From: Chief, Smallpox Eradication 19 March 1973

To: Smallpox Staff

Subject: Target Zero - Progress Report 6

1.0 Present smallpox situation

The highly gratifying progress in the eradication campaign throughout Africa, Afghanistan, Nepal and Indonesia continues to be clouded by a significant setback in Bangladesh and the development of major and extensive epidemics in India which have not yet begun to come under control. In Pakistan, meanwhile, smallpox incidence since December has stabilized and with a number of additional measures taken in recent weeks to strengthen surveillance activities at provincial and District levels, the future looks cautiously hopeful.

Comparative totals for 1973 and 1972 show, for India, a two-fold increase in incidence and a projected total for the year which will almost certainly exceed the highest incidence recorded since 1967. Some portion of this year's record incidence is certainly due to more complete notification but it is abundantly clear that the notification system has not improved dramatically enough in only a year's time to account for this change. In fact, the actual totals are undoubtedly greater than are being recorded as reports from several states (e.g. Bihar and Jammu and Kashmir) continue to be greatly delayed and incomplete. In the states experiencing the most extensive and major epidemics (West Bengal, Uttar Pradesh, Bihar and Jammu and Kashmir), there is little indication as yet that control is being achieved. Meanwhile, endemic transmission persists at low levels in Rajasthan and Andhra Pradesh, long after programme staff had expected it to be interrupted and, now, many previously smallpox-free areas are reporting cases and outbreaks, for only a few of which information has been provided to indicate that they represent well-documented and contained importations. Unless there is a substantially more intensive effort in India which can be sustained throughout the summer and autumn months, the next smallpox season may bring an even higher incidence. Future prospects for eradication in India remain far more uncertain than in any other area.

In both Bangladesh (as previously noted) and now in Pakistan, a considerable number of measures have been taken in recent weeks to strengthen the eradication programme and to intensify activities. The relative success of these efforts will be difficult to appraise much before summer.

In Africa, Ethiopia continues to report a continuing decline in cases and a rapidly shrinking endemic area. The mobile surveillance teams are being selectively dispersed to permit a maximum effort to be applied in the remaining endemic areas. Those teams remaining in the smallpox-free areas are continuing their ceaseless active search to detect unsuspected foci. It is expected that by the beginning of the rainy season, smallpox will be restricted to three of the 14 provinces. Decreased levels of transmission during the rainy season should facilitate interruption of transmission in the remaining problem areas. In Sudan, only a single suspect case has been identified since December and this, on laboratory examination, has now proved not to be smallpox. An active search for cases is continuing throughout the country.

2.0 Progress in meeting the 31 March objectives

All countries except Bangladesh and India appear now to be making sufficient progress so that the originally agreed 31 March goals may be essentially achieved. Problem areas do persist in Harar Province, Ethiopia, where the interruption of transmission among scattered, highly nomadic groups is proving more difficult than was anticipated. At the same time, however, in Tigre Province which was anticipated to be a persistent problem, transmission appears to have been interrupted. Thus, smallpox foci may still persist in four Ethiopian provinces after 31 March although not the same four which had originally been targeted. In Pakistan, limited problem areas persist in the Khyber and Kurram Agencies of North West Frontier Province, in Lahore in Punjab Province and in several districts of Baluchistan. Intensified surveillance activities in these areas are planned or are in progress at this time. Thus, in Pakistan, the 31 March targets may be able to be achieved although the task will not be easy.

As noted in section 1.0, neither Bangladesh nor India will approach achievement of the 31 March targets.

Future targets will need to be established for 31 December 1973 and 31 May 1974. These will be finally decided upon at the end of May in consultation with the Regional Advisers who, in the meantime, will be in contact with programme staff.

2.1 Cases occurring within original March 31 target area	Dec.	Jan.	Feb.
Ethiopia	282	192	95
Pakistan	625	471	640
India	2 808	4 148	3 555
Bangladesh	649	1 450	1 460
Cases occurring outside target area but specifically traced to importations			
Ethiopia	0	5	8
Nepal	5	3	2
Sudan	1	0	0
India (Orissa, Haryana, Maharashtra, Gujarat)	27	63	138
French Terr. of the Afars and Issas	-	-	1
Total of all cases in category 2.1	4 397	6 332	5 899
Per cent of world total cases in category 2.0	69	62	63

2.2 Cases occurring outside target area			
Sudan	18	0	0
Ethiopia	362	448	449
Pakistan	177	248	229
India	1 037	1 605	1 294
Bangladesh	370	1 601	1 492
Total of all cases in category 2.2	1 964	3 902	3 464
Per cent of all cases in category 2.2	31	38	37

Note: Data as of 13 March 1973

3.0 Reporting

By 13 March, reports from all areas should have been received by WHO through week 9. Deficiencies remain, as before, in Bangladesh (still one week in arrears) and in India where the cumulative number of weeks for which all states are in arrears has once again increased to 32 compared to a low of 11 per report 5. The correlation between a deficient reporting system and disappointing progress in the eradication programme is all too apparent.

	No. of weeks
Bangladesh	1
India - Arunachal Pradesh	1
Assam	1
Bihar	1
Chandigarh	2
Goa	1
Haryana	3
Himachal Pradesh	2
Jammu and Kashmir	2
Kerala	2
Madhya Pradesh	3
Manipur	2
Meghalaya	1
Nagaland	4
Punjab	2
Rajasthan	3
Tripura	1
West Bengal	1