



The poorest had most to gain

by Jarl Tranaeus

Sweden helped to finance WHO's Smallpox Eradication Programme because it was a venture that fell exceptionally well in line with Swedish development assistance policies. Those policies were laid down by Parliament 25 years ago, and they were reaffirmed and amplified in 1968 when the decision was taken that one per cent of Sweden's gross national product should be appropriated annually to development assistance.

The established aid objectives are to promote economic growth, economic and social equality, economic and political independence and the development of democracy in society. No single objective takes precedence when it comes to carrying out the policies in the 17

countries which are today regular recipients of Swedish bilateral assistance. In each country, an attempt is made to arrive at a mix of objective-oriented projects and programmes which take into ac-

Dr Jarl TRANAEUS is Head of Division on special assignment at the Swedish International Development Authority in Stockholm.

count the direction of that country's own development plans.

As the 17 countries are all among the least developed in the Third World, there is considerable scope

for efforts aiming to improve life for the poor, the vast majority of whom live in the remote countryside. Experiences over a quarter-century have shown, however, that projects and programmes to promote economic and social equality are difficult to design and even more difficult to implement successfully. Examples are manifold. Typically, rural development or work projects may turn out to be of benefit not to the prime target group but to those on a higher rung of the poverty ladder and having access to the local power base. The poorest have no effective spokesmen and are at a disadvantage in community politics, where dispensation of services or benefits hinge on caste, tribe or land ownership.

This was a unique achievement. No longer will smallpox claim lives or deprive human beings of eyesight. And the principal beneficiaries of this achievement are the poorest and most disadvantaged in all countries, because it was among them that smallpox took its major toll.

Smallpox eradication offered a very different opportunity for a donor to become involved in an undertaking of real benefit to the poorest. The vast majority of smallpox victims, actual as well as potential, were the truly poor and underprivileged; those with no access or limited access to health facilities, those weakened by malnutrition, those most vulnerable in the battle for survival. This is why Sweden responded positively when invited by WHO to help to finance the death of smallpox.

It all began at the end of 1973, when I was Head of Development Cooperation at the Swedish Embassy in New Delhi. I was approached by members of the Smallpox Eradication Project, working out of WHO's South-East Asia Regional Office in New Delhi. Would Sweden be willing to provide finance for a programme aiming to wipe out this killer disease? India was at the focus of such a programme, for at that time the country accounted for some 80 per cent of all known smallpox cases in the world.

The target Smallpox Zero stirred our imagination: here was the prospect of eradicating a disease which had plagued mankind for two thousand years. Equally impressive was the conviction that the strategy drawn up was right and that, given the necessary finance, the job could be done.

I contacted the headquarters of SIDA the Swedish International Development Authority, endorsing the proposal, and their response was equally positive. A formal request from the Government of India was obtained with unprecedented swiftness, and the Swedish Government made its decision shortly thereafter. At the same time, Sweden provided funding for the eradication programme in neighbouring Bangladesh. Additional finance to the India

programme was made available on two occasions, and Sweden also contributed to the final effort in Africa.

The conduct of the campaign in India is well documented. Let me just record that, on a field trip in early 1975, I saw what was probably one of the last cases of smallpox in India. This was a young boy who had been hidden away by family elders when their household members were vaccinated. The only village inhabitant later to contract the disease, he was living testimony to the correctness of the containment strategy.

Sweden's confidence in WHO and in that strategy was amply justified. In 1977 India was officially declared free of smallpox and, not long afterwards, global eradication was proclaimed.

This was a unique achievement. No longer will smallpox claim lives or deprive human beings of eyesight; by the middle of the next century there will be very few, if any, disfigured survivors of the disease to remind mankind that smallpox once existed. And the principal beneficiaries of this achievement are the poorest and most disadvantaged in all countries, because it was among them that smallpox took its major toll.

Facing page: *Checking a baby's vaccination scar in Kenya.*

Below: *Pockmarked feet of a victim during a 1972 smallpox outbreak in Yugoslavia.*

Photos WHO/C. Simayu and WHO/D. Egli



The preservation of lives and the relief of human suffering cannot be measured in monetary terms. But the eradication of smallpox also brought very quantifiable benefits. Sweden's contribution to the WHO component of the programme in India was of the order of US \$8 million, which was small in comparison with the costs borne by the government of India and state governments. Once global eradication was confirmed vaccination was no

The Swedish International Development Authority went into action in 1965. About 40 per cent of Sweden's annual appropriation for development assistance (now equivalent to \$1,400 million) is allocated to bilateral programmes on a grant basis handled by SIDA. A third of the aid budget is earmarked for contributions to multilateral programmes, the principal recipients being the World Bank, UNDP and UNICEF.

longer necessary and the resulting annual saving in India exceeded the total cost of the 1973-1977 campaign. In the United States alone, the annual expenditure associated with vaccination requirements was \$150 million. So by any cost/benefit calculation, the global eradication of smallpox stands out as a singularly successful programme.

This success gave encouragement to further programmes aiming at disease control or eradication, and also raised expectations about the role to be played by WHO. Sweden has supported WHO-executed programmes in malaria, leprosy and tuberculosis in India, and has also helped to fund international research programmes on communicable diseases under WHO auspices.

The last few years have alerted the world community to the frightening threat of AIDS, a disease for which no cure is yet known and which, if unchecked, may become a global plague even before the end of this century. This crisis calls for both national and international efforts on an unprecedented scale—and the Third World in particular will no doubt expect WHO to play a leading role in coping with it. ■