From: Chief, Smallpox Eradication

To: Smallpox Programme Staff 28 July 1972

On the surface, it might appear that the year 1972 has been the least satisfactory of any for smallpox eradication since the programme began. It would seem difficult to speak of progress when one notes:

1) That over 45 000 cases have been reported to date compared to only 32 500 at this time last year.

2) That the total of cases in 1972 will almost certainly exceed 60 000 - the highest number recorded since 1969.

3) That the 10 536 cases so far recorded for May 1972, represents the highest monthly incidence since January 1968.

4) That the number of countries reporting cases each month this year is almost identical to that of last year.

5) That there were more cases resulting from importations in 1972 than in any year since the programme began.

Beneath the surface of these statistics, however, is the recognition that for the first time since the programme began, some sort of surveillance activity is now being conducted in all endemic areas. Within the past 16 months, such has commenced in Botswana, in the southern provinces of Sudan, in the remaining nine (of 14) provinces of Ethiopia, in the remaining three (of 4) provinces in Pakistan, in several of the states of India, and in western Nepal. While neither the quality nor the intensity of surveillance measures in many areas are yet up to the standard required to interrupt smallpox transmission, I sense that increasing progress is being made and that the gap between what is present and what is required is steadily narrowing.

With this in mind, I believe that the increased incidence this year may well be echoing the Brazilian crisis of 1969 when, as you will recall, with improved surveillance and better reporting, the number of cases notified rose from 4 372 in 1968 to 7 487 in 1969 only to fall to nil little more than 12 months later. It is recognized that those 12 months were marked by renewed

efforts on the part of national, state and local authorities but, nevertheless, and despite a still inadequate surveillance scheme at the beginning of 1970, the efforts were successful.

With a renewed effort at all levels throughout the programme, there would seem to be no reason why, over the next 18 months, a similar "miracle" could not be achieved on a global scale. It will, of course, require that every suspect case of smallpox be dealt with as a public health emergency in every sense of the word and that containment measures be promptly and effectively carried out everywhere. In addition, an active search for cases will be required in many areas. With cases in virtually all endemic countries at a low seasonal ebb in September, I believe that we are, for the first time, able to deal with the problem in this manner.

Accordingly, I propose to designate September 1972, as the beginning of the "final phase" of the smallpox programme - the objective of this final phase being to reduce smallpox to a nil incidence within 18 months. Methods and problems associated with this "final phase" will be the principal theme of the seminars to be conducted this autumn in New Delhi, Karachi, Addis Ababa and Khartoum.

While the past five years have seen remarkable progress, I would hope that with renewed efforts on the part of both national and WHO staff, the next 18 months will effect a "miracle". Success, however, will depend on each and every person bearing his full responsibility.