WORLD HEALTH ORGANIZATION

INTER-COUNTRY SEMINAR ON
SURVEILLANCE IN SMALLPOX ERADICATION

New Delhi, 30 October - 2 November 1972

RECOMMENDATIONS FORMULATED BY THE COMMITTEE

From 30 October 1972 to 2 November 1972, the WHO Inter-Country Seminar on Surveillance in Smallpox Eradication was held in New Delhi. Delegations attended from Bangladesh, Bhutan, India and Nepal.

The Seminar particularly reviewed the surveillance and containment elements of smallpox eradication, since these have proved to be the most important components of a successful programme.

The meeting recognized that, since the inauguration of the smallpox eradication programme on a global basis in 1967, considerable progress has been made. In that year, 30 countries were considered endemic for smallpox but by 1972, there are only 7 countries where smallpox foci still exist - three countries in the African continent (Botswana, Ethiopia and Sudan) and four countries in the Indian subcontinent (Bangladesh, India, Nepal and Pakistan).

Previous experience, both in countries now free from the disease and in the three African states where endemic foci are rapidly diminishing, has convincingly demonstrated the efficacy of surveillance as an effective means of eradication. In S.E. Asia itself, a programme based on surveillance has apparently succeeded in Indonesia, although further surveillance is necessary before it can be declared smallpox-free. Full implementation of this concept of surveillance needs to be ensured in all the Asian countries where smallpox still occurs, especially in those states of India where there is still no adequate programme in action.

Provided that such a surveillance component is implemented in the programmes of India and the adjacent countries, it is possible that the incidence of smallpox could reach zero within eighteen months. Needless to say, an intensified search for cases will need to be continued for at least 2 years after the last recorded case.

With regard to the countries participating in the Seminar, the surveillance part of the programme has developed rapidly to cope with

the present epidemic in Bangladesh. In Nepal at this moment, smallpox appears to be localised to the border areas in the western part of the country, whilst there is no indication of the existence of any smallpox in Bhutan. However, in India, major epidemic foci exist in Uttar Pradesh, Bihar and West Bengal and localised foci are present in other states in Central India. The southern part of the country appears to be free of smallpox. However, except for a few states in India, where the existing system is already satisfactory, the surveillance component of programmes needs to be substantially intensified.

Mindful of the present position, the Seminar discussed the problems of reporting, case finding, containment measures, follow-up procedures, the efficacy of surveillance teams and concluded that the methods discussed during the Seminar will be most effectively implemented and the programmes will be successful if the following recommendations are fulfilled:

1. For the effective development of surveillance activities, it is essential to delineate the region into smallpox endemic and non-endemic areas within the state or country.

   The endemic area should receive the highest priority and the major part of the resources presently available should be devoted to surveillance in an attempt to interrupt transmission. On no occasion should staff or supplies be diverted from smallpox eradication to other programmes.

   In the non-endemic areas, an active search for cases (see recommendation no. 9) should be planned and implemented to ensure its smallpox-free status. In this area, the occurrence of any suspect case should be dealt with as a National Public Health emergency to prevent the importation or re-establishment of any endemic foci.

2. In states where surveillance teams are not yet in existence, state or central teams should be created as soon as possible as a matter of urgency. Certainly by 1 December 1972, these teams should be in existence and working in each region. These teams should be recruited from the most efficient members of the present health staff.

3. The investigation of all outbreaks occurring in their area by the State Programme Officer or at least by the State Surveillance teams is essential. This will encourage local staff and ensure the acceptable level of competence in investigation of source of infection, containment and follow-up.

4. In non-endemic regions or states, if the diagnosis of smallpox in a suspect case cannot be determined by clinical or epidemiological evidence, specimens should be taken by the programme officer or the central surveillance team and sent to the designated smallpox diagnostic laboratory.

   The results of laboratory investigations must be available to the programme officer within one week.

5. Whilst general improvement in reporting is required, particular attention should be paid to the improvement of reporting in presently endemic regions.

   The newly introduced reporting system in India should be improved as rapidly as possible.

   Efforts should be made to alert all health workers at the peripheral level to the importance of reporting all suspect cases of smallpox.

6. Prompt cross-notification between districts, states and countries must be ensured by the most rapid means available.

   In India, in non-endemic regions, it is most desirable that the central SE unit receive copies of all cross-notification cables and thereby ensures appropriate follow-up action.

   Arrangements should be made, where smallpox occurs in border districts, for adjacent states or countries to exchange pertinent information on the smallpox situation. This could possibly be done by contacts between the staff of neighbouring districts, states or countries.

7. It is recommended that the Health Education of the public be promoted in an attempt to prevent the concealment of cases. This will ensure a satisfactory tracing of sources of infection in epidemic situations.

8. In view of the incomplete reporting of all cases in this area, careful tracing of the source of infection in all foci is essential.

   For containment measures, 100% vaccination of all contacts in outbreak areas should be ensured. The follow-up visits should be made by the state surveillance team or the programme officer to ensure the completeness of containment of all the outbreaks.

9. When an area becomes smallpox-free, an active search for cases should be implemented by visiting schools, markets, shop-keepers, religious and other local leaders, health stations and any other possible source of information, where the smallpox recognition card will be shown and information on cases sought.

10. Present routine vaccination should continue in all areas, with emphasis on neo-natal and primary vaccination. In all participating countries, regular vaccination of hospital staff and of patients on admission should be mandatory.

11. Provision should be made for the payment of daily and travel allowances to the SEP staff.

12. It would be useful for the Indian border states, if the WHO smallpox surveillance report included a district breakdown of cases occurring in neighbouring countries.

    Extra copies of these reports to be circularized to peripheral staff might also be helpful and informative.