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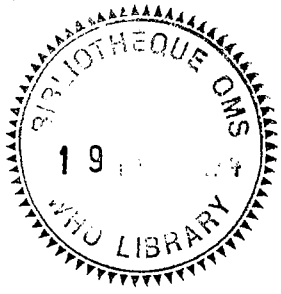
ORGANISATION MONDIALE DE LA SANTÉ

SE/WP/74.3

ENGLISH ONLY

INTERNATIONAL ASSESSMENT OF SMALLPOX ERADICATION IN INDONESIA

15-26 April 1974



The Smallpox Eradication Programme in Indonesia[1]

by

Dr I. F. Setiady[2]

1. Introduction

The Smallpox Eradication Programme (SEP) started in July 1968 for Java and Bali, and was extended to the other islands in 1969.

Due to the aid, made available by the World Health Organization and the five-year Development Plan of the Government, the implementation of the SEP activities was not handicapped by material or financial shortcomings as was experienced by previous smallpox campaigns, and substantial progress was made accordingly.

Smallpox became endemic in Indonesia since the introduction of the disease to the island of Kundur (Riau Province) in 1947 from Malaya. From there the disease spread rapidly to the big cities on the main islands. No proper control programme was launched; the so-called routine vaccination was done irregularly and sporadically and could not prevent flare-ups of outbreaks.

Up to 1967 many efforts were made to control the epidemic by launching all kinds of programmes with the principal objective: the vaccination of as many people as possible with a minimum target of 80%. However, despite this great effort, no permanent long lasting result was achieved, smallpox remained prevalent throughout the country.

Since the start of the smallpox eradication programme in 1968 the smallpox situation in Indonesia had changed dramatically. Within three years the number of reported cases had dropped from 17 350 in 1968 to 1951 in 1971 (up to week 42).

A short description of how the smallpox eradication programme had been carried out and the future trend of the programme is given below.

2. The programme

Although the smallpox eradication programme in Indonesia had officially started in July 1968, the importance of the preparatory period before the start should also be taken into account. The agreement between WHO and the Government of Indonesia, in which the latter joined the global smallpox eradication programme, was signed in December 1967.

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[1] Previously issued as SE/WP/71.71

[2] Chief, Directorate for the Control of Epidemics, Ministry of Health, Indonesia.

The first smallpox eradication programme seminar, held in February 1968, was attended by the provincial health staffs of Java and Bali and other parties outside the Ministry of Health such as a high official from the Ministry of Interior and representatives of the Health Directorates of the Armed Forces. In this seminar the Ministry of Health stressed the importance of the smallpox eradication programme and consequently was given high priority.

The second seminar was held in January 1969 and was attended by the provincial health staffs of the other provinces outside Java and Bali.

As has been stated earlier, the programme was initiated on the islands of Java and Bali only and was extended to the other islands the following year. This policy was adopted because of the following considerations:

Java and Bali were highly endemic and inhabited by 65% of the total population;

in Java and Bali the health infrastructure was already established;

the limited funds and forces available.

Apart from the breakdown of the programme into these two phases, other important factors had to be considered in the execution of the programme, i.e.:

flexibility of the programme;

a clear organizational structure;

strong leadership;

integration into the general health services.

The programme consists of two components:

1. Routine vaccination;
2. Surveillance and outbreak containment.

At the beginning of the programme emphasis was put on routine vaccination; after one-and-one-half years however, no satisfactory results had been achieved due to the fact that most of the vaccinators were not able to reach their targets which had resulted in accumulation of susceptibles. Special measures were taken to eliminate this backlog in West Java and Central Java by establishing special teams apart from the fire-fighting teams and the routine vaccinators.

From the situation in West Java it became more and more obvious that not the routine vaccination but the surveillance containment measures were of major importance in the interruption of smallpox transmission.

In the third seminar, held in September 1970 in Makassar, emphasis was put on the surveillance containment component of the programme. Another important outcome of the seminar was the clearly defined guidance for the implementation of the programme for the following year both at headquarters and provincial levels.

The latest seminar held in Berastagi in October 1971 had in some aspects a different character as compared with the previous ones; not only smallpox matters were discussed, but also the future task of the smallpox workers was considered.

2.1 Organization

The smallpox eradication programme at headquarters level is carried out by one of the divisions of the Directorate for the Control of Epidemics of the Directorate General for Communicable Disease Control. It is headed by a chief of the division and assisted by a medical and administrative staff. In the job description it is stated that this division is responsible to the Director who in turn is responsible to the Director-General for all the activities of the SEP (see Annex 1). Because of the high priority given to the smallpox eradication programme, the SEP has, unlike the other divisions, a bigger staff: a total of 8 medical officers, 10 health inspectors and 12 persons for administration.

The SEP's organizational structure of the provincial health services is built up along the same pattern. Thus in each province there is a smallpox eradication programme section under the CDC Division, with one full-time medical officer or one senior supervisor. Further down at regency level the SEP is directly under the Regency Medical Officer assisted by a senior supervisor and one or more assistant supervisors. At sub-district level there are one or more vaccinators depending on the extent of the area or the population to be covered.

For Java and Bali there are Advance Teams which have the function to supervise and co-ordinate the whole smallpox eradication in a group of regencies formerly known as the administrative unit "residency".

In every regency a special "Fire-fighting Team" was established, which consisted of three to four paramedical workers taken from other health units. This team can be called upon whenever outbreaks occur.

As is mentioned earlier, at national level a well-staffed Fire-fighting Team, consisting of medical officers and sanitarians, are always available to assist and stimulate those provinces which lack initiative.

2.1.1 Logistics

As it is with any programme, logistics play a very important role to make the programme a success. In our organizational structure, logistics (finance and supply) are managed by the secretary of the Directorate (see Annex 1). The section "Supply" in the smallpox eradication programme division is headed by a Supply Officer, who is in charge of the management of all SEP materials including vaccine.

All materials, with the exception of vaccine, are supplied by WHO (see Annex 2). This vaccine is produced by and purchased from P.N. Bio Farma. The handling and distribution of these materials to the periphery are done as follows.

The smallpox eradication programme headquarters is responsible for the clearance and handling at the port of arrival (Tandjung Prick) and the further transportation to the capitals of the provinces. Difficulties concerning these materials are the following:

In general the timing of the arrival and distribution of the materials could not be estimated with certainty. Particularly for items which have to be sent on a regular basis, like spare parts. It should be possible to solve this problem by better planning and by using a fixed time schedule.

Many complaints were received about the bicycles which seemed to be of poor quality.

Refrigerators to be used in the regencies are needed. The ones which have been sent to Indonesia are too big; these are more suitable for the provinces.

2.1.2 Finance

The smallpox eradication programme is included in the five-year Development Plan (Pelita) of the Government. This means that the budget for the smallpox eradication programme is taken from the Development Budget. From the start of the Pelita in 1969/1970 up to the fiscal year 1971/1972, a total of Rp 449 594 000 has been spent (see Annex 3). Before the Pelita in 1968/1969 the routine budget was provided by the Ministry of Health, approximately amounting to Rp 35 000 000.

In the agreement with WHO it is stated that the World Health Organization will provide financial subsidy which amounts to Rp 58 983 292.50 to meet the expenditures which cannot be covered by the national budget (see Annex 2) for 1969, 1970 and 1971.

Apart from these two financial sources, each province is paying the salary of the SEP workers, and the routine expenditures of the SEP office; data about the total amount spent by all provinces are not available, but roughly estimated it is approximately Rp 110 000 000 annually.

Generally speaking, there is no lack of funds in the execution of the smallpox eradication programme. What is often believed to be a financial problem is not a shortage in funds but the irregular flow of money from headquarters to the provinces, due to the existing bureaucracy.

2.2 Surveillance

Before 1968, uniformity in reporting procedures did not exist. There were no standard reporting forms. Although the provincial health services were expected to report every week to the CDC, only a few complied. Complete reports of past years are not available at the CDC as, due to careless filing, many reports have been lost.

In 1968, it was still not possible to obtain a steady flow of good reports. However, improvement was apparent. The number of reports increased and their quality, though still far from perfect, improved considerably. The number of missing reports was still high. Again, however, many reports for 1968 were lost at CDC due to carelessness and no serious attempts were made to complete them. Feed-back reporting to enhance understanding between reporter and receiver was not done.

In 1969, particularly during the last months of the year, the reporting system improved considerably. At national level increasing efforts were made to promote good reporting. In order to fill the gaps of missing reports, a table was prepared by weekly periods of all cases and deaths reported during the year. This table was sent to all provincial health services with the request that it be submitted to the CDC after any errors had been corrected and missing reports obtained. Most of them responded. All provinces and regencies of Java now use the new standardized reporting forms. At national level reports were received with ever-increasing frequency and regularity. Their quality and reliability improved markedly. When the final report for 1969 was prepared, only 110 out of the 1378 (26 provinces, 53 weeks) reports were missing (7.9%).

In 1970 all provinces, with a few exceptions, had reported regularly. Missing reports were rare. However, beyond the control of the reporters, a small number of reports were still unaccountably lost.

To give an idea of progress in the completeness and speed of reporting, two corresponding periods of time in 1970 may be compared for eight provinces. On 17 September 1969 a table was prepared of the reported cases for the first 35 weeks of that year. The same was done on 15 September 1970. In 1969, 138 reports out of the 280 (8 x 35 weeks) were missing (49.3%), while in 1970 only 15 reports (5.4%) were missing (Table 1).

TABLE 1. NUMBER OF MISSING REPORTS FOR THE FIRST 35 WEEKS FOR EIGHT PROVINCES IN 1969 AND 1970

Province	1969	1970
Sulawesi Selatan	5	1
Sumatra Atjeh	35	5
Sumatra Barat	19	3
Sumatra Djambi	21	1
Sumatra Lampung	10	-
Sumatra Riau	28	1
Sumatra Selatan	9	1
Sumatra Utara	11	3
Total	138	15

A comparison in speed of reporting between 1969 and 1970 is presented in Table 2. In 1970, a maximum delay of three weeks in receiving reports is observed, while in 1969, the delays range from one to 21 weeks to no report at all.

TABLE 2. NUMBER OF MISSING REPORTS AFTER THE LAST REPORT RECEIVED FOR 1969 AND 1970

Province	1969	1970
Sulawesi Selatan	5	1
Sumatra Atjeh	35	3
Sumatra Barat	1	3
Sumatra Djambi	21	1
Sumatra Lampung	10	-
Sumatra Riau	2	1
Sumatra Selatan	10	1
Sumatra Utara	11	3
Total	95	13

A table of the number of missing reports of all 26 provinces for the first 44 weeks of 1971 was prepared in week 45, 1971 (Table 3).

TABLE 3. NUMBER OF MISSING REPORTS FOR THE FIRST 44 WEEKS OF 1971

Provinces	Total No. of missing reports	Missing reports after last received report
1. Bali	4	2
2. Djawa Barat (West)	2	2
3. (Djawa) Jakarta	-	-
4. (Djawa) Jogjakarta	4	2
5. Djawa Tengah (Central)	1	1
6. Djawa Timur (East)	1	-
7. Irian Barat	3	1
8. Kalimantan Barat	2	2
9. Kalimantan Selatan (South)	2	2
10. Kalimantan Tangah	15	15
11. Kalimantan Timur	3	1
12. Maluku	5	1
13. Nusa Tenggara Barat	-	-
14. Nusa Tenggara Timur	-	-
15. Sulawesi Selatan	2	2
16. Sulawesi Tengah	1	1
17. Sulawesi Tenggara (South-east)	2	2
18. Sulawesi Utara (North)	3	3
19. (Sumatra) Atjeh	3	3
20. Sumatra Barat	3	2
21. (Sumatra) Bengkulu	3	3
22. (Sumatra) Djambi	2	1
23. (Sumatra) Lampung	1	1
24. (Sumatra) Riau	1	1
25. Sumatra Selatan	1	1
26. Sumatra Utara	1	1
Indonesia Total	65	50

A total of 65 reports out of 1144 (26 x 44 weeks) were missing (5.8%). With the exception of Central Kalimantan which for some reason had a delay of 15 weeks, all other provinces had reported with a maximum delay of only three weeks (three provinces). All other provinces had a delay of two weeks or less and reports of four provinces had arrived in time.

At national level the Surveillance Unit now possesses good files and most information, whenever requested, can be produced within a matter of minutes. The incoming reports are carefully controlled. Delays in reporting are checked and, if necessary, the province concerned is sent a reminder by mail or telegram.

As a routine, a reminder is sent every three months to all provinces in which the missing weekly reports and the last weekly reports received by the CDC's Surveillance Unit are indicated with the request to complete all missing and delayed reports (see Annex 4).

Since 27 April 1970, the CDC's Surveillance Unit has issued a weekly report as a feed-back to all provincial health services with enough copies to be distributed to all regencies and municipalities (see Annex 5). These reports are also sent to WHO. In the past, only the number of cases and deaths of the preceding week and the regencies where these cases had occurred were reported; the new reports give a complete summary of the entire smallpox situation of the country.

At the time this report was made only one province, i.e. South Sulawesi province, still reported cases. North Sumatra, which had been a problem area, reported its last smallpox cases in week 34, 1971. In spite of the fact that rigid surveillance is practised, particularly in those provinces which had in the past been problem areas, no cases could be found. Several alarming reports were received which were thoroughly investigated by the national team (West Java, Jakarta); none of these reports had led to the detection of cases.

At the fourth national SEP seminar at Berastagi, North Sumatra, held in October 1971, it was decided that surveillance activities should be intensified to make sure that no hidden pockets of infection still exist. All vaccinators (some 3400 - all sub-districts have at least one vaccinator) are to discontinue vaccination activities for a period of three to four months. In this period they will cover systematically the whole area assigned to them with the task to look for cases. Without performing the usual vaccinations their rounds can be finished at a much greater speed and a more purposeful and intensive search can be done. Every case resembling smallpox is to be reported at once and to be checked by qualified personnel. At regency level, every single suspected case with all details is to be registered in a book exclusively designed for this purpose to facilitate possible follow-up actions and to assess activities of the local health personnel.

2.2.1 Laboratory

Now that the smallpox eradication programme has entered the maintenance phase, and every single suspected case is considered an emergency and consequently checked by the national team from headquarters, prompt laboratory confirmation for immediate action is needed.

For this purpose a smallpox diagnostic laboratory was established in November 1971 in the CDC compound, Jakarta.

The smallpox diagnostic laboratory which is located in the P.N. Bio Farma compound in Bandung, still functions as a reference laboratory, while the one in Medan will not be used any more for this purpose.

2.3 Latest situation

In 1971 only six out of the total 26 provinces (comprising 25 regencies and municipalities) had reported smallpox cases and deaths, namely:

	Cases	Deaths
Djawa Barat	62	3
Jakarta municipality	4	-
Sulawesi Selatan	1 431	74
Sumatra Utara	285	32
Djambi	147	16
Riau	22	4
Total	1 951	129

The last infected provinces were North Sumatra (Sumatra Utara) and South Sulawesi (Sulawesi Selatan), from where cases had still been reported up to week 34 (total: 285 cases, 32 deaths) and week 42 (total 1431 cases, 74 deaths) respectively.

Difficulties in containing outbreaks were:

1. Lack of leadership. No one seems to be accountable for the activities in both provinces. Assistance from the national staff is always needed and assigned temporarily until the provinces can take over.

2. Insufficiency of the surveillance system. In both provinces outbreaks were usually not reported till the third or fourth generation. The last one in Deli Serdang regency (North Sumatra)[1] and Gowa regency (South Sulawesi) were reported after the tenth generation. The fact hampers proper investigation. To overcome the delay in reporting an active search was introduced. It is mainly implemented in an epidemiologically suspected area. Depending on the grade of suspicion, a house-to-house visit, or a visit to key persons only, and visits to schools by a special team, is carried out. This method beside the usual containment action proved to be effective.

3. Lack of proper follow up. Due to the difficult terrain the workers were often reluctant to follow up outbreaks. For this reason, a modification of the follow-up system was introduced in South Sulawesi province. The field workers were to stay in the village where the outbreak had occurred for a period of two weeks to visit the scene of the outbreak once every three days for a period of nine days, followed by once after five days. Thereafter weekly for two weeks after the last case is found.

4. Lack of interest of the civil authorities. Instructions to give assistance to the programme had been issued by the Minister of Interior to lower echelons. Unfortunately not all provinces had responded favourably. During the active search meetings are held as frequently as possible with the key persons of the village to create better understanding. Additionally, smallpox posters are displayed in strategic places.

2.4 Future trends of the programme

The smallpox eradication programme in Indonesia is not a separate programme, but is integrated into the general health services. This implies that all smallpox workers should be efficiently utilized in other similar programmes if the situation so permits. This is an important principle which more or less determines the future trend of the programme.

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[1] Epidemiological Bulletin, Republik Indonesia, Third Quarter 1971, page 1: Smallpox outbreak in Padang Bedagi, Deli Serdang, North Sumatra, Indonesia. Week 4 to week 34, 1971 (The Utjok Story) by W. L. R. Emmet.

Other important factors which play a role in determining the future trend of the programme are:

The change in strategy, i.e. from its former objective of mass protection of the people against smallpox to its new objective of eliminating the source of infection by an intensified surveillance-containment action and active search.

The change in the concept of routine vaccination: vaccinations will in the future be given only twice during life, a primary vaccination as soon as possible after birth and revaccination at school entry (at the age of six to seven years).

In the last (fourth) smallpox eradication programme seminar in Berastagi, October 1971, this matter was discussed in detail by all provinces and headquarters. The following conclusions were reached:

(1) intensification of the surveillance-containment action;

(2) change in the concept of routine vaccination;

(3) expansion of the vaccinators' duties.

In Java and Bali, combined smallpox and BCG vaccinations will be initiated in April 1972. The execution of this programme will depend on the results of a trial which is at present done in four regencies of Central and East Java. A similar integrated programme will be planned for the other islands beginning in April 1973, while the Advance Teams in Java and Bali are to include other important communicable diseases such as cholera in their surveillance and containment activities.

This newly adopted plan which has been agreed upon in the fourth seminar will be implemented in the next two years to come.

3. Problems

Difficulties, obstacles and other problems in executing the programme always exist. The important factors which are considered the cause of the problems are the following:

(1) communication problems;

(2) quality of personnel;

(3) poor administration;

(4) uncooperative attitude of the population;

(5) lack of collaboration and understanding between health officials - population - local civil authorities.

Communication problems

By communication is meant both contact between places and between persons. As for the first, one look at the map of Indonesia will convince anyone that this problem is, to say the least, considerable; the more so where facilities are still inadequate. As for the latter, new concepts of the programme were not always immediately understood or accepted.

Quality of personnel

The problem of personnel was often believed to be a lack of personnel; however, in many instances it was rather the quality that was the cause of the problem. Improvement of the organization and close supervision of personnel with the provision of a clear job description were the solution.

Poor administration

Often poor administration was the cause of many failures. However, this is not a problem of the health services only but exists almost everywhere. In many instances the best way to avoid bureaucracy is by handling the matter personally, through unconventional methods.

Uncooperative attitude of the population

In general people are still ignorant of the principles of disease mechanism and smallpox is still considered some sort of sacred disease (King's disease) in some areas. Vaccinations are considered harmful, particularly for infants.

With the right approach through village and religious leaders, school teachers and other members of the community who are held in high esteem, much was achieved; schoolchildren have been particularly helpful in volunteering important information leading to case detection.

Lack of collaboration and understanding between health officials - population - civil authorities

A good collaboration between these three parties is essential for the success of the programme. Every effort should be made to secure and maintain a good relationship between the population and the local authorities. Very often this has failed because the health worker had not been active enough to involve himself in the local social life.

4. Discussions

The implementation of the smallpox eradication programme, since the agreement between the Government and WHO was signed in December 1967, was not without difficulties. Numerous problems, some of them serious, had to be solved.

Years of frustration and failure in our early smallpox control activities had left a persistent mark on our attitude towards this disease. People had come to believe that nothing could be done about it and the health worker, demoralized by too many failures, gradually had become indifferent. No explanations are needed to understand how difficult it was to change this negative attitude.

To overcome all these seemingly insurmountable problems which hampered the proper implementation of the smallpox eradication programme, improvement of communication among the health workers to create better understanding and secure optimal cooperation seemed to be the solution. For this purpose meetings and seminars were frequently held and close supervision of the health workers done.

Improved communication and prompt provision of money and material for the smallpox eradication programme had restored the confidence of the health workers considerably; in this respect the WHO financial subsidy had been invaluable.

Where excellent results were achieved by the surveillance-outbreak-containment actions and active search, the number of cases had decreased rapidly and the number of areas freed from smallpox had grown steadily; no satisfactory results had ever been achieved with routine vaccination campaigns since vaccination targets were never reached.

In several areas in West Java it was proven that most satisfactory results could be achieved and that transmission of the infection could be permanently interrupted with the proper execution of surveillance and containment actions in spite of the low coverage of vaccination. This was confirmed in a special study done in West Java.[1]

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[1] WHO/SE/71.30, page 117: "Is routine vaccination a necessity in a smallpox eradication programme?" by P. A. Koswara.

The realization of the fact that smallpox could be wiped out by the proper execution of surveillance-outbreak-containment actions and the active search for cases in spite of low vaccination coverage, was the crucial turning point in Indonesia's smallpox eradication programme. This new concept of strategy in smallpox eradication was implemented after the third smallpox seminar in Makassar.

Now that vaccination activities, which had always been costly and difficult to manage, has lost its importance, a much simpler and more purposeful execution of the programme can be done.

Another aspect of the programme which deserves mentioning is the development of an effective surveillance system which had contributed considerably in the success which has been achieved. Where before the start of the smallpox eradication programme the data available were inadequate and the reporting system left much to be desired, today a well functioning system exists.[1]

Considering the favourable trend towards eradication during the past three years, we can reasonably expect that there should be no more smallpox within Indonesia by the end of 1971.

5. Summary

A brief report is given on the implementation of the smallpox eradication programme in Indonesia. The features were described and the problems encountered discussed. Emphasis was put on surveillance, outbreak containment actions and active search for cases, which were considered decisive factors in the success achieved by Indonesia's smallpox eradication programme.

Finally, the future trend of the smallpox eradication programme was explained.

6. Acknowledgements

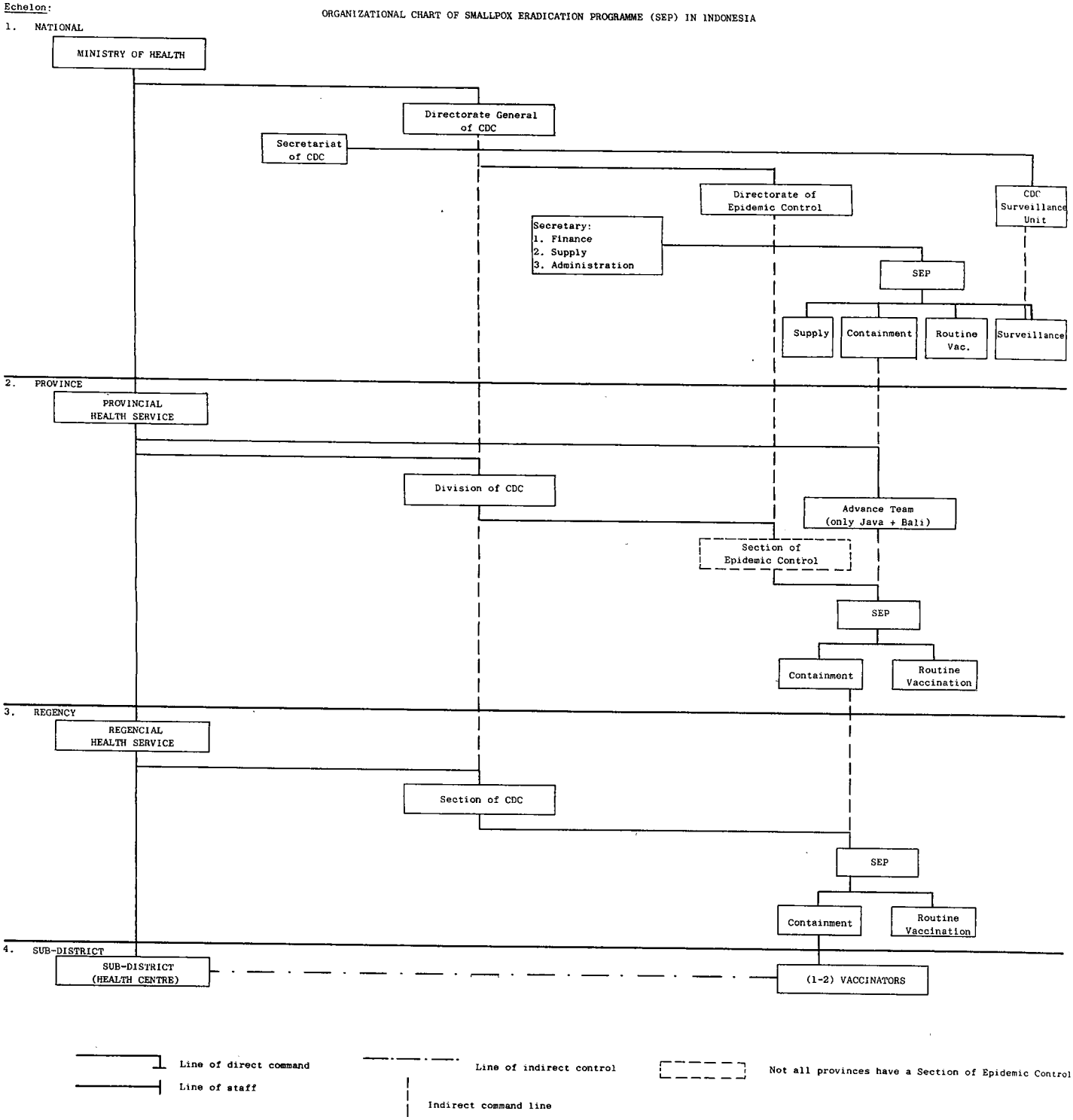
The writers are grateful for the guidance and advice given by Professor Dr J. Sulianti Saroso, Director General, CDC, and various WHO consultants in preparing this report.

[1] WHO/SE/71.30, page 112: "The establishment of an effective reporting system for smallpox in Indonesia" by A. Karyadi.

ANNEX I

Echelon:

ORGANIZATIONAL CHART OF SMALLPOX ERADICATION PROGRAMME (SEP) IN INDONESIA



ANNEX II

LIST OF WHO EQUIPMENT FOR SMALLPOX ERADICATION PROGRAMME IN INDONESIA
(INDONESIA - 0001)

No.	Description	1968	1969	1970	1971	Total
1	Landrover 109"	15	-	-	3	18
2	Landrover 88"	-	4	2	-	6
3	Motorcycle (Honda C50)	135	-	-	-	135
4	Motorcycle (Honda C90)	-	135	-	-	135
5	Motorcycle (Honda S90)	-	-	160	-	160
6	Cycle	1 550	1 550	-	-	3 100
7	Outboard motor (40HP)	-	9	-	-	9
8	Outbroad motor (20HP)	-	-	10	-	10
9	Refrigerator	23	16	34	-	73
10	Jeep CJ-6 (Kaizer)	-	20	-	-	20
11	Haversacks	-	3 193	-	-	3 193
12	Megaphone	-	-	65	-	65
13	Filing cabinet	-	1	1	-	2
14	Typewriter	-	1	1	-	2
15	Calculator	-	1	1	-	2
16	Duplicator	-	1	-	-	1
17	Vaccination kit	1 550	1 700	-	-	3 250
18	Jet injector	25	-	-	-	25
19	Bifurcated needles	No special record				
20	Vaccine					
21	Spare parts					
22	Printed matters					

FINANCIAL STATEMENT OF THE SMALLPOX ERADICATION PROGRAMME IN INDONESIA

I. Government 5-year Development Plan (Pelita) Budget - in rupiah

Year	Routine vaccination		Outbreak containment		Supervision	Total
	Vaccine	Incentives for vaccinators	Vaccine	Fire fighting team		
1969/70	67 000 000	18 750 000	22 250 000	10 000 000	15 000 000	133 000 000
1970/71	69 250 000	19 811 000	20 000 000	19 000 000	15 533 000	143 594 000
1971/72	64 325 000	42 675 000	16 000 000	20 000 000	30 000 000	173 000 000
Total	200 575 000	81 236 000	58 250 000	49 000 000	60 533 000	449 594 000

II. WHO subsidy (in rupiah)

Year	Supervisory staff	Medical officer	Workshop	Total
1969	12 825 000	2 812 500	2 358 815	17 996 315
1970	14 745 561.50	4 725 000	1 875 000	21 345 561.50
1971 (three-quarters)	13 853 916	3 712 500	2 075 000	19 641 416
Total	41 424 477.50	11 250 000	6 308 815	58 983 292.50

ANNEX IV

DEPARTEMEN KESEHATAN R.I.
DIREKTORAT DJENDERAL
PENTJEGAHAN, PEMBERANTASAN/PEMBASMIAN PENJAKIT MENULAR
Djl. Pertjetakan Negara I, Jakarta

No. : 3597/DDB-I/71
Lampiran : -
Perihal : Laporan mingguan Penderita/Kematian Tjatjar

Jakarta, 19 Oktober 1971

Kepada:

Jth. Seluruh Pengawas, Kepala Dinas Kesehatan Propinsi di
INDONESIA

Daftar Laporan mingguan Penderita/Kematian Tjatjar jang belum diterima (missing reports), dan laporan mingguan jang terachir diterima (last report received)

Code	Provinces	Missing reports week	Last report received week
(1)	(2)	(3)	(4)
01	Bali	36,37	39
02	Djawa Barat	-	39
03	(Djawa) Jakarta	-	37
04	(Djawa) Jogjakarta	-	40
05	Djawa Tengah (Central)	-	39
06	Djawa Timur (East)	37	39
07	Irian Barat	-	40
08	Kalimantan Barat (West)	-	39
09	Kalimantan Selatan (South)	-	40
10	Kalimantan Tengah (Central)	-	29*
11	Kalimantan Timur (East)	33,35	40
12	Maluku	31,33,34,37	38
13	Nusa Tenggara Barat	-	40
14	Nusa Tenggara Timur	-	40
15	Sulawesi Selatan (South)	38	39
16	Sulawesi Tengah (Central)	-	36
17	Sulawesi Tenggara (South-east)	31 s/d 35	36
18	Sulawesi Utara (North)	-	38
19	(Sumatera) Atjeh	-	39
20	Sumatera Barat (West)	-	38
21	(Sumatera) Bengkulu	-	37
22	(Sumatera) Djambi	36,37	39
23	(Sumatera) Lampung	-	39
24	(Sumatera) Riau	-	38
25	Sumatera Selatan (South)	-	39
26	Sumatera Utara (North)	-	39

* Mohon perhatian.

Daftar ini dibuat pada tanggal 19 Oktober 1971 (awal minggu 42).

Untuk melengkapi laporan mingguan Penderita/Kematian Tjatjar kwartal III/1971, kami minta dikirim semua "missing reports" (kolom 3) dan melengkapi semua laporan selandjutnja jang belum kami terima.

Atas bantuan Saudara kami utjapkan banjak terima kasih.

a.n. Direktur Djenderal P4.M.
Unit Surveillance Epidemiologi

ANNEX V

WEEKLY REPORT ON SMALLPOX CASES
BY PROVINCE IN INDONESIA

Issue No. 19, 18 May 1971

Code	Province	Population (in 1000) 1971	Total reported up to 11 May	Addition 12-18 May	Total reported up to 18 May 1971
01	Bali	2 308	-	-	-
02	Djawa Barat (West)	21 625	62	-	62
03	(Djawa) Jakarta	4 555	4	-	4
04	(Djawa) Jogjakarta	2 850	-	-	-
05	Djawa Tengah (Central)	23 406	-	-	-
06	Djawa Timur (East)	27 751	-	-	-
07	Irian Barat	982	-	-	-
08	Kalimantan	5 312	-	-	-
12-14	Maluku and Nusa Tenggara	5 903	-	-	-
15	Sulawesi Selatan (South)	5 856	892	60	952
16	Sulawesi Tengah	885	-	-	-
17	Sulawesi Tenggara (South-east)	716	-	-	-
18	Sulawesi Utara (North)	1 710	-	-	-
19	(Sumatera) Atjeh	2 110	-	-	-
20	Sumatera Barat	3 004	-	-	-
21	(Sumatera) Bengkulu	326	-	-	-
22	(Sumatera) Djambi	965	142	4	146
23	(Sumatera) Lampung	2 170	-	-	-
24	(Sumatera) Riau	1 599	22	-	22
25	Sumatera Selatan	5 777	-	-	-
26	Sumatera Utara	6 427	180	1	180
	Indonesia Total	124 237	1 302	65	1 367

Note: See page 17 for explanation

Directorate General for CDC
Ministry of Health, Jakarta

(dr. Mardjohan)
for Surveillance Medical Officer
of SEP

Annex V

BREAKDOWN OF ADDITIONAL SMALLPOX CASES
(18 MAY 1971)
BY REGENCY/MUNICIPALITY AND WEEK

Province	Regency/municipality	Week	Cases
15 Sulawesi Selatan	Djeneponto	14	4
	Djeneponto	18	6
	Gowa	14	16
	Gowa	18	17
	Makassar M	14	8
	Makassar M	18	2
	Maros	14	2
	Pangkadjene	14	2
	Takalar	14	3
22 Djambi	Sarolangun Bangko	16	2
	Tandjung Djabung	16	1
	Tandjung Djabung	17	1
26 Sumatera Utara	Deli Serdang	18	1
Total			65
Previous Report on 11 May 1971			1 302
New Total on 18 May 1971			1 367

To:
1. Minister of Health, Jakarta
2. Chief, Smallpox unit, WHO, Geneva; SEARO, New Delhi; WR Jakarta; All WHO Advisers
3. Chief, Epidemiological Surveillance and Quarantine unit, WHO, Geneva
4. Director General for CDC, Ministry of Health, Jakarta
5. Director of Epidemic Control, CDC, Jakarta
6. Director of Quarantine, CDC, Jakarta
7. Project Director for SEP, CDC, Jakarta
8. Chief, Epidemiological Surveillance, CDC, Jakarta
9. Chief, Virus Laboratory, P.N. Bio Farma, Bandung
10. All Directors of Provincial Health Services of Lampung (7x), Sumatera Selatan (13x), Djambi (9x), Riau (9x), Sumatera Utara (20x), Atjeh (13x), Sulawesi Selatan (26x), Djawa Tengah (36x) and other provinces (4x each).