SPOX PROGRAM AGRA / INDIA APRIL '71

Pleasure to be ~~here – particularly opportunity to~~ talk c̄ colleagues who themselves ~~represent~~ occupy the most important, the most vital positions in this global program to eradicate spx.

This campaign, as you may know, [unanimously] designated as a priority program by the [131 countries of the] WHA and termed by various eminent public health ~~persons~~ authorities as potentially representing ~~one of~~ [today] the greatest land mark achievement in man's fight vs. disease [this program] is being watched with great interest by nations throughout the world.

My ~~greater~~ interest and concern in visiting at this time is quite simple – the two states – Haryana and Rajasthan ~~are~~ have reported in 1970 and 1971 more than 20% of the world's total of cases – more than half of all cases reported in India. The D-G has been requested to [provide a special] report to the World Health Assembly next month as to the progress and problems in this great campaign. My visit at this time is to ascertain, as best I can, why this should be so ~~and what~~ but more important, what is being done about it. Your comments and observations during the course of this meeting will be of the greatest help in this regard.

Helpful in introduction to review the ~~status~~ development of this program and its status today.

Global program for SE – proposed and unanimously adopted in 1957 by the Assembly.

Strategy – vaccination 80%, 90% → 100%

even where good vaccine was used – a dismal failure.

Most areas – liquid vaccine & impotent f.d. vaccine was used.

At end of 10 years, few programs really successful. In India, p̄ 10 years, there were in fact as many reported cases as there were at the beginning of the program.

1966 – Program reconsidered by the Assembly.

~~Decided to make available~~ Serious or not.

Technical problem? No. Central America. Indochina, Malaysia, Thailand.

Another effort
$3,000,000 Assembly. USSR. USA. 20 other countries
1 Jan 1967 - a global program began in interest. I assumed my post as

Strategy -
Tools
Vaccine - 15%.

Vaccination devices -

Strategy
Vaccination - 80% - failure.
Indonesia - 92%. Other areas - 30%. (WER)
obviously of value + necessary - clearly alone - not stop spread / disease.
Studies of epidemiology of smallpox. -
~~Spread~~ Man-to-man - continuous chain. Scabs, fomites, market places.
Spreads slowly - 14 days. - no. infected.
Households, hospitals -
Occurs as clusters of cases -
no. of villages affected.

Delhi experience.

Visualize as number of chains of infection - objective: to interrupt chains.
Back tracing.
Analogy - painting a room.
Weight - quality vs. quantity. What do we mean by quality
→ Primary vaccination < old studies 50% / new studies 5%.
→ Vaccination at site of outbreak. - Indonesia
Emphasis in overall strategy -
① Stop spread
② ~~Mass~~ Vaccination. - 1° outbreaks.

Illustrate - Parana State, Brazil.
70 lacs. - ½ size Rajasthan - 30% vaccination coverage - no reporting.
2 days to reach periphery local points.
Mass vaccination campaign (28 persons)
Surveillance officer + vaccinator + driver
8 months - 1000 cases + ^(generally catching outbreaks -) est. reporting system. -
No smallpox - vac. campaign ⅓ finished.
Same story repeated again + again.
Everywhere (Africa, Asia, S. America) effort to report + every case in at 2 years.

(3)

World-wide – what has happened in the 4 years since program began.

~~South Am~~ 1967	42 countries – ~~30 end~~	1970	23 countries	1971 12
	30 endemic		14 endemic	5 endemic
	131 000 cases		30 000 cases	20 000
	< 5 %		25 %	35 %

South America –
1969 8000
1970 1700
1971 17
Continental search for cases.
West Africa – no cases for > 1 year
East Africa – 3 countries → 2 countries.
Asia – Indonesia – began July 1968 –
Afghanistan – " April 1969 –
East Pakistan –
West Pakistan –
Nepal.
India – concept more slowly appreciated than elsewhere.
1967 – 85000 → 1970 – 10 000. (lowest in history)
A.P., Tamil Nadu, Punjab, H.P., Maharashtra.

~~Developments progressing~~ –
Dec. last year – seminar on this in Delhi.
A number of states have now modified strategy appropriately.
Last two days – review of state program – Rajasthan – no. of steps.
Review in Jaipur District – not ~~very~~ wholly satisfactory as yet
but coming close to it.
Other districts in Rajasthan + Haryana ?

What is the status & what are the problems?
Perhaps, if summarized a few - might save us time -
Wherever a program unsuccessful - Asia, America, Africa -
same explanation.

1. People won't accept vaccination -
Dahomey
Afghanistan
India. - lack of effort
2. lack of Transport - nearness to road - 90% > 2 miles.
Ethiopia - 23 x 10^6 - ~~17 vehicles~~
17 vehicles -
Afghanistan - surveillance team.
3. Not enough B.H.S.
Most of Africa virtually none.
Nothing whatsoever to do with it.
4. Need more H.E. -
In few countries any H.E.S per se. Program staff.
5. Difficult to train people in use bifurcated needles.
Myself trained totally illiterate African vaccinators in
1 day classroom and two days field work.

Dispensed with these problems - truly believe can be overcome.
Helpful to hear what are the real problems - not in vaccination -
levels in India already higher than in most areas when eradicated.
Where is smallpox occurring, what is being done, what are problems
in stopping spread.

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