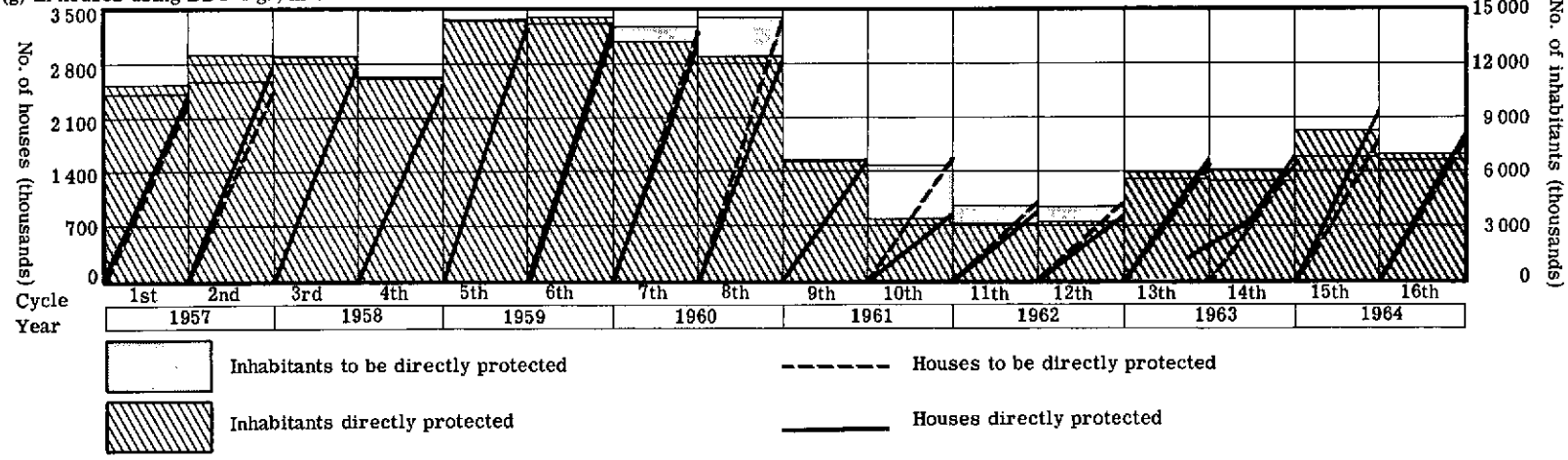
(a) Rented

MEXICO (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Houses sprayed						Inhabitants directly protected		Insecticide used per house (g. technical)		Average houses sprayed per spray-man/day
		DDT			Dieldrin							
		Cycle	Planned	Sprayed	Cycle	Planned	Sprayed	Planned	Protected	DDT	Dieldrin	
1st	Jan. 57-Dec. 57	1st	2 292 841	2 143 023	1st	(a)	219 662	10 464 526	10 802 292	495	99	9.3
		2nd	2 434 486	2 298 952		(a)	459 064	11 113 428	12 597 171	417		9.9
2nd	Jan. 58-Dec. 58	3rd	2 060 985	2 103 570	2nd	731 872	685 814	12 545 513	12 531 599	402	110	10.3
		4th	1 869 911	1 971 557		666 929	531 742	11 362 506	11 212 496	424	113	10.5
3rd	Jan. 59-Dec. 59	5th	2 973 820	3 050 952	3rd	321 520	246 753	14 492 905	14 505 650	434	112	10.8
		6th	3 018 184	3 219 340		160 136	45 548	14 226 160	14 614 270	434	118	10.4
4th	Jan. 60-Dec. 60	7th	3 177 380	3 027 089	4th	68 977	21 390	14 163 856	13 301 924	369	94	10.9
		8th	3 376 695	2 869 083		(a)	1 000	14 681 870	12 481 041	247	83	11.1
5th	Jan. 61-Dec. 61	9th	1 575 106	1 582 503	-	-	-	6 571 342	6 602 052	356	-	11.2
		10th	1 575 106	852 287				6 409 106	3 468 283	414		10.5
6th	Jan. 62-Dec. 62	11th	1 036 386	783 060b	-	-	-	4 151 927	3 135 873	514	-	8.6
		12th	1 036 386	825 082				4 070 924	3 241 041	517		8.9
7th	Jan. 63-Dec. 63	13th	1 477 793	1 551 297c	-	-	-	5 686 547	5 969 938	512	-	8.6
		14th	1 477 793	1 606 125d				5 572 757	6 056 473	...		8.7
8th	Jan. 64-Dec. 64	15th	1 808 906	2 190 136e	-	-	-	6 869 682	8 317 653	486	199 g	8.7
		16th	1 808 906	1 848 155f				6 770 916	6 917 988	476	249 g	8.7

(a) Included in DDT column. (b) Includes 386 746 houses sprayed three times a year and 5 963 once a year. (c) Includes 160 295 houses sprayed three times a year, and 5 697 once a year. (d) Includes 128 743 houses sprayed three times a year, and 4 029 once a year. (e) Includes 11 457 houses sprayed once a year, 732 900 three times a year and 51 423 four times a year. (f) Includes 3 907 houses sprayed once a year, 522 194 three times a year, and 42 692 four times a year. (g) In houses using DDT 1 g. /m^2.



MEXICO (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Jan.57-Dec.57	175 080	4 387	2.51	514	3 856	17
2nd	Jan.58-Dec.58	399 124	3 290	0.82	487	2 779	24
3rd	Jan.59-Dec.59	815 038	3 202	0.39	443	2 705	54
4th	Jan.60-Dec.60	1 208 712	3 569	0.29	245	3 251	73
5th	Jan.61-Dec.61	828 360	8 735	1.05	337	8 283	115
6th	Jan.62-Dec.62	727 262	9 642 [a]	1.33	139 [a]	9 450 [a]	53 [a]
7th	Jan.63-Dec.63	710 448	12 906	1.82	279	12 581	46
8th	Jan.64-Dec.64	761 832	11 722	1.54	371	11 334	17

CONSOLIDATION PHASE AREAS

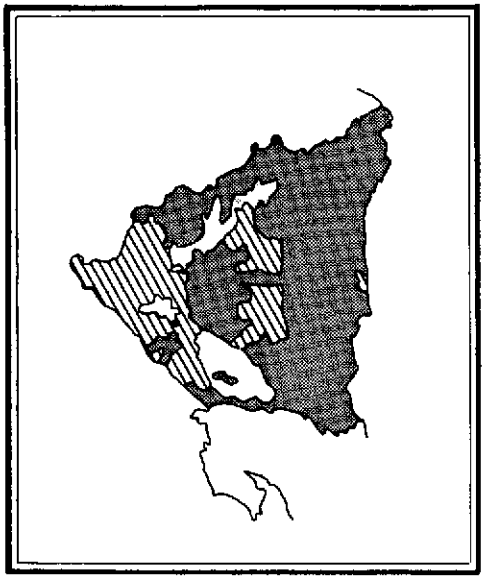
Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified and not Investigated	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1958	1 - 4	59	4 449	7.5	-	-	-	-	-	-	-	-	-	-	-
1959	1 - 4	59	6 560	11.1	-	-	-	-	-	-	-	-	-	-	-
1960	1 - 3	70	4 058	7.7	-	-	-	-	-	-	-	-	-	-	-
1961	1 - 4	11 721	745 907	6.4	3 114	1 248	446	387		12	90	931	91	3 004	19
1962 [a]	1st	15 592	241 563	6.2	456	134	97	-	174	-	17	34	17	438	1
	2nd		275 037	7.1	632	111	77	-	83	-	34	327	14	610	8
	3rd		302 124	7.7	1 458	209	111	1	151	2	176	808	8	1 447	3
	4th		421 406	10.8	2 091	757	202	2	287	-	415	428	4	2 082	5
1963	1st	16 830	218 815	5.2	303	47	39	1	82	1	14	119	1	298	4
	2nd		295 992	7.0	719	156	8	-	127	-	60	368	4	710	5
	3rd		291 242	6.9	1 604	666	12	-	170	2	252	502	29	1 568	7
	4th		316 054	7.5	1 209	645	14	-	115	2	64	369	149	1 058	2
1964	1st	12 740	196 755	6.2	298	165	36	1	87	3	6	-	7	291	-
	2nd		217 828	6.8	309	134	31	-	87	1	3	53	19	290	-
	3rd		223 695	7.0	521	229	11	1	153	-	-	127	17	500	4
	4th		195 213	6.1	555	386	...	-	80	...	...	...	40	514	1

(a) Revised figures.

Country: NICARAGUA

Date attack phase began: 10 November 1958

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	1 740	139 000
Non malarious areas	69	6 615
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	695	91 799
Attack phase	976	40 586
Preparatory phase	0	0
Total originally malarious areas	1 671	132 385

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	-	126	126
Evaluation operations	6	218	224
Administrative and other	2	38	40
Transport	-	61	61
Total	8	443	451

TRANSPORT FACILITIES

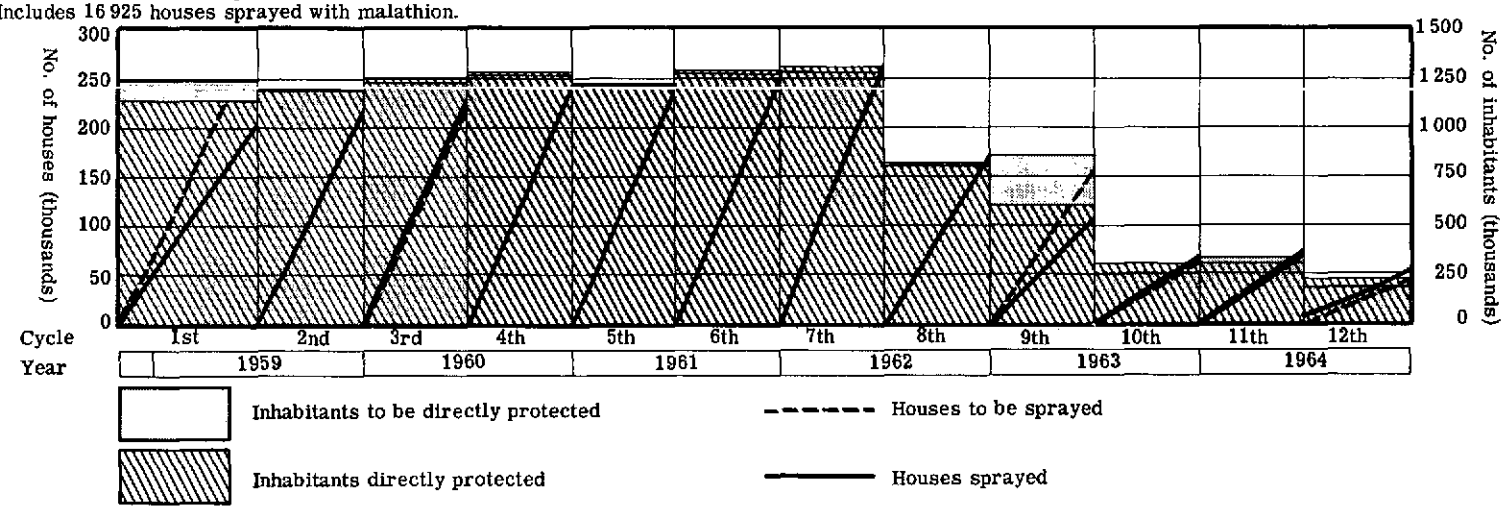
Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	21	39	3	63
Two-wheel vehicles	-	-	-	-
Boats	-	11	-	11
Animals	-	-	-	-
Other	-	-	-	-
Total	21	50	3	74

NICARAGUA (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Cycle DDT	Houses sprayed		Inhabitants directly protected		Insecticide used per house (g. technical) DDT	Average houses sprayed per spray-man/day
			Planned	Sprayed	Planned	Protected		
1st	Nov. 58-Dec. 59	1st 2nd	223 220 218 312	205 930 218 645	1 244 452 1 202 244	1 148 052 1 204 139	401 325	9.2 10.3
2nd	Jan. 60-Dec. 60	3rd 4th	226 831 237 553	230 478 239 076	1 232 373 1 275 185	1 252 160 1 283 375	367 396	9.4 8.9
3rd	Jan. 61-Dec. 61	5th 6th	237 062 248 739	239 375 251 537[a]	1 244 338 1 276 530	1 256 399 1 290 900	403 397	9.5 9.1
4th	Jan. 62-Dec. 62	7th 8th	259 760 169 118	264 822[b] 170 333[c]	1 289 708 821 913	1 314 866 827 823	409 440	9.6 9.3
5th	Jan. 63-Dec. 63	9th 10th	176 538 62 121	126 483[d] 71 232[e]	863 624 267 680	618 699 306 925	465 471	9.0 9.0
6th	Jan. 64-Dec. 64	11th 12th	74 596 45 443	67 982[f] 54 064[g]	337 690 187 480	307 741 223 046	491 493	8.3 7.7

(a) Includes 2 469 houses sprayed with malathion. (b) Includes 5 079 houses sprayed with malathion. (c) Includes 5 710 houses sprayed with malathion.
(d) Includes 11 460 houses sprayed with malathion. (e) Includes 11 356 houses sprayed with malathion. (f) Includes 12 098 houses sprayed with malathion.
(g) Includes 16 925 houses sprayed with malathion.



EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Nov.58-Dec.59	38 966	1 875	4.81	619	1 256	-
2nd	Jan. 60-Dec.60	74 074	7 528	10.16	4 217	3 311	-
3rd	Jan. 61-Dec.61	109 293	8 722	7.98	3 001	5 721	-
4th	Jan. 62-Dec.62	162 733	11 200	6.88	3 428	7 772	-
5th	Jan. 63-Dec.63	152 339	10 593	6.95	2 742	7 851	-
6th	Jan.64-Dec.64	173 068	11 197	6.47	2 403	8 794	-

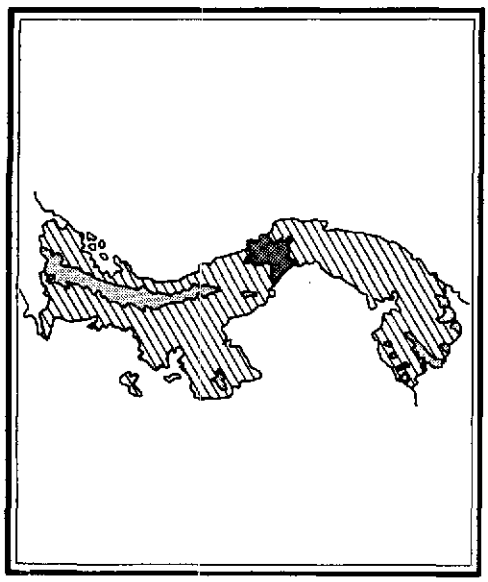
CONSOLIDATION PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1962	3rd	515	9 463	7.3	41	8	6	-	20	-	1	6	10	30	1
	4th	515	9 531	7.4	118	49	7	-	30	-	-	32	16	102	-
1963	1st	533	8 974	6.7	52	7	1	-	28	-	2	14	9	43	-
	2nd	533	10 731	8.0	110	10	11	-	26	-	-	63	19	91	-
	3rd	668	21 869	13.1	385	169	15	-	78	1	-	122	278	107	-
	4th	668	20 937	12.5	419	308	12	-	98	-	1	-	172	247	-
1964	1st	695	17 564	10.1	343	200	33	-	45	-	-	65	169	174	-
	2nd		19 395	11.2	362	105	27	-	84	-	-	146	101	261	-
	3rd		21 520	12.4	527	143	42	-	86	1	-	255	87	440	-
	4th		16 064	9.2	587	206	38	-	149	-	1	193	149	438	-

Country: PANAMA

Date attack phase began: 19 August 1957

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	1 210	75 650
Non malarious areas	45	5 806
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	0	0
Attack phase	1 165	69 844
Preparatory phase	0	0
Total originally malarious areas	1 165	69 844

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	-	257	257
Evaluation operations	2	41	43
Administrative and other	1	30	31
Transport	-	9	9
Total	3	337	340

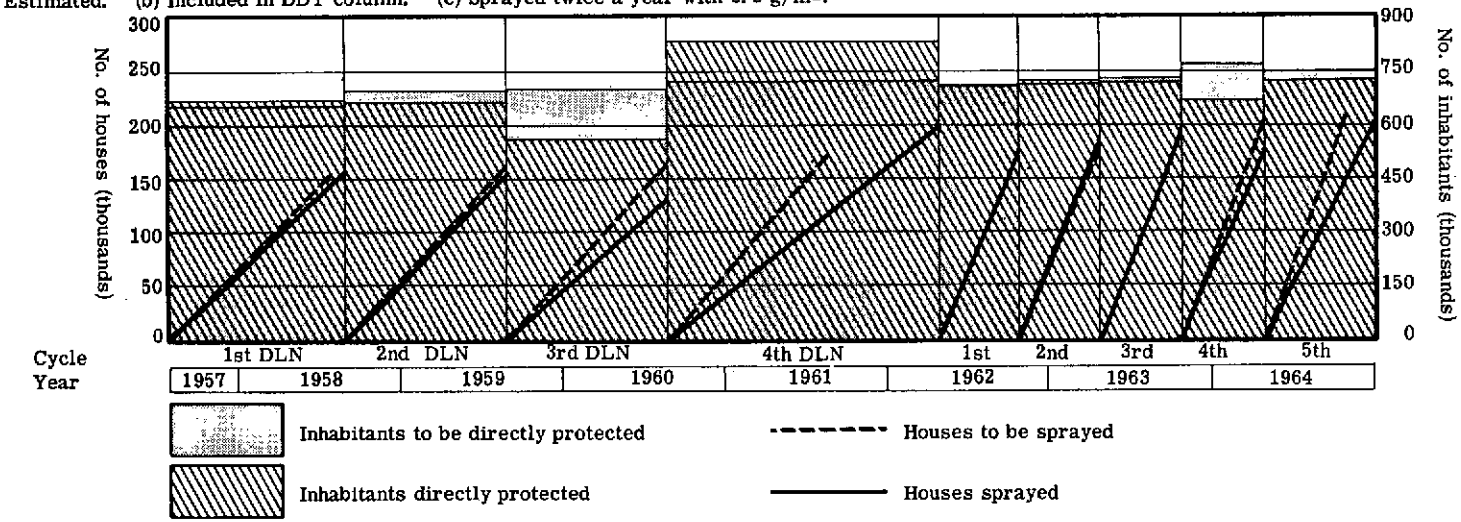
TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	55	21	4	80
Two-wheel vehicles	-	11	-	11
Boats	15	3	2	20
Animals	-	-	-	-
Other	-	-	-	-
Total	70	35	6	111

SPRAYING OPERATIONS

Year of total coverage	Date	Houses sprayed						Inhabitants directly protected		Insecticide used per house (g. technical)		Average houses sprayed per spray-man/day
		DDT			Dieldrin							
		Cycle	Planned	Sprayed	Cycle	Planned	Sprayed	Planned	Protected	DDT	Dieldrin	
1st	Aug. 57-Aug. 58	-	-	-	1st	152 957	155 963	659 856 [a]	671 824 [a]	-	119	6.5
2nd	Sep. 58-Aug. 59	-	-	-	2nd	161 700	154 638	697 574	667 095	-	145	6.9
3rd	Sep. 59-Aug. 60	-	-	-	3rd	165 102	131 270	707 462	562 514	-	129	7.3
4th	Sep. 60-Apr. 62	-	-	-	4th	172 121	199 265	722 392	836 229	-	138	6.8
5th	May 62-Apr. 63	1st	175 622	174 779	-	(b)	1 101 [c]	710 918	711 983	490	63	8.1
		2nd	182 784	184 355			1 192 [c]	714 320	726 944	510	103	8.8
6th	May 63-Apr. 64	3rd	197 379	193 960	-	(b)	1 024 [c]	733 060	724 166	477	77	8.9
		4th	205 165	176 912			1 268 [c]	771 827	670 310	455	71	9.3
7th	May 64-Dec. 64	5th	209 126	201 976	-	(b)	1 078 [c]	750 420	728 633	440	77	9.0

(a) Estimated. (b) Included in DDT column. (c) Sprayed twice a year with 0.3 g/m^2.



PANAMA (Cont.)

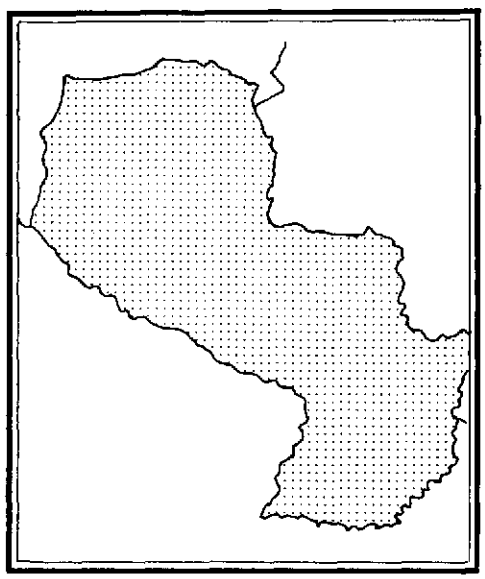
EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Aug. 57-Aug. 58	69 429	5 634	8.11	1 717	...	5
2nd	Sep. 58-Aug. 59	93 338	4 921	5.27	720	4 126	5
3rd	Sep. 59-Aug. 60	76 984	5 232	6.80	751	4 479	2
4th	Sep. 60-Apr. 62	160 620	5 817	3.62	1 660	4 155	2
5th	May 62-Apr. 63	147 711	3 310	2.24	538	2 772	-
6th	May 63-Apr. 64	140 078	2 246	1.60	175	2 070	1
7th	May 64-Dec. 64	96 472	1 183	1.23	85	1 098	-

Country: PARAGUAY

Date attack phase began: -

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	1 900	406 752
Non malarious areas	321	162
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	0	0
Attack phase	0	0
Preparatory phase	1 579	406 590
Total originally malarious areas	1 579	406 590

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	2	32	34
Evaluation operations	7	59	66
Administrative and other	1	50	51
Transport	-	21	21
Total	10	162	172

TRANSPORT FACILITIES

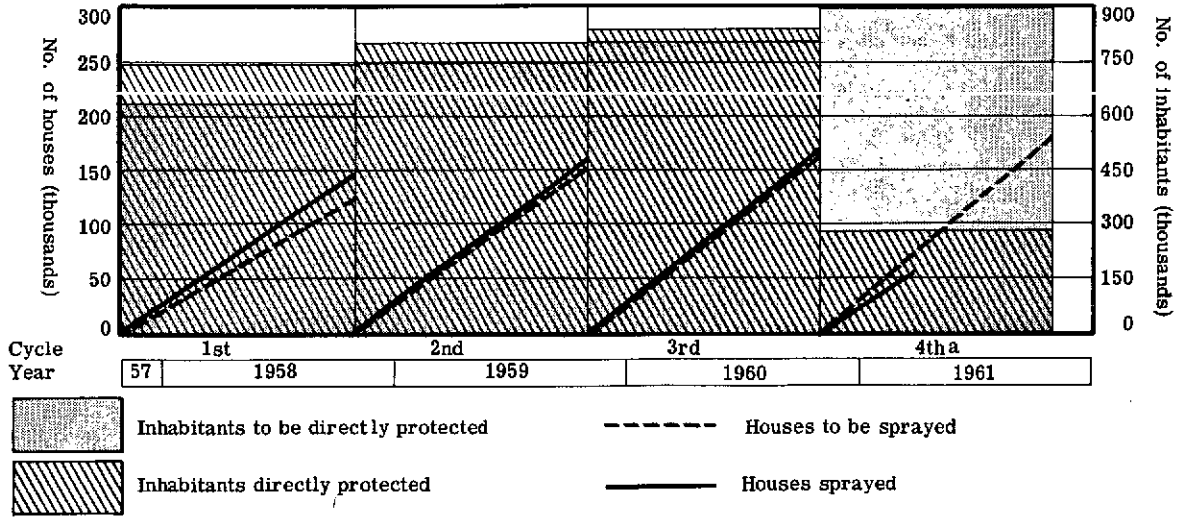
Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	1	6	20	27
Two-wheel vehicles	-	-	5	5
Boats	-	5	11	16
Animals	8	4	-	12
Other	-	-	-	-
Total	9	15	36	60

PARAGUAY (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Cycle Dieldrin	Houses sprayed		Inhabitants directly protected		Insecticide used per house (g. technical) Dieldrin	Average houses sprayed per spray-man/day
			Planned	Sprayed	Planned	Protected		
1st	Nov. 57-Oct. 58	1st	126 902	148 626	638 190	747 541	105	10.9
2nd	Nov. 58-Oct. 59	2nd	150 033	161 261	749 115	805 232	111	14.3
3rd	Nov. 59-Oct. 60	3rd	163 586	171 086	807 460	844 515	118	11.7
4th [a]	Nov. 60-Mar. 61	4th [a]	181 097	56 656	898 060	280 982	138	8.1

(a) Program suspended, new program being planned.



EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Nov. 57-Oct. 58	13 526	500	3.70	3	496	1
2nd	Nov. 58-Oct. 59	11 963	621	5.19	3	618	-
3rd	Nov. 59-Oct. 60	42 396	1 033	2.44	5	1 028	-
4th[a]	Nov. 60-Dec. 61	34 452	1 745	5.07	9	1 735	1
(b)	Jan. 62-Dec. 62	48 184	5 756	11.95	313	5 443	-
(b)	Jan. 63-Dec. 63	92 806	3 443	3.71	313	3 130	-
(b)	Jan. 64-Dec. 64	103 169	8 851	8.58	961	7 889	1

(a) Spraying operations suspended in March 1961, program replaced in preparatory phase.
(b) Preparatory phase.

Country: PERU

Date attack phase began: 17 November 1957

STATUS OF MALARIA PROGRAM AT DECEMBER 1964

	Population (thousands)	Area km^2
TOTAL COUNTRY	10 794	1 381 800
Non malarious areas	7 502	438 600
Originally malarious areas		
Maintenance phase	43	31 040
Consolidation phase	2 204	268 210
Attack phase	1 045	643 950
Preparatory phase	0	0
Total originally malarious areas	3 292	943 200

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	5	298	303
Evaluation operations	18	191	209
Administrative and other	1	179	180
Transport	-	70	70
Total	24	738	762

TRANSPORT FACILITIES

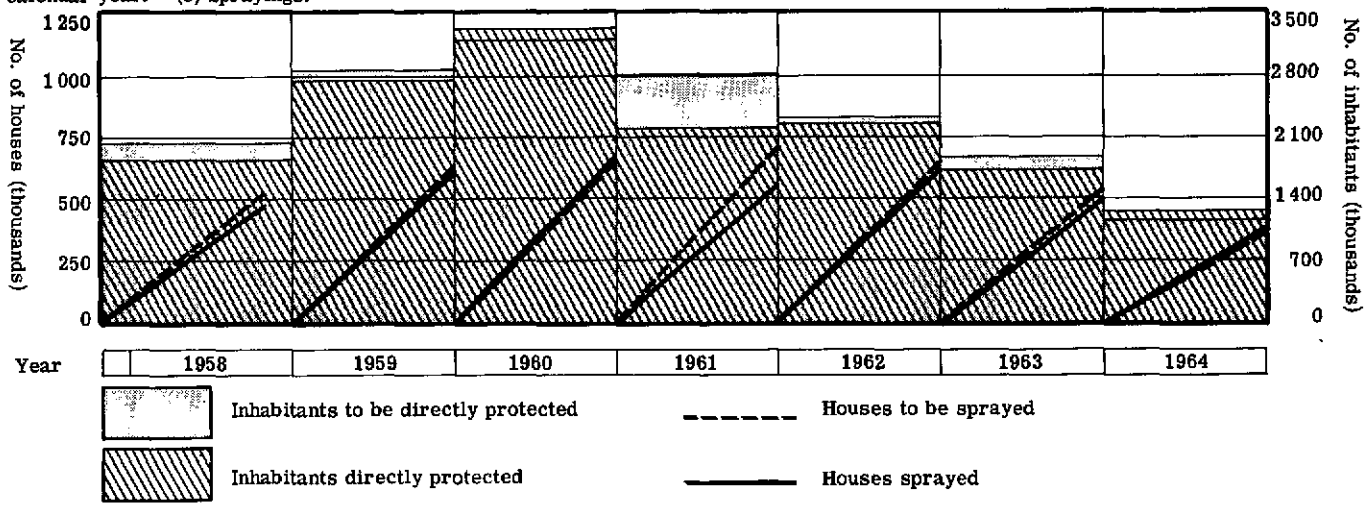
Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	59	66	52	177
Two-wheel vehicles	-	-	1	1
Boats	-	-	61	61
Animals	-	-	-	-
Other	-	-	-	-
Total	59	66	114	239

PERU (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Houses sprayed						Inhabitants directly protected		Insecticide used per house (g. technical)		Average houses sprayed per spray-man/day
		DDT			Dieldrin							
		Cycle	Planned	Sprayed	Cycle	Planned	Sprayed	Planned	Protected	DDT	Dieldrin	
1st	Nov.57-Oct. 58	1st + 2nd	527 081	286 764 [a] 70 266 [b]	1st	(c)	122 120	2 054 035	1 867 208	426	115	7.8
2nd	Jan. 59-Dec. 59	(d)	637 241	271 065 [e]	2nd	(c)	341 804	2 886 064	2 775 694	424	118	8.4
3rd	Jan. 60-Dec. 60	(d)	654 825	447 848 [e]	3rd	(c)	234 643	3 209 952	3 345 726	468	95	8.4
4th	Jan. 61-Dec. 61	(d)	714 740	534 037 [e]	4th	(c)	25 005	2 826 797	2 210 988	410	109	7.9
5th	Jan. 62-Dec. 62	(d)	646 992	627 527 [e]	-	-	-	2 354 405	2 283 960	465	-	8.7
6th	Jan. 63-Dec. 63	(d)	537 112	500 218 [e]	-	-	-	1 885 800	1 756 286	459	-	8.1
7th	Jan. 64-Dec. 64	(d)	357 805	379 184 [e]	-	-	-	1 182 617	1 253 290	473	-	7.9

(a) Sprayed once a year. (b) Sprayed twice a year. (c) Included in DDT column. (d) Owing to different spray cycle timing in different regions, these data refer to the calendar year. (e) Sprayings.



PERU (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Nov. 57-Oct. 58	...	649[a]	...	77	526	27
(b)	Jan. 59-Dec.59	148 413	4 658[a]	3.14	302	4 265	51
(b)	Jan. 60-Dec.60	342 503	3 901	1.14	256	3 559	86
(b)	Jan. 61-Dec. 61	403 748	3 055	0.76	185	2 804	66
(b)	Jan. 62-Dec. 62	399 309	2 196	0.55	81	2 035	80
(b)	Jan. 63-Dec.63	313 649	1 630	0.52	101	1 389	140
(b)	Jan. 64-Dec.64	302 086	1 605[a]	0.53	273	1 207	91

CONSOLIDATION PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified and not Investigated	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1959	1 - 4	14	1 378	9.8	-	-	-	-	-	-	-	-	-	-	-
1960	1 - 4	15	7 277	48.5	5	-	-	1	-	4	-	-	-	1	4
1961	1 - 4	47	13 780	29.3	1	-	-	-	1	-	-	-	-	1	-
1962	1st	864	15 09	7.0	9	1	1	-	3	4	-	-	-	7	2
	2nd		20 414	9.4	1	-	-	-	1	-	-	-	-	1	-
	3rd		17 056	7.9	4	-	-	1	3	-	-	-	-	4	-
	4th		18 769	8.7	6	1	-	-	5	-	-	-	1	4	1
1963	1st	2 199	35 455	6.4	25	1	2	4	16	2	-	-	-	24	1
	2nd		34 049	6.2	26	3	-	-	18	-	-	5	-	25	1
	3rd		51 120	9.3	19	5	-	1	12	1	-	-	-	18	1
	4th		48 103	8.7	17	4	4	-	5	-	-	4	-	16	1
1964	1 - 3	2 204	150 002	9.1	298	190	32	-	34	2	3	37	1	294	3
	4th		33 675	6.1	21	...	...	...	...	...	...	...	-	21	-

(a) Includes undifferentiated mixed infections. (b) Owing to different spray cycle timing in different regions, these data refer to the calendar year.

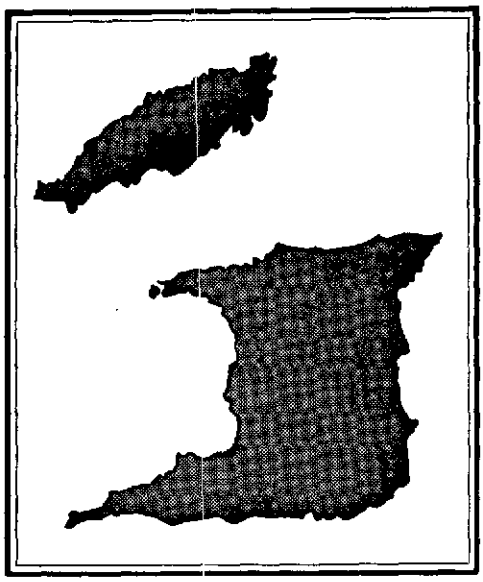
PERU (Cont.)

MAINTENANCE PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1963	1st	43	1 990	18.5	1	-	-	1	-	-	-	-	-	1	-
	2nd		1 751	16.3	3	-	-	-	1	2	-	-	-	1	2
	3rd		1 744	16.2	-	-	-	-	-	-	-	-	-	-	-
	4th		3 066	28.5	-	-	-	-	-	-	-	-	-	-	-
1964	1st	43	1 876	17.4	-	-	-	-	-	-	-	-	-	-	-
	2nd		2 652	24.7	-	-	-	-	-	-	-	-	-	-	-
	3rd		1 985	18.5	-	-	-	-	-	-	-	-	-	-	-
	4th		1 743	16.2	-	-	-	-	-	-	-	-	-	-	-

Country: TRINIDAD AND TOBAGO Date attack phase began: 2 January 1958

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	962	5 605
Non malarious areas	140	161
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	822	5 444
Attack phase	0	0
Preparatory phase	0	0
Total originally malarious areas	822	5 444

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	-	30	30
Evaluation operations	1	124	125
Administrative and other	-	24	24
Transport	-	30	30
Total	1	208	209

TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	3	11	15	29
Two-wheel vehicles	-	-	-	-
Boats	-	-	1	1
Animals	-	-	-	-
Other	-	-	-	-
Total	3	11	16	30

TRINIDAD AND TOBAGO (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Jan. 58-Dec. 58	51 159	374	0.73	316	58	-
2nd	Jan. 59-Dec. 59	101 039	92	0.09	63	28	1
3rd	Jan. 60-Dec. 60	91 388	11	0.01	9	2	-
4th	Jan. 61-Dec. 61	89 569	-	-	-	-	-

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1958	1 - 4	160	21 279	13.2	2	-	-	2	-	-	-	-	2	-	-
1959	1 - 4	160	361	0.2	5	-	-	5	-	-	-	-	4	1	-
1960	1 - 4	185	17 612	9.5	2	-	-	2	-	-	-	-	-	-	-
1961	1 - 4	197	11 602	5.9	1	-	-	1	-	-	-	-	1	-	-
1962	1st	877	36 719	16.7	-	-	-	-	-	-	-	-	-	-	-
	2nd		27 947	12.7	-	-	-	-	-	-	-	-	-	-	-
	3rd		35 614	16.2	1	-	-	1	-	-	-	-	-	-	-
	4th		20 687	9.4	-	-	-	-	-	-	-	-	-	-	-
1963[a]	1st	828	32 746	15.8	-	-	-	-	-	-	-	-	-	-	-
	2nd		24 640	11.9	-	-	-	-	-	-	-	-	-	-	-
	3rd		18 825	9.1	-	-	-	-	-	-	-	-	-	-	-
	4th		32 712	15.8	-	-	-	-	-	-	-	-	-	-	-
1964	1st	822	22 906	11.1	-	-	-	-	-	-	-	-	-	-	-
	2nd		28 920	14.1	2	-	1	1	-	-	-	-	-	1	1
	3rd		16 579	8.1	1	-	-	1	-	-	-	-	-	-	1
	4th		13 633	6.6	-	-	-	-	-	-	-	-	-	-	-

(a) Includes 1 145 slides from Tobago, divided equally among the quarters.

Country: VENEZUELA Date attack phase began: 1945

STATUS OF MALARIA PROGRAM AT DECEMBER 1964

	Population (thousands)	Area km^2
TOTAL COUNTRY	8 336	912 050
Non malarious areas	2 111	312 050
Originally malarious areas		
Maintenance phase	5 822	469 552
Consolidation phase	116	7 681
Attack phase	287	122 767
Preparatory phase	0	0
Total originally malarious areas	6 225	600 000

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	1	330	331
Evaluation operations	19	642	661
Administrative and other	...	...	...
Transport	-	35	35
Total	20	1 007	1 027

... No information

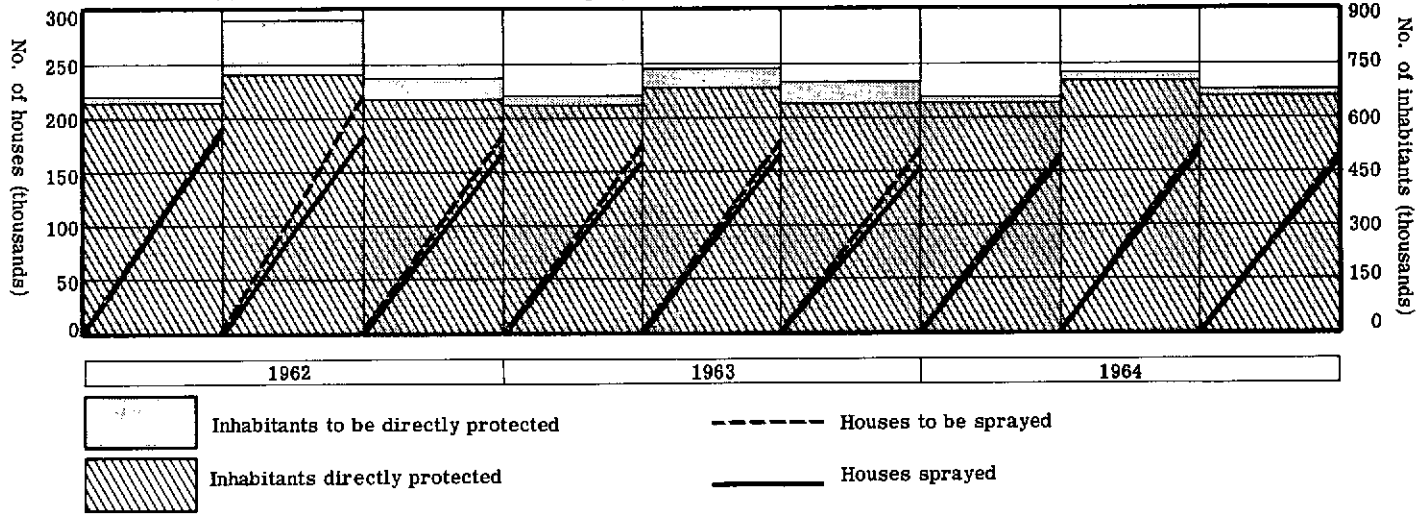
TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	73	79	42	194
Two-wheel vehicles	6	327	-	333
Boats	18	93	11	122
Animals	225	335	-	560
Other	62	-	-	62
Total	384	834	53	1 271

SPRAYING OPERATIONS

Year of total coverage	Date	Houses sprayed						Inhabitants directly protected		Insecticide used per house (g. technical)		Average houses sprayed per spray-man/day
		DDT			Dieldrin							
		Cycle	Planned	Sprayed	Cycle	Planned	Sprayed	Planned	Protected	DDT	Dieldrin	
...	Jan. 62-Dec. 62	...	189 083	170 848	...	(a)	3 381 13 125 [b]	712 276	643 634	422	198 173 [b]	6.3
		...	220 919	175 962	...	(a)	1 100 5 704 [b]	877 711	726 147	340	210 148 [b]	6.5
		...	185 755	163 477	...	(a)	1 595 4 877 [b]	715 343	654 399	332	247 126 [b]	7.0
...	Jan. 63-Dec. 63	...	177 294	158 263	...	(a)	789 151 [b]	712 190	639 525	359	198 182 [b]	7.0
		...	179 385	163 952	...	(a)	870 1 161 [b]	739 963	684 615	376	322 187 [b]	7.0
		...	169 947	153 538	...	(a)	773 368 [b]	703 241	640 057	370	303 163 [b]	7.0
...	Jan. 64-Dec. 64	...	165 656	160 867 [c]	...	(a)	(a)	659 840 [d]	640 780	373	...	7.4
		...	174 388	169 599 [c]	...	(a)	(a)	727 564 [d]	707 599	391	...	7.5
		...	165 206	160 418 [c]	...	(a)	(a)	681 949 [d]	662 186	389	...	7.0

(a) Included in DDT column. (b) BHC. (c) Includes some houses sprayed with BHC. (d) Estimated.



VENEZUELA (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
...	Jan. 58-Dec. 58	269 448	975 [a]	0.36	60	901	4
...	Jan. 59-Dec. 59	232 710	765 [a]	0.33	92	646	14
...	Jan. 60-Dec. 60	247 429	1 346 [a]	0.54	165	1 163	6
...	Jan. 61-Dec. 61	230 336	1 175 [a]	0.51	68	1 075	21
...	Jan. 62-Dec. 62	172 280	883 [b]	0.51	53	812	14
...	Jan. 63-Dec. 63	153 406	2 194 [b]	1.43	80	2 083	20
...	Jan. 64-Sep. 64	116 513	2 934	2.52	...	...	...

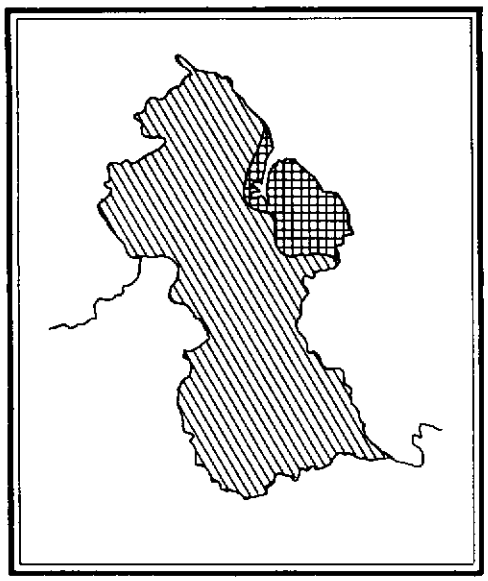
CONSOLIDATION PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections						Species of parasite		
						Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
Year	Quarter							from abroad	from areas within country						
1958	1 - 4	469	69 614	14.8	50	-	-	27		-	23	-	2	46	2
1959	1 - 4	685	101 878	14.9	45	-	-	37		1	7	-	2	43	-
1960	1 - 4	291	93 047	32.0	112 [a]	-	2	31	45	1	33	-	-	108	2
1961	1 - 4	174	64 923	37.3	57	-	4	15	9	-	29	-	-	57	-
1962	1 - 4	150	93 646	62.4	74 [a]	-	1	29	7	-	37	-	22	51	-
1963	1 - 4	102	61 724	60.5	89 [a]	-	-	32	7	-	50	-	26	62	-
1964	1 - 3	116	42 082	48.4	81	-	-	24	7	-	50	-	4	77	-
MAINTENANCE AND NON-MALARIOUS AREAS															
1958	1 - 4	4 720	145 654	3.1	113 [a]	-	-	79		5	28	1	6	100	6
1959	1 - 4	5 097	169 189	3.3	101 [a]	-	-	87		6	7	1	14	73	9
1960	1 - 4	6 092	224 193	3.7	216 [a]	-	6	44	92	4	70	-	14	197	4
1961	1 - 4	7 111	305 252	4.3	522 [a]	-	11	52	122	4	333	-	13	498	5
1962	1 - 4	7 410	282 314	3.8	253 [a]	-	5	52	84	2	110	-	5	244	3
1963	1 - 4	7 701	284 814	3.7	570	-	-	79	286	3	202	-	6	562	2
1964 [c]	1 - 3	5 822	213 844	4.9	1 371 [a]	-	1	147	735	1	487	-	3	1 365	2

(a) Includes undifferentiated mixed infections. (b) Includes undifferentiated mixed infections and unclassified species of parasites. (c) Maintenance phase areas only.

Country: BRITISH GUIANA Date attack phase began: April 1946

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	631	215 800
Non malarious areas	0	0
Originally malarious areas		
Maintenance phase	589	10 600
Consolidation phase	0	0
Attack phase	42	205 200
Preparatory phase	0	0
Total originally malarious areas	631	215 800

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	1	8	9
Evaluation operations	(1)	24	24 (1)
Administrative and other	-	10	10
Transport	-	12	12
Total	1 (1)	54	55 (1)

Part-time personnel in parentheses

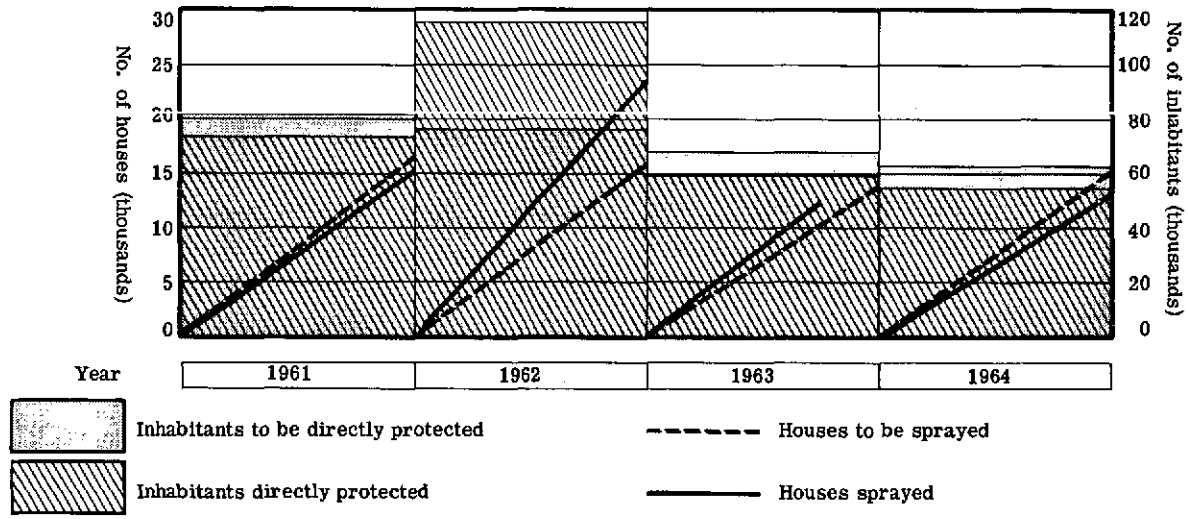
TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	3	4	-	7
Two-wheel vehicles	-	-	-	-
Boats	-	-	4	4
Animals	1	-	-	1
Other	-	-	-	-
Total	4	4	4	12

BRITISH GUIANA (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Houses sprayed with DDT						Inhabitants directly protected		Insecticide used per house (g. technical)	Average houses sprayed per spray-man/day
		Once a year			Twice a year						
		Cycle	Planned	Sprayed	Cycle	Planned	Sprayed	Planned	Protected	DDT	
...	Jan. 61-Dec. 61	...	16 538	15 107	-	-	-	82 062	74 964	195	4.6
...	Jan. 62-Dec. 62	...	9 542	10 273	...	6 131	13 535	76 563	116 305	183	8.3
...	Jan. 63-Sep. 63	...	6 726	4 270	...	7 218	7 961	68 123	59 542	346	7.3
...	Jan. 64-Dec. 64	...	6 563	5 408	...	4 236 4 236	5 280 2 384	63 243	54 986	295	4.3



EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
...	Jan. 58-Dec. 58	1 520	51	3.34	23	8	20
...	Jan. 59-Dec. 59	3 754	176[a]	4.68	53	100	13
...	Jan. 60-Sep. 60	3 674	263	7.16	175	67	12
...	Jan. 61-Dec. 61	15 515	218	1.40	57	156	5
...	Jan. 62-Dec. 62	14 358	425	2.96	266	159	-
...	Jan. 63-Dec. 63	16 780	473[a]	2.81	414	56	-
...	Jan. 64-Dec. 64	35 091	223	0.64	190	33	-

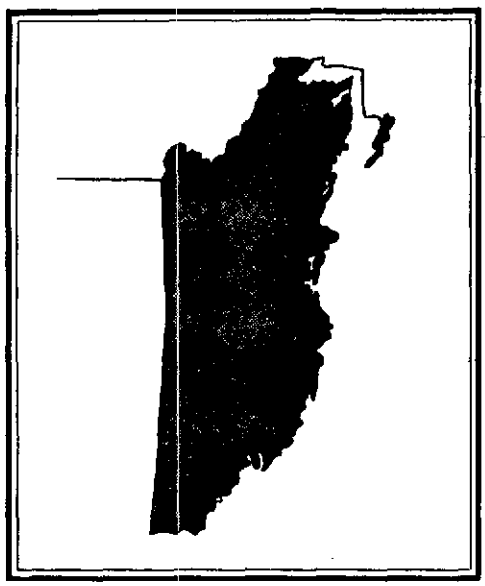
MAINTENANCE PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
						Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
Year	Quarter							from abroad	from areas within country						
1958	1 - 4	430	1	0.0	-	-	-	-	-	-	-	-	-	-	-
1959	1 - 4	460	-	0	-	-	-	-	-	-	-	-	-	-	-
1960	1 - 4	494	-	0	-	-	-	-	-	-	-	-	-	-	-
1961	1 - 4	515	1 374	0.3	13	-	-	1	12	-	-	-	1	12	-
1962	1 - 4	556	21 088	3.8	21	17	3	-	1	-	-	-	-	21	-
1963	1 - 4	572	15 475	2.7	3	-	2	1	-	-	-	-	1	2	-
1964	1st	589	6 031	4.1	-	-	-	-	-	-	-	-	-	-	-
	2nd		4 341	2.9	-	-	-	-	-	-	-	-	-	-	-
	3rd		6 014	4.1	-	-	-	-	-	-	-	-	-	-	-
	4th		3 708	2.5	2	-	-	2	-	-	-	-	2	-	-

(a) Includes undifferentiated mixed infections.

Country: BRITISH HONDURAS Date attack phase began: 4 February 1957

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	104	22 696
Non malarious areas	0	0
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	104	22 696
Attack phase	0	0
Preparatory phase	0	0
Total originally malarious areas	104	22 696

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	-	-	-
Evaluation operations	1	11	12
Administrative and other	1	3	4
Transport	-	3	3
Total	2	17	19

TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	-	8	3	11
Two-wheel vehicles	-	2	1	3
Boats	-	11	-	11
Animals	-	-	-	-
Other	-	-	-	-
Total	-	21	4	25

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Feb. 57-Jan. 58	2 132	256	12.01	148	56	52
2nd	Feb. 58-Apr.59	8 081	593	7.34	321	226	46
3rd	May 59-Jun. 60	12 985	819	6.31	542	207	70
4th	Jul. 60-Jun. 61	15 149	82	0.54	11	71	-
5th	Jul. 61-Jul. 62	12 741	12	0.09	-	12	-

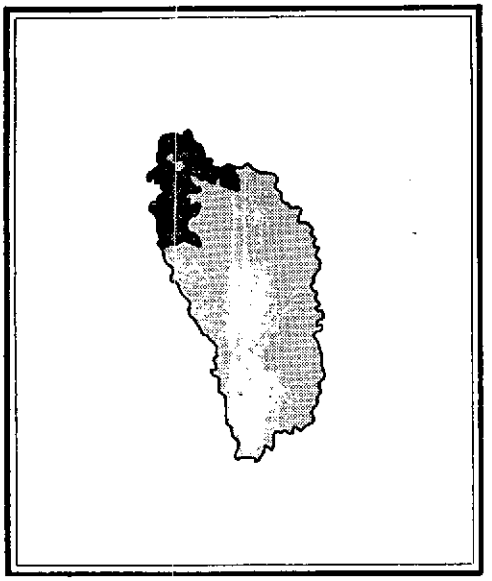
CONSOLIDATION PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1962	3rd[a]	100	3 004	12.0	14	6	7	1	-	-	-	-	-	14	-
	4th		3 657	14.6	4	4	-	-	-	-	-	-	-	4	-
1963	1st	100	3 284	13.1	2	2	-	-	-	-	-	-	-	2	-
	2nd		2 622	10.5	2	2	-	-	-	-	-	-	-	2	-
	3rd		3 114	12.5	-	-	-	-	-	-	-	-	-	-	-
	4th		4 065	16.3	13	13	-	-	-	-	-	-	-	13	-
1964	1st	104	3 439	13.2	7	7	-	-	-	-	-	-	-	7	-
	2nd		2 706	10.4	2	2	-	-	-	-	-	-	-	2	-
	3rd		3 173	12.2	18	16	1	1	-	-	-	-	-	18	-
	4th		2 508	9.6	8	7	1	-	-	-	-	-	-	8	-

(a) August-September.

Country: DOMINICA Date attack phase began: 8 June 1959

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	60	790
Non malarious areas	46	638
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	14	152
Attack phase	0	0
Preparatory phase	0	0
Total originally malarious areas	14	152

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	-	-	-
Evaluation operations	(1)	7	7 (1)
Administrative and other	-	1 (1)	1 (1)
Transport	-	1	1
Total	(1)	9 (1)	9 (2)

Part-time personnel in parentheses

TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	-	3	-	3
Two-wheel vehicles	-	4	-	4
Boats	-	-	-	-
Animals	-	-	-	-
Other	-	-	-	-
Total	-	7	-	7

DOMINICA (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

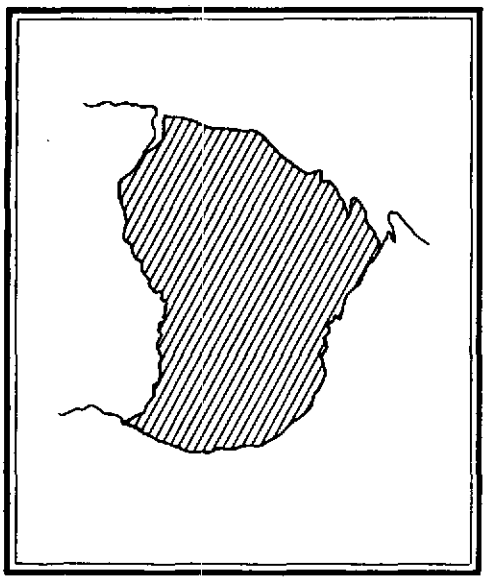
Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	Jun. 59-May 60	5 233	51	1.0	51	-	-
2nd	Jun. 60-Oct. 61	12 136	3	0.0	2	-	1
3rd	Nov.61-Dec. 62	15 069	1	0.0	-	-	1

CONSOLIDATION PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1963	1st	14	4 093	116.9	-	-	-	-	-	-	-	-	-	-	-
	2nd		4 441	126.8	-	-	-	-	-	-	-	-	-	-	-
	3rd		3 648	104.2	-	-	-	-	-	-	-	-	-	-	-
	4th		4 593	131.2	-	-	-	-	-	-	-	-	-	-	-
1964	1st	14	4 663	133.2	-	-	-	-	-	-	-	-	-	-	-
	2nd		4 057	115.9	-	-	-	-	-	-	-	-	-	-	-
	3rd		3 506	100.2	-	-	-	-	-	-	-	-	-	-	-
	4th		3 928	112.2	-	-	-	-	-	-	-	-	-	-	-

Country: FRENCH GUIANA Date attack phase began: May 1958

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	35	86 000
Non malarious areas	0	54 000
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	0	0
Attack phase	31	32 000 [a]
Preparatory phase	4	0
Total originally malarious areas	35	32 000 [a]

(a) Includes some areas in preparatory phase

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	-	29	29
Evaluation operations	1	3	4
Administrative and other	-	3	3
Transport	-	6	6
Total	1	41	42

TRANSPORT FACILITIES *

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	4	-	5	9
Two-wheel vehicles	-	-	2	2
Boats	1	-	-	1
Animals	-	-	-	-
Other	-	-	-	-
Total	5	-	7	12

* 1963 information; 1964 information not received

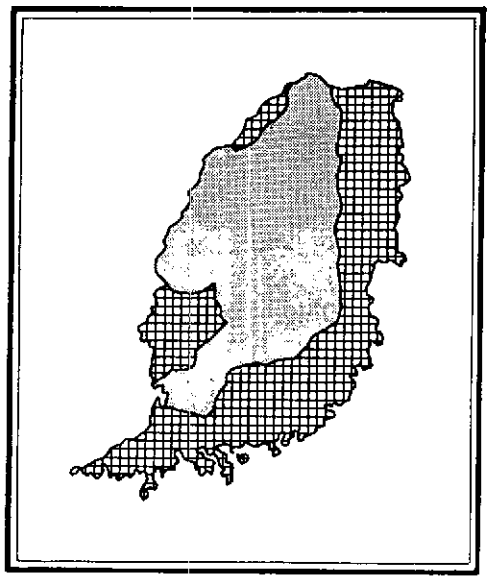
FRENCH GUIANA (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
...	Jan. 60-Dec. 60	3 343	37	1.11	30	6	1
...	Jan. 61-Dec. 61	1 197	33	2.76	33	-	-
...	Jan. 62-Dec. 62	2 183	70	3.21	60	10	-
...	Jan. 63-Sep. 63	2 648	70	2.64	61	9	-
...	Jan. 64-Dec. 64	3 025	48	1.59	16	32	-

Country: GRENADA AND CARRIACOU Date attack phase began: 12 February 1957

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



(Island of Carriacou in Maintenance phase not shown in the Map)

	Population (thousands)	Area km^2
TOTAL COUNTRY	93	344
Non malarious areas	54	114
Originally malarious areas		
Maintenance phase	39	230
Consolidation phase	0	0
Attack phase	0	0
Preparatory phase	0	0
Total originally malarious areas	39	230

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	-	-	-
Evaluation operations	-	25 (2)	25 (2)
Administrative and other	-	1 (1)	1 (1)
Transport	-	-	-
Total	-	26 (3)	26 (3)

Part-time personnel in parentheses

TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	-	-	-	-
Two-wheel vehicles	-	-	-	-
Boats	-	-	-	-
Animals	-	-	-	-
Other	-	-	-	-
Total	-	-	-	-

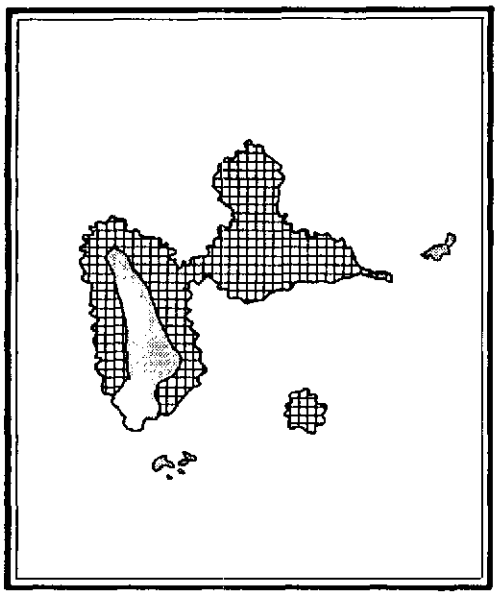
GRENADA AND CARRIACOU (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, MAINTENANCE PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1962	1 - 4	37	1996	5.4	-	-	-	-	-	-	-	-	-	-	-
1963	1 - 3	37	56	0.2	-	-	-	-	-	-	-	-	-	-	-
1964	1 - 4	39	517	1.3	-	-	-	-	-	-	-	-	-	-	-

Country: GUADELOUPE Date attack phase began: July 1956

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	298	1 779
Non malarious areas	32	643
Originally malarious areas		
Maintenance phase	266	1 136
Consolidation phase	0	0
Attack phase	0	0
Preparatory phase	0	0
Total originally malarious areas	266	1 136

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	-	37	37
Evaluation operations	2	10 (8)	12 (8)
Administrative and other	-	3 (26)	3 (26)
Transport	-	6	6
Total	2	56 (34)	58 (34)

Part-time personnel in parentheses

TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	6	4	1	11
Two-wheel vehicles	-	-	-	-
Boats	-	-	-	-
Animals	-	-	-	-
Other	-	-	-	-
Total	6	4	1	11

GUADELOUPE (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
...	Jan. 58-Dec. 58	1 150	3	0.26	-	-	3
...	Jan. 59-Dec. 59	3 903	-	0	-	-	-
...	Jan. 60-Sep. 60	4 450	2	0.04	...	...	...

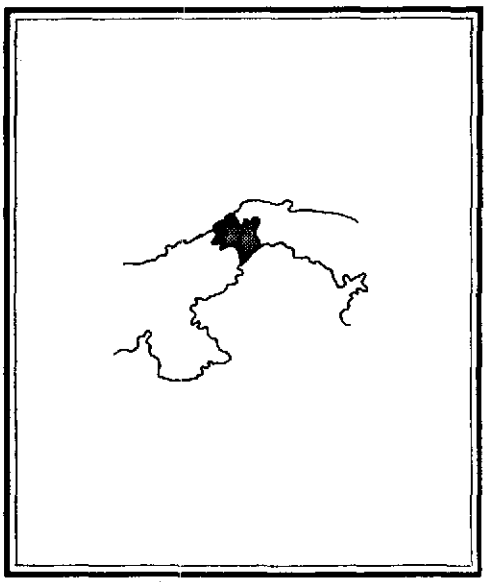
CONSOLIDACION PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1958	1 - 4	129	4 887	3.8	-	-	-	-	-	-	-	-	-	-	-
1959	1 - 4	133	3 691	4.8	-	-	-	-	-	-	-	-	-	-	-
1960[a]	1 - 3	145	7 080	4.9	-	-	-	-	-	-	-	-	-	-	-
1961	1 - 4	186	11 857	6.4	-	-	-	-	-	-	-	-	-	-	-
1962	1 - 4	66	11 196	17.0	-	-	-	-	-	-	-	-	-	-	-
MAINTENANCE PHASE AREAS															
1961	1 - 4	58	2 407	4.1	-	-	-	-	-	-	-	-	-	-	-
1962	1 - 4	187	5 239	2.8	-	-	-	-	-	-	-	-	-	-	-
1963[a]	1 - 3	260	17 170	8.8	1	-	-	1	-	-	-	-	-	-	-
1964	1 - 4	298[b]	21 831[c]	7.3	-	-	-	-	-	-	-	-	-	-	-

(a) January-September. (b) Includes population of areas originally non-malarious. (c) Includes slides taken in non-malarious areas.

Country: PANAMA CANAL ZONE Date attack phase began: 1957

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	51	1 432
Non malarious areas	0	0
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	50	1 432[a]
Attack phase	1	0[a]
Preparatory phase	0	0
Total originally malarious areas	51	1 432

(a) Spraying is continued in a limited area showed as in Consolidation phase.

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	(1)	(26)	(27)
Evaluation operations	(11)	(29)	(40)
Administrative and other	-	(2)	(2)
Transport	-	(4)	(4)
Total	(12)	(61)	(73)

Part-time personnel in parentheses

TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	2 [a]	-	-	2 [a]
Two-wheel vehicles	-	-	-	-
Boats	2 [a]	-	-	2 [a]
Animals	-	-	-	-
Other	-	-	-	-
Total	4 [a]	-	-	4 [a]

(a) Part-time

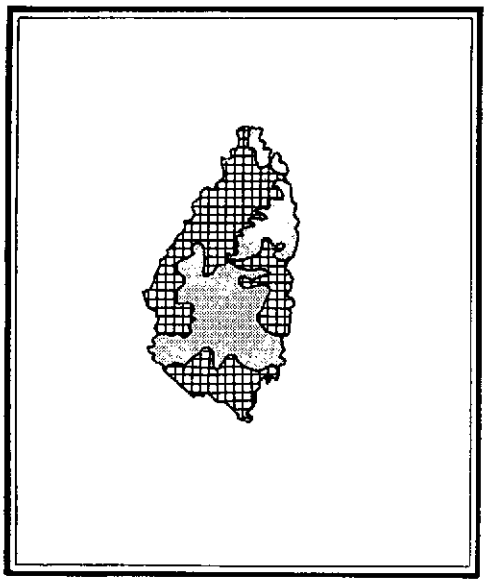
PANAMA CANAL ZONE (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, CONSOLIDATION PHASE AREAS

Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
Year	Quarter					Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
								from abroad	from areas within country						
1960	1 - 4	41	2 656	6.5	27	27	-	-	-	-	-	-	3	24	-
1961	1 - 4	41	5 984	14.6	25	25	-	-	-	-	-	-	2	23	-
1962	1 - 4	44	677	1.5	18	18	-	-	-	-	-	-	-	18	-
1963	1 - 4	47	21 008	44.7	22	-	1	16	-	-	-	5	2	20	-
1964	1 - 4	51	26 228	51.4	21	7	3	1	10	-	-	-	-	21	-

Country: ST. LUCIA Date attack phase began: 16 January 1956

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	99	603
Non malarious areas	15	93
Originally malarious areas		
Maintenance phase	84	510
Consolidation phase	0	0
Attack phase	0	0
Preparatory phase	0	0
Total originally malarious areas	84	510

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	-	-	-
Evaluation operations	(1)	7 (2)	7 (3)
Administrative and other	(1)	(3)	(4)
Transport	-	-	-
Total	(2)	7 (5)	7 (7)

Part-time personnel in parentheses

TRANSPORT FACILITIES

Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	-	-	-	-
Two-wheel vehicles	-	-	3	3
Boats	-	-	-	-
Animals	-	-	-	-
Other	-	-	-	-
Total	-	-	3	3

ST. LUCIA (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, MAINTENANCE PHASE AREAS

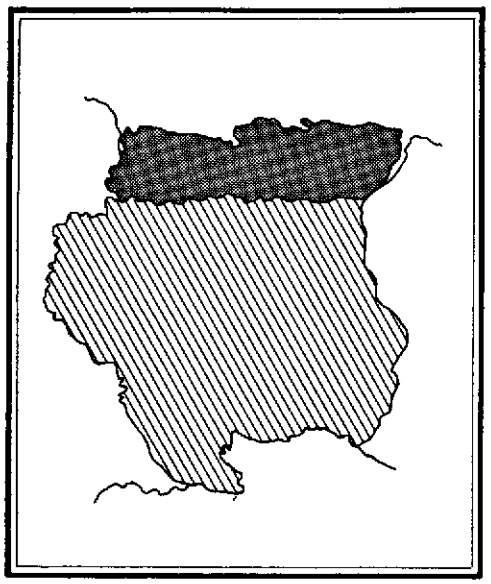
Date		Estimated population in the area (thousands)	No. of slides examined	% of population sampled (annual rate)	Total No. of positive	Origin of infections							Species of parasite		
								Imported							
Year	Quarter					Autochthonous	Relapsing	from abroad	from areas within country	Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
1962	4th	82	5 059	24.7	-	-	-	-	-	-	-	-	-	-	-
1963	1st	82	3 530	17.2	-	-	-	-	-	-	-	-	-	-	-
	2nd		3 764	18.4	6	2	1	-	-	-	-	3[a]	-	-	6
	3rd		2 834	13.8	1	-	1	-	-	-	-	-	-	-	1
	4th		5 008	24.4	-	-	-	-	-	-	-	-	-	-	-
1964	1 - 4	84	13 368	15.9	4	-	4	-	-	-	-	-	-	-	4

(a) Uncertain origin.

Country: SURINAM

Date attack phase began: 5 May 1958

STATUS OF MALARIA PROGRAM AT DECEMBER 1964



	Population (thousands)	Area km^2
TOTAL COUNTRY	315	163 820
Non malarious areas	125	70
Originally malarious areas		
Maintenance phase	0	0
Consolidation phase	128	5 600
Attack phase	62	158 150
Preparatory phase	0	0
Total originally malarious areas	190	163 750

PERSONNEL

Activity	Professional	Non-professional	Total
Spraying operations	-	46	46
Evaluation operations	1	33	34
Administrative and other	-	31	31
Transport	-	40	40
Total	1	150	151

TRANSPORT FACILITIES

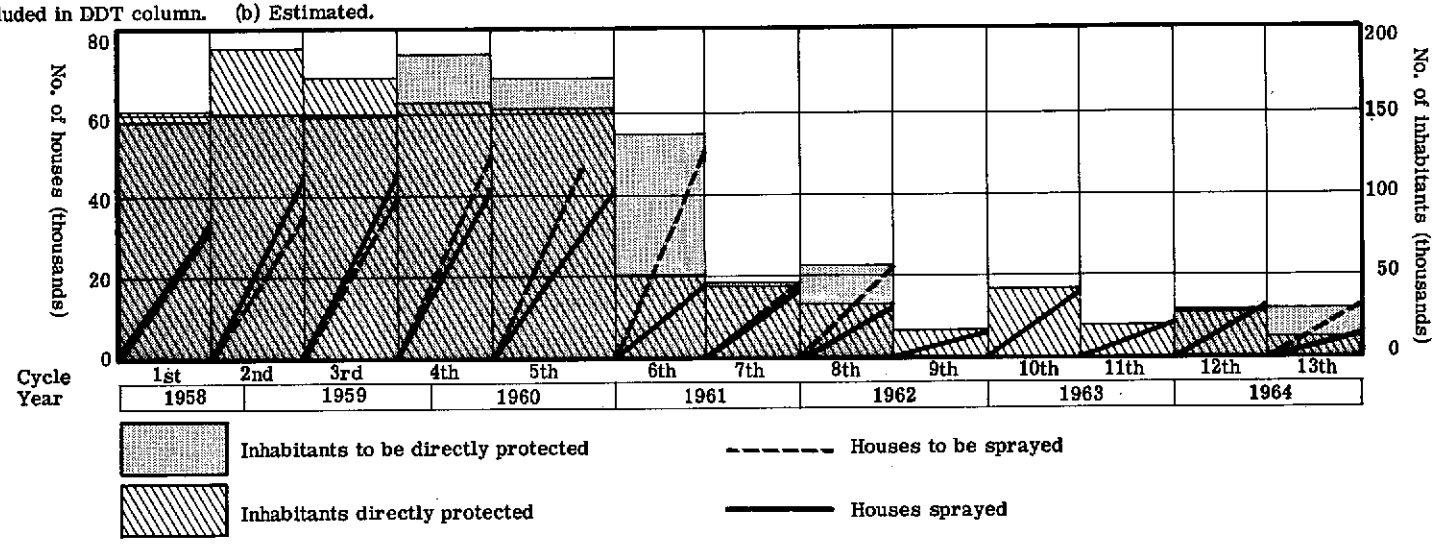
Type	Spraying Operations	Evaluation Operations	Mixed or other operations	Total
Four-wheel vehicles	4	1	4	9
Two-wheel vehicles	-	10	-	10
Boats	-	-	24	24
Animals	-	-	-	-
Other	-	-	-	-
Total	4	11	28	43

SURINAM (Cont.)

SPRAYING OPERATIONS

Year of total coverage	Date	Houses sprayed						Inhabitants directly protected		Insecticide used per house (g. technical)		Average houses sprayed per spray-man/day
		DDT			Dieldrin							
		Cycle	Planned	Sprayed	Cycle	Planned	Sprayed	Planned	Protected	DDT	Dieldrin	
1st	May 58-Apr. 59	1st 2nd	32 722 35 540	31 299 40 211	1st	(a) (a)	2 554 4 930	147 314 150 334	152 422 190 951	310 318	58 60	5.8 6.9
2nd	May 59-Apr. 60	3rd 4th	39 683 50 024	37 563 37 445	2nd	(a) (a)	8 342 4 713	149 287 187 640	172 694 158 143	274 250	58 57	8.0 7.8
3rd	May 60-Jun. 61	5th 6th	46 537 50 652	36 861 16 298	3rd	(a) (a)	4 571 2 187	172 233 138 229	153 687 50 462	263 211	65 56	6.2 6.0
4th	Jul. 61-Jun. 62	7th 8th	18 485 22 351	15 533 12 984	-	-	1 320 -	47 746 57 732 [b]	43 526 33 537 [b]	211 -	54 -	5.7 ...
5th	Jul. 62-Jun. 63	9th 10th	... ...	6 397 16 681	-	-	-	... ...	16 523 [b] 42 558	- -	- -	... ...
6th	Jul. 63-Jun. 64	11th 12th	... 12 824	8 458 5 603	- 1st	- (a)	- 6 605	... 29 300	19 164 27 893	- 175	- 61	... 6.5
7th	Jul. 64-Dec. 64	13th	12 824	682	2nd	(a)	4 708	28 693	12 060	217	62	6.3

(a) Included in DDT column. (b) Estimated.



SURINAM (Cont.)

EPIDEMIOLOGICAL EVALUATION OPERATIONS, ATTACK PHASE AREAS

Year of total coverage	Date	Slides examined			Species found		
		Total No.	Positive		P. falciparum	P. vivax	P. malariae
			Number	Percentage			
1st	May 58-Apr. 59	37 297	3 547	9.51	3 356	71	120
2nd	May 59-Apr. 60	46 158	1 944	4.21	1 665	7	272
3rd	May 60-Jun. 61	43 012	1 007	2.34	938	3	66
4th	Jul. 61-Jun. 62	20 267	543	2.68	515	-	28
5th	Jul. 62-Jun. 63	20 643	1 443	6.99	1 416	7	20
6th	Jul. 63-Jun. 64	31 090	1 305	4.20	1 271	5	29
7th	Jul. 64-Dec. 64	9 027	1 182	13.09	1 171	-	11

CONSOLIDATION PHASE AREAS

Date		Estimated population in the area (thousands) (a)	No. of slides examined (b)	% of population sampled (annual rate)	Total No. of positive (b)	Origin of infections							Species of parasite		
						Autochthonous	Relapsing	Imported		Induced	Introduced	Unclassified	P. falciparum	P. vivax	P. malariae
Year	Quarter							from abroad	from areas within country						
1961	1st	225	4 057	7.2	4	-	-	-	4	-	-	-	3	-	1
	2nd		2 123	3.8	5	-	-	-	5	-	-	-	5	-	-
	3rd		4 101	7.3	6	-	-	-	6	-	-	-	5	-	1
	4th		4 613	8.2	11	-	-	-	11	-	-	-	10	-	1
1962	1st	240	5 144	8.6	8	-	-	-	8	-	-	-	6	-	2
	2nd		3 746	6.2	-	-	-	-	-	-	-	-	-	-	-
	3rd		5 352	8.9	3	-	1	-	2	-	-	-	1	-	2
	4th		4 783	8.0	11	-	-	-	11	-	-	-	10	-	1
1963	1st	240	8 899	14.8	9	-	-	-	9	-	-	-	9	-	-
	2nd		11 054	18.4	4	-	-	-	4	-	-	-	3	-	1
	3rd		9 012	15.0	13	-	-	-	13	-	-	-	12	1	-
	4th		9 896	16.5	7	-	-	-	7	-	-	-	4	2	1
1964	1st	253	11 207	17.7	3	-	-	-	3	-	-	-	3	-	-
	2nd		13 444	21.3	6	-	-	-	6	-	-	-	5	-	1
	3rd		12 309	19.5	10	-	-	-	10	-	-	-	8	1	1
	4th		16 491	26.1	19	-	-	-	19	-	-	-	19	-	-

(a) Includes the population of the city of Paramaribo, originally non-malarious area. (b) Includes slides taken and positives found in Paramaribo, originally non-malarious area.

Table 16

PAHO/WHO FULL-TIME PROFESSIONAL AND TECHNICAL STAFF ASSIGNED TO COUNTRY, INTER-COUNTRY AND INTER-ZONE MALARIA ERADICATION PROJECTS IN THE AMERICAS, FROM 1962 TO MAY 1965

Country or other politica unit	Medical Officers				Sanitary Engineers				Sanitary Inspectors				Entomologists				Other			
	1962	1963	1964	1965	1962	1963	1964	1965	1962	1963	1964	1965	1962	1963	1964	1965	1962	1963	1964	1965
Argentina	1	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Bolivia	1	1	1	1	1	1	-	-	2	2	2	2	-	-	-	-	-	-	-	-
Brazil (Excl. São Paulo)	3	2	2	2	3	3	3	3	2	2	2	3	-	-	-	-	1[a]	1[a]	2[b]	2[b]
Brazil (São Paulo)	-	-	-	-	1	1	1	-	2	2	1	-	-	-	-	-	-	-	-	-
Colombia	2	2	1	1	1	1	2	2	4	4	6	6	-	-	1	1	1[c]	1[c]	1[d]	1[d]
Costa Rica	1	-	-	1	-	-	-	-	3	3	3	3	1	-	-	-	-	-	-	-
Cuba	1	1	1	1	1	1	-	-	1	1	2	2	-	-	-	-	-	-	-	-
Dominican Republic	1	1	2	1	1	1	1	1	3	3	2	2	1	-	-	-	-	-	2[ad]	2[ad]
Ecuador	1	1	2	2	1	1	1	1	4	4	3	3	1	1	-	-	-	-	-	-
El Salvador	1	2	2	2	1	1	1	-	2	1	2	2	1	1	-	-	1[d]	1[d]	1[d]	1[d]
Guatemala	1	2	1	1	1	1	1	1	3	3	3	3	-	-	1	1	-	-	-	-
Haiti	1	1	2	2	1	1	1	1	3	3	3	3	-	-	-	-	1[d]	1[d]	-	-
Honduras	1	1	1	1	1	1	-	-	2	2	2	2	1	1	1	-	-	-	-	-
Jamaica	1	1	-	-	-	-	-	-	1	1	-	-	-	-	-	-	-	-	-	-
Mexico	2	2	3	2	1	1	1	1	1	1	1	1	1	1	-	-	2[e]	2[e]	-	-
Nicaragua	2	2	2	2	1	1	1	1	2	2	2	3	-	1	1	1	1[d]	1[d]	-	-
Panama	1	1	1	1	1	1	1	1	3	3	3	3	-	-	-	1	-	-	-	-
Paraguay	-	-	-	-	-	-	-	-	1	1	1	1	1	1	-	-	-	-	-	-
Peru	1	1	1	1	1	1	1	1	5	5	4	4	-	-	-	-	-	-	-	-
British Guiana	-	-	-	-	-	-	-	-	2	2	1	1	-	-	-	-	-	-	-	-
British Honduras	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Surinam	1	1	1	1	-	-	-	-	3	3	3	3	1	1	1	1	1[e]	1[e]	1[e]	1[e]
Windward Islands	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-	-	-	-	-
Inter-zone or inter-country projects	9	8	7	8	2	2	1	1	-	-	-	-	5	4	2	2	13[f]	14[g]	8[h]	8[i]
Total	33	32	31	30	19	19	16	14	50	49	46	47	13	11	7	7	21	22	15	15

- None

(a) Administrative officer. (b) Administrative officer and assistant engineer. (c) Malaria statistician. (d) Entomological aide. (e) Health educator. (f) Five administrative officers, one entomological assistant, three entomological aides, one laboratory technician, one operations analyst, one parasitologist assistant, and one translator. (g) Six administrative officers, one laboratory technician, three entomological aides, one entomological assistant, one operations analyst, one parasitologist assistant, and one translator. (h) Three administrative officers, one entomological assistant, one program officer, one operations analyst, one laboratory technician, and one health educator. (i) Three administrative officers, one entomological aide, one program officer, one operations analyst, one laboratory technician, and one health educator.

Table 17

FELLOWSHIPS FOR STUDY TRAVEL IN MALARIA ERADICATION, 1963 AND 1964

Country and other political unit	Total		Physicians		Engineers		Entomologists		Others	
	1963	1964	1963	1964	1963	1964	1963	1964	1963	1964
Argentina	1	1	-	1	1	-	-	-	-	-
Brazil	-	1	-	1	-	-	-	-	-	-
Colombia	-	2	-	1	-	1	-	-	-	-
Costa Rica	-	1	-	1	-	-	-	-	-	-
Cuba	2	-	2	-	-	-	-	-	-	-
Dominican Republic	1	-	1	-	-	-	-	-	-	-
Ecuador	1	2	-	1	-	1	1	-	-	-
El Salvador	1	1	1	-	-	-	-	1	-	-
Guatemala	1	1	1	-	-	1	-	-	-	-
Haiti	1	-	-	-	1	-	-	-	-	-
Mexico	4	-	2	-	1	-	1	-	-	-
Nicaragua	1	-	1	-	-	-	-	-	-	-
Panama	2	-	-	-	-	-	1	-	1[a]	-
Paraguay	1	-	1	-	-	-	-	-	-	-
Peru	2	-	2	-	-	-	-	-	-	-
Trinidad and Tobago	1	-	1	-	-	-	-	-	-	-
British Guiana	1	-	-	-	-	-	1	-	-	-
Total	20	9	12	5	3	3	4	1	1	-

- None.

(a) Administrator

Table 18

EQUIPMENT AND SUPPLIES, EXCLUDING DRUGS, CONTRIBUTED BY PAHO TO MALARIA ERADICATION PROGRAMS IN THE AMERICAS, 1958 TO DECEMBER 1964

Country or other political unit	Protective equipment						Laboratory supplies						Others				
	Helmets	Bands	Visors	Gloves	Ponchos	Life-jackets	Mailing tubes	"Surgi-tube" (rolls)	Plastic tubes	Micro-scopes	Micro-scope acceso-ries	Slides (gross)	Vehicles and motors (a)	Insecti-cides (lbs.)	Kardex files	Test kits adults	Test kits larvae
Argentina	-	-	-	-	-	-	6 000	10	20	1	22	-	-	-	-	1	-
Bolivia [b]	50	180	160	40	80	55	10 000	15	70	1	-	-	3	-	-	5	-
Brazil [c]	-	-	-	-	-	90	283 000	32	40	90	17	-	3	-	-	51	8
Colombia [d]	-	-	-	-	-	450	100 000	10	20	3	2	-	-	-	-	17	2
Costa Rica	-	-	-	-	-	35	500	40	52	-	-	-	-	-	40	1	-
Cuba	-	-	-	-	-	-	10 000	20	20	10	-	-	-	-	-	-	3
Dominican Rep. [e]	366	332	664	166	166	-	17 000	28	20	3	1	-	1	-	-	3	2
Ecuador [f]	431	412	824	206	206	151	50 000	30	20	2	15	-	2	-	-	4	-
El Salvador	230	476	952	238	238	30	20 000	190	56	4	6	-	3	2 900	24	4	1
Guatemala	541	500	1 000	250	255	24	35 000	40	52	4	2	1 340	2	-	7	2	1
Haiti [g]	341	682	1 364	341	341	40	9 000	11	-	1	8	-	6	-	-	1	2
Honduras	165	330	660	165	165	10	20 000	60	52	1	2	70	-	-	1	2	-
Jamaica [h]	25	200	400	194	209	-	22 500	10	20	-	-	-	1	-	-	8	12
Mexico [i]	-	-	-	-	-	75	555 040	108	15	-	-	-	1	-	-	37	1
Nicaragua	117	234	468	117	117	-	21 000	100	64	3	4	157	1	-	65	4	1
Panama [j]	137	274	548	137	137	50	19 000	62	52	4	2	35	1	-	26	3	-
Paraguay	174	808	408	102	773	40	30 000	18	20	1	-	-	2	-	-	6	1
Peru	618	1 236	3 672	368	668	200	75 000	10	20	2	1	-	1(1)	46 410	24	3	-
Trinidad and Tobago	-	-	-	-	-	-	1 150	10	20	-	-	-	-	-	-	-	1
British Guiana	36	72	144	96	36	-	2 000	-	-	-	3	-	-	-	-	-	-
British Honduras	61	38	76	19	19	10	1 900	10	20	-	1	-	2	-	-	1	-
Dominica	-	-	-	-	-	-	630	-	-	-	-	-	1 [k]	-	-	-	-
French Guiana [l]	-	-	-	-	-	-	-	-	-	1	-	-	5(3) [m]	-	-	2	1
Grenada	-	-	-	-	-	-	120	-	-	-	-	-	-	-	-	-	-
St. Lucia	-	-	-	-	-	-	110	10	20	-	-	-	3 [n]	-	-	-	-
Surinam [o]	55	10	20	5	5	-	2 550	26	20	2	2	-	1(4)	-	-	2	1
Total [p]	3 347	5 784	11 360	2 444	3 415	1 260	1 291 500	850	693	133	88	1 602	39(8)	49 310	187	157	37

- None.

(a) Station wagons unless otherwise indicated; marine motors in parentheses. (b) Plus $750.00 for the local purchase of tires. (c) Plus $3,707.00 in miscellaneous items. (d) Plus $542.50 in miscellaneous items. (e) Plus $400.00 in miscellaneous items. (f) Plus $13.50 in miscellaneous items. (g) Plus $21.20 in miscellaneous items. (h) 210,000 imperial gallons of kerosene also provided. (i) Plus 8,500 lancets for taking blood samples and $539.80 in miscellaneous items. (j) Plus $20.00 in miscellaneous items. (k) Motorcycles. (l) Plus $1,194.00 in miscellaneous items. (m) Two motorcycles. (n) One station wagon and two motorcycles. (o) Plus $4,763.72 in miscellaneous items. (p) Plus $11,302.24 in miscellaneous items for inter-zone projects.

Table 19

DRUGS PROVIDED BY PAHO TO MALARIA ERADICATION PROGRAMS IN THE AMERICAS, 1958-1964

(in thousands of tablets)

Country or other political unit	1958-1963[a]					1964[b]					Total				
	Chloroquine 150 mg.	Primaquine		Pyrimethamine 25 mg.	Chloroquine Primaquine combined	Chloroquine 150 mg.	Primaquine		Pyrimethamine 25 mg.	Chloroquine Primaquine combined	Chloroquine 150 mg.	Primaquine		Pyrimethamine 25 mg.	Chloroquine Primaquine combined
		15 mg.	5 mg.				15 mg.	5 mg.				15 mg.	5 mg.		
Argentina	1 144	65	35	297	-	-	-	-	-	-	1 144	65	35	297	-
Bolivia	2 865	63	30	21	10	600	27	10	-	-	3 465	90	40	21	10
Brazil (excl. São Paulo)	34 613	358.5	174	-	200	15	300	120	-	-	34 628	658.5	294	-	200
Brazil (São Paulo)	2 143	87.5	19	184	-	-	30	7	-	-	2 143	117.5	26	184	-
Colombia	11 176	304.5	129.5	664	-	1 200	70	(10)	-	-	12 376	374.5	119.5	664	-
Costa Rica	1 024	133	35	213	1 385	100	14	(9)	-	-	1 124	147	26	213	1 385
Cuba	830	30	14	80	-	500	-	10	-	-	1 330	30	24	80	-
Dominican Republic	2 694	39	164	10	-	500	(20)	4	-	-	3 194	19	168	10	-
Ecuador	2 590	93.5	90	195	-	2 300	172	100	-	-	4 890	265.5	190	195	-
El Salvador	2 790	187.5	65	118	2 070	1 300	(30)	175	10	-	4 090	157.5	240	128	2 070
Guatemala	4 269	367	59	27	8 071	1 100	277	-	-	(22)	5 369	644	59	27	8 049
Haiti	4 238	82.5	-	280	-	1 382	-	-	-	-	5 620	82.5	-	280	-
Honduras	4 719	231.6	229	88	1 290	(25)	(25)230	(75)225	-	-	4 694	436.6	379	88	1 290
Jamaica	879	18	-	288	50	-	-	-	-	-	879	18	-	288	50
Mexico	12 511	1 172	1 151	5 260	5 500	2 000	1 000	1 000	(10)	(1 408)	14 511	2 172	2 151	5 250	4 092
Nicaragua	3 399	117.5	83	6	5 525	1 000	95	79	-	1 408	4 399	212.5	162	6	6 933
Panama	1 922	162.5	23	146	-	350	40	5	-	-	2 272	202.5	28	146	-
Paraguay	2 200	25	5	48	-	630	-	2	-	-	2 830	25	7	48	-
Peru	7 456	569.5	138	196	-	500	(10)60	50	-	-	7 956	619.5	188	196	-
Trinidad and Tobago	965	940.5	859	180	-	-	-	-	-	-	965	940.5	859	180	-
British Guiana	286	181.5	73	267	-	-	-	-	-	-	286	181.5	73	267	-
British Honduras	190	14	13	6	-	10	-	-	-	22	200	14	13	6	22
Dominica	90	1	1	45	-	-	-	-	-	-	90	1	1	45	-
French Guiana	-	-	-	-	32	30	1	-	-	-	30	1	-	-	32
Grenada	43	0.5	-	45	-	-	-	-	-	-	43	0.5	-	45	-
St. Lucia	68	1	-	70	-	-	-	-	-	-	68	1	-	70	-
Surinam	1 043	9	10	497	200	2	1	-	-	-	1 045	10	10	497	200
Total	106 147	5 254.6	3 399.5	9 231	24 333	13 494	2 232	1 693	-	-	119 641	7 486.6	5 092.5	9 231	24 333

- None

The figures in parentheses represent transfers to other programs.

(a) Plus 258 500 aspirin tablets, 400 000 camoprin tablets, 56 120 lbs. of chloroquine diphosphate, 3 510 lbs. of tricalcium phosphate, 20 tons of calcium arsenate, 401 000 aspirin-caffeine tablets and 20 000 tablets of quinine sulphate.

(b) Revised amounts according to transfers made among countries in 1964. Besides there were provided 5 000 tablets of quinine sulphate, 10 000 aspirin-caffeine tablets, 20 000 aspirin tablets and one Kg. of chloroquine silicate powder.

Table 20

INTERNATIONAL CONTRIBUTIONS TO MALARIA ERADICATION PROGRAMS IN THE AMERICAS
1964 AND ESTIMATED 1965
(U. S. dollars)

Country or other political unit	Date of initiation of total coverage	1964				1965 (estimated)			
		PAHO/SMF	WHO and WHO/TA	UNICEF [a]	AID(USA) (fiscal year) [b]	PAHO/SMF	WHO and WHO/TA	UNICEF [a]	AID(USA) (fiscal year) [b]
Argentina	Aug. 1959	17 467	-	49 900	-	29 149	-	100 000	-
Bolivia	Sep. 1958	65 142	-	67 100	268 000 [c]	64 054	-	28 000	200 000 [c]
Brazil(Excl. São Paulo)	Aug. 1959 [d]	201 882	-	-	210 758 [e]	334 785	12 000	-	125 000
Brazil (São Paulo)	Jan. 1960	35 930	-	-		16 815		-	
Colombia	Sep. 1958	171 670	-	182 800	-	208 304	-	300 000	-
Costa Rica	Jul. 1957	61 701	11 820	20 700	-	34 658	36 356	20 000	-
Cuba	1962	-	101 769	-	-	-	64 193	-	-
Dominican Republic	Jun. 1958	155 975	-	303 300	-	124 619	-	200 000	-
Ecuador	Mar. 1957	107 547	16 562	303 600	330 000	101 856	20 727	200 000	250 000
El Salvador	Jul. 1956	110 389	28 944	216 100	200 000	57 993	71 886	30 000	100 000 [f]
Guatemala	Aug. 1956	113 514	-	108 200	140 000	67 731	69 569	180 000	250 000 [g]
Haiti	Jan. 1962	113 644	10 000	297 200	1 488 200	109 009	-	250 000	1 400 000
Honduras	Jul. 1959	78 754	-	153 000	116 000	20 653	36 534	25 000	150 000 [h]
Jamaica	Jan. 1958	-	-	4 200	15 000	-	-	4 000	-
Mexico	Jan. 1957	46 949	102 956	1 669 200	-	75 168	214 539	1 200 000	-
Nicaragua	Nov. 1958	116 917	-	40 300	335 000 [i]	64 917	69 979	110 000	100 000 [j]
Panama	Aug. 1957	88 144	-	144 600	-	43 497	66 075	130 000	-
Paraguay	Oct. 1957	35 338	-	-	-	79 967	-	-	-
Peru	Nov. 1957	136 766	-	255 300	-	111 549	-	220 000	-
Trinidad and Tobago	Jan. 1958	-	-	200	-	-	-	-	-
British Guiana	Jan. 1947	27 124	-	4 200	-	19 414	-	4 000	-
British Honduras	Feb. 1957	14 078	-	4 200	-	500	-	-	-
Dominica	Jun. 1959	12 964	-	-	-	-	-	-	-
French Guiana	Sep. 1963 [k]	127	-	-	-	13 263	-	-	-
St. Lucia	Jan. 1956	-	-	-	-	-	-	-	-
Surinam	May 1958	105 409	-	13 000	-	102 833	-	12 000	-
Inter-country Projects and general services		337 880 [l]	153 308 [l]	-	18 000	217 039 [l]	253 940 [l]	-	-
Total		2 155 311	425 359	3 837 100	3 120 958	1 897 773	915 798	3 013 000	2 575 000

- None.
(a) Rounded to the nearest thousands; shipping not included. (b) AID fiscal year does not necessarily coincide with fiscal years of the countries shown. (c) Counterpart fund. (d) Program developed by stages, date of first area shown.
(e) $210,758 in technical aid, plus a loan under negotiation in amount of $6,500,000 for the years of 1964 and 1965. (f) Plus a loan under negotiation for local costs from 1965 to 1968 of $990,000. (g) Plus a loan under negotiation of $1,900,000 for local costs from 1965 to 1968. (h) Plus a loan under negotiation of $920,000 for local costs from 1965 to 1968.
(i) $200,000 in a subvention to IAPSP. (j) Plus a loan under negotiation of $2,400,000 for local costs from 1965 to 1968.
(k) Date of signature of agreement between PAHO/French Guiana Prefecture. (l) Not included PAHO and WHO Regular Fund for the Washington Office.

Annex 3

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS [1]

Pursuant to Resolution XXVI [2] of the XIII Meeting of the Directing Council, the fourth revision of the estimated requirements for the PAHO Special Malaria Fund is presented herewith for study by the Directing Council.

This document includes estimated total requirements in each year from 1965 through 1969 for individual country programs as well as for zone and regional projects and Headquarters. These requirements are shown by source of funds: Government and Other Sources, and PAHO/WHO.

The PAHO/WHO section includes information both on the Special Malaria Fund and on financing from the PAHO Regular, WHO Regular, WHO Malaria Eradication Special Account, and the Expanded Program of Technical Assistance budgets.

The tables show separately for PAHO/WHO, the estimated requirements for personnel, supplies and equipment, fellowships, grants, and other expenses for each program in which PAHO/WHO participates. Standard budgeting methods have been used. All amounts are shown in U.S. dollars.

The level of requirements for PAHO-SMF funds in 1967, 1968, and 1969 is adversely affected by the anticipated depletion of the WHO-MESA fund, which will provide a substantial amount for the program in 1965 and 1966.

The tables giving a breakdown of personnel by type and year for each program are presented as usual, as well as a short description of the status of the program and the Organization's plans for the future. The collaboration of UNICEF and the U.S. Agency for International Development is indicated where applicable.

The requirements of programs in which the Organization does not directly participate are not shown nor are these included in the summary table.

Calculations of the amounts shown were made in May 1965 and are based on information available at that time concerning the progress of the campaigns and their probable duration. Experience has shown that frequent evaluation of programs is necessary and entails frequent revision of expected requirements, particularly for programs struggling against technical problems. The requirements presented in this document should therefore be considered as the minimum expected level.

Progress was made during 1964 with reference to administrative problems of organization, personnel, and finances in several important programs and no serious new technical problems arose during the year. However, the difficulties in Central America, which are discussed in Annex 2 (see p. 218) increased in severity during 1964 and 1965; available resources were insufficient even to maintain previous gains, and malaria incidence increased, in some places sharply. Efforts are being made by the Governments of the countries concerned to arrange for suitable financing for the 1965-1967 triennium, but the work of eradication has been lengthened and become considerably more difficult by the deterioration which has occurred. Solutions to the technical problems exist and have been included in new long-range plans of operation in the Central American programs. PAHO/WHO is strengthening its advisory staff in Zone III to assure optimum possible coordination of the various campaigns.

[1] Document CD16/14 (2 August 1965).
[2] *Official Document PAHO* **41**, 29-30.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Summary

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	44,677,560	55,065,357	54,957,942	41,989,900	29,361,916	226,052,675
GOVT. AND OTHER SOURCES 1/	41,655,000	52,030,000	52,019,000	39,225,000	27,115,000	212,044,000
PAHO/WHO PORTION						
Personnel costs and travel	2,391,853	2,474,564	2,461,402	2,386,650	1,954,266	11,668,735
Supplies and equipment	319,460	285,678	304,400	296,900	246,800	1,453,238
Fellowships	76,585	50,800	23,000	5,100	5,100	160,585
Grants and others	234,662	224,315	150,140	76,250	40,750	726,117
SUB-TOTAL PAHO/WHO	3,022,560	3,035,357	2,938,942	2,764,900	2,246,916	14,008,675

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	76,223	79,761	80,742	84,000	87,000	407,726
PAHO-SMF	1,897,773	1,729,894	2,293,661	2,126.102	1,633,906	9,681,336
WHO-Reg.	277,052	455,001	469,000	458,550	420,328	2,079,931
WHO-MESA	686,246	684,596	-	-	-	1,370,842
WHO-TA	85,266	86,105	95,539	96,248	105,682	468,840
TOTAL	3,022,560	3,035,357	2,938,942	2,764,900	2,246,916	14,008,675

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	42	40	40	38	36
Sanitary Engineer	19	16	14	14	9
Entomologist	10	9	8	7	3
Health Educator	2	2	2	2	1
Sanitary Inspector	55	53	53	47	35
Entomologist Assistant or Entomology Aide	6	5	5	6	1
Others	21	21	20	20	17
TOTAL	155	146	142	134	102

OBSERVATIONS

1/ Estimated costs for Jamaica, Trinidad and Tobago, Venezuela and West Indies not included.

Estimates including field projects, Zone Offices supporting services, and Malaria Eradication Branch.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Argentina

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	1,593,149	1,364,155	1,244,316	1,245,066	835,816	6,282,502
GOVT. AND OTHER SOURCES	1,564,000	1,328,000	1,210,000	1,210,000	800,000	6,112,000
PAHO/WHO PORTION						
Personnel costs and travel	21,549	29,755	31,316	32,066	32,816	147,502
Supplies and equipment	2,500	3,000	3,000	3,000	3,000	14,500
Fellowships	5,100	3,400	-	-	-	8,500
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	29,149	36,155	34,316	35,066	35,816	170,502

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	29,149	36,155	34,316	35,066	35,816	170,502
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	29,149	36,155	34,316	35,066	35,816	170,502

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	-	-	-	-	-
Sanitary Engineer	1	1	1	1	1
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	1	1	1	1	1
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	2	2	2	2	2

OBSERVATIONS

UNICEF collaborates in this program.

Attack phase began in 1959, except in the provinces El Chaco and Formosa which are not yet under total coverage with attack measures. It is expected that consolidation phase will be completed in 1970.

PAHO supplies the services of a sanitary engineer and one sanitarian, plus antimalarial drugs for presumptive treatment of fever cases and radical cure of confirmed malaria cases. Fellowships are granted to help strengthen epidemiological evaluation personnel in preparation for extension of the consolidation phase.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Bolivia

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	644,054	446,744	343,137	255,127	239,117	1,928,179
GOVT. AND OTHER SOURCES	580,000	375,000	270,000	200,000	200,000	1,625,000
PAHO/WHO PORTION						
Personnel costs and travel	59,054	64,744	66,137	50,127	34,117	274,179
Supplies and equipment	5,000	7,000	7,000	5,000	5,000	29,000
Fellowships	-	-	-	-	-	-
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	64,054	71,744	73,137	55,127	39,117	303,179

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	64,054	71,744	73,137	55,127	39,117	303,179
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	64,054	71,744	73,137	55,127	39,117	303,179

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	1	1	1	1	1
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	3	3	3	2	1
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	4	4	4	3	2

OBSERVATIONS

UNICEF and AID collaborate in this program.

The program underwent a set-back at the end of 1963 and first part of 1964 because of a severe financial crisis, and while the prospects for eradication are still excellent the achievement of this goal will be delayed by the seeding of malaria parasites which occurred. Attack phase operations continue in the northern frontier region and in areas of persistent transmission in several river valleys.

In addition to consultant personnel, PAHO provides anti-malarial drugs for radical cure of cases and for administration in residual foci in consolidation areas.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Brazil (excl. São Paulo)

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	10,006,785	12,686,827	15,049,164	16,262,164	12,856,514	66,861,454
GOVT. AND OTHER SOURCES	9,660,000	12,375,000	14,700,000	15,910,000	12,500,000	65,145,000
PAHO/WHO PORTION						
Personnel costs and travel	231,185	236,449	244,064	247,064	251,414	1,210,176
Supplies and equipment	110,500	70,278	100,000	100,000	100,000	480,778
Fellowships	5,100	5,100	5,100	5,100	5,100	25,500
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	346,785	311,827	349,164	352,164	356,514	1,716,454

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	334,785	241,549	335,814	340,164	344,514	1,596,826
WHO-Reg.	12,000	70,278	13,350	12,000	12,000	119,628
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	346,785	311,827	349,164	352,164	356,514	1,716,454

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	5	5	5	5	5
Sanitary Engineer	3	2	2	2	2
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	4	4	4	4	4
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	2	2	2	2	2
TOTAL	14	13	13	13	13

OBSERVATIONS

AID collaborates in this program.

In Brazil eradication is programmed in phases extending gradually to cover the entire malarious area. The program received new impetus in 1964 and it is expected that attack phase will have been reached in all areas by 1968. Some areas are scheduled for consolidation phase in 1965.

In addition to consultant services, PAHO/WHO supplies drugs for presumptive treatments, and fellowships.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Brazil (São Paulo)

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	2,256,815	1,018,384	819,166	400,400	200,400	4,695,165
GOVT. AND OTHER SOURCES	2,240,000	1,000,000	800,000	400,000	200,000	4,640,000
PAHO/WHO PORTION						
Personnel costs and travel	14,915	17,984	18,766	-	-	51,665
Supplies and equipment	200	400	400	400	400	1,800
Fellowships	1,700	-	-	-	-	1,700
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	16,815	18,384	19,166	400	400	55,165

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	16,815	18,384	19,166	400	400	55,165
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	16,815	18,384	19,166	400	400	55,165

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	1	1	1	-	-
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	1	1	1	-	-

OBSERVATIONS

AID collaborates in this program.

This program has developed very satisfactorily from the beginning of attack phase in 1960 and it is expected that the consolidation phase will be completed in 1968. Much care must be taken to guard against re-initiation of transmission by cases imported from neighboring states of Brazil which are less advanced in eradication. The program is undertaking work against Chagas disease as malaria eradication nears completion.

PAHO supplies drugs for treatment of cases and elimination of residual foci, and fellowships.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Brazil-0202

Training Center for Malaria Eradication - São Paulo

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	5,000	5,000	5,000	5,000	-	20,000
GOVT. AND OTHER SOURCES	1/	1/	1/	1/	-	1/
PAHO/WHO PORTION						
Personnel costs and travel	-	-	-	-	-	-
Supplies and equipment	-	-	-	-	-	-
Fellowships	-	-	-	-	-	-
Grants and others	5,000	5,000	5,000	5,000	-	20,000
SUB-TOTAL PAHO/WHO	5,000	5,000	5,000	5,000	-	20,000

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	5,000	5,000	5,000	5,000	-	20,000
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	5,000	5,000	5,000	5,000	-	20,000

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	-	-	-	-	-
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	-	-	-	-	-

1/ Government contribution included in Brazil (São Paulo)

OBSERVATIONS

A subsidy is accorded to the Faculty of Hygiene and Public Health of the University of São Paulo to cover the costs of equipment, teaching materials and auxiliary personnel connected with courses on the techniques of malaria eradication. Both national personnel and PAHO fellows receive training in these courses.

Continuation of this program is foreseen through 1968, by which time the need for training is expected to have tapered off.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Colombia

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	3,568,304	3,154,746	2,562,627	1,891,777	1,405,727	12,583,181
GOVT. AND OTHER SOURCES	3,360,000	2,940,000	2,350,000	1,680,000	1,290,000	11,620,000
PAHO/WHO PORTION						
Personnel costs and travel	180,104	189,946	191,227	193,777	97,727	852,781
Supplies and equipment	18,000	18,000	18,000	18,000	18,000	90,000
Fellowships	10,200	6,800	3,400	-	-	20,400
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	208,304	214,746	212,627	211,777	115,727	963,181

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	208,304	214,746	212,627	211,777	115,727	963,181
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	208,304	214,746	212,627	211,777	115,727	963,181

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	1	1	1	1	1
Sanitary Engineer	2	2	2	2	1
Entomologist	1	1	1	1	-
Health Educator	-	-	-	-	-
Sanitary Inspector	6	6	6	6	4
Entomologist Assistant or Entomology Aide	2	2	2	2	-
Others	-	-	-	-	-
TOTAL	12	12	12	12	6

OBSERVATIONS

Attack phase began in 1958 and at present 6.1 million persons live in areas in consolidation phase. There is still a sparsely-populated area with 362 thousand inhabitants in which no eradication measures are currently in progress. Special measures are being taken in areas of persistent transmission.

PAHO provides anti-malarial drugs for treatment of cases and elimination of residual foci, and fellowships to strengthen the personnel structure of the program.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Costa Rica

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	608,014	643,785	607,398	398,536	203,114	2,460,847
GOVT. AND OTHER SOURCES	537,000	570,000	530,000	320,000	150,000	2,107,000
PAHO/WHO PORTION						
Personnel costs and travel	63,014	65,785	69,398	70,536	45,114	313,847
Supplies and equipment	8,000	8,000	8,000	8,000	8,000	40,000
Fellowships	-	-	-	-	-	-
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	71,014	73,785	77,398	78,536	53,114	353,847

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	34,658	35,178	35,674	34,174	8,000	147,684
WHO-Reg.	-	-	41,724	44,362	45,114	131,200
WHO-MESA	36,356	38,607	-	-	-	74,963
WHO-TA	-	-	-	-	-	-
TOTAL	71,014	73,785	77,398	78,536	53,114	353,847

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	1	1	1	1	1
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educater	-	-	-	-	-
Sanitary Inspector	3	3	3	3	1
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	4	4	4	4	2

OBSERVATIONS

UNICEF collaborates in this program.

This program has progressed well in most areas but limited regions of persistent transmission, thought to be occasioned by excito-repellency of the vector toward DDT and outdoor biting still exist. A change of insecticide to dieldrin in semi-annual cycles was scheduled but could not be put into operation for financial reasons, and outbreaks occurred in consolidation areas during 1964.

Anti-malarial drugs to treat cases and to employ in foci are provided by PAHO/WHO, in addition to consultant personnel.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Cuba

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	2,045,359	1,265,844	812,329	444,574	-	4,568,106
GOVT. AND OTHER SOURCES	1,981,000	1,200,000	750,000	400,000	-	4,331,000
PAHO/WHO PORTION						
Personnel costs and travel	51,959	53,444	51,329	33,574	-	190,306
Supplies and equipment	10,000	10,000	10,000	10,000	-	40,000
Fellowships	1,400	1,400	-	-	-	2,800
Grants and others	1,000	1,000	1,000	1,000	-	4,000
SUB-TOTAL PAHO/WHO	64,359	65,844	62,329	44,574	-	237,106

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	-	-	-	-	-	-
WHO-Reg.	64,359	65,844	62,329	44,574	-	237,106
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	64,359	65,844	62,329	44,574	-	237,106

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	1	1	1	1	-
Sanitary Engineer	1	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	2	2	2	1	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	4	3	3	2	-

OBSERVATIONS

Attack operations were begun in 1962 and malaria incidence has markedly declined, although transmission has not been completely interrupted as yet. Shortages of equipment and means of transportation have hindered the campaign.

WHO provides consultants, anti-malarial drugs and fellowships.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS
Dominican Republic

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	1,601,619	1,477,219	1,234,727	586,027	296,397	5,195,989
GOVT. AND OTHER SOURCES	1,477,000	1,375,000	1,150,000	500,000	250,000	4,752,000
PAHO/WHO PORTION						
Personnel costs and travel	121,619	94,119	81,727	83,027	43,397	423,889
Supplies and equipment	3,000	3,000	3,000	3,000	3,000	15,000
Fellowships	-	5,100	-	-	-	5,100
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	124,619	102,219	84,727	86,027	46,397	443,989

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	124,619	102,219	84,727	86,027	46,397	443,989
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	124,619	102,219	84,727	86,027	46,397	443,989

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	2	1	1	1	1
Sanitary Engineer	1	1	1	1	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	2	2	2	2	1
Entomologist Assistant or Entomology Aide	1	-	-	-	-
Others	1	1	-	-	-
TOTAL	7	5	4	4	2

OBSERVATIONS

UNICEF collaborates in this program.

Good progress was made in this program from its reorganization in 1962 through 1964; the entire malarious area is in attack phase, some parts in late attack phase. PAHO provides consultants, drugs to treat cases, and fellowships aid for the training of epidemiological personnel.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Ecuador

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	1,287,583	1,046,213	946,194	691,251	445,620	4,416,861
GOVT. AND OTHER SOURCES	1,165,000	930,000	850,000	630,000	400,000	3,975,000
PAHO/WHO PORTION						
Personnel costs and travel	109,183	102,813	88,194	53,251	39,620	393,061
Supplies and equipment	10,000	10,000	8,000	8,000	6,000	42,000
Fellowships	3,400	3,400	-	-	-	6,800
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	122,583	116,213	96,194	61,251	45,620	441,861

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	101,856	96,722	74,324	40,617	22,607	336,126
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	20,727	19,491	21,870	20,634	23,013	105,735
TOTAL	122,583	116,213	96,194	61,251	45,620	441,861

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	2	2	2	1	1
Sanitary Engineer	1	1	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	4	3	3	2	1
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	7	6	5	3	2

OBSERVATIONS

UNICEF and AID cooperate in this program.

Attack phase began in 1957 and was reorganized in 1961. Over a million persons are now in consolidation phase areas, and good results have been achieved in about 70% of the attack phase areas. In the remaining areas persisting transmission is being attacked with special measures suited to the varying causes of persistence.

PAHO/WHO provides personnel, anti-malarial drugs and fellowships. WHO/TA finances a medical officer.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

El Salvador

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	1,042,879	1,102,722	1,087,032	634,884	486,634	4,354,151
GOVT. AND OTHER SOURCES	913,000	975,000	960,000	500,000	350,000	3,698,000
PAHO/WHO PORTION						
Personnel costs and travel	117,819	113,422	112,732	124,884	126,634	595,491
Supplies and equipment	10,360	10,000	10,000	10,000	10,000	50,360
Fellowships	1,700	4,300	4,300	-	-	10,300
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	129,879	127,722	127,032	134,884	136,634	656,151

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	57,993	33,539	33,787	39,737	39,987	205,043
WHO-Reg.	71,886	94,183	93,245	95,147	96,647	451,108
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	129,879	127,722	127,032	134,884	136,634	656,151

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	2	2	2	2	2
Sanitary Engineer	1	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	3	3	3	3	3
Entomologist Assistant or Entomology Aide	1	1	1	1	1
Others	-	-	-	-	-
TOTAL	7	6	6	6	6

OBSERVATIONS

UNICEF and AID collaborate in this program.

Resistance of the vector to both DDT and dieldrin in extensive coastal areas has greatly obstructed the program, and while transmission was interrupted in considerable areas of the country, 1964 saw re-infection spread from problem areas to some of those previously cleared. The Government is making effort to provide an adequate national budget for 1965 and thereafter to permit attack on problem areas at an effective level.

PAHO/WHO provides personnel, drugs for treatment of cases, and fellowships for national staff.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Guatemala

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	1,944,300	1,982,572	1,893,675	1,453,329	758,089	8,031,965
GOVT. AND OTHER SOURCES	1,807,000	1,837,000	1,750,000	1,300,000	680,000	7,374,000
PAHO/WHO PORTION						
Personnel costs and travel	125,300	128,872	126,975	138,329	63,089	582,565
Supplies and equipment	12,000	15,000	15,000	15,000	15,000	72,000
Fellowships	-	1,700	1,700	-	-	3,400
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	137,300	145,572	143,675	153,329	78,089	657,965

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	67,731	64,683	143,675	153,329	78,089	507,507
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	69,569	80,889	-	-	-	150,458
WHO-TA	-	-	-	-	-	-
TOTAL	137,300	145,572	143,675	153,329	78,089	657,965

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	2	2	2	2	1
Sanitary Engineer	1	1	1	1	-
Entomologist	1	1	1	1	-
Health Educator	-	-	-	-	-
Sanitary Inspector	3	3	3	3	2
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	7	7	7	7	3

OBSERVATIONS

AID and UNICEF collaborate in this program.

Attack phase began in 1956 and interrupted transmission in most of the malarious area, but problems of vector resistance to insecticides and large population movements have created areas of persisting transmission. For lack of resources to apply supplementary attack measures in these areas, infection has spread to areas once clear. Budgetary problems are receiving much attention from the Government and it is hoped that during 1965 intensive attack measures can be instituted to regain lost ground and interrupt transmission in all areas.

In addition to personnel, PAHO/WHO provides drugs for treatment of cases and fellowships to train national personnel.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Haiti

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	1,937,009	1,886,733	1,477,111	1,076,211	659,001	7,036,065
GOVT. AND OTHER SOURCES	1,828,000	1,760,000	1,350,000	950,000	550,000	6,438,000
PAHO/WHO PORTION						
Personnel costs and travel	87,309	111,733	112,111	114,211	99,001	524,365
Supplies and equipment	20,000	15,000	15,000	12,000	10,000	72,000
Fellowships	1,700	-	-	-	-	1,700
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	109,009	126,733	127,111	126,211	109,001	598,065

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	109,009	126,733	127,111	126,211	109,001	598,065
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	109,009	126,733	127,111	126,211	109,001	598,065

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	2	2	2	2	2
Sanitary Engineer	1	1	1	1	1
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	3	4	4	3	3
Entomologist Assistant or Entomology Aide	-	-	-	1	-
Others	-	-	-	-	-
TOTAL	6	7	7	7	6

OBSERVATIONS

UNICEF and AID collaborate in this program.

The campaign was reorganized in 1961 and succeeded in reducing incidence markedly and presumably interrupted transmission in areas including about half the population of originally malarious areas. In remaining areas, however, transmission continues despite good insecticide coverage and a pilot program of collective treatment with anti-malarial drugs carried out in 1964 is being expanded to include a population of over half a million.

PAHO is providing personnel (including a co-director of the program), drugs, and a fellowship.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Honduras

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	1,080,187	1,200,198	1,116,244	585,264	250,157	4,232,050
GOVT. AND OTHER SOURCES	1,023,000	1,137,000	1,050,000	520,000	200,000	3,930,000
PAHO/WHO PORTION						
Personnel costs and travel	51,687	53,198	56,244	57,264	44,157	262,550
Supplies and equipment	5,500	10,000	10,000	8,000	6,000	39,500
Fellowships	-	-	-	-	-	-
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	57,187	63,198	66,244	65,264	50,157	302,050

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	20,653	23,588	23,607	21,857	6,000	95,705
WHO-Reg.	-	-	42,637	43,407	44,157	130,201
WHO-MESA	36,534	39,610	-	-	-	76,144
WHO-TA	-	-	-	-	-	-
TOTAL	57,187	63,198	66,244	65,264	50,157	302,050

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	1	1	1	1	1
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	2	2	2	2	1
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	3	3	3	3	2

OBSERVATIONS

UNICEF and AID collaborate in this program.

Attack phase began in 1958 and has succeeded in passing areas with 82% of the population of the originally malarious area into consolidation phase. A problem area exists in the south, however, where resistance of the vector to insecticides and heavy immigration have prevented interruption of transmission. Additional resources are expected to be provided for supplementary attack with a collective drug program in 1965.

PAHO/WHO provides, in addition to consultant personnel, antimalarial drugs for radical cure of cases.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Mexico

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	8,639,707	19,091,132	19,947,314	11,746,509	7,442,214	66,866,876
GOVT. AND OTHER SOURCES	8,500,000	18,952,000	19,800,000	11,600,000	7,300,000	66,152,000
PAHO/WHO PORTION						
Personnel costs and travel	93,807	97,882	106,064	108,659	116,364	522,776
Supplies and equipment	37,000	37,000	37,000	37,000	25,000	173,000
Fellowships	8,600	3,400	3,400	-	-	15,400
Grants and others	300	850	850	850	850	3,700
SUB-TOTAL PAHO/WHO	139,707	139,132	147,314	146,509	142,214	714,876

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	75,168	72,518	73,645	70,895	59,545	351,771
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	64,539	66,614	73,669	75,614	82,669	363,105
TOTAL	139,707	139,132	147,314	146,509	142,214	714,876

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	3	3	3	3	3
Sanitary Engineer	1	1	1	1	1
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	2	2	2	2	2
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	6	6	6	6	6

OBSERVATIONS

UNICEF collaborates in this program.

Attack phase began in 1957 and interrupted transmission in the major part of the malarious area. Areas of persistent low transmission have remained, primarily on the Pacific Coast of the country. Trials of various combined attack measures have been made and in 1966 it is expected that the government will be able to provide resources for attack on the problem with the intensity technically required.

PAHO/WHO has provided assistance through AMRO - 0210, in addition to consultant personnel and drugs for treating cases. A grant for operational research activities has been provided with PAHO/WHO funding (see next page).

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Mexico - 0201

Malaria Eradication in Problem Areas

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	150,000	150,000	75,000	-	-	375,000
GOVT. AND OTHER SOURCES	1/	1/	1/	-	-	1/
PAHO/WHO PORTION						
Personnel costs and travel	-	-	-	-	-	-
Supplies and equipment	-	-	-	-	-	-
Fellowships	-	-	-	-	-	-
Grants and others	150,000	150,000	75,000	-	-	375,000
SUB-TOTAL PAHO/WHO	150,000	150,000	75,000	-	-	375,000

1/ Govt. contribution included in Mexico.

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	-	-	75,000	-	-	75,000
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	150,000	150,000	-	-	-	300,000
WHO-TA	-	-	-	-	-	-
TOTAL	150,000	150,000	75,000	-	-	375,000

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	-	-	-	-	-
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	-	-	-	-	-

OBSERVATIONS

Study of the efficacy of various combined attack measures in eliminating the persistent low-level transmission in the problem area of Oaxaca-Guerrero will be carried out with support from PAHO/WHO and the Government of Mexico. Measures to be employed and evaluated will include 4-month cycles of DDT spraying, total case detection coverage, prompt radical treatment of all cases, short collective drug treatment programs in localities of high positivity, rapid ecological studies of all localities and special epidemiological and entomological studies as necessary. The area has a population of 220,000 persons.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Nicaragua

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	1,865,689	1,691,120	1,707,188	1,137,688	687,888	7,089,573
GOVT. AND OTHER SOURCES	1,727,000	1,560,000	1,570,000	1,000,000	550,000	6,407,000
PAHO/WHO PORTION						
Personnel costs and travel	124,489	118,420	126,488	128,688	130,888	628,973
Supplies and equipment	12,500	11,000	9,000	9,000	7,000	48,500
Fellowships	1,700	1,700	1,700	-	-	5,100
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	138,689	131,120	137,188	137,688	137,888	682,573

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	64,917	54,340	53,628	52,778	51,628	277,291
WHO-Reg.	-	76,780	83,560	84,910	86,260	331,510
WHO-MESA	73,772	-	-	-	-	73,772
WHO-TA	-	-	-	-	-	-
TOTAL	138,689	131,120	137,188	137,688	137,888	682,573

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	2	2	2	2	2
Sanitary Engineer	1	1	1	1	1
Entomologist	1	1	1	1	1
Health Educator	-	-	-	-	-
Sanitary Inspector	3	3	3	3	3
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	7	7	7	7	7

OBSERVATIONS

UNICEF and AID collaborate in this program.

Attack operations began in 1957 and have interrupted transmission in areas with about 40% of the population of originally malarious areas, but vector resistance to DDT and dieldrin has created a serious problem area along the Pacific coast and in some inland valleys. Malathion has been employed as an alternative insecticide and larviciding and collective drug treatment programs used on a limited scale with some success, but resources have not been sufficient for adequate attack on the program. The Government is making efforts to increase the budget and it is hoped that this obstacle will be removed in 1965.

PAHO/WHO provides consultant personnel, drugs for treatment of malaria cases and elimination of foci of transmission in consolidation areas, and fellowships to strengthen epidemiological personnel.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Panama

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	1,367,572	1,471,145	1,048,050	586,035	389,505	4,862,307
GOVT. AND OTHER SOURCES	1,258,000	1,350,000	928,000	480,000	320,000	4,336,000
PAHO/WHO PORTION						
Personnel costs and travel	96,772	111,445	112,050	98,035	63,505	481,807
Supplies and equipment	6,000	8,000	8,000	8,000	6,000	36,000
Fellowships	6,800	1,700	-	-	-	8,500
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	109,572	121,145	120,050	106,035	69,505	526,307

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	43,497	39,768	120,050	106,035	69,505	378,855
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	66,075	81,377	-	-	-	147,452
WHO-TA	-	-	-	-	-	-
TOTAL	109,572	121,145	120,050	106,035	69,505	526,307

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	1	1	1	1	1
Sanitary Engineer	1	1	1	1	-
Entomologist	1	1	1	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	3	3	3	3	2
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	1	1	1	-
TOTAL	6	7	7	6	3

OBSERVATIONS

UNICEF collaborates in this program.

This program was reorganized in 1962 on a basis of semi-annual cycles of DDT but has not achieved complete and regular coverage of spraying or of evaluation. Incidence has been markedly reduced in a great part of the malarious area but five areas of persistently high transmission remain.

In addition to advisory personnel, PAHO/WHO supplies drugs to treat cases and fellowships to assist in training of national professional personnel.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS
Paraguay

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	369,967	927,768	1,242,121	1,265,921	1,247,421	5,053,198
GOVT. AND OTHER SOURCES	290,000	850,000	1,161,000	1,185,000	1,165,000	4,651,000
PAHO/WHO PORTION						
Personnel costs and travel	71,367	72,568	75,921	77,421	78,921	376,198
Supplies and equipment	3,500	3,500	3,500	3,500	3,500	17,500
Fellowships	5,100	1,700	1,700	-	-	8,500
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	79,967	77,768	81,121	80,921	82,421	402,198

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	79,967	77,768	81,121	80,921	82,421	402,198
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	79,967	77,768	81,121	80,921	82,421	402,198

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	1	1	1	1	1
Sanitary Engineer	1	1	1	1	1
Entomologist	1	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	3	3	3	3	3
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	6	5	5	5	5

OBSERVATIONS

A new plan of operations for this program, which has been suspended since March 1961, has been drawn up, but geographical reconnaissance has still to be completed before a new attack phase can be begun. This stage is expected to be reached in the latter part of 1966.

PAHO provides advisory personnel, drugs for treatment of cases and fellowships to strengthen the professional competence of the national staff.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Peru

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	1,389,549	1,167,422	616,124	312,437	146,750	3,632,282
GOVT. AND OTHER SOURCES	1,278,000	1,060,000	540,000	250,000	100,000	3,228,000
PAHO/WHO PORTION						
Personnel costs and travel	93,549	86,422	66,124	52,437	38,750	337,282
Supplies and equipment	18,000	15,000	10,000	10,000	8,000	61,000
Fellowships	-	6,000	-	-	-	6,000
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	111,549	107,422	76,124	62,437	46,750	404,282

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	111,549	107,422	76,124	62,437	46,750	404,282
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	111,549	107,422	76,124	62,437	46,750	404,282

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	1	1	1	1	1
Sanitary Engineer	1	1	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	4	3	3	2	1
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	6	5	4	3	2

OBSERVATIONS

UNICEF collaborates in this program.

Additional areas were placed in maintenance phase at the beginning of 1965 and it is expected that consolidation phase will be completed in the whole country in 1971, although difficulties are being experienced in the Amazonas region. Two serious outbreaks occurred in consolidation-phase areas during 1964, however, both of which were brought under control.

In addition to consultants, PAHO provides anti-malarial drugs and fellowships.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

British Guiana

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	73,414	63,332	42,610	25,500	-	204,856
GOVT. AND OTHER SOURCES	54,000	46,000	25,000	25,000	-	150,000
PAHO/WHO PORTION						
Personnel costs and travel	17,214	16,832	17,110	-	-	51,156
Supplies and equipment	500	500	500	500	-	2,000
Fellowships	1,700	-	-	-	-	1,700
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	19,414	17,332	17,610	500	-	54,856

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	19,414	17,332	17,610	500	-	54,856
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	19,414	17,332	17,610	500	-	54,856

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	-	-	-	-	-
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	1	1	1	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	1	1	1	-	-

OBSERVATIONS

UNICEF collaborates in this program.

Transmission has been interrupted in almost the entire country. A chloroquinized-salt program has been utilized as the main attack measure in the interior region of Rupununi, supplemented by DDT spraying since a chloroquine-resistant strain of P. falciparum was discovered there in 1962; this combined program has been quite successful. It is expected that the last areas may enter consolidation phase by 1967.

PAHO provides drugs for radical cure of cases and a fellowship.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

British Honduras

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	34,500	34,500	15,500	-	-	84,500
GOVT. AND OTHER SOURCES	34,000	34,000	15,000	-	-	83,000
PAHO/WHO PORTION						
Personnel costs and travel	-	-	-	-	-	-
Supplies and equipment	500		500	-	-	1,500
Fellowships	-	-	-	-	-	-
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	500	500	500	-	-	1,500

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	500	500	500	-	-	1,500
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	500	500	500	-	-	1,500

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	-	-	-	-	-
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	-	-	-	-	-

OBSERVATIONS

UNICEF collaborates in this program.

Attack phase operations began in 1957 and the entire malarious area had entered consolidation phase by 1962. An outbreak in the Orange Walk area has proved difficult to control and consolidation phase is expected to be extended to 1967.

PAHO provides drugs for treatment of cases.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

French Guiana

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	109,263	98,000	62,000	47,000	32,000	348,263
GOVT. AND OTHER SOURCES	96,000	96,000	60,000	45,000	30,000	327,000
PAHO/WHO PORTION						
Personnel costs and travel	11,263	-	-	-	-	11,263
Supplies and equipment	2,000	2,000	2,000	2,000	2,000	10,000
Fellowships	-	-	-	-	-	-
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	13,263	2,000	2,000	2,000	2,000	21,263

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	13,263	2,000	2,000	2,000	2,000	21,263
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	13,263	2,000	2,000	2,000	2,000	21,263

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	-	-	-	-	-
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	1	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	1	-	-	-	-

OBSERVATIONS

The entire coastal area, which contains almost 90% of the country's population is in attack phase but the interior of the country, with a population of 4,000, has not yet been brought under attack.

PAHO will provide a sanitarian in 1965, and drugs for treatment of cases.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Surinam

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	385,833	396,720	299,180	219,080	180,680	1,481,493
GOVT. AND OTHER SOURCES	283,000	280,000	200,000	120,000	80,000	963,000
PAHO/WHO PORTION						
Personnel costs and travel	97,633	104,620	92,480	94,080	95,680	484,493
Supplies and equipment	3,500	7,000	5,000	5,000	5,000	25,500
Fellowships	1,700	5,100	1,700	-	-	8,500
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	102,833	116,720	99,180	99,080	100,680	518,493

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	102,833	116,720	99,180	99,080	100,680	518,493
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	102,833	116,720	99,180	99,080	100,680	518,493

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	1	1	1	1	1
Sanitary Engineer	-	-	-	-	-
Entomologist	1	1	-	-	-
Health Educator	1	1	1	1	1
Sanitary Inspector	2	2	2	2	2
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	1	1	1	1	1
TOTAL	6	6	5	5	5

OBSERVATIONS

UNICEF collaborates in this program.

The coastal area continues successfully in consolidation phase but in the interior social difficulties continue to obstruct spraying. A system of hiring local inhabitants in each village to perform house-spraying there is being tried, with considerable success, and a small trial of medicated salt is also being made.

PAHO provides personnel, drugs and fellowships.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Project AMRO -0200

Malaria Technical Advisory Team

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	116,620	148,008	147,938	151,429	134,339	698,334
GOVT. AND OTHER SOURCES	-	-	-	-	-	-
PAHO/WHO PORTION						
Personnel costs and travel	105,320	135,708	135,638	139,129	122,039	637,834
Supplies and equipment	1,000	1,000	1,000	1,000	1,000	5,000
Fellowships	-	-	-	-	-	-
Grants and others	10,300	11,300	11,300	11,300	11,300	55,500
SUB-TOTAL PAHO/WHO	116,620	148,008	147,938	151,429	134,339	698,334

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	96,263	109,101	147,938	151,429	134,339	639,070
WHO-Reg.	-	17,000	-	-	-	17,000
WHO-MESA	20,357	21,907	-	-	-	42,264
WHO-TA	-	-	-	-	-	-
TOTAL	116,620	148,008	147,938	151,429	134,339	698,334

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	2	2	2	2	2
Sanitary Engineer	-	-	-	-	-
Entomologist	1	1	1	1	1
Health Educator	-	-	-	-	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	3	3	3	3	2
TOTAL	6	6	6	6	5

OBSERVATIONS

The objective of this program is to provide consultant services to the various governments concerning certain aspects of their program which do not require long-term consultants, and to assist in the supervision of international personnel assigned to country programs who perform functions related to these specialties.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS
Project AMRO - 0201
Malaria Technical Advisory Services (Zone I)

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	41,432	18,432	15,650	15,950	16,250	107,714
GOVT. AND OTHER SOURCES	-	-	-	-	-	-
PAHO/WHO PORTION						
Personnel costs and travel	40,832	17,832	15,050	15,350	15,650	104,714
Supplies and equipment	600	600	600	600	600	3,000
Fellowships	-	-	-	-	-	-
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	41,432	18,432	15,650	15,950	16,250	107,714

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	41,432	18,432	15,650	15,950	16,250	107,714
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	41,432	18,432	15,650	15,950	16,250	107,714

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	1	-	-	-	-
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	2	1	1	1	1
TOTAL	3	1	1	1	1

OBSERVATIONS

This program has provided advisory services to the countries of Zone I and the many small Caribbean islands with malaria eradication programs. As these programs progressively achieve maintenance phase, the need decreases and beginning with 1966 the team will be reduced to one laboratory advisor, presently stationed in Surinam.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS
Project AMRO-0203

Malaria Technical Advisory Services (Zone III)

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	82,905	109,557	109,771	112,850	115,550	530,633
GOVT. AND OTHER SOURCES	-	-	-	-	-	-
PAHO/WHO PORTION						
Personnel costs and travel	81,705	107,557	107,771	110,850	113,550	521,433
Supplies and equipment	1,200	2,000	2,000	2,000	2,000	9,200
Fellowships	-	-	-	-	-	-
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	82,905	109,557	109,771	112,850	115,550	530,633

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	-	-	109,771	112,850	115,550	338,171
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	82,905	109,557	-	-	-	192,462
WHO-TA	-	-	-	-	-	-
TOTAL	82,905	109,557	109,771	112,850	115,550	530,633

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	2	2	2	2	2
Sanitary Engineer	1	1	1	1	-
Entomologist	-	-	-	-	-
Health Educator	1	1	1	1	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	2	2	2	2	1
TOTAL	6	6	6	6	3

OBSERVATIONS

This program complements the technical assistance provided to individual country programs in Zone III. As regionalization of malaria eradication activities in the Zone is intensified and the country programs redouble their efforts to overcome the technical problems existing in many of these countries, a strengthened team will be provided to coordinate the activities of the country programs, to supervise international personnel assigned to them and to advise on specialized aspects of the programs.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS
Project AMRO - 0204
Malaria Technical Advisory Services (Zone IV)

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	26,132	27,351	27,816	28,316	28,816	138,431
GOVT. AND OTHER SOURCES	-	-	-	-	-	-
PAHO/WHO PORTION						
Personnel costs and travel	26,132	27,351	27,816	28,316	28,816	138,431
Supplies and equipment	-	-	-	-	-	-
Fellowships	-	-	-	-	-	-
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	26,132	27,351	27,816	28,316	28,816	138,431

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	26,132	27,351	27,816	28,316	28,816	138,431
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	26,132	27,351	27,816	28,316	28,816	138,431

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	1	1	1	1	1
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	1	1	1	1	1

OBSERVATIONS

This program rounds out the advisory services provided to the countries of Zone IV and allows closer supervision of international personnel assigned to country programs. The medical officer also functions as chief consultant to Colombia-0200.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS
Project AMRO -0209
Insecticide Testing Team

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	114,245	114,692	114,886	115,153	-	458,976
GOVT. AND OTHER SOURCES	-	-	-	-	-	-
PAHO/WHO PORTION						
Personnel costs and travel	58,645	68,692	68,886	69,053	-	265,276
Supplies and equipment	15,600	15,600	15,600	15,600	-	62,400
Fellowships	-	-	-	-	-	-
Grants and others	40,000	30,400	30,400	30,500	-	131,300
SUB-TOTAL PAHO/WHO	114,245	114,692	114,886	115,153	-	458,976

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	-	-	114,886	115,153	-	230,039
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	114,245	114,692	-	-	-	228,937
WHO-TA	-	-	-	-	-	-
TOTAL	114,245	114,692	114,886	115,153	-	458,976

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	-	-	-	-	-
Sanitary Engineer	-	-	-	-	-
Entomologist	2	2	2	2	-
Health Educator	-	-	-	-	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	2	2	2	2	-
Others	-	-	-	-	-
TOTAL	4	4	4	4	-

OBSERVATIONS

The testing of the efficacy of proposed new insecticides is done by this program. One of the more promising insecticides studied so far, OMS-33 (a carbamate), will be taken through additional stages of testing, beginning with Stage IV in the WHO insecticide testing program (experimental huts) and proceeding to village-scale tests.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS

Project AMRO - 0210

Malaria Eradication Epidemiology Team

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	30,948	47,957	58,680	60,480	62,280	260,345
GOVT. AND OTHER SOURCES	-	-	-	-	-	-
PAHO/WHO PORTION						
Personnel costs and travel	30,948	45,357	56,080	57,880	59,680	249,945
Supplies and equipment	-	2,300	2,300	2,300	2,300	9,200
Fellowships	-	-	-	-	-	-
Grants and others	-	300	300	300	300	1,200
SUB-TOTAL PAHO/WHO	30,948	47,957	58,680	60,680	62,280	260,345

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	-	-	58,680	60,480	62,280	181,440
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	30,948	47,957	-	-	-	78,905
WHO-TA	-	-	-	-	-	-
TOTAL	30,948	47,957	58,680	60,480	62,280	260,345

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	2	2	2	2	2
Sanitary Engineer	-	-	-	-	-
Entomologist	1	1	1	1	1
Health Educator	-	-	-	-	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	3	3	3	3	3

OBSERVATIONS

This program provides personnel specialized in epidemiology to study problems of malaria transmission continuing despite adequate normal attack measures. The team is now located in Oaxaca, Mexico, where its first objective is evaluation of an attack on persistent low-level transmission by integration of the best spraying routine, intensive case-finding and complete radical treatment of all cases. Other attack methods will be evaluated later.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS
Project AMRO - 0211
Seminar, Local Health Services in MEP

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	32,825	-	-	-	-	32,825
GOVT. AND OTHER SOURCES	-	-	-	-	-	-
PAHO/WHO PORTION						
Personnel costs and travel	10,140	-	-	-	-	10,140
Supplies and equipment	2,000	-	-	-	-	2,000
Fellowships	20,685	-	-	-	-	20,685
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	32,825	-	-	-	-	32,825

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	32,825	-	-	-	-	32,825
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	32,825	-	-	-	-	32,825

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	-	-	-	-	-
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	-	-	-	-	-

OBSERVATIONS

The second Seminar on the rôle of general public health services in malaria eradication was held in March 1965 in Cuernavaca, Mexico, with attendance from the countries of Central America, Mexico, Panama and the Caribbean region. The final reports of this and the preceding Seminar held for South American countries are being combined and will be issued as a single document.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS
Project AMRO - 0212
Resistance of Malaria Plasmodia Strains to Drugs

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	5,485	-	-	-	-	5,485
GOVT. AND OTHER SOURCES	-	-	-	-	-	-
PAHO/WHO PORTION						
Personnel costs and travel	-	-	-	-	-	-
Supplies and equipment	500	-	-	-	-	500
Fellowships	-	-	-	-	-	-
Grants and others	4,985	-	-	-	-	4,985
SUB-TOTAL PAHO/WHO	5,485	-	-	-	-	5,485

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	-	-	-	-	-	-
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	5,485	-	-	-	-	5,485
WHO-TA	-	-	-	-	-	-
TOTAL	5,485	-	-	-	-	5,485

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	-	-	-	-	-
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	-	-	-	-	-
TOTAL	-	-	-	-	-

OBSERVATIONS

The Strain Screening Center for testing plasmodium resistance to drugs was closed at the end of March, 1965. Resistance to chloroquine was confirmed in a number of strains from Brazil, Colombia, Venezuela and British Guiana, and the effects of different drugs, particularly various dosage schedules of pyrimethamine and sulfonamides, were studied.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS
Zone Offices Supporting Services

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	15,387	16,402	17,097	17,792	18,487	85,165
GOVT. AND OTHER SOURCES	-	-	-	-	-	-
PAHO/WHO PORTION						
Personnel costs and travel	15,387	16,402	17,097	17,792	18,487	85,165
Supplies and equipment	-	-	-	-	-	-
Fellowships	-	-	-	-	-	-
Grants and others	-	-	-	-	-	-
SUB-TOTAL PAHO/WHO	15,387	16,402	17,097	17,792	18,487	85,165

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	-	-	-	-	-	-
PAHO-SMF	15,387	16,402	17,097	17,792	18,487	85,165
WHO-Reg.	-	-	-	-	-	-
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	15,387	16,402	17,097	17,792	18,487	85,165

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	-	-	-	-	-
Sanitary Engineer	-	-	-	-	-
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	3	3	3	3	3
TOTAL	3	3	3	3	3

OBSERVATIONS

To provide supporting administrative services for the hemisphere-wide program, 3 posts were established. These services will be maintained at reduced levels.

ESTIMATED REQUIREMENTS FOR MALARIA ERADICATION IN THE AMERICAS
Malaria Eradication Branch

	1965	1966	1967	1968	1969	TOTAL
TOTAL COST	205,030	210,677	212,897	218,150	223,150	1,069,904
GOVT. AND OTHER SOURCES	-	-	-	-	-	-
PAHO/WHO PORTION						
Personnel costs and travel	181,953	185,212	186,607	190,850	194,850	939,472
Supplies and equipment	-	-	-	-	-	-
Fellowships	-	-	-	-	-	-
Grants and others	23,077	25,465	26,290	27,300	28,300	130,432
SUB-TOTAL PAHO/WHO	205,030	210,677	212,897	218,150	223,150	1,069,904

SOURCES OF PAHO/WHO FUNDING

SOURCE	1965	1966	1967	1968	1969	TOTAL
PAHO-Reg.	76,223	79,761	80,742	84,000	87,000	407,726
PAHO-SMF	-	-	-	-	-	-
WHO-Reg.	128,807	130,916	132,155	134,150	136,150	662,178
WHO-MESA	-	-	-	-	-	-
WHO-TA	-	-	-	-	-	-
TOTAL	205,030	210,677	212,897	218,150	223,150	1,069,904

PAHO/WHO PERSONNEL

CATEGORY	1965	1966	1967	1968	1969
Medical Officer	4	4	4	4	4
Sanitary Engineer	1	1	1	1	1
Entomologist	-	-	-	-	-
Health Educator	-	-	-	-	-
Sanitary Inspector	-	-	-	-	-
Entomologist Assistant or Entomology Aide	-	-	-	-	-
Others	7	7	7	7	7
TOTAL	12	12	12	12	12

OBSERVATIONS

The Branch coordinates and advises the malaria eradication programs in the hemisphere and directs and supervises international field personnel. Evaluation of the progress of country programs in malaria eradication is made by headquarters personnel, assisted by zone and country advisers; technical advice on specialized aspects of country programs is provided, and operational research projects to meet problems in the Americas are directed and coordinated with the WHO general research program in eradication means and techniques.

Annex 4

FINANCING OF THE MALARIA ERADICATION PROGRAM IN THE AMERICAS [1]

At its XV Meeting, the Directing Council approved Resolution XX [2] requesting the Director of the Pan American Sanitary Bureau to consult with the Director-General of the World Health Organization with a view to finding an appropriate method of assuring the financing of the malaria eradication program in the Americas, and to report thereon to the 52nd Meeting of the Executive Committee.

Accordingly, the Director presented a report on the steps taken to that meeting of the Executive Committee. After careful consideration of that report, the Committee adopted a resolution [3] in which it stressed the importance of voluntary contributions to the PAHO Special Malaria Eradication Fund and WHO Special Account for Malaria Eradication in continuing the malaria eradication program in the Americas. It expressed the hope that these contributions would continue at the level necessary to achieve the objectives of the program, and decided to transmit the report to the XVI Meeting of the Directing Council, together with such additional information as might be available.

In compliance with that resolution, the Director has the honor of submitting the afore-mentioned report (Appendix) to the Directing Council for consideration. Any additional data which may be received will be reported subsequently to the meeting.

[1] Document CD16/7 (11 June 1965).
[2] *Official Document PAHO* **58**, 73.
[3] Resolution III. *Official Document PAHO* **62**, 29-30.

Appendix

FINANCING OF THE MALARIA ERADICATION PROGRAM IN THE AMERICAS [1]

Pursuant to Resolution XX of the XV Meeting of the Directing Council, the Director of the Bureau immediately undertook consultations with the Director-General of the World Health Organization on this subject. As a result, the Director-General, bearing in mind the need for maintaining a fully effective program in the Americas, and taking into account the availability of funds for malaria eradication in the WHO regular budget, as well as in the Malaria Eradication Special Account, decided to increase the WHO allocation for malaria eradication in the Americas.

The provision for malaria in the WHO regular budget of $182,011 for 1964 [2] was increased in 1965 to $256,355 and to $335,287 in 1966.[3] For 1967 the Director-General has established $469,000 as the target planning figure.

[1] Document CE52/10 (18 March 1965).
[2] *Off. Rec. Wld Hlth Org.* **130**, 229.
[3] *Off. Rec. Wld Hlth Org.* **138**, xx.

From the WHO Malaria Eradication Special Account the Director-General allocated $683,214 for 1965 and $605,559 in 1966. In the Report of the Executive Board on Review of the Proposed Program and Budget Estimates for 1966 [4] it was noted that the maintenance of the planned level for 1966 was dependent on the receipt of substantial additional voluntary contributions, the shortfall amounting to $1,928,636. Nevertheless, availability of the above-mentioned amount of $605,559 for 1966 has been maintained in preparing the table. In view of the potential deficit in the Special Account in 1966, however, it does not appear prudent to assume any funds from this source in 1967.

The actual and potentially available funds in relation to estimated requirements for the three year period 1965, 1966 and 1967 are summarized in the table. It will be noted that expected availability of funds is approximately equal to requirements for the three-year period, assuming that voluntary contributions are maintained at the 1965 level. The Director will consult with Governments of the Americas, particularly with the Government of the United States of America which has contributed so generously to the PAHO Special Malaria Fund, with a view to assuring a level of voluntary contributions necessary to maintain an efficient program in future years. The Director will also continue to consult with the Director-General of WHO concerning the amount of funds which can be made available from the WHO budget.

Attention is invited to the fact that the figures in the table are based on estimates. It is impossible to foresee with any certainty the problems which may arise in future years. Although the program is proceeding successfully when taken as a whole, special technical problems continue to arise in certain areas. The nature, extent, and duration of such problems, as well as their budgetary implications cannot be foreseen. Furthermore, experience and analyses made in the preparation of future plans have shown that special efforts will be needed to bridge the gap between the eradication program and the creation of an adequate system of health centers to protect the efforts and financial investment in eradication by assuring surveillance in future years. It is expected, therefore, that additional consultants will have to be added to promote coordination of the malaria eradication services with public health and medical care services, as well as to advise on the creation of new or expanded services. All of these factors will be reflected in the budgetary estimates which are presented from year to year. Likewise they will be taken into account in the Director's consultations with Governments with regard to voluntary contributions and with the Director-General of WHO.

Source of funds for malaria eradication

Fund	1965	1966	1967
PAHO SMF	1,800,000[a]	1,800,000[b]	1,800,000[b]
PAHO Regular	78,355[c]	79,761[d]	79,761[d]
WHO Regular	256,355[c]	335,287[e]	469,000[f]
WHO MESA	683,214[c]	605,559[c]	–0–[g]
WHO TA	86,300[c]	63,400[c]	63,400
Totals	2,904,224	2,884,007	2,412,161
Est. requirements	2,909,204[h]	2,640,557[h]	2,640,557[i]
Excess	(4,980)	243,450	(228,396)

[a] U. S. pledge for 1965.
[b] Assumes maintenance of 1965 level of voluntary contributions.
[c] *Official Document PAHO* **52**.
[d] Document CE52/3, Revised estimate for 1966; assumes same level for 1967.
[e] *WHO Official Records* **138**.
[f] Planning figure allocated for 1967 by Director-General of WHO.
[g] Assumes exhaustion of WHO MESA in 1966 according to estimates given to the 35th Session of the WHO Executive Board.
[h] Requirements shown in *Official Document PAHO* **52**, plus provision for problem area in Mexico shown under WHO MESA in *WHO Official Records* **138**.
[i] Assumes continuing requirements at 1966 level, including provision for problem areas.

[4] *Off. Rec. Wld Hlth Org.* **141**, 60.

Annex 5

STATUS OF SMALLPOX ERADICATION IN THE AMERICAS [1]

The XIII Pan American Sanitary Conference (Ciudad Trujillo, 1950), recognizing the extent of the problem of smallpox in the Americas, recommended to the countries the development of systematic programs of smallpox vaccination and revaccination with a view to eradicating the disease and that these programs be carried out under the auspices of the Pan American Health Organization in agreement with the interested countries.

In a series of 12 resolutions [2] adopted in successive years, the Governing Bodies of the Organization expressed their concern with regard to smallpox in the Americas, and their desire to see the disease eradicated in the Western Hemisphere.

In 1958, "noting that smallpox still remains a very widespread and dangerous infectious disease and that in many regions of the world there exist endemic foci of this disease constituting a permanent threat of its propagation and consequently menacing the life and health of the population," the Eleventh World Health Assembly [3] requested the Director-General to carry out an investigation of the means of ensuring world-wide eradication of the disease. In 1959, the Twelfth World Health Assembly [4] requested the Director-General "to collect from the countries concerned information on the organization and progress of their respective eradication programs and to report further to the Thirteenth World Health Assembly." A similar request was made by the Thirteenth and Fourteenth World Health Assemblies. The Fourteenth World Health Assembly [5] urged the more economically advanced countries to make voluntary contributions in cash or kind so as to increase the funds of the WHO Special Account.

The above-mentioned resolutions reaffirm the priority that the Governing Bodies of PAHO and WHO give to the problem of smallpox. Since all these resolutions were approved unanimously, the Governments of both Organizations are pledged to eradicate the disease.

In accordance with the successive resolutions of the Governing Bodies, the Organization in concert with many countries, has, since 1950, actively engaged in a hemisphere-wide program for the eradication of this disease.

The Organization has continued to assist the Governments in planning smallpox eradication programs based on vaccination campaigns which can, in due course, be incorporated into the general public health services of the countries. This assistance has included technical advisory services for the production of smallpox vaccine and the provision of equipment for the preparation of freeze-dried vaccine. In other cases the provision of vaccine ready for use was facilitated, the services of consultants specialized in organizing and implementing vaccination campaigns were provided, and fellowships were awarded for training national personnel. The services of an accredited laboratory, where the purity and potency of smallpox vaccine prepared by the national laboratories can be tested, has also been made available to the Governments.

From 1948 to 1964 the Organization has assigned to the different smallpox eradication programs in the Americas the amount of US$599,277. Its distribution, by country, is given in Table 1.

Substantial progress toward the eradication of smallpox has been made since 1950. The progress varies greatly from country to country, so that although an important group of countries has achieved the objective of eliminating the disease

[1] Document CD16/29 (14 September 1965).
[2] *Official Document PAHO* **60**, 293-294.
[3] *Off. Rec. Wld Hlth Org.* **87**, 41-42.
[4] *Off. Rec. Wld Hlth Org.* **95**, 47.
[5] *Off. Rec. Wld Hlth Org.* **110**, 16.

Table 1—*PAHO/WHO and UNICEF Funds Alloted to Smallpox Eradication Projects, 1948-1964 (In U.S. Dollars)*

Projects	PAHO/WHO	UNICEF	Total
AMRO-0300	130,426	—	130,426
Argentina-2	9,736	—	9,736
Bolivia-0300	51,544	—	51,544
Brazil-0300	48,414	—	48,414
Chile-0300	12,172	—	12,172
Colombia-17	103,789	15,000	118,789
Cuba-8	30,741	—	30,741
Ecuador-0300	179,368	—	179,368
Haiti-0300	3,848	—	3,848
Mexico-31	5,307	—	5,307
Paraguay-15	10,164	—	10,164
Peru-51	1,148	—	1,148
Uruguay-12	6,870	—	6,870
Venezuela-12	5,750	—	5,750
Total	599,277	15,000	614,277

and others are close to the goal, there are still some countries in which smallpox is present and where eradication campaigns must begin without delay. It is also necessary for countries where eradication programs have become indefinitely prolonged and which have a very high incidence of smallpox, to give ample and decided attention to this type of activity.

Full international participation in the eradication effort has not yet been attained. The foci of smallpox remaining in the Hemisphere constitute not only a problem for the countries in which they occur, but also a continuous threat and cause of concern to other countries which, thanks to their spirit of perseverance and continental solidarity, are already free of the disease. The persistence of these foci forces those countries to continue their efforts to maintain the immunity of the population at a high level. The reintroduction or the threat of reintroduction of smallpox has forced individual countries already free of the disease to repeat their national mass vaccination campaigns.

The efforts made by the Governments and the Organization to provide adequate amounts of a stable freeze-dried vaccine have been successful. With the Organization's assistance, several countries are now producing enough vaccine not only to satisfy their needs, but also to supply the nonproducing countries. In general, the countries are not making adequate use of the facilities offered for the testing of the vaccine, and a few are experiencing difficulties in the preparation of their vaccine since some lots do not meet the minimum standards of potency, safety, and stability established by WHO. It will be necessary to have the vaccines tested routinely if their high quality is to be maintained. The Organization is ready to provide assistance to ensure the effective functioning of vaccine production laboratories and again reiterates its offer of the testing facilities, which should be used more frequently by the countries.

The eleven laboratories for the production of smallpox vaccine, which have received assistance from PAHO/WHO, produced in 1964, 32,300,823 doses of freeze-dried smallpox vaccine and 32,660,791 of glycerinated vaccine. Table 2 shows the production of freeze-dried and glycerinated vaccines according to the reports received.

Table 2—*Reported Production of Smallpox Vaccine in the Americas, 1964*

Country	Glycerinated	Freeze-dried	Total
Argentina	7,190,000	—	7,190,000
Bolivia	—	864,200	864,200
Brazil	500,000	22,014,500	22,514,500
Chile	3,825,000	717,500	4,542,500
Colombia	—	3,069,500	3,069,500
Cuba	1,280,650	—	1,280,650
Ecuador	—	864,360	864,360
Guatemala	1,417,165	—	1,417,165
Mexico	10,754,400	—	10,754,400
Peru	2,944,000[a]	3,553,700[a]	6,497,700[a]
Uruguay	2,493,000	—	2,493,000
Venezuela	2,256,576	1,217,063	3,473,639
Total	32,660,791	32,300,823	64,961,614

[a] January-August.
— None.

Brazil, Colombia, Guatemala, Mexico, Peru, and Venezuela continued to donate freeze-dried or glycerinated vaccine to the programs being carried out in several countries of Central and South America. The Organization has acted as a coordinating agency on behalf of both the countries requesting vaccine and those producing it.

However, the smallpox eradication campaign in the Americas is progressing more slowly than anticipated. Despite the excellent results obtained by various countries that have completed eradication or reduced the incidence of smallpox to a low level, the disease is still an important public health problem in the Americas. The achievement of eradication throughout the Hemisphere requires the concentrated efforts of the countries concerned, both for the protection of their own population and for

Table 3—*Reported Number of Smallpox Vaccinations in the Americas, 1960-1964*

Area	1960	1961	1962	1963	1964
Argentina	1,990,467	4,407,020	1,344,401	638,502	284,239
Bolivia	42,603	34,215[a]	164,449	280,427[b]	1,040,797[c]
Brazil	4,910,091	...	2,061,179[d]	6,955,330	8,016,713
Canada	1,332,000	...	...	...	...
Chile	285,314	382,946	703,297	946,000	1,481,820
Colombia	3,195,355	1,250,685	191,083[e]	1,936,676	1,702,972
Costa Rica	14,657	79,553	106,252[f]	39,224[g]	220,518
Cuba	38,635[a]	129,647	135,319[h]	50,755[g]	63,173
Dominican Republic	26,057	10,000	35,135	20,492[g]	66,552[i]
Ecuador	783,338	535,668	685,595	653,517[g]	652,571
El Salvador	33,373	24,554[a]	143,835	200,091[j]	435,839
Guatemala	123,590[k]	129,590[a]	127,004	109,249[g]	555,724
Haiti	441[k]	3,135	180,719	350,156	293,441[l]
Honduras	17,843	9,509	127,144[f]	51,069[g]	91,105
Jamaica	79,973	70,129	131,652	47,333	70,958
Mexico	3,637,334	2,588,149	5,226,096[m]	3,143,916[b]	5,524,600
Nicaragua	8,803	19,385	3,335[e]	19,280[g]	94,752
Panama	24,835	31,596	11,547[a]	12,591[g]	39,716
Paraguay	122,897	110,142	28,283[e]	88,350[g]	135,223
Peru	1,049,740	969,808	593,336	277,298[n]	3,165,404[l]
Trinidad and Tobago	3,839	11,438	1,271[o]	40,730[g]	44,901
Uruguay	214,360	188,674	81,754[e]	55,364[g]	188,702
Venezuela	1,104,389	1,140,842	1,147,574[m]	1,150,324	953,868
Antigua	1,603	1,186	446[e]	3,552[g]	1,558
Bahamas	...	17,941	3,196	7,653[g]	3,213
Barbados	10,564[p]	14,070	86,507	4,591[g]	10,490
Bermuda	783[o]	579	...	...	1,154
British Guiana	3,165	...	6,982	4,087[g]	7,447
British Honduras	3,939	4,900	10,617	4,953[g]	...
Cayman Islands	...	...	...	...	9,000
Dominica	...	1,351[a]	2,315[e]	1,470[g]	1,585
Falkland Islands	128	...	...	...	...
French Guiana	2,204[a]	1,120[a]	1,122[m]	1,922[n]	1,590
Grenada	3,402	2,695	1,031	1,445[n]	2,477
Guadeloupe	13,567[k]	5,000[a]	750[e]	...	13,076[q]
Martinique	18,817	7,650[a]	10,685	11,641[n]	9,779
Montserrat	1,204	903	927	873[g]	458
Netherlands Antilles	3,665[k]	...	2,400[e]	...	...
Panama Canal Zone	9,528[k]	...	...	...	...
Puerto Rico	...	...	...	...	...
St. Kitts—Nevis-Anguilla	3,300	2,979	...	...	...
St. Lucia	...	...	3,200	1,500[n]	...
St. Pierre & Miquelon	224	...	...	...	...
St. Vincent	...	...	2,405	1,512[g]	1,820
Surinam	6,375	8,400	5,286	6,237[g]	6,250
Turks & Caicos Islands	...	...	...	58[n]	65[l]
Virgin Islands (U.K.)	44	...	...	73[g]	104

[a] Incomplete data.
[b] January-November 1963.
[c] January 1964—May 1965.
[d] São Paulo State.
[e] January-April.
[f] January-November.
[g] January-October 1963.
[h] January-September.
[i] January 1964-April 1965.
[j] January-September 1963.
[k] Primo-vaccinations.
[l] January-September 1964.
[m] Provisional.
[n] January-August 1963.
[o] January-March.
[p] Excludes vaccinations given by general practitioners. Source of data: Government reports.
[q] January 1964—June 1965.
... No data available.

the safety of other countries that have already taken the necessary steps to eradicate the disease.

Priority considerations and political, financial, or administrative reasons, operating either singly or in association, were responsible for the inability to move faster. Governments should make the necessary provisions in the national budgets for the prosecution of the eradication activities.

Experience shows that the disease disappears very quickly wherever smallpox exists, whether in an epidemic or endemic form, when the Governments are firmly decided to initiate eradication programs and provide the necessary funds with which to carry them out.

It is therefore clear that the continued existence of smallpox is due not to lack of experience or of technical knowledge as to how to eliminate the disease, but to the lack of will to do so and a failure to provide the funds necessary for such an undertaking.

Smallpox vaccination programs should be either initiated or stepped up. There is an equally pressing need to vaccinate the population of countries where the level of protection is low and which are situated near other countries where the disease exists.

The vaccination levels among populations in areas or countries in which national vaccination programs have been completed are being maintained below the rates and ratios recommended (see Table 3). At the same time, the reporting of suspected cases of smallpox in areas where the population had already been vaccinated is deficient, and both research (clinical and epidemiological) and laboratory diagnosis are being carried out on a restricted scale and cover only a small proportion of the cases reported. This points to the need for the organization of epidemiological surveillance services in countries where smallpox eradication programs have been completed or are in progress.

With the establishment of epidemiologist posts for all the Zone Offices, the Organization will be in a better position to cooperate with the countries in the establishment of those surveillance services. Preparation is well advanced for the organization of two courses on the laboratory diagnosis of smallpox, to be held in 1966. It is hoped that training in this field will contribute substantially toward improving diagnosis and reporting of cases of smallpox.

It is difficult to know the actual incidence of smallpox in the Hemisphere because of the incompleteness and delay of reporting. In 1964 only Brazil, Colombia, and Peru recorded significant foci of the disease. Brazil continues to report the great majority of cases (2,502) and although a vaccination program was begun in 1962 the disease remains widely prevalent. Peru, which eradicated the disease in 1954, experienced a recurrence in 1963 in areas bordering with Brazil and reported 454 cases in 1964. Colombia, Uruguay, and Argentina reported 21, 3, and 12 cases, respectively. In 1965, up to 31 August, Brazil has reported 448 cases; Argentina, 11; Colombia, 146; and Paraguay, 10.

The reduction in the incidence of smallpox in the Americas since 1947 (see Table 4) parallels the progress made by the eradication programs being carried out by the countries. Of course, all these figures should be interpreted with caution owing to the incompleteness of reporting, but they give an idea of the trend of the disease. The efforts made by the countries to improve systems for the reporting, registration, and diagnosis of smallpox are gradually leading to an improvement in our knowledge of the disease.

The following is a summary of the progress made in smallpox campaigns in several countries of the Hemisphere.

El Salvador, Guatemala, and Honduras, where the percentage of the population immunized against smallpox was small, are making good progress in their vaccination programs, which are being carried out as part of the routine activities of the regular health services.

In Argentina, the national vaccination campaign which began in 1961, made little progress in 1964, owing to economic and administrative difficulties. In 1964, 284,239 persons were vaccinated. Twelve cases occurred in 1964 and at the present there is an outbreak with 11 cases in Corrientes Province, near the border with Paraguay. Argentina does not produce freeze-dried smallpox vaccine. The Organization is providing the equipment for the production of this type of vaccine. The reestablishment of the campaign in Argentina will be an important step in the eradication of smallpox from the Americas.

The campaign in Bolivia, which is being carried out with the cooperation of PAHO and WHO/TA,

Table 4—*Reported Cases of Smallpox in the Americas, 1948-1964**

Area	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963[a]	1964[b]
Argentina	166	1,176	4,462	1,404	982	309	256	55	86	335	27	36	65	6	2[c]	—	12[d]
Bolivia	831	805	644	728	432	429	624	372	499	1,310	183	7	1	—	—	—	—
Brazil[e]	1,288	670	706	1,190	1,668	923	1,035	2,580	2,385	1,411	1,232	2,629	2,644	7,656	7,589	6,211[f]	2,502[f]
British Guiana	—	—	—	11	—	—	—	—	—	—	—	—	—	—	—	—	—
British Honduras	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Canada	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Chile	5	4	3,564	47	15	9	—	—	—	—	—	1	—	—	1[g]	—	—
Colombia	7,356	3,040	4,818	3,844	3,235	5,526	7,203	3,404	2,572	2,145	2,009	950	209	16	41	4	21
Costa Rica	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Cuba	—	5	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Dominican Republic	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Ecuador	3,856	657	241	174	665	708	2,516	1,831	669	913	863	1,140	2,185	496	204	45	—
El Salvador	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guatemala	6	4	10	3	1	1	—	—	—	—	—	—	—	—	—	—	—
Haiti	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Honduras	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Martinique	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—
Mexico	1,541	1,060	762	27	—	—	—	—	—	—	—	—	—	—	—	—	—
Netherlands Antilles	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—
Nicaragua	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Panama	—	—	—	—	—	—	—	—	—	—	8[b]	—	—	—	—	—	—
Paraguay	1,451	175	135	282	797	770	207	57	132	103	21	—	35	—	—	—	—
Peru	7,105	6,305	3,753	1,218	1,360	172	115	—	—	—	—	—	—	—	—	865	454
Trinidad and Tobago	13	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
United States of America	57	49	39	11	21	4	9[i]	2[i]	—	1[i]	—	—	—	—	—	—	—
Uruguay	—	9	3	—	16	7	1	45	42	2	—	—	19[j]	1[g]	10[j]	1[k]	3[k]
Venezuela	6,358	3,951	2,181	280	109	72	13	2[i]	4[c]	—	—	—	—	—	11	—	—
Total	30,034	17,910	21,318	9,221	9,301	8,930	11,979	8,348	6,389	6,220	4,343	4,763	5,158	8,175	7,858	7,126	2,996

* Revised figures according to latest reports from the Governments (for 1961-1963).

[a] Latest figures received.
[b] Up to 30 June 1965.
[c] Includes 1 imported case.
[d] Includes ten imported cases.
[e] State capitals only, 1948-1964.
[f] Information incomplete: covers 19 States and 1 territory.
[g] Imported case.
[h] Includes 4 imported cases.
[i] Clinical diagnosis only.
[j] Includes 2 imported cases.
[k] Imported.
— None.

has met with numerous obstacles. The Organization is providing the services of a health inspector who is cooperating with the national health authorities in the organization and operation of field activities. Political, economic, and administrative factors have considerably delayed the development of the campaign. In 1964, 535,049 persons were vaccinated, or 66.4 per cent of the original target figures of 739,200.

Brazil continued its smallpox eradication program under which it is proposed to vaccinate 64,000,000 persons in six years. During 1964 the vaccination of 8,016,713 persons brought the total number of those vaccinated since the start of the program to 15,901,304 (June 1962). The Brazilian health authorities understand the need to step up the campaign if eradication is to be achieved. At the present rate, it would take at least 10 years to vaccinate 64,000,000 persons. At that time, the population of the country would have increased 30 per cent and a great majority of the vaccinated population would have lost their immunity. Taking these facts into account, the national health authorities are at present engaged in revising their plans to intensify the campaigns, based on a more flexible administration and on the use of better means of transport and of modern equipment for vaccination. For this purpose, additional support in the form of personnel and equipment will be needed.

The Recife and Pôrto Alegre laboratories, as well as the Oswaldo Cruz Institute in Rio de Janeiro, to all of which the Organization supplied the equipment necessary to prepare freeze-dried vaccine, are producing good quality vaccine, and their joint production is sufficient to meet the present demands of the country.

Of the 2,996 cases reported in the Americas in 1964, the great majority (2,502, or 83.5 per cent) continued to occur in Brazil. There is no doubt that the incidence of the disease in that country is much larger than indicated by the number of cases reported, since reporting is incomplete and late. In 1964, only 10 states reported cases; no information was obtained from the rest of the country, although it is known that the disease is widespread both in the urban and rural populations.

Brazil is the key to the eradication of smallpox in the Americas and once the attack is effectively mounted there and coordinated with programs in the neighboring countries, it will be possible to eliminate the disease from the Americas. It is evident, however, that the resources of the country are insufficient for a task of such magnitude and external help will be necessary.

In Colombia, after a well-organized campaign had ended in 1961 and covered 93 per cent of the total population of the country, cases have been occurring: 16 in 1961; 41 in 1962; four in 1963; 21 in 1964; and 155 in 1965 (up to 16 August). At the beginning the cases were restricted to a few areas, but lately the occurrence has been widespread. According to the plans established by the campaign, the general health services of the country would be responsible, after the termination of the campaign, for maintaining a level of immunity of the population, through the annual immunization of 80 per cent of newborns and 20 per cent of the population. The objective could not be attained for various reasons and the population of newborns vaccinated every year is around 30 per cent while the proportion of the general population vaccinated is 10 per cent.

In view of the increasing number of cases reported, the Government is considering a new vaccination program which would cover at least 80 per cent of the population in three years. External assistance will be necessary for this purpose.

Peru, which eradicated the disease in 1954, experienced a resurgence in 1963, when 865 cases were reported. In 1964, 454 cases of smallpox were notified, most of them in the Department of Loreto, in the northeastern region of the country. In this area, the percentage of the population vaccinated against smallpox during the eradication campaign was low. The outbreak was limited to this area, and the disease did not spread to the rest of the country. The Government initiated a smallpox vaccination program which had succeeded in vaccinating 3,165,404 persons by September 1964. A surveillance service was established to investigate any suspected cases that might arise after the completion of the intensive vaccination program.

The objective of the smallpox vaccination program in Haiti, which began in July 1962, is to vaccinate 80 per cent of the population in a period of five years. Between that date and 15 October 1964, 847,109 persons were vaccinated; 293,441 of these vaccinations were made in the first nine months of 1964. Only 58 per cent of the target

figures for 1964 was attained. The program has been beset by financial and administrative difficulties.

The smallpox eradication campaign in Ecuador, which started in 1958, was completed in May 1964. During this period, 3,531,989 persons (85 per cent of the entire population) were vaccinated. No cases of smallpox were reported in 1964 or 1965 (up to the present). In 1960, 2,185 cases were notified, 496 in 1961, 204 in 1962, and 45 in 1963. It will be necessary to strengthen the measures to keep the immunity of the population at a high level, as well as to improve the machinery for vigilance and case notification, diagnosis, and epidemiological investigation of such new cases as may occur in the future.

Conclusions

Since the only reservoir is man and vaccination provides effective protection for a number of years, smallpox eradication in endemic areas is well within the scope of modern preventive medicine.

However, although the means for prevention of smallpox have been known since the end of the Eighteenth Century, the disease is still endemic in many countries of the Hemisphere. Properly organized and systematic campaigns to administer smallpox vaccine to the population are measures sufficient to achieve the eradication of the disease.

Failure to achieve it heretofore has been due to a variety of factors, the most important being the incomplete coverage of the population because of inadequate health services, lack of priority, and financial and administrative difficulties.

Expenditures for the completion of an eradication program, although considerable, are small compared with the cost in money and especially in terms of human lives and suffering caused by the continuous presence of the disease. The eradication of smallpox is of extreme importance to all countries, both to protect their own population and to safeguard other countries already free from the disease. It is therefore important to urge all countries where the disease is still present, to make all efforts necessary to surmount the financial and administrative difficulties that may have delayed the anti-smallpox activities and to assign to the smallpox eradication program the priority it deserves from the standpoint of national and international health.

It is clear that eradication of smallpox is a national responsibility and can only be achieved by national effort. However, it should also be emphasized that the eradication of smallpox is a matter of concern not only to the infected countries but to all countries, as those now free constantly run the risk of the introduction of the infection from endemic areas.

There is no doubt that substantially increased effort and support, both on the national and on the international scale, must be given to the smallpox eradication program if it is to achieve success within the foreseeable future.

Even if increased national resources are allocated to smallpox programs, the endemic countries will not be able to eradicate the disease without substantial help from the international organizations and from the countries which are no longer endemic.

The endemic countries could rapidly bring the disease under control and ultimately eliminate it, if they decided to take energetic action and received help from countries already free from the disease and provided they also enacted and adopted the necessary legislation and took budgetary action to comply with the international obligation all the Governments assumed when they approved the resolutions of the Governing Bodies of both the Pan American Health Organization and the World Health Organization.

Annex 6

STATUS OF NATIONAL HEALTH PLANNING [1]

Highlights of the Past Year

The general status of national health planning in the Americas is reported in subsequent sections of this document, but two events deserve special mention: the meeting of a Study Group on Health Planning in February, and the Technical Discussions held at the Eighteenth World Health Assembly in May 1965.

Study Group on Health Planning [2]

Under the auspices of the Pan American Sanitary Bureau, and in cooperation with the Government of Venezuela, a Study Group on Health Planning met in Puerto Azul, Venezuela, from 1 to 6 February 1965 to review recent experience in health planning in the countries of Latin America and to recommend measures which would help these countries attain the health planning objectives established in inter-American agreements. The Group included 14 senior health planners from seven countries of Latin America, six PASB planning specialists, a staff member of the Latin American Institute for Economic and Social Planning, and an observer from Johns Hopkins University.

In reviewing the present status of health planning in Latin America, the Group found that some countries had made considerable advances, while difficulties had arisen in other countries because of lack of adequate data, lack of personnel trained in planning at all levels, need for wider knowledge of the planning method such as developed by the Center for Development Studies (CENDES), Central University of Venezuela, and the Pan American Health Organization and for improvements in the method itself, deficient organization and administration of health services, insufficient exchange of experience and information, and a variety of other problems.

As regards the CENDES-PAHO planning method, the Group felt that difficulty in application was due in part to gaps or weaknesses in the method proper, and in part to a lack of scientific knowledge of the subject being planned. The Group considered it essential to establish a research program to remedy both kinds of deficiencies, and to establish a center to direct and promote such research with particular reference to field work being conducted in experimental areas of the different countries.

The Group felt that national health planning units should be basically advisory in nature and at the service of the authorities who define and decide on sectoral policy, and that such units should have representation in general national planning units. Health planning units required the full-time services of the highest level personnel, owing to the technical quality required for the exercise of their duties.

Finally, the Group recommended that basic training of higher-level planning personnel should include the theory and practice of health planning together with other related disciplines, that training of intermediate-level personnel should have the same general content but with less emphasis on theory and more on application, and that training of third-level personnel should be essentially operational and given on an in-service basis. This would be facilitated if the center proposed by the Group for the direction and promotion of research would also assume the duty of organizing and directing international courses and advising and cooperating in higher-level national courses, preferably in close cooperation with schools of public health.

[1] Document CD16/15 (7 July 1965).

[2] The conclusions of this meeting appear in the Appendix, pp. 386-390.

Technical Discussions at the Eighteenth World Health Assembly [3]

The Technical Discussions held at the Eighteenth World Health Assembly in Geneva, Switzerland (7-8 May 1965) were on the topic "Health Planning." PASB staff served on the Secretariat, members of delegations of the Governments of the Americas to the Assembly participated actively in the Discussions, and a number of PAHO publications and national health plans from various nations of the Americas formed part of the background documentation.

It was recommended that the World Health Organization institute or support research into the establishment of "norms" of provision for use in the planning of health services as well as training courses in health planning, and that it should provide guidelines in health planning with a view to facilitating planning operations in developing countries.

Table 1 indicates the growing activity in the Region of the Americas in the development of norms or standards for health activity, while Table 3 summarizes training activities. The PAHO publication for general distribution, *Health Planning: Problems of Concept and Method*,[4] represents the first step in the provision of guidelines. Work in all three of the areas included in the recommendation to WHO is proceeding steadily in the Americas.

General Status of National Health Planning

The general status of national health planning in mid-1965 is shown in Table 1. Of the 22 Governments reporting, 16 had national planning units in operation and even in countries where there was no officially-designated planning unit for the health sector (e.g., Ecuador), a plan for health had been drawn up in collaboration between the national health authorities and the global economic and social planning unit.

A total of 10 Governments had completed the diagnosis stage of the planning process, while 11 had completed at least a short-term national health plan. The discrepancy between these figures arises

[3] The Report of the Technical Discussions appears in WHO mimeographed Document A18/Technical Discussions/6, Rev. 1 (12 May 1965).

[4] *Scientific Publication PAHO* 111, Washington, D. C., 1965. 84 pp.

Table 1—*Status of National Health Planning in the Americas, Mid-1965*

Country	Health planning unit in operation	Diagnosis completed	Plan completed	Program budget formulated	Norms established	Plan being implemented
Argentina	X	—[a]	—	—	—	—
Bolivia	X	...	X[b]	X	...	...
Brazil	X	—	—	—	...	—
Chile	X	X	X	X	X	X
Colombia	X	X	X[c]	X	X	X
Costa Rica	X	X	X[d]	X	—	—[d]
Cuba	X	X[c]	X[c]	X	...	X[c]
Dominican Republic	—	—	—	—	—	—
Ecuador	—	X	X	X	X	—
El Salvador	X	X	X	X	X	X
Guatemala	X	—[a]	—	X	—	—
Haiti	—	—	—	—	—	—
Honduras	X	X	X[f]	—[a]	X	—[a]
Jamaica	—	—	—	...	...	—
Mexico	—[g]	—	—	—	—[a]	—
Nicaragua	X	X	X	X	—[a]	X
Panama	X	X	X	X[h]	X[h]	X
Paraguay	X	X	X[b]	X	—[a]	X
Peru	X	X	X[f]	X	X	X
Trinidad and Tobago	X	—	—	...	...	—
Uruguay	—	—[a]	—	—	—	—
Venezuela	X	—[a]	—	—	—	—

[a] In preparation.
[b] Two-year plan.
[c] Four-year plan; new plan in preparation.
[d] Four-year investment plan; currently being revised.
[e] One-year plan for 1966. Diagnosis to 1970 in preparation.
[f] Five-year plan.
[g] Planning Unit being organized.
[h] For some programs only.
... No information available.

from the fact that some of the earlier plans were based on readily available data and did not include the type of formal diagnosis that has been adopted more recently. While the initial aims of the Alliance for Progress had been framed in terms of a ten-year health program, it will be observed that a number of countries concentrated their planning on a shorter period, most commonly four or five years.

The adoption of the program budget technique has been considered an important step in the planning process, both as a planning tool in itself and as a means of presenting planned activity in a coherent and orderly manner to the national financial authorities and the sources of external financial aid. It will be noted that 12 Governments, including one whose plan had not yet been completed, had formulated program budgets.

Information on norms was compiled because the setting of standards for planned activity is increasingly being recognized as an indispensable step in deciding on the instruments to be used in carrying out a health plan and in the subsequent evaluation of performance. This was reflected in the Technical Discussions at the World Health Assembly cited above. Norms had already been established in six countries, while in four others they were being studied or had been established for at least some activities. In the Americas, the adoption of norms covered, in addition to the amounts of service to be provided, detailed standards for the output of the various instruments.

Finally, it will be noted that in eight countries the health plans had already reached the phase of implementation, and that the administrative and operational problems arising during the carrying out of the health plans will call for far more attention in the future from public health administrators in general, and from planning officials in particular.

Health Plans and General Plans for Economic and Social Development

The percentage of central government expenditure devoted to public health, as shown in Table 2, remained by and large unchanged from the previous year. The change in rank of a few countries from the positions shown in 1964 in Document CD15/4 [5] relates principally to borderline cases which rose or fell by a few percentage points. The relative stability of the percentage of government funds devoted to health does not indicate stagnation, however, since in many countries government budgets as a whole were rising, and the relative share for health remained unchanged simply because health shared the general increase in government activity in a wide range of economic and social sectors.

Table 2—*Distribution of Countries by Percentage of Central Government Expenditure on Public Health, 1963-1964*

Countries devoting 10 per cent or more of central government expenditure to public health:
El Salvador
Haiti
Panama
Venezuela
Countries devoting at least 5 but less than 10 per cent of central government expenditure to public health:
Chile
Colombia
Cuba
Dominican Republic
Ecuador
Guatemala
Honduras
Mexico
Peru
Uruguay
Countries devoting less than 5 per cent of central government expenditure to public health:
Argentina
Bolivia
Brazil
Costa Rica
Nicaragua
Paraguay

Source: Computed by PAHO and based principally on data taken from the 1963 and 1964 *Annual Reports* of the Social Progress Trust Fund, Inter-American Development Bank.

No attempt has been made this year to rank the countries by dollars spent per capita for health in the public sector. Considerable doubt has been cast on dollar comparisons because of the influence of changes in exchange rates, and the estimates of the relative purchasing power of national currencies made by the United Nations Economic Commission for Latin America are based on the prices of the basket of goods and services that enter into economic life and cannot therefore be applied to the rather special group of goods and services purchased by the health sector.

[5] *Official Document PAHO* **60**, 300-304.

It had been hoped to initiate a direct inquiry in 1965 so as to make inter-country comparisons of health expenditures, but in order to avoid duplication of effort it was decided to rely on the information that is to be collected as part of the studies on hospital construction and on health expenditures by ministries of health and social security institutions.[6]

As regards the integration of health plans with national plans for economic and social development, this has been greatly advanced through the mechanism of annual country reviews by the Inter-American Committee on the Alliance for Progress (CIAP). The first CIAP reviews of national investment plans for the public sector, held in 1964, were mainly concerned with balance of payment problems and the principal economic aggregates such as consumption, investment, imports, and exports. The 1965 country reviews, scheduled from July through October, however, will give separate consideration to the health sector; in the case of selected countries they will involve exhaustive reviews of major health projects requiring external financial assistance or having direct impact on other investment programs. The Pan American Sanitary Bureau is participating actively in the preparation of material for the CIAP secretariat.

While in the preparation of documentation for the CIAP by national economic and social planning agencies increasing attention has been given to the role and requirements of the health sector, two main gaps should be noted.

First, the CIAP reviews are mainly concerned with investment programs. Investment in the field of health relates largely to the construction of hospitals and other permanent facilities, and even the scanty information now available for Latin America shows that, by and large, current operating expenses (with wages and salaries the principal component) are quantitatively more important than capital (investment) expenditure. Many preventive activities and "penetration" programs, in particular, have small investment components. In addition, one of the important effects of the systematic planning of health services has been to concentrate effort on the improved utilization of existing facilities. When the effective number of available hospital beds is increased by shortening the average stay in the hospital, for example, this positive advance may involve no increase in hospital construction, or may even reduce the amount of planned new construction, so that it would not be apparent in the statistics presented to the CIAP.

Second, because the private practice of medicine is subject to very few restrictive controls and very little government intervention in most of the Americas, data for this important area of activity have thus far been lacking. While there is little likelihood of obtaining comprehensive information for the private sector in the near future, it is hoped that the PAHO studies on the relationship between social security medical programs and those of ministries of health or other official health agencies will result in substantially improved information on health expenditures in the public sector.

Training

The international Spanish-language health planning course which has been given annually in Santiago, Chile, since 1962 in collaboration between PAHO and the Latin American Institute for Economic and Social Planning has been by far the most important influence on the development of health planning in the Hemisphere.

By December 1964, 73 senior national health officials as well as numerous PASB staff members had received training in international courses. The record of utilization of planners is exceptionally favorable. Attrition has been exceptionally low—one planner died, one became governor of a state, one national planner joined the PASB, and one Bureau staff member reentered national service, and the remainder of the Santiago graduates are actively engaged in health planning as members of sectoral health planning units, as high-level officials in other health services, as professors of public health or preventive medicine and as PASB consultants in health planning or in the general field of public health services. Details are given in Table 3.

While the subject matter and approach of the Santiago course have remained basically unchanged, major innovations in 1964 were the increasing emphasis on the administrative problems of carrying out health plans and on the program

[6] See *Administration of Medical Care Services—New Elements for the Formulation of a Continental Policy. Scientific Publication PAHO* **129**, 1966.

Table 3—*Training and Utilization of Health Planners in the Americas, Mid-1965*

Country	International training courses			National training courses		
	No. trained	No. engaged in health planning	No. engaged in other health activities	No. trained in major courses[a]	No. trained in short courses	
					Professionals	Auxiliaries
Argentina	5	2	3	—	—	—
Bolivia	4	...	...	...	...	...
Brazil	9	...	...	[b]	—	—
Chile	6	5	1	3	30	20
Colombia	5	2	3	—	19	—
Costa Rica	2	1	1	—	20	—
Cuba	1	1	0	...	...	...
Dominican Republic	2	...	...	—	—	—
Ecuador	2	1	1	—	—	—
El Salvador	5	1	4	—	12	73
Guatemala	2	2	—	—	18	84
Haiti	—	—	—	—	—	—
Honduras	3	2	1	—	—	20
Jamaica	1	—	1	—	—	—
Mexico	3	—	3	—	60	10
Nicaragua	2	1	1	—	10	30
Panama	3	1	2	—	6	6
Paraguay	3	2	1	—	—	—
Peru	5	5	—	132	—	18
Trinidad and Tobago	—	—	—	[b]	—	—
Uruguay	3	1	1	40	60	100
Venezuela	7	2	4	78	—	—
Total	73	29	27	253	235	361

[a] Major courses are considered to be those involving a minimum of six weeks of attendance.
[b] Course held July-August 1965.
... No information available.

budget in particular, and the use of recent experience in Colombia and Peru as a guide to the use of stratified sampling in the preparation of health plans for large countries.

PASB staff continued to participate in the international English-language training course which has been given annually since 1963 at the Johns Hopkins University School of Hygiene and Public Health, with the financial support of the Agency for International Development (AID), of the United States of America. This course also serves as a bridge between the Americas and the rest of the world because significant numbers of AID and WHO staff participate, together with health officials from many countries, and an exhaustive analysis of Latin American health planning forms part of the curriculum.

Heavy emphasis continued to be given to national training courses, and by June 1965, 253 officials had been trained in courses of at least six weeks duration, while 235 professionals and 361 auxiliary personnel had been trained in short courses. PASB staff engaged in the third international course in Santiago also participated in a special course for training Chilean national personnel which was held simultaneously in the last quarter of 1964, and arrangements were completed for courses to be held in Trinidad, and in Brazil (for health officials of the northeast States), in July-August 1965. PAHO also collaborated in a national training course held in Venezuela in 1964. In addition, PAHO Zone and project staff in a number of countries participated in the organization and presentation of short courses, round-tables, and lectures on health planning.

ANNEX 6

Appendix

FINAL REPORT OF THE STUDY GROUP ON HEALTH PLANNING—CONCLUSIONS [1]

Item I: Present Status of Health Planning in Latin America

1. To analyze the present status of health planning in Latin America, the Study Group considered it necessary to define what, in its opinion, were the health planning process and national health plans.

Health planning is a continuous process which begins when steps are taken to plan health activities within the economic and social development plan through the creation of a specific organization. The process thus acquires a dynamic character and generates its own improvement.

A national health plan, as an integral part of a general development plan, should define the existing health problems and include every activity aimed at their solution under the responsibility of the agencies comprising the health sector. The plan should be the result of a complete diagnosis of the health situation, which makes it possible to formulate a basic policy for establishing the targets to be met within the time periods set forth in the general development plan.

In terms of the above definition it may be said that effective progress has been made in Latin America in the past three years, even though the degree of development of the process differs among the countries. Most countries have already taken initial steps; they have trained personnel and have entered the stage of plan formulation, but only one country has a composite health plan which is being implemented.

In general, the advances made are creating factors which help to promote and consolidate the process itself, and it is the opinion of the Study Group that the outlook for the immediate future is optimistic.

2. The Study Group considered that the different stages of development in health planning in the countries are due to various factors, some of which are favorable, while others present difficulties that need to be analyzed.

Generally speaking, some of these difficulties are inherent in the requirements of the method, while others arise from general administrative and political factors.

2.1. *Lack of adequate data.* The Group recognized that the lack of adequate data was due in large part to the underdevelopment of the Latin American countries. At the same time it felt that the planning process was basic to improving the production and use of statistical data. National health plans should therefore include programs to improve the statistics involving personnel training and the provision of supplies and equipment, as well as suitable coordination with other data-producing agencies.

Although the lack of adequate data is a serious problem, it was considered that it should not be viewed as an obstacle to initiating the health planning process.

The Group considered that advantage should be taken of the techniques of sampling and special surveys to supply missing basic data or to complement existing data to the degree necessary.

2.2. *Lack of personnel trained in planning.* It was recognized that the shortage of trained personnel affects not only planning but the entire field of health. This fact is directly responsible for the slowness in initiating and developing the planning process. The situation is further aggravated by the fact that, although training has begun in most countries, the selection and utilization of personnel has not been entirely suitable, and this is due partly to the fact that trained personnel are not being placed where they can utilize the knowledge acquired, and partly that such personnel fall victim to political and administrative instability.

The Study Group considered it evident that such a situation can only be overcome through intensive training in planning at all levels, including not only the personnel directly involved in plan preparation but all other officials of the services with executive duties.

2.3. *Lack of a suitable method.* One of the obstacles to initiating the planning process in the Latin American countries was the lack of method for planning for health within the framework of economic and social development planning. Because of this, there was no conceptually appropriate unit for evaluating problems within the health sector and intersectoral relations.

The method developed by the Center for Development Studies (CENDES) and the Pan American Health Organization solved many of these difficulties, but in spite of this it is not fully accepted because it is not universally known or fully understood. The improvement of this method and its dissemination will be an important step toward eliminating some of the obstacles encountered in initiating the planning process.

2.4. *Defaults in the existing administrative structure.* Undoubtedly, the present structure of health services in some countries is not suited to the planning process because of their heterogeneity, multiplicity, and deficient organization and administration. A central mechanism and the necessary legal provisions to promote and develop the general and the sectoral planning process have been lacking.

Experience in some countries has shown that planning provides motivation for making changes, substantial ones at times, in the administrative organization of the sector. Nevertheless, radical changes in administrative structure should not be made a precondition for initiating the planning process. Such changes should be gradual and take into account the institutional rigidity of the coun-

[1] Document PS18 (6 February 1965).

tries. If they are gradual, they will avoid a resistance which could be detrimental to the process, and will facilitate making adjustments on the basis of the results obtained by the plan.

2.5. *Insufficient exchange of experience and information.* The Study Group considered that the lack of sufficient exchange of experience and information among those who work in health planning has been one of the difficulties which have limited the rapid spread of the planning process in Latin America.

2.6. *Political problems.* Notwithstanding the interest in planning expressed by the Governments, especially in international agreements, in practice not all of them have given due support to the initiation and development of the process. Several factors have been responsible for this, among them the lack of knowledge about the advantages of planning, the erroneous assumption that planning is simply a means for requesting external financial assistance, the fear of loss of political power, and others.

Among other things, the Group considered it necessary to establish closer ties with government authorities so as to show them the political and social value of the plan and of the concrete actions derived from the process which, in addition, enhance the planner's activities.

Much of the resistance is due to the unwitting tendency of the planner to adopt positions that exceed his advisory functions. The planning process should be considered as an instrument for improving decision-making, and in no way a substitute for administrative and political mechanisms.

Item II: Method of Health Planning Developed by CENDES and PAHO—Results of its Application

1. The Study Group considered that a review of experience in the application of the CENDES-PAHO health planning method first called for a definition of its bases and of the methodological requirements which inspired it, as follows:

1.1 Measurement of the health level in an area, region, or country in quantifiable terms.

1.2 Establishment and quantification of the relationship between the health level and the physical, economic, and social environment. This in turn requires the following:

(a) An expression of the health level in terms of its component elements.

(b) An identification of the factors which give rise to each of the hazards to health.

(c) The establishment of coefficients of relationship between these hazards and the conditions which create them.

(d) The establishment of the relationship between the health level and the economic and social context of the area, region, or country through the relationship between the economic and social context and the factors which affect the health level.

(e) The definition of the minimum geographical unit for programming purposes, so that the knowledge of the relationship between the health level and the environmental conditions which affect it may be as realistic as possible and avoid the abstraction implicit in the use of country-wide averages.

1.3 Establishment of the amount of resources used, and analysis of the health policy followed in their utilization. This process includes:

(a) Determination of the total amount of resources in use, their distribution among techniques and activities, their cost, and the way in which they are utilized, that is, composition, concentration, coverage, degree of utilization, output, etc.

(b) Establishment of the amount of resources allocated to combat each hazard which affects the level of health.

(c) Establishment of the efficiency of the health policy, by measuring the effects produced on each health hazard through the use of the resources, expressed in terms of cost/effect.

1.4 Formulation of a basic health policy which leads to the establishment of the plan targets. This requires the following:

(a) A prognosis of the health level based on anticipated changes in its conditioning factors and on the effect of the general development plan.

(b) The establishment of a normative model, and evaluation of the present health policy, by comparison with the model in order to see how far it meets the standard of the model and how much it needs to be changed.

(c) The establishment of the most effective techniques for combating each health hazard.

(d) The establishment of priorities for each health hazard according to its magnitude, susceptibility to attack, social importance, and cost.

1.5 Establishment of plan targets, considering possible alternatives, the length of time required to achieve them, and their importance from the viewpoint of the relation between the health plan and the development plan.

2. The CENDES-PAHO method cannot at present be judged by the results obtained because of the short period of its application. Nevertheless, the Study Group considered that conceptually it meets the methodological requirements for health planning within the framework of development planning and that it should therefore be judged in terms of the ease or difficulty of its application. It was stated that most difficulties arose from the limited scientific knowledge of the subject being planned, and that a basic knowledge of the subject is essential for any planning process. This limitation therefore cannot be imputed to any defects in the method as such.

Comparing the difficulties of applying the CENDES-PAHO method with the methodological requirements listed earlier, the Study Group considered the following:

2.1 That the method expresses the health level in terms of mortality and of the amount and structure of the demand for medical care. This measurement, the only one available at present, does not take into account

such aspects as morbid conditions which do not come to the attention of the medical services or the after-effects of disabling or debilitating diseases. Experience shows that, despite these limitations, the indicators used at present provide a sufficient approximation for planning purposes.

2.2 That the method clearly shows the need to establish the relationships between the health level and the physical, social, and economic environment. The fact that these relationships have not as yet been expressed quantitatively is due in the first instance to the lack of scientific knowledge previously indicated. The method nevertheless fulfills the purpose of making explicit the need to express these relationships numerically and also makes it clear in what areas such a quantitative expression should be made.

2.3 The knowledge and measurement of the resources used for health has thus far presented the least difficulty and one of the major contributions of the method is that it provides a highly satisfactory analysis of the use of resources. The difficulties are confined to the lack, or lack of clarity, of the required data. It should be noted, however, that there are still some points which require additional study and refinement.

2.4 There are difficulties in making the prognosis, since this has to take into account the factors which affect the health level and their changes. The difficulty of weighing such factors, and the absence of a development plan which would make it possible to visualize future variations in the environment, greatly reduces the precision of the forecast.

2.5 That the establishment of a normative model has presented serious obstacles owing to the lack of technical standards and the difficulty of setting them.

2.6 That operational difficulties exist for establishing priorities for health hazards, especially hazards which cause no mortality but endanger health, and that it is therefore necessary to establish criteria aimed at overcoming this deficiency.

2.7 That in addition to methodological criteria, the Study Group considered it necessary to propose other criteria which make it possible to delineate the health sector so as to avoid the exclusion of health activities and the inclusion of activities relating to other sectors. It was further noted that the problem of the quality of the services presented operational difficulties.

In conclusion, from the experience gained in Latin America it is clear that the CENDES-PAHO method is contributing new conceptual and operational elements for defining the relationships between health and the economic and social context and for the attempt to articulate health plans with development plans, and that the method is applicable to the formulation of health plans integrated into social and economic development.

3. The difficulty in applying the methodology is due mainly to a lack of scientific knowledge of the subject being planned, and the other difficulties can be attributed to gaps or weaknesses in the method itself. In both cases, the Study Group considered it essential to establish a research program so as gradually to remedy both kinds of deficiencies. It was therefore considered necessary that a center be established to direct and promote such research, and that this center be linked to the field work being conducted in the countries, especially in experimental areas.

The Study Group further considered that the use of the method helps to improve the coverage and quality of statistical information and that this improvement is an important factor in improving the application of the method and in executing and evaluating plans. The data must be related to the requirements of the method and of the plans.

Finally, special emphasis was placed on the international exchange of communications on the experience gained in applying the method as a priceless aid for solving operational problems.

Item III: Organization and Administration for Health Planning

1. The Study Group considered that the process of economic and social development planning, and within this the process of health planning, requires the institutionalization of certain administrative mechanisms by means of which the continuity and permanence of the process can be assured, and that Health Sector Planning Units are the answer to this need.

2. The Study Group considered it necessary to study those factors which either facilitated or impeded the establishment and operation of Health Sector Planning Units in the countries of Latin America. Among the favorable factors the following were pointed out:

2.1 The positive attitude of some Governments in the Hemisphere toward the need for planning.

2.2 The existence in some countries of national development planning systems.

2.3 The inter-American agreements adopted in recent years to meet the need for institutionalizing the planning process, and the pertinent recommendations of the technical agencies involved.

2.4 The national awareness in some countries of the need for planning as a means for overcoming underdevelopment.

On the other hand, one of the factors which had delayed the establishment of planning units is the natural resistance to change, which gives rise to mistrust of the planning process, and to fear of possible loss of position and freedom of action, as well as of limitations in the use of resources.

3. A Health Sector Planning Unit should be an administrative entity that is basically advisory and at the service of the authorities who define and decide on sectoral policy. To fill its advisory role, the duties of the Unit may be grouped according to its participation in the formulation of long-range and intermediate plans, the formulation of the program aspects of functional budgets, and the evaluation of planned activities, all of which are stages of the planning process.

4. The fact that various organizations exist which carry out health activities makes it necessary to develop an effective system of functional coordination designed toward the creation of programming subunits in each of these agencies. These should maintain a close functional relationship with the Health Sector Planning Unit.

Moreover, since health planning needs to be integrated into general development planning, the Sector Planning Unit should be represented in the general National Planning Unit. An effective operational coordination among these units will ensure a satisfactory articulation of health plans with general development plans.

5. Because of its duties and responsibilities, the Health Sector Planning Unit should be placed at the level of the highest authority, which defines and decides on sector policy.

6. To better fulfill its functions, the Health Sector Planning Unit should utilize the technical and administrative resources established within the sector organization by means of coordinating mechanisms and the establishment of committees and commissions for given functions or tasks.

7. The structure of the Health Sector Planning Unit will be conditioned by the magnitude of the institutional administrative apparatus for executive health activities and by the availability of suitable human resources. Its structure, however, should rest basically on the duties it must fulfill and on the stages of the planning process, which will require a certain minimum of internal differentiation.

8. The Health Sector Planning Unit should have the highest level staff owing to the technical quality required for the exercise of its duties. Professional health personnel should possess the following: specialization and experience in public health, training in health planning techniques, and a knowledge of general planning. The incorporation of specialists in the techniques of other disciplines is recommended to facilitate and refine the planning process, and it is also of importance that planning staff be engaged on a full-time basis.

Staff for the Health Sector Planning Unit should be selected in accordance with these conditions, and above all on the basis of their technical and personal qualifications and not on the basis of representing all the different professions and specialties in the field of health.

Item IV: Education and Training of Health Planning Personnel

1. The Study Group considered that the planning process in the Latin American countries will require a sustained effort in personnel training in order to make available the minimum number of personnel to initiate and later carry on the tasks which the process involves. It was considered, however, that personnel involved in programming activity at the local and regional levels should not be added to existing health services, but rather that service personnel should adapt themselves to the new ways of health planning. For this purpose, all the staff should, if possible, receive the training indicated by their responsibilities.

2. The Group considered further that the following three distinct levels of personnel would be engaged in the planning process, as follows:

2.1 A higher level composed of persons specifically assigned to planning, with the highest responsibility for advisory and normative aspects. This level also includes planners engaged in teaching and research.

2.2 A second level composed of persons who, although not engaged full-time in planning, participate in the planning process because of their administrative responsibilities.

2.3 A third level composed of auxiliary or operating personnel who are required for such supporting tasks as data collection, primary analysis, etc.

Training for the three levels of personnel should have the following characteristics:

2.4 The basic training of higher-level personnel should include the theory of planning and the practical application of the method together with other related disciplines, in order to provide the basis for an over-all understanding of the problem.

2.5 The basic training of intermediate level personnel should have the same general content as that of the higher level, but with less emphasis on theory and more emphasis on application. The course thus would be aimed mainly at teaching the method of health planning with the principles of general planning introduced only as a frame of reference for sectoral planning.

2.6 Training of third-level personnel should be elementary, and essentially operational in the specific aspects of the duties persons in this group will be called on to perform and may be given as part of in-service training.

Depending on the administrative structure of the countries, they themselves should define the level of training to be given to officials with different levels of responsibility in the planning process. Thus, for example, training at the higher level should be given to the staff of the Health Sector Planning Unit and to those chiefs of central or regional health services who will have an advisory and decision-making rate in plan formulation and execution.

It was considered advisable to emphasize the fact that in all training courses, the health planning method cannot be taught in a purely theoretical way and must be supplemented by practical training.

3. In view of the importance of the international courses given by the Pan American Health Organization and the Latin American Institute for Economic and Social Planning for promoting the health planning process in Latin America, the Study Group considered the need to institutionalize this effort. To this end it considered that the recommendations contained in point 3 of Item II should be expanded to the effect that the agency which was proposed to direct and promote research in health planning should also assume the duty of organizing and

directing the international courses, and advising and cooperating in higher-level national training courses, preferably in close cooperation with the schools of public health.

4. There is no doubt that the introduction of planning concepts and their application in the health services will have deep repercussions on the traditional programs of schools of public health, as these will have to incorporate the teaching of health-planning method into their curricula on a permanent basis. Moreover, the schools of public health should urgently face the need for giving training in planning to those of their graduates who are holding or will be holding executive positions in health administration.

5. To facilitate a better understanding of the concepts of planning by professional personnel who will have to participate in some way in the planning process, the Study Group considered it necessary to recommend that schools of medicine and of other disciplines related to health attach importance and give appropriate orientation to the teaching of such basic sciences as epidemiology and statistics, whose content helps to develop the planning mentality.

It was considered indispensable that the teaching of preventive medicine in medical schools include a general appreciation of the problems arising from health planning which are directly related to the future duties of the students as professional staff in health services.

Annex 7

RESEARCH POLICY AND PROGRAM OF THE PAN AMERICAN HEALTH ORGANIZATION [1]

Chapter V of the Director's Annual Report for 1964 [2] presents a general review of the substantial progress made in research activities of the Organization during that year, and gives an account of a number of important studies which are coming to fruition in 1965. As in previous years, great indebtedness is acknowledged to the PAHO Advisory Committee on Medical Research (ACMR). The Committee continues its dedicated interest in the Organization's research program, as reflected in its helpful responses to questions regarding specific research projects and the program as a whole, its balance as to major emphases, and its priorities.

Some indication of the program's scope and nature, as well as of its financial commitments, is shown in the document "Current PAHO Collaborative Research Program," [3] which was prepared for the Fourth Meeting of the ACMR held from 14-18 June 1965. In it, it is noted that 55 projects are active in 1965, representing an investment of $2,769,213 and contributed by 22 voluntary and governmental agencies. The total amount requested to complete these projects in future years totals $7,915,005. The grant requests currently under consideration total nine and are in the amount of $1,146,249.

These figures, however, do not reflect the situation as a whole, for with the approval of the Directing Council in successive meetings since 1962, gradually increasing amounts have been allocated in the PAHO regular budget for research and training purposes at the Pan American Foot-and-Mouth Disease Center, the Pan American Zoonoses Center, and the Institute of Nutrition of Central America and Panama.

The general effectiveness and efficiency of the program, as planned and coordinated by PASB staff, is indicated by the fact that while the research program continues to expand, the budget figures for the Office of Research Coordination remain at about the same level as when it was organized in 1962 (under a grant from the National Institutes of Health amounting to $200,000) and was incorporated into the regular budget in 1964. Rather than increasing the number of permanent technical expert personnel, the policy is to appoint short-term consultants, as needed, to explore research resources and potentialities in specific subject matter fields of priority value to PAHO's activities in relation to its research program and responsibilities. More than 200 such appointments of leading bioscientists, including experts in public health research, have responded with enthusiasm to these assignments and have made definite contributions. The quality of the program, as well as its scope and balance, reflect the value of their reports and recommendations.

PAHO has attempted to marshall and draw upon the experience and creative ideas of the best talent available in order to support and stimulate the advisory and service program of the Organization in research. This provides the professional expertise needed to move forward vigorously to work with the Governments in carrying on research required to solve their health care problems, including the creation and strengthening of regional and national institutional resources for research and for the training of scientific, teaching, and research manpower, in an attempt toward regional self-sufficiency.

In reviewing the Director's Annual Report for 1964 it will be noticed that, departing from previous formats, Chapter V on "Research" consolidates the entire PAHO research program.

One of the most important studies the Organization has ever undertaken is now in its fourth year

[1] Document CD16/20 (11 August 1965).
[2] *Official Document PAHO* **63**, 97-104.
[3] Mimeographed document.

and will be concluded in 1966. This is the Inter-American Investigation of Mortality; the results so far obtained are described in the Report.[4] The preliminary findings indicate significant and unexplained differences in death rates by some diseases in the cities studied that is, tuberculosis, cancer by organ systems, cirrhosis of the liver, arteriosclerotic and degenerative heart diseases (including Chagas' disease), among others. Investigations are already being established locally to determine the reasons for the differing rates.

The high incidence of deaths from Chagas' disease in Riberão Prêto, Brazil, for example, stimulated an intensive study by two consulting pathologists, of the pathogenesis of this condition as it affects the heart and autonomic nervous system. Their report and the recommendations of the Advisory Committee on this matter reserve careful study, for major advances in knowledge of this disease, as well as preventive and control implications, are set forth. Some controversial points among medical men about the pathogenesis of the disease are finally settled.

Finally, the Colombia pilot research study of health manpower and medical education is reported. The study is testing research methods for measuring health manpower and medical education requirements in relation to the health conditions, health care facilities, and socioeconomic development of a rapidly growing population. This study, carried out by the Ministry of Public Health and the Association of Medical Schools of Colombia, with the technical and financial support of the Milbank Memorial Fund and PAHO, is well advanced. After completion of the study in 1966, a Pan American seminar will be convened to review the findings and possible applicability of the methods used and of the findings to other countries of the Region.

Attention is also called to the section of the Director's Report[5] on environmental sanitation, which indicates substantial progress in activating the centers for training, research, and advisory services on environmental and industrial health, including water and air pollution. These centers, located in Chile, Venezuela, and Brazil, will become important regional resources for the training of sanitary engineers and research personnel who are in such short supply and who are required to meet the expanding requirements of the Region.

The tempo and pace of the present times, stimulated in part by the dynamics of science and technology, pose unusual problems for Governments and the societies they serve. Science today is involved in or at least touches on almost every policy question considered by Governments. In Latin America biomedical scientists are of great importance in the society, both in and out of Governments, yet few have adequate policies, structure, and financial support for biomedical research. Recognizing this, the ACMR called for a study of the problem at its Third Meeting (1964). The report[6] by Dr. Charles V. Kidd, Chairman of the PAHO Study Group on Biomedical Research Policy in Latin America was reviewed by the Advisory Committee on Medical Research at its Fourth Meeting. In its report to the Director,[7] the Advisory Committee stated that for historical reasons a scientific tradition has been slow to develop in Latin American countries. The basic need, therefore, is to foster a climate of opinion that understands the role of scientific research as part of the cultural life of the community. Research and teaching are inseparable and the universities are the natural centers for developing research traditions. In many cases, however, changes in the organization of the universities and in the scope of their curricula are needed before they can play their role effectively. The Advisory Committee stressed the importance of the part that can be played by scientific and academic organizations that already exist. There is need for strong bodies of this kind, and due care must be taken to avoid unnecessary overlapping and duplication.

The PAHO Advisory Committee on Medical Research called attention to the serious problem of the loss of scientific manpower by emigration to seek better working conditions elsewhere and recommended that PAHO make a detailed study of the extent of this "drain of scientists" from the developing countries of Latin America. Such a study is already in progress under the direction of Dr. Kidd.

[4] *Official Document PAHO* **63**, 101-102.
[5] *Ibid.*, pp. 36-37.
[6] Published subsequently with the title *Science Policy in Latin America. Scientific Publication PAHO* **119**, 1966.
[7] Mimeographed document RES 4/13 (30 June 1965).

Another closely related report [8] dealt with public health research in Argentina, a report that was requested by the Ministry of Social Welfare and Public Health. It contained specific recommendations approved by the Advisory Committee, calling for the development of a national policy on public health research in which the "Community is the laboratory," and desirable ways of organizing resources and research support mechanisms that would be responsive to national health policy requirements and Ministry decisions in a systematic, sustained manner, including the training of needed research manpower.

Most of the medical libraries of Latin America have not kept up with the pace of growth of scientific literature. As a result, teachers, research workers, and students in large areas are seriously handicapped in their studies and scientific investigations. This is a world-wide phenomenon. However, the National Library of Medicine of the U.S. Public Health Service provides bibliographic and literature services, upon request, to scientists throughout the world, Latin America being the biggest user. "Over half of the Library's interlibrary loans to foreign countries go to Latin America." [9] During the past year several reports of conferences, including a PASB consultant's report, were reviewed by the Advisory Committee. There is agreement that a Regional Medical Library for Latin America, to be serviced by and closely related to the National Library of Medicine (USPHS) should be established in South America, where existing library and other necessary services of modern communication technology are well developed.

Such a library would be based on local resources which would be expanded to augment the resources for teaching and research and training in medical schools, hospitals, and institutes elsewhere. The library would be expected to become an active continuing force "promoting and encouraging medical library development in the Americas through functioning as a demonstration and training center," and in "fostering cooperative library and bibliographic programs among its constituent groups" and by "utilizing modern photocopy and communications technology in improving such accessibility." [10]

The proposal of the consultants, strongly supported by the Advisory Committee is that the Regional Medical Library should be under the joint sponsorship of PAHO and the Pan American Federation of Associations of Medical Schools.

Detailed recommendations include, among others, the suggestion that "policy for the Regional Medical Library would be established by the Board of Governors appointed by PAHO, which would include representation from the Pan American Federation of Associations of Medical Schools, and the Governments of PAHO, as well as a member of the host institution, and its services would be available to all eligible users in Latin America." [11] The Director would be expected to have a technical advisory group of experts in contemporary library and communications science.

The proposed budget for non-recurring capital investment cost and for the first year of operations is $205,600, which would fall to $163,000 in the second and third years.

Such an undertaking is basic to a program of research and to improve the quality of health manpower training, and in the long run, the quality of health care programs of the Region. The matter of financing has not yet been considered by national or international bodies.

Significant conferences and program developments have taken place since the approval of Resolution XXXI [12] by the Directing Council at its XV Meeting. In that resolution the Council took note of the importance of population growth in relation to community and individual health in the context of socioeconomic development, urban and rural, and recommended a comprehensive program of research and research training in medical demography and human reproduction. Those developments were reviewed and endorsed by the ACMR.

The Eighteenth World Health Assembly (1965) adopted a resolution [13] on the health aspects of world population in which it requested the Director-General to develop further the program proposed:

(a) in the fields of reference services, studies on medical aspects of sterility and fertility control methods and health aspects of population dynamics; and

[8] Mimeographed document RES 4/5 (14 May 1965).
[9] Mimeographed document RES 4/12 (9 June 1965), p. i.
[10] *Ibid.*, p. 5.
[11] *Ibid.*, p. 6.
[12] *Official Document PAHO* **58**, 83-84.
[13] *Off. Rec. Wld Hlth Org.* **143**, 35.

(b) in the field of advisory services . . . on the understanding that such services are related, within the responsibilities of WHO, to technical advice on the health aspects of human reproduction and should not involve operational activities.

The PAHO and WHO programs are being developed concurrently. The PAHO program, it might be noted, stresses institutional resources development, manpower training, and community research studies under the following main headings:

1. Epidemiological study of mortality.
2. Operational research on methods of collecting data on births and deaths in areas of limited facilities.
3. Demographic research on pregnancy, natality, and mortality.
4. Medical demography faculty training centers.
5. The encouragement of research and teaching in the biology of human reproduction. It is a field in which much has yet to be learned about this complex process. Findings will surely emerge which have practical implications for preventive medicine and community and family health.

The Third Meeting of the PAHO Advisory Committee on Medical Research (1964) held a one-day special session on "Environmental Determinants of Community Well-Being."[14] Because of the growing interest in this subject, from the standpoint of the aggravation of the problems of modernization of cities by the rural-urban migration phenomenon and because of the low standard of living and lack of well-being of village people who do not migrate, the Fourth Meeting of the Advisory Committee took note of the report of the special session held the previous year and recommended:

(1) That a research consultant mission of PAHO travel to selected areas in Latin America for the purpose of analyzing and evaluating the environmental health potential of the institutions visited, giving special attention to the availability of existing facilities and to the research interests of the scientific staff.

(2) The report of the research consultants should provide a practical basis for developing specific projects which would be useful in exploring sources of research support to supplement local resources.

(3) That the Committee delineate several specific areas of research which would be most fruitful in supporting the current environmental health programs in Latin America. For practical reasons, emphasis might be given, for the time being, to the fields of urban and rural water supply, waste disposal, and air and water pollution.

This program is being implemented. This is an area of research which is obviously of enormous practical importance to the health and well-being of the people of the Region.

Growing out of the 1964 discussion on the Environmental Determinants of Community Well-Being, the Committee suggested that the special session during its Fourth Meeting be devoted to the subject of "Deprivation in Psychobiological Development," thus rounding out the consideration of both the bisocial and the biomedical aspects of some of the basic determinants of health and well-being.

At that special session seven consultant experts reported in some detail on various aspects of knowledge, and state-of-the-experimental-art of this complex field, dealing specifically with mechanisms and forces affecting psychobiological development. These included: Molecular-Cellular Aspects of Coding and Information Storage in the Nervous System, Current Concepts in the Neurophysiology of Learning, Studies in Animals and in Man on Nutritional Deprivation in Psychobiological Development, Psychosocial and Cultural Deprivation in Psychobiological Development, and, finally, Research Needs and Opportunities in Latin America for Studying Deprivation in Psychobiological Development. The proceedings of this special session have been published by the Organization.[15]

In a separate report, the Committee learned of the results of several study conferences in which experts from the Americas considered various means of developing research in protein malnutrition. Discussion focused on the possibility of establishing, through experimental studies under field conditions, a relationship between mental health and nutritional status. Future meetings will consider the problem of research design in this subject field. The Committee considered that, while many different factors, of which nutrition is only one, may affect mental development, concentration on the role of nutrition is justified on scientific grounds and because this is a factor which is susceptible to improvement.

In conclusion, it is felt that the research policy and program of the Pan American Health Organ-

[14] The proceedings of this session were published in *Scientific Publication PAHO* **123**, 1965.

[15] *Scientific Publication PAHO* **134**, 1966.

ization, as approved at successive meetings of the Governing Bodies, is developing according to plan, with increasing emphasis on the biosocial and biosanitary engineering fields, without neglecting biomedical studies in communicable diseases and problems of psychobiological determinants of human behavior.

For long-term development, measured in decades, it is to be noted that a substantial program proposal is being developed for regional centers for faculty teaching and research training. Also, increasing attention is being given to the problems of national policy and structure for the support of biomedical, biosocial, and biosanitary engineering studies and training. And, rounding out the policy proposal of supporting the development of institutional resources for teaching and research, is the recommendation for establishing a Regional Medical Library for bibliographic and reference purposes and for research and training in library and communication science.

Latin America is in the main stream of international medical science and technology, but its resources for self-sustained activity need strengthening. The ministries of health and the universities carry the main responsibility for marshalling local resources to take advantage of the international cooperative support which is available, and which PAHO endeavors, to help materialize in support of the health programs of Governments.

Annex 8

AIR AND WATER POLLUTION IN LATIN AMERICA [1]

Introduction

The Executive Committee, at its 51st Meeting in September 1964, called attention [2] to the growing problems of air and water pollution in Latin America and suggested that the Director review and report on this situation. In response to this action, the Director has the honor to submit this report, which discusses factors influencing problems of air and water pollution; reviews actions taken by the Organization in response to requests from the Governments; and outlines program activities the Directing Council may wish to consider in recommending a course of action the Organization should take to assist and support specific programs of Governments.

Developments Influencing Air and Water Pollution

Most Latin American countries have initiated significant programs to promote and accelerate industrial expansion which is a vital part of economic growth. This trend further stimulates the widespread rural-urban migration. Currently, 50 per cent of the population of Latin America lives in urban centers, whereas six years ago the urban population was only 40 per cent. This trend of population shift to cities will continue and is likely to increase. In most Latin American countries, 25 to 50 per cent of the total population resides in the few larger cities. Ten such cities already exceed 1,000,000 inhabitants, with Buenos Aires, Rio de Janeiro, São Paulo, and Mexico City above 4,000,000. Lima, Santiago, Bogotá, and Havana each have about 2,000,000 population, and Montevideo and Caracas are above 1,000,000. Most other cities are below 500,000, with the majority under 100,000. As expected, widespread problems of air and water pollution are more pronounced in the few major cities, with localized problems in the smaller urban areas. The principal industrial complexes are emerging in and around metropolitan centers. The population growth rate in Latin America is increasing (now 2.9 per cent per year), with urban growth more pronounced (now 5 to 7 per cent per year). With urban and industrial growth, air and water pollution will also spread.

Health-related problems of the environment are complicated not only by the fact of increasing population densities and industrial growth, but also by the technological changes taking place in the production and use of industrial products. Industrial processes and industrial products are changing so rapidly that the resulting impacts on health have not been adequately evaluated. In the past, the health problems of air and water pollution were related to microbiological contaminants. In the future, increasing attention must be given to microchemical pollutants, especially to synthetic organics. The great emphasis on rapid industrialization —and the urgency for such development—encourages Governments to minimize restrictions and obstacles to industrial progress. As a result, there are few regulatory controls to limit air and water pollution. There is little doubt that contamination of air and water resources will become more pronounced, with air pollution affecting wider land areas and water pollution affecting more and more miles of major waterways. Air and water pollution not only affects health and well-being of people but, if excessive, reduces land and water values and can limit industrial development.

[1] Document CD16/17 (12 July 1965).
[2] *Official Document PAHO* **60**, 242.

The Public Health Problem of Air and Water Pollution

Effective health-related programs and the devices for administering these programs must reflect emerging social, economic, and political forces. The task of statesmanship in public health is to recognize and anticipate these trends and to adapt to them the content of programs and the administrative structures and processes. Obviously, these adaptations must be based on sound technical judgments and on scientific appraisal of problems. For example, in the case of air and water pollution, the regulatory agencies must take into account the importance and urgency of industrial development and should not interfere with such progress through impractical regulatory controls. In other words, some deterioration of air and water resources must be accepted as the price of economic advancement. This is especially true in the early stages of industrialization. As the economy advances, this trend can be reversed. However, even in the early stages of development, the responsibility of health authorities for the health and well-being of people requires that contamination of air and water resources be kept within reasonable limits. To maintain this balance is not a simple task. The decisions are highly technical, and the economic implications are of major importance. For example, to reflect some order of magnitude, reasonable control of air and water pollution in the more critical situations in Latin America will cost about $400 million per year over the next 10 years. To this capital investment must be added the cost of operation and maintenance. These figures further emphasize the importance of a clear understanding of problems and needs and for sound technical judgment in determining the types and extent of wastes treatment works.

With respect to waste discharges from major industrial plants, appropriate consideration should be given to practical legal requirements for pollution control as part of industrial planning and urbanization. In general, it is more economical to provide for reasonable pollution control in the location and design (including production methods) of industrial establishments than to correct excessive pollution after the industry is in operation. Technical assistance funds for this purpose should be included in development loans and grants.

As a combined effect of metropolitan growth with high population densities and expansion of industrial production, problems of air and water pollution are becoming more pronounced. It is clearly predictable that the impacts on health created by these forces will become more acute before they are alleviated. Taken together, these and related influences constitute in fact a description of the manner in which man's changing environment will affect his physical and mental well-being. These influences are pervasive and important. Their full significance does not emerge until they are viewed as a whole—in terms of the full implications of a modern, technologically inspired economy upon the total health and well-being of humans. It is therefore prudent to anticipate the extension of health hazards and related effects arising as a by-product of air and water pollution and to develop the scientific intelligence needed to determine when and how to apply corrective actions and remedial measures. It is in this area of need that the resources of PAHO might now be applied to assist the Governments of the Organization.

Present and Future Plan of Action

Over the past two years, in response to requests from the Governments, the Organization has provided technical and consultant assistance to 14 countries on problems of air and water pollution. These include areas in Brazil, Uruguay, Argentina, Chile, Peru, Colombia, Venezuela, Mexico, and a number of Caribbean countries. This assistance involved a wide range of technical problems. For example, in Montevideo, acute beach pollution required a critical analysis of wastewater disposal, with cost data for alternate methods. In São Paulo and Buenos Aires, both air and water pollution were involved, including studies on control methods and the strengthening of organizational structures. In the Caribbean countries, there were a number of special industrial waste problems, and in four countries urban waste disposal was a factor. In Bogotá, assistance was given on operation of oxidation ponds; in Caracas, on metropolitan wastes; and in Lima on the effects of heavy industrial waste discharges to the metropolitan sewerage system. An increasing number of countries are requesting assistance on studies of sewer outfalls, either to the ocean or to estuaries. As indicated, PAHO assistance, rendered generally through specialized expert

consultants, has been on a particular air pollution problem created by an industrial complex or on a particular water pollution problem of specialized industrial wastes or metropolitan waste.

Urban and industrial development in Latin America is now reaching levels where problems of air and water pollution should be viewed and analyzed on a broader basis. In general, excessive air and water pollution do not result from a single source or even a few sources, but is a result of the composite pollution from concentrations of people and industry and the production and use of the products of industry. For example, water pollution should be appraised by major river basins in terms of the total contaminants discharged; water needs, uses, and values; and the ability of the stream to assimilate waste without serious deterioration. In like fashion, air pollution should be appraised on an area basis in terms of the total gaseous discharges and their composite effects and on the meteorological conditions of the area. As these examples imply, there is need for improved laboratory facilities and for more technical manpower to carry out at least minimum monitoring services in the more congested areas of Latin America.

As a move in this direction, the Organization is now developing, in collaboration with Governments, a network of air sampling stations, including a system of analysis of air samples. Initially, the network will include 10 key cities in Latin America, with the maintenance and collection of samples under the jurisdiction of the respective Governments and the analytical work on the samples carried out at a central point. Over the first few years, the analytical sampling will be limited to the more basic indicators of pollution. This surveillance network should provide valuable data on which to base such future control programs as might be considered essential or desirable by the Governments.

With respect to water pollution, the Organization proposes to broaden its assistance program in 1966. Activities will include a series of consultant missions to Latin America to appraise the status and trends of water pollution in segments of major river basins. To the extent of its resources, the Organization will attempt to meet the more urgent requests of Governments. The purpose of these appraisals will be to assist them in establishing the necessary surveillance on water pollution, with special attention to the more complex health-related problems.

For both air and water pollution, the Organization proposes to establish a practical system for the collection and dissemination of technical information as a means of keeping the Governments apprised of research studies and investigations carried on within the Region and in other parts of the world. The Organization will also encourage, sponsor, and assist procedures to have air and water pollution integrated into the education and training programs under way throughout the Americas. In organizing the regional research program in environmental sanitation, the Organization will give appropriate attention to problems of air and water pollution that need special study. The primary objective of air and water pollution activities will be to assist the Governments in the sound appraisal of the problems; and in determining the status and trends of such pollution. The assistance program will also include studies on the effects of air and water pollution on the health and well-being of people; on agriculture and other industrial developments; and on uses and values of waters and land areas. Special attention will be given to the development of practical, reasonable, and effective corrective actions or remedial measures.

Facing the fact of urban growth and industrial expansion, special emphasis is needed on methods of air and water pollution control. Problems of such pollution are well known, as are present control practices. However, effective treatment of such waste is quite expensive, often taxing the economic and operational capacity of an area or a country. Accordingly, there is need for research and investigation to provide simple methods of control that will be within the administrative and financial reach of areas affected. It is proposed to give increasing attention to this problem area.

Summary

In any area, the pattern of human diseases and infirmities reflect the response of man to his total environment. As in all industrialized areas, the physical environment in Latin America is undergoing rapid and profound change. Pertinent influences include population growth, rapid industrialization, increased urbanization, the speed of travel, the intermingling of people, and the advancing technological processes.

Increased air and water pollution and their effects on man's health and well-being are significant factors resulting from the rapid changes in the physical environment. Contamination of air and water resources is increasing not only in volume, but also in the complexity of contaminants. In the past, air and water pollution was considered largely in terms of microbiological contaminants. In the future, this vista must broaden to include air and water contaminants that have their source in microchemical substances.

Recognizing the significance of industrialization to economic progress, unduly restrictive regulatory controls should be avoided, with due consideration to the capacity of air and water resources to assimilate, within limits, reasonable amounts of polluting wastes. At the same time, the health and well-being of people require that contamination of air and water be kept within safe and reasonable limits. The immediate need, therefore, is to develop effective monitoring services and the scientific intelligence required to determine when and how to apply corrective actions and remedial measures. Where pollution controls are required, the procedures applied should be kept within the administrative and financial capacity of the Governments concerned.

The resources of PAHO are used, in response to requests from Governments, to provide technical and consultant assistance on air and water pollution problems in specific areas. This assistance will continue and will be increased. In addition, the Organization is developing an air surveillance network of sampling stations in 10 major cities in Latin America. As requested and required, this network will be extended. On water pollution, the Organization proposes to broaden its assistance program, including consultant missions, to appraise the status and trends of water pollution over wide segments of major rivers and estuary areas. Both air and water pollution will be given appropriate consideration in the Organization's assistance programs for education, training, and research.

Annex 9

EPILEPSY IN THE AMERICAS [1]

The Directing Council at its XV Meeting approved a resolution [2] in which it requested the Director to study the incidence and distribution of epilepsy in the Americas, and the legal and other types of discrimination to which sufferers from this condition are subject and which impede programs directed toward the solution of the problem of epilepsy.

The Mental Health Section (Health Promotion Branch, Pan American Sanitary Bureau), organized a meeting of a study group which dealt with the epidemiology of mental disorders in Latin America. The group attempted to establish certain standards aimed at achieving the unification of techniques, classification, operational definitions, and areas of study.

The study group, which was composed of 15 participants and 11 observers from seven countries in the Americas and from the World Health Organization and the Pan American Health Organization, met in Washington, D. C., from 29 March to 3 April 1965. The study group examined various items, among them the resolution of the Directing Council, and held specific discussion on the epidemiology of epilepsy, in connection with which it adopted a provisional terminology for use in epidemiological research on the disease.

In addition, the study group made the following statement:

Having considered Resolution III of the XV Meeting of the Directing Council of PAHO, XVI Meeting of the Regional Committee of the WHO for the Americas it is recommended that:

1. The existing literature on epilepsy research in the Americas be collected.

2. The existing epilepsy programs and services in the Region be evaluated, and the establishment of services, particularly of community care centers for purposes of case detection and follow-up, be promoted.

3. A study group be convoked as early as possible to design a program aimed at:

(a) Conducting an epidemiological survey of the prevalence and incidence of epilepsy in selected areas in the Americas.

(b) Conducting an investigation of the social conditions, and ecologic, nutritional, and toxic factors relating to possible causes of this condition, as well as of the cultural attitudes relating to the adjustment of the epileptic to the community and to work.

On its part, the Mental Health Information Center on Latin America (MHICLA), established within the PASB for the purpose of collecting, analyzing and distributing information on mental health, has begun to make bibliographical studies, and has made an inventory of epilepsy services and of the legal aspects of the disease. It has collected the papers, articles, and other publications which have appeared on the subject between 1950 and 1963. A directory of psychiatric services in Latin America is now in preparation and will serve as the basis for an inventory of anti-epilepsy services.

As to the legal aspects of epilepsy, an investigation was begun in two different but complementary directions. The first was centered on bibliographical research. In this regard, mention should be made of the major research effort made by the American Bar Foundation, which devoted five years to the compilation and analysis of the legal aspects of mental disease in the United States of America, including a study of epilepsy, and of *The Legal Rights of Persons with Epilepsy—A Survey of State Laws and Administrative Policies Relating to Persons with Epilepsy*,[3] a document published by the Epilepsy Foundation in 1965.

In addition to these studies, books and articles on the subject were also reviewed.

The second activity was a direct investigation of legislation currently in force in Latin America

[1] Document CD16/18 (27 July 1965).

[2] *Official Document PAHO* **58**, 58-59.

[3] Washington, D. C.: The Epilepsy Foundation, 1965. 51 pp.

regarding legal restrictions for epileptics. In this area, mention should be made of the cooperation given by the International Labour Office through its representatives in the Americas. Data on 19 countries are currently available. Apart from the information on the United States of America prepared by the American Bar Foundation and by the Epilepsy Foundation, the remaining information is less useful because it lacks data on the legal capacities and legal responsibilities of epileptic persons, as well as on the administrative and social consequences of epilepsy. Social restrictions do, in fact, exist and have been publicly denounced by national institutions for the protection of epileptics. But these declarations have not been supported by methodical study, and originated rather from unorganized observations. A study of the public attitude toward epileptics would require the training of teams of specialists in the behavioral sciences and a considerable outlay of funds for research.

Briefly, the work done in compliance with Resolution III of the XV Meeting of the Directing Council has been preliminary and exploratory. It has laid the foundation for epidemiological research on a continental scale. Although data on the legal status of epileptic persons were compiled, they need to be completed at the regional level before programs aimed at the treatment of epilepsy can be established. Such studies will require sufficient numbers of personnel and a sufficient amount of funds. MHICLA would act as the coordinating agency and provide the necessary technical advice.

No concrete study has been made of the financial implications of a regional study of legal and other types of discrimination against epileptics in the Americas. It would therefore seem advisable to make a study of the entire Hemisphere, bearing in mind that legal provisions and social measures applying to epileptics are not stated specifically and must therefore be searched for or discovered within the legal order and social conditions of each country. Such a study could serve as the basis for formulating standards and programs for every aspect of epileptic care at both the national and international levels.

One of the countries of the Hemisphere has begun an epidemiological study of mental disorders which specifically includes epilepsy. A similar project in another country is now under consideration.

It is hoped that the results of these two projects will facilitate a correct evaluation of the personnel and financial requirements for a continent-wide project of epidemiological and legal research on epilepsy in the Americas.

A progress report on these studies will be submitted by the Director to the Directing Council in due course.

Annex 10

INTERNATIONAL TRANSPORTATION OF HUMAN REMAINS [1]

The 52nd Meeting of the Executive Committee examined Document CE52/17,[2] which contained a summary of legislation currently in force on the international transportation of human remains in 21 countries and political entities in the Americas. This document has been brought up to date by the addition of the replies subsequently received from the Governments.[3] These replies now number 31 so that a more complete picture of current legislation is available.

In compliance with Resolution XVIII[4] of the 52nd Meeting of the Executive Committee, the Director entrusted the preparation of a report on the matter to a study group. The study group, composed of Mr. William M. Annetti, Memorial Division, Department of the Army, and Mr. John F. Horty, Director, Health Law Center, Graduate School of Public Health, University of Pittsburgh, prepared a report [5] and also established a set of basic regulations [6] for the international transportation of human remains in the Americas.

In compliance with the same resolution, the Director has the honor of transmitting to the Directing Council for its consideration, the document on current legislation and the report of the study group.

It is also appropriate to mention the discussion on this item during the Executive Committee meeting, at which time Dr. Alberto E. Calvo, Representative of Panama, indicated the possibility of having the XVII Pan American Sanitary Conference take a decision, with the authorization of the Governments, and suggested that regulations governing the international transportation of human remains might possibly be incorporated into the International Sanitary Regulations. Dr. Manuel B. Márquez Escobedo (Mexico) was not in favor of including them in the International Sanitary Regulations because, as was subsequently explained, these consist of a codification and revision of earlier international sanitary conventions and of other agreements.

These two representatives, as well as Dr. Manoel José Ferreira of Brazil, Dr. Charles C. Wedderburn of Jamaica, and Dr. Daniel Orellana of Venezuela, all agreed that the opinion of the Governments should be sought. It was further stated that any regulations that might be prepared should not be limited to the Americas but should be of worldwide application, and that the Director-General of the World Health Organization should therefore be consulted. Dr. Orellana pointed out that a detailed study of the situation would have to be made in each country in order to change current provisions which had not been revised for some time.

The Director of the Pan American Sanitary Bureau will comply with any recommendations the Directing Council may wish to make. The Council might, for instance, wish to recommend that the Governments of the Organization be consulted directly, in which case the Secretariat would transmit the report of the study group and excerpts of the pertinent minutes to the Governments, and would subsequently prepare a document summarizing the replies received. That document could then be submitted to a special committee representing the legal, moral, social, and health interests concerned, which could also prepare a set of draft regulations to govern the international transportation of human remains in the Americas.

Alternatively, the Council might decide to have the Executive Committee constitute itself into a working party to advise the Council or the Conference. The draft regulations could then be sub-

[1] Document CD16/27 (23 August 1965).
[2] See Appendix 1, pp. 403-404.
[3] See Appendix 2, pp. 404-405.
[4] *Official Document PAHO* **62**, 40.
[5] See Appendix 3, pp. 405–406.
[6] See Appendix 4, pp. 407–408.

mitted to a special conference, or even to the XVII Pan American Sanitary Conference, if there was a desire to give the regulations the formal nature of an international agreement or convention within the Inter-American system.

The sole aim of outlining these alternate procedures is to facilitate discussion by the Directing Council, which may approve or so modify them as it deems advisable to gain the ultimate objective, which is to achieve uniformity in the Americas in regulations on the international transportation of human remains.

Appendix 1

SUMMARY OF EXISTING LEGISLATION ON INTERNATIONAL TRANSPORTATION OF HUMAN REMAINS [1]

The legislation on the international transportation of human remains which is currently in force in the countries of the Americas is most varied and complex. In fact, each country has its own provisions which, although similar in some basic aspects, are distinct in all the other aspects. Some countries have specific regulations governing the entry or departure of human remains, while others have only a general rule which states that the authorities concerned may decide on the matter; still another group of countries has no regulations or provisions of any kind, and each case that arises is decided according to previous administrative practices.

To give a clearer idea of the present situation, a list of countries appears below with an indication of its current legislation in this regard:

Brazil. Has no law or regulation on the matter but rather a service standard of the Department of Civil Aeronautics (Traffic Division) establishes the requirements for the transportation of human remains on board commercial airplanes.

Bolivia. Permission to bring into, or take human remains out of the country is given by the Ministry of Public Health in accordance with Article 139 of the Sanitary Code of 1958.

British Guiana. In accordance with the Public Health Ordinance, the entry of human remains into the national territory requires the approval of the Central Health Board.

British Honduras. Has no law or regulations on the matter.

Chile. The General Provisions Regulating Cemeteries of 14 April 1932 provide that the entry of human remains coming from abroad either by land, sea, or air, must be requested from the National Department of Health, which requires documents duly authorized by the health authorities at the point of origin indicating that the human remains represent no (health) hazard. Such documentation shall bear the visa of a Chilean consul (Article 35).

Colombia. Has no law or special regulations in the matter.

Costa Rica. Human remains may be brought into the national territory only upon authorization by the Ministry of Public Health (Article 142 of the Sanitary Code of 1949).

Cuba. The provisions for introducing human remains into the national territory are contained in the Manual on Standards and Procedures of the Ministry of Foreign Affairs. In addition, there is the Special Instruction No. 1-67 of 20 July 1961, issued by the Department of Environmental Sanitation of the Ministry of Public Health regulating the matter.

Dominican Republic. The relevant provisions are Article 138 of the Public Health Code and the Cemetery Regulations.

Ecuador. The international transportation of human remains must in each case be authorized by the Department of Health, which will bear in mind the international regulations and internal provisions for either granting or denying permission (Article 106 of the Sanitary Code).

El Salvador. According to the Sanitary Code, human remains or bones may only be introduced into the national territory upon authorization by the Ministry of Public Health and Social Welfare, which will grant such permission upon a favorable report from the National Department of Health.

Guatemala. Has no specific legislation on the international transfer of human remains and every case that arises is decided by the National Department of Public Health together with the Higher Health Council.

[1] Document CE52/17 (27 March 1965).

Haiti. Has no law or regulation governing this matter but the Public Hygiene Department of the Ministry of Public Health and Population has established a procedure for transporting human remains out of the country.

Honduras. There are provisions to the effect that human remains may not be taken in or out of the country without the permission of the health authorities in question or the Ministry of Public Health and Social Welfare issued upon a favorable report from the National Department of Health (Article 114 of the Sanitary Code and Regulations of Hygiene and Public Health).

Mexico. The Sanitary Code requires that the introduction or departure of human remains must be approved by the Federal Health Authorities (Article 111 of the Sanitary Code). In addition, the Federal Regulations of 28 February 1928 on Cemeteries, Inhumations, Exhumations, Conservation, and Transfer of Human Remains, contains in its Chapter III the provisions regulating this matter (Articles 23 and 41, and subsequent articles).

Nicaragua. Has no legislation or special regulations on the matter.

Panama. According to the Health Code, permits for the exhumation and international transportation of human remains are issued by the Department of Public Health in accordance with the relevant international regulations.

Paraguay. No legislation of any kind on this matter. In practice this matter is handled by the Biostatistics Department of the Ministry of Public Health and Social Welfare.

Peru. The pertinent legislation is the Executive Decree of 8 June 1923 regulating the introduction into the country of human remains of persons who have died abroad and the export of human remains.

United States of America. Section 72.12 of the Department of State Regulations deals with the transportation of human remains to the U.S.A. and establishes the requisites to be met in such cases. The Department of the Army likewise has regulations on the care and transfer of human remains, with a section which deals with transportation.

Venezuela. Regulations on Cemeteries, Inhumations, and Exhumations (Decree No. 115 of 3 November 1948) states that for the transfer to or from abroad to Venezuela the corpse must be embalmed except where burial is to take place within 36 hours after death, and without prejudice to the provisions of international agreements.

The preceding summary indicates that there is no uniformity in the rules and regulations governing the international transportation of human remains. It would therefore be useful to establish a standard system for general application in the Americas in a manner deemed most advisable. From the moral viewpoint there is no doubt that clearly established regulations would greatly ease the situation in which the relatives of a deceased person find themselves when they wish to bury that person in native soil. The matter is one of possible solution in the interest of such moral considerations. It is a problem which has recently become more topical because land, sea, and air travel between countries has become more frequent and commonplace in our times.

The Director of the Bureau submits this information to the Executive Committee for consideration, at the invitation of the Delegation of the United States of America, which has repeatedly indicated its interest in the matter. The Director requests the Committee to indicate the measures which it considers should be taken.

Appendix 2

DATA ON LEGISLATION RECEIVED AFTER THE 52ND MEETING OF THE EXECUTIVE COMMITTEE [1]

Antigua. Sections 24 and 161 of the Public Health Ordinance No. 34 (1956) contain the provisions relating to the transportation of human remains to another Leeward island or any other place. The Central Board of Health is authorized to grant permission for the removal of a body from the island.

Argentina. Title VII (Chapters 1 (Resolution of 16 January 1937) and 2 (Resolution of 19 January 1937)) of the *Digesto Sanitario* refers to the shipment of corpses. The authorization to send human remains to other cities within or outside the country is given directly by the Health Department for Borders and Transport, under certain conditions, and the authorization to unload a corpse is given by the medical sanitary officer of the harbor.

Barbados. The Director of Medical Services or any Medical Officer appointed by him for the purpose, gives or rejects permission for the transportation of remains,

[1] Document CD16/27, Annex II.

under certain conditions. (Public Health Act, 1954, Importation and Exportation of Human Remains, Regulations. 1959.)

Dominica. The Medical and Sanitary Services Ordinance No. 9, of 1935, Section 11, regulates the conditions under which a dead human body can be brought into the island.

Jamaica. There is no legislation relating to the importation of human remains; however, they have been acting on a circular from the Secretary of State for the Colonies (United Kingdom), of 1955.

Montserrat. Has no law on the matter.

St. Kitts. There are no provisions in the Sanitary or Customs Ordinance on the transportation of corpses; some health regulations have been drawn up, but do not have the force of law. According to them, corpses must be in a coffin sealed in a leaden casket.

St. Lucia. The official of the Sanitary Authority is the only person to whom the dead body entering the island should be delivered. The body must be delivered in an impermeable coffin.

St. Vincent. There are no sanitary or customs regulations governing the importation or exportation of human remains. Moreover, there are no facilities for embalming or cremation. The Health Authority requires the human remains to be encased in a hermetically sealed metal container and placed in a wooden coffin or box.

Surinam. The Burial Ordinance issued, 1926, indicates that in order to transport a dead body from or to Surinam, permission is needed from the Attorney General. Transportation must be done in a hermetically sealed metal coffin, contained in a wooden coffin that is properly closed.

Appendix 3

REPORT OF THE STUDY GROUP ON INTERNATIONAL TRANSPORTATION OF HUMAN REMAINS [1]

SUMMARY

The legislation on international transportation of human remains which is currently in force in the countries of the Americas is varied and complex. In the group of countries which have no regulations or provisions of any kind, each case that arises is decided according to previous administrative practices. In general, existing requirements for international transportation of human remains are not compatible to the modern-day travel needs of a world society.

It is particularly important to note that many countries require that an entire baggage freight car, or individual compartment of an aircraft, be used for the single purpose of transporting a corpse. The expense of such exclusive transit could well reach several thousand dollars and, in effect, preclude the return of a remains to the homeland for internment in native soil.

It is recommended that international legal and health requirements covering importation and/or exportation of human remains within the Americas be unified and standardized.

[1] Document CD16/27, Annex III.

GENERAL

1.1 *References*

a. *Item 19: International Transportation of Human Remains,* Ninth Plenary Session, 52nd Meeting of the Executive Committee.[2]

b. Resolution XVIII,[3] 52nd Meeting of the Executive Committee.

1.2 *Authority*

Resolution XVIII,[4] 52nd Meeting of the Executive Committee.

1.3 *Objectives*

To review and evaluate the suitability of existing requirements for importation and/or exportation of human remains within the Americas, taking into consideration:

a. The moral viewpoint concerned with the facility of movement of a human remains, in accordance with the desires of the next of kin, for internment in native soil.

[2] See Appendix 1, pp. 403-404, and *Official Document PAHO* **64**, 146-149.

[3] *Official Document PAHO* **62**, 40.

[4] *Ibid.*

b. The pressing need for the establishment and application of a standard procedure for transportation of human remains in the Americas owing to the more frequent and routine travel by land, sea, and air between these countries.

c. The documentation pertaining to a corpse, unlike the transfer of a parcel of real estate, is a sensitive matter which should be handled in a decorous manner, with minimal inconvenience and delay.

1.4 *Responsibilities*

Each individual country of the Americas bears a deep responsibility for facilitating the national and/or international movement of human remains, in accordance with the desires of the next of kin.

1.5 *Background*

a. From time to time a group of countries have endeavored to establish "international agreements" concerning the movement of human remains, for example the Berlin Convention of 1937 on Shipment of Dead Bodies; however, in most instances, the signatory countries have failed to ratify these agreements. In general, each nation has developed its own legal and sanitary regulations for national and international transportation of human remains. In general, these regulations have been developed without taking into account the requirements of neighboring or distant countries. In fact, each country has its own provisions which, although similar in some basic aspects, are distinct in all the other aspects. This has resulted in a series of regulations which are most varied and complex, and in general are inadequate and outdated with regard to modern medical knowledge, transportation facilities, and experience.

b. A factor which has prompted the development of this maze of rules and regulations is undoubtedly the ingrained fear of communicating infectious diseases through the exportation and/or importation of human remains. The United States of America through its importation of tens of thousands of war dead following World War II and during the Korean war, in addition to those currently being brought back from all quarters of the world, has clearly demonstrated that the theory of communicating infectious disease through international transportation of human remains is unfounded.

c. The procedure utilized during World War II was simple. The human remains was liberally sprinkled with a powder compound containing formalin, wrapped in a blanket, and placed in an airtight metal (rubber sealed) casket, which in turn was placed in a wooden box for transportation. During the Korean war, remains were embalmed in accordance with United States standards and placed in an airtight metal (rubber sealed) casket, which was placed in a wooden box for transportation.

d. The increased use of air transportation prompted the U.S. Armed Services to develop a re-usable, light weight, aluminum transfer case. Accordingly, the present military procedure provides that the remains be embalmed, wrapped in a plastic sheet, and placed in the re-usable, airtight (rubber sealed) transfer case for transportation to the United States. Each time the transfer case is used it is disinfected and returned overseas for further use.

Since the transfer case is a re-usable item, the plastic sheet helps to maintain the aseptic condition of the transfer case by containing any leakage which might occur from the corpse.

e. A single-use (less complicated and less costly), airtight (rubber sealed) steel transfer case has been commercially developed. This transfer case has been used by the Government of the Netherlands for returning deceased servicemen to the homeland.

1.6 *Legislation*

a. Legislation on the international transportation of human remains currently in force in the Americas is most varied and complex. Each country has its own provisions which, although similar in some basic aspects, are distinct in other aspects.

b. Some countries have specific regulations, while others have only a general rule which states that the authority concerned decides on the matter. Still another group has no regulations or provision of any kind on the subject, and each case is decided as it arises, according to previous administrative practices.

c. It is noted that some countries require consular inspection, as well as a certificate attesting that the casket contains only the body of the decedent. Granted that it is possible for contraband to be concealed with a human remains, it is considered a remote possibility since it would require the coordination of many factors including death at the opportune moment.

1.7 *Conclusions*

a. In general, existing requirements for international transportation of human remains are not in keeping with the travel patterns of a world society and are not compatible with modern scientific knowledge; these requirements should be simplified, standardized, and brought up to date in order to alleviate unnecessary international difficulties for the survivors in their efforts to transport remains for internment.

b. To this end, the study group has prepared a working paper outlining a set of standards and regulations which might be of value in the Americas.

Appendix 4

PROPOSED GENERAL STANDARDS FOR THE AMERICAS ON THE INTERNATIONAL TRANSPORTATION OF HUMAN REMAINS [1]

I. BASIC CRITERIA

1. Difficulties resulting from differences in the regulations concerning the transportation of human remains should be avoided and uniform and standardized rules on the subject should be established.

2. Transit of human remains between countries should be simplified in order to take into account the moral and social aspects of the matter.

3. Transportation of human remains should not be authorized when the cause of death has been yellow fever, plague, cholera, smallpox, typhus, relapsing fever, or any other epidemic disease subject to notification under the International Sanitary Regulations, unless special requirements are met to avoid the possibility of transmission.

4. It is necessary to simplify the administrative procedures to be followed in these cases; specifically, authority should be vested in one officer, normally of the Public Health Service, who shall grant permission for the export and/or import of human remains.

5. Transportation of human remains between frontier districts should be considered as taking place in a single country.

6. Transportation of human ashes should not be subject to any regulations.

7. International transportation of human remains refers exclusively to that which is used immediately after death or exhumation. Each country establishes its own rules with respect to burial and exhumation.

8. The countries of the Americas are free to reduce the formalities, either by bilateral agreements or by decisions made by mutual agreement in particular cases.

II. DOCUMENTATION

1. The following documents will be required for international transportation of human remains:

a. A legalized death certificate issued by the local registrar of death, or similar authority, showing the name, age, nationality of the deceased person; the place, date, and cause of death shall be certified by the attending physician.

b. A statement by the person who prepared the remains, certifying that the body was properly prepared by him, and that he has complied with the ideal measures stipulated in Section III.

c. A transit permit stating the surname, first name, and age of the deceased person, and the place and cause of death, issued by the competent authority for the place of death, or the place of burial in the case of exhumed human remains.

2. The aforesaid transit permit shall not be issued by the responsible authority without the presentation of:

a. A legalized death certificate; and

b. An official statement to the effect that the transfer of the corpse meets the legal requirements, and that it has been placed in a container (transfer case, coffin, casket) in accordance with those regulations.

III. HEALTH MEASURES

The human remains are subject to the following measures:

a. Thorough washing with an effective disinfectant, disinfection of all orifices, packing of same with cotton also saturated with an effective disinfectant, wrapping in a sheet saturated with an effective disinfectant, and placing in a metal container (transfer case, coffin, casket); or

b. Proper embalming (arterial and cavity) and placing in an airtight metal (rubber sealed or soldered) container (transfer case, coffin, casket).

IV. SHIPMENT REQUIREMENTS

Human remains prepared for international shipment shall be placed in a metal container (transfer case, coffin, casket). Where the cause of death was a contagious disease, the corpse must be embalmed (arterial and cavity) and placed in an airtight metal container, or properly cremated.

The metal container (transfer case, coffin, casket) must be airtight (soldered or rubber sealed). The airtight container (transfer case, coffin, casket) may be shipped without further encasement (except when shipped by sea); or, for protective purposes, it may be fitted in a wooden or composition box to avoid movement. It may also be wrapped in some fabric especially designed for this purpose.

V. RAIL TRANSPORTATION

The following regulations shall apply in cases of transportation by rail:

a. The metal container (transfer case, coffin, casket) must be conveyed in a baggage car or in the baggage section of a passenger car, unless it is conveyed in a closed hearse or vehicle (truck) and is kept there.

[1] Document CD16/27, Annex III, Appendix 1.

b. Each country shall be responsible for fixing the time limit within which the body must be removed on arrival.

c. Transportation shall be by the fastest route, and as far as possible, without trans-shipment.

d. No articles may be transported along with the metal container other than wreaths, flowers, etc.

VI. HIGHWAY TRANSPORTATION

The following regulations shall apply for this type of transportation:

a. The metal container (transfer case, coffin, casket) shall be conveyed preferably in a closed hearse or, failing such, in an ordinary closed van.

b. No articles may be transported with the metal container other than wreaths, flowers, etc.

VII. AIR TRANSPORTATION

The following regulations shall apply in cases of transportation by air:

a. The metal container shall be transported in special aircraft (chartered), or in the baggage compartment of a passenger aircraft or cargo plane.

b. No articles may be transported along with the metal container in the same aircraft or in the same compartment, other than wreaths, flowers, etc.

VIII. SEA TRANSPORTATION

The following regulations shall apply:

The metal container shall be packed in an ordinary wooden or composition material case, or wrapped in a fabric designed especially for this purpose, so as to avoid movement.

Annex 11

ORGANIZATION OF THE PAN AMERICAN SANITARY CONFERENCE AND AMENDMENTS TO ARTICLES 7-D, 12-B, AND 14 OF THE CONSTITUTION [1]

1. Organization of the Conference

The 47th Meeting of the Executive Committee (Minneapolis, Minnesota, 3 September 1962) recommended [2] that a study be made of the pertinent provisions of the Basic Documents of the Organization with a view to simplifying the organization of the Pan American Sanitary Conference and clarifying its Rules of Procedure.

The study was to be based on the observations and suggestions of the Governments. At its XIV Meeting, the Directing Council (Washington, D. C., 16-25 September 1963),[3] bearing in mind that many Governments had still not expressed their opinions, urged those that had promised to make comments on the organization of the Pan American Sanitary Conference to send them in as soon as possible, and instructed the Director of the Bureau to submit to the XVI Meeting of the Directing Council a detailed report on the subject containing the opinions expressed by the Governments.

The Executive Committee at its 50th Meeting (Washington, D. C., 27 April to 1 May 1964) requested [4] the Director to pursue the study, and to communicate with the Governments which had not yet expressed their views on the matter, and also suggested to the Director the value of submitting a preliminary report to the XV Meeting of the Directing Council.

In compliance with that suggestion, the Director presented a report (Document CD15/26) [5] together with an Addendum [6] in which the opinions expressed by the Governments were classified and summarized, and copies of the communications received were attached.

The XV Meeting of the Directing Council (Mexico, D.F., 31 August-11 September 1964) considered Items 25 and 36 simultaneously; the first related to the place of the XVII Pan American Sanitary Conference, and the second to the study of the organization of the Pan American Sanitary Conference. Both these items were discussed in detail in plenary session.[7] During the discussion, the Representatives of Peru and Ecuador submitted amendments to Articles 14, 7-D, and 12-B of the Constitution. The Directing Council, in Resolution XXXIX,[8] requested the Director to inform the Governments of the Organization of the constitutional amendments proposed at the meeting and those that might be received in due time before the 52nd Meeting of the Executive Committee; it also instructed the Executive Committee to submit a report to the XVI Meeting of the Directing Council on the organization, structure, and place of the meetings of the Governing Bodies of the Pan American Health Organization.

The Director submitted to the 52nd Meeting of the Executive Committee (Washington, D. C., 19-23 April 1965) a report[9] which set forth simply and exclusively the practice followed heretofore and the experience gained in recent years. The report was also intended to facilitate the work of the Executive Committee by pointing out the chief functions of the secretariat of a meeting and related problems.

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[1] Document CD16/22 (12 August 1965).
[2] *Official Document PAHO* **49**, 308-310.
[3] Resolution XXVI. *Official Document PAHO* **54**, 20.
[4] Resolution VIII. *Official Document PAHO* **57**, 24.
[5] Mimeographed document.
[6] See Appendix 2, pp. 414-415.
[7] *Official Document PAHO* **60**, 183-189 and 194.
[8] *Official Document PAHO* **58**, 90.
[9] See Appendix 1, pp. 412-414.

After considering the document submitted by the Director, the Executive Committee appointed a working party composed of Dr. Alberto E. Calvo of Panama and Dr. Daniel Orellana of Venezuela to present a report based on the following points: (1) organization and structure of future Conferences; (2) place of future Conferences; (3) proposed amendments to Articles 7-D and 12-B of the Constitution submitted by the Representative of Ecuador; and (4) proposed addition of paragraph F to Article 14, submitted by the Representative of Peru at the XV Meeting of the Directing Council. The Committee examined the report of the working party in plenary session, introduced a few amendments, and resolved:[10] to take note of the report of the Director on the organization of the Pan American Sanitary Conference; to transmit it to the XVI Meeting of the Directing Council, and to approve the report of the working party as amended and to transmit it as its own to the Directing Council for appropriate action.

The report of this working party was added to the Final Report of that meeting.[11]

2. Amendments to Articles 7-D and 12-B of the Constitution

At the fifteenth plenary session of the XV Meeting of the Directing Council the Representative of Ecuador submitted a draft resolution[12] which, owing to the complexity of the matter, was in no way considered definitive; it authorized the reimbursement of the travel expenses of the chief delegate, or the sole delegate, appointed by each Government to attend the meetings of the Conference, and the payment of his per diem allowance. In this connection, he proposed the following constitutional amendments:

Present text	*Proposed text*
Article 7-D	*Article 7-D*
"Each Government shall pay the expenses of its delegation to the Conference and the Bureau shall pay the expenses of its personnel."	"The Bureau shall pay the expenses of the chief, or sole, delegate of each Government to the Conference, as well as the expenses of the Bureau personnel."
Article 12-B	*Article 12-B*
"Each Government shall pay the expenses of its representation, and the Bureau shall pay the expenses of its personnel."	"The Bureau shall pay the expenses of one representative of each Government, as well as the expenses of the Bureau personnel."

In compliance with Resolution XXXIX of the XV Meeting of the Directing Council, the Director communicated these proposed constitutional amendments to the Governments (CT/Doc-CL-6-65 of 25 March 1965).

The Executive Committee at its 52nd Meeting studied these amendments and made several recommendations which are included in its report on the organization of the Pan American Sanitary Conference.[13] Among those recommendations are the following:

5. To recommend to the Directing Council that in studying the constitutional amendment proposed by the Representative of Ecuador at the previous Directing Council meeting, it bear in mind that the Executive Committee studied the various implications of this amendment.

After considering the possibility of adopting the proposed amendment or of making no recommendation whatsoever, the Executive Committee studied the form and the substance of the proposal of Ecuador. The amendment was considered from the viewpoint of the practice followed by other international agencies, particularly inter-American agencies. General reference was made to the financial consequences of its adoption, and the advisability of ascertaining the real effect that the amendment might have on attendance at meetings of the Governing Bodies.

6. To request the Director to submit to the Directing Council a report in which information is provided on: (1) the practice of other organizations of the inter-American system as well as the organizations of the United Nations system with respect to the payment of travel or expenses of representatives to meetings; (2) the attendance records of members of (a) organizations in which the travel and expenses are paid by the Organization; (b) organizations in which the travel or expenses are paid by the Member States.

7. To recommend to the Directing Council that in considering the proposed amendments, the purpose of which is to encourage and secure the attendance of as many delegations as possible of Member Governments at the Conference, and when studying the amendment to Articles 7-D and 12-B (of the Constitution), it bear in mind the following two points:

a) That in both cases the expenses of one representative of each Government who is a high-ranking

[10] Resolution VIII. *Official Document PAHO* **62,** 33.

[11] The complete text of the report appears in *Official Document PAHO* **62,** 41-43.

[12] *Official Document PAHO* **60,** 187.

[13] The complete text of the report appears in *Official Document PAHO* **62,** 41-43.

technical official of the ministry of health will be paid; and

b) That such expenses will include only the cost of the round trip, by an authorized route, from the capital city of the Member Government to the place of the meeting.

The Director informed the Governments of these recommendations (CT/Doc-CL-10-65, dated 28 May 1965). Together with that communication he also sent the pertinent excerpts of the minutes of the fourth, fifth, sixth, and seventh plenary sessions [14] at which this matter was discussed, the proposal made by the Government of Ecuador, and Resolution VIII adopted by the Executive Committee at its 52nd Meeting.

A report containing the requested data will be submitted in due course by the Director to the Directing Council for consideration.

3. Amendment to Article 14 of the Constitution

At the fifteenth plenary session [15] of the XV Meeting of the Directing Council, the Representative of Peru presented an amendment to Article 14 of the Constitution to consist of adding a new paragraph F thereto, as follows:

"F. The Executive Committee shall be responsible for the direct surveillance of the work of the Organization, fiscalizing the execution of its programs and its finances, and shall submit to the Directing Council and the Conference for its approval a detailed report thereon. This report shall be one of the main items of business of those bodies.

In compliance with Resolution XXXIX of the XV Meeting of the Council, the Director transmitted the proposed amendment to the Governments of the Organization in a circular letter (CT/Doc-CL-7-65 dated 25 March 1965).

After studying the proposed constitutional amendment, the Executive Committee reached the following conclusion which is included in its report on the organization of the Pan American Sanitary Conference (paragraph 8):

8. To inform the Directing Council that it was the unanimous opinion of the Executive Committee, with which the Observer of Peru also agreed, that the functions assigned to the Executive Committee by Article 14 of the Constitution, particularly paragraphs D and E, are so broad that the amendment proposed at the XV Meeting of the Directing Council by the Representative of Peru is unnecessary.

However, the submission of the proposed amendment by the Government of Peru had served a very useful purpose in that it had led to the study and the definition of the functions and responsibilities which the Executive Committee could discharge and fulfill to effectively reduce the work and shorten the duration of the meetings of the Governing Bodies of the Organization when these Governing Bodies deem it advisable.

The Executive Committee unanimously accepted the proposal of the Observer of Peru to the effect that the Executive Committee be officially represented at the meetings of the Directing Council and the Conference by its Chairman or by another member appointed by the Executive Committee. The expenses of transportation and subsistence of this representative of the Executive Committee shoud be borne by the Organization.

In his communication CT/Doc-CL-9-65 dated 28 May 1965 the Director reported this to the Governments and attached the pertinent parts of the fourth, fifth, sixth, and seventh plenary session minutes at which the subject had been discussed, as well as the amendment proposed by the Government of Peru and a copy of Resolution VIII adopted by the Executive Committee at its 52nd Meeting.

4. Final Observations

In its Resolution XXVI, the XIV Meeting of the Directing Council instructed the Director of the Bureau to submit to the XVI Meeting of the Council a detailed report on the organization of the Pan American Sanitary Conference. For its part, the XV Meeting of the Council, in Resolution XXXIX, instructed the Executive Committee to submit a report to the XVI Meeting of the Directing Council on the organization, structure, and place of the meetings of the Governing Bodies of the Pan American Health Organization.

In accordance with the provisions of Article 28 of the Constitution, the Directing Council is empowered to approve or reject the proposed constitutional amendments.

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[14] *Official Document PAHO* **64**, 57-66, 67-81, 85-87, 90-95, and 99-100.

[15] *Official Document PAHO* **60**, 185.

Appendix 1

ORGANIZATION OF THE PAN AMERICAN SANITARY CONFERENCE [1]

The XIV Meeting of the Directing Council, XV Meeting of the Regional Committee of the WHO for the Americas, instructed [2] the Director of the Bureau to submit to the XVI Meeting of the Council a detailed report including the opinions expressed by the Governments on the organization of the Pan American Sanitary Conference. At its 50th Meeting, the Executive Committee suggested [3] to the Director the advisability of submitting a preliminary report on the matter to the XV Meeting of the Directing Council. This report appears in Document CD15/26, and its Addendum [4] classifies and summarizes the opinions expressed by the Governments and includes copies of the original letters.

This report is being submitted in accordance with the decision of the XIV Meeting of the Directing Council which supplements Resolution XXXIX [5] adopted by the XV Meeting of the Council, which instructs the Executive Committee to submit a report to the XVI Meeting of the Directing Council on the organization, structure, and place of the meetings of the Governing Bodies of the Pan American Health Organization. This report sets forth simply and exclusively the practice followed heretofore and the experience gained in recent years.

COMPETENCE AND ORGANIZATION

According to the Constitution, the Pan American Sanitary Conference is the supreme governing authority of the Organization. Its function is to determine the general policies of the Organization, including financial policy and, when deemed necessary, to instruct the Council, the Executive Committee, and the Director of the Bureau with respect to any matter within its scope of activity. The meetings of the Conference are also meetings of the Regional Committee of the World Health Organization, except when discussing matters relating to constitutional matters, the legal relationship between the Pan American Health Organization and the World Health Organization or the Organization of American States, or other matters relating to the Pan American Health Organization as an inter-American specialized agency.

The Conference, which meets every four years, has always had the same structure. It is composed of a Committee on Credentials, a General Committee, two main committees (one deals with technical matters and the other with administrative, financial, and legal matters), and the plenary sessions of the Conference. At the Conferences held in Puerto Rico (1958) and in Minneapolis (1962), a Joint Committee on the Program and Budget was also established.

From the point of view of competence, all matters may be dealt with in plenary session. In fact, some of them only fall within the competence of plenary sessions, for example, the election of the Member Governments to the Executive Committee, and the election of the Director of the Bureau. It is also a function of the plenary sessions of the Conference to examine the Annual Report of the Executive Committee and the Quadrennial and Annual Reports of the Director. When the latter are being considered, it has become the practice for the heads of the delegations to report on the health work carried out in their countries since the previous Conference. This practice arose from a recommendation [6] of the III Meeting of the Directing Council inviting Governments to submit to the Conference a report in writing. Since then the Conference itself has made new recommendations concerning the quadrennial reports on health conditions and the progress achieved in each country in the period between Conferences.

The Bureau has been invited to continue to publish the four-year reports on health conditions. This report is also examined in plenary session of the Conference, which in this instance serves as a forum for the interchange of information related to the prevention of disease and the promotion and restoration of mental and physical health.

The so-called main committees supplement the plenary sessions. They are established pursuant to Rule 28 of the Rules of Procedure, the number depending on what the Conference considers necessary for the orderly despatch of the business of the meeting. As a matter of fact, the purpose of the main committees is to simplify the work and shorten the duration of the Conference. Indeed, they submit to the plenary session, through their rapporteurs, matters ready for approval without further debate. That is recognized in Rule 13 of the Rules of Procedure of the Conference, which establishes that "the plenary sessions will be devoted to matters of general interest and to the discussion and approval of the reports of the various committees." Generally speaking, the main committees facilitate the work of the Conference since the plenary sessions only consider the reports of the rapporteurs and modify, revise, or approve the draft resolutions prepared in committee.

It has become traditional to set up two main committees at the Conferences. The first, on technical matters, deals with items of this nature on the agenda. Some of the items assigned to it call for extensive discussion, during which many delegates report on activities in their countries.

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[1] Document CE52/13 (27 March 1965).
[2] Resolution XXVI. *Official Document PAHO* **54**, 20.
[3] Resolution VIII. *Official Document PAHO* **57**, 24.
[4] See Appendix 2, pp. 414-415.
[5] *Official Document PAHO* **58**, 90.
[6] Resolution XV. *PAHO Publication* **247**, 31.

The second main committee deals with the administrative, financial, and legal items on the agenda of the Conference. The duration of the Conference will depend on whether or not the practice of establishing a joint committee to examine the program and budget is followed. In any event, it must not be forgotten that the main committees meet, not at the same, but at different times, whenever difficulties arise concerning meeting rooms.

SECRETARIAT SERVICES

Because of the functions of the Conference, a secretariat consisting of administrative, technical, and auxiliary staff is needed.

These include protocol officers, interpreters, translators, précis-writers, and secretaries, as well as a documents service which is concerned with the checking, copying, correcting, reproducing, distributing, and stocking of documents, and the technicians responsible for the electronic equipment for simultaneous interpretation and recording of the discussions.

There are also administrative and financial services responsible for the buildings and premises, communications and transport, security and medical aid, as well as the recruiting, paying, and discharging of employees. Accommodation, reception of delegates, and travel are sometimes a part of the protocol services, but are usually dealt with by the administrative services.

The cost of all these services, depending on whether or not two main commissions are established, has not previously been studied. It is even possible that the savings that might be effected on rooms and other items if there were only one main committee would be considerably reduced as a result of an increase in other expenses mentioned.

It would therefore be advisable to have a general assessment of the proposals of the Governments with reference to modifying the organization of the Conference. This type of study would provide the Governments with a breakdown of the secretariat services and their cost (personnel, rooms, equipment, supplies, and documents).

The study could also examine the advisability of changes in the structure and its financial implications. To decide at this point on a new structure, without sufficient background information and prior experience, might jeopardize the Conference services which have generally recognized to have functioned well. The answers to the questions raised—possible reductions in time and expenses—are not so clear and evident as not to require a further examination.

CONSTITUTIONAL AMENDMENTS

When the Governments were again consulted concerning the organization of the Pan American Sanitary Conference, pursuant to Resolution XXVI of the XIV Meeting of the Directing Council, some of them submitted constitutional amendments and others proposed changes in the Rules of Procedure of the Conference.

At the XV Meeting of the Directing Council, the General Committee agreed that the plenary session should first examine matters of a general nature (organization, purpose of plenary sessions, establishment of main committees, etc.), then the amendments to the Rules of Procedure, and finally the role of Headquarters in the holding of Pan American Sanitary Conferences and, in general, in the meetings of the Governing Bodies.

During the discussion, the Representatives of Peru and of Ecuador submitted amendments to Articles 14, 7-D, and 12-B of the Constitution. These amendments have been transmitted to the Member Governments pursuant to Resolution XXXIX of the XV Meeting of the Directing Council. The Government of the United States of America had earlier proposed several changes in the Rules of Procedure of the Conference, which had been endorsed by the Government of Jamaica.

PLACE OF THE XVII PAN AMERICAN SANITARY CONFERENCE

At its XV Meeting, the Directing Council postponed taking a decision on this matter until the XVI Meeting in 1965.

At the XVI Pan American Sanitary Conference, XIV Meeting of the Regional Committee of the World Health Organization for the Americas, the Governments of Uruguay and Cuba invited the Organization to hold the Conference in their countries. At the XV Meeting of the Directing Council the Government of Peru invited the Conference to Lima. The Governments of Bolivia, Honduras, France, and Paraguay, have proposed that the Conference should always be held at the Headquarters of the Organization in Washington. Finally, the Representative of Venezuela, in the discussion during the fifteenth plenary session of the XV Meeting of the Council [7] suggested that a system of rotation should be adopted which, while ensuring that full use was made of the headquarters building, would also allow the Conference to be held in other places. The Representative of Nicaragua stated [8] that it was essential for the next Conference to be held in Washington, since the Organization will have its own building, although that did not mean to say that the Conference would always have to be held in Washington. Indeed, the Conference should decide on each occasion where its next meeting was to be held. With respect to these last proposals it should be recalled that the United States of America pointed out that a constitutional amendment was necessary in order to hold the XVII Conference in Washington.

In this connection it is worth mentioning that, in accordance with Resolution XXIII [9] of the XIII Pan American Sanitary Conference, when because of unforeseen circumstances a country selected for the meeting is unable to meet its commitment, the meeting of the Conference will automatically be held at the Headquarters of the Pan American Sanitary Bureau. This

[7] *Official Document PAHO* **60**, 186-187.
[8] *Ibid.*, p. 188.
[9] *PAHO Publication* **261**, 162.

provision appears in the Rules of Procedure of the XV Pan American Sanitary Conference (Rule 13)[10] and Rule 2 of the present Rules of Procedure reads as follows: "If for any reason the Conference cannot be held in the country chosen, the meeting shall take place at the Headquarters of the Bureau."[11] This provision applied to the XVI Pan American Sanitary Conference.

[10] *Official Document PAHO* **27**, 10.
[11] *Official Document PAHO* **65**, 50.

FINAL OBSERVATION

This report is submitted to the Executive Committee bearing in mind that the Directing Council instructed it to present a report to the XVI Meeting of the Directing Council on the organization, structure, and place of the meetings of the Governing Bodies of the Pan American Health Organization and, with a view to facilitating its work, to cover the main aspects of the functioning of the secretariat of a Conference and related problems.

Appendix 2

STUDY OF THE ORGANIZATION OF THE PAN AMERICAN SANITARY CONFERENCE [1]

The Director of the Pan American Sanitary Bureau, in conformity with Resolution VIII [2] adopted by the Executive Committee at its 50th Meeting, has the honor to submit the following report to the Directing Council:

I. NUMBER AND CLASSIFICATION OF REPLIES

Twenty replies have been received to the two letters which the Director sent to the Governments on 9 November 1962 and 1 November 1963 pursuant to the instructions of the Executive Committee and the Directing Council. These replies can be classified into three groups: (1) those from Governments that consider the present system satisfactory, namely, Mexico, Panama, the Kingdom of the Netherlands, and the United Kingdom; (2) those from Governments that will make their views known at a later date (Costa Rica, Ecuador, Guatemala, and Trinidad and Tobago); and (3) those from the Governments of Argentina, Bolivia, Cuba, Dominican Republic, El Salvador, France, Honduras, Jamaica, Paraguay, Peru, United States of America, and Venezuela, which have made very appropriate recommendations among which there are broad areas of agreement. These are of great interest and are examined in this report.

II. CONFERENCE PROCEDURES

The meeting is considered to be both lengthy and costly. This latter point is set forth in letters from Argentina, France, and the Dominican Republic. The former point is contained both expressly and tacitly in letters from the Governments placed in the third group. The Argentine Government, "regards as important any change in the organization or operation of the Conference, which, while maintaining it as the supreme governing authority of the Organization and assuring the efficient discharge of its functions, will make it possible to simplify its administration and to reduce its cost" (see p. 415).

There are three specific proposals on the duration of the Conference, one from Venezuela, another from Cuba, and a third from Jamaica. Venezuela and Jamaica propose that the duration be 11 days, and Cuba, 12 days. The Venezuelan proposal, endorsed by Paraguay, shows evidence of a very close study, with a day-by-day breakdown of the work, and even of agenda items, based on the procedures followed at previous meetings.

III. MAIN COMMITTEES

Various opinions have been put forward on the establishment of two main Conference committees as in the past, with the one taking up all technical matters, and the other all administrative, financial, and legal matters. Some Governments (Bolivia and Jamaica) feel that all matters should be dealt with in plenary sessions, so that there would be no need for two committees; it will be recalled that under Rule 28 of the Rules of Procedure, the establishment of committees is at the discretion of the Conference. The Governments of France, the Dominican Republic, and Paraguay propose that the meetings of the two main committees be held at different hours; in their view this would allow all the delegates to attend and would eliminate the need for a second committee room and the attendant services. The Government of the United States of America is of the opinion that either of these two proposals is to be recommended; that is, either suppress the two com-

[1] Document CD15/26, Addendum (26 March 1965).
[2] *Official Document PAHO* **57**, 24.

mittees and take up all matters in plenary sessions, or have the committees meet at different hours. Cuba has made a similar suggestion. Both the United States of America and Cuba state a preference for the first proposal, that is, the suppression of the two committees.

A steadily increasing tendency has been noted in international meetings toward a division of activities into two fields: one at the expert level, and the other at the ministerial level. This procedure was followed in the Task Force on Health at the Ministerial Level, and it is used by the Inter-American Economic and Social Council of the Organization of American States. The Ministers of Health of Central America and Panama at their IX Meeting (Nicaragua, 16-18 July 1964) also declared themselves in favor of this procedure.

IV. AMENDMENTS TO THE RULES OF PROCEDURE OF THE CONFERENCE

The Government of the United States of America has proposed amendments to Rules 8, 13, 15, 20, 22, 28, 43, 46, and 54 of the Rules of Procedure of the Conference in order to correct shortcomings and anomalies. The Government of Jamaica has in turn stated its agreement with the proposals of the United States of America.

On the other hand, the Government of the Kingdom of the Netherlands recommends "a supple application" of the Rules of Procedure "which have been modified not long ago."

V. CONFERENCE DOCUMENTS

The Government of the United States of America believes that it would be advisable to provide the Governments with a provisional agenda 60 days prior to the date set for the opening of the Conference. The Government of Cuba has suggested that the agenda be sent together with the conference documents 60 days prior to the date set for the beginning of the Conference and that these be received by the Governments concerned not less than 45 days before the scheduled date.

VI. PLACE OF THE CONFERENCE

The Governments of Bolivia and Honduras have proposed that the Headquarters of the Organization in Washington be designated as the permanent meeting place of the Pan American Sanitary Conference. As stated by the Government of Honduras, "in addition to the fact that that city is the Headquarters of the Organization, the Organization will now have its own building there with all the necessary facilities for holding such meetings." Paraguay endorsed the view of the Government of France that "if the Conference could be organized at Headquarters itself in Washington, the expenses would certainly be less. This suggestion might be borne in mind with respect to the next Conference, which will be held in 1966, at which time the new building will probably be ready." An amendment was presented to this effect by France, couched in the following terms: "The Pan American Sanitary Conference will be held every four years at the Headquarters of the Organization in Washington, D.C., U.S.A." This proposal appears as Annex to Document CD14/5 of 8 July 1963, which was duly distributed.

VII. ESTABLISHMENT OF A WORKING PARTY

The Government of El Salvador has proposed that a working party be established "which, together with Bureau personnel, can prepare a report in sufficient time to allow the Executive Committee to present it in 1965. The work of this working party might possibly be made easier if it knew when the Pan American Sanitary Bureau will be moving into its new headquarters building, since such a move will eliminate certain problems which have sometimes occurred when the Conference was held in premises not suited for the purpose." The Government of Peru supported this proposal.

Appendix 3

LETTERS FROM THE GOVERNMENTS TO THE DIRECTOR, PASB, ON THE ORGANIZATION OF THE CONFERENCE

REPUBLIC OF ARGENTINA
MINISTRY OF SOCIAL WELFARE AND PUBLIC HEALTH

Ref: No. 627/63 Buenos Aires, 3 September 1963

I take pleasure in replying to your letter concerning the structure and organization of the Pan American Sanitary Conference, a matter which was examined by the Executive Committee of the Pan American Health Organization at its 47th Meeting.

I should like to thank you for consulting us on this matter and to state that this Ministry regards as important any change in the organization or operation of the Conference, which, while maintaining it as the su-

preme governing authority of the Organization and assuring the efficient discharge of its functions, will make it possible to simplify its administration and to reduce its cost.

Its organization and operation might be modified in the light of a critical examination of present arrangements. That calls for a detailed knowledge of the administration and cost of earlier meetings, and of the advisability of adopting a new machinery or system. In that connection, nobody is more competent than the Pan American Sanitary Bureau to propose, in the light of the information at its disposal and the findings of any critical examination it may make, the adoption of the measures it deems advisable for the solution of the problems to which attention has been called and in order to attain the goal suggested.

Very sincerely yours,

(Signed)
DR. VICTORIO VICENTE OLGUÍN,
Director of International Health and Social Affairs

REPUBLIC OF BOLIVIA
MINISTRY OF PUBLIC HEALTH

Ref. No. 4909 La Paz, 15 June 1964

In reply to your letter CT/Doc-CL-8-64 of 8 June 1964, I should like to present the apologies of my Ministry for not having replied promptly to your letter of 9 November 1963 on the same subject.

In connection with Resolution VIII of the 50th Meeting of the Executive Committee, the only suggestions my Government has to offer are as follows:

1. It would be to the advantage of countries such as Bolivia, which as a rule are not able to send more than one or two representatives to meetings of the Pan American Health Organization, if the main committees were not established so that all the important Conference matters could be considered in plenary session, and if *ad hoc* committees could be established only for special matters and their reports presented in plenary session. Since the establishment of committees is optional, this compromise proposal, which would effect savings to the Organization and benefit the countries unable to send more than two delegates, might find a favorable reception.

2. Since the suggestions to modify the Rules of Procedure of the Conference have been submitted by the Member Countries with the purpose of preventing the Organization from incurring heavy expenditures on meetings, it would be advisable to accept Washington Headquarters, where the most suitable facilities for these are available, as the permanent site for the meetings. However, meetings of the Executive Committee, which has a smaller number of members, could be held in each of the capitals of the Member Countries on a rotating basis.

Very truly yours,

(Signed)
DR. GUILLERMO JÁUREGUI G.,
Minister of Public Health

REPUBLIC OF COSTA RICA
MINISTRY OF PUBLIC HEALTH

No. 2119-62 San José, 22 November 1962

I acknowledge receipt of your letter No. CT-CL-16-62 of 9 November, and I should like to inform you that due note has been taken of its contents.

Very sincerely yours,

(Signed)
DR. MAX TERÁN VALLS,
Minister

REPUBLIC OF COSTA RICA
MINISTRY OF PUBLIC HEALTH

No. 2973-64 San José, 8 July 1964

I acknowledge receipt of your letter CT/Doc-CL-8-64 of 8 June 1964, calling attention to Resolution VIII on the status of the study of the structure and organization of the Pan American Sanitary Conference.

I am pleased to inform you that in due course such comments and suggestions as are deemed advisable will be forwarded for inclusion in the report you are to submit to the next meeting of the Directing Council, which is to be held in Mexico City from 31 August to 11 September 1964.

Very sincerely yours,

(Signed)
DR. MAX TERÁN VALLS,
Minister

REPUBLIC OF CUBA
MINISTRY OF PUBLIC HEALTH

International Relations Havana, 29 July 1964
No. 3252 "Year of the Economy"

We wish to reply to your letter CT/Doc-CL-8-64 of 8 June 1964, in which attention is called to Resolution VIII adopted by the Executive Committee at its 50th Meeting, held in Washington from 27 April to 1 May. The Committee has requested comments and observations on the organization of the Pan American Sanitary Conference, aimed basically at simplifying the work of the Conference. On behalf of the Revolutionary Government, the following views are submitted on the Rules of Procedure of the Conference and on the organization of the Conference itself.

Clarification with reference to the Rules of Procedure

Rule 8. It is suggested that, if possible, the provisional agenda be distributed 60 days prior to the date of the opening of the Conference, and that all the available documentation be in the hands of the Governments not less than 45 days before that date.

Rule 13. We understand that the plenary sessions should be entitled to hear all matters submitted to them, in addition to those specified in this Rule.

Rule 31. The first sentence of this Rule states that the reports of all committees or working parties "shall be referred to the General Committee for coordination;" the next sentence reads "after being examined by the General Committee." In order that there be no misunderstanding about the meaning of this Rule, we interpret it to mean "once the reports, including draft resolutions, have been examined," etc.

With respect to the organization of the Conference, our views may be summarized as follows:

1. The duration of the Conference should not exceed 12 calendar days, as follows:

Every weekday from Monday through Saturday would be a working day, Sunday would be free, and the second Tuesday would be devoted to the Technical Discussions. Thus, if the Conference were to begin on a Monday, there would be six working days in the first week and in the second three (Monday, Wednesday, and Thursday), since, we repeat, Tuesday would be devoted to the Technical Discussions. This method would permit the members of delegations who are to attend the Technical Discussions to arrive later at the Conference and, moreover, would allow the secretariat to utilize Tuesday for the preparation of documents, etc. We believe that, in this way, the Conference could advance its work and finish its business before the Friday of the second week, and the delegates could return to their countries at an earlier date.

2. The working day should extend over 7 hours, from 9:00 to 12:30 in the morning, with half an hour for a coffee break and from 3:00 to 6:30 p.m., with another half hour break, making a total of six hours of work. In the nine days of the Conference this would give 54 hours for sessions, which would be sufficient, in our opinion, for the examination of all the agenda items. This, of course, does not include the Tuesday of the second week, which would be set aside for the Technical Discussions. Moreover, nothing in this arrangement precludes the possibility of holding a night session if it were necessary.

3. The Conference should decide that a strict timetable of work be maintained and that no special circumstances should be allowed to modify it. The opening of each session should be announced 10 minutes before the time indicated and every effort should be made to ensure that at mid-day or at the hours appointed for lunch there be no commitments to prevent the delegates from being present when the afternoon meeting begins; any social events planned should begin after 7:00 p.m.

4. We also believe that the following merits consideration: once the Quadrennial Report of the Director has been submitted to the Conference, the reports of the delegates should be as short and concise as possible, since a full report on the health activities of each country could be submitted in writing by the delegations at the beginning of the Conference. We also believe it advisable for the Quadrennial Report of the Director to be submitted to a working party which could examine it in detail. We support the proposal to abandon the traditional arrangement of having two committees, since most of the items before the Conference could be dealt with in plenary sessions. Items which require it could be dealt with by committees or specific working parties; this would not only advance the work of the Conference but would result in great savings since fewer interpreters would be necessary and the expenses on equipment, personnel, premises, etc., would also be reduced. Finally, if the two committees are to be maintained, their timetables should be revised so as to ensure that they do not sit at the same time and that the same meeting room can be used by both committees.

These are the views that our Revolutionary Government wishes to submit through you to the delegates to the XV Meeting of the Directing Council and the XVI Meeting of the Regional Committee of the WHO for the Americas which is to be held in Mexico from 31 August to 11 September 1964.

I am, Sir, yours truly,

(Signed)
DR. JOSÉ R. MACHADO VENTURA,
Minister of Public Health

DOMINICAN REPUBLIC
MINISTRY OF HEALTH AND SOCIAL WELFARE

No. 02508 Santo Domingo, D.N., 8 November 1963

I take pleasure in acknowledging receipt of your letter No. CT-CL-28-63 of 1 November 1963, together with its Annex, and in informing you that due note has been taken of its contents.

I am, Sir,

Yours truly,

(Signed)
DR. TOMÁS ALCIBIADES ESPINOSA,
Secretary of State for Health
and Social Welfare

DOMINICAN REPUBLIC
MINISTRY OF HEALTH AND SOCIAL WELFARE

No. 04668 Santo Domingo, D.N., 5 December 1963

Further to our letter No. 02508 of 8 November 1963 and in reply to your letter CT-CL-28-63 of 1 November, I have the honor of making the following observations:

(a) The expenses involved in holding the Pan American Sanitary Conference which, according to the Rules of Procedure must be held every four years in one of the capitals of the Member States, place a very heavy burden on the budget of the Pan American Health Organization, at a time when some Member States are not meeting their financial obligations to the Organization;

(b) On the other hand, because of the nature of the Directing Council, the meetings of that body are shorter and less expensive and should be held successively in one of the Member Countries. The meeting place chosen would depend on the country concerned submitting a prior invitation, which would have to be accepted by an absolute majority of the votes of the delegations.

(c) Further, by properly coordinating the timetable of the Conference so as to ensure that the two main committees do not meet simultaneously, it would not be necessary to use twice the number of interpreters, thus effecting savings in this respect, in other types of personnel, and in meeting rooms if the main committees were held at different hours.

I am, Sir,

Yours truly,

(Signed)

DR. TOMÁS ALCIBIADES ESPINOSA,
Secretary of State for Health
and Social Welfare

REPUBLIC OF ECUADOR
MINISTRY OF SOCIAL WELFARE AND LABOR

Section: Health and Hygiene

No. 4982-S Quito, 20 November 1962

I acknowledge receipt of your letter CT-CL-16-62 of 9 November, in which you reported that the Executive Committee of the Pan American Health Organization, at its 47th Meeting held in Minneapolis, Minnesota, on 3 September 1962, drew attention to the advisability of making a study of the pertinent statutory provisions with a view to simplifying the organization of the Pan American Sanitary Conference and of clarifying its Rules of Procedure. You also requested that this Ministry submit any comments or observations it considered pertinent in this connection.

I should like to state that in due course we will forward our comments and suggestions so that they may be included in the report you are to submit to the next meeting of the Directing Council in the fall of 1963.

Very sincerely yours,
For the Minister of Health and Hygiene

(Signed)

ARMANDO ENDARA C.,
Assistant Secretary

REPUBLIC OF ECUADOR
MINISTRY OF SOCIAL WELFARE AND LABOR

Section: Health and Hygiene

No. 673-S Quito, 8 November 1963

I am pleased to inform you that I have received your letter CT-CL-28-63 of 1 November 1963, in which you were good enough to ask this office to submit, in accordance with Resolution XXVI of the XIV Meeting of the Directing Council, XV Meeting of the Regional Committee of the World Health Organization for the Americas, such comments and suggestions as were deemed advisable in connection with the study on the organization of the Pan American Sanitary Conference.

I should like to inform you that this Ministry is making a careful study of the documents forwarded with

the letter and that in due course I shall inform you of any suggestions we may have in this respect.

I am, Sir,

Very sincerely yours,
For the Minister of Social Welfare

(Signed)
RAMÓN YULEE T.,
Assistant Secretary

REPUBLIC OF EL SALVADOR
MINISTRY OF PUBLIC HEALTH
AND SOCIAL WELFARE

Ref. 301-3 San Salvador, 28 February 1963

I acknowledge receipt of your letter No. CT-30-63 of 23 January of 1963. I should like to inform you that I have read the Final Report of the 47th Meeting of the Executive Committee, wherein it is shown that the members favor initiating a study of the organization of the Conference with a view to simplifying it, clarifying its Rules of Procedure, removing certain anomalies, and improving certain provisions of the Rules.

The observations made by Mr. Calderwood, the Representative of the United States of America, are very interesting and worth taking into account. The undersigned is of the opinion that they should be submitted for consideration to the next meeting of the Council in 1963, at which time it might be advisable to establish a committee to present the amendments to be approved in 1964 or in 1965.

Very truly yours,

(Signed)
ERNESTO R. LIMA,
Minister of Public Health and Social Welfare

REPUBLIC OF EL SALVADOR
MINISTRY OF PUBLIC HEALTH
AND SOCIAL WELFARE

No. 04412 San Salvador, 18 June 1964

With reference to your letter CT-CL-28-63 of 1 November 1963, in which you requested suggestions concerning the organization of the Pan American Sanitary Conference, I have carefully read the opinions of 10 countries, some of which have made what appear to be very important suggestions. However, I believe it advisable for the Pan American Sanitary Bureau, which has experience in administering and conducting these Conferences, to make its views known. This would help guide the representatives of the countries, since they only receive the "product," but do not have a detailed knowledge of how the "product" is prepared.

It is regrettable that the opinions of only a few countries are at hand. We therefore suggest that even though the report is not required until 1965, the Directing Council in 1964 establish a working party which, together with Bureau personnel, can prepare a report in sufficient time to allow the Executive Committee to present it in 1965. The work of this working party might possibly be made easier if it knew when the Pan American Sanitary Bureau will be moving into its new headquarters building, since such a move will eliminate certain problems which have sometimes occurred when the Conference was held in premises not suited for the purpose.

I am, Sir,

Yours truly,

(Signed)
ERNESTO R. LIMA,
Minister of Public Health and Social Welfare

REPUBLIC OF FRANCE
MINISTRY OF FOREIGN AFFAIRS

United Nations and
International Organizations
No. 001 Paris, 7 January 1963

In your letter CT-CL-16-62 of 9 November 1962 you were good enough to inform us that the Executive Committee of the Pan American Health Organization had recommended at its 47th Meeting that a study be made of the statutory provisions for the purpose of simplifying the organization of the Pan American Sanitary Conference and of clarifying its Rules of Procedure.

I have the honor to submit to you the following observations:

The expenses involved in organizing the Pan American Sanitary Conference which, according to the Constitution, is held every four years in one of the Member Countries of the Organization whose capital is in the American Hemisphere, are in fact rather heavy in relation to the budget of the Pan American Health Organization, at a time when certain Member Countries still do not manage to meet their financial obligations to the Organization.

If the Conference could be organized at Headquarters itself, in Washington, the expenses would certainly be less. This suggestion might be borne in mind with respect to the next Conference which will be held in 1966, at which time the new building will probably be ready.

On the other hand, the meetings of the Directing

Council which are much shorter and less expensive, might be held every other year at the request of at least half the delegations, in countries other than the United States.

The regulations could therefore be amended to read as follows:

The Pan American Sanitary Conference will be held every four years at the Headquarters of the Organization in Washington, D.C., U.S.A.

The Directing Council will also meet at the Headquarters of the Organization; however, it may, at the request of at least half the delegations, meet, every other year, in a host country that is a Member of the Organization.

Another point is that if the technical committees meet simultaneously during the Conference, there have to be two teams of interpreters throughout the Conference, which is very expensive. At Minneapolis these two committees met simultaneously only once, since the number and the particular fields of competency of the delegates did not allow two concurrent meetings.

It is therefore clear that an arrangement of the timetable of the Conference would make it possible, without altering the duration of the meeting, to have the two committees sitting at different times and thus to save on interpreters, personnel, and premises.

Very sincerely yours,

(Signed)
For the Minister and with his authority
THE MINISTER PLENIPOTENTIARY,
Director of United Nations and
International Organization Affairs

REPUBLIC OF GUATEMALA
MINISTRY OF PUBLIC HEALTH
AND SOCIAL WELFARE

No. 096114 Guatemala, 7 November 1963

I acknowledge receipt of your letter CT-CL-28-63 of 1 November 1963, together with which you were good enough to send a copy of Resolution XXVI adopted at the meetings of the Directing Council and of the Regional Committee of the World Health Organization for the Americas, requesting such comments and suggestions as are deemed appropriate concerning the study on the organization of future conferences.

In due course I shall be pleased to send the comments requested.

Very truly yours,

(Signed)
DR. ALFONSO PONCE ARCHILA,
Minister of Public Health
and Social Welfare

REPUBLIC OF HONDURAS
OFFICE OF THE SECRETARY OF STATE
MINISTRY OF PUBLIC HEALTH
AND SOCIAL WELFARE

No. 5008 Tegucigalpa, D.C., 20 November 1962

I acknowledge receipt of your letter No. CT-CL-16-62.

I should like to inform you that in due course we shall send you the "observations and suggestions" deemed pertinent for facilitating the work of future Conferences of the Organization of which you are the Director.

Very sincerely yours,

(Signed)
DR. R. MARTÍNEZ V.

REPUBLIC OF HONDURAS
OFFICE OF THE SECRETARY OF STATE
MINISTRY OF PUBLIC HEALTH
AND SOCIAL WELFARE

No. 248 Tegucigalpa, D.C., 11 December 1963

Further to our letter No. 5008 of 20 November 1962, we very respectfully make the following suggestions:

1. We believe that the meetings should be held in Washington, D.C., since, in addition to the fact that that city is the Headquarters of the Organization, the Organization will now have its own building there with all the necessary facilities for holding such meetings.

2. We suggest that the election of the Director of the Bureau (Rule 53 of the Rules of Procedure of the Conference) should be simplified by requiring only an absolute majority for election, that is, one half plus one of the votes.

3. We believe that the records of the meetings are too long and detailed; we therefore suggest that in the future they be shorter, that details be omitted, and that only essential statements be included. A very short summary might accompany lengthy records.

We trust that these three foregoing suggestions are worth taking into account, since they are intended to improve the work of the Organization under your worthy direction.

I am, Sir,

Yours truly,

(Signed)
DR. ABRAHAM RIERA H.,
Minister of Public Health

JAMAICAN FOREIGN SERVICE
MINISTRY OF EXTERNAL AFFAIRS

No. 69/012 Kingston, 12 June 1964

Please refer to your letter addressed to the Prime Minister, No. CT-CL-28-63 of 1 November 1963, requesting comments in regard to the study on the organization of the Pan American Sanitary Conference.

I am directed to offer the following comments and suggestions:

(a) The Government supports the need for correction of the anomalies and of amendments to the Rules of Procedure as suggested by the Director of the Office of International Economic and Social Affairs of the Government of the United States.

(b) It is further suggested that a serious attempt be made to shorten both the duration and cost of the Conference, by abolishing the two main committees and having all the work done in plenary session.

It is felt that the adoption of suggestion (b) would entail the appointment of small working parties to provide the Conference in plenary session with all detailed information and the means of studying any particular proposal.

In addition, the limiting of the Conference to, say, a maximum of eleven working days would ensure that all the delegations would understand from the outset that the work must be completed in that specific time.

Yours sincerely,

(Signed)
J. M. LLOYD,
Ag. Permanent Secretary

KINGDOM OF THE NETHERLANDS
MINISTRY OF SOCIAL AFFAIRS AND PUBLIC HEALTH

Ref.: DGV/ISVA/IVG 7223

The Hague, 22 April 1963

In reply to your letter dated 9 November 1962, I inform you that my Government sees no reason to submit proposals for a study of the rules and regulations with a view to simplifying the organisation of the Pan American Sanitary Conference.

We are of the opinion that the points raised during the 47th meeting of the Executive Committee of the PAHO do not necessarily require amendments of those regulations, which have been modified not long ago. We would rather recommend a supple application of those rules.

Yours sincerely,

(Signed)
PROF. P. MUNTENDAM,
Director General of Public Health

MEXICO
OFFICE OF THE SECRETARY OF
HEALTH AND WELFARE

Office of the Undersecretary for Health
International Affairs Section
Ref: No. 021-240 Mexico, D.F., 15 January 1963

I acknowledge receipt of the Rules of Procedure of the Pan American Sanitary Conference (Document CSP16/2).

After reading it, I should like to inform you that I agree with the proposed text appearing in the first column of the document forwarded.

Very sincerely yours,

(Signed)
DR. MIGUEL E. BUSTAMANTE,
Undersecretary

REPUBLIC OF PANAMA
MINISTRY OF LABOR, SOCIAL WELFARE,
AND PUBLIC HEALTH

No. 519-M Panama City, 16 June 1964

With regard to your letter CT/Doc-CL-8-64 of 8 June 1964, I have the honor to inform you that after my experience at the meeting of the Conference held in Minneapolis, I have no comment to make on the structure and organization of the Pan American Sanitary Conference, and that from my country's point of view no change is required.

Very truly yours,

(Signed)
DR. BERNARDINO GONZÁLEZ RUIZ,
Minister of Labor, Social Welfare,
and Public Health

REPUBLIC OF PARAGUAY
MINISTRY OF PUBLIC HEALTH
AND SOCIAL WELFARE

Ref: O.A.I. No. 15 Asunción, 20 August 1964

We have received your letter CT/Doc-CL-8-64 in which you kindly informed us that the Executive Committee of the Pan American Health Organization, at its 50th Meeting held in Washington from 27 April to 1 May 1964, adopted Resolution VIII relating to the status of the study of the structure and organization of the Pan American Sanitary Conference, in accordance with the proposal made at the 47th Meeting of the Executive Committee (September 1962), and the resolution adopted by the XIV Meeting of the Directing Council (September 1963).

From our reading of Document CE50/14 we find that the observations made by the Governments of France and Venezuela coincide with our own, and we therefore propose the two as a motion by this Ministry.

Yours very sincerely,

(Signed)
DR. DIONISIO GONZÁLEZ TORRES,
Minister

REPUBLIC OF PERU
MINISTRY OF PUBLIC HEALTH
AND SOCIAL WELFARE

No. 74/62.-O.I.I. Lima, 19 November 1962

I am very pleased to acknowledge receipt of your letter CT-CL-16-62 of 9 November 1962, the contents of which were of much interest to me and of which due note has been taken.

. . . .
. . . .

Very sincerely yours,

(Signed)
DR. EDUARDO GOICOCHEA,
Chief Medical Officer,
Office of International Exchanges

REPUBLIC OF PERU
MINISTRY OF PUBLIC HEALTH
AND SOCIAL WELFARE

No. 615-64-D95 Lima, 19 June 1964

I am pleased to reply to your letter CT/Doc-CL-8-64 regarding the study on the organization of the Pan American Sanitary Conference.

I should like to state in this regard that we believe it necessary to introduce changes in the Constitution and the Rules of Procedure of the Conference, Directing Council, and Executive Committee, with a view to harmonizing their functions and thereby shortening the duration of each meeting, which is the specific objective pursued in this case.

We believe that the Executive Committee should be an organ for study and analysis, to which the Governments delegate true executive powers, so that the items it studies, especially such routine ones as the Emergency Revolving Fund, Technical Discussions, Amendments to the Staff Rules, etc., need not be reviewed by the Council or by the Conference, and that the report of the Chairman of the Executive Committee should be the focal point of the discussion.

In our opinion, the Executive Committee does not fulfill the role it should, namely that of simplifying the operational machinery of the Governing Bodies of the Organization.

We are in full agreement with the suggestion made by some Governments to the effect that the Conference should work with only one main committee; the expenditure for two committees is not justified, provided the agenda is reduced as indicated above.

It would take too long to examine in detail each article of the Constitution and of the Rules of Procedure; therefore, the suggestion made by the Government of El Salvador to establish a committee to study this matter and submit a proposal, seems to be a good one and is possibly the only practical procedure for arriving at a definitive solution which will modernize the operations of the Governing Bodies of the Organization.

This committee, which could be appointed by the Directing Council at its next meeting, could submit preliminary draft amendments to the Constitution and to the Rules of Procedure of the Governing Bodies to the 52nd Meeting of the Executive Committee for examination. They could then be submitted to the Council before the next meeting of the Pan American Sanitary Conference.

Very sincerely yours,

(Signed)
JAVIER ARIAS STELLA,
Minister of Public Health
and Social Welfare

TRINIDAD AND TOBAGO
MINISTRY OF EXTERNAL AFFAIRS

POL 3/2/6 St. Ann's, Trinidad, W.I., 26 November 1963

Thank you for your letter CT-CL-28-63 of 1 November 1963, enclosing Resolution XXVI adopted by the XIV Meeting of the Directing Council, XV Meeting of the Regional Committee of the World Health Organisation for the Americas and other documents.

Any comments or suggestions this Government may have with regard to the study on the organisation of the Pan American Sanitary Conference will be transmitted to you after this document has been studied.

Yours faithfully,

(Signed)
A. MCNAMARA,
For, Permanent Secretary,
Ministry of External Affairs

UNITED KINGDOM
DEPARTMENT OF TECHNICAL COOPERATION

Ref: SS 223/245/06 London, 14 August 1964

Following receipt of your letter of 8 June 1964, and paper reference No. CD15/26 for Item 36 of the agenda for the XV Meeting of the Directing Council, we consulted the Governments of British West Indies dependent territories about the structure and organisation of the Pan American Sanitary Conference.

This is to let you know that none of the Governments concerned has expressed any views on this subject or on the comments already made (Document CE50/14) by other Members.

Yours sincerely,

(Signed)
A. H. TANSLEY

UNITED STATES OF AMERICA
DEPARTMENT OF STATE

Washington, D.C., 1 February 1963

In reply to your letter of 9 November 1962 to the Secretary of State, in regard to a study of pertinent rules and regulations with a view to simplifying the organization of the Pan American Sanitary Conference and clarifying its Rules of Procedure, I have the honor to submit on behalf of the United States Government the following observations:

With respect to clarification of the Rules of Procedure, I would invite your attention to a few imperfections and anomalies in the following rules which, it seems to us, should be corrected:

Rule 8. The qualifying words "whenever possible" apply to the provisional agenda as well as to documentation. The provisional agenda should be made available to Governments at least 30 days before the Conference; 60 days would be even better.

Rule 13. This Rule or Rule 28 should be amended since the former limits the terms of reference of plenary sessions to matters of general interest and action on reports of committees. According to Rule 28, the establishment of committees is optional.

Rule 15. Since all Delegations participating in the Conference have the right to vote, even if limited, in the case of certain Delegations, the phrase "with the right to vote" in this rule, which applies to the establishment of a quorum, is superfluous.

Rule 20. Authorizing the President, or a Vice President while presiding, to appoint another member of his Delegation to act as the Delegate of his Government in plenary sessions implies that (1) only Chiefs of Delegation may be elected President and (2) that only Chiefs of Delegation may speak in plenary sessions. This is contrary to established practices and an unnecessary restriction on the representation of governments.

Rule 22. This rule does not take account of meetings of the Conference held at Headquarters, which are provided for in Rule 2. The equivalent to this rule in the Rules in effect before their revision at the XVI Conference was applicable to last year's meeting of the Conference.

Rule 28. (see Rule 13).

Rule 43. If votes are equally divided, the motion, strictly speaking, should be regarded as "not adopted," not as "rejected." The requirement of a majority for a decision would apply to the rejection as well as to the adoption of a motion.

Rule 54. The words "take account of" would be more accurate than "in conformity with." Article 52 of the WHO Constitution provides for the appointment of a Regional Director by the Executive Board of WHO in agreement with the Regional Committee, not for nomination by the Regional Committee.

Rule 46. In 1961 when the revised text of the rules of the Directing Council was considered, the United States suggested the inclusion of language in this rule which would prohibit the use of a secret ballot when votes were taken on budgetary matters. It did not press for this amendment when it was pointed out that the use of the secret ballot in these instances would be contrary to established practice. Since rules have been introduced into the revised text to bring them into conformity with established practices (Rule 36, for example), Rule 46 might be amended for the same purpose.

As to simplification of the organization of the Conference and at the same time achieving a reduction in its costs, we would suggest for your consideration that the practice of establishing two main committees be abandoned or, if this does not appear to be desirable, that the two committees be scheduled to meet at different times. In this connection, it might be noted that the establishment of committees is optional under Rule 28 of the Rules of Procedure.

It would appear to be possible to conduct all of the business of the Conference in plenary sessions, and if deemed advisable, in order to expedite the work of the Conference, to set up *ad hoc* committees or working parties on particular questions. In addition to the reduction in cost of the Conference which would be realized, such an arrangement would have the further advantage of permitting those Members which are represented by a single delegate to be represented at all meetings.

At the XVI Conference most of the business was transacted either in the Committee on Technical Matters or in joint meetings of the two main committees. The Committee on Administrative, Financial, and Legal Matters completed its agenda in a few hours. All the meetings, except the meeting of the Committee on Administrative, Financial, and Legal Matters, which occurred at the same time as a meeting of the Committee on Technical Matters, could have been held in one room. Since arrangements had been made which would allow the two main committees to meet simultaneously, the result was that one room and the IBM equipment in that room were not utilized for the greater part of the session. Moreover, several interpreters were not required for the purpose for which they were employed except at the time of the meeting of the Committee on Administrative, Financial, and Legal Matters.

Alternatively, in the event it is considered desirable to continue the practice of establishing two main committees, it is suggested that their meetings be scheduled for different times so that both committees might be accommodated in the same room.

Sincerely yours,

(Signed)
NATHANIEL M. KITTERICK,
Director
Office of International, Economic, and Social Affairs

REPUBLIC OF VENEZUELA
THE MINISTER OF HEALTH AND SOCIAL WELFARE

SI-626 Caracas, 20 December 1962

In reply to your letter No. CT-CL-16-62 of 9 November I am very pleased to send you the attached suggestions of this Ministry for simplifying the Pan American Sanitary Conference.

I hope these suggestions and those submitted by other members of the Organization will further the purpose of obtaining more efficiency in the functions of the Conference at the same time as a reduction in its cost.

Very sincerely yours,

(Signed)
ARNOLDO GABALDON,
Minister of Health and Social Welfare

Suggestions of the Ministry of Health and Social Welfare of Venezuela for the simplification of the Pan American Sanitary Conference

1. The Conference should not last for more than 11 calendar days, of which 9 would in fact be working days. If it were to begin on the Tuesday of one week, it could end on the Friday of the following week. The Conference would work full-time every working day, including Saturday, leaving Sunday and the second Thursday free, the latter to enable the necessary Secretariat work to be completed in time for the closing session.

The opening of the Conference on Tuesday would make it possible to overcome any travel difficulty of delegates since they would have 3 possible days prior to the opening for travelling, namely Saturday, Sunday, or Monday, and the majority could thus be present at the opening session. Closure on a Thursday would likewise facilitate the return journey both for delegates and such personnel of the Bureau as have to travel and this would also constitute a saving of time.

2. The working day should be 7 hours long; of these 6 would be devoted to meetings, 1 hour being set aside for coffee breaks in the morning and afternoon. If we subtract these breaks, the morning of the first Tuesday for a preliminary session and an inaugural session, one complete day for the Technical Discussions (which might be the Tuesday of the second week), and all of the last Friday, which would be devoted to the closing session, the amount of time available would be 39 hours.

An examination of the proceedings of the Conference in Minneapolis shows that, excluding the inaugural and closing sessions, but not the coffee breaks, 39½ hours were actually devoted to meetings. The arrangements proposed would produce the same number of hours, plus the sum of the coffee breaks.

3. If there is a real desire to shorten the Conference, the most important thing to do is to fix beforehand the dates of opening and closing the Conference and not to alter them. With the daily program and timetable proposed here it would be possible to do in 11 calendar days what was done in Minneapolis in 14. In order to achieve this, it is recommended that the full suggestions be taken into account:

(a) To plan the Conference for a period of 11 days during which, except for Sunday, there will be no other non-working day;

(b) To establish the following timetable for the sessions: Morning: 9:00-12:30, with a break of 30 minutes at 10:30. Afternoon: 2:30-6:00, with a break of 30 minutes at 3:30 or 4:00 p.m.

This arrangement produces 6 active hours of work in sessions and 7 hours a day in all, including the two breaks of half-an-hour each. To return to the Minneapolis Conference: it will be found that 19 separate sessions were held (plenary sessions of the Conference, the separate sessions of the Committees and joint sessions of the Committees) in a period of about 40 hours, which gives an average of about 2 hours per session. If the above-mentioned timetable is accepted, the same number of hours of work will be available in a smaller number of days, and this is what it attempts to achieve.

(c) To avoid receptions and visits between 12:30 and 2:30 p.m. on those days on which there is an afternoon session at 2:30. These receptions and any other social activities should be arranged for the evenings but never before 7:00 p.m. Visits to institutions, sight-seeing trips, and other similar activities which require more time should be made only on the two non-working days of the Conference, that is, on the Sunday and on the second Thursday.

(d) To call the delegates to the session by a bell rung 5 minutes before the time for the beginning of the session; to begin at the exact time established and also to end the session at the exact time, although the latter may depend upon whether or not there are immediate commitments at the end of the session.

(e) To hold night sessions—of not more than 2 hours—whenever it is obvious that the time available during the day is not sufficient to ensure that all the work will be finished by the afternoon of the second Wednesday of the Conference.

4. Among the items and documents submitted to the Conference a division should be made between those that are simply for the information of the delegates, which will not be subject to debate, and those which refer to specific subjects which the Conference must examine and on which it must take a decision.

For example, the resolutions that the Conference adopts on the report of the Executive Committee, the collection of quotas, the Emergency Revolving Fund, Technical Discussions, Resolutions of the WHO of interest to the Regional Committee, are nothing more than protocolary decisions. These items, some because of their slight importance (Emergency Revolving Fund), others because they are already known by the delegates (Technical Discussions), and still others because the decision of the Conference on them is obvious (resolutions of the World Health Assembly) should not be subject to debate in the Conference but should merely be presented for information.

5. The examination of the Quadrennial Report of the Director should not be an occasion for bouts of oratory nor should it be the basis for each representative to explain what has been done in his own country. That might be done in a summary to be circulated as an information document among the delegates during the Conference. The examination of this Report and that of the Summary of the Quadrennial Reports on health conditions in the countries usually gives rise to very similar speeches by the delegates. It therefore seems advisable to limit these speeches to a single general statement by each delegate on both items, which will result in a considerable saving of time.

6. The examination of the Program and Budget of the Organization is perhaps the most important task of the Conference. The practice up to now has been for this examination to be made by Committees I and II in a joint session and then by the Conference in plenary session. The experience gained during the Directing Council Meeting held in Guatemala in 1956 and that held in Washington in 1957 showed that the use of a working party to make a thorough analysis of the budget is an advisable procedure. Even though the working party is made up of a small number of delegates (minimum 5, maximum 7) any delegate who is not a member must of course submit to it the observations of his Government, either in writing or orally. The report of this working party can be submitted direct to the Conference, where discussion will be confined to the specific items to which the group draws attention.

It should be borne in mind that the budget is already known to the countries as a preliminary draft one year beforehand, that it is analysed in detail by the Executive Committee at its meeting that is held prior to the Conference, and that the countries have thus had sufficient time to examine it and to formulate criticisms and suggestions. These criticisms and suggestions should be brought to the attention of the working party which will examine them in conjunction with the program and budget and shall be entitled to include them in its report. The working party may also be set up as a sub-committee of Committee II but in this case its report will not go direct to the Conference but to this Committee.

7. The Quadrennial Report of the Director might be dealt with in the same way, namely, a working party (or a sub-committee of Committee I) should study it in detail, receive observations from delegates, and report back to the Committee.

8. As a final proposal the following program of sessions is suggested:

Tuesday: Morning: Preliminary meeting during which the heads of the delegations meeting as a kind of committee on nominations agree on the candidates for the position of officers of the Conference: President, Vice-Presidents, Chairmen of the Committees, Committee on Credentials, General Committee, officers of the Technical Committees, etc. At this meeting the program of sessions might also be approved. Immediately after

	this meeting the inaugural session will be held.
	Afternoon: Working session
Wednesday:	Working sessions
Thursday:	Working sessions
Friday:	Working sessions
Saturday:	Working sessions
Sunday:	Free
Monday:	Working sessions
Tuesday:	Technical Discussions
Wednesday:	Working sessions
Thursday:	Free. The Secretariat services will have this day for the preparation of the Final Report.
Friday:	Closure, in the morning or afternoon, according to when the Secretariat completes its work.

Annex 12

THIRD ANNUAL MEETINGS OF THE INTER-AMERICAN ECONOMIC AND SOCIAL COUNCIL AT THE EXPERT AND THE MINISTERIAL LEVELS [1]

The Director presented to the Executive Committee at its 52nd Meeting a report on the Third Annual Meetings of the IA-ECOSOC at the Expert and the Ministerial Levels, which had been held in Lima, Peru, from 30 November to 11 December 1964.

After a careful examination of the report, the Committee adopted Resolution XII,[2] in which it took note with great satisfaction and interest of the report of the Director on the Third Annual Meetings of the IA-ECOSOC; resolved to transmit the above-mentioned report to the XVI Meeting of the Directing Council; and invited the Directing Council to express its satisfaction with the interest shown by the Third Annual Meetings of the IA-ECOSOC in health in the Americas, and especially the recommendations approved at the expert level on foot-and-mouth disease, rural and urban water supply, and the inclusion of investment proposals on health in the requests for international loans for land settlement, road building, urbanization, and other programs. In addition, it recommended to the Directing Council that: (1) it instruct the Director of the Bureau to continue to develop and strengthen relations between the Organization, IA-ECOSOC, and the Inter-American Committee on the Alliance for Progress (CIAP), in order to bring about the integration of health activities in economic and social development programs; and (2) it urge the Governments of the Organization to include representatives of Ministries of Health in their delegations to the Annual Meetings of the IA-ECOSOC and that they endeavor to have included in the agenda of those meetings specific items concerning the participation of the health sector in the dynamic process of development of the countries of the Americas.

The Director therefore has the honor to submit the preceding resolution and Document CE52/2, Rev. 1, (see Appendix), a revised form of the report on which it was based.

[1] Document CD16/10 (24 June 1965).
[2] *Official Document PAHO* **62**, 35-36.

Appendix

THIRD ANNUAL MEETINGS OF THE INTER-AMERICAN ECONOMIC AND SOCIAL COUNCIL AT THE EXPERT AND THE MINISTERIAL LEVELS [1]

Introduction

The Third Annual Meetings of the IA-ECOSOC at the Expert Level and the Ministerial Level were held in Lima, Peru, from 30 November to 11 December 1964.

The Meetings were attended by delegations from all the Member States of the Organization of American States (OAS) and by observers from Canada, Trinidad and Tobago, Israel, Japan, and certain European countries. Representatives of the Economic Commission for Latin America (ECLA), the Inter-American Develop-

[1] Document CE52/2, Rev. 1 (24 June 1965).

ment Bank (IDB), the Inter-American Committee on the Alliance for Progress (CIAP), and the Panel of Nine were present as special participants, and there were also observers from the specialized organs of the OAS and certain United Nations agencies.

As in previous years, the purpose of the Meetings was to make an annual review of the Alliance for Progress and to formulate policy, and to make general and specific recommendations for the ensuing year. On this occasion, because of the existence of CIAP, which was established at the meeting of the IA-ECOSOC held in São Paulo in 1963, the Meetings in Lima differed somewhat from earlier ones. In the opinion of the Secretariat, CIAP had already accomplished a large part of the work formerly assigned to the Special Commissions—one of which dealt with health matters—and that, in addition, the Committee had already evaluated the status of the Alliance for Progress program, which would make it possible to reduce the reports, documentation, program analysis, and the agenda. There was also a clear desire to limit the contents of the Final Report and to reduce the number of resolutions adopted by IA-ECOSOC.

The agenda of the meeting at the ministerial level was as follows:

I. ANNUAL REVIEW OF THE ALLIANCE FOR PROGRESS

A. Recent trends in and projections of, the economic and social development of the countries of Latin America.

B. Activities of, and report by, the Inter-American Committee on the Alliance for Progress (CIAP).

C. Special aspects of economic and social development.

D. The ideological advance of the Alliance for Progress.

II. FOREIGN TRADE AND LATIN AMERICAN ECONOMIC INTEGRATION

A. Results of, and prospects arising from, the United Nations Conference on Trade and Development.

B. Activities of the Latin American Free Trade Association and the Central American Common Market and multinational projects.

III. SPECIAL DEVELOPMENT ASSISTANCE FUND

Draft Statutes of the Special Development Assistance Fund.

IV. PROGRAMS AND BUDGETS

A. Program and budget of the Pan American Union within the sphere of competence of IA-ECOSOC, 1965-1966.

B. Program and budget of the Special Development Assistance Fund.

C. Plan of activities and budget of the Technical Cooperation Program.

V. OTHER BUSINESS

In accordance with the nature and the agenda of the meeting, the discussions were focused on economic and political questions and the discussion of the program and budget. A summary of the main items discussed and the resolutions adopted is given below:

Economic Development

The documentation and discussions indicate that economic development in Latin America in 1964 shows signs of recovery although this must be considered with reservations. Whereas in previous years in the majority of countries of the Hemisphere the rate of growth of the national product did not keep pace with population growth, it appears that in 1964 the increase in per capita production will be about 3 per cent, or more than the average minimum growth established in the Charter of Punta del Este. Other positive factors cited were the national development plans submitted by nine countries to the Panel of Experts; the gradual introduction of structural reforms, which are creating economic and social conditions favorable to development; and the increase in value of exports during the past year.

Among problems that still exist, mention was made of unfavorable foreign trade conditions as the most important factor for Latin American development; inflation, which in five countries has exceeded 25 per cent, in two has reached 48 per cent, and in one 87 per cent; agricultural production, which has remained stagnant for the last three years; and the high short-term foreign indebtedness and a need for long-term foreign financial assistance.

Inter-American Committee on the Alliance for Progress (CIAP)

The meeting expressed its satisfaction with the work carried out by CIAP in its first year of existence. It praised the country studies made by this body, since they will make it possible to determine Latin America's need for external resources. The opinion was expressed that the preparation of country reviews should constitute the main activity of CIAP and the basis for the annual review of the Alliance for Progress; and that these studies could be strengthened if statistical services were improved and there was a more thorough analysis of operating and sectoral problems. It was recommended that, if CIAP considered it necessary, it should convene a meeting of the chiefs of national planning offices to study the methodological bases to be used in each country for the preparation of the annual country studies and recommended that, as was done in 1964, a general summary of the problems and prospects of the Alliance for Progress based on these studies, should be prepared and submitted to the next annual meeting.

The administrative situation of CIAP was discussed, since it now serves as a Permanent Special Commission of IA-ECOSOC in multilateral representation of the Alliance for Progress. The result of these discussions was a decision to ask CIAP itself to prepare a report, together with such recommendations as it deemed advisable to strengthen its activities. It was also authorized to engage a small group of highly qualified technical personnel and it was given new functions with respect to trade the development problems.

Special Development Assistance Fund

Approval was given to the statutes and budget of the Special Development Assistance Fund for financing the activities of the Alliance for Progress. These activities should not duplicate or replace those that are included in the regular program and budget of the General Secretariat or in programs of other agencies. The Fund, which is a multilateral one, will be financed by voluntary contributions from the Member States of the OAS and other public and private sources of funds.

The program approved for 1965 consists of technical assistance missions for over-all and regional planning, sectoral programs, training projects under the Program of Technical Cooperation, and other activities directly connected with the Alliance for Progress.

At the meeting the following contributions were pledged: the five Central American republics, $125,000; Colombia, $150,000; Ecuador, $35,000; Peru, $60,000; Brazil, 20 million Cruzeiros; and the United States of America, up to $4.5 million, with the proviso that this amount should not exceed 66 per cent of the total Fund. The pledge made by the Government of Brazil includes only its contribution to the Program of Technical Cooperation; its contribution to the other activities of the Fund will be announced at a later date.

For various reasons connected with the administrative and budgetary systems in their countries, it was not possible for the representatives of other Governments to announce the amount of their contribution to the Special Fund, but it was agreed that they would inform the Secretary General of the OAS of their pledges at a later date.

The Fund will be organized and financed by IA-ECOSOC and administered under its authority. It will be the responsibility of CIAP to establish procedures and priorities within the framework of the policy established by IA-ECOSOC, and to supervise the operation of the Fund. The Secretary General shall be responsible to IA-ECOSOC for the administration of the Fund and the execution of its activities.

Planning

The meeting discussed planning activities in Latin American countries. The view was expressed that planning had made it possible to obtain a better knowledge of the fundamental problems to be faced in economic and social development, a more effective use of available local resources, and the channeling of external financing toward projects with the highest national priority. The plans prepared have not yet managed to coordinate all aspects of economic development with those of social progress. The content of the plans should be improved and the usual excessively broad goals and projections should be avoided; more importance should be given to sectoral analysis of the programs and it was important to overcome many defects still to be observed in the plans for the social sectors, particularly in those for health and education; in preparing general programs, greater attention should be given to the redistribution of income as one of the basic objectives of these programs.

Manpower Resources

Bearing in mind that one of the main obstacles to development in Latin American countries is the shortage of properly trained personnel, it was recommended that OAS should intensify its assistance programs to Member Countries for programming available manpower.

Programs for Community Promotion of Cooperation or Community Development

Considerable time was devoted to this subject and some delegations called attention to the merit of these programs in promoting economic and social development in Latin America, even though not all the countries referred to the same activities. The resolution approved at the Ministerial Meeting states in its operative part: [2]

1. To recommend that the Secretariat of the Organization of American States and the Inter-American Committee on the Alliance for Progress lend ample cooperation to those member states that may wish to carry out integral community development programs.

2. To increase insofar as possible direct technical assistance to those countries that are carrying out community development programs on a national level.

Resolutions Relating to Health in the Americas

Only three of the 20 delegations of the Member States represented at the Meeting included representatives of the ministries of public health. The main decisions taken with respect to health were as follows:

Foot-and-Mouth Disease. The Meeting had before it two documents, one entitled "Importance and Consequences of Foot-and-Mouth Disease in the Americas, Report of the Pan American Foot-and-Mouth Disease Center on Progress in Planning and Executing Foot-and-Mouth Disease Control Campaigns," [3] and the other entitled "Evaluation of Project 77 of the Technical Cooperation Program of the Organization of American States." [4] The Meeting at the Expert Level adopted the following resolution,[5] the operative part reads as follows:

1. To recommend to the Pan American Sanitary Bureau that, acting through the Pan American Foot-and-Mouth Disease Center, it continue to give the countries all the cooperation and technical assistance in its power in the fight against foot-and-mouth disease, and in the preparation of draft applications for loans from international credit agencies to implement the national campaigns against foot-and-mouth disease that were presented and analyzed at the South American conference in Rio de Janeiro.

2. To hold as soon as possible, in accordance with the proposal made by the Inter-American Committee on the Alliance for Progress in regard to Project 77 of the Program

[2] Resolution 7-M/64. *OAS Official Records,* Ser. H/XII.8 (Eng.), p. 15.
[3] Document IA-ECOSOC/644.
[4] Document IA-ECOSOC/648.
[5] Resolution 1-E/64. *OAS Official Records,* Ser. H/XII.8 (Eng.), pp. 9-10.

of Technical Cooperation (Document CIES/621) and approved by the Inter-American Economic and Social Council at the Third Annual Meeting at the Expert Level, the meeting proposed in the recommendation with the participation suggested, in order to consider an expanded inter-American program with adequate financing and with multinational emphasis.

3. To recommend that the necessary measures be adopted at that meeting to increase, in the shortest possible time, the resources required by the Pan American Foot-and-Mouth Disease Center in order to meet the greater responsibilities that will result from the intensive development of national and multinational foot-and-mouth disease campaigns.

Rural and Urban Water Supply. Two draft resolutions, one dealing with urban water supply and the other with rural water supply, were submitted. The operative part of both resolutions were incorporated in the Final Report [6] as follows:

The IA-ECOSOC recommends that international credit agencies broaden their lending by the adoption of flexible financing systems, so as to intensify and extend development of programs for supplying drinking water to urban communities.

Owing to the interest shown by the countries and by international financing agencies, there has been a significant step-up in the installation of urban water-supply systems in recent years. However, the supplying of drinking water to rural areas continues to be one of the more neglected fields in the field of public health. It is necessary that external loans be obtained under favorable conditions and that the active participation of communities in programs to overcome this deficiency be encouraged.

Health Implications of Investments. A resolution was approved on this subject, the operative part of which was included in the Final Report [7] and reads as follows:

IA-ECOSOC suggests that when studies are being prepared on resettlement, urbanization, road-building, and other programs, health-service requirements should be taken into account, and that when applications for international financing are made, sufficient funds should be included to take care of the necessary expenses in this area. It will be advisable to use the technical resources of the ministries of health at the national level and the advisory services of the Pan American Health Organization in programming campaigns of investment in public health.

Regional Training Center for Technical and Administrative Personnel of Medical Care Institutions and Services in American Countries. A draft resolution was presented on this subject, and the following was incorporated into the Final Report: [8]

In the field of medical care, the ratio between hospital beds and population has, generally speaking, remained stationary. In some cases there has even been a falling-off. Moreover, training opportunities for medical and health officers are very limited. IA-ECOSOC thinks that consideration should be given to the possibility of establishing a regional school or center to meet this need. The General Secretariat of the Organization of American States might undertake a study on this matter.

Studies on Economic Development Needs and Social Progress and their Relation to Population Growth. A draft resolution on this subject was discussed, and the following was incorporated into the Final Report: [9]

Bearing in mind the importance of problems arising from demographic growth, IA-ECOSOC believes that studies should be carried out to determine the requirements of economic development and social progress as they relate to the population increase. In such studies proper attention should be given to the fact that Latin American population consists of high percentage of children and adolescents. Consequently, IA-ECOSOC recommends that Latin American countries carry out such studies, and charges CIAP with coordinating them on an international level and with providing the countries necessary technical assistance, in collaboration with international specialized agencies.

Other activities are mentioned in Chapter VI of the Final Report, "Social Programs in Development"; the introduction contains certain considerations on the end and means of social policy and sub-chapter D [10] deals with health:

At Punta del Este, the Latin American countries agreed to work to improve the health of their peoples and to increase life expectancy at birth by at least five years in the ensuing decade. Some progress has been achieved in this direction which, while it is still insufficient, shows the concern that exists in the fields of planning, improvement of health statistics, of personnel training, improvement in the organization and administration of services, environmental sanitation, particularly as regards water supply and drainage, the fight against diseases, nutritional improvement, and a rational organization of medical-care services.

IA-ECOSOC has noted the progress made in the continental program for the eradication of malaria, in spite of the existence of certain technical problems in some of the countries. In addition, programs aimed at the eradication of smallpox and yellow fever have continued, together with the ones for the control of communicable diseases such as tuberculosis, poliomyelitis, and others.

Other Resolutions

Other resolutions adopted at the meeting call upon the Member Countries to adopt decisions aimed at achieving the goals of economic integration; to continue plans for agrarian reform; and to intensify the information program concerning the Alliance for Progress.

The Director of the Pan American Sanitary Bureau has the honor to present this Report to the Executive Committee so that it may adopt whatever resolution it deems appropriate.

[6] *Ibid.*, p. 71.
[7] *Ibid.*, p. 71.
[8] *Ibid.*, p. 71.
[9] *Ibid.*, p. 55.
[10] *Ibid.*, p. 71.

Annex 13

REPORT ON ADMINISTRATIVE RATIONALIZATION IN THE PAN AMERICAN SANITARY BUREAU [1]

The Director presented to the 52nd Meeting of the Executive Committee a report on the progress of administration rationalization in the Pan American Sanitary Bureau which is set forth in the Appendix hereto.

After considering this topic the Committee approved a resolution [2] in which it took note of the report of the Director on administrative rationalization in the PASB; commended the Director and the staff of the Bureau on their efforts to date in effecting economies in administration; requested the Director to continue the program of rationalization and to report progress to the 54th Meeting of the Executive Committee; and resolved to transmit this resolution and the report of the Director to the XVI Meeting of the Directing Council.

Since the Director submitted his progress report on administrative rationalization, work on the continued improvement of internal methods and procedures and on the planning and implementation of additional data-processing applications has proceeded according to schedule.

In the financial area, certain of the applications involving unliquidated obligation, budgetary controls, income tax, and pension reports are now in the testing stage and are expected to be operational during the second half of 1965. Computer systems for processing duty travel claims and monthly reporting of financial data and leave status also have been developed and are now being tested in one country prior to organization-wide implementation.

In the personnel area, the changeover to the new process involving new forms, new equipment (automatic writing machine), and new computer-produced reports on staff employed, vacant posts, staff strength, and distribution of staff by nationality was accomplished during April-May and is now fully operational. Implementation of the new techniques in the recruitment segment of the personnel operation is planned to follow during late summer or early fall of this year. Other applications relative to the annual computer production of certain forms for staff employed and to additional personnel reports are expected to be implemented at the same time.

Preparation for system analyses of the supply and inventory functions have been completed. Detailed work on this stage of data-processing planning will commence during August-September.

In other functional areas, including Evaluation and Reports, Fellowships, and Health Statistics, initial studies and planning for data processing applications are under way and will be followed up during the second half of 1965 with detailed systems analyses where necessary. It is expected that certain aspects of the work in these organizational units can be ready for data processing before the end of the year.

As the work to increase the use of the latest methods and techniques in the Organization goes forward, continued consideration is being given not only to specific means of data storage and retrieval, but also to the question of actual processing of each particular job and to types of equipment to be used, so as to ensure that the most practicable and least costly arrangements are made at all times.

Further reports on the progress and development of administrative rationalization and data processing in the Bureau will be submitted to the future meetings of the Governing Bodies.

[1] Document CD16/16 (9 July 1965).
[2] Resolution VI. *Official Document PAHO* **62**, 32.

Appendix

REPORT ON ADMINISTRATIVE RATIONALIZATION IN THE PAN AMERICAN SANITARY BUREAU [1]

In accordance with Resolution I [2] of the 50th Meeting of the Executive Committee, the Director has the honor to present a further progress report on the program of rationalization in the Pan American Sanitary Bureau. This report brings up to date the statements made on this subject to the 48th and 50th Meetings of the Executive Committee and to the XIV and XV Meetings of the Directing Council.

The objective of this program is the centralization of virtually all administrative activities of the field into the administrative machinery of the Washington headquarters office.

As previously reported to the Executive Committee at its 50th Meeting (Document CE50/7),[3] the initial target of positions to be saved, established provisionally at a net reduction of 57, with an annual savings of $434,000 in the estimate of early 1963, had been realized. At that time a new target was established and the Director is happy to report that the actual net reduction in administrative staff amounted to 68 positions representing an annual savings of some $530,000, which are being utilized for direct program assistance to the Governments.

Administrative rationalization has also been extended to the Institute of Nutrition of Central America and Panama (INCAP), which has resulted in an initial reduction of 21 posts, equal to an estimated annual saving of $53,000.

The incorporation of the major part of field administrative operations into the headquarters system has increased substantially the work of the Washington Office. The absorption of this additional work without a simultaneous net increase of staff has been possible in large measure thanks to a continuing review and improvement of internal methods and procedures and to the introduction of new techniques. Thus, in order to cope with a large and ever-increasing volume of administrative work resulting from the growth of the program and staff of the Organization, while at the same time realizing economy as well as greater quality in performance, the role of mechanization and of other elements of a modern and rapidly changing technology in the Bureau's administration is being further emphasized in the continuing effort to provide the best tools for sound and effective management.

From the inception of the program of administrative rationalization the gradual introduction of mechanized processes and procedures as an integral part of the over-all program was clearly anticipated. At the same time, the use of computers and electronic data-processing applications in the several administrative areas was foreseen and plans were laid to pave the way for the eventual use of the latest equipment and techniques in this field by the Bureau.

As a first step in this direction, two accounting machines had been installed in the Washington Finance Section by late 1961. One desirable feature of this equipment lay in its ability to adapt to electronic data-processing methods. During the next few years, as administrative rationalization progressed, further mechanization was considered, and it was decided to make the necessary preparations for an early changeover from purely mechanical accounting machine operation to electronic data-processing applications involving the use of a computer. Certain adaptations to the accounting machines were made in 1963 which permitted the preparation on these machines of punched paper tape to serve as input for the computer.

The initial approach to the task at hand has been to contract with an outside company for the programming support and machine time necessary to process the Bureau's work, while systems analyses, forms and reports design, and work on internally related procedures and processes are all being handled by regular staff of the Bureau. For the time being, this arrangement is considered the most practicable and least costly. Later, as work involving computer processing grows in volume and as experience and knowledge in these techniques within the Bureau reach the self-sufficient level, it may be appropriate to reconsider this arrangement.

Following considerable preparatory work, the Bureau's payroll was produced for the first time by the computer early in 1964. In addition to the production of checks, deposit lists, check register, and earnings/deductions statements, numerous reports started coming off the computer as a by-product of the payroll application, namely, reports on organizational expenses and staff entitlements; individual deductions and net salary; payroll reports in allotment order; payroll voucher reports; pension accounting reports; and service benefit reports. Work is now going forward on additional applications in the financial area involving reports on unliquidated obligations balances; budgetary controls for personal services and allowances; reimbursements of U.S. income tax; annual pension reports; and certain types of general accounting.

At the same time, preparations have been completed for the introduction of similar techniques in the personnel area. This new process is based on personnel documentation and punched paper tape being produced simultaneously on an automatic writing machine; the establishment of magnetic tape masterfiles containing all

[1] Document CE52/5 (25 March 1965).
[2] *Official Document PAHO* **57**, 19.
[3] *Official Document PAHO* **60**, 347.

pertinent information on current as well as on prospective staff; and the print-out by the computer of a given item or combination of items of information in the form of reports, analyses or statistics involving a staff member's post, grade, title, duty station, allotment, entrance on duty date, tenure, birth date, sex, marital status, nationality, home leave, salary and allowances, dependents' names and birth dates, languages, and other qualifications, pension and insurance numbers and deductions, due dates for salary increments, and the dates certain allowances come to an end. Similar reports will be computer produced in relation to applicants.

Work is now in process relative to additional applications in the personnel area involving computer preparation of certain forms, namely, annual certification of dependents, annual appraisal, and annual salary increment.

Preparatory work on computer-oriented applications has also been started in other administrative areas, including the supply and inventory functions. Plans are also in the making for the eventual hook-up via the computer of the master file established for the payroll with the one for personnel so as to provide automatic up-dating of the former by the latter.

The service bureau which processes the Bureau's computer work is currently utilizing a well-known medium-sized computer. However, a newer and more versatile system has already been ordered by this company for delivery early in 1966 which calls for the conversion of present PASB applications from one system to the other. Similarly, training of staff in the programming languages and techniques of the new system is also scheduled.

As experience in this activity grows the Bureau has every intention of adapting its applications to the rapidly changing computer technology and to become as versatile as is considered feasible and practicable. To this end, several staff members are being trained in computer programming and related computer technology.

Ultimately, it is hoped to have within the Bureau a cadre of trained staff knowledgeable in the computer field and capable of writing the Bureau's own programs.

The overriding objective remains the continued improvement of administrative efficiency, without corresponding increases in staff and costs, and through this to give the best possible service to the Governments.

It is felt that with constant review and analysis of all administrative operations and with increased use of computer applications and related techniques, this objective will be realized.

Further reports will be submitted on the progress and development in this field of endeavor.

Annex 14

REPORT ON BUILDINGS AND INSTALLATIONS FOR HEADQUARTERS [1]

The Director has the honor to report further to the XVI Meeting of the Directing Council on the progress of the program for the construction of the permanent headquarters building of the Pan American Health Organization and the sale of the property owned by the Organization.

Sixty-three years of effort and planning for a permanent headquarters building for the Pan American Sanitary Bureau culminated on 16 August 1965 with the occupancy of the new headquarters building by the first group of staff members of the Organization. Plans called for the remainder of the staff to be moved to the new building by 23 August, when the Bureau would be fully in operation at its new site.

Years of study by the Governing Bodies and the Secretariat and continuing negotiations of a decade had resulted in action in March 1960 when a bill was signed by the President of the United States of America authorizing the donation of the present site to the Organization. In May 1961 and October 1962 loans were made by the W. K. Kellogg Foundation which, with the proceeds from the Building Fund and those from the sale of the two buildings of 1501 and 1515 New Hampshire Avenue, N.W., made possible the construction of the building.

The new headquarters building is based on a design by Mr. Román Fresnedo Siri, who was awarded the first prize in the hemisphere-wide competition held in 1961.

The properties at 1501 and 1515 New Hampshire Avenue, N.W., the former temporary Headquarters, were sold in 1965 to the American Council on Education for $1,125,000. The new owners are to take occupancy of the building on 7 September 1965. Authorization [2] was given at the 52nd Meeting of the Executive Committee for the Director of the Bureau to borrow up to $900,000 to finance construction until receipt of the final payment of the sale of these buildings on 7 September. It appears at this juncture that it will not be necessary to borrow, the rate of expenditure having been within the available cash balance in the Building Fund.

The XV Meeting of the Directing Council held in 1964 in Mexico, D.F., considered the possibility of the Governments' donating works of art that would reflect the culture of their people, for the adornment of the new headquarters building, and adopted Resolution XXVI [3] requesting the Permanent Subcommittee on Buildings and Installations to study various methods connected with these donations and to establish rules and procedures for the acceptance or rejection of such donations. After discussing the matter with Mr. Fresnedo Siri, the architect, it was agreed that donations might consist of pieces of sculpture, paintings, tapestries or wall hangings, and ceramics. The 52nd Meeting of the Executive Committee held in April 1965 considered the matter [4] and instructed the Director to inform the Governments on the agreed-upon specifications for the works of art they might wish to donate. This was done on 7 June by means of a circular letter to all Governments (Appendix 1).

To date response has been received from five Governments: Bolivia, British Honduras, Honduras, Peru, and Surinam.

In addition, a private individual and a business association have extended offers of objects of art. All offers will be considered by the Permanent Subcommittee and the Director, assisted by expert counsel.

[1] Document CD16/21 (20 August 1965).

[2] Resolution XI. *Official Document PAHO* **62**, 35.

[3] *Official Document PAHO* **58**, 79-80.

[4] *Official Document PAHO* **64**, 111-114.

Other Properties

The Director wishes to take this opportunity to report the following property transactions that have taken place in the field installations. In the past the Bureau rented property to house the office staff in Rio de Janeiro. The arrangement did not prove satisfactory and, in view of this, the Bureau purchased a house at a cost of US$58,000. In Buenos Aires, additional space was purchased on the floor of the office building at present occupied by the Zone Office. In Guatemala, the Zone Office is moving to another building where space was obtained on a rental basis. In Mexico the lease for the office space was recently renewed.

For the information of the Directing Council, copies of the minutes of the meetings held by the Permanent Subcommittee on Buildings and Installations since the 52nd Meeting of the Executive Committee are attached (Appendix 2).

Appendix 1

CIRCULAR LETTER TO ALL GOVERNMENTS

CT/Doc-CL-15-65 7 June 1965

Sir:

At its XV Meeting held last year in Mexico, D.F., the Directing Council considered the possibility of the Governments' donating works of art reflecting the culture of their peoples for the adornment of the new headquarters building of the Pan American Health Organization.

The Council adopted Resolution XXVI, which charged the Permanent Subcommittee on Buildings and Installations to study various matters connected with these donations and to establish rules and procedures for the acceptance or rejection of such donations.

In accordance with these instructions, the Subcommittee made a detailed study of the matter and discussed it with the architect of the building, Mr. Fresnedo Siri, who suggested that the donations might consist of pieces of sculpture, paintings, tapestries or wall hangings, and ceramics and recommended that the dimensions of these articles should be as follows:

Sculpture:	3′ x 4′
	3′ x 5′
Painting:	3′ x 5′
	4′ x 6′
Tapestries or wall hangings:	5′ x 10′
	5′ x 7′
	6′ x 8′

At its 52nd Meeting held in Washington, D. C., from 19 to 23 April, the Executive Committee also considered the matter and instructed me to inform the Governments of the above-mentioned specifications for the works of art they might wish to donate.

We should very much like the new building to be an expression both of the culture and of the art of the various peoples of the Americas. For that reason I should be very pleased to receive from the Government of your country a contribution which would be in accordance with the specifications mentioned above.

I should also like to draw your attention to the fact that the new building will be inaugurated toward the end of September, during the course of the XVI Meeting of the Directing Council.

I am, Sir,

Yours, very truly,

(Signed)

Dr. Abraham Horwitz,

Director, Pan American Sanitary Bureau

Appendix 2

PERMANENT SUBCOMMITTEE ON BUILDINGS AND INSTALLATIONS

[*On Thursday, 20 May 1965, a meeting was called of the Permanent Subcommittee by the Chairman. However, owing to the lack of a quorum, the meeting was postponed until 4:00 p. m. on Tuesday, 25 May 1965.*]

Report of the Meeting Held 25 May 1965, at 4:00 p.m.

Present:

Mr. Paul J. Byrnes (United States of America), Chairman
Mr. Francisco Borrego (Mexico)
Mr. Regis Novaes de Oliveira (Brazil)

The Subcommittee was assisted by:

Dr. Stuart Portner, Chief of Administration, PASB
Mr. Eugene J. Settino, Chief, Services and Supply Section, PASB
Mr. A. Cray, Construction Supervisor, PASB

The Chairman of the Permanent Subcommittee on Buildings and Installation, Mr. Paul J. Byrnes (United States of America), opened the meeting, which was called for the purpose of reviewing the status of the construction of the new building.

Dr. Portner discussed the matter in some detail. He pointed out that the critical date of occupancy had been set for 15 August 1965 in order that the Secretariat might move in and be situated well in advance of the September meeting of the Directing Council. He informed the Subcommittee that in order to meet the deadline it was necessary to authorize overtime for the construction workers, thereby permitting continued operation seven days a week. He then asked Mr. Cray to provide the Subcommittee with detailed information regarding the status of the operations.

Mr. Cray addressed the Subcommittee and discussed at length the current status of construction. He indicated that the plaster work was completed from the third to the ninth floors of the Secretariat building, with the tenth floor to be completed that day. Upon completion of the tenth floor plastering, it would be possible to install the wooden wall panels and place carpeting and furniture.

Mr. Cray then reviewed the situation of the meeting rooms. In view of the plan to work through the weekend, it would be possible to finish plastering by 31 May and to commence paneling of the meeting chambers within two weeks. During the month of June, the simultaneous interpretation system was to be installed; that operation would be followed by the installation of conference chairs and tables. In summary, he felt that the major portion of the work in the building would be completed by 31 July and that by 15 August movement into the new quarters could begin.

Mr. Cray indicated a problem area concerning marble ordered from Italy, which was in transit, and somewhat delayed. Mr. Byrnes and Dr. Portner commented on the efforts that were being made to assure receipt of the marble in sufficient time.

Dr. Portner reviewed the need for authorizing overtime for the construction workers in order to ensure that the deadline was met. He indicated that the cost involved was minimal, considering that to remain in the present quarters after 31 August would cost $5,000 per month for rental and approximately $40,000 to hold the meeting of the Directing Council at another location in Washington, D. C.

Mr. Byrnes asked what the estimated cost of the overtime would be, to which Dr. Portner indicated that a maximum of $25,000 for past and future work could be anticipated, but that most probably it would be less. He pointed out that that was not an unforeseen expense, since such action had to be taken into consideration in the construction business, especially when a target date had to be met.

Dr. Portner then called the Committee's attention to the plan for the design and installation of a chandelier in the Council Chamber. The latest estimate indicated a cost of between $70,000 and $80,000, which Dr. Portner stated was completely out of order. It was planned to simplify the design in order to bring the cost down to something in the neighborhood of $30,000-$40,000.

At the request of the Chairman, Dr. Portner briefed the Committee on the plans for eating facilities for the staff of the Bureau in the new building.

He added that only one thing might cause considerable trouble and that was the rate of progress on the E Street Throughway, which was the only access to parking in the building. It was agreed that an approach should be made to the District of Columbia officials concerned with the matter to see if it could be resolved.

Dr. Portner then informed the Committee that the Director had authorized the purchase of new furniture for the new Headquarters. He indicated that to move the present furniture, only a small portion of which was really adaptable or suitable for the new building, to the new location would have cost $24,000. He estimated that approximately $18,000 could be obtained by disposing of the present furniture and that another $20,000-$25,000 could be realized by the sale of old equipment. That would materially reduce the $100,000 estimate of the cost of new furniture.

Dr. Portner explained that a dedication ceremony was planned for the week of the Directing Council meeting and that the Ministers of Health of the Member Governments, the Ambassadors to the Organization of American States, the President of the United States of America, and other high dignitaries would be invited.

In conclusion, he suggested that the Subcommittee visit the premises. A tentative date was set for 3 June, at 4:00 p.m., for the members to meet at the site of the building.

At the request of the Chairman, Dr. Portner gave a brief review of the current situation of the field installations. In the past space had been rented for the office in Rio de Janeiro which had not been too satisfactory. However, the Bureau had recently purchased property at a cost of $58,000. In Buenos Aires, additional space had been purchased on the floor of the building occupied by the Zone Office. In Guatemala, the Zone Office was moving to another building; the space had been obtained on a rental basis. In Mexico the lease for the office space had just been renewed.

The Chairman thanked Dr. Portner and Mr. Cray for their complete and most satisfactory report on the status of the new building.

The meeting adjourned at 5:00 p.m.

Report of the Meeting Held 3 June 1965, at 4:00 p.m.

The Permanent Subcommittee on Buildings and Installations met at the construction site of the new PAHO building on 3 June 1965 at 4:00 p.m., to inspect the building and evaluate the progress to date.

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