



Plate 10.12. **A:** Zdeněk Ježek (b. 1932) was attached to the WHO Regional Office for South-East Asia in 1972, working for smallpox eradication in India. He later served in Somalia, before joining the Smallpox Eradication unit at WHO Headquarters in 1980 and succeeding Arita as Chief of the unit in 1985. **B:** Ehsan Shafa (b. 1927) was the smallpox eradication adviser in the Eastern Mediterranean Region of WHO, 1967-1971, and then served with the Smallpox Eradication unit at WHO Headquarters until 1977.

gists from a number of countries who were interested in the programme and aware of its demands and who screened and referred former students and colleagues. Such epidemiologists included Dr Karel Raška, Czechoslovakia; Dr Jan Kostrzewski, Poland; Dr Holger Lundbeck, Sweden; Dr Viktor Zhdanov, USSR; and Dr Paul Wehrle, USA. From early in 1972, when smallpox epidemics unexpectedly occurred in Bangladesh, until 1977, Dr David Sencer, then Director of CDC, made available the services of 5 full-time CDC staff, and from 1974, the High Institute of Public Health in Alexandria, Egypt, provided a number of faculty members and former students.

As the programme progressed, the number of capable staff with field experience gradually increased, and those who had successfully worked in their own national programmes were recruited for service in other countries. These included staff from Afghanistan, Bangladesh, Brazil, India, Indonesia, Nepal, Pakistan, the Sudan, Togo and Yemen.

International volunteers contributed significantly, both while serving as such and subsequently when recruited as consultants or staff. Arranging such volunteer support was difficult, however, because WHO policy until the mid-1970s was that volunteer assistance had to be arranged strictly between recipient and donor governments, WHO staff

not being allowed to assist in the process. Unofficial contacts and private correspondence, however, served to facilitate the assignment of United States Peace Corps volunteers in Afghanistan, Ethiopia and Zaire; volunteers from Japan and Austria, who served in Ethiopia; and British volunteers from OXFAM (a British private charitable organization), who worked in India and Bangladesh. Regrettably, an offer by Sweden, in 1970, to assign young medical officers at Swedish government expense to WHO itself had to be rejected by the Organization for policy reasons.

Until 1973, international staff assigned to a country rarely numbered more than 1-4, with the exception of large countries and those with an especially difficult terrain and a shortage of national personnel—Afghanistan, Bangladesh (from 1972), Ethiopia, Nigeria and Zaire. From 1973 onwards, increasingly large numbers of international staff worked in Bangladesh and India and later in Ethiopia and Somalia as more funds became available and efforts were intensified to achieve eradication in the shortest possible time. Throughout the course of the global programme, however, international staff of all types at any given time never numbered more than 150. In all, 687 WHO staff and consultants from 73 different countries eventually served in the programme for periods

ranging from 3 months to more than 10 years; approximately 125 others served with the programme under bilateral agreements. Most of the staff were less than 40 years of age and some less than 30, youth being an advantage where living and travelling conditions were difficult.

Although international staff were few, they played an important role in sustaining national government support, providing programme continuity where national leadership changed for political or other reasons, and expediting the transfer of new techniques from one programme to another. In retrospect, it may be said that few national programmes achieved much success where international staff were of poor quality, but national staff, given the necessary support and encouragement, showed themselves to possess a skill and dedication which equalled and often exceeded those of the international advisers.

OBTAINING NATIONAL AGREEMENTS TO UNDERTAKE PROGRAMMES

Although commitments assumed by governments by virtue of votes in favour of resolutions at the World Health Assembly were morally binding, WHO could not force governments to undertake programmes. Thus, although the Intensified Smallpox Eradication Programme was unanimously approved by the Health Assembly, only certain countries were, in fact, then prepared to undertake eradication programmes—much as had been the case during the period 1959–1966. Some lacked resources, while others considered that other health problems were of higher priority. Universal participation was essential if the programme was to succeed but, as described earlier, WHO's role in actively promoting and advocating a particular programme in all countries was an unaccustomed one. Malaria eradication was the only other programme in which this had been attempted but, in that programme, the necessary but substantial additional national costs had distorted health allocations, and the extent to which its secondary objective, the improvement of basic health services, had been attained had fallen far short of expectations. Mindful of this experience and doubtful of the feasibility of smallpox eradication,

the Director-General cautioned his regional directors, at a meeting immediately after the 1966 World Health Assembly, against appearing to impose a smallpox eradication programme on any country. Thus, in 2 regions, Africa and South-East Asia (unfortunately also those most seriously affected by smallpox), the regional directors did not initially promote smallpox eradication programmes, assistance being provided only to countries specifically requesting it. In the Region of the Americas and the Eastern Mediterranean Region, however, eradication programmes were actively promoted from the beginning.

In the Americas, smallpox eradication was not a new objective, a regional eradication programme having been in existence since 1950 (see Chapter 9). A Regional Adviser on Smallpox Eradication, Dr Bichat Rodrigues, was appointed in 1966 to coordinate the effort, and Brazil, the only endemic country, committed itself to a national smallpox eradication programme employing what were then the new jet injectors (see Chapter 12). Vaccination campaigns in many other countries in South America began soon thereafter. In the Eastern Mediterranean Region, there were then 3 endemic countries—Ethiopia, Pakistan and Yemen—and there, also, an adviser on smallpox eradication, Dr Shafa, was immediately appointed. He successfully promoted programmes in Pakistan, Yemen and other countries of the region although, for reasons beyond his control, he was unsuccessful in Ethiopia, in which a programme did not begin until 1971 (see Chapter 21).

In the South-East Asia Region, the Regional Director shared the Director-General's belief that eradication represented an unattainable goal, given the stage of development of national health services (see Chapter 9). Responsibility for smallpox eradication was assigned to a 2-man intercountry advisory team which dealt with other communicable diseases as well and whose budget for travel was small. Little was done in the Region until Dr Herat Gunaratne was elected Regional Director in 1968; coming from Sri Lanka, a country which had eliminated endemic smallpox decades before, he saw no reason why this could not be achieved elsewhere. He therefore made the intercountry team, Dr Keja and Dr Louis Grem-liza, responsible solely for smallpox eradication and, from the time of his election, played

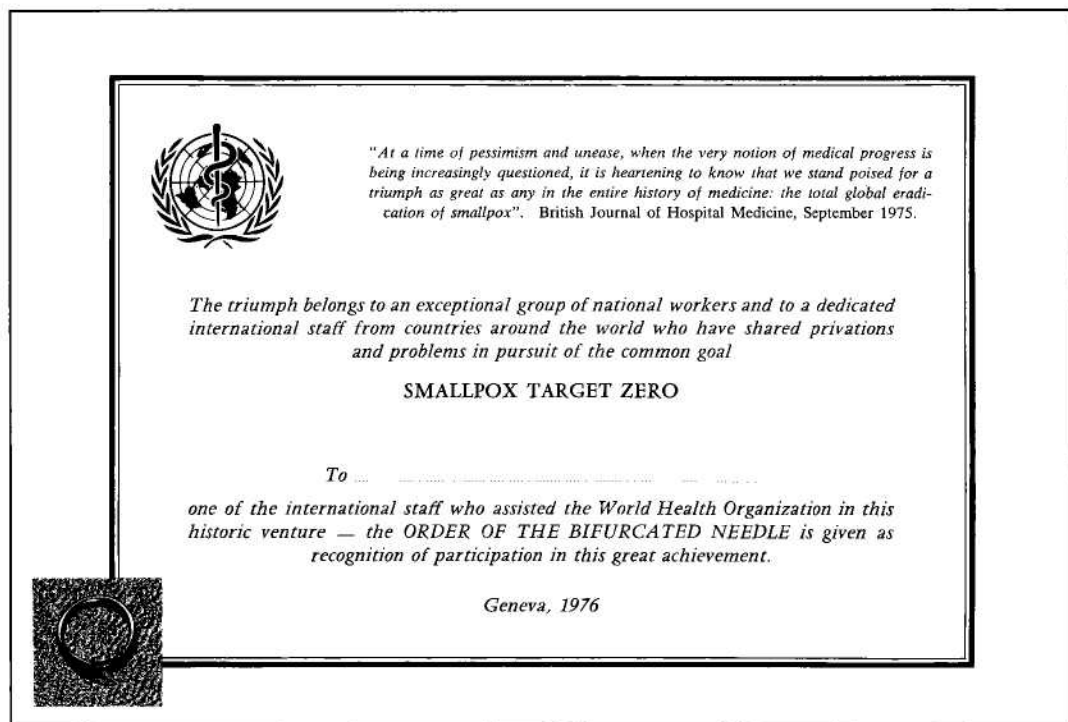


Plate 10.13. The contribution of the international staff who participated in the eradication of smallpox was given sincere if informal recognition by their promotion to the mock "Order of the Bifurcated Needle", accompanied by an official-looking certificate and a hand-made lapel pin. The pins (inset) were fashioned from bifurcated needles in the form of an "O" to symbolize "Target Zero", the objective of the programme.

an active role in encouraging national programmes. The response was generally enthusiastic and within a year effective programmes were in progress in all endemic countries of the region except India, where the programme started later (see Chapter 15).

In the African Region, by late 1966, a number of countries had already committed themselves to national smallpox eradication programmes. These included the 20 countries of western and central Africa which were participating in the smallpox eradication and measles control programme being carried out with the assistance of the USA; Zambia, which had begun a national vaccination campaign in 1966 because of epidemic smallpox; and Zaire, whose WHO-supported activities were then coordinated by Geneva Headquarters. The other African countries did not officially express any interest in 1966 and early in 1967. This was disturbing to the staff in Geneva, but also puzzling because funds were then available to meet all the costs of the programmes except salaries for the comparatively small number of national personnel who would be required. Because

WHO was prepared to provide vaccine free of charge and because many countries already employed smallpox vaccinators, it was actually cheaper for most of them to participate in the eradication programme than to continue smallpox control activities. They failed to express interest, as was later discovered, because no effort was made by the Regional Office to encourage programmes, acquaint national authorities with the programme's budgetary implications, or indicate the amount of support which could be provided by WHO; instead, the national authorities were expected to request WHO's assistance on their own initiative. The WHO representatives in the countries, as well as Ladnyi, then intercountry smallpox adviser for East Africa, were informed of this policy in September 1966. In the spring of 1967, the problem was resolved fortuitously when a member of the Headquarters Smallpox Eradication unit was given permission to visit several of the countries for the purpose of gathering information for the Director-General's report to the 1967 World Health Assembly. Although he was forbidden to

suggest to any country that a programme should be undertaken, he made the health authorities aware of the nature of the programme and the resources available and, within weeks, letters requesting WHO assistance were received from almost all of them.

By the summer of 1969, smallpox eradication programmes had begun in all the endemic countries in Africa except South Africa, Southern Rhodesia (now Zimbabwe) and Ethiopia. WHO then had no official relations with the first two of these, South Africa having ceased to participate in the Organization and Southern Rhodesia being technically still a colony of the United Kingdom, although it had unilaterally declared independence. Visits by WHO staff were not permitted and little information could be obtained about the status of smallpox or their programmes. However, neither was thought to represent a serious impediment to eventual global eradication because neither officially reported many smallpox cases and their health services were comparatively well developed. Both began special programmes in 1970 (see Chapter 20), stimulated largely by reports in the *Weekly epidemiological record*, which described excellent progress in smallpox eradication elsewhere in Africa but noted the lack of information from South Africa and Southern Rhodesia. The third country, Ethiopia, although in Africa, was served (until late in 1977) by the Regional Office for the Eastern Mediterranean and presented quite a different problem. Smallpox was widely endemic and health services were few, but malaria eradication staff and their international advisers, fearing that another programme would be a harmful distraction, persuaded government officials to refuse to discuss with WHO the implications of a smallpox eradication project. Not until late in 1969 did the government permit Henderson and Dr Shafa to visit the country. At that time, Ministry of Health officials declined to participate but the Emperor himself, who by chance had heard about the programme, intervened to commit the government and, in 1971, the last of the programmes in the endemic countries began (see Chapter 21).

Thus, although many countries needed to be encouraged and persuaded to undertake smallpox eradication programmes, these had, in fact, been initiated in all endemic countries within 5 years of the 1966 decision. It was quite another problem to ensure that the

various governments were sufficiently committed for eradication of the disease to be achieved.

SUSTAINING GOVERNMENT INTEREST AND COMMITMENT

A continued high level of interest and support for the eradication programme was difficult to sustain in many countries, just as it was in WHO. Changes in governments and/or senior health personnel were often associated with differences in priorities and in levels of commitment. Smallpox was but one of many problems competing for attention and resources and, in countries in which the mild variola minor form was prevalent, it was understandably not of high priority. After the last known cases had occurred, resources were particularly difficult to obtain from recently endemic and donor countries, as well as from WHO itself, in order to continue surveillance and thus permit certification.

Role of the World Health Assembly

The World Health Assembly, convened each year for a period of several weeks, was a particularly important opportunity for promoting and sustaining interest in the smallpox eradication programme. Senior health officials from all Member States attended and, in addition to reviewing the proposed WHO budget, discussed the Organization's overall programme of work as well as specific programmes, such as that for smallpox eradication. During the debate, delegates frequently described what their own countries were doing, some asked questions of a technical nature and others took the opportunity to announce voluntary contributions. The Intensified Smallpox Eradication Programme, if included as an agenda item, might be discussed for 2-4 hours or more. Such a discussion served to focus the attention of health officials on the subject, and important principles—such as the role of surveillance and the need to use only freeze-dried vaccine—could be emphasized by the Secretariat. It also enabled government officials to hear what were often heartening or optimistic reports of progress in other countries, causing them to reexamine their own programmes. If, however, smallpox eradication was not included in the agenda as an item for

debate, it could still be discussed when the overall programme of the Organization was considered, but it was unusual for many delegates to prepare themselves to speak on the topic and the debate was usually brief.

Because the Health Assembly had identified smallpox eradication as a priority programme of the Organization and it had been on the agenda each year from 1959 to 1967, the Smallpox Eradication unit staff assumed that the topic would continue to be an annual subject for debate on which the Director-General would provide a special report to the Health Assembly. From 1968 onwards, however, it began to be omitted from the provisional agenda. The resolution on smallpox eradication adopted by the Twentieth World Health Assembly (1967), called only for the Director-General "to report further" on smallpox eradication to the Executive Board and the Health Assembly. "Further" was interpreted to mean at some time in the future and the topic was omitted from the provisional agenda of the Twenty-first World Health Assembly (1968), an action which was reversed at the request of the USSR. Resolutions adopted at the 1969, 1971, 1972, 1976 and 1977 Health Assemblies called specifically for special reports to each of the subsequent ones and for smallpox eradication to be included in their agendas. In the other years until 1977, when transmission was interrupted, smallpox eradication was the subject only

of a brief general discussion in the context of the overall WHO programme. A report by the Director-General was nevertheless prepared and kept in readiness in case one was requested by delegates. To it was attached a comprehensive review of the programme's progress and status that was published twice a year in the *Weekly epidemiological record* to coincide with the January session of the Executive Board and with the Health Assembly. Although the report was not to be distributed unless requested by delegates, the interest expressed, particularly by two delegates, one from the USSR and the other from the USA (Dr Dmitriy Venediktov and Dr Paul Ehrlich, Jr, respectively), ensured that it was distributed and the programme discussed.

Surveillance Reports

Regularly published surveillance reports, both international and national, were an essential component of the surveillance process and, as experience had demonstrated in other disease control programmes, were also important in stimulating and sustaining the interest of those concerned with the programme. Such reports documented the numbers of cases reported weekly by administrative area, charted trends in incidence and in the progress of the programme, and discussed alternative strategies and tactics in

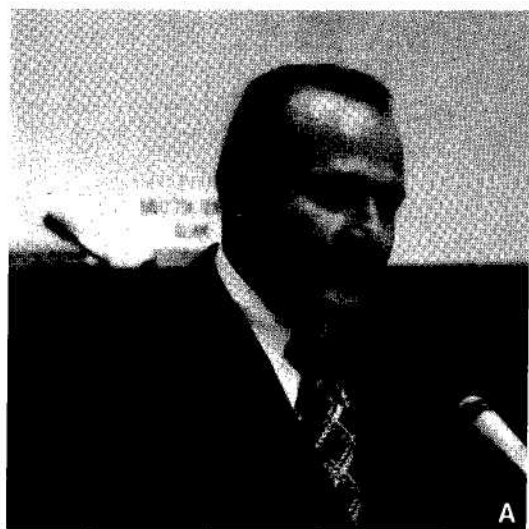


Plate 10.14. Two delegates to the World Health Assembly and members of the Executive Board of WHO who were strong advocates of smallpox eradication. **A:** S. Paul Ehrlich Jr (b. 1932), Surgeon General of the United States Public Health Service. **B:** Dmitriy D. Venediktov (b. 1929), Deputy Minister of Health of the USSR.

different areas. The first WHO surveillance reports on smallpox eradication were issued in September and December 1967, and from May 1968 onwards, they began to be published every 2-3 weeks in the *Weekly epidemiological record*, some 5000 copies being distributed to health officials and others throughout the world. The system was not established without difficulty, however, as is discussed later in this chapter in the section entitled "International surveillance reports". The WHO Regional Office for South-East Asia also issued surveillance reports from 1974 onwards, and national surveillance reports were published monthly and sometimes weekly or every 2 weeks in a number of countries.

In addition to providing information to widely scattered health staff, the reports also served to inform both public officials and the press, sometimes with unexpected consequences. When, in Brazil, Ethiopia and India, for example, better surveillance and improved reporting were accompanied by marked increases in the numbers of notified cases, national officials and the press expressed concern, and even alarm, although the increases were attributed, at least in part, to better reporting. Greater political commitment and increased resources soon followed. In other countries, interest in the programme grew significantly when national officials read of more satisfactory progress being made in other countries, some of which they believed to have health services inferior to their own.

Interregional and Intercountry Meetings of Smallpox Eradication Staff

Meetings of senior staff from different national programmes also served to sustain and stimulate the interest of governments and staff while bringing to their notice the new observations which were being made. The WHO Headquarters budget provided for at least one such meeting a year, the venue changing from year to year, as did the participants (Table 10.2). In addition, over the period 1967-1972, CDC supported a yearly conference for the countries of western and central Africa.

The first of these meetings was held in Thailand in 1967 for countries in eastern Asia. At first they were largely devoted to the presentation of reports on national programmes by the respective national directors; over time, their nature gradually changed and each country was asked to present papers illustrating specific findings, the outcome of particular strategies and interesting new approaches. The ensuing discussions made it possible to determine whether the observations made in a particular national smallpox eradication programme were of relevance to the others. Most of these reports were distributed by WHO to all concerned with smallpox eradication through the special WHO/SE, SE and SME series of mimeographed documents (see References: WHO documents); some were also published in the medical literature.

Table 10.2. WHO seminars and meetings on smallpox eradication, 1967-1978 (excluding those associated with certification of eradication)

Date	Country in which held	Participants ^a
December 1967	Thailand	13 countries of South-East Asia, Eastern Mediterranean and Western Pacific Regions
November 1968	Zaire	11 countries of southern and eastern Africa
May 1969	Nigeria	18 countries of western and central Africa (joint seminar with CDC)
November 1969	Pakistan	11 countries of Eastern Mediterranean and South-East Asia Regions
December 1970	India	11 countries of South-East Asia, Eastern Mediterranean and African Regions
September 1972	Ethiopia	4 countries of eastern Africa
November 1972	India	5 countries of South-East Asia Region
November 1972	Pakistan	4 countries of Eastern Mediterranean Region
September 1973	Ethiopia	Ethiopia and WHO Eastern Mediterranean Region smallpox eradication advisers
November 1973	Pakistan	Pakistan and WHO Eastern Mediterranean Region smallpox eradication advisers
August 1974	India	Bangladesh, India and Nepal
January 1976	Nepal	6 countries of South-East Asia Region
March 1977	Kenya	4 countries of eastern Africa
September 1977	Kenya	5 countries of eastern Africa
April 1978	Kenya	5 countries of eastern Africa and the Eastern Mediterranean Region

^a Participants included national programme staff and WHO smallpox advisers and other smallpox eradication staff from the regional offices and WHO Headquarters. Advisers from the regional offices in the 4 endemic regions were invited to all meetings from 1967 to 1970 and to the 1972 meeting in India.



Plate 10.15. Participants in the first interregional seminar on smallpox eradication held in Bangkok, Thailand, 11-16 December 1967. *Left to right, front row:* A. M. Khan (Pakistan), A. R. Rao (India), M. K. Singh (India), S. A. Mallick (Pakistan), D. A. Henderson (WHO), E. Na Bangxang (Thailand), S. Falkland (WHO), J. J. Dizon (Philippines), I. F. Setiady (Indonesia), U Thuang (Burma); *middle row:* Z. Rahman (Pakistan), C. Rubinstein (WHO), C. H. James (United Kingdom), J. Singh (Malaysia), K. S. Ramakrishnan (India), G. P. Nikolaevskij (WHO), W. H. Foege (USA), J. Keja (WHO), B. Ignjatovic (WHO), F. G. L. Gremliza (WHO), B. Wirjodipoero (Indonesia), J. C. Pitkin (WHO), Khin Mu Aye (WHO), K. Chatiyononda (Thailand), S. Somachai (Thailand); *back row:* C. Patanacharoen (Thailand), A. Prajapati (Nepal), J. S. Copland (WHO), T. M. Mack (USA), G. H. Waheed (Afghanistan), B. Chantasut (Thailand), E. Shafa (WHO), R. M. Lyonnet (WHO), Y. K. Subrahmanyam (India), S. Singh (WHO), P. Tuchinda (Thailand), T. Phetsiriseng (Lao People's Democratic Republic), N. D. Tiep (Viet Nam), P. Kunasol (Thailand), C. Debyasuvarn (Thailand).

The meetings had both tangible and intangible benefits. Several specific changes in programmes can be associated with them: Indonesia's full commitment to smallpox eradication followed the 1967 meeting in Thailand; agreements to grant national surveillance and vaccination teams free passage across specified international borders, a hitherto unprecedented occurrence, followed the 1968 conference sponsored by CDC in Côte d'Ivoire and the 1973 meeting in Ethiopia; and India's decision to adopt the surveillance-containment strategy and to undertake an intensified programme followed the 1972 meeting in New Delhi.

Use of the Mass Media

The Smallpox Eradication unit staff actively sought publicity for the programme in national and international media, believing that it was important to make what was happening in the programme widely known to potential donors and to those in the endemic countries. For many sectors of

government, this was a natural and logical approach but there was then, both in WHO and in many countries, a reluctance on the part of physicians and other health personnel to meet representatives of the mass media or to use the media except to convey traditional health education messages. The very small staff and limited programme of WHO's Division of Public Information at that time was a reflection of this attitude.

The publication of the semi-annual summaries of progress in smallpox eradication in the *Weekly epidemiological record* provided suitable occasions for press conferences, as did the occurrence of the last cases of smallpox in large countries and the certification of eradication in each of the countries and Regions. Efforts to obtain publicity were not without their embarrassing moments, however, the most awkward occurring on 14 October 1975, when Henderson, then on a visit to New York City, announced at a press conference that 8 weeks had elapsed since the last case of smallpox in Asia and, in view of the extent and effectiveness of surveillance, confidently stated that the last case of variola

major had been seen. Only 4 days later, however, another outbreak was found in Bangladesh (see Chapter 16).

As the programme progressed, increasing attention was given to contacts with the media (see Plate 10.16), particularly as the need for voluntary contributions became more urgent. Geneva was not so important a news centre as New York, in which there were more correspondents from many more countries. Fortunately, WHO maintained a small liaison office at the United Nations in

New York with two public information officers, Ms Joan Bush and Mr Peter Ozorio, who were particularly effective in interesting the media in the programme. Among the unique ideas which they fostered were transatlantic press conferences, one in 1974, in which science writers and correspondents in New York and Washington interviewed Henderson in Geneva, and a second, in 1975, in which science writers in London and Dr Nicole Grasset, the adviser on smallpox eradication in the South-East Asia Region,



Plate 10.16. **A:** Lawrence K. Altman (b. 1937), correspondent for the *New York Times*, had been an epidemiologist with the measles control programme in western Africa in 1964–1965. **B:** James Magee (b. 1929) was the public information officer with the Smallpox Eradication unit, 1978–1980. **C** and **D:** Joan Bush (b. 1928) and Peter Ozorio (b. 1928) served in New York as public information officers attached to the WHO Liaison Office with the United Nations.

La mortiferaçao esta Libre de la viruela

La mortiferaçao esta Libre de la viruela... (Spanish text about smallpox eradication)



La bataille contre la variole a été gagnée

La bataille contre la variole a été gagnée... (French text about smallpox eradication)



Uma guerra sem fim da varíola em todo o mundo

Uma guerra sem fim da varíola em todo o mundo... (Portuguese text about smallpox eradication)

DEATH OF A KILLER

ariote en grande Bretagne : alerte à peste.

It Hickey the director-general of the World Health Organization, Dr. Hasdonk Manter, confirmed in Nairobi...

Endlich frei

Als letzter Kontinent wurde nun auch Afrika

Feu la variole ?

Le mythe dangereux d'un vaccin universel... (German text about smallpox)

की कलत्रा कलम एवं अरबों के की.

(Hindi text about smallpox eradication)

天痘、地球上から科学と国際協力

(Japanese text about smallpox eradication)

Advertisement for '天痘' (Smallpox) with various text and graphics.

Erradicada la viruela

Erradicada la viruela... (Spanish text about smallpox eradication)



Smallpox virus escapes in England; 'extinct' disease rears its ugly head

Smallpox virus escapes in England; 'extinct' disease rears its ugly head... (English text about smallpox in England)

天痘、地球上から科学と国際協力の勝利

(Japanese text about smallpox eradication)

La variole en Grande-Bretagne : pas de panique, recommande l'O.M.S.

La variole en Grande-Bretagne : pas de panique, recommande l'O.M.S. (French text about smallpox in Britain)

Un triumphe de l'OMS

Un triumphe de l'OMS... (French text about WHO success)

Vaccinations : l'antivariolique n'est plus obligatoire

Vaccinations : l'antivariolique n'est plus obligatoire... (French text about smallpox vaccination)

Un primo de 1.000 dollars

Un primo de 1.000 dollars... (English text about a prize)

WHO Ready to Declare Eradication of Smallpox

WHO Ready to Declare Eradication of Smallpox... (English text about WHO declaration)

Un año sin un solo caso de viruela en el mundo

Un año sin un solo caso de viruela en el mundo... (Spanish text about smallpox eradication)

VARIOLE récompense de 100 000 F.D.

VARIOLE récompense de 100 000 F.D. (French text about smallpox reward)

The Doctor's World Eradication of Smallpox

The Doctor's World Eradication of Smallpox... (English text about smallpox eradication)

Plate 10.17. A montage of newspaper articles published in 1978.

answered questions from New Delhi, India. Especially extensive and helpful press coverage was provided twice during the programme—in 1974 and 1978. The first related to epidemic smallpox in India during

1974, the most critical year for smallpox eradication in Asia (see Chapters 15 and 16). In that year, a large number of correspondents, who had come to India to report on the detonation for the first time of an Indian

Publicizing the Programme

Special issues of the WHO magazine *World health*, stamps and medals served to publicize the programme and its accomplishments. In addition to the special issues of *World health* in 1965 on the theme "Smallpox: Constant Alert" and in 1975 on "Smallpox: Point of No Return", a third special issue was published in October 1972, with the slogan "Smallpox: Target Zero" (Plate 10.18). It coincided with the launching of what was termed the "final phase" which, at that time, was expected to result in eradication by the summer of 1974. As its introduction stated: "The global eradication programme this year, for the first time, extends into every state and province of every country where the disease exists. The final phase of the campaign is beginning." Unforeseen problems, however, resulted in the final phase lasting fully 3 years longer than had been optimistically envisaged.

World health featured the subject of smallpox on two other covers—in October 1979, on the occasion of certification of eradication in the last of the endemic countries, and in May 1980 (see Chapter 24, Plate 24.2), when the Thirty-third World Health Assembly accepted the recommendation of the Global Commission for the Certification of Smallpox Eradication that "smallpox eradication has been achieved throughout the world" and that "smallpox vaccination should be discontinued in every country except for investigators at special risk".

Postage stamps and cachets on the theme of smallpox eradication and vaccination were issued by many different governments between 1965 and 1980, as illustrated in Plates 10.19–10.22. The largest number were produced in 1978, the year after the world's last outbreak, in response to a recommendation by the Universal Postal Union to its member governments that smallpox eradication should be a principal philatelic theme. In 1978, too, the United Nations issued special stamps and silver medals in recognition of the achievement (Plate 10.23).

In some countries, stamps echoed the 1965 World Health Day theme of "Smallpox: Constant Alert"; several countries of western and central Africa issued stamps between 1968 and 1972 during the course of the programme for smallpox eradication and measles control, most of which featured pictures of the jet injector; and Guinea, on completion of its WHO-supported smallpox vaccine production laboratory, issued a full set of stamps depicting various stages in the vaccine production process (see Chapter 11, Plate 11.10).

In commemoration of the declaration at the Thirty-third World Health Assembly of the global eradication of smallpox, all delegations were presented with a set of medals as mementos (Plate 10.23); these bore inscriptions in the six official languages of WHO—Arabic, Chinese, English, French, Russian and Spanish.

nuclear device, discovered that the recorded incidence of smallpox was the highest for 20 years and reported this as well. Also in 1974, a series of articles published in the *New York Times* by Dr Lawrence Altman, who was on an extended tour of India and Bangladesh, vividly documented the magnitude of the effort being made and, in turn, stimulated the interest of other publications. The consequent international publicity brought greatly increased and badly needed support for the programme from senior government officials and played an important role in obtaining additional voluntary contributions. In 1978, world-wide press coverage followed the

occurrence of 2 laboratory-associated smallpox cases in Birmingham, England (see Chapter 23) at a time when the Smallpox Eradication unit was having difficulties in persuading laboratories to destroy or transfer their stocks of variola virus. As a result, national governments took a special interest in the matter and compliance followed rapidly throughout the world.

As the goal of global eradication was approached, it was important for a quite different reason to publicize the status of smallpox and its anticipated demise. With the achievement of eradication, it would be possible to discontinue routine smallpox

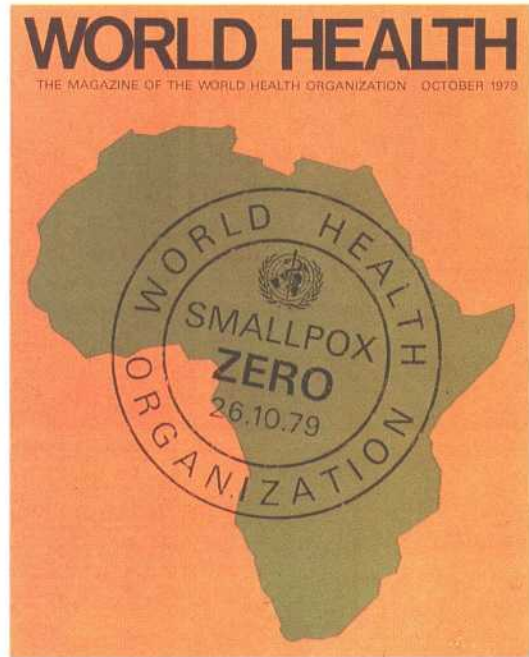
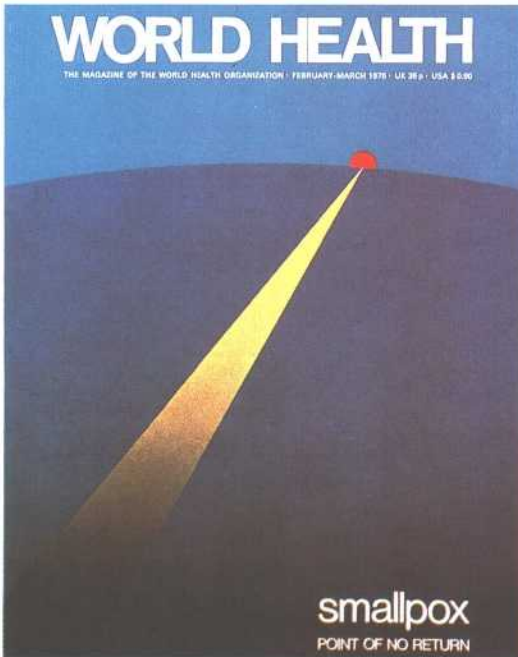
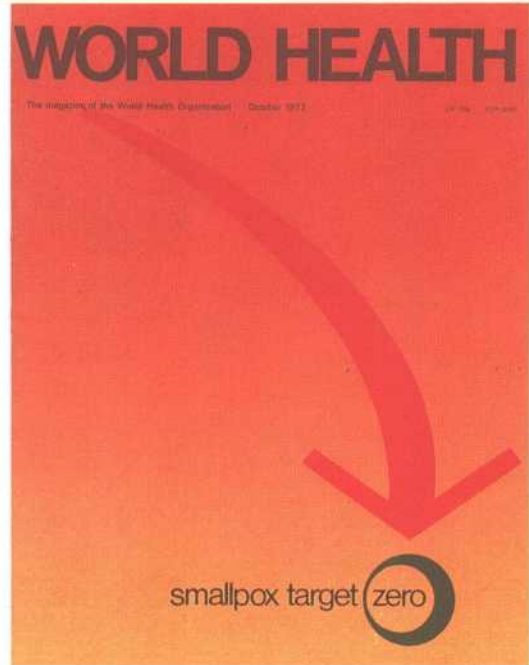
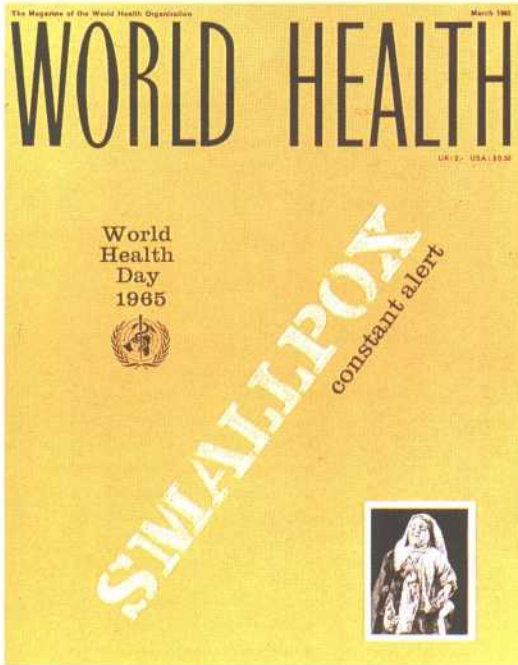


Plate 10.18. The smallpox eradication programme was presented in several issues of *World health*, an illustrated magazine published in many languages by WHO and directed to the general public.



Plate 10.19. Postage stamps depicting smallpox eradication activities issued by western and northern African countries between 1968 and 1975. The Libyan stamps at the lower right take up the theme of World Health Day, 7 April 1975: “Smallpox: Point of No Return”.



Plate 10.20. Postage stamps issued in 1978 by Brazil, Egypt, Iraq, Ireland, Kuwait and Lesotho to celebrate the eradication of smallpox.



Plate 10.21. Postage stamps issued in 1978 by Malaysia, Maldives, Mozambique and Nigeria to celebrate the eradication of smallpox.



Plate 10.22. Postage stamps issued in 1978 by the Philippines, Senegal, Togo, Tunisia and the United Nations to celebrate the eradication of smallpox.



A



B

Plate 10.23. A: A proof set, presented to the Director-General of WHO by the United Nations, of sterling silver medals struck to celebrate the eradication of smallpox. The medals were issued on 31 March 1978 in the 5 original official languages of the United Nations in conjunction with the stamps shown in Plate 10.22. **B:** In May 1980, when the Thirty-third World Health Assembly had formally declared the global eradication of smallpox, each delegation to the Health Assembly received a set of commemorative medals in the 6 official languages of WHO.