

6980394 (3)

PD-AAC-365
MAR 1 1976

4.

ACTION MEMORANDUM FOR THE ADMINISTRATOR

THRU : ES

W/s/ Alexander Shakow *js*

FROM : AA/PPC, Philip Birnbaum

SUBJECT : Proposed Africa Regional Project to Provide \$2.0 Million to Complete the W.H.O. Ethiopia Smallpox Eradication Program (ESEP)

Problem: The World Health Organization's (WHO) successful program to eradicate smallpox from the globe is nearing completion. Remaining eradication efforts are centered in Ethiopia, the only country now reporting smallpox. Surveillance teams are active in Ethiopia, in nearby countries and in the Indian sub-continent. The WHO global program lacks \$5.9 million of the estimated \$15.4 million needed now through 1978; during that year, complete eradication worldwide is predicted and surveillance may then be discontinued. The program in Ethiopia lacks financing for \$3.2 million of its \$4.2 million estimated costs. The WHO has requested USG financial assistance to support the smallpox programs. HEW will provide \$1.0 million in support of the Ethiopian program and we believe there are cogent reasons for AID to grant finance an additional \$2.0 million of the Ethiopian program. The total U.S. contribution of \$3.0 million will essentially cover the Ethiopian program deficit, and WHO has given assurances that they would cover any balance from other donor contributions or their general budget.

AFR and TAB recommend that you approve the allocation of \$2.0 million from FY 1976 and Interim Quarter grant funds to support this activity, that you notify Congress of AID's intention to provide a \$2.0 million grant to the WHO to support this activity and that you sign the attached letter to Dr. Mahler, Director General of the World Health Organization, informing him of AID's plans to provide the \$2.0 million grant.

Discussion: By November 1975, Ethiopia was the only country in the world with endemic smallpox. There has been a rapid decrease in the smallpox endemic areas of the world, from 91 countries in 1945, down to 42 countries by 1967, 30 in 1969, 23 in 1970, 17 in 1971 and only 2 by mid-1975. Bangladesh, by last summer the sole remaining country reporting smallpox besides Ethiopia, appears to have achieved complete eradication in the late fall. The rapid containment and reduction of this disease stems from the effective efforts of WHO and governments of smallpox endemic countries to contain and eradicate the disease and the fact that the disease spreads only to humans from humans with an active case.

The WHO Worldwide Smallpox Eradication Program (WSEP) began in 1966. It focused on 30 countries which did not have the domestic capacity to eradicate the disease. To date the WSEP has expended about \$63.1 million, of which some \$24 million came from the regular WHO budget, which the U.S. presently provides 25%. The remainder came from WHO's Voluntary Fund for Health Promotion financed by contributions from many different countries and from direct bilateral assistance earmarked for specific countries participating in the program. AID supported the program through its \$24.0 million grant financing of the West Africa Smallpox Eradication/Measles Control Project which was implemented by HEW's Communicable Disease Center. This program succeeded in eradicating smallpox from 21 West African countries.

The WHO now estimates the Worldwide Smallpox Eradication Program (WSEP) will cost \$15.4 million more for calendar years 1976 through 1978. All eradication efforts should be completed during CY 1976 and by the end of 1978 no further surveillance should be needed. Smallpox will then have been eradicated worldwide. The WHO currently has about \$9.5 million either available from its own resources or from voluntary contributions to finance the remaining campaign. The worldwide program shortfall is about \$5.9 million, and the WHO reports that after taking into account in kind contributions from several donors, the Ethiopia program needs \$3.2 million more than the known available funds of about \$1.0 million.

With the proposed USG contributions of \$3.0 million (\$2.0 million from AID and \$1.0 million from H.E.W.) the WHO reports it expects little difficulty raising the remaining worldwide program needs of \$2.9 million from other donors, given the history of voluntary fund contributions in the past and the expectation of final eradication of smallpox. An intensive appeal has been made and bilateral discussions with potential donors appears to be yielding results. WHO reports that, within a few weeks, Denmark is likely to contribute \$600,000 earmarked for Bangladesh surveillance efforts. If funding shortfalls still remain, the WHO will divert regular budget funds to the program to avoid unnecessary delays in completing the campaign.

You should be aware that if AID provides the proposed \$2.0 million grant to WHO, the funds may be used to finance local costs and foreign exchange costs other than U.S. dollar costs of the program. We will stipulate, however, that funds may be used only to finance legitimate goods and services whose source and origin are from AID Free World countries including Ethiopia. The details of HEW's recent \$1.0 million pledge have not yet been determined. The funds will probably be used to continue to finance the cost of helicopters for the campaign which HEW supported in FY 75.

We understand that some of the vaccine that will be used in Ethiopia may be supplied by the USSR. The dollar value is small, perhaps \$50,000. Other bloc countries, namely Czechoslovakia, East Germany, Hungary and Poland have contributed nominal amounts to the voluntary fund (less than \$100,000 in total over ten years). It is possible that small amounts of their possible future contribution may be utilized in Ethiopia. We do not see any particular problem with respect to this, other than to perhaps advise Congress of the probable Soviet vaccine contribution and probable small contributions by other bloc countries to the voluntary fund.

It is possible that hostilities in Ethiopia may temporarily stop or curtail eradication and surveillance efforts in parts of the country. Both AID and the WHO view this as improbable, since hostilities in susceptible areas have decreased and in the past year the ESEP teams have been remarkably effective in getting into infected areas. However, there remains the risk of disruption which would cause increased costs over the long run. There seems to be a greater risk to the program if increased support is not forthcoming soon; it is close to success and the proposed acceleration of the Ethiopia program should result in eradication of the disease in six to nine months. The longer it takes to eradicate the disease, the greater the chance is that hostilities will slow or stop the progress of eradication.

The ESEP's direct target groups are the poor in isolated rural areas in Ethiopia. The smallpox eradication teams are now penetrating the most isolated areas of the country. The teams provide, in many instances, the only direct health care many of the people have received. Besides vaccinating against smallpox, the teams also identify and treat other communicable diseases and report serious cases to regular health authorities. AID support of this program will eventually benefit other AID programs in Ethiopia and East Africa directly by helping to eliminate smallpox and indirectly by freeing more of the countries' health manpower to work on other health needs. If the program failed or was delayed, more resources would have to be devoted in the future to eradicate the disease.

Eradication of smallpox will save countless millions of dollars annually worldwide. Freed funds can then be spent on other health needs. In the mid-60's, for instance, the U.S. expended an estimated \$150 million a year to vaccinate people and keep the U.S. free of smallpox. This annual expenditure has decreased considerably due to the rapid decrease of smallpox. Now it is considerably more risky in the U.S. to vaccinate people than to leave them unvaccinated. Nevertheless, we estimate

that the U.S. alone still incurs annual costs associated with smallpox control which are far in excess of the proposed \$3.0 million USG contribution. It is for these reasons that HEW has provided assistance in FY 75 and has now pledged further assistance.

In view of the very attractive humanitarian aspects of this program, we believe that AID, in cooperation with HEW, should arrange for maximum appropriate publicity for the U.S. contribution.

Recommendations:

1. That you approve the allocation of \$2.0 million from FY 1976 and I.Q. grant funds to support this activity. (The Project Paper and related procurement waiver will be forwarded for your authorization after expiration of the Congressional notification period.)

APPROVED /s/ DE
DISAPPROVED _____
DATE MAR 2 1976

2. That you approve the attached Notification to Congress.

APPROVED /s/ DE
DISAPPROVED _____
DATE MAR 2 1976

3. That you sign the attached letter to Dr. Mahler, Director-General of the World Health Organisation.

APPROVED /s/ DE
DISAPPROVED _____
DATE MAR 2 1976

Attachment: a/s

AFR/DS:GThompson:2/13/76

Clearances:

PPC/DPRE: AHandly <u> AH </u>	AFR/DP: RHuesman <u> (draft) </u>
AFR/DS: ECross <u> (draft) </u>	AA/TA: MBelcher <u> (draft) </u>
PPC/IA: LLauffer <u> (draft) </u>	PPC/DPRE: JWelty <u> (draft) </u>
GC/AFR: STisa <u> (draft) </u>	IO/HDC: Andrew <u> (draft) </u>
IO/EX: Cummins <u> (draft) </u>	OPA: CWheeler <u> (info) </u>
PPC/RB: GCauvin <u> (draft) </u>	GC/LPC: JKessler <u> (draft) </u>
AFR/EA: DConroy <u> (draft) </u>	DAA/AFR: DSBrown <u> </u>
AA/AFR: SScott <u> SS </u>	AA/TA: CFarrar <u> CF </u>

**WORLD HEALTH
ORGANIZATION**



6980394 (4)
**ORGANISATION MONDIALE
DE LA SANTÉ**
PD-AAC-365

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Tél. 34 60 61 Télex. 27821

1211 GENÈVE 27 - SUISSE
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In reply please refer to:
Prière de rappeler la référence:

8 December 1975 7p

Dear Dr. Cross,

It was a great pleasure for me to have had the opportunity of meeting with you and your colleagues on 26 November and to explain somewhat more fully our problems and requirements in the smallpox eradication programme as we enter the final but most critical phase. As you may recall when we met, the report had only recently been received that a further outbreak had been detected in Bangladesh, the last case having occurred on 16 October. Intensive search has continued and will continue, but as of 8 December no further outbreaks had been detected.

Ethiopia thus remains as the world's only remaining reservoir of smallpox - the last apparent significant obstacle which now stands between us and the ultimate goal of global eradication. At present, between 40 and 60 cases are being detected each week and as of 29 November, there were 92 villages which had experienced one or more cases during the preceding six weeks. These were located in Gojjam (69), Hararghe (22) and Arussi (one, imported from Hararghe).

I am happy to respond to your letter of 21 November and to provide to you as complete a response as possible to the many questions raised. As I indicated during our meeting in Washington, some of the questions are difficult to answer and some are able to be answered in part only. However, if further information is required beyond that which I am able to supply, please do not hesitate to contact me again. We will do the best we can.

1. Background - Development of the Programme

I believe it is important to understand the background of development of the Ethiopian programme in appreciating the present pattern of funding and staffing. As you know, the present global eradication programme began in January 1967. By 1969, programmes had commenced in all endemic countries except Ethiopia. In most countries, the WHO contribution to the programme was comparatively modest and consisted essentially of one or two advisers, transport and vaccine. In Ethiopia, the situation was different. Until 1970, and despite repeated efforts to explore the feasibility of a smallpox eradication programme in Ethiopia, the government refused even to receive myself or other WHO staff to discuss the possibilities of

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Office of Development Services
Bureau for Africa
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Washington, D.C. 20523
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Dr. E. B. Cross, Principal Health Adviser,
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a programme. The stated reason for this was that the country was engaged in a malaria eradication programme which absorbed effectively all health manpower which could be spared from other duties as well as all funds that the government could make available from its health budget. Further, the government had erroneously understood that a smallpox eradication programme would be equally as costly as the malaria programme, both in terms of funds and personnel. While this was far from the truth, efforts on the part of myself and other WHO staff in meetings at the Assembly to persuade government officials otherwise were originally unsuccessful.

By early 1970, it was apparent that progress in smallpox eradication in Africa was such that within a matter of three to four years, Ethiopia might well be the only endemic country on the continent. Unless the disease could be eradicated in Ethiopia, not only would the goal of global eradication be frustrated but campaigns in the other African countries would have to be continued indefinitely and at considerable cost. When finally our WHO Regional Advisor and myself were permitted to visit Ethiopia, the government insisted it could provide no more than 30 sanitarians and their salaries. The government informed us that all else, including the Programme Director, would have to be provided from external sources. Under these circumstances, we had little choice but to accept these conditions. Accordingly support was solicited and provided by volunteers from the USA, Japan and Austria, WHO inter-regional funds and personnel were diverted to Ethiopia and additional funds were allocated by the Regional Office. Efforts to obtain bilateral support met with no success. In January 1971, a very modest programme commenced in Ethiopia which was felt to offer at best an 80% chance of achieving the interruption of smallpox transmission.

Despite the limited resources available, the programme proved to be surprisingly successful. By the end of 1974, more than 10 million persons had been vaccinated and smallpox transmission appeared to have been interrupted in 14 of the 19 Provinces. During 1974, activities were able to be somewhat increased utilizing funds donated by various donors to WHO and some additional staff was provided to the programme by the Ethiopian government. Beginning in November 1974, funds provided by the U.S. Public Health Service permitted two helicopters to be chartered. Substantial additional support was considered necessary to interrupt transmission in the difficult residual endemic areas, but little additional help could be given since global strategy dictated the maximum possible use in Asia of such funds as were contributed. There the more virulent variola major was prevalent.

Since mid-1975, with the decrease in variola major in Asia, some additional funds have been able to be made available to Ethiopia, permitting an expansion of field activities. The government assigned a higher priority to the programme and additional international staff have been assigned. However, because of deteriorating economic conditions in Ethiopia, it has not been possible to obtain a greater financial participation by the government than was originally agreed - specifically, the government being responsible for salaries of regular health staff assigned only.

2. Budget

a) Permanent Staff

Five full-time WHO staff are assigned to the programme: one serves as the chief executive officer; one serves as senior epidemiologist-coordinator of strategy and operations and three are responsible for activities in major geographical areas in the country. Four of the five are medical epidemiologists

Dr. E. B. Cross, Principal Health Adviser,
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all but one of whom has had five years or more of experience in smallpox eradication programmes in Ethiopia as well as in other countries. The fifth member of the staff served originally with the Ethiopian programme as an American Peace Corps Volunteer and because of his outstanding performance, was recruited as a WHO consultant for one year's service with the Pakistan programme. Subsequently, he returned to service with the Ethiopian programme. All are full-time staff with the programme, supported by funds from the WHO Regular Budget (country budget and inter-regional programme budget).

b) Consultants

Ten WHO consultants joined the programme between September and November 1975, to provide additional support in supervision and planning to the vastly expanded Ethiopian staff. They work under the overall supervision and guidance of the permanent WHO staff. Eight of the ten are medical epidemiologists and most have had prior experience in programmes in Asia. Two are non-medical staff - one an American who has worked with programmes in five countries over the past eight years and is considered to be one of our principal trouble shooters and the second an Austrian who has done outstanding work in the Ethiopian programme over the past three years while serving with an Austrian volunteer service group. All are full-time and are paid from donations to the WHO voluntary fund. Should hostilities occur throughout the country precluding work anywhere in the country, all would be either shifted to programmes in adjacent African countries to prevent importations, transferred to Asia or terminated.

c) Supplies and Equipment

Supplies and equipment budgeted for the period 1976 onwards are primarily for vehicle spare parts, tyres (an average set of tyres lasts about six months), camping equipment for both national and international staff and a host of miscellaneous items such as bifurcated needles, needle containers, specimen kits, flares for identification of field teams by helicopter pilots, radio spare parts, etc. The projection for supply costs, while approximate, is based on five years' experience in supply to the programme. In the event of a total cessation of activities in Ethiopia, some savings would be realized. Should such occur, however, it might be necessary to augment activities in adjacent countries to prevent importations of smallpox from Ethiopia. Beginning in January, the government will provide all office accommodation but, for reasons noted earlier, states it is unable to provide funds for supplies and equipment from its own resources. The source of the equipment would be varied - spare parts for Toyota vehicles would necessarily be from Japan and for Motorola radios, from the USA. Vaccine is a major item of supply, but this is covered by donations from several countries. The balance of supplies are purchased wherever it is most economical - camping equipment has usually come from the UK, bifurcated needles from Germany (only available supplier), needle containers from India, specimen kits from the USA, training aids from various sources, etc.

Dr. E. B. Cross, Principal Health Adviser,
Office of Development Services, Bureau for Africa.

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d) Local Costs

The local costs to be paid from international resources break down approximately as follows:

Per diem of Ethiopian sanitarians, student volunteers, local hire staff	30%
Transport (local air fares, rental of mules, camels, etc.)	6%
Petrol for vehicles	13%
Vehicle maintenance and repairs	15%
Office expenses - secretarial staff, communication, paper, etc.	12%
Petrol for helicopters and positioning costs	20%
Miscellaneous	4%

Understandably, these represent "best approximations" based on the experiences of the past five years. Some variation is to be expected. For example, per diem will vary depending on the number of Ethiopian health staff and local staff employed in the programme and this, in turn, will be contingent upon the number of existing outbreaks to be contained. For reasons explained earlier, the government bears none of these costs. If the programme cannot proceed as proposed, the immediate costs would certainly be lower but non-expansion of the programme implies a much later date for interruption of transmission and a continued expenditure for smallpox activities beyond 1978 in Ethiopia as well as in other countries throughout Africa.

e) Helicopters

Hughes C-500 helicopters will be leased from Viking Helicopters, Ottawa, at an average cost of \$265 per hour for 5 000 hours' flying time, extending from January 1976 through December 1977. Competitive bids reveal this company and a Calgary-based company to offer far lower rates than those offered by other companies from the USA, Switzerland and Germany. In fact, except for the bid from the Calgary-based company which was competitive, all other bids ranged from \$430 to \$500 per hour. The costs noted provide for all costs of the helicopter operation except for fuel (which we can buy much more inexpensively under a U.N. agreement), positioning of the fuel (less expensive using WHO transport) and food and accommodation of the aircrews at field bases outside of Addis Ababa. These costs are estimated at \$35 per flying hour. In case of hostilities preventing use of the helicopters, provision is made for cessation of operation without penalty.

f) Funds availability

In regard to Budget, the amount shown in the Budget summary sent to you earlier refers only to requirements in the form of cash from international sources. To determine the overall budget for the programme as a whole, one would need to add 1) costs of office space provided by the government, 2) salaries for Ethiopian health officers and sanitarians, 3) costs of maintenance and support of nine Japanese volunteers who are serving as radio and automotive mechanics and field operations officers and 4) costs of approximately 2 500 000 doses of vaccine donated by Kenya, USSR and Canada.

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Some apportioned cost of the time of provincial health and coordinating officers; provincial, awraja and woreda governors; staff from other cooperating health units; military and police, would also need to be added to obtain an overall budgetary figure. We have not endeavoured to determine precisely what these costs are because of the obvious complexity of such an exercise.

By the end of 1975, approximately \$200 000 will remain in the WHO Voluntary Fund which can be utilized during 1976 for the Ethiopian Programme. (This represents the residua of contributions made to the Voluntary Fund from many countries during the past years). In addition, through the Regular Budget of WHO, \$411 690 is available for 1976 and 1977 for the programme. All other funds will have to be obtained through contribution. As explained during our meeting, our overall projected cash requirement for the global eradication programme from 1 January 1976 through declaration of eradication is now estimated at \$15.4 million. From contributions and the WHO Regular Budget, we have in hand some \$9.5 million. In addition, pledges of vaccine sufficient to complete the programme are also in hand. The overall cash deficit at this moment is, therefore, some \$6 000 000. Assistance from USAID is requested solely for the Ethiopian component of the activities. Other donors have been approached for assistance in regard to the balance and we are most hopeful that such assistance will be forthcoming.

The budget for the first half of 1976 is similar to that for 1975 in that it provides for staff, transport, local costs, etc. to permit the maximum input we feel is required to stop transmission. With the assumption that transmission will be stopped by August, a less intensive programme has been budgeted for the balance of the time to permit the extensive but less costly search activities to continue until two years have elapsed since occurrence of the last case. Should plans be disrupted, the implications in regard to budget would depend on the extent of the disruption. If disruption involves a not too extensive area, budgetary implications are minimal as it would be possible to cordon off the area and to anticipate that disease transmission would terminate spontaneously due to the well-known phenomenon of "exhaustion of susceptibles". Should the programme be seriously disrupted over more extensive areas, there is simply no way to predict what the implications might be without forecasting precisely the area and the epidemiological situation at that time. As noted in the meeting, however, civil disturbances have recently subsided so markedly (except in Eritrea) that teams are now able to penetrate all parts of the endemic provinces. Various recent developments provide encouragement that this situation may persist for some period. I see little choice at this time, considering the crucial position of the programme, but to do all possible to stop transmission as rapidly as possible and to hope, meanwhile, that political stability persists as at present, or improves.

3. Operational Plan

The numbers and categories of personnel deployed in the programme vary depending on needs and activities. The basic core group of operational smallpox staff is now comprised of the following: 15 international staff, 9 Japanese Health Corp. Volunteers, 5 Ethiopian Health Officers, 63 Sanitarians and 39 Assistant Health Officers. All are full-time. Note has already been made of the role of international staff. Ethiopian staff serve to supervise a carefully programmed search and vaccination activity in smallpox-free areas and containment activities

Dr. E. B. Cross, Principal Health Adviser,
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in the endemic areas. They are assisted by between 400 and 500 other workers, some of whom are health staff assigned to health centers or other programmes, such as leprosy or malaria and work part-time with the programme, some of whom are students assigned broadly to rural development projects and some are locally recruited and trained villagers from infected areas. Students and locally recruited villagers serve primarily as vaccinators or as search workers. The Ethiopian government provides the salaries of the Ethiopian health officers and sanitarians but all other costs are borne by WHO funds - the staff being paid on a per diem basis. In addition to these, there are four clerk typists, two drivers, three custodial staff, a storekeeper and an administrative officer at the national headquarters who are paid for by WHO funds.

The operational plan, as earlier alluded to, by its very nature must be flexible and has in fact demonstrated considerable flexibility in dealing with a host of difficulties over the past several years. When fighting occurred earlier this year in Gojjam, the staff quickly shifted to an operation designed to provide maximum possible surveillance and vaccination over a broad belt surrounding the areas where hostilities were occurring. At the same time, local staff from the problem areas were trained in surveillance-vaccination activities so as to begin immediately to reinfiltrate the problem sectors. Experience has shown that if an area is not more populous than perhaps 100 000 to 200 000 persons, smallpox can be expected to die out in such an area over a matter of some months. Obviously, the process is incrementally accelerated by higher levels of immunity. Thus, the present strategy focusses strongly on widespread vaccination throughout all areas of Ethiopia. The fact that virtually all areas of Ethiopia except Eritrea are now accessible provides increasing optimism that the task can be achieved. As noted in the meetings, Eritrea is not of real concern since this province is well-endowed with health centers, was comparatively well-vaccinated when the programme began and, in fact, interrupted transmission more than three years ago. However, should widespread serious difficulties occur throughout Ethiopia, one simply cannot forecast the longer-term budgetary implications except to say that the implications not only to Ethiopia but to countries throughout Africa and especially those surrounding Ethiopia would be profound. I would guess the order of magnitude of costs to these countries would be not less than \$10 000 000 annually for each year that smallpox eradication is delayed in Ethiopia.

Further to our discussions in Washington, in regard to the need for funds according to fiscal year, we have again reviewed costs and obligations as closely as they could be forecast. It would seem that approximately \$1 000 000 would be required for the period concluding on 30 September 1976. Taking into account WHO's mandated procedures for obligating and disbursing funds, it would appear that by early March, we will begin to encounter an acute cash-flow problem in regard to the Ethiopian programme. If funds could be made available by 1 March and an additional \$2 000 000 to complete the programme, I believe we would be able to sustain the present programme impetus. As it was proposed at the meeting that consideration be given to only two allocations, i.e. for this fiscal year and next, we did not endeavour to project a further breakdown.

I apologise for the considerable length of this letter but to provide reasonable answers to the many questions asked, there was no alternative. But, in case you need more, we will try to do our best. I'm leaving Tuesday once again - this time for Addis and Dacca and will be back about 21 December.

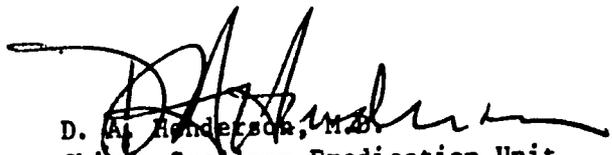
Dr. E. B. Cross, Principal Health Adviser,
Office of Development Services, Bureau for Africa.

8 December 1975

Once again, many thanks for your personal interest and support. I do feel confident that "given the tools, we will do the job!" What most concerns me is that having progressed this far, we should relax in our efforts with the final goal almost in hand.

With all best regards.

Sincerely yours


D. A. Henderson, M.D.
Chief, Smallpox Eradication Unit.



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Department of State

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TELEGRAM

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TAGS:

SUBJECT: FIRST AMENDMENT TO GRANT AGREEMENT FOR SMALLPOX
ERADICATION BETWEEN USG AND WORLD HEALTH ORGANIZATION (WHO)
DATED APRIL 28, 1976

1. FUNDS NOW AVAILABLE TO COMPLETE USG CONTRIBUTION OF \$0.8
 2. MILLION TO WHO FOR ERADICATION OF SMALLPOX IN ETHIOPIA
- REQUEST YOUR ASSISTANCE PREPARE FORMAL AMENDMENT FOR SIGNA-
TURE BY USG AND WHO REPRESENTATIVES. REST OF AMENDMENT



Department of State

TELEGRAM

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PAGE 03

STATE 109884

EXECUTE THIS FIRST AMENDMENT TO THE GRANT AGREEMENT WITH WHO TO PROVIDE AN ADDITIONAL DOLS 1.2 MILLION FOR THE PURPOSES STIPULATED IN THE GRANT.

3. THE FOLLOWING FISCAL DATA SHOULD BE CITED AS FUNDING AUTHORIZATION:

APPROPRIATION: 72-11X1024
ALLOTMENTS: 424-61-698-00-69-51
OBLIGATION: 6117250

4. PLEASE SIGN TWO COPIES OF THE AMENDMENT. CABLE DATE AMENDMENT SIGNED AND RETURN TWO SIGNED COPIES TO ADDRESS CONTAINED GRANT AGREEMENT. KISSINGER

Statement Regarding "Grant by the United States of America to the World Health Organization" concerning Smallpox Eradication in Ethiopia signed in Washington, D.C. on April 26, 1976.

Explanation of Agreement: The purpose of this Grant is to provide funds to assist the World Health Organization (WHO) in financing the cost of goods and services required for the WHO Smallpox Eradication Program in Ethiopia. A waiver of Source and Origin requirements for goods procured under this Grant was provided to permit such procurement in Ethiopia or in countries included in Code 935 of the A.I.D. Geographic Code Book in effect at the time orders are placed or contracts let.

Background Information on Negotiations: Ethiopia is the only country in the world where smallpox still exists. The proposed contribution to the WHO smallpox eradication program is designed to help eliminate smallpox in Ethiopia thereby benefitting neighboring countries and the rest of the world by eradicating the disease from its last global stronghold. A.I.D.'s participation in this final phase of the program is a logical follow-on to its West African Smallpox and Measles project of several years ago. Furthermore, WHO's long and successful program experience with smallpox, and a review of many documents, convinced A.I.D. that the eradication program will be successful within the general time and monetary constraints projected by WHO.

Effect of Agreement: According to the accepted smallpox eradication strategy developed by WHO, smallpox is expected to be eliminated from the world by the end of 1976.

BEST AVAILABLE COPY

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AFR/RA:GGJespersen:mcl:10/21/76

Clearance: AFR/RA:JKraus JK
AFR/RA:EDConroy ED

GRANT
BY THE
UNITED STATES OF AMERICA
TO
THE WORLD HEALTH ORGANIZATION

This Grant Agreement is made and entered into on the 26th day of April, 1976, by the United States of America, acting through the Agency for International Development (hereinafter referred to as "A.I.D."), and the World Health Organization (hereinafter referred to as "WHO" or the "Grantee").

WHEREAS, the WHO worldwide smallpox eradication program is entering its final phase;

WHEREAS, the program has residually eliminated smallpox throughout the world except for some areas of Ethiopia;

WHEREAS, the smallpox eradication program in Ethiopia (hereinafter the "Program") has achieved sufficient success since 1971 to permit planning to eradicate smallpox in Ethiopia by 1977;

WHEREAS, WHO has called for international support for the final phase of the worldwide eradication and surveillance program, and in particular has requested support from the United States for the Program in Ethiopia;

WHEREAS, the elimination of smallpox will benefit other countries in Africa which must maintain vaccination and surveillance programs as long as the disease continues in Ethiopia;

WHEREAS, A.I.D. has agreed to provide to WHO funds to be used to assist the Program;

Now therefore, in order to assist WHO to meet the cost of the Program, A.I.D., pursuant to the Foreign Assistance Act of 1961, as amended (the "Act"), hereby makes a Grant to WHO for the purposes and under the terms and conditions of this Agreement.

ARTICLE I

The Grant

SECTION 1.01 Purpose of the Grant. The purpose of this Grant is to provide funds to assist the WHO in financing the cost of goods and services required for the WHO Smallpox Eradication Program in Ethiopia.

SECTION 1.02. Amount of Grant. A.I.D. intends to provide a total of \$2 million for the purposes set forth in Section 1.01. The amount of the Grant provided herewith is \$800,000. Subject to the availability of funds, A.I.D. will

make an additional grant in the amount of \$1,200,000 to further assist in carrying out the Program.

ARTICLE II

Condition Precedent to Disbursement

SECTION 2.01. First Disbursement. Prior to the first disbursement, or to the issuance of the first Letter of Commitment, under the Grant, WHO will, except as A.I.D. may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) Evidence of the source and availability of the funds, in addition to this Grant, required for the Program.

(b) A statement of the names of the persons holding or acting in the office of the Grantee specified in Section 5.13, and a specimen signature of each person specified in such statement.

SECTION 2.02. Notification. When A.I.D. has determined that the conditions precedent specified in Section 2.01 have been met, A.I.D. will promptly satisfy the Grantee.

SECTION 2.03. Terminal Dates for Conditions Precedent. If all of the conditions specified in Section 2.01 have not been met within ninety days from the date of this Agreement, or such later date as A.I.D. may agree to in writing, A.I.D. at its option, may terminate this Agreement by written notice to the Grantee.

ARTICLE III

Disbursements

SECTION 3.01. The Advance. Pursuant to the procedures outlined in the Attachment hereto, entitled "Disbursement of Funds", A.I.D. shall open in a United States Federal Reserve a letter of credit in the amount of \$800,000 in favor of the Grantee. The procedure governing the establishment of the letter of credit and the drawdown of funds made available under the letter of credit is outlined in the Attachment, which is made a part of this Grant Agreement.

SECTION 3.02. Other Forms of Disbursement. A.I.D. may also make disbursements upon such other terms and conditions as may be mutually agreed upon in writing by A.I.D. and the Grantee.

SECTION 3.03. Interest on Grant Funds. Any interest or other earnings on Grant funds disbursed by A.I.D. to the Grantee under this Agreement prior to the authorized use of such funds for the Program will be returned to A.I.D. in dollars by the Grantee.

SECTION 3.04. Terminal Disbursement Date. No portion of the funds granted by A.I.D. under this Agreement shall be disbursed after three (3) years from the effective date of this Agreement, unless such date is extended by A.I.D. in writing, and any funds granted hereunder by A.I.D. which remain undisbursed on that date shall revert to A.I.D.

ARTICLE IV

PROCUREMENT

SECTION 4.01. Source and Origin. Except as otherwise agreed by A.I.D. in writing, goods and services required for the Program and procured under this Grant shall have their source and origin in Ethiopia or in countries included in Code 935 of the A.I.D. Geographic Code Book as in effect at the time orders are placed or contracts are entered into for such goods and services.

SECTION 4.02. Special Rules. (a) Any financing by A.I.D. of motor vehicles hereunder will be subject to Section 636(i) of the Act; and (b) any financing of drug and pharmaceutical products hereunder will be subject to Section 606(c) of the Act.

SECTION 4.03. Utilization of Goods and Services. Except as A.I.D. may otherwise agree in writing, any goods and services furnished pursuant to this Grant shall be devoted to the Program and thereafter shall be used so as to further the objectives of the Program. If at any time A.I.D. concludes that goods or services procured under this Grant are not procured or used in accordance with the terms of this Agreement, A.I.D. after consultation with the Grantee, may cease further disbursements other than those required for the liquidation of outstanding legally binding commitments entered into under this Agreement except as A.I.D. may otherwise agree in writing.

ARTICLE V

SPECIAL COVENANTS

SECTION 5.01. Additional Resources for the Program.

The Grantee agrees to provide or cause to be provided for the Program all funds, in addition to the Grant, and all other resources required to carry out the Program effectively and in a timely manner.

SECTION 5.02. Amendments. This Agreement may be revised only by the written mutual consent of the parties hereto.

SECTION 5.03. Consultation and Coordination. The Grantee and A.I.D. shall consult with each other, and with the Government of Ethiopia, at the request of either party to this Agreement concerning the operation of the Program and of this Agreement.

SECTION 5.04. Financial Records. Financial records, including documentation to support entries on accounting records and to substantiate charges to this Grant shall be kept in accordance with Grantee's usual accounting procedures, which shall follow generally accepted accounting principles. All such financial records shall be maintained, and be required to be maintained, for at least three years after final disbursement of funds under this Grant. The Grantee semi-annually shall submit a report on the expenditures incurred under the Grant to the authorized representative of A.I.D. or to the Comptroller General of the United States.

SECTION 5.05. Program Reports. The Grantee shall submit semi-annual reports to A.I.D. describing the operation of the Program and the goods and services financed under this Grant.

SECTION 5.06. Delegate to Congress and Resident Commissioner. No member or delegate to the Congress or resident commissioner shall be admitted to any share or part of the Grant or to any benefit that may arise therefrom; but this provision shall not be construed to extend to this Grant if made with a corporation for its general benefit.

SECTION 5.07. Assignment of Claim. The Grantee agrees to execute an assignment to A.I.D., upon request, of any cause of action that may accrue to the Grantee in connection with or arising out of a contractor's performance or breach of performance of any contract financed in whole or in part out of funds provided by A.I.D. under this Agreement.

SECTION 5.08. Termination. Either party may terminate this Agreement by giving the other party thirty (30) days written notice of intention to terminate it. Termination of this Agreement shall terminate any obligations to make contributions pursuant to this Agreement, except for payments either party is committed to make pursuant to non-cancellable commitments entered into with third parties prior to termination of the Agreement. It is expressly understood that all other obligations under this Agreement shall remain in force after such termination.

SECTION 5.09. Refund. If any A.I.D. funds disbursed under this Agreement are not used, applied or accounted for in accordance with the terms of this Agreement, Grantee agrees to refund to A.I.D. within thirty (30) days after receipt of a request therefor, the amount thereof, provided that A.I.D.'s request is made not later than five (5) years after final disbursement under this Grant.

SECTION 5.10. Laws and Regulations of the United States. A.I.D. shall expend funds and carry on operations under this Agreement only in accordance with the applicable laws and regulations of the United States Government.

SECTION 5.11. Implementation Letters. From time to time, for the information and guidance of both parties, A.I.D. may issue Implementation Letters that will describe the procedures applicable to the implementation of this Agreement.

SECTION 5.12. Communications. Any notice, request, document or other communication submitted by either party to the other under this Agreement will be in writing or by telegram, cable or radiogram, and will be deemed duly given or sent when delivered to such party at the following addresses:

To the Grantee:

Mail Address: Mr. Warren W. FURTH
Asst. Director - General
W.H.O.
Avenue Appia
1211 Geneva 27
Switzerland

To A.I.D.

Mail Address: Office of Regional Affairs
Bureau for Africa
Agency for International
Development
Washington, D.C. 20523

All such communications shall be in English, unless the parties hereto otherwise agree in writing. Other addresses may be substituted for the above upon the giving of notice. The Grantee, in addition, will provide the USAID Mission in Ethiopia with a copy of each communication sent to A.I.D.

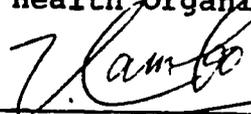
SECTION 5.13. Representatives. For all purposes relevant to this Agreement, the Grantee shall be represented by the person holding or acting in the Smallpox Eradication Unit and A.I.D. will be represented by the person holding or acting in the Office of Africa Regional Affairs, each of whom, may designate additional representatives for all purposes under this Agreement. The names of the representatives of the Grantee, with specimen signatures, will be provided to A.I.D., which may accept as duly authorized any instrument signed by such representatives in implementation of this Agreement, until receipt of written notice of revocation of their authority.

IN WITNESS WHEREOF, The Grantee and the United States of America, each acting through its duly authorized representative, have caused this Agreement to be signed in their names and delivered as of the day and year first above written.

FOR:

The World Health Organization

BY:


Thomas A. Lambo, M.D.

TITLE: Deputy Director General

DATE: April 26, 1976

FOR:

The United States of America

BY:


Daniel Parker

Administrator, Agency
for International
TITLE: Development

DATE: April 26, 1976

Appropriation: 72-11X1024

Allotment: 424-61-698-00-69-61

Obligation: 6167115

ATTACHMENT

DISBURSEMENT OF FUNDS

A. A.I.D. shall open a Federal Reserve Letter of Credit in the amount of this grant against which the Grantee may present payment vouchers. Funds drawn by the Grantee against the Federal Reserve Letter of Credit shall be only in such amounts as may be needed to meet current programme expenditures under the grant, and such drawdowns shall be made as close to the day of actual expenditure as is administratively feasible. Within the foregoing ceiling amount, the amount of any payment voucher shall not in any event be less than \$100,000 nor more than \$300,000.

B. In no event shall the accumulated total of all such payment vouchers exceed the amount of the Federal Reserve Letter of Credit.

C. Procedure for Grantee.

1. After arranging with a commercial bank of its choice for operation under this Letter of Credit and obtaining the name and address of the Federal Reserve Bank or branch serving the commercial bank, the Grantee shall deliver to the A.I.D. Office of Financial Management (SER/FM/FSD) three originals of Standard Form 1194, "Authorized Signature Card for Payment Vouchers on Letters of Credit" signed by those official(s) authorized to sign payment vouchers against the Federal Reserve Letter of Credit and by an official of the Grantee who has authorized them to sign.

2. Upon execution of the grant, the Grantee shall receive one certified copy of the Federal Reserve Letter of Credit.
3. The Grantee shall confirm with its commercial bank that the Federal Reserve Letter of Credit has been opened and is available if funds are needed.
4. To receive payment, the Grantee shall:
 - (a) Periodically, although normally not during the last five days of the month, prepare payment vouchers (Form TUS-5401) in an original and three copies.
 - (b) Have the original and two copies of the voucher signed by the authorized official(s) whose signature(s) appear on the Standard Form 1194.
 - (c) Present the original, duplicate and triplicate copy of the Form TUS-5401 to its commercial bank.
 - (d) Retain the quadruplicate copy of the voucher.
5. After the first payment voucher (Form TUS-5401) has been processed, succeeding payment vouchers shall not be presented until the existing balance of previous payments has been expended or is insufficient to meet current needs. Each drawdown should be initiated at approximately the same time that checks are issued by the Grantee in payment of program liabilities and in an amount approximately equal to the United States share of such payments.
6. In preparing the payment voucher, the Grantee shall assign a voucher number in numerical sequence beginning with 1 and continuing in sequence on all subsequent pay-

ment vouchers submitted under the Federal Reserve Letter of Credit. The current status of the pertinent Federal Reserve Letter of Credit funds shall be presented on the reverse side of the last two copies of the Form TUS-5401 in the following format:

Cash on hand prior to preceding advance	\$ _____
Plus amount of last advance on TUS-5401 No. _____	_____
Less total payments subsequent to last advance	_____
Equals cash on hand prior to receiving current advance on TUS-5401 No. _____	_____

7. A report of expenditures shall be prepared and submitted semi-annually to A.I.D. Office of Financial Management (SER/FM/FSD). This Report, submitted on Standard Form 1034, "Public Voucher for Purchases and Services other than Personal", shall be supported by certification, listing of expenditures against withdrawals and documentations as required.
8. Simultaneously with the submission of the report of expenditures the Grantee shall submit to SER/FM/FSD a report on the status of the Federal Reserve Letter of Credit as of the close of the periods covered by the report of expenditures. The report is prepared in the following format:

STATUS OF FUNDING REPORT

Federal Reserve Letter of Credit (FRLC)

No. _____

Period from _____ through _____

A. Letter of Credit Position:

1. Current amount of FRLC (including amendments) through reporting period..... \$ _____

2. Payment Vouchers on Letter of Credit presented (Form TUS-5401):

a. Credited prior to reporting period..... _____

b. Credited during reporting period via TUS-5401 Voucher Nos. _____ through _____ inclusive..... _____

c. Presented but not credited during report via TUS-5401's numbered _____ through _____ inclusive. _____

3. Total of all Payment Vouchers against FRLC credited or presented..... _____

4. Balance of FRLC not drawn or requested this reporting period..... _____

B. Cash Position:

1. Cash on hand at beginning of period.. _____

2. Plus: cash drawn during period..... _____

3. Plus: refunds, rebates or other amounts received, to the extent allocable to disbursements charged against this FRLC..... _____

4. Total cash available (sum of 1, 2, and 3)..... _____

5. Less: disbursements during period.... _____

6. Balance of cash on hand at close of reporting period..... _____

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7. Estimated number of days requirements covered by balance on hand (Item 6 above) Days: _____
8. Advances to contractors \$ _____ (included in B. 6 above).

FIRST AMENDMENT
TO
GRANT AGREEMENT
(SMALLPOX ERADICATION IN ETHIOPIA)
BETWEEN THE
WORLD HEALTH ORGANIZATION
AND THE
UNITED STATES OF AMERICA

The Grant Agreement between the World Health Organization ("WHO") and the United States of America, acting through the Agency for International Development ("A.I.D.") dated April 26, 1976, is hereby amended as follows:

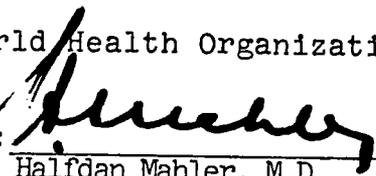
1. Section 1.02 is deleted in its entirety and the following is substituted in its place:

"Section 1.02 - Amount of Grant. The amount of the Grant provided herewith is DOLS 2,000,000."

This Amendment shall be effective upon execution.

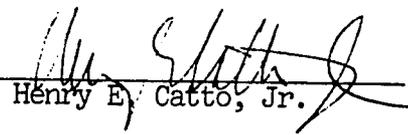
Except as specifically modified and amended hereby, the Grant Agreement dated April 26, 1976, shall remain in full force and effect. All references in said Agreement to the words "Grant Agreement" or "this Agreement" shall be deemed to mean the Grant Agreement as amended.

In witness whereof, the United States of America and WHO, each acting through its duly authorized representative have caused this First Amendment to be signed and delivered.

FOR:
World Health Organization
BY: 
Halfdan Mahler, M.D.

TITLE: Director-General

DATE: 6 August 1976

FOR:
United States of America
BY: 
Henry E. Catto, Jr.

TITLE: Ambassador

DATE: 6 August 1976

PD-AAC-365

Notification to the Congress

COUNTRY : World Health Organization (Africa Regional Funds earmarked for the Ethiopian Smallpox Eradication Program)

PROJECT TITLE : Africa Regional Smallpox Eradication Program

APPROPRIATION CATEGORY : Population Planning and Health

INTENDED OBLIGATION : \$2,000,000; \$800,000 from FY 1976 Funds; \$1,200,000 from Interim Quarter Funds

In accordance with Section 113 of the Foreign Assistance and Related Programs Appropriation Act, 1975, we are providing notification that we intend to obligate FY 1976 and FY 1976 Interim Quarter funds for the following grant activity: The Africa Regional Smallpox Eradication Program.

This activity was not included in the FY 1976 Congressional Presentation because it was not until May of 1975 that AID knew that both the World Health Organization's Worldwide Smallpox Eradication Program and its Ethiopia Smallpox Eradication Program (ESEP) would not have enough funds to complete the eradication of smallpox. In later discussions with AID and HEW, the WHO stressed that loss of momentum in these extremely successful programs could cause serious setbacks which could increase costs and delay final eradication of the disease.

AID would finance approximately 47.7% or \$2.0 million of total estimated program expenditures of \$4.2 million. AID funds would cover local and foreign exchange costs, primarily costs associated with keeping smallpox eradication and surveillance teams in the field. HEW plans to finance \$1.0 or 23.8% of the program. HEW's funds will finance helicopter leasing expenses. The WHO will finance about \$612,000 or 14.5%, primarily covering the salaries and expenses of experts and consultants and administrative overhead. Ethiopia's contribution (for salaries of local personnel) is estimated at a minimum of \$300,000 or 7.1% of the program's costs. Some \$100,000 of vaccines are being donated by other donors (2.4% of the program's costs). Financing for the remaining needs of the program, some \$220,000, will come either from other donors as is fully expected by the WHO or will be provided directly by the WHO by reallocation of budget funds to this high priority program.

(11575) 2210:22\00

**WORLD HEALTH
ORGANIZATION**

1211 GENEVA 27 - SWITZERLAND
Télegr.: UNISANTE-Geneve

Office of the Director General



Tél. 34 60 81 Téléx. 27821

PD-AAC-365

6920314 ①

**ORGANISATION MONDIALE
DE LA SANTÉ**

1211 GENÈVE 27 - SUISSE
Télégr.: UNISANTÉ-Geneve

Bureau du Directeur Général

Ref.: DG

Geneva, 12 September 1975 2p.

PERSONAL

Dear Mr Parker,

The global eradication of smallpox, as you may know, appears now to be virtually within reach. And yet, despite the evident success of the programme to date and the considerable benefits which all countries would realize from its achievement, the Organization is facing a difficult problem in securing the comparatively small additional funds we believe are required to complete the task. Knowing well from our previous conversations of your own personal interest and concern in the well-being of the Organization, I am taking the liberty of bringing this problem directly to your attention as well as to that of Dr Cooper.

During the nine years in which the smallpox eradication programme has been operative, smallpox has been eliminated from 28 of the 30 countries which were initially endemic. Only two countries remain - Bangladesh and Ethiopia. Bangladesh should record its last case within the next four weeks. In Ethiopia, however, the issue remains in doubt. Only 110 villages in five provinces are now known to be infected but these are located in difficult highland terrain among a population which has known no health services and, not surprisingly, can be persuaded to accept vaccination only with difficulty. To solve these problems, additional experienced WHO epidemiologists have been assigned, the government has substantially increased its support and three helicopters have been provided to facilitate transport. Funds in support of this effort have been made available from several governments - Canada, Japan, Netherlands, United Kingdom and from the United States of America (Department of Health, Education and Welfare). However, these funds will be exhausted within four months.

But even when the point is reached when no further cases are detected, programmes must be continued. In Ethiopia, and similarly in the other

Mr Daniel Parker
Administrator
Agency for International Development
Department of State
Washington, D.C., 20523

cc: Dr T. Cooper, Assistant Secretary for Health, Department of Health,
Education, and Welfare, Washington

Mr Daniel Parker
Our ref: DG

Page 2
12 September 1975

recently endemic countries, smallpox must be reduced to the point at which there are no known human cases and, following this, two years of active search must be conducted to be certain that there are no hidden foci of infection. Following this, an international commission must be convened to assess the programme and to decide whether or not it is satisfied that eradication has been achieved.

The activities of the programme require and have required substantially more money and other forms of assistance than can be made available from WHO's own resources. Contributions from more than 35 countries have sustained the programme to date. In this regard, as you well know, AID's assistance to the programmes in western and central Africa between 1966 and 1971 was decisive in eliminating smallpox from the countries there.

But all of this could well be in vain if the task cannot be completed. Between January 1976 and December 1977, when eradication should be able to be certified in most if not all countries, an overall need for \$13 700 000 is foreseen. Funds available from the WHO Regular Budget and contributions already in hand or pledged, amount to \$7 900 000. This still leaves us a deficit of \$5 800 000 - not a large sum of money in the context of bilateral and multilateral assistance programmes and a miniscule sum indeed in relation to the savings to be realized by your own and other countries by the eradication of smallpox.

If convenient for you, I should very much like to discuss further with you this problem sometime during the week of 28 September when I shall be in Washington to attend the Twenty-seventh Session of the WHO Regional Committee for the Americas/XXIII Meeting of the PAHO Directing Council. If convenient and agreeable to you, I would like to propose that Dr Cooper and Dr Ehrlich join in these discussions as well as Dr Henderson who is Chief of the Smallpox Eradication Programme and who also will be in Washington that week.

I do hope you will give this very frank presentation your earnest consideration since the success of this programme could provide to WHO as a whole and the health programmes of all the countries concerned a very important stimulus to energy and morale and the courage to undertake more ambitious schemes in health care.

With best personal regards,

Yours sincerely,



R. Mahler, M.D.
Director-General