From: Chief, Smallpox Eradication 27 February 1973

To: Smallpox Staff

Subject: Target Zero - Progress Report 5

1.0 Present smallpox situation

The 11 281 cases reported thus far during 1973 is a 63% increase over the 6 911 cases recorded at this time last year.

	1973 (through 20 Feb.)	1972 (same period)
India	6 874 (61%)	3 012 (44%)
Bangladesh	2 723	0
Pakistan	870	789
Ethiopia	810	2 756
Sudan	1	85
Other countries	3	269
	11 281	6 911

The number of cases in India has more than doubled as massive epidemics have developed in Uttar Pradesh and West Bengal with frequent importations of cases into less endemic and neighbouring states. India now accounts for more than 60% of the world's total of cases. In addition, the epidemics in Bangladesh have now extended to involve much of the country. While Pakistan's total shows little change, the incidence in Ethiopia, Sudan and other countries has fallen precipitously and far faster than was expected.

It is now clear that the estimates of 16 January (Progress Report 3) were much too optimistic in regard to expected progress in Asia and somewhat pessimistic in regard to progress in Africa. Revisions as follows would appear to be in order:

		Estimates		
	1972	1973 (16 Jan.)	1973 (26 Feb.)	
India	27 309	17 000	35 000	+ 18 000
Bangladesh	10 540	5 000	15 000	+ 10 000
Pakistan	7 046	4 000	4 000	0
Ethiopia	16 935	4 000	3 000	- 1 000
Sudan	1 141	200	100	- 100
Others	2 018	500	400	- 100
	64 989	30 700	57 500	

Because of mounting concern throughout the world regarding problems both in Bangladesh and India, I visited these countries during February to endeavour to elucidate the nature of the problems and expectations for the future.

In Bangladesh, efforts which had been made in the spring of 1972 to restrict the spread of smallpox to the south-western districts were necessarily hampered by the many problems which beset the country during its early phases of restitution of health services, transport and communication, and many foci persisted. Unfortunately, nature conspired against the programme as the amount of rain during the monsoon period was much less than has occurred in many years. Many foci remained which otherwise might have died out during this period. Even more serious, however, has been the extensive population movement occasioned by the poor harvest and consequent food shortages. Smallpox spread widely to involve most districts and major outbreaks are now occurring in Dacca itself. With a high density of population and a reduced level of population immunity due to a restricted programme of maintenance vaccination in recent years, conditions were ideal for major epidemics. The existing surveillance-containment programme simply could not cope. The situation, however, is now being dealt with as a first priority emergency from the highest levels of Government. Many measures have been and are being implemented - malaria staff throughout the country have been enlisted to undertake a three month intensive drive to vaccinate the unvaccinated pre-school population; the assistance of other health staff, including family planning workers, has been obtained; additional SE staff have been recruited. Special efforts will be made to prevent transmission from becoming re-established in Sylhet and Chittagong Districts while endeavouring to contain outbreaks in the other Districts. An intensive programme will be continued throughout the monsoon period. With these efforts, it is hoped that the problem may be sufficiently restricted in scope to permit interruption of transmission during the September-December period, the beginning of the next smallpox season.

In India, three major epidemic problem areas have become apparent - (1) Uttar Pradesh and neighbouring areas of Madhya Pradesh; (2) West Bengal and (3) Jammu and Kashmir. In 1972, Uttar Pradesh and northern Madhya Pradesh was the major smallpox focus in India accounting for over 40% of all cases reported. Considerable efforts were made to strengthen reporting, surveillance and containment measures with what seemed to be some measure of success. However, precisely during the period of the seasonal increase in smallpox (September-December), many smallpox workers were directed to other programmes and, in many areas, nothing was done to contain the developing outbreaks. Major epidemics developed and are now occurring throughout the state. Special programmes with additional staff began on 22 February in 20 border districts and intensified activities in the 34 other Districts of the state. West Bengal which has recorded comparatively low smallpox incidence for the past 10 years, experienced an increased incidence in 1972 following the spread of smallpox from the Salt Lake refugee camp near Calcutta. These outbreaks were not satisfactorily contained and this year the disease spread to involve the city itself. Calcutta is now experiencing its worst epidemic in over a decade - over 200 cases are being reported weekly and there are, in addition, many unreported cases. Migrants from the city are carrying disease to other states in eastern India - 19 importations thus far have been detected in Orissa and over 30 in Bihar. Health staff are being mobilized in Calcutta

and elsewhere in West Bengal to combat the epidemics but it is already regretably late in the season. Finally, major outbreaks which began last spring are continuing to occur in Jammu and Kashmir - comparatively little information, however, is yet available either about the extent of the outbreaks or the measures being taken.

Overall, the pace of programmes and intensity of activity in such as Ethiopia, Sudan, Nepal and Afghanistan, would now seem to commensurate with meeting or sustaining the goal of a nil incidence during the next 12 months. However, the situation on the subcontinent remains in doubt with a very great deal to be done yet in India and with uncertainties about the possible success of efforts in Pakistan and Bangladesh.

	Nov.	Dec.	Jan.	Feb.
2.0 Cases occurring within March 31 target area				
Ethiopia	215	282	208	0
Pakistan	469	625	471	100
India	986	2 801	4 309	635
Bangladesh	663	649	1 277	...
Cases occurring outside target area but specifically traced to importations				
Afghanistan	4	0	0	0
Ethiopia	0	0	5	1
Somalia	5	0	0	0
Nepal	21	5	3	0
Sudan	0	1	0	1
India (Orissa, Haryana, Maharashtra, Gujarat)	3	29	63	53
Total of all cases in category 2.0	2 366	4 392	6 336	790
Per cent of world total cases in category 2.0	54	69	64	56
2.1 Cases occurring outside target area				
Sudan	16	18	0	0
Ethiopia	595	362	408	188
Pakistan	100	178	248	51
India	689	1 030	1 428	386
Bangladesh	654	370	1 446	...
Total of all cases in category 2.1	2 054	1 958	3 530	625
Per cent of all cases in category 2.1	45	31	36	44

Note: Data as of 20 February 1973

3.0 Reporting

By 20 February, reports from all areas should have been received by WHO through week 6. Bangladesh remains one week in arrears but recent changes in the reporting system are expected soon to solve this problem. Considerable improvement is noted in India where the cumulative number of weeks for which all states are in arrears is now only 11 compared to 52 per Report 4 and 58 per Report 3.

The following endemic areas were in default:

	No. of weeks
Bangladesh	1
India - Meghalaya	1
Nagaland	1
Chandigarh	1
Haryana	1
Himachal Pradesh	1
Jammu and Kashmir	2
Punjab	1
Madhya Pradesh	1
West Bengal	1
Goa	1