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Iris Borowy, James H. Mills and Yong-an Zhang

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Preface

Sam Willner

We have the great honour to welcome guest editors Professors Iris Borowy, James H. Mills and Yong-an Zhang from the College of Liberal Arts at Shanghai University and the University of Strathclyde to introduce this thematic issue of *Hygiea Internationalis* regarding international health organisations and their histories.

Introduction: International Health Organisations and their Histories

Iris Borowy, James H. Mills and Yong-an Zhang

The papers in this collection date from conferences held at Shanghai University from 2013 onwards under the auspices of the International Health Organizations (IHOs): The History for the Future Network set up in that year.¹ Designed to bring together scholars all over the world engaged in various aspects of writing the history of IHOs, the lively debates at subsequent events show that, while the field can look back to a formidable publication record already, these organizations are clearly of greater interest than ever before as a topic for current and future historical research.

Part of the fascination of IHOs results from the fact that they have a dual nature, being at once immersed in the politics of international governance and in the processes by which health has been defined and debated. As a result, they sit at a point where they connect two different fields and historiographies, those of international relations and of medicine. On the one hand IHOs can be perceived as part of a larger story of the evolution of international organizations in general, which came to occupy an increasingly important place in the twentieth century. On the other, they can be seen as one of many actors in the development of modern health systems as these have been wrought in the changing concepts, technologies and biological challenges of the modern period. Approaching IHOs from one perspective or the other means that relevant questions differ dramatically. With regard to international relations, relevant factors include the prevailing political climate, the interests of individual governments and their departments, and the alliances, tensions and conflicts between particular nations. For scholars exploring international organizations in general crucial questions address institutional set-up, leadership, structure, decision-making processes, funding mechanisms, working procedures and

¹ The organizers would like to thank the UK's Arts and Humanities Research Council for resourcing the early stages of this network, the Wellcome Trust for funding its inaugural conference in 2013, and the Universities of Shanghai and Strathclyde for their support. The network's first organizing committee in 2013 consisted of Sanjoy Bhattacharya (York University), Iris Borowy (Shanghai University), Walter Bruchhausen (Aachen University), Nitsan Chorev (Brown University), Martin Gorsky (London School of Hygiene and Tropical Medicine) and James Mills (University of Strathclyde).

hiring strategies. For scholars studying developments in health, relevant questions address issues of bio-medical knowledge, of interpretations of health as primarily grounded in biology or social circumstances, of etiological theories and of therapeutic and preventive practices and the politics behind them. Scholars confronted with IHOs need therefore to draw on several sets of questions and approaches, and, depending on the focus of the particular study, some will loom larger than others.

A further challenge is to establish what exactly should count as an IHO: is it a public organization with governments as members? Does it have to be affiliated with the League or United Nations system of global governance which emerged in the twentieth century? Or can it be just any institution in which groups engaged in health work in different countries collaborate? There is a risk that, in drawing the definition too narrowly, the focus is limited to the largest or most enduring organisations and therefore analyses are offered of only the most successful or adept institutions. By contrast, applying too broad a definitions risks creating a field that becomes unwieldy for those seeking to survey it while the very idea of an IHO becomes unstable or unusable in the face of multiple forms and case studies. Implicitly or explicitly, any scholar studying IHOs faces the two questions raised above: what exactly constitutes an IHO and what is the primary characteristic by which it could or should be approached?

Histories of IHOs have approached these questions in various ways. The earliest narratives of IHO history were set by participants, staff members who took to writing the history of what they saw as their sector of work after years of service in one or several of the IHOs. For years the only available monograph on the topic was *International Health Organizations And Their Work*, published in 1952 by Neville Goodman.² His history of IHOs begins with the Sanitary Conferences during the nineteenth century and continues forward to the organizations, established by agreements between governments, in the twentieth century. His answers to the questions above were shaped by his focus on those IHOs in which he was personally involved, the *Office International d'Hygiène Publique*, the League of Nations Health Organisation and the World Health Organization. In his account, and reflecting his experience, administrative structure was as important as the health issues at hand, and he set the template for subsequent research by discussing both, while largely ignoring the impact of scientific, non-governmental or commercial groups external to the IHOs. This basic premise of IHOs as intergovernmental agencies was confirmed twenty years later by long-time WHO staff member Norman Howard-Jones. In a narrative that would soon become outdated, his account privileges a view of great men making history. While this focus on personalities in various positions within and outside of IHOs does offer some colour to what might otherwise be dry institutional history, his reliance on key official documents privileges the

2 Neville M. Goodman, *International Health Organizations and Their Work*, (Edinburgh / London: Churchill Livingstone, 1952, 2nd extended edition 1971).

administrative side of IHOs, notably those processes by which they were created, modified or ended. As a result, the long years in between i.e. the time in which IHOs did the work that would define them, receive comparatively scant attention.³ Some decades later, other colleagues took a wider view. Writing in 1993, Milton Roemer interpreted “internationalism in medicine and public health” as encompassing a broader range of possible actors while being more connected to the underlying medical questions. As a long-time partisan of social approaches to health policies, this perspective inevitably shaped his writings.⁴ Socrates Litsios, still writing today, broadened the field by freely mixing publications on his former employer, the WHO, with studies of private groups active in international health during the twentieth century, including the Rockefeller Foundation and the Christian Medical Commission.⁵

The studies of historians without a background in IHO careers have continued to add depth to the narrative by addressing more topics and agencies. Scholars still see the beginning of systematic international health cooperation in the arrival of cholera in mid-nineteenth century Europe and the Sanitary Conferences which were organized in response.⁶ But they complement this picture by acknowledging that from early on issues other than infectious diseases also played a role, including such diverse topics as the perceived need to coordinate policies regarding narcotic drugs,

3 Norman Howard-Jones, *International Public Health between the Two World Wars – The Organizational Problems*, (WHO, Genf 1978); Norman Howard-Jones, *The Pan-American Health Organization: Origins and Evolution*, (WHO, Geneva 1981).

4 Milton I. Roemer, “Internationalism in Medicine and Public Health.” in W. F. Bynum and Roy Porter, eds., *Companion Encyclopedia of the History of Medicine* (London / New York, 1993), pp. 1928-1939.

5 Socrates Litsios, *The third ten years of the World Health Organization* (Geneva, 2009); Socrates Litsios, *The fourth ten years of the World Health Organization* (Geneva, 2012); Socrates Litsios, “Selskar Gunn and China: The Rockefeller Foundation’s ‘Other’ Approach to Public Health”, *Bulletin of the History of Medicine*, 79: 2 (2005), 295-318; Socrates Litsios, “Fred L. Soper’s Ignored Criticism of WHO’s Approach to Malaria Eradication”, *Parasitologia*, 42 (2000), 167-172; Socrates Litsios, “The Long and Difficult Road to Alma-Ata: A Personal Reflection”, *International Journal of Health Services*, 32: 4 (2002), 709-732; Socrates Litsios, “WHO, PHC and the NGO Community : the Need for a More Focused Commitment”, *Development journal on Politics of Health*, 47: 2 (2004), 57-63; Socrates Litsios, “The Christian Medical Commission and the Development of WHO’s Primary Health Care Approach”, *American Journal of Public Health*, 94: 11 (2004), 1884-1893; Socrates Litsios, “Selskar Gunn and China: The Rockefeller Foundation’s ‘Other’ Approach to Public Health”, *Bulletin of the History of Medicine*, 79 (2005), 295-318; Socrates Litsios, “The Rockefeller Foundation’s Struggle to Correlate Its Existing Medical Program with Public Health Work in China” in Iris Borowy, ed., *Uneasy Encounters: The Politics of Medicine and Health in China 1906-1937*, (Berlin, 2009), pp. 177-203.

6 Mark Harrison, “Disease, diplomacy and international commerce: the origins of international sanitary regulation in the nineteenth century”, *Journal of Global History*, 1: 2 (2006), 197-217.

alcohol, occupational safety and transboundary pollution.⁷ Nevertheless, many recent studies have still focused on IHOs in a narrow sense, e.g. IHO whose main function was to work on international health work and which carried “health” in its name, mainly the World Health Organization (WHO),⁸ the League of Nations Health Organisation,⁹ or the Pan-American Health Organization.¹⁰ But as time and IHO activities progress, historical studies increasingly focus on individual programs, campaigns or regions, which invariably contextualizes IHO as actors within a larger web of global, regional and local actors (including other IHOs) working towards a specific health-related goals. To name just a few examples, this is true with regard to eradication campaigns, notably smallpox¹¹ and malaria,¹² child care,¹³ social approaches to health policies,¹⁴ or the relations of IHO work to specific regions such as Asia,¹⁵ or Latin America.¹⁶

In a diversion from this pattern a comparatively large amount of research has consistently focused on the Rockefeller Foundation, whose International Health Board/Division engaged in international health from the early twentieth-century. It formed part of a private institution and cooperated with, but never belonged to, the public IHOs listed above.¹⁷ The integration of the Rockefeller Foundation into the standard canon of IHO literature opened up the question of what defines an IHO beyond those of intergovernmental organizations dedicated to health (and nothing else). The Rockefeller Foundation was not based on governmental membership, it

7 David Fidler, “The globalization of public health : the first 100 years of international health diplomacy”, *Bulletin of the World Health Organization*, 79: 9 (2001), 842-49.

8 Kelley Lee, *The World Health Organization* (London/New York, 2009).

9 Iris Borowy, *Coming to Terms with World Health* (Berlin, 2009).

10 Norman Howard-Jones, *The Pan-American Health Organization: Origins and Evolution*, (Geneva, 1981); Marcos Cueto, *The Value of Health. A History of the Pan American Health Organization* (Washington, 2007).

11 Sanjoy Bhattacharya, *The Global Eradication of Smallpox* (Hyderabad, 2011).

12 Darwin Stapleton, “Internationalism and nationalism: the Rockefeller Foundation, public health, and malaria in Italy, 1923-1951”, *Parassitologia*, 42: 1-2 (2000), 127-34; Kamini Mendis, et al. “From Malaria Control to Eradication: The WHO Perspective”, *Tropical Medicine & International Health*, 14: 7 (2009), 802-809.

13 James Gillespie, “International organizations and the problem of child health, 1945-1960”, *Dynamis*, 23 (2008), 115-142.

14 Esteban Rodríguez-Ocana, ed., *The Politics of the Healthy Life* (Sheffield, 2003); Iris Borowy, “International Social Medicine Between the Wars. Positioning a Volatile Concept,” *Hygiea Internationalis*, 6: 2 (2007), 13-35.

15 Sunil Amrith, *Decolonizing International Health. India and Southeast Asia, 1930-65* (Houndmills, 2006).

16 Paul Weindling, “As origens da participação da América Latina na Organização de Saúde da Liga das Nações, 1920 a 1940,” *Historia ciencia saúde-Manguinhos*, 13: 3 (2006), 555-570.

17 Marcos Cueto, ed., *Missionaries of Science. The Rockefeller Foundation and Latin America* (Bloomington, 1994); John Farley, *To Cast Out Disease. A History of the International Health Division of the Rockefeller Foundation (1913-1951)* (Oxford, 2004); Stephen Palmer, *Launching Global Health. The Caribbean Odyssey of the Rockefeller Foundation* (Ann Arbor, 2010).

was not financed by public money nor was its work decided by some body whose members cooperated under some sort of representative voting system. It was not even international in the sense that its leading officials had different nationalities. But its work was directed at health in countries around the world, its financial power provided it with a lot of room for manoeuvre, and its close cooperation with other IHOs, notably the League of Nations Health Organisation, firmly integrated it into the system in which multiple IHOs collectively formed a field perceived as international health. Studies of their working methods revealed that a lot of the activities in international health involved inter-agency collaboration as experts in the field often regarded each other as colleagues in a shared endeavor rather than as members of distinct institutions. Using health-related activities as a defining characteristic rather than organizational character certainly increased the number of actors and broadened perspectives for historians.

Paul Weindling took this approach that focused on health work rather than on institutional framework when he dedicated his 1995 collected volume to *International Health Organisations and Movements 1918-1939*. Among others, it included contributions on the League of Red Cross Societies and the Pasteur Institutes, effectively adding social work and laboratory science to this field of research.¹⁸ Conversely, analyses based on organizations could come with a new interpretation of health. When Amy Staples combined studies of the Food and Agriculture Organization, of the World Bank, and of the WHO she portrayed them as partners in a common endeavor towards world development. In doing so she implicitly defined health as a component of a larger socio-economic framework, rather than as an isolated aim in itself.¹⁹ This drew attention to other organizations whose work on general developmental issues led them to become involved in health matters. This has been particularly true for the World Bank, an organization without an original mandate in health, but which became one of the major players in international health in recent decades, affecting and sometimes eclipsing the work of traditional IHOs for whom health is the core responsibility.²⁰ Other institutions such as UNDP or UNICEF have also contributed substantial funds and efforts in international health work.²¹ Adding new actors, such as the People's Health Movement or the Global

18 Paul Weindling, ed., *International Health Organisations and Movements 1918-1939* (Cambridge, 1995), pp. 134-153.

19 Amy Staples, *The Birth of Development* (Kent, 2006).

20 Ane Ubalde and J.T. Jackson, "The World Bank and International Health Policy: A critical review", *Journal of International Development*, 7: 3 (1995), 525-541; Jennifer Ruger, "The Changing Role of the World Bank in Global Health", *American Journal of Public Health*, 95: 1 (2005), 60-70; Theodore Brown, Marcos Cueto and Elizabeth Fee, "The World Health Organization and the Transition from 'International' to 'Global' Public Health", *American Journal of Public Health*, 96: 1 (2006), 62-72; Devi Sridhar, *The Battle Against Hunger: Choice, Circumstance and the World Bank* (Oxford, 2008).

21 For an interesting, though somewhat dated overview see Meri Koivusalo and Eeva Ollila, *Making a Healthy World* (London, 1997).

Fund, and those writing the history of international health organizations find themselves in an increasingly crowded field.²² This is likely to remain the case as “new” IHOs keep being discovered. An upcoming volume by Peter Carroll and Adrian Kay, which explores the role of the OECD and that of its predecessor, the OEEC, in the global health interactions and policies, forms the latest example of this trend.²³

As the number of potential IHOs available for study by historians is growing while categories and perspectives multiply, writing the histories of IHOs has never been a more diverse practice. This collection of papers is meant to be a contribution to this evolving field and, by encapsulating a diversity of actors, topics and approaches, to make the job of any future definitive work, should it be attempted, even more difficult. The spectrum of material covered in these seven papers is deliberately broad. The list of IHOs includes WHO, UNICEF, ILO, the World Council of Churches Christian Medical Commission, the League of Red Cross Societies (LRCS), the International Office of Public Health (OIHP), the International Union against Venereal Diseases (UICPV), the Union against Venereal Diseases and Treponematoses (IUAVDT) and the Commission for Technical Cooperation in Africa South of the Sahara. The health issues discussed range from tuberculosis to sexually-transmitted diseases, from environmental health to cannabis consumption, and from development aid to Health for All programmes. In the process, the papers address debates on topics as diverse as preventive measures, health infrastructures for itinerant workers, the problems of defining emerging health issues, the goals of health aid policies, the organization of regional responsibility for IHOs as well as theories about how IHOs fit into the larger picture of international organizations. The geographical range stretches from the European Rhineland to South Asia, from French Colonies to post-War Occupied Territories, and from the offices of New York to the churches of West Germany. The period ranges from the 1920s to today. If nothing else, these papers demonstrate that research on IHOs draws on a large spectrum of research questions, case studies, places, people and eras.

Nevertheless, it is evident that common themes lurk behind this diversity. Not surprisingly, money and its impact is a recurring theme. Nils Brimnes argues that, eventually, superior funds carried the day for UNICEF in its struggle with WHO and allowed it to establish its anti-tuberculosis as the international norm. Sławomir Łotysz demonstrates how the difficulty of coordinating health insurance across numerous borders and different health care systems complicated efforts to provide

22 Ravi Narayan and Claudio Schuftan, “People’s Health Movement,” in Guy Carrin et al., eds. *Health Systems Policy, Finance and Organization* (Oxford and San Diego, 2009), 124-127; Isabel Yan, Eline Korenromp and Eran Bendavid, “Mortality changes after grants from the Global Fund to Fight AIDS, tuberculosis and malaria: an econometric analysis from 1995 to 2010”, *BMC Public Health*, 15: 977 (2015), DOI: 10.1186/s12889-015-2305-1.

23 Peter Carroll and Adrian Key, *Global Health Governance and the OECD* (World Scientific Publications, 2016).

anti-VD services to sailors working on the Rhine. Jessica Pearson-Patel points out that part of international opposition to a WHO office in Africa resulted from anxieties about future costs. Jim Mills suggests that when the WHO dismissed cannabis as a source of medicines in the 1950s the protests of the Indian government were driven by pharmaceutical interests at home. Finally, Iris Borowy argues that the global chemical industry created its own IHO to produce evidence to support claims about the safety of its products from fear of the economic implications of finding health hazards in synthetic compounds. Her discussion of the industry-funded European Centre for Ecotoxicology and Toxicology of Chemicals is important as it draws attention to corporations as a type of IHO often neglected by historians looking at such organizations. They commercial businesses differ from non-profit oriented IHOs in important ways, it is nevertheless important to acknowledge that the many companies selling anything from top of the range hospital equipment or pharmaceuticals to everyday items like soap, sanitary towels and plasters often have global reach. Their agendas and actions are as mixed as those of any other IHOs and their impacts likely to be just as significant in transmitting ideas, changing practices and shaping lives.

Secondly, several papers recount the various struggles of IHOs in determining scientific knowledge and transforming it into authoritative information, clearly one of their core responsibilities. Brimnes and Mills demonstrate that these struggles were neither agenda- nor interest-free and that the selection and interpretation of information formed part of the strategies of different IHOs to establish their position within the scene of international organizations. Conversely, Borowy focuses on the real difficulty of making sense of an emerging health threat whose nature seemed to contradict established scientific regimes.

Another theme that emerges from a number of these papers is the importance of IHOs as actors. Contradicting a view of international organizations as mere vehicles for the policies of member countries a number of organizations emerge from this collection with some form of corporate identity and agency of their own. Nitsan Chorev makes this thesis the centre of her analysis of IHOs as objects for theorists of international organizations. The idea is also implicitly adopted by Niels Brimnes in his analysis of the competition between WHO and UNICEF for practical and conceptual supremacy in global anti-tuberculosis policies and by Jim Mills in his analysis of the ways in which both WHO and UN commissions used a selective reading of available data regarding Cannabis consumption to serve their own agendas by condemning the substance. The idea is also inherent in Jessica Pearson-Patel's paper on French efforts to prevent or contain the establishment of a regional WHO office in Africa. The French aversion to such an office was based on the assumption that it would pursue a political line that would not necessarily fit in with the interests of French colonies there. The papers by Iris Borowy and Walter Bruchhausen bolster the view that IHOs came with their own specific religious, scientific or economic characters which influenced their perspectives on issues of international health. In all

cases, IHOs pursued agendas of their own derived from their own well-established, if evolving, institutional identities.

However, this does not mean that IHOs were either homogeneous or that they acted in vacuums. Repeatedly the papers demonstrate that national actors could and did try to influence the policies of IHOs, successfully in the cases of the Indian and British governments regarding Cannabis (Mills) and of German non-governmental development aid agencies with regard to health development policies (Bruchhausen), but unsuccessfully in the case of others, such as the French government and its approach to WHO representation in Africa (Pearson-Patel). Even more strongly, the papers portray a scene of international health in which inter-agency cooperation was the norm rather than the exception. The multiplicity of health and social organizations active along the river Rhine, the WHO and UNICEF tuberculosis commissions, bodies involved with chemical safety in various international organizations or WHO and UN in general, have all been compelled to cooperate in this complex field of international health, where diseases and health conditions do not recognize national borders and where determinants of health cut across disciplines. Even the Commission for Technical Cooperation in Africa South of the Sahara, whose main purpose was to counteract a regional WHO body, was characterized by large overlap of members with the office it was supposed to oppose.

Finally, the papers in this collection are united in their top-down approach which grants only fleeting appearances to those at whom the policies in question were addressed: the Asian cannabis consumers, the boatmen of the Rhine, the congregations of the Christian missions and those of us unknowingly consuming substances thought to be endocrine disruptors. This omission, owed largely to the difficulty of finding suitable sources, is a common characteristic of this literature, shared by other historians in the field. Nevertheless, the people concerned are omnipresent, albeit indirectly, as subjects of IHO surveys, debates, regulations, therapeutic or preventive provisions or other policies, and repeated references over time hint at their agency in a web of mutually reinforcing or contradicting determinants. When cannabis consumers in India (and elsewhere) have continued their habit, when boatmen on the Rhine have chosen the location for medical consultation, when church members in Africa and Germany have communicated their expectations to missionary organizations, when patients around the world have chosen (not) to cooperate with measures in anti-TB campaigns and when consumers have seen fit to challenge the material security of a range of products, they have hardly been in full control of events, but nor have they been passive victims of far-away decisions. Unfortunately, far too little is known about the ways in which patients, citizens, workers and consumers have negotiated their positions in relation to IHO policies, adding their agendas to those of other actors. If it is an under-researched topic then this collection has served the purpose of identifying an area for future work.

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International Health Organizations as Purposive and Strategic Actors: Theoretical Gains and Methodological Implications

Nitsan Chorev

Introduction

What are international health organizations? Can they be studied like other international organizations or is there something unique about them, about the fact that their mandate encompasses health, that sets them aside? And is there a reason to think that all international health organizations are the same? Specifically, does the conventional understanding of a shift from an ‘international’ to ‘global’ public health require a different way of conceptualizing international health organizations?¹

This paper makes a number of claims, in regard to international organizations in general but with particular attention to international health organizations. In the second section of the paper I argue that international organizations are purposive actors. This means that they have independent goals and purposes that may, but may also not, influence the international realm. I argue that international health organizations do have unique qualities – because international health organizations are likely to have a clear organizational mission and because the bureaucracies of international health organizations have traditionally been dominated by a relatively unified professional community, they are likely to act purposively as well as strategically. I also argue, however, that this might have changed over time – so that today international health organizations are less ideationally coherent and professionally unified, which may also mean lesser capabilities to effectively influence the external environment. In the third section I argue that

1 Theodore Brown, Marcos Cueto, and Elizabeth Fee, “The World Health Organization and the Transition from ‘International’ to ‘Global’ Public Health”, *American Journal of Public Health* 96: 1 (2006), 62-72.

international organizations are not only purposive but also strategic actors. This means that they are at least at times able to successfully pursue their goals even in the face of external constraints. The section describes the types of strategic action that are available to international bureaucracies. I differentiate between passive and strategic responses – and between those that lead to compliance and those that lead to resistance. I illustrate the various options by briefly referring to cases from the World Health Organization (WHO) as well as other specialized agencies of the United Nations (UN). In the fourth section, I identify a number of conditions that make strategic response likely and more likely to succeed. These include: having independent goals and preferences, minimal supervision and strong leadership. Based on these conditions, I argue, recent international health organizations seem less likely to act strategically than older ones. Finally, in the fifth section of the paper I analyze a number of methodological implications of viewing international organizations as purposive and strategic actors.

International health organizations as purposive actors

In the social sciences, it is common to view international organizations as sites where member states are the only carriers of interests and the only ones capable of acting. In the field of international relations, the neorealist perspective generally views international institutions as ‘arenas for acting out power relationships’ and scholars do not normally grant them causal power of their own.² A competing theoretical perspective, neoliberal institutionalism allows international organizations to have some causal, albeit indirect, relevance.³ Institutional arrangements, according to this approach, ‘change the incentives for states to cheat; they... reduce transaction costs, link issues, and provide focal points for cooperation’ and in this way transform states’ preferences, their behavior and, ultimately, policy outcomes.⁴ However, while neoliberal institutionalists argue that institutional frameworks impose constraints on states, like neorealists they do not grant international

2 Tony Evans and Peter Wilson, “Regime theory and the English School of International Relations: A Comparison”, *Millennium: Journal of International Studies* 21: 3 (1992), 329-351; John Mearsheimer, “The False Promise of International Institutions”, *International Security* 19: 3 (1994), 5-49.

3 Robert Keohane, *After Hegemony: Cooperation and Discord in the World Political Economy* (Princeton, 1984); Robert Keohane and Lisa L. Martin, “The Promise of Institutional Theory”, *International Security* 20:1 (1995), 39-51.

4 Ibid., 49.

organizations any capacity to act.⁵ In sociology theories interested in the international realm tend to see it as more homogenous than scholars of international relations do, including using terms such as ‘world culture’ and ‘world society’,⁶ but here too international norms and conventions originate from nation states, particularly Western Europe and North America.⁷

But international organizations – and, I would argue, particularly international health organizations – are not simply arenas where only others get to act. While negotiations and compromises among members are central to the decision-making process in international organizations, policies are often influenced by the international bureaucracy itself. The leadership and staff of an international organization – those who plan the budget, rank program priorities, author position papers, formulate arguments, and advocate policies to its members – have an essential role in influencing policies. And this is not simply about being a *neutral* mediator – helping to find a workable compromise among competing positions or disseminating ideas developed elsewhere. Instead, I argue that international bureaucracies may act as interested, and therefore biased, actors. They incorporate their own goals and perceptions into the policies negotiated by members.

Purposive Action and Its Limits

The view of international organizations as purposive actors is held by a number of theories in international relations that challenge the state-centered approach that is dominated in the scholarship on international relations. Earlier theories that regarded international organizations as actors include the epistemic communities literature⁸ and the international organization decision-making literature.⁹ Contemporary formulations include

5 Michael Barnett and Martha Finnemore, *Rules for the World: International Organizations in Global Politics*, (Ithaca, 2004).

6 John Meyer, John Boli, George M. Thomas and Francisco O. Ramirez, “World Society and the Nation-State”, *American Journal of Sociology* 103: 1 (1997), 144-181; Georg Krücken and Gili S. Drori, eds, *World Society: The Writings of John W. Meyer* (New York, 2009).

7 Meyer et al.

8 Ernst Haas, *Beyond the Nation-State: Functionalism and International Organization* (Stanford, 1964).

9 Robert Cox, “The Executive Head: An Essay on Leadership in the ILO”, *International Organization* 23:2 (1969), 205-29; Robert Cox and Harold Jacobson, eds, *Anatomy of Influence: Decision Making in International Organization* (New Haven, 1974).

constructivism¹⁰ and the principal-agent theory.¹¹ While in agreement with these theories in regard to some of their insights, this paper offers a different approach to analyzing both the origins of an organizational autonomy and, even more importantly, the interplay between autonomy and external constraints.

To identify the institutional factors determining the partial autonomy of international organizations, it is useful to draw on insights from political sociology and organizational sociology. Political sociology is useful for understanding the capacity of public bureaucracies to develop independent goals, preferences and interests. Indeed, the debate over the nature of international organizations echoes the debate on the nature of the state, between society-centered and state-centered approaches. State-centered scholars have shown that elected officials and civil servants develop interests independently of their constituencies and donors and that while ‘autonomous state actions will regularly take forms that attempt to reinforce the authority, political longevity, and social control of the state organizations’¹² these interests go beyond sheer need of survival.¹³ In turn, sociologists of organizations have shown that organizations develop distinct identities: beliefs about what kind of organization it is, what it should look like, and how it should behave.¹⁴ Similarly, international bureaucracies too are actors with independent goals. These include both material and ideational goals.

10 Martha Finnemore, *National Interests in International Society* (Ithaca, 1996); Barnett and Finnemore 2004; Catherine Weaver and Ralf J. Leiteritz, “‘Our Poverty is a World Full of Dreams’: Reforming the World Bank”, *Global Governance* 11:3 (2005), 369–388.

11 D. Roderick Kieweit and Mathew D. McCubbins, *The Logic of Delegation* (Chicago, 1991); Barbara Koremenos, Charles Lipson and Duncan Snidal, eds, *The Rational Design of International Institutions* (New York, 2001); Don Nielson and Michael Tierney, “Delegation to International Organizations: Agency Theory and World Bank Environmental Reform”, *International Organization* 57:2 (2003), 241–276.

12 Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, 1992), 15.

13 Fred Block, “The Ruling Class Does Not Rule: Notes Toward a Marxist Theory of the State” *Socialist Revolution* 7 (1977), 6-28; Peter Evans, Dietrich Rueschemeyer and Theda Skocpol, eds, *Bringing the State Back In* (New York, 1985); Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, 1992).

14 Stuart Albert and David A. Whetten. “Organizational Identity”, *Research in Organizational Behavior* 7 (1985), 263-295; Jane Dutton and Janet M. Dukerich. “Keeping an Eye on the Mirror: Image and Identity in Organizational Adaptation”, *Academy of Management Journal* 34:3 (1991), 517-554; Karen Golden-Biddle and Hayagreeva Rao, “Breaches in the Boardroom: Organizational Identity and Conflicts of Commitment in a Nonprofit Organization”, *Organization Science* 8: 6 (1997), 593-611; Mary Ann Glynn,

Most generally, the *material* goals of international bureaucracies include possessing authority to act and having funds to act effectively. International bureaucracies also develop expansionary tendencies, attempting to attain broader mandates and bigger budgets. However, material goals are not absolute. Opportunities for expansion may be rejected, for example, if they threaten the autonomy of the organization or undermine its legitimacy.¹⁵ Similarly, the amount of funds is rarely the sole consideration. International bureaucracies, for example, would prefer to maintain control over how resources are spent.

But international bureaucracies do not only have material preferences. They also develop principles, preferences, and philosophies that guide their perception in regard to the mission of the organization and their understanding of the best way to achieve that mission.¹⁶ These principles shape the staff's view on the organization's policies and programs. Although both the sources that generate ideational goals and the perceptions drawn from those sources may change over time, there are two sources that are particularly important. First, an international bureaucracy is heavily influenced by the values and goals of the organization's founders, especially as these are expressed in the organization's foundational texts, such as its constitution.¹⁷ Second, if the bureaucracy is dominated by one profession, the organization's principles are strongly shaped by professional expertise and ethos.¹⁸ Interestingly, these two sources – founding declarations and expert knowledge – are considered, also by members, to be legitimate references to justify preferences. Consistency with the Constitution confirms that the organization functions within its mandate and that it is apolitical; reliance on

“When Cymbals Become Symbols: Conflict Over Organizational Identity Within a Symphony Orchestra”, *Organization Science* 11:3 (2000), 285-298.

15 Michael Barnett and Liv Coleman, “Designing Police: Interpol and the Study of Change in International Organizations”, *International Studies Quarterly* 49 (2005), 593–619.

16 Ron Jepperson, “Institutions, Institutional Effects, and Institutionalism” in W. W. Powell and Paul DiMaggio, eds, *The New Institutionalism in Organizational Analysis* (Chicago, 1991), 143-163; Barnett and Finnemore 2004; Barnett and Coleman 2005.

17 Lloyd Harris and Emmanuel Ogbonna. “The Strategic Legacy of Company Founders”, *Long Range Planning* 32:3 (1999), 333-343; Victoria Johnson, *Backstage at the Revolution: How the Royal Paris Opera Survived the End of the Old Regime* (Chicago, 2008).

18 Paul DiMaggio and Walter W. Powell, “The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields”, *American Sociological Review* 48:2 (1983), 147-160; Mary Ann Glynn 2000, 285-298; Sarah Babb, “Embeddedness, Inflation, and International Regimes: The IMF in the Early Postwar Period”, *American Journal of Sociology* 113 (2007), 128-64; Jeffrey Chwieroth, “Normative Change From Within: The International Monetary Fund’s Approach To Capital Account Liberalization” *International Studies Quarterly* 52 (2008), 129–158; Weaver and Leiteritz.

professional knowledge signifies impartiality and objectivity – as well as reliance on legitimate expertise – and creates the appearance of political neutrality.¹⁹

While most international bureaucracies are likely to have similar material goals, there is a reason to think that there is more variance in regard to ideational goals – in regard both to the substance of the goals as well as to the commitment to them. Such variance is likely to be the outcome of differences in the ideational contours of the founding documents and of differences in professional socialization. International health organizations are among the international organizations most likely to have bureaucracies that develop autonomous ideational goals and that are highly committed to those goals. This is because international health organizations are likely to have foundational documents that are inherently ideational (these they share with many other international organizations, of course) *and* because they are often dominated by staff coming from the same profession – public health – so they are professionally socialized into a coherent, and shared, professional ethos. Interestingly, this is where one can predict differences between the more traditional international health organizations, such as the WHO, and the newer organizations, like the Global Fund to Fight AIDS, Tuberculosis and Malaria. It is possible that the presence of high commitment to shared ideational goals may be less present in the newer international health organizations. They are designed as public-private partnerships are more ‘open’ in regard to disciplinary orientation and therefore are less dominated by public health or other medical expertise as they also employ other experts – such as health economists, lawyers, and others – who may have a different interpretation of the mission of the organization and how to achieve it.

In short, while there is variation across types of organizations, international bureaucracies are likely to develop material goals and ideational perceptions that determine their positions on initiatives and other demands placed by members. We also need to remember, however, that the capacity of international bureaucracies to act upon their independent preferences is constrained by their relations with members and other external forces. To analyze the relations between international bureaucracies and those who make demands on them, it is useful to once again refer to sociological theories of organizations, particularly the resource dependence approach²⁰ and the

19 Michael Barnett and Martha Finnemore, “The Politics, Power, and Pathologies of International Organizations”, *International Organization* 53:4 (1999), 708.

20 Jeffrey Pfeffer and Gerald R. Salancik, *The External Control of Organizations: A Resource Dependence Perspective*, (New York, 1978).

neoinstitutionalist approach.²¹ Drawing on that literature, I argued that the ability of international bureaucracies to pursue these goals is bounded by three types of dependence: resource dependence, procedural dependence, and normative dependence.

Resource dependence

International organizations need financial resources to survive and accomplish their goals but most are not self-sufficient. They are therefore heavily dependent on external actors who provide the needed funds.²² The extent of resource dependence may vary depending on the institutional arrangements in place. A number of conditions are particularly relevant in determining international organizations' level of resource dependence on rich countries. In spite of attempts to draw contributions from private foundations and the private sector, rich countries are still by far the greatest contributors for international organizations. Interestingly, these conditions suggest that new health organizations, such as the Global Fund, are likely to be more dependent on rich countries than older health organizations, such as the WHO.

(1) *The amount of external funds needed.* The greater the amount of funds required by an international organization for pursuing its mission, the more dependent it is on exogenous donors. The World Bank, for example, is especially vulnerable to donors because its operations require great amounts of funds. The World Trade Organization, in contrast, requires a small budget and therefore exogenous actors cannot influence its actions and policies simply by withholding resources or promising additional ones. The International Monetary Fund, in turn, needs significant resources but is less vulnerable than the World Bank since it generates its own revenues.²³ International health organizations do not generate their own revenues. Their level of resource dependence, in turn, largely depends on whether they are operational or focus on policy advocacy or technical assistance. The WHO is clearly dependent on member states and other donors for funds. Still, its programmatic scope is

21 Paul DiMaggio, "Constructing an Organizational Field as a Professional Project: U.S. Art Museums, 1920-1940" in Walter W. Powell and Paul J. DiMaggio, eds, *The New Institutionalism in Organizational Analysis*, (Chicago, 1991), 267-292.

22 Pfeffer and Salancik 1978; see also Peter Blau, *Exchange and Power in Social Life*, (New York, 1964), James Thompson, *Organizations in Action*, (New York, 1967); Sarah Babb, *Behind the Development Banks*, (Chicago, 2009).

23 Nitsan Chorev and Sarah Babb, "The Crisis of Neoliberalism and the Future of International Institutions: The IMF and the WTO in Comparative Perspective", *Theory and Society* 38 (2009), 459-484.

limited compared to the Global Fund, which is therefore even more dependent than the WHO on financial support.²⁴

(2) *The difference in the size of members' contributions.* The greater the amount of funds given by wealthy members compared to the amount of funds given by poor members the more international organizations are dependent on their wealthier members. International organizations like the World Bank, which only rely on contributions of rich countries, are particularly vulnerable. UN specialized agencies, including the WHO, normally rely on a proportionate formula for assessing contributions, usually according to member-states' capacity to pay. While clearly appropriate, this created disproportionate dependence on the United States and other rich countries. Of course, organizations such as the Global Fund, where only some members are donors (the others are recipients) rely even more heavily on rich countries. A related condition is *the number of those who contribute significant funds to the organization and the coherence of their position*. The smaller the number of consequential contributors and the more homogeneous their position, the less leverage an international organization has.

(3) *Mandatory versus voluntary contributions.* Mandatory contributions reduce the ability of wealthy members to use their payments as a bargaining leverage. At the WHO, the budget used to be mostly made of mandatory contributions of member states but over the years the balance has changed and today voluntary contributions, which are also earmarked, consist of a very large part of the annual budget.²⁵ In organizations like the Global Fund contributions are entirely voluntary.

(4) *Competition with other organizations for access to resources.* Resource dependence is greater when a number of institutions with overlapping mandates compete for the same funds. In this regard, the WHO's dependence increased with the establishment of the Global Fund and many public-private health partnerships in the 2000s.

24 Between 2002 and 2011 the WHO's total budget was approximately \$1.4 billion per year on average. During the same period the Global Fund was able to raise around \$2 billion per year on average. See Global Fund, "Strategic Investments for Impact: Global Fund Results Report 2012" <http://www.theglobalfund.org/en/library/publications/>). For WHO budgets see http://www.who.int/about/resources_planning/en/index.html

25 Since the mid-1970s the share of voluntary contributions gradually increased. Voluntary contributions increased to almost 30 percent of WHO total expenditures in 1974–1975, and then to 53 percent in 1980–1981. During the 1980s they remained around 50 percent but increased to closer to 60 percent during the 1990s. By 2004 it was 70 percent (Kelley Lee, *The World Health Organization*, (London and New York, 2009); Patrick Vaughan et al., "Financing the World Health Organization: Global Importance of Extrabudgetary Funds", *Health Policy* 35 (1996), 229–245.

Procedural dependence

Since members are often represented in the governing body, international organizations are vulnerable not only to the power of external forces to withhold their funds but also to the power of members to withhold their votes. To function properly, international organizations require a majority of voting members to agree on policies and programs. If international bureaucracies were neutral, they would have little interest in the content of the policies and programs that are passed by a majority of members. However, since international bureaucracies are interested in the content of the policies and programs, they do depend on members' positions as manifested in the votes. As with resource dependence, institutional arrangements shape the degree of procedural dependence.

(1) *Voting arrangements.* Voting patterns vary across international organizations. Some international organizations that have nation-states as their members follow one-country/one-vote rule, while others follow a 'weighted' arrangement, in which the weight of a state's vote reflects its proportionate financial contribution to the organization. Arguably, procedural dependence has not attracted much attention in the literature because in the international organizations most often studied, the World Bank and the IMF, rich countries have the majority of votes, which creates a likely overlap between resource dependence and procedural dependence. In UN agencies, however, the one-country/one-vote rule has created procedural dependence on poor countries, which have the majority of votes. Because the WHO follows a one-country/one-vote rule, its bureaucracy depends on a majority rule of member-states. The WHO Executive Board – where members reflect the geographical and economic diversity of the WHO member-states – creates an additional layer of procedural dependence that is similarly divorced from resource dependence. The Global Fund is structured very differently. Instead of an assembly of nation-states, the main governing body of the Global Fund is the Board. The Global Fund board has twenty voting members that represent seven 'constituencies.' Constituencies are donor country governments (8 votes), 'implementing' country governments (7 votes), NGOs from both developed and developing countries (1 vote each), private foundations (1 vote), the private sector (1 vote), and people living with AIDS, tuberculosis and malaria (1 vote). One important difference between the WHO and the Global Fund, then, is that voting members are not only member-states. Another is the fact that the board is designed so that it is divided into two groups of ten voting members each: donors in one, and

beneficiaries in the other.²⁶ This eliminates the procedural advantage that poor countries – those that cannot rely on resource dependence – had at the WHO.

(2) *Location of decision-making authority.* Voting arrangements matter only as long as decisions are made by voting members and are not diverted to non-representative sites. At the WHO, one effective way for rich countries to reduce the organization's dependence on the majority of votes has been providing voluntary contributions, which are earmarked. The Global Fund, in contrast, does not allow for earmarking. This prevented the US government, for example, from ordering the Global Fund not to use US contributions to fund, for example, clinics that also support abortion. But it is also the case that the Global Fund is relatively decentralized and many of the decisions are not made by the Board.

Normative dependence

As sociologists of organizations remind us, international organizations need symbolic resources in addition to material ones. To generate support, an organization's presentation of itself, its mission, and its programs have to be accepted as legitimate.²⁷ Most sources of legitimacy are internal.²⁸ To be considered 'internally' legitimate, the policies and programs of international organizations need to be consistent with and not go beyond their original mandate. They also have to be seen as neutral: they cannot be seen, for example, as serving the interests of rich countries (or multinational corporations) or to be the mouthpiece of poor countries. Finally, international organizations have to show managerial competence. Competence and efficiency have often been related to the question of neutrality, as rich countries, in particular, blamed politicization for leading to organizational malfunction. Other sources of legitimacy are external. To attain 'external' legitimacy, international organizations need to conform to global norms,

26 Michel Kazatchkine, "Blog-interview", *The Herald Tribune*, March 12 (2008), <http://blogs.iht.com/tribtalk/business/globalization/?p=672>.

27 John Meyer and Brian Rowan, "Institutional Organizations: Formal Structure as Myth and Ceremony", *American Journal of Sociology* 83:2 (1977), 340-63; Mark Suchman, "Managing Legitimacy: Strategic and Institutional Approaches", *Academy of Management Review* 20:3 (1995), 571-610; Ian Hurd, *After Anarchy: Legitimacy and Power in the United Nations Security Council*, (Princeton, 2007).

28 Barnett and Finnemore 2004, 166-170; Hurd 2007; Terence Halliday and Bruce G. Carruthers, *Bankrupt: Global Lawmaking and Systemic Financial Crisis*, (Stanford, 2009).

rules, and principles as they are defined and redefined by dominant global actors.²⁹

To summarize, international organizations are dependent on resources, voting majorities, and legitimacy. Due to the institutional arrangements characterizing many international organizations, resource dependence has made them attentive to the demands of rich countries, as well as to private foundations and business. This seems to be even more the case with new international health organizations. Procedural dependence could potentially balance resource dependence by forcing international organization to attend to the wishes of the poor majority. Procedural dependence, however, characterizes older international health organizations but not the new ones. Finally, normative dependence makes international organizations particularly vulnerable to criticisms regarding their scope of authority, neutrality, and competence.

Notably, the focus on the dependence of international organizations on their member states is compatible with the theories that suggest significant influence of member states over policy outcomes, but it shifts the source of this influence from relations among states, which is the focus of most theories of international relations, to relations between states and the international bureaucracy. Policy outcomes, according to the analysis here, do not depend only on the ability of members to shape the position of other members, but also on their ability to control the international organization's leadership and staff. In the next section I argue that, on the contrary, international bureaucracies are often able to bypass exogenous pressures, in spite of their dependence.

International health organizations as strategic actors

The likely tensions between potentially-autonomous international bureaucracies and their members (as well as non-members) that are emphasized in this paper bring up a question that the literature frequently ignores: given the dependence of international organizations on members, how can international bureaucracies protect their goals and interests when those clash with exogenous demands?

²⁹ Meyer and Rowan 1977; W. Richard Scott and John W. Meyer, "The Organization of Societal Sectors" in John W. Meyer and W. Richard Scott, eds, *Organizational Environments: Ritual and Rationality*, (Beverly Hills, 1983), 129-153; DiMaggio and Powell 1983; Elizabeth Goodrick and Gerald R. Salancik, "Organizational Discretion in Responding to Institutional Practices: Hospitals and Cesarean Births", *Administrative Science Quarterly* 41:1 (1996), 1-28; Hurd 2007.

General formulations of the constructivist view do acknowledge the external constraints imposed by states.³⁰ In most of the empirical analyses, however, the potential tension between the independent goals of the international bureaucracy and external demands is bypassed by choosing case studies in which international organizations act independently but in line with states' interests, or case studies in which international organizations act where states are indifferent to the outcome.³¹ Hardly any of the analyses in the literature pays attention to instances in which international organizations fail to carry out state demands or act in ways that run against states' interests.³² One of the outcomes of this bias in the choice of empirical cases is that, in practice, many constructivist accounts tend to overstate the power available to international organizations and downplay the influence of external pressures and constraints.³³ In other words, the oversight of constructivist accounts is not in overstating the autonomy of international organizations, but in neglecting to explore the factors that enable international organizations to advance their autonomous interests under conditions of external opposition.

Principal-agent analyses, in turn, hold that an international organization (the agent) 'can exhibit significant independence' because member states (the principals) are impeded by the complications of 'collective principal,' 'multiple principals' and 'chain of delegation,' which limit their effective supervision.³⁴ While this formulation reflects greater attentiveness to the potential tensions between member states and international organizations than most constructivist accounts, the principal-agent literature has mostly focused on identifying the characteristics of principals that allowed for more or less effective supervision. As a result, by some scholars' own admission, the analysis 'contains a remarkably thin view of agent behavior'.³⁵

In short, most constructivist and principal-agent studies have not analyzed the capacity of international organizations to protect those goals *when these clash with the preferences of member states*. I argue that to understand the capacity of international organizations to protect their goals and preferences also in cases of a potential conflict with member states, we have to analyze not organizations' symbolic resources, such as authority or knowledge, as these

30 Barnett and Finnemore 2004, 12.

31 Rawi Abdelal, *Capital Rules: The Construction of Global Finance*, (Cambridge, 2007).

32 Barnett and Finnemore 2004, 28.

33 Barnett and Finnemore 2004; Abdelal 2007; Chwiero 2008a.

34 Nielson and Tierney 2003.

35 Darren Hawkins and Wade Jacoby, "How Agents Matter" in Darren G. Hawkins, David A. Lake, Daniel L. Nielson, and Michael J. Tierney, eds, *Delegation and Agency in International Organizations*, (New York, 2006), 1999.

theories often do, but their practices, particularly their capacity for strategic action. Indeed, my analysis of the strategic responses available to international bureaucracies when facing demands that threaten their goals builds on explorations that have begun among principal-agent scholars and constructivists. In one study by principal-agent theorists, Hawkins and Jacoby atypically investigate not the agents' characteristics but the strategies they use to try to circumvent principals' controls. Their analysis, however, is limited to strategies intended to influence the agent's level of autonomy, such as reinterpretation of mandates, and they do not discuss strategies used by agents within given levels of autonomy.³⁶ Some constructivist accounts have also begun to investigate the possibility of autonomous action under conditions of existing pressures.³⁷

To more systematically identify the strategies that are available to international bureaucracies to protect their goals in the face of incongruous demands I draw on organizational sociology. The focus on strategic action in organizational sociology came as scholars questioned early articulations of neo-institutionalist theory that suggested that organizations conformed to the dictates of their environments and came to recognize instead organizations' possibility for purposive action and strategic choice.³⁸ Among other contributions, these studies recognized that exogenous dictates were susceptible to interpretation, manipulation, revision, and elaboration by those subject to them.³⁹ Most systematically, Christine Oliver listed five possible responses by organizational actors to exogenous pressures.⁴⁰ Briefly, the possible responses include: acquiescence (acceding to pressures); compromise (exactng concessions); avoidance (attempting to preclude the necessity of conformity); defiance (rejecting expectations); and manipulation (attempting

36 Ibid.

37 Barnett and Coleman 2005; Catherine Weaver, *Hypocrisy Trap: The World Bank and the Poverty of Reform*, (Princeton, 2008).

38 Paul DiMaggio, "State Expansion and Organizational Fields", in Richard H. Hall and Robert E. Quinn, eds, *Organizational Theory and Public Policy*, (Beverly Hills, 1983), 147-161; Walter Powell, "Institutional Effects on Organizational Structure and Performance", in Lynne G. Zucker, ed., *Institutional patterns and organizations: Culture and environment*, (Cambridge, 1988), 115-136.

39 W. Richard Scott, "Approaching Adulthood: The Maturing of Institutional Theory", *Theory and Society* 37 (2008), 430; see also DiMaggio 1991; Jerry Goodstein, "Institutional Pressures and Strategic Responsiveness: Employer Involvement in Work-Family Issues", *The Academy of Management Journal* 37:2 (1994), 350-382; Goodrick and Salancik 1996.

40 Christine Oliver, "Strategic Responses to Institutional Pressures", *Academy of Management Review* 16:1 (1991), 145-179. She draws on earlier articulations of possible strategies, including Pfeffer and Salancik (1978) and Richard Scott, *Organizations: Rational, Natural and Open Systems*, (New Jersey, 1981), chapter 8.

to actively change the content of the expectations). Barnett and Coleman have argued that the same range of strategies was available to international organizations, and suggested a sixth response, that of strategic social construction (tailoring the environment so that it is consistent with the organization's goals);⁴¹ in her work, Weaver has described in detail the use of avoidance (or 'organized hypocrisy') as a central strategy of the World Bank.⁴²

While useful, the list of available responses as described in the literature can be analytically confusing. In particular, responses seem to follow a dual linear logic, varying 'from passive conformity to active resistance'.⁴³ But the two dichotomies – passive-active and conformity-resistance – do not neatly overlap. What makes a response passive or active is not whether it conforms to or resists the exogenous demands. Rather, it is whether the response includes an attempt to alter the meaning of those demands, be this part of either conforming to or resisting them. For example, Oliver lists manipulation – the purposeful attempt to co-opt, influence, or control institutional pressures in order to change the content of the expectations – as resistance, because it is 'the most active response to these pressures'.⁴⁴ If due to manipulation the organization is able to avoid compliance with the original demands, then manipulation should indeed be viewed as resistance. However, if after manipulating their content the organization adheres to the altered expectations in a way that seems to satisfy the original demands, manipulation should instead be viewed as a form of active – or strategic – compliance. (What Oliver calls 'active' responses I refer to from now on as 'strategic'). Lumping the two dichotomies together prevents an independent assessment of passive vs. active/strategic responses as distinct from compliance vs. resistance, which, I suggest below, is fundamental for our understanding of the ability of international bureaucracies to successfully deviate from exogenous prescriptions.

Table 1 displays the different types of responses that emerge if we create a distinction between the two dichotomies, so that the categories are based on (1) compliance / resistance = whether the response leads to changes that satisfy the exogenous forces (compliance) or whether the response avoids changes or leads to changes that do not satisfy the exogenous forces (resistance) and (2) passive / strategic = whether the organization takes the pressures 'as a given constraint to be obeyed or defied' (passive) or whether it attempts to redefine

41 Barnett and Coleman 2005.

42 Weaver 2008.

43 Oliver 1991, 146.

44 Ibid., 157.

– ‘alter, re-create, or control’ – the meaning of the exogenous pressures (strategic).⁴⁵

Table 1. Types of possible responses

	Compliance	Resistance
Passive	Adherence to original expectations	Disobedience
Strategic	Adherence to <u>reinterpreted</u> expectations	Voidance

This categorization creates four types of possible responses.

- Passive compliance & passive resistance

Passive responses are those that accept the demands as given and include *passive compliance*, when the international bureaucracy adheres to the original expectations, and *passive resistance*, when the international bureaucracy explicitly disobeys the exogenous demands. The familiar dichotomy between compliance and resistance refers, in fact, to these ‘passive’ categories. One familiar illustration of passive compliance is the response of the United Nations Educational, Scientific and Cultural Organization (UNESCO) in the 1970s to the relatively radical demands of developing countries. In line with those demands, UNESCO initiated a controversial New International Information Order with no regard to the likelihood that it would undermine the legitimacy of the organization in the eyes of developed countries. Indeed, the US government argued that the proposed policies undermine independent journalism and withdrew from the Organization.⁴⁶ An example of passive resistance is provided by Barnett and Coleman, who describe how Interpol defied pressures to become involved in counterterrorism, in fear that if it became involved in political cases the organization would break up. In response, members punished the organization by establishing competing police networks to coordinate their antiterrorist policies.⁴⁷

- Strategic compliance & strategic resistance

The two brief examples above reveal the risk attached to both passive compliance and passive resistance – they often require the sacrifice of the bureaucracy’s material and/or ideational goals. It is for this reason that

⁴⁵ Ibid. 159.

⁴⁶ Mark Imber, *The USA, ILO, UNESCO AND IAEA: Politicization and Withdrawal in the Specialized Agencies*, (London, 1989); Robert Wells, “Introduction: the UN’s Specialized Agencies: Adaptation and Role Changes in an Altered International Environment” in Robert N. Wells, ed, *Peace by Pieces- United Nations Agencies and Their Roles: A Reader and Selective Bibliography*, (New Jersey, 1991).

⁴⁷ Barnett and Coleman 2005.

international bureaucracies often apply the alternative responses of strategic compliance and strategic resistance. Both strategic responses involve altering the meaning of the demands but with different outcomes. In the case of *strategic compliance*, the international bureaucracy alters the meaning of the demands – so the demands are more easily reconciled with bureaucracy’s own position – before it adheres to them. In the case of *strategic resistance*, the international bureaucracy reframes the demands so that it is no longer expected to conform to them. By formulating policies according to altered expectations, international bureaucracies are able, at times, to comply in a way less disagreeable to them, hence minimizing the cost of compliance, and, at other times, to refuse compliance in a way that is not considered resistance, thereby minimizing the risk of sanctions.

When strategically complying with exogenous demands, an international bureaucracy endorses the demands of member states but only after giving those demands a meaning that, while compatible with the original expectations, could be reconciled with the organization’s independent goals. Importantly, reinterpreting expectations (altering the meaning of the demands) is not the same as changing expectations (altering the demands), which should be considered an act of resistance rather than compliance. Strategic compliance is not about making the exogenous forces change their demands so much as convincing those forces that the *original* demands were met. Such strategic compliance leads not to partial compliance, which is one expected outcome of passive compliance (for example, in compromise), but to distorted compliance, that is, a complete adherence to the requirements, once those requirements are reinterpreted. By offering an acceptable reframing of the dominant logic – the challenge is exactly in making such reframing acceptable – international bureaucracies make a distorted compliance look complete.

Unlike UNESCO, the WHO bureaucracy responded to the demands of developing countries in the 1970s not with passive compliance but strategic compliance. By redefining the principles articulated in the developing countries’ call for a New International Economic Order (NIEO) – including regarding development as social development, focusing on intra-state rather than inter-state inequities, championing self-reliance while downplaying the duties of developed countries, and supporting the transfer only of appropriate technologies – the WHO bureaucracy was able to successfully present its agenda of Health for All by the Year 2000 and the primary health care approach as compatible with those demands.

When strategically resisting exogenous demands, an international bureaucracy accepts, but does not adhere to, the external principles. Strategic resistance involves directly confronting, rather than bypassing (as in

avoidance), the exogenous demands. Unlike passive articulations of defiance, however, strategic resistance attempts to minimize the extent to which external forces would view the response as challenging the legitimacy of their expectations. An international bureaucracy that strategically resists external expectations does not reject the dominant logic, but rather relies on that very logic to legitimate its refusal to comply. Such justifications may allow an international bureaucracy to void the expectation to comply, thereby rendering what member states might have viewed as provocative (passive) resistance into an agreeable action.

The WHO bureaucracy provides a number of examples of strategic resistance. In the 1980s, the WHO leadership was able to successfully oppose an international code of marketing practices of pharmaceutical products by drawing on NIEO principles of political and economic sovereignty. In a dispute over intellectual property protection a decade later, the WHO secretariat was able to resist the demands of rich countries by implying that it was not resisting at all, since intellectual property rules already contained the flexibilities that the secretariat believed should be used for the manufacturing of generic versions of patented AIDS drugs.

Conditions for strategic response

Under what conditions do international bureaucracies engage in strategic rather than passive forms of response? When do they choose strategic compliance and when strategic resistance? And under what conditions are they more likely to succeed? Scholars have argued that an organization's choice of response to exogenous pressures is determined by the perceived cost to the organizational goals that compliance would require compared to the cost to the organization if it resisted the exogenous demands.⁴⁸ However, strategic responses to exogenous demands lower potential costs: altering the meaning of the demands that the organization complies with reduces the degree to which the organization's principles and goals are sacrificed, and being able to convincingly justify resistance reduces the risk of being penalized for it. The potential ability to reduce costs, by means of strategic compliance or resistance, means that costs alone cannot explain an organization's choice of action. Instead, we need to consider the factors that provide capacity for reducing the potential costs, that is, capacity for adaptive strategies. I argue that there are at least three factors that influence strategic response: how

48 Ibid.; Oliver 1991.

independent the goals and preferences are, scope of supervision, and type of leadership.

Independent goals and preferences. Strategic adaptation is called for only when there is a clash between the demands made by the environment and the bureaucracy's understanding of its material or ideational goals.⁴⁹ For such a clash to occur the organization's goals have to develop independently of its political environment. This would normally be the case unless the dominant forces in environment are able to co-opt the organization or its leadership. Cooptation by exogenous forces is more likely when an organization is dependent on the same parties both for votes *and* funds (for example, the World Bank) but can also occur without such an intentional design (for example, UNESCO during the NIEO era was arguably over-committed to the NIEO at the expense of the Organization's own goals). Without the presence of other conditions, however, independent goals and preferences could still lead to passive, rather than strategic, responses. Of course, independent goals and preferences reflect the organization's level of autonomy. Since, as discussed above, international health organizations like the Global Fund are more dependent on rich countries than international health organizations like the WHO – and they also include a more diverse bodies of experts – it is likely that they will act more passively and less strategically than the WHO.

Scope of supervision. As principal-agent theorists claim, the scope of supervision available to members over the international bureaucracy affects the agent's capacity for strategic action. Principal-agent theories identify a number of likely imperfections of oversight mechanisms, including uncertainty, lack of information, and multiple-principal problems. One potentially significant condition for effective supervision, not mentioned in the principal-agent analyses, is the position of the delegates representing and talking on behalf of member states at the international organization. States themselves are fragmented into partially autonomous bureaucracies, with officials often representing the position of their respective departments rather than of the government as a whole.⁵⁰ Most delegates to the World Health Assembly and other international health organizations come from health ministries and are likely to have their own reasons (such as competition for budget allocations at home) to support policies advocated by the international health organizations. These delegates, like the officials of international health organizations, may also share the professional ethos of public health experts

49 Barnett and Coleman 2005, 595.

50 Nitsan Chorev, *Remaking U.S. Trade Policy: From Protectionism to Globalization*, (Ithaca, 2007).

(it is interesting that at the Global Fund the US government is today represented not by the Department of Health and Human Services but by the Office of the U.S. Global AIDS Coordinator, under the US Department of State). This potential alliance of delegates with the international organization may undermine effective supervision. This is all the more so when the delegates come from departments relatively marginalized in the government, such as health or education, rather than departments that are likely to be more influential in the government, such as finance or foreign affairs.

Scholars often suggest that a multiplicity of external demands, made by competing parties, decreases members' supervision and increases the organization's room for maneuvering.⁵¹ But conflicting expectations – in international health organizations it may include wealthy countries, poor countries, health activists, pharmaceutical companies, and so on – may limit the bureaucracy's adaptive capacity. In such cases, especially when conflict between members puts the legitimacy of the organization at risk, strategic adaptation is often used to reach a compromise agreeable to the competing exogenous interests at the cost of the bureaucracy's own position. The presence of a multiplicity of demands may also affect the type of strategic responses, when those are employed: a multiplicity of demands limits the organization's interpretive flexibility while providing some external support for a defiant response, and so multiple demands often lead to strategic resistance rather than to strategic compliance, as was the case in the WHO bureaucracy's response to the code of conduct of marketing of pharmaceutical products.

Another factor that determines the scope of supervision relates to the precision of the demands. Goodrick and Salancik have convincingly argued that exogenous pressures are most influential – that is, most likely to lead to passive compliance – when they are certain, since uncertainty creates discretion, which allows organizations to use their own particularistic interests to guide their definition of appropriate action. When the exogenous expectations are imprecise, organizations can 'generate variation in practice while conforming to their [political environment] by pursuing their strategic interests within the limits of the discretion permitted by the [environment] generating it'.⁵² The types of expectations, then, set the boundaries of permitted discretion and therefore the range of available strategies. Some organizations are more likely to face loose expectations while others more

51 Oliver 1991; Nielson and Tierney 2003.

52 Goodrick and Salancik 1996, 2; see also Lauren Edelman, "Legal Ambiguity and Symbolic Structures: Organizational Mediation of Civil Rights", *American Journal of Sociology* 97:6 (1992), 1531-1576.

often receive tailored instructions. The specificity of demands may also affect the choice between the two adaptive strategies: while loose expectations allow for strategic compliance, the possibility for creative interpretation is more restricted when demands are more concise, and organizations are therefore likely to resort to strategic resistance in such cases.

Leadership. Another factor affecting the likelihood of strategic action is the leadership of the organization. Most of the literature on international relations concerned with the question of executive leadership has followed a ‘great-man theory of international organization,’ which focused on the personal characteristics of the leader in question. The exception was the work by Ernst B. Haas, which situated the leader within a given environment and emphasized the leader’s capacity to manipulate that environment to expand the agency’s authority.⁵³ Robert Cox, while agreeing with Haas, has criticized him for an underestimation of the constraints which are inherent in the set of relationships of which the executive head is a part, particularly with the rest of the bureaucracy, member states and the international system.⁵⁴ Indeed, just the way that the agency of international organizations is constrained by its environment, as analyzed in detail above, the agency of individuals in an international organization, including leaders, is also constrained by both the organization and the environment. We can think of it in terms of ‘nested agents,’ where individual agents act within the constraints of their organizations that act, in turn, within the constraints of their environments.

Here once again it is useful to draw from organizational sociology, which has similarly struggled with the ‘paradox of embedded agency’,⁵⁵ that is, with the possibility for human agency in conditions of organizational constraints. Scholars of organizations identified two types of conditions that enable ‘institutional entrepreneurship’;⁵⁶ that is, agents capable of introducing changes that are ‘divergent with reference to the institutional environment in which they are embedded’. The first type of enabling conditions includes ‘field-level’ institutional characteristics that determine the institutional scope of action. The two factors highlighted above – independent goals and imprecise expectations – are such field-level characteristics. However, ‘Although field-level conditions ... seem to play an important enabling role in institutional entrepreneurship, all actors embedded in the same field are not equally likely to act as institutional entrepreneurs’. The second type of

53 Haas 1964.

54 Cox 1969.

55 Petter Holm, “The dynamics of Institutionalization: Transformation Processes in Norwegian Fisheries”, *Administrative Science Quarterly* 40:3, 1995, 398-422.

56 Paul DiMaggio, “Interest and Agency in Institutional Theory” in Lynne Zucker, ed., *Institutional Patterns and Organizations: Culture and Environment*, (Cambridge, 1988).

enabling conditions emphasizes actors' specific, but still institutional rather than personal, characteristics. Particularly important is 'the social position an actor occupies within an organizational field'. An actor's social positions both in the organization *and* in the environment are important.⁵⁷

In regard to a leader's social position in the organization, I suggest that strategic response is more likely to occur when the institutional conditions allow for strong, effective leadership. Institutional conditions for strong leadership provide the head of the organization with the means to transform the organization without such attempts being paralyzed by external opposition or internal debates. UN specialized agencies and programmes have been relatively conducive to strong leaders, such as Raul Prebisch at the United Nations Conference on Trade and Development (UNCTAD) and James P. Grant at UNICEF. At the WHO, too, the institutional conditions have allowed Directors-General to effectively shape the direction of the Organization. For example, the Director-General has control over the budget and therefore great influence over the organization's priorities. In addition, Directors-General can often create new divisions, hire new recruits to run those divisions, and in other ways 'layer' new priorities on top of old programs, while avoiding the conflicts which would emerge out of actively abandoning previous priorities.⁵⁸ The authority that Directors-General have over staffing is essential for strategic adaptation because, as Chwierothe convincingly argues, while it is possible to change the position of existing staff, it is more common for organizations to change their perceptions through the entry into the organization of new recruits.⁵⁹

The organizational literature on individual characteristics focuses mostly on actors' social position in their organization. In addition, we have to consider the social position of the actor in the environment.⁶⁰ I suggest that strategic response is more likely to occur when the leaders are partially

57 Julie Battilana, Bernard Leca and Eva Boxenbaum, "How Actors Change Institutions: Towards A Theory of Institutional Entrepreneurship", *The Academy of Management Annals* 3:1 (2009), 377–419.

58 Eric Schickler, *Disjointed Pluralism: Institutional Innovation and the Development of the U.S. Congress*, (Princeton NJ, 2001); Wolfgang Streeck and Kathleen A. Thelen, "Introduction: Institutional Change in Advanced Political Economies" in Wolfgang Streeck and Kathleen A. Thelen, eds, *Beyond continuity: institutional change in advanced political economies*, (New York, 2005), 22-24.

59 Jeffrey Chwierothe, "Organizational Change "From Within": Exploring The World Bank's Early Lending Policies", *Review of International Political Economy* 15:4 (2008), 481–505.

60 Patricia Thornton and William Ocasio, "Institutional Logics and the Historical Contingency of Power in Organizations: Executive Succession in the Higher Education Publishing Industry, 1958-1990", *American Journal of Sociology* 10:3 (1999), 801-843.

embedded in the exogenous environment, which allows them to function as bridges between the organization and the broader environment. This requires being familiar with and appreciative of the dominant logic that as leaders of international organizations they are expected to navigate. Being part of the new logic allows leaders to adopt, at least in part, to the exogenous principles, and being in possession or being able to gain sufficient knowledge of the environment to be able to manipulate it. While partial embeddedness is an important condition, complete embeddedness – leading to greater loyalty to the environment than to the organization – may lead to passive compliance. Moreover, I argue that there is a tendency for strategic capacity of leaders to decline over the course of their tenure. Newly recruited leaders can rethink the organization's position and introduce strategic changes that, if the leaders are also well-positioned in the environment, are likely to be successfully accepted by the environment. However, these policy changes, and the ideas that inform or legitimate them, then get institutionalized and become barriers if new exogenous conditions introduce themselves and require a response from the organization.

In short, strategic adaptation is more likely to occur when the organization has independent goals and preferences, when external supervision is relatively loose, and when the organization has a strong, well positioned, and recently appointed leader.

Studying international organizations *as* agents: methodological implications

Studying international organizations as *interested* agents rather than as arenas where others get to act requires a careful conceptualization of the players and a nuance methodological approach to complex organizations.

First, how to define the boundaries of the organization? It is not always clear, for example, which parts of an organization are the 'bureaucracy' and which parts are the external environment. At the WHO, for example, the paid staff – including the Director-General – should be considered the organization's bureaucracy but the World Health Assembly, which consists of delegates of the various member-states, is already part of the exogenous environment that the bureaucracy is facing. This is a relatively simple case since the staff is expected to follow – and likely to internalize – the perceptions of the organization as a whole while the delegates are formally requested to represent their respective countries. For the same reason, the Global Fund's Executive Board is also part of the environment rather than part of the

organization. Other cases, however, may be more complicated. The WHO's Executive Board, for example, is made of representatives of member-states who are expected to serve, however, in their individual capacity. The Board is still part of the environment, since Board members are not expected to consider the interests of the organization but, at minimum, this complicates a clear dichotomy, and other cases may be even more complicated.

Second, how to identify the material and ideational preferences of the organization? Two risks need to be avoided. One is tautology, where preferences are inferred from action. We should not infer bureaucracy's preferences based on its actions given the possibility that the actions already reflect a compromise of the preferences. The other risk is rationality, where preferences are inferred from what a hypothetical 'rational' organization is likely to prefer. Instead, material and ideational preferences – including the balancing between competing preferences – have to be identified through empirical observation that is independent from the choices made in response to a particular event. In addition, of course, there's a need to clearly identify and define the environment and the demands made by the environment.

Finally, and most importantly, there is a need to clearly identify the bureaucracy's response. Is it compliance or resistance? Passive or strategic? This categorization is not trivial. Specifically, it cannot be judged by the outcome alone. Indeed, one of the reasons that the literature has focused on resistance and compliance – outcomes that can be measured *by looking at the outcome* – rather than on the types of resistance or compliance – strategic or passive – is likely to be that types can only be identified by looking at the processes and practices preceding the outcomes. In my study on the World Health Organization the main empirical focus was on showing the possibility of interested, strategic behavior by international bureaucracies, including both strategic resistance and strategic compliance.⁶¹ For that purpose, my analysis was of the interaction between the bureaucracy, on the one hand, and the external environment, on the other. The focus was on the strategies, policies and programs of the bureaucracy as they are presented to and negotiated with the external environment. There are two ways to advance this inquiry. One is through a systematic comparison across international organizations. A comparative analysis across relatively similar organizations (for example, UN agencies) would enrich our understanding of the conditions under which strategic action is possible and the conditions under which it is successful. A comparative analysis between state-centered international organizations (for example, UN agencies) and newer organizations that are structured as public-

⁶¹ Nitsan Chorev, *The World Health Organization between North and South*, (Ithaca, 2012).

private partnerships or as networks would provide a useful way to think of the differences between former and current forms of global governance. Another way of advancing the inquiry is to analyze the internal processes in the bureaucracy that led to the chosen response, which will again help identify the conditions under which strategic action is possible. How are the organizational interests and preferences articulated? What is the process by which such decisions are made? How is opposition, if there is one, managed?

Of course, considering international organizations as agents open very many other important questions, not only in regard to their response to external pressures. We still need to learn much more, for example, about how interests and preferences are constructed and internalized by staff. And once international organizations are recognized as carriers of interests we can also start asking about their ability not only to respond to the external environment but also to influence and shape the external environment. For scholars of international organizations – and international health organizations specifically – this should be an exciting terrain.

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Sailors and syphilis on Europe's waterways

International Health Organizations and the Rhine Commissions, c. 1900-1953

Sławomir Łotysz

Introduction

While historians have considered the place of seamen in the emergence of modern health policies before, their research has often been into particular national contexts and has tended to focus on those men working on the open seas.¹ Where those working on the Rhine have been mentioned in previous studies, it has usually been in passing.² This article will focus on the efforts to address the problem of sexually-transmitted disease among this labour force in the first half of the twentieth-century as it became a core concern for a wide range of international health organizations in this period. It will explore the reasons why, despite concerted efforts at comprehensive systems of surveillance and treatment,

1 For general accounts on STDs among seamen, see J. W. Kerr, "Venereal Diseases Among Seamen of the Merchant Marine", *Journal of the American Public Health Association*, 1.3 (March, 1911): 192-197, A. O. F. Ross, "Treatment of Venereal Diseases in the Allied Merchant Navies", *The British Journal of Venereal Diseases*, 21.3 (Sept. 1945): 123-134, "Treatment of Venereal Disease in Merchant Seamen", *The British Journal of Venereal Diseases*, 28.3 (Sept. 1952): 105, C. B. S. Schofield, "Difficulties in the Management of Venereal Disease in Mariners", *Bulletin of the World Health Organization*, 33.6 (1965): 867-880, O. Idsøe and T. Guthe, "The Frequency of Venereal Disease among Seafarers", *Bulletin of the World Health Organization*, 29.6 (1963): 773-780, R. R. Willcox and T. Guthe, "The Management of Venereal Diseases in Ports: an International Survey", *Bulletin of the World Health Organization*, 16.5 (1957): 1033-1038.

2 Apart from reports and news from the field in various journals and bulletins published by the health organizations, particularly the WHO (which should also be regarded as a primary source), very little written has been on this topic. Only a few authors have mentioned the case of the Rhine boatmen in their works. Among others, see P. Weindling, "The politics of international co-ordination to combat sexually transmitted diseases, 1900-1980s", in V. Berridge and P. Strong, eds., *AIDS and contemporary history* (Cambridge, 2002), 93-107, N. M. Goodman, *International Health Organizations and their Work* (London, 1952), 11, and T. J. Bauer, "Half a Century of International Control of the Venereal Diseases", *Public Health Reports*, 68.8 (Aug. 1953): 779-787.

those involved with tackling the problem remained unable to fully realise their plans for the best part of half a century.

The Rhine and its boatmen

Part of the reason that those working on the Rhine became a focus of efforts at international cooperation in this period is geographical. The river crosses a number of frontiers and its basin embraces – also through navigable canals – large parts of Germany, France, Switzerland, the Netherlands and Belgium, connecting them all with the wider world through the ports of Antwerp and Rotterdam. Given this, the efficient running of traffic on the waterway was important for multiple national economies; by the 1930s it was estimated that the volume of trade along it amounted to 85 million tons of cargo per annum, more than six times that of any other European river. It was carried on around 12000 freight vessels that included passenger boats, tugs and lighters and towards the end of the decade it was estimated that the “floating population” of those who made their livings from transportation along its length numbered between eighty and one hundred thousand people.³ This flow of goods and of human beings meant that many who worked on the river lived itinerant lives and that it carried a perpetually mobile population. It was certainly believed in policy-making circles that this necessarily brought with it a certain lifestyle, and what the WHO euphemistically referred to in noting “the special risk of frequent infections to which sailors were exposed because of their mode of life”⁴ earlier organisations like the Rhine River Commission called simply “alcoholism and debauchery”.⁵ This is no surprise as the management of the syphilitic sailor had been discussed by naval surgeons since at least the eighteenth-century⁶ and had often involved efforts at international cooperation in the past.⁷ As early as 1899 the issue of sailors and venereal disease had been at the heart of wider discussions about how to better coordinate efforts across national borders to control STDs at the Brussels *Conférence internationale pour la prophylaxie de la syphilis et des maladies*

3 For these numbers, see W. A. Brumfield, “Venereal Disease Control in the Rhine River Valley”, *Journal of Social Hygiene*, 36.1 (Jan. 1950): 13–19, quotation on 14.

4 World Health Organization, “An International Anti-Venereal Disease Commission of the Rhine (IAVDC)”, WHO/VD/20, 20 June 1949, p. 5, WHO/ANTIB, 1–22, World Health Organization Archives, Geneva, Switzerland (henceforward: WHOA). See also: L. M. Pautrier, “A plan for the establishment of an international body for venereal disease control among Rhine River boatmen. Presented at General Assembly of the International Union Against Venereal Diseases, Copenhagen 6–7 September 1948”, p. 7, Rhine River Commission, 465–2–1, WHOA.

5 “Antivenereal disease campaign in the Rhine River region”, p. 1, Rhine River Commission, 465–4–6, WHOA.

6 Idsøe and Guthe, “The Frequency of Venereal Disease”, (see note 1), quotation on 773.

7 Schofield, “Difficulties in the Management”, (see note 1), 867.

vénériennes. But it was the First World War and its aftermath that saw the problem emerge as a priority for a number of the nascent IHOs of that period.

The conflict ensured that by the time it ended there was an increased morbidity rate of syphilis, gonorrhoea and chlamydia in the whole Europe.⁸ The causes of this were numerous. Young soldiers flowed backwards and forwards across the continent, as did displaced populations. In many countries, both victorious and defeated, the social order fell apart and the loosening of family ties changed behaviours and attitudes towards sexual contact. Prostitution flourished, mainly near areas of high military activity and in ports, and rapes increased along the main routes of the marching armies.⁹ The civilian population of Europe had limited access to pharmaceuticals and medical care. After the First World War the fear that all of these circumstances had combined to leave populations along the Rhine struggling with venereal infections was prevailing.¹⁰

Global syphilis and the Brussels Agreement

Before the war organisations like the League of Red Cross Societies (LRCS), the International Office of Public Health (Office International d'Hygiène Publique –

8 The are numerous references to the critical serological situation in Europe after both world wars, but compiling a data summary for Europe generally, or for Rhine basin in particular, is rather difficult for various reasons, such as lack of systematic statistics, different infection definitions, or data interpretations. However, the data from individual countries show a growing tendency in infection ratio until the end of the war, and then almost equally sharp drop as a result of anti-STD campaigns and prophylaxis. The case of Sweden, where detailed statistics spanning the period 1916–47 are available, is a useful point of reference. The number of reported cases of syphilis in Swedish clinics rose sharply from 2549 in 1916 to 5827 in 1919, and dropped to 2232 in 1921. For chancroid the numbers were, respectively, 1101, 3341, and 867, while for gonorrhoea – 12100, 20471, and 12723. See: M. Tottie, “Mesures prises en Suède contre les maladies vénérienne”, p. 7, Venereal Diseases – Brussels Agreement and Maritime Aspects, Baltic Basin Commission, 465–4–8, WHOA. Similar drop in the number of patients of venereal clinics was reported in Netherland in 1920–25, but in applied only to civilians – the number of infected sailors in Rotterdam ‘remained stubbornly high’. See A. Mooij, *Out of otherness: characters and narrators in the Dutch venereal disease debates 1850–1990* (Amsterdam, 1998), p. 111.

9 See N. Henry, *War and rape: law, memory, and justice* (New York, 2011), p. 28, and R. G. Moeller, *War Stories: The Search for a Usable Past in the Federal Republic of Germany* (Berkeley, 2001), pp. 66–67.

10 Weindling refers to ‘the fear that soldiers might spread the STDs among the civilian populations’ in the time of transition from war to peace, (see note 2), 96. Of course this was not an impact of the First World War limited to the Rhine. For example, shortly after the First World War the level of STD morbidity in Shanghai became a matter of urgent concern for the London-based Eastern Commission of the National Council for Combating Venereal Diseases. In 1921 the council urged the Shanghai Municipal Council to provide free diagnosis and treatment of STDs to sailors, who were labelled a ‘vulnerable population’. See G. Hershat, *Dangerous pleasures: prostitution and moaernity in twentieth-century Shanghai* (Berkeley, 1997), p. 228.

OIHP), and the International Union against Venereal Diseases (Union Internationale Contre le Péril Vénérien – UICPV) had to some degree produced competing visions of how the challenge of controlling STDs on a global scale should be approached. The LRCS, being heavily based on American views (and funds), strongly condemned prostitution and emphasised moral education and self-control as the most effective weapons against STDs. Meanwhile, organisations like the OIHP which were dominated by those from medical circles in France and Germany emphasised technical solutions such as prevention through wider use of condoms and more effective methods of treatment for diagnosed cases.¹¹ The OIHP was the first IHO in the post-war world to return to the problem of STDs and its plan mooted an international agreement to provide free medical treatment in ports for infected sailors of all merchant navies. This proposal was considered at the First Maritime Labour Conference in 1920. This was held under the auspices of the newly founded International Labour Organization (ILO) in Geneva and included representatives of various organisations including the International Maritime Federation (IMF) and the International Seaman’s Federation (ISF). All agreed to focus their efforts on two goals: first, fostering awareness of the need for detection and treatment of all cases of infection among sailors, and second, to encourage organised “social meetings in ports to combat the idleness of the crews, which resulted in alcoholism and debauchery”.¹² Apparently, the scale of the problem was serious enough for all involved to overcome past disputes and to reach a compromise. While STD infection in mariners was framed clearly as a health issue to be solved by medical means, the American view of its moral roots remained. The medical approach recommended specifically included prophylaxis and treatment centres in all major ports along the Rhine and the inclusion of STDs on the list of disorders for which inland sailors should receive free treatment. Wide dissemination of knowledge about the program among sailors on duty, and particularly those still undergoing training, was also advocated.

After the Conference the challenge of implementing these recommendations was taken up by a range of agencies, the OIHP, the ILO and also the new League of Nations Health Organization (LNHO), to be coordinated by a team made up of representatives of each. In 1923 they were joined by others from the recently founded International Union against Venereal Diseases and Treponematoses (IUAVDT) led by Dr. Andre J. Cavaillon, an official from the French Ministry of Public Health.¹³ The outcome of all this coordination was “The Agreement respecting facilities to be

11 This entanglement has been fully explained in Weindling’s “The politics of international co-ordination”, (see note 2), 94–99.

12 “Antivenereal disease campaign in the Rhine”, (see note 5), p. 1.

13 “Obituary. Andre J. Cavaillon, 1887–1967”, *The British Journal of Venereal Diseases*, 44 (1968): 93.

given to merchant seamen for the treatment of venereal diseases”, better known as the Brussels Agreement which was revealed to the world on 1st December 1924.¹⁴

The Brussels Agreement “prescribed”, as Cavaillon put it, specialised medical centres at all major sea and river ports.¹⁵ The centres had to be accessible to all sailors in need regardless of their nationality. The intention was to offer free treatment to seamen of all nations, whether their governments were signatories to the agreement or not.¹⁶ The medical staff running those facilities were to be specialists trained with the very latest knowledge of venereology. The capacity of each centre, as well as the number of beds, was to be planned by the volume of traffic at the port. Hospitalisation was to be free for as long as the doctor considered it necessary. Finally, patients leaving the clinics were to receive free medication for their journey to the next port.¹⁷ However, putting these ambitious recommendations into practice was not easy. Two main obstacles had to be overcome – the lack of standardisation in the diagnosis and treatment of venereal diseases, and the diversity of welfare services in different countries.

Although an antibody test for syphilis, named after its developer August Paul von Wasserman, had been in wide use since 1906 the emergence of a universal, reliable interpretation of the obtained results remained elusive.¹⁸ In 1923 the LNHO organised in Copenhagen an international team of scientists to test some 500 specimens from eight countries using different techniques, all in order to work out a standardised interpretation.¹⁹ Agreement remained ambiguous however, and the standardization of the Wasserman test remained at the top of the agenda for national and international health bodies throughout the inter-war period²⁰ and afterwards.²¹

If standardized scientific and medical processes for dealing with syphilis and its treatment remained elusive in this period then so did agreement on how to provide facilities for dealing with the infected among the labour force of the Rhine waterways. It has been argued that because it was limited to technical matters the LNHO did not pay much attention to the second obstacle facing its programme, namely the

14 Goodman, *International Health Organizations*, (see note 2), p. 11.

15 Cited after “Antivenereal disease campaign in the Rhine”, (see note 5), p. 5.

16 Goodman, *International Health Organizations*, (see note 2), p. 12.

17 “Antivenereal disease campaign in the Rhine”, (see note 5), p. 2.

18 This author is indebted to Dr. Walter Bruchhausen for bringing up the issue of testing standardisation.

19 Weindling, “The politics of international co-ordination”, (see note 2), 99.

20 The progress reports were published regularly in leading medical journals. See, for example, R. Gilbert, “Standardization of the Wassermann Test. Abstract of Progress Test”, *American Journal of Public Health and the Nation's Health*, 20.1 (Jan. 1930): 47-48, R. Gilbert and V. Langworthy, “Standardization of the Wasserman Test. Report of Progress for 1926”, *American Journal of Syphilis, Gonorrhea and Venereal Diseases*, 11 (1927): 475, and others.

21 “International Serodiagnostic Conference to be Organized by WHO”, *Journal of Venereal Disease Information*, 31.7 (July 1950): 193.

financing of medical provision for all sailors regardless of their nationality.²² Its core recommendation was that those treated or hospitalised would be so for free, an assumption that had clear historical precedents, in the Danish law of 1802 for example, which offered treatment without charge to foreign seamen.²³ Few had followed this example though for the obvious reason noted by Sybil Neville-Rolfe in 1934 in her role as UK representative on the IUAVDT and the Secretary-General of the National Council for Combating Venereal Diseases. She observed that “one cannot expect that governments should offer to foreign seamen advantages which they do not offer to their own nationals”.²⁴

The First Rhine Commission

Britain had unilaterally moved to offering free treatment to those sailors suffering from STDs in the early 1920s and the Netherlands and France joined them in the early 1930s as a response to the Brussels Agreement.²⁵ By 1938 the agreement had been signed by 56 countries but not all provided free care for sailors with venereal disease.²⁶ The problem for those working on the waterways of the Rhine Basin was

22 Weindling, “The politics of international co-ordination”, (see note 2), 100.

23 J. Huisman, “Venereal Diseases (Sexually Transmitted Diseases: STD)” in W. H. G. Goethe et al., eds., *Handbook of Nautical Medicine Berlin* (Berlin, 1984), 207–212, quotation on 207.

24 Cited after “Antivenereal disease campaign in the Rhine”, (see note 5), p. 4.

25 R. R. Willcox, “IV Harrison Lecture 1981: the international venereological scene as viewed by Harrison and St Mary’s”, *The British Journal of Venereal Diseases*, 58 (1982): 72–85, quotation on 76. While French and Dutch accession was a result of their joining the Brussels Agreement, the exception remained the United States, which until the outbreak of the Second World War had not signed it. However, with the passing of its Venereal Disease Control Act of 1938, the United States opened its ports’ specialised medical centres to foreign sailors. A network of such clinics was set up in major US ports under this act, and their locations were included in the informational materials distributed among sailors as part of the activities of the European venereal clinics set up under the Agreement. See Bauer, “Half a Century of International Control”, (see note 2), 782.

26 No detailed listing is available, but by 1931 the Agreement claimed the following signatories (in order of their signing): 1925 – Great Britain, Canada, New Zealand; 1926 – Belgium, Finland, Greece; 1927 – Romania; 1928 – Denmark, Italy, Island, Australia; 1930 – France, Netherlands, Ireland, and 1931 – Sweden, Poland. The total of 56 includes colonies, on behalf of which the agreement was signed by their metropolises, and as such in 1926 Great Britain signed the agreement for most of her overseas colonies, including Ceylon, Gibraltar and the Seychelles; 1927 – France for Morocco, and Belgium for Congo, 1928 – Great Britain for Iraq and in 1930 for Cyprus. This list comes from an annex to the Polish enactment of 1931, published in the Polish Journal of Laws in February 1932. See “Oświadczenie rządowe z dnia 17 lutego 1932 r. w sprawie zgłoszenia przez Polskę przystąpienia do porozumienia w sprawie ułatwień marynarzom handlowym leczenia chorób wenerycznych, wraz z protokołem podpisania, podpisanych w Brukseli 1 grudnia 1924”, *Dziennik Ustaw. Poz. 92*, 17 February 1932.

that even where free medicine and treatment was notionally available sailors had to navigate the complexities of the different social insurance systems of each nation they passed through. For the Rhine boatmen this could mean facing multiple bureaucracies on a single trip down the river. In practice this became so complex that in 1929 various insurance companies asked the Central Rhine Commission (CRC a body established after the 1815 Congress of Vienna to ensure free navigation on the river) to take steps to coordinate the relevant parts of the social security systems in the Rhine countries and in Belgium. Observers remained suspicious of their motives however, arguing that in this period insurance providers

seek out all boat men who travelled along the Rhine through the territory of each state ... to claim social insurance contributions from them. This ultimately led to an intolerable superimposition of taxation; on the other hand these same social insurance institutions were by no means averse to evading their responsibilities by invoking the fact that the Rhine boatmen were foreigners when the latter, in the case of illness or accident, applied for special insurance benefits.²⁷

Because the situation in the Rhine basin was so complex the General Assembly of the IUAVDT in Amsterdam decided to appoint a new body to coordinate the work along the river between Germany, Belgium, France, the Netherlands and Switzerland. The first Rhine Commission met in Strasbourg in December 1936 and elected its chair, Lucien M. Pautrier, a Professor of Dermatology at the Medical Faculty of the University of Strasbourg. From the moment of its inception the Commission worked to solve the legal and organisational issues hindering the introduction of a programme to tackle the STD epidemic among the Rhine boatmen. This was no easy task, since two of the Commission's member countries, Switzerland and Germany, had not signed the Brussels Agreement.²⁸

Despite these problems there is some evidence that the Brussels Agreement did have some impacts on the ground in the Rhine. Education and information were very important in the plan and a register of specialised centres at all European ports was created, which by the end of March 1933 had been sent out to diplomatic missions in Paris, and to the ministries of foreign affairs of the countries involved.²⁹ The Agreement also recommended that all sailors visiting clinics or hospitals for treatment of STDs be provided with individual treatment books in which their medical history was recorded. The sailor-patients would also receive free medicines and a map that showed other ports and clinics where they could get further help, if required, as well as a variety of educational materials in different languages.³⁰ Between

27 Pautrier, "A plan for the establishment", (see note 4), p. 16–17.

28 See Weindling, "The politics of international co-ordination", (see note 2), 97.

29 "Antivenereal disease campaign in the Rhine", (see note 5), p. 3.

30 Pautrier, "A plan for the establishment", (see note 4), p. 9.

1930 and 1938 nineteen thousand such books were distributed which provides a glimpse of the numbers of those passing through the system.

Detailed data exists for Strasbourg, which shows that between 1921 and 1936 three thousand and ninety-three syphilitic sailors sought help from the special venereal clinic at the Skin and Syphilis Department of the Civic Hospital in the city.³¹ They were treated for free and 835 received arsenical injections, 934 bismuth injections, and 480 mercury injections. Thirty-one were hospitalised.³² Those assisted included French, German, Belgian, Dutch and Swiss nationals.³³ Only ninety-six answered the questionnaires they were presented with at the clinics, and of these forty reckoned they had been infected in France (30 in Strasbourg and 10 in the interior), eighteen in Germany, five in the Lower Rhine, three in the Netherlands, and two in Switzerland. Twenty-seven did not remember, or chose not to remember, where they had been poxed.³⁴ In reviewing the data from Strasbourg Pautrier himself stated that he was satisfied with these “considerable results” although he admitted that they might appear “insignificant in view of the number of boatmen who travel up and down the Rhine”.³⁵ Seventy-five thousand sailors visited Strasbourg in 1937 alone.³⁶

The Second World War and the new Rhine Commission

In the wake of the Second World War efforts to control STDs among those working on the waterways of the Rhine basin seemed to become more tangled and time-consuming. For example, starting from 1949, boatmen crossing the German-Dutch border on their tugs and barges were forced to stop in the small Dutch village of Lobith to have their cargo and shipping documents checked by customs officers. While there they were subjected to compulsory serological testing, and if adult family members travelling with them these were also forced to undergo examination.³⁷

31 Ibid., p. 10.

32 Ibid.

33 Ibid., p. 7–10. The ethnic composition of this number is unknown, but one may assume that the vast majority must have been of foreign origin. This can be concluded from Pautrier’s own estimates for 1937, when the river port in Strasbourg received over twelve thousand vessels, which included 8893 lighters and 1236 tugs. Well over half of these vessels were sailing under the Dutch flag. According to Pautrier, French vessels amounted to less than 5%. One may assume that percentage of French patients visiting the clinic was similar.

34 Ibid., p. 12. This result suggests that sailors usually sought help in the same port in which they were infected.

35 Ibid., p. 12.

36 Ibid., p. 7.

37 L. M. Pautrier, “The Anti-Venereal Organization of the Rhine Traffic. A report delivered at General Assembly of the International Union Against Venereal Diseases, Rome, 12–16 Sept. 1949”, p. 8. Various correspondence with: Union Internationale Contre Le Péril Vénérien, Paris, 465-2-1, WHOA.

It is perhaps for this reason that Paul Weindling has stated that the newly founded World Health Organization had a “special concern for Rhine River Boatmen and conditions in Poland” in this period.³⁸ As far as Poland was concerned the WHO had little to do but cheer it on as it embarked on its own ambitious anti-STD programme as early as 1946.³⁹ However, the WHO was certainly a more active participant in the Rhine boatmen issue and looked to the work of the pre-war Rhine Commission as it began implementing the different health programmes it had taken on, including the regulation of the Brussels Agreement.⁴⁰ Other groups became involved as the CRC returned to the issue of social insurance for Rhine boatmen and set up a special sub-committee for this purpose. In 1947 it made contact with the Transport Commission of the ILO about the matter.⁴¹

The starting point for their efforts was a technical report, presented by Pautrier, on the activities of the pre-war incarnation of the Rhine Commission. The report argued that if the boatmen were to be “induced to use” medical facilities for the treatment of STDs the system would have to be designed with a “maximum degree of simplification” so that medical support to sailors was provided on a walk-in basis without the need for them to provide any type of insurance documents. He also pointed out that sailors rarely stayed longer than two days in port, and so would not have the time to visit an insurance office twice, to pick up a health book, and then to collect a refund. Pautrier argued that coordination between the organisations funding national health schemes would have to be in place to make the system work; “co-operation between the social insurance institutions can, from an administrative

38 Weindling, “The politics of international co-ordination”, (see note 2), 102.

39 This author argues that Poland had egged herself on to start such a programme. Its mass anti-STD campaign, simply called “Operation ‘W’” (where the W stood for *weneryczny* – Polish for ‘venereal’), was launched in 1948, based partly on an assumed abundance of penicillin from the country’s first penicillin factory, which was then still under construction. The factory had been promised in early 1946 by the United Nations Relief and Rehabilitation Administration (UNRRA) as part of a larger rehabilitation programme for war-torn Eastern Europe. However, for various reasons construction was delayed by two-and-a-half years and ‘Operation W’ finally launched basing entirely on imported antibiotic. For a detailed account on the origin, realisation and broad consequences of UNRRA’s penicillin plant program see S. Łotysz, “A ‘Lasting Memorial’ to the UNRRA? Implementation of the Penicillin Plant Programme in Poland, 1946–1949”, *ICON: Journal of the International Committee for the History of Technology*, 20.2 (2014): 70–91. Nevertheless “Operation ‘W’” was praised by the WHO’s experts as being the world’s first fully comprehensive plan to combat STDs – see the *Official Records of the World Health Organization*, 14 (1948): 20. It aimed at reducing the post-war STD epidemic to a “socially meaningless extent” to cite M. Kacprzak, *Choroby weneryczne i ich zwalczanie* (Warszawa, 1948), p. 3–4. For a general account on combating STDs in post-war Poland see, among others, P. Barański, “Walka z chorobami wenerycznymi w Polsce w latach 1948–1949”, pp. 11–97 in M. Kula, ed., *Kłopoty z seksem w PRL* (Warszawa, 2012).

40 Willcox and Guthe, “The Management of Venereal Diseases in Ports”, (see note 1), quotation on 1033.

41 Pautrier, A plan for the establishment, (see note 4), p. 17.

standpoint, facilitate venereal disease prophylaxis on the river”.⁴² In his opinion the easiest solution was to impose the costs of any periods of hospitalisation on the respective state treasury, through the ministries of health or competent national institutes of public hygiene. He argued that since the number of cases requiring hospital care would be relatively low, the cost to tax payers would not be excessive.⁴³

In January 1948 the Expert Committee on Venereal Diseases of the WHO confirmed the commitment of the Organization to ensure free treatment of STDs for all sailors and to provide them with a wide range of social services, as “prescribed” by the Brussels Agreement. The Committee also stressed the importance of tracking the sources of infection on an international scale, and went as far as advocating the extension of the provisions of the Brussels Agreement to all displaced persons and migrants.⁴⁴ Had it done so, the Agreement could have evolved into a broader international welfare scheme.⁴⁵ Pautrier pushed further. In September 1948, at the General Assembly of the IUAVDT in Copenhagen, he called for the creation of an international group to focus on the Rhine on the lines of the pre-War body.⁴⁶ His position was supported at the Expert Committee’s second meeting in October 1948 and was greeted with a positive response from all the Rhine countries.⁴⁷ At the end of May 1949 their delegates, mainly members of the pre-war Rhine Commission, met in Paris and recommended the formation of the International Anti-venereal Disease Commission of the Rhine (IAVDCR). In practice this would be the second Rhine Commission, but this time it would operate under the auspices of the WHO.⁴⁸ The

42 Ibid.

43 Ibid., p. 18.

44 Ibid., p. 6.

45 Significantly, the recommendations of the Expert Committee were incorporated into the provisions of the first General Assembly of the WHO, which took place in Geneva in June and July of 1948.

46 When presenting the plan, Pautrier proposed his native Strasbourg as the seat of the new Rhine Commission. Specifically, he was thinking of the Palais du Rhin in the city. Since 1920 it had been the headquarters of the Central Rhine Commission. Prior to that it had first been established in Mainz, and then in 1868 relocated to Mannheim, both in Germany. Pautrier stressed Strasbourg’s central location, midway between Basel and the Ruhr. Besides, he said, the most important waterways connecting the Rhine with the heart of France start from there: the Marne-Rhine canal running towards Paris and the Rhone-Rhine heading towards Lyon. Of course, this was only the French perspective. Both the geographical and economic centre of the Rhine basin was lower down the river in Germany. Obviously, in early post-WWII Europe the French position was strong enough to support such claims. In the CRC France was the only occupying power. Meanwhile Germany, now split into zones, was represented by members of British, American and French military administrations. See Pautrier, “A plan for the establishment”, (see note 4), *passim*.

47 “Antivenereal disease campaign in the Rhine”, (see note 5), p. 6.

48 Representing France was Professor Lucien M. Pautrier of Strasbourg. Representing Belgium was Dr. Paul van de Calseyde, the Director-General of Hygiene in the Ministry of Public Health, while the Netherlands sent Dr. Edward M. Hermans, who was a Professor of Dermato-Venerology in Rotterdam. From Switzerland came Dr. Rudolf Schuppli, the Director of the

idea proved to be of wider interest and by the end of the year Poland, Finland, Sweden, Norway and Denmark had approached the WHO for help in setting up something similar for the Baltic region.⁴⁹ The WHO also considered taking the model to Southeast Asia and the Mediterranean.⁵⁰ Eventually the IAVDCR was formally established on 27 January 1951.⁵¹

The revived Rhine Commission resumed its pre-war activities, such as distributing educational leaflets and maps of medical centres from the fifteen largest ports along the Rhine.⁵² The information now also included details of tuberculosis clinics, maternal and paediatric health centres, and hostels for sailors. The Commission even dusted off the idea of issuing a multi-language treatment book for each patient too. The books would be written in four languages, German, French, Dutch and English. The latter was included because many British and American sailors who worked the tugs and lighters on the Rhine, so were as exposed to infection as their continental colleagues.

While much of this may have seemed like treading old ground the second Rhine Commission was more effective than its predecessor in one regard. Its greatest achievement was the creation of the Rotterdam Port Demonstration Centre, a combined medical clinic, research lab and training centre. This idea originated at the

Dermato-Venerology Clinic from the university in Basel. Present for Germany were: Major General J. Gill of the British occupation zone, Dr. J. Chanton from the French zone, Dr. W. Radcliffe of the American zone, and representatives of the German Public Health Administration from Westphalia and Württemberg, Dr. Lange and Dr. A. Unger respectively. The meeting was also attended by observers from the WHO (Dr. W. Bonne, Dr. T. Guthe, and Dr. A. Spillmann), ILO (Dr. de Viado, Miss Bodmer), IUAVDT (Dr. A. Cavaillon), and the Central Rhine Commission (M. Bonet-Maury). See Brumfield, "Venereal Disease Control", (see note 3), 16.

49 *Chronicle of the World Health Organization*, 4.3 (March 1950): 82. As for the health conditions in the post-War Baltic basin see H. Gordziakowski, "The pathology of foreign seamen in the port of Gdańsk", *Bulletin of the Institute of Marine and Tropical Medicine of the Medical Academy in Gdańsk, Polana*, 2:1-2 (1949), 9-25, T. Putkonen, "Gonorrhoea among merchant seamen in Finland: material collected 1946-9, and the official measures to prevent the danger", *Bulletin of World Health Organization*, 4 (1951): 121-129, and O. Idsøe and T. Guthe, "The rise and fall of the treponematoses. Ecological aspects and international trends in venereal syphilis", *British Journal of Venereal Diseases*, 43 (1967): 238. A comprehensive accounts on Poland's activities in realization of Brussels Agreement in communist Poland can be found in M. Krzyżanowski, "Control of venereal diseases in seamen", *Bulletin of the Institute of Marine and Tropical Medicine of the Medical Academy in Gdańsk, Poland*, 2.3-4 (1949): 255-266, and H. Gordziakowski, "Organization of Maritime Health Service in Poland", *Bulletin of the Institute of Marine and Tropical Medicine of the Medical Academy in Gdańsk, Polana*, 2.1-2 (1949): 3-7.

50 World Health Organization, Maritime aspects of venereal disease control, WHO/VD/53, 10 December 1949, p. 5, WHOA.

51 "WHO appoints International Anti-Venereal Disease Commission of the Rhine", *Journal of venereal disease information*, 32.4 (April 1951): 99-100.

52 These were: Amsterdam, Antwerp, Basle, Cologne, Dordrecht, Duisburg-Ruhrbort, Dusseldorff, Frankfurt am Main, Gand, Karlsruhe, Liege, Mannheim-Ludwigshaven, Mayence, Rotterdam and Strasbourg. See Brumfield, "Venereal Disease Control", (see note 3), 16.

1947 IUAVDT General Assembly in Paris, and was then taken up by the WHO through its Expert Committee on Venereal Diseases. Rotterdam was the obvious choice for the hub as it was the largest seaport on the continent and also the destination of most of the inland traffic on the Rhine. Another advantage was that it was already home to a state medical clinic for sailors established in 1925.⁵³ It also boasted well-equipped laboratories and a profusion of qualified medical personnel.⁵⁴ The Rotterdam Port Demonstration Centre opened its doors on 21 December 1951, with Dr. M. Hermans as acting Director. From its first few days the Centre ran training courses for personnel from other medical centres along the Rhine.

The second Rhine Commission lasted little more than two years and in 1953 it was abruptly disbanded. This despite fresh reports at the time that European “port cities have not had the decline in venereal disease evident in many inland areas”.⁵⁵ In considering this Weindling has concluded that “WHO initiatives for the eradication of syphilis were unsuccessful” because Rhine boatmen remained “reservoirs of STDs”.⁵⁶ The decision in part reflected post-War expectations that a wider “socialisation of medicine with free and universal medical treatment for all health problems”⁵⁷ in European countries would ensure that Rhine boatmen would find it easier to access medical care for all their problems and not just for venereal disease. This was not always the case however. For example, in France sailors had been offered a free bed in clinics since the early 1930s under the Brussels Agreement. Everything changed with the introduction of social insurance in April 1945. According to the new rules each sailor-patient had to pay for the equivalent of third-class hospital accommodation at a rate of 946 francs a day in the expectation that their expenses would later be reimbursed by their insurance company. This worked for French boat workers who paid their social security dues in that country, but not for others who were not part of the national scheme.

It also appeared that, perhaps because of the wider availability of penicillin in this period, there was an increasing tendency toward treating the symptoms of STDs on

53 The Netherlands acceded to the Brussels Agreement in 1930, and from that moment the care of sailors was the responsibility of the Dutch state. See Mooij, *Out of otherness*, (see note 8), p. 113.

54 “The agreement of Brussels, 1924, respecting facilities to be given to merchant seamen for the treatment of venereal diseases. Report of a Study Group (which met in Oslo, from 3 to 7 December 1956)”, *World Health Organization Technical Report Series*, 150 (1958): 12. The location was negotiated between the Dutch government, the WHO regional office for Europe, the Rotterdam municipal authorities, and the port management.

55 “Venereal Disease Control Center”, *American Journal of Public Health*, 42 (Feb. 1952): 225.

56 Weindling, “The politics of international co-ordination”, (see note 2), quotation on 102 and 95 respectively.

57 *Ibid.*, quotation on 95.

board ships without waiting for the results of properly conducted serological tests.⁵⁸ To this end the WHO took to recommending that all ships employ “a reliable medical technician to ensure that all marines treated at sea are referred to a venereologist at the next port”⁵⁹ but it is not at all clear that many bothered with this. The new medicines of the 1950s seemed to offer the infected on the Rhine quick and easy remedies without the need for time-consuming contact with the region’s health bureaucracies, even if those remedies were not always effective.

Conclusions

Despite international cooperation on the issue of STDs among Rhine boatmen throughout the first half of the twentieth-century concerted action failed to have significant impacts on the problem. A range of IHOs and international organizations that included health among their remits created a wider context of collaboration on venereal disease throughout the first decades of the twentieth-century. The League of Red Cross Societies, the International Office of Public Health, the International Union against Venereal Diseases and the League of Nations all played parts in the process that lead to the Brussels Agreement on facilities for infected sailors that was designed to have a global impact. The complexities of applying it in the Rhine basin meant that more focused international cooperation was considered necessary and this explains the creation of the Rhine Commission in 1936 and its reformulation under the WHO after the Second World War. Throughout the assumption was that international bodies and agreements were the best ways to deal with the problem of STDs in the region.

One key reason that the impact of international cooperation on the problem of STDs along the Rhine remained limited seems to be the technocratic nature of the proposals that emerged. The emphasis on cure that emerged was suited to the medical and scientific mind of the doctors and bureaucrats that populated the IHOs but did not always fit in with the thinking of those infected. George Scott has argued that the Brussels Agreement largely failed because after an initial visit to the clinic, patients “rarely continued their attendance until thoroughly cured. The moment the outward signs of the disease have vanished they cease to attend”.⁶⁰ Of course the principle that treatment should be free was laudable but in the context of the Rhine its practical application proved to be a long-running problem. The differences between the health and national insurance systems of the various countries along the Rhine were difficult

58 G. L. M. Mcelligott, “Venereal Disease and the Public Health”, *Bulletin of the World Health Organization*, 36.4 (Dec. 1960): 207–215, quotation on 207.

59 Schofield, “Difficulties in the Management”, (see note 1), quotation on 869.

60 See G. R. Scott, *A history of prostitution from antiquity to the present day* (New York, 1976), p. 208.

to resolve. Even where agreement was forged on the provision of free treatment to syphilitic sailors on the river the practicalities of implementing this in ways that were consistent with each nation's system could present formidable obstacles to accessing facilities and medicines for boatmen that had neither time or money to spare.

Despite this they were unable to overcome national differences and agendas along the river. Political circumstances were often against them. Neither Germany or Switzerland signed up to the Brussels agreement between the wars. Rivalry and tensions between France and Germany impacted upon cooperation on syphilis throughout the period. For example, France was initially against German participation in the International Union against Venereal Diseases and only agreed to it under Anglo-American pressure.⁶¹ By 1933 Germany had withdrawn from the League of Nations so no longer participated in its Health Organization or the ILO. It seems that impulses towards greater international cooperation in this period could often be overwhelmed by stronger currents in the tides of the period.

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⁶¹ Weindling, "The politics of international co-ordination", (see note 2), 97.

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French Colonialism and the Battle against the WHO Regional Office for Africa

Jessica Pearson-Patel

Introduction

In his opening address to the second annual meeting of the World Health Organization (WHO) Regional Committee for Africa in 1952 the President of Liberia extolled the virtues of the gathering

Thanks to the invention of the airplane and other forms of quick and comfortable transportation, the world today appears to be shrinking ... No country can therefore fail to take interest in the general conditions of health and well-being in the other members of our family of nations. It was for this reason that the United Nations wisely established the World Health Organization, which in turn created our Regional organization, which has been charged with the task of helping those nations in need ameliorate their level of health.

William Tubman went on to explain that he considered the WHO to be fulfilling the 'primordial needs of humanity'. He argued that only through cooperation within the domain of health could real peace be achieved and recommended that all the member states give themselves over fully to the 'principles that are at the hearts of these institutions' in order to show their solidarity with this quest for justice.¹

Many present would have agreed with his sentiments. At a 1950 meeting of the Commission for Technical Cooperation in Africa South of the Sahara (CTCA) a delegate from South Africa stated 'no continent has greater need for health and medical progress than Africa' and support for addressing this through the creation of a WHO Regional Office in Africa had been overwhelming from the two independent states in sub-Saharan Africa, Liberia and South Africa itself. But despite

1 Archives de l'Institut de Médecine tropicale des Services de Santé des Armées (IMTSSA) 238, Organisation des Nations Unies (ONU), Organisation Mondiale de la Santé (OMS), RC2/AFR/Min/1 Rev. 1, 10 septembre 1952, Comité Régional de l'Afrique, Deuxième Session, Procès-Verbal de la Première Séance, Tenue au Centennial Memorial Pavilion, Monrovia, Liberia, le jeudi 31 juillet 1952, à 10 heures, Président: le Dr. J.N. Togba (Libéria), 9–10.

this the creation of the Africa Regional Office was the most contested of all the WHO's regional branches. Colonial administrations in Africa vehemently opposed the involvement of the organization on the African continent. French officials led this opposition. This article will explore both their strategies for dealing with plans for a WHO regional branch and the reasons that lay behind their actions. It will show that for all the idealism of the postwar moment voiced by those like Tubman, the new international health organizations of this period often found themselves in a fight to operate.

Re-imagining Empire, Re-mapping Health

The structure of France's overseas empire had long been built on important legal, political, social, and economic inequalities between colonial populations and French settlers and administrators. But the Second World War brought with it some very significant changes in the way the empire was run and the kinds of rights that colonial constituents would be able to access. The Brazzaville Conference of 1944 launched a new kind of French empire, or 'French Union,' as it was now called. In 1946 all colonial subjects living within the bounds of the empire became citizens, with full voting rights, equal in law to all French citizens living in metropolitan France. As some colonial empires began to consider ways to peacefully devolve authority to territories in the process of becoming independent, the French Union was an attempt to bring France and its overseas constituents closer together.²

At the same time that French politicians and colonial administrators were re-thinking the political structure of France's overseas empire, international organizations were re-imagining the kind of regional structures that would come into play when attempting to provide for the health and well-being of people living in the developing world. Built into the constitution of the WHO is a provision for 'decentralization'. In practice this meant the creation of regional offices staffed by experts native to that region and concerned primarily with problems of health within their geographical boundaries. The motivation behind the principle of decentralization was a desire to provide services and facilities sensitive to local needs and informed by a close knowledge of conditions on the ground.³

2 On the re-imagining of France's overseas empire after 1945, see *Frederick Cooper, Citizenship between Empire and Nation: Remaking France and French Africa, 1945–1960* (Princeton, NJ: Princeton University Press, 2014).

3 On the history of the World Health Organization, see Amy L. S. Staples, *The Birth of Development: How the World Bank, Food and Agriculture Organization, and World Health Organization Changed the World, 1945–1965*. (Ohio: Kent State Univ. Press, 2007); Javed Siddiqi, *World Health and World Politics: The World Health Organization and the UN System* (Columbia,

Before a regional office could be created, a geographic region needed to be defined by the WHO. The First World Health Assembly defined the Africa region as follows: 'all Africa south of the 20 degree N. parallel of latitude of the western border to the Anglo-Egyptian Sudan, to its junction with the north border of Belgian Congo, thence eastwards along the northern borders of Uganda and Kenya; and thence southwards along the eastern border of Kenya to the Indian Ocean.'⁴ In other words, a Regional Office for Africa, if created, would cover the entire Africa continent with the exception of Northern Africa (Morocco, Algeria, Tunisia, Libya and Egypt), and parts of Eastern Africa (including Sudan, Ethiopia and Somalia).⁵

While each regional organization established by the WHO had some latitude in terms of the way it ran its affairs, much of the institutional framework of those offices was established by the WHO constitution.⁶ Regional offices were not permitted to deviate from any requirements stipulated by the WHO constitution. A regional organization, once created, would comprise a Committee composed of the member-states of the region as well as representatives from Associated Member States. It would also include a Regional Office under the charge of a director named by the Executive Bureau of the WHO and approved by the Regional Committee.⁷ By 1949 two had been created, for Southeast Asia and for the Eastern Mediterranean, and others were in the process of being established for Europe and the Americas. The WHO constitution stipulated that an official request to create an office had to be submitted by a member state that had the seat of its government in the region. In Africa this meant that even though colonial powers could be full members of the regional organization, only the two independent states of Liberia and of the Union of South Africa would be able to take action to create an Africa Regional Office.⁸

But a future WHO regional office faced a rival in Africa. The Commission for Technical Cooperation in Africa South of the Sahara (CTCA) was quickly established in the wake of the Second World War after Franco-British discussions

SC: University of South Carolina Press, 1995); and Nitsan Chorev, *The World Health Organization Between North and South* (Ithaca, NY: Cornell University Press, 2012).

4 Archives Diplomatiques La Courneuve (ADLC), Nations Unies – Organisations Internationales (NUOI) 330, World Health Organization: Establishment of African Region, Position at 1950, 2 Mai 1950, Appendix 2.

5 IMTSSA 222, Note au sujet de la Région Africaine du Comité Régional Africain et Bureau Régional Africain de l'O.M.S., 1. Note: Côte Française des Somalis would be included in the Eastern Mediterranean Region.

6 For an overview of WHO activity in a different region, see Sunil Amrith, *Decolonizing International Health: India and Southeast Asia, 1930-1965* (New York: Palgrave Macmillan, 2006).

7 IMTSSA 238, Note de l'Union Sud Africaine (1949), Organisation Mondiale de la Santé, Création d'une Région africaine, Situation en Avril 1950, 2.

8 IMTSSA 238, Note de l'Union Sud Africaine (1949), Organisation Mondiale de la Santé, Création d'une Région africaine, Situation en Avril 1950, 5–7. Also see NUOI 330, Direction des Affaires Politiques, 3ème Bureau, Création d'un Bureau Régional Africain de l'Organisation Mondiale de la Santé.

about the possibilities of technical cooperation in and between their African empires. The British and the French later invited the Belgian government to participate, followed by Rhodesia, Portugal, and South Africa. While earlier technical cooperation between colonial powers had been limited, the experience of the Second World War made a joint conversation about public health increasingly appealing. Early conferences led by the CTCA preceded meetings of a similar nature that would later be organized by the WHO. The CTCA's first medical conference took place in Accra followed by a 1948 conference in Brazzaville on sleeping sickness and a 1949 meeting in Cameroun on nutrition.⁹

CTCA members did develop a working relationship with the WHO's Regional Office for Africa but delegates always emphasized their perception that the WHO externally imposed programs from a place of ignorance about the on-the-ground realities of life in Africa; 'it became apparent very early that the program for sanitary cooperation within the framework of the CTCA had a very different orientation than that of the WHO [which was] more concerned, on one hand, with global perspectives, and on the other hand, with bilateral assistance within the framework of programs of technical assistance.'¹⁰ The CTCA was important for setting out a precedent for cooperation that would be acceptable to French colonial administration in the postwar era. While it appeared that the earlier, more isolated approaches of individual colonial powers were being abandoned in favor of more cooperative efforts in the postwar period, the CTCA took care not to step on the toes of colonial administrations. It focused instead on the sharing of expertise and technical information, rather than coordination on the ground. It was into this context of recent, limited, calculated cooperation between territories where health services had been run almost exclusively by colonial administrations that the WHO entered in the late 1940s.¹¹

9 Ibid., 44. Sleeping sickness was the object of earlier cooperative efforts in colonial Africa. See Deborah J. Neill, *Networks in Tropical Medicine: International, Colonialism, and the Rise of a Medical Specialty* (Stanford: Stanford University Press, 2012). On the CTCA, also see John Kent, *The Internationalization of Colonialism: Britain, France, and Black Africa, 1939–1956* (Oxford: Clarendon Press, 1992) and Jessica Pearson-Patel, "Promoting Health, Protecting Empire: Inter-Colonial Medical Cooperation in Postwar Africa," *Monde(s): histoire, espaces, relations*, no. 7, mai 2015, pp. 213–230.

10 Ibid., 43.

11 On colonial health services in Africa, see Alice Conklin, *A Mission to Civilize: The Republican Idea of Empire in France and West Africa, 1895–1930* (Stanford, CA: Stanford University Press, 1997); Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Stanford, CA: Stanford University Press, 1991); Myron Echenberg, *Black Death and White Medicine: Bubonic Plague and the Politics of Public Health in Colonial Senegal, 1914–1945* (Portsmouth, NH: Heinemann, 2002); Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1906–1940* (New York: Cambridge University Press, 1992); and Randall Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: University of California Press, 1989). Also see Shula Marks, "What is Colonial

Protecting Imperial Autonomy

On 18 February 1949 the Minister of External Affairs for the Union of South Africa submitted a proposal to the General Assembly of the WHO for the establishment of a Regional Organization for Africa.¹² In advance of this the South African delegation to the CTCA had been careful to make a case for this action. In a memo to other members their argument first focused on the importance of international public opinion. They hoped that in creating a regional organization they would ‘demonstrate to the world the desire of the States concerned in Africa to improve the health of African peoples; and conversely not to deny to Africa the benefits of modern medicine and health.’ They also expressed a desire to ‘fit into the accepted principle of regionalization being rapidly applied by the rest of the world’ and to ‘obtain their share of WHO advantages, possibly in rivalry with other Regions’.¹³ The South African delegation feared that the refusal to create a regional office would open the African states up to criticism by the international community, and that such a reaction from other members of the Assembly would create an ‘embarrassing situation’.¹⁴ However, in an effort to quell the fears of its colonial colleagues the South Africa delegation reminded the other member states involved that ‘a WHO African Regional Organization is limited to African Member States and would offer no direct right for extra-African powers to interfere in African affairs’.¹⁵

The South African delegation made the explicit link between the involvement of the WHO in African affairs and the future of the continent. In their memo to the other members of the CTCA they wrote ‘since the development of Africa is a direct function of the control of African maladies and menaces to public health ... we would be wrong to dismiss the crucial importance of a Regional Organization for Africa.’¹⁶ They went on to emphasise this conviction that tackling Africa’s health problems was central to all government ambitions in the continent:

If the Regional Office for Africa of the WHO is created, and when it is, it will be called on to become a technical element of fundamental importance in all matters concerning development in Africa. Public Health being the essential factor in all plans for Africa (in matters relating to policy, society, industry, agriculture, science,

about Colonial Medicine? And What has Happened to Imperialism and Health?,” *Social History of Medicine* 10 (2) (1997): 205–219.

12 Ibid., Appendix 2.

13 ADLC, NUOI 330, World Health Organization: Establishment of African Region, Position at 1950, 2 Mai 1950, 6.

14 ADLC, NUOI 330, World Health Organization: Establishment of African Region, Position at 1950, 2 Mai 1950, 7.

15 Ibid., 7.

16 IMTSSA 238, Note de l’Union Sud Africaine (1949), Organisation Mondiale de la Santé, Création d’une Région africaine, Situation en Avril 1950, 13.

military and communications), this means that the Regional Office will exercise a considerable influence, directly or indirectly.¹⁷

According to the French delegation at the CTCA the proposal was a dangerous one. Danger did not lie specifically in the creation of a regional health organization for Africa, but in the fact that this particular health organization would be a precedent that paved the way for the other specialized agencies of the United Nations and possibly even the Economic and Social Council itself.¹⁸ Correspondence reveals that the French Ministry of Foreign Affairs had already taken steps to delay the creation of a WHO regional office in Africa and had been appealing to other colonial administrations via the French embassies in London, Brussels and Lisbon.¹⁹ A letter from the Ministry pointed out to the South African embassy the danger of allowing the WHO to 'interfere directly and in a permanent fashion in the administration of non-autonomous territories in Africa' as well as the financial burden that would fall on the member states.²⁰

The advantages of delaying the creation of a regional organization, the French delegation claimed, were that there would then be sufficient time to further develop cooperative efforts within the framework of the CTCA, which would be important for offsetting the potential influence of a WHO office for Africa. They even spoke of a situation analogous to that of the Pan-American Sanitary Bureau, which was a previously independent organization brought into the WHO framework in lieu of a regional organization.²¹ The Ministry of Overseas France, for its part, was even more

17 IMTSSA 238, Note de l'Union Sud Africaine (1949), Organisation Mondiale de la Santé, Création d'une Région africaine, Situation en Avril 1950, 11.

18 See ADLC, NUOI 330, 5 Mai 1950, JBD/ML, Direction d'Afrique-Levant, Bureau d'Afrique, Bureau Africain de l'OMS, 2.

19 ADLC, NUOI 330, Communiqué à Ministère de la France d'Outre-Mer, Direction du Service de Santé, Ministère de la France d'Outre-Mer, Direction des Affaires Politiques, Direction d'Afrique Levant, a/s 11ème session du Conseil Economique et Social, Extrait d'une lettre du chef de la délégation française no. 120 du 8 Août, concernant une intervention du délégué de l'Inde en faveur de la création d'un bureau régional africain de l'Organisation Mondiale de la Santé, 11 août 1950, 1–2.

20 ADLC, NUOI 330, 5 Mai 1950, JBD/ML, Direction d'Afrique-Levant, Bureau d'Afrique, Bureau Africain de l'OMS, 2.

21 See ADLC, NUOI 330, Communiqué à Ministère de la France d'Outre-Mer, Direction du Service de Santé, Ministère de la France d'Outre-Mer, Direction des Affaires Politiques, Direction d'Afrique Levant, a/s 11ème session du Conseil Economique et Social, Extrait d'une lettre du chef de la délégation française no. 120 du 8 Août, concernant une intervention du délégué de l'Inde en faveur de la création d'un bureau régional africain de l'Organisation Mondiale de la Santé, 11 août 1950, 2. Also see NUOI 330, AL/GP, Délégation Française Permanente auprès de l'Office des Nations Unies, Palais des Nations, Genève, le 14 septembre 1950, Bernard Toussaint, Représentants permanent de la France auprès de l'Office des Nations, à Son Excellence Monsieur Robert Schumann, Ministre des Affaires Etrangères, Secrétariat des Conférences. Objet: Organisation régional de l'OMS en Afrique, 2.

convinced about the potential for using the CTCA as a counterbalance to the WHO's project, which it feared was bound to succeed 'sooner or later'. In a letter to the Ministry of Foreign Affairs, Monsieur D.G. Pirie of the Ministry of Overseas France pointed out that members of the CTCA would hold a majority in a future regional organization. Pirie suggested that in these circumstances the powers of the CTCA should hold a separate preliminary session before each meeting of a future regional organization, in order to strategize as a group and coordinate a joint position on the various issues that would be discussed at the annual meeting. While Pirie was more optimistic about working a future WHO regional office to French advantage, his efforts remained focused on the French strategy of drawing in other colonial administrations to oppose and delay the creation of the WHO office.²²

The delegations from the other colonial powers, however, responded negatively to French appeals to act together to delay the WHO regional organization, even where they too were fundamentally opposed to it. The Portuguese delegation was anxious about the costs that were likely to follow the arrival of a WHO office in Africa but was of the opinion that delaying its creation would be practically very difficult given the steps already taken by the South African government.²³ The French Ambassador to the United Kingdom, René Massigli, was of the opinion that British officials were unlikely to oppose it given the support of both Liberia and South Africa for the proposal.²⁴ So it proved, and in the end the French failed in their efforts. After 1950 they could only hope to stem the tide of WHO involvement deeper into the political and social affairs of their African territories'.²⁵

The French and the WHO Regional Organization

After South Africa's proposal was approved, the first order of business was choosing a location for the headquarters of the WHO's Africa Region. The choice of city for the headquarters was a thorny issue for several reasons. First, for the World Health Organization, the choice of a headquarters location was an inherently political one. Any city chosen—whether located in an independent country or a colonial territory—had to uphold a certain standard of living for its population, as well as

22 NUOI 330, BH/GW, Direction des Affaires Politiques, 3ème Bureau, Création d'un Bureau Régional Africain, 2–3.

23 ADLC, NUOI 330, Télégramme, Lisbonne, le 6 Mai 1950, 17h45, no. 194.

24 ADLC, NUOI 330, Télégramme, Londres, le 8 Mai 1950, 21h40, no. 1625.

25 ADLC, NUOI 330, Communiqué à Ministère de la France d'Outre-Mer, Direction du Service de Santé, Ministère de la France d'Outre-Mer, Direction des Affaires Politiques, Direction d'Afrique Levant, a/s 11ème session du Conseil Economique et Social, Extrait d'une lettre du chef de la délégation française no. 120 du 8 Août, concernant une intervention du délégué de l'Inde en faveur de la création d'un bureau régional africain de l'Organisation Mondiale de la Santé, 11 août 1950, 3–4.

demonstrate a commitment to equal political participation and a strong dedication to promoting human rights. On top of this, however, the headquarters needed to be located in a city with extensive modern amenities that could support a truly global institution like the WHO, including a reliable postal service, sufficient working space for employees, ample hotel accommodations for hosting conferences, and an efficient local and international transportation network. Among the major cities in sub-Saharan Africa, this left few viable options.

In order for a headquarters to be established in the Africa region, a location needed to be extended by the member state in which the city was located, and the offer then needed to be accepted by the WHO Executive Council. Because this decision was a complex one with serious political implications, debates about the location of the future headquarters dominated the first meeting of the Regional Committee, held in Geneva in 1951. At the preliminary meeting the South African delegation proposed Kampala, a proposal that both Britain and Rhodesia supported. Knowing that the World Health Organization would never accept Léopoldville, the Belgian delegation proposed Brazzaville, the administrative capital of French Equatorial Africa, just across the Congo River. The French and Portuguese delegations supported the proposal. Finally, the Liberian delegation proposed its own capital, Monrovia, as a possible headquarters, although this suggestion received no support from the other members of the Committee.²⁶

For the Regional Committee, several factors were important to assess in determining whether a city could be considered a viable candidate for the headquarters, including the absence of racial discrimination, a well developed communication and transport infrastructure, the placement of the city within the broader region, the cost of living and availability of housing for WHO employees, the climate, and finally the quality of educational and medical facilities, including those geared towards medical research and laboratory testing. The first criterion—the absence of racial discrimination—was of particular importance to the Liberian delegation, headed by Dr. Joseph Togba. As representatives of the only member state in the Africa region never to have been colonized by a European power, Liberian doctors and government officials were especially sensitive to conditions in colonial territories in Africa and were often hostile to the members states that participated in the CCTA, since Liberia had not been allowed to join. The Liberian delegation thus served as an important counterweight to the goals and opinions of the colonial members within the Regional Committee, reminding the European delegations of the need to take into account the interests of Africans. In one of the debates regarding the placement of the future WHO Africa headquarters, Togba stated:

26 IMTSSA 222, Ministère de la France d’Outre-Mer, Direction du Service de Santé, Rapport du Médecin-Colonel Garcin à Monsieur le Ministre des Affaires Etrangères, Objet: Réunion préparatoire des Gouvernements Africains pour l’Organisation régional de l’Afrique, 5.

In taking a decision in regard to the establishment of a regional organization, the Board should remember that non-self-governing territories might one day be represented in the Organization. A decision should take account of the special interests of Africans themselves. There were still regions in Africa where Africans were not granted equal treatment with Europeans or other races. The Board should therefore instruct the Director-General that the headquarters of an Office for Africa—if established—should be located where Africans would be treated on an equal basis with other races.²⁷

For the Liberian delegation, Monrovia was the clear choice: it was one of two independent states in the Africa region, was accessible from both Europe and the rest of Africa, and according to Togba, had the best track record for human rights among the options put forward. Moreover, since the administration was on site, there would be no need to consult a far-away government, which would allow the Regional Office to save valuable time.²⁸

The second choice for the Liberian delegation—if Monrovia was voted down—was to headquarter the organization in a French territory, although Togba worried about the short distance between Brazzaville and Leopoldville in the Belgian Congo. While Brazzaville fit the WHO's criteria for absence of racial discrimination, Togba worried that WHO employees might seek housing or entertainment across the river, creating a delicate situation for black employees working for the office. Besides its proximity to Leopoldville, however, Brazzaville boasted a well-developed communications network in addition to a favorable placement within the region—easily accessible to all Member States, with ninety flights per week.²⁹ In response to other delegations' concerns that the cost of living in Brazzaville was prohibitively expensive, the French delegation stated that the French government would be willing to promise four furnished apartments to house WHO employees. Dr. Daubenton, the director of the Regional Committee lauded the French for the generous offer, noting that no employee would ever be able to afford housing in Brazzaville at the level of salary offered by the WHO.

A memo from the French Foreign Ministry about living conditions in Brazzaville assured the delegations that the construction of more affordable housing was currently underway. The memo also touted the various scientific facilities that would be available to the new office, including the Pasteur Institute, a new hospital, and a

27 See IMTSSA 238, ONU, OMS, EB8/Min/4, 4 June 1951, Provisional Minutes of the Fourth Meeting, 7.

28 IMTSSA 238, ONU, OMS, AFR/Min/1, 11 juin 1951, Organisation Régionale de l'Afrique, Réunion Préparatoire des Gouvernements Africains, Procès-Verbal Provisoire de la réunion tenue au Palais des Nations, Genève, le lundi 11 juin 1951, à 10 heures, 7.

29 Ibid., 10.

new facility for AEF's mobile health services.³⁰ For many of the delegations, Kampala seemed a better choice when considering the cost of living and accommodation. Kampala also offered superior medical facilities and a climate that many of the representatives thought would be more agreeable to European employees. Dr. Togba, however, spoke out against choosing Kampala, noting that on a previous trip to the city he had been forced to connect in cities where racism was present—Johannesburg and Leopoldville—and that in Kampala medical facilities were segregated.³¹

The ultimate choice of location by the committee was the result of a series of political maneuverings by the different delegations, each trading favors to ensure that at least some of their propositions for the future of the Committee would be passed. Liberia, for example, offered to support the Brazzaville for the headquarters—if Monrovia failed—in exchange for the French delegations vote in support of Dr. Togba for the position of Committee president and of Monrovia as the next site for the Committee's annual meeting. The French won Daubenton over to the Brazzaville camp in return for a promise to support his renewal as Regional Director. When the issue of the headquarters location was finally put to a vote, there were three votes for Brazzaville (France, Belgium, and Portugal), two for Monrovia (Liberia and Spain), and two for Kampala (Great Britain and South Africa). A second round eliminated Monrovia and the final vote went to Brazzaville, with all delegations but the British and the South Africans voting in support of AEF's capital.

Once the committee had settled on Brazzaville as their choice for the site of the future headquarters of the WHO Regional Office for Africa, all that remained was for the French government to extend a formal offer and for the WHO Executive Committee to accept that offer. But French representatives disagreed as to whether it would be wise to allow an international organization like the WHO to set up shop in one of France's African territories and the issue provoked a heated debate between officials in the Ministry of Foreign Affairs and the Ministry of Overseas France. When discussing the possibility of proposing a French territory as the seat of the new organization, certain members of the French administration were of the mind "keep your friends close and your enemies closer," while others warned of the danger of WHO involvement too close one of the major epicenters of France's African empire.

Dr. Georges Garcin, head of the French delegation to the Regional Committee for the first annual meeting, argued that France had a "major interest in the seat of the bureau being established in one of its territories, [since] this organism will be

30 See IMTSSA 238, Memorandum on the Conditions of Establishment in Brazzaville of the World Health Organization's Regional Office For Africa.

31 IMTSSA 238, ONU, OMS, Comité Régional de l'Afrique, Première Session, RC1/AFR/Min/2, 24 septembre 1951, Procès-Verbal Provisoire de la Deuxième Séance, Palais des Nations, Genève, Lundi 24 septembre 1951, à 14 heures. Président: Dr. J.N. TOGBA (Libéria), Vice-Président: Médecin-Colonel G. Garcin (France), 12–14.

called to take on a considerable importance in Africa where Public Health is one of the most essential factors in all matters relating to development.” The downside of establishing the headquarters in French territory, however, were the various charges the French government would incur in setting up the office, as the general budget of the WHO did not cover expenses relating to the installation of regional branches.³² The Ministry of Foreign Affairs, for its part, was a proponent of setting up the WHO Regional Office in Brazzaville, and prior to the first annual meeting sent instructions to the French delegations reminding them that “from the time of your arrival in Geneva, you should rally the other members of the regional committee to our cause...emphasizing the central location and rapid development of this city, as well as the exceptional communications network and lack of racial discrimination.”³³

Some members of the French colonial administration were less than thrilled, however, at the idea of inviting an international organization to establish its regional headquarters in a French territory. Médecin-Général Ambroise Gourvil, from the Direction of Health Services in French Equatorial Africa, explained that the Regional Office would have the potential to become an important forum for opponents of France’s colonial regime and would set a dangerous precedent for international interference in France’s overseas empire. By allowing a WHO Regional Office to install headquarters on French soil, he wrote, ““We are effectively giving the right of extraterritoriality to numerous persons whose comings and goings are beyond our control, who are not necessarily our friends, and will have the ability to create, *sur place*, a political climate unfavorable to French rule.” The result of these complications, according to Gourvil, would be “serious difficulties” for the French administration, “especially for the proper functioning of our Public Health in Africa, whose action depends on a climate of confidence in order to be effective.” He suggested that the Direction de la Santé Publique de l’A.E.F. would find itself in a particularly difficult position. Gourvil suggested in turn that, instead of offering to allow the Regional Office for Africa to install itself on French soil, “to ensure instead its installation as far as possible from any of our territories.”³⁴

In the end the French government decided that the potential benefits of being able to watch over the WHO’s activities from close by outweighed the potential complications that the office posed, and the French administration extended an

32 IMTSSA 222, Ministère de la France d’Outre-Mer, Direction du Service de Santé, Rapport du Médecin-Colonel Garcin à Monsieur le Ministre des Affaires Etrangères, Objet: Réunion préparatoire des Gouvernements Africains pour l’Organisation régionale de l’Afrique, 5–6.

33 IMTSSA 238, Ministère des Affaires Etrangères, Secrétariat des Conférences, no. 1614 SC, Paris le 19 sep 1951, Le Ministre des Affaires Etrangères à Monsieur le Médecin-Colonel Garcin, Chef de la section technique du Service de Santé au Ministère de la France d’Outre-Mer, Objet: Comité régional de l’O.M.S. pour l’Afrique, 1–2.

34 IMTSSA 238, Note pour Monsieur le Directeur des Affaires Politiques, 3ème Bureau, no. 6843, DSS/4, 4 Juil 1951, 1–2.

official offer to house the Regional Office in Brazzaville. The WHO Executive Council accepted the offer and on 23 July 1952 an agreement was signed by Brock Chisholm, the Director-General of the WHO, and by Maurice Schuman, the French Minister of Foreign Affairs. Construction of the Regional Office was slated to begin shortly after. While the signing of the agreement was executed with little trouble, the political drama surrounding the choice of headquarters foreshadowed a decade of conflict between international and colonial forces that would follow the decision to install a branch of the World Health Organization on the African continent.³⁵

With all of the drama surrounding the installation of the regional office, it is perhaps not surprising that questions of health were rarely discussed in the initial gatherings of the WHO Regional Committee. These meetings were often highly political given the need 'to delineate [the WHO's] functions, to determine the way its activities will unfold, and to define its relationship to other technical and regional organizations'.³⁶ This explains why, at a session of the second annual meeting of the WHO Regional Committee for Africa in 1952, the Liberian representative Dr. Togba congratulated the other delegations for having treated all the issues at hand 'as doctors and not as politicians'. The French representatives, in their report to the Ministry of Foreign Affairs, noted the irony of this statement arguing that it was the Liberian delegation that was the first to 'politicize the debates' which they had used to attack those present from colonial governments.³⁷ The Liberians often accused others of forming a colonial clique but France in particular rejoined that this was misleading since all decisions made at the WHO Regional Committee were subject to approval by the General Assembly of the WHO, where they were a small minority pitted against an overwhelmingly anti-colonial majority. As the other colonial delegations were often content to remain silent during the proceedings of the regional sessions, it was easy for the Liberian delegation to designate the French 'heads of a colonial coalition having as its primary goal the reduction of the scope of the Regional Office'.³⁸

35 ANS, 1 H 50 (163), « Accord entre le Gouvernement français et l'Organisation Mondiale de la Santé sur les privilèges et immunités, signé les 23 Juillet et 1er Août 1952 (Région Afrique).

36 IMTSSA 238, Ministère de la France d'Outre-Mer, Direction des Affaires Politiques, 3ème Bureau, Monsieur le Directeur du Service de Santé, Copie d'une note no. 5474 du 17 Juillet 1952, adressée à M. le Directeur du Cabinet a/s 2ème Session du Comité Régional Africain de l'O.M.S.

37 Archives Nationales du Sénégal (ANS), 1 H 50 (163), Compte-Rendu sur la 2ème Session du Comité Régional pour l'Afrique de l'Organisation Mondiale de la Santé (Monrovia, 31 Juillet – 7 Août 1952), 9. The French delegation warned of future trouble in the case that Liberia were to join the CTCA, despite the benefit its participation would have for 'the equilibrium [of the committee]...and a more equitable participation of the African territories.'

38 Ibid., 10.

Some French medical personnel had seen the potential of the WHO regional branch for securing greater resources for health projects, and concerted colonial action within the General Assembly and the Executive Committee to extend the budgetary power of the regional committee was recommended as a strategy.³⁹ However, the overwhelming sense from the archives is of suspicion of the organization on the part of French officials. Liberian attacks at the early meetings only confirmed what French officials had anticipated. In the wake of the second meeting the French delegation advised both the Ministry of Foreign Affairs and the Ministry of Overseas France to proceed with extreme caution in all dealings with the WHO. They noted that none of the colonial governments in Africa could any longer consider themselves 'at home' in the region. Despite their 'immediate knowledge' of local affairs they felt that their expertise was now subordinated to 'an incompetent extra-African majority'. As such the French delegation vowed to adopt a strategy of 'close surveillance' of all WHO activities in the region, with the goal of 'blocking its extension, within the constraints of our limited means'.

* * *

As the colonial powers in Africa felt forced to defend their empires many of the delegates regretted having conceded so much of their imperial autonomy as it was proving to be increasingly difficult to protect the independence that remained. In the French delegation's report on the second annual meeting, they noted that even if the resolutions to delay the installation of a public relations officer and to extend regional control over the budget succeeded, that the 'delegation should not allow itself to be deceived. It would be but a Pyrrhic victory'.⁴⁰ The report continued:

We would like to note that all of our fears about the installation of the WHO in Africa have now been confirmed and to express that we were in fact correct not to cede to the argument of the South Africans, supported by the British, that 'the committee will not be dangerous, it will have almost the same composition as the CTCA. Apart from the participation of Liberia and Spain, *we would be among friends*.' It is clear now that this view was entirely incorrect. The Regional Committee for Africa is not the emanation of the six members of the CTCA plus Liberia, it is the emanation of the sixty-eight nations of the World Health Organization ... We do not represent, within this Committee, the eighth vote, but rather the sixty-eighth.⁴¹

39 Ibid., 13.

40 Ibid., 10.

41 Ibid., 12.

The French had been anxious that the WHO regional office would present challenges both to the independence and the legitimacy of their colonies in Africa. They were quickly proven right, and would continue to rue its creation and to seek to frustrate its operations until the empire ended.

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Settling the Matter on Indian Soil: Frictions between WHO and UNICEF over Vaccination against Tuberculosis, 1947-51¹.

Niels Brimnes

It is seductively easy to portray the first two decades after the Second World War as the period when the WHO and UNICEF in unison took the lead in international health and jointly rolled out a number of initiatives against yaws, malaria and tuberculosis in developing countries. Maggie Black's semi-official account of UNICEF, *The Children and the Nations*, describes these efforts under headlines such as 'A Great Humanitarian Adventure' and 'The Mass Onslaught on Disease'² while Amy Staples lauds the WHO in these decades as 'an international manager in health matters' which, through co-operation with other agencies, was able to extend its influence. In such accounts the relationship between the two organisations is described as one of mutual benefit where they 'shared many of the same operational priorities' and in which UNICEF provided the supplies and the WHO the technical advice and medical personnel.³

To the credit of Maggie Black she does refer at some length to early frictions between WHO and UNICEF. These are described as mainly related to issues of money and 'territory', namely about which organisation was entitled to available funds, and which organisation was in control of the field of 'health' within the UN-system. Black's account suggests that the friction was largely overcome in the service of higher goals, arguing that 'the purpose of the two organisations was to further health among the peoples, the nations and the children, and issues of territory were

1 This article further elaborates and reframes arguments and analyses, which have been presented previously in different forms and contexts. See Niels Brimnes, "Vikings against Tuberculosis. The International Tuberculosis Campaign in India 1948–51", *Bulletin of the History of Medicine*, 81, 2 (2007), 407–430; Niels Brimnes, "BCG vaccination and WHO's global strategy for tuberculosis control 1948–83", *Social Science & Medicine*, 67 (2008), 863–73; Niels Brimnes, *Languished Hopes. Tuberculosis, the State and International Assistance in Twentieth-century India* (New Delhi: Orient Blackswan, 2016).

2 Maggie Black, *The Children and the Nations. The Story of Unicef*, (UNICEF, 1986).

3 Amy L. S. Staples, *The Birth of Development. How the World Bank, Food and Agriculture Organization, And world Health Organization changed the world 1945–65* (Kent: Kent State University Press, 2006), 154–55.

minor compared with the overall good'.⁴ This statement is followed in her work by a description of the seemingly frictionless working relationship mentioned above. Black also touches upon disagreements between the WHO and UNICEF which were not about resources or political power, but were rooted in fundamentally different approaches to international health. This was the difference between, in Black's terminology, 'technical assistance' and 'material assistance', the former focused on the transfer of technology and know-how to build up sustainable health infrastructures in developing countries and the latter being driven by a more immediate concern to supply food, drugs and vaccines.⁵ Given its original status as a temporary emergency fund it is not surprising that UNICEF represented the latter approach, while the WHO saw itself as a provider of 'technical assistance'.

James Gillespie has explored this friction, using the joint efforts of the WHO and UNICEF in maternal and child health as his case-study. He concludes that despite efforts from the WHO to focus efforts on integrating a broader social and public health framework 'the focus remained on providing cheap and effective food supplements'.⁶ A major reason for the triumph of UNICEF's supply-oriented approach was that it, much to the detriment of WHO, inherited ample funds from the UN relief and refugee organisation UNRRA.⁷ In this way Gillespie demonstrates how institutional rivalry over funding and authority had implications for the kind of international health work that actually came to be conducted in the field.

Gillespie refers in passing to the efforts to control tuberculosis as another area where the approaches and interests of WHO and UNICEF collided.⁸ This article takes up the case of tuberculosis, and more specifically BCG vaccination, to further examine the tensions and contradictions between the WHO and UNICEF immediately after the Second World War. First, it shows that the two organisations had different views on the introduction of BCG in global tuberculosis control. The analysis then moves to the extensive and complicated BCG campaign in India, conducted by the Scandinavian vaccination initiative The International Tuberculosis Campaign (ITC). The paper argues that the tension between the WHO and UNICEF impacted on the nature of the campaign so that it became neither a short term demonstration campaign nor a systematic mass vaccination

4 Black, *The Children*, 52–3.

5 Black, *The Children*, 80–1. The term 'technical assistance' is ambiguous; in some contexts it might be taken as referring to assistance, which give priority to technological solutions. To Black the difference is between the transfer of knowledge (technical assistance) and goods (material assistance). For a different use of technical assistance, see Sunil S. Amrith, *Decolonizing International Health. India and Southeast Asia 1930–65* (Basingstoke: Palgrave, 2006).

6 James A Gillespie, "International Organizations and the Problem of Child Health", *DYNAMIS* 23 (2003), 142.

7 Gillespie, "International Organizations", 133–34.

8 Gillespie, "International Organizations", 134.

effort. The article ends with an analysis of a renewed dispute over the position of BCG in tuberculosis control which emerged as the two organisations prepared to take over from the ITC as the major international partners in India's efforts to control tuberculosis. Generally, UNICEF's approach prevailed, suggesting that its greater financial strength was decisive for the nature of anti-tuberculosis work conducted in India and beyond during the 1950s.

Accepting BCG

The way mass vaccination with BCG against tuberculosis became one of the main activities in post-war international health is an early, illustrative example of the power relations between WHO and UNICEF. Prompted by the post-war rise of tuberculosis in Europe the Danish Red Cross, backed and funded by the Danish state, began to vaccinate with BCG in Poland, Hungary and Schleswig-Holstein in the spring of 1947. Later that year sister organisations from Norway and Sweden, together with UNICEF, began negotiations with the Danes about joining the initiative. On March 1948 UNICEF's executive board donated \$4 million to mass BCG vaccination campaigns, stipulating that half of the money must be spent outside Europe. In July The International Tuberculosis Campaign (ITC) was formally established as a joint enterprise between the three Scandinavian organisations and UNICEF. Mass BCG vaccination would become one of the major global health interventions in the first fifteen years after the Second World War.⁹

But BCG was a controversial choice as both the safety and the efficacy of the vaccine was questioned. Developed in the Pasteur institutes by French scientists Calmette and Guérin, BCG was first used on humans as early as 1921. Because it was the first vaccine based on living, attenuated bacteria there was a concern that the vaccine might cause tuberculosis rather than prevent it, and before 1945 its use, at least in western countries, was both cautious and limited.¹⁰ Doubts about the safety of BCG were amplified in 1930 when seventy-six infants died shortly after vaccination in Germany. Investigations established that the deaths were due to an unfortunate mix between the vaccine and unattenuated tuberculosis bacteria, but in the broader public suspicion towards BCG lingered on into the post-war years. By 1947 most experts believed that the vaccine was safe but disagreements over its

9 Brimnes, "Vikings", 409–13.

10 BCG seems to have been much more used in Asia. Between 1926 and 1931 300,000 were given BCG in French Indochina, while nearly 400,000 were vaccinated in Japan during WWII. Laurence Monnais, "Preventive Medicine and 'Mission Civilisatrice'. Uses of the BCG Vaccine in French Colonial Vietnam between the Two World Wars", *International Journal of Asia-Pacific Studies*, 2, no. 1, 2006, 57; William Johnston, *The Modern Epidemic. A History of Tuberculosis in Japan* (Cambridge, MA: Harvard University Press, 1995), 284.

efficacy remained. While advocates of BCG maintained that it provided 80 per cent protection against tuberculosis influential voices, particularly in the United States, doubted that the vaccine had any protective effect at all.¹¹

In this context the WHO was hesitant to endorse the emerging mass vaccination initiative. There were ‘clinical’ reservations linked to the issues of the safety and efficacy of the vaccine, but those at the organisation also wavered because they had a preference for more comprehensive programmes. In August 1947 the WHO’s Expert Committee on Tuberculosis made specific reference to the Scandinavian mass vaccination drive, and while this initiative was approved, it emphasized that the programme should be seen as an emergency measure only and not as a substitute for other more durable approaches. The committee preferred to send out expert teams for short-term periods to demonstrate how to build sustainable, longer-term control programmes.¹² UNICEF did not have similar reservations. Mass vaccination was ideally suited to the needs of a temporary fund with ambitions of becoming permanent as it provided immediate and measurable results. Even if mass vaccination did not have an immediate effect on morbidity, it provided impressive numbers of children vaccinated and comforting narratives about reaching out to the world’s most disadvantaged. Three months later the WHO’s expert committee, possibly concerned about UNICEF taking the bolder initiatives in its core field, assessed BCG more positively but maintained that it should not ‘take the place of other recognized methods of tuberculosis control’. Moreover, the WHO joined the ITC as technical advisor and established a tuberculosis research centre in Copenhagen in an attempt to clear the ‘clinical’ uncertainties of BCG. In July 1948 the first World Health Assembly made BCG an integral part of the organization’s formal policy on tuberculosis control.¹³ In 1949 mass vaccination was in full swing and expanded beyond Europe as the ITC’s large programme in India was launched in February. UNICEF paid for the supplies of vaccine and the WHO provided scientific approval and advice. The reservations of the WHO expert committee faded, but they were not entirely abandoned however. In 1950 it expressed the hope that mass vaccination could ‘stimulate development of all other phases of tuberculosis control’ and expected that the campaigns ‘which had already accomplished so much for tuberculosis control and public health, may be continued

11 Brimnes, “BCG Vaccination”, 864–65. For the origin of the belief that BCG provided 80 per cent protection, see Christian W. McMillen, *Discovering Tuberculosis. A Global History 1900 to the Present* (New Haven: Yale University Press, 2015), 71–83.

12 “Report of the Expert Committee on Tuberculosis”, *Bulletin of the World Health Organization*, 1, 2 (1948), 208, 211.

13 ‘Expert Committee on Tuberculosis. Report of the Second Session’, WHO Archives, IC/TBC/2; Official Records of the WHO, 13, 300. For a useful overview of the official WHO resolutions on tuberculosis, see World Health Organization, *Handbook of Resolutions and Decisions of the World Health Assembly and the Executive Board*, I, Geneva: WHO, 1973), 85–88.

at the same high level of quality and with the same extensive coverage of so many parts of the world'.¹⁴ Their eye was still fixed on the longer-term.

In this way the WHO cautiously embraced mass vaccination, despite continuing controversy about the value of the vaccine and despite reservations about mass vaccination as a manifestation of the quick technological fix. Helped by the independent initiative of the Scandinavians, UNICEF won this contest between a 'horizontal' system-oriented approach and a 'vertical' supply-oriented approach. 'Technical assistance' had lost out to 'material assistance' in tuberculosis control. The WHO was pushed to approve of a tuberculosis strategy which, contrary to its official commitment to the broader social and economic context of disease, focused almost exclusively on vaccination.¹⁵ The pivotal position of ITC director Johannes Holm as both chairman of the WHO expert committee and member of UNICEF's medical sub-committee obviously goes a long way to explaining why WHO came to this position. But the process also suggests that WHO had to 'follow the money' in the UNICEF coffers. As Gillespie has concluded 'the WHO was faced with the choice of developing its own approach to tuberculosis, but with no funding, or reluctantly join UNICEF's as technical adviser, on terms set by the fund'.¹⁶

BCG vaccination in India

The mass vaccination campaign in India was among the most extensive conducted by the ITC. In terms of population reached it was the third largest as only those in Poland and Germany reached more people. Financially the Indian campaign was surpassed only by the programmes in Poland and Yugoslavia (and presumably in Germany, for which no figure is available). Among the campaigns conducted outside Europe it was by far the largest as more than four million Indians received the pre-vaccination tuberculin test and almost a half a million dollars was spent.¹⁷ There was, however, always uncertainty about the nature and duration of the ITC's involvement in India. This might be seen as another manifestation of the friction between the WHO and UNICEF.

14 'Expert Committee on Tuberculosis. Report of the Fourth Session', *WHO Technical Report Series*, 7 (1950), 8; Expert Committee on Tuberculosis. Report of the Fifth Session', *WHO Technical Report Series*, 32 (1951), 9.

15 In the constitution of WHO, 'health' was defined in a strikingly broad way as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. See *The first Ten years of the World Health Organization* (Geneva: WHO, 1958), 459.

16 Gillespie, "International Organizations", 134. Black suggest that the centrality of Holm in both WHO and UNICEF funded ITC was a tactical move on the part of UNICEF to co-opt WHO into supporting BCG mass vaccination. Black, *The Children*, 51.

17 Brimnes, "Vikings", 408.

In accordance with UNICEF priorities the ITC was prepared to vaccinate entire populations in European countries but this was not necessarily possible in large, populous developing countries. In November 1948 the Scandinavian co-ordination committee, the executive body of ITC, discussed this issue at some length. Four days earlier the ITC had entered into an agreement with the Government of India about the introduction of BCG. ITC Director Johannes Holm, who favoured a comprehensive mass campaign approach, noted the need to distinguish between campaigns conducted inside and outside Europe, and emphasized that 'UNICEF exists only for a limited time and cannot commit itself to long-term costs'. In many non-European countries, India being the prime example, the ITC's involvement would, Holm conceded, mainly be 'demonstrations aiming to train a large number of domestic doctors'.¹⁸ This was, it should be noted, close to the 'technical assistance' approach favoured by WHO. The Scandinavian doctors and nurses who began their work in India in early 1949 therefore believed that they were part of a six-month demonstration tour.

It was quickly realised, however, that this was vastly inadequate to make any impact in a country harbouring 15 per cent of the world population.¹⁹ As early as August 1949 the Government of India suggested that the agreement with ITC be extended to two years. Although he was not able to comply with this request Holm readily admitted that conditions in India were exceptional and that 'a campaign in India will have an impact only if mass vaccination is conducted on a colossal scale'.²⁰ In the end ITC remained in India for two and half years. But even with ample funding from UNICEF vaccinating South Asia with BCG was clearly more than the Scandinavians were prepared for, and by 1950 it became clear that ITC was going to withdraw from India. The ITC saw itself as an enterprise responding to an emergency in Europe, and to the UNICEF programme committee Holm explained that the ITC had concluded that elsewhere they were 'not dealing with true emergency situations; instead, it is felt that the work should be planned on a long term basis, proceeding step by step'.²¹ By distancing himself from assisting in long-term efforts to build health services Holm revealed that the ITC was much closer to UNICEF than to the WHO. However, Holm personally was not comfortable with

18 Proceedings of the 'Scandinavian Coordination Committee', 29. November 1948, 11. Private Archive no. 7369, Box 2 (C), Danish National Archives (hereafter DNA). My translation.

19 The population of the Indian Union in 1950 was above 350 million. Kingsley Davies, *The Population of India and Pakistan* (Princeton. Princeton University Press, 1951), 17. See also 'Central Bureau of Health intelligence data', at <http://www.cbhidghs.nic.in/hia2005/1.01.htm>, (accessed 7. December 2015).

20 Proceedings of the 'Scandinavian Coordination Committee', 13. August 1949, 8–9. Private Archive no. 7369, Box 2 (C), DNA. My translation.

21 'Statement by Dr. Johannes Holm for the Programme Committee on 3 November 1949', 1–2. Private Archive no. 7369, Box 2 (D), DNA

the decision to withdraw from India. He deplored that the ITC's work was coming to an end in India, because the organisation had not yet shown 'how a real mass vaccination' could be carried out under the challenging circumstances there.²² The final section of this article reveals how Holm managed to influence the priorities of tuberculosis control in India, even after the ITC left the scene.

Between Demonstration Centres and 'real' mass vaccination

The only and obvious candidates to take over from the ITC in India were the WHO and UNICEF. Although the two organizations had followed ITC's activities closely, the transition was anything but smooth. Disagreements between the WHO on the one hand, and the ITC seconded by UNICEF on the other, over the future design of BCG vaccination materialized during the summer of 1950. Eventually this meant that the ITC, which had planned to withdraw from India by the end of that year, had to extend its activities to the summer of 1951. The problems arose when WHO suggested that the three remaining international vaccination teams be attached to three tuberculosis demonstration centres that would be established with support from WHO and UNICEF in Delhi, Trivandrum and Patna. Their main task would be to train local teams.²³ Establishment of such centres was given high priority in the WHO's general recommendations for tuberculosis control programmes and it was envisaged that each centre 'should undertake the training of basic personnel in all aspects of tuberculosis'.²⁴

The control demonstration centres were a further development of the multipurpose tuberculosis clinic which had occupied centre stage in Indian plans developed before 1947, when comprehensive vaccination campaigns had been a distant possibility. The influential Bhore Committee of 1946 described clinics as an essential link in the institutional framework to be set up to control tuberculosis and envisaged that 'the clinic will form the centre from which both curative and preventive work in tuberculosis will spread into the homes of the people'.²⁵ In 1950 the Delhi tuberculosis clinic, which had been running a relatively successful pre-drug home treatment scheme was upgraded to a tuberculosis control demonstration centre through a donation from WHO and UNICEF. When fully extended the new

22 Proceedings of the 'Scandinavian Coordination Committee', 16. December 1950, 3–4. Private Archive no. 7369, Box 2 (C), DNA. English in original.

23 See for instance T.G. Davies (New Delhi) to Sam Keeny (Bangkok) 27. June 1950. Box CF/RA/BX/FD/1985/T001, folder C0038, UN Archives (UNICEF).

24 "Expert Committee on Tuberculosis. Report on the Fourth Session", *WHO Technical Report Series*, 7 (1950), 12.

25 *Report of the Health Survey and Development Committee* (Calcutta: Government of India Press, 1946), II, 161. See also Brimnes, *Languished Hopes*, 63–65.

centre was to include curative, preventive, and laboratory sections. The preventive section was further divided into inter-related departments, mass radiography and BCG, 'the two modern weapons of tuberculosis control'.²⁶ The tasks of the BCG department were described as follows:

The B.C.G. department, which apart from routine vaccination of contacts and as a general preventive measure in the areas ear-marked for public health control, will initiate a control programme of B.C.G. vaccination to study the efficacy of the methods in a given locality. Further it will be a training ground for technicians in field work, and could undertake investigations in testing and vaccination procedures which will be suitable for Mass Vaccination Programme in the country.²⁷

The essential function of the new centre was described as initiating 'training schemes at the highest modern level, in order that such training may progressively expand and diffuse throughout the country with the ultimate aim of developing a fully integrated efficient national T.B. service'.²⁸ Moreover, the centre was supposed to be the training ground for tuberculosis workers from the entire South East Asian Region of the WHO. Essentially, the WHO was trying to 'claim back' the ideology behind the Indian tuberculosis control effort. Instead of continuing the narrow 'vertical' mass vaccination approach, which was tailor-made to serve UNICEF interests, the WHO insisted that the future belonged to broader, 'horizontally' oriented schemes, of which mass vaccination was only one element.

At a meeting of UNICEF's medical subcommittee in August 1950 in which representatives of the WHO and the ITC participated, it became clear that the WHO was not ready to continue mass BCG vaccination along the lines developed by the Scandinavians. In November a UNICEF liaison officer noted that 'the question [of] ... whether WHO is ready to assume responsibility for the further development of the campaigns remains still unanswered'.²⁹ The ITC saw the situation in a similar light, concluding in December that while UNICEF was interested in continuing mass vaccination according to existing principles 'WHO is not prepared to take over to such a degree'.³⁰

The ITC was not content with the position of the WHO and Holm in particular was upset. He criticized the WHO's plans for mentioning 'BCG teams only in

26 The Tuberculosis Association of India, *Twelfth Annual Report, 1950* (New Delhi, n.d.), appendix XI, "Report on the New Delhi TB Centre", 158.

27 The Tuberculosis Association of India, *Twelfth Annual Report*, 159.

28 The Tuberculosis Association of India, *Twelfth Annual Report*, 159.

29 B. Fraser (Copenhagen) to Karl Borders (New York), 7. September 1950; B. Fraser (Paris) to Karl Borders (New York), 3. November 1950. Both in Box CF/RA/BX/FD/1985/T001, folder C0038, UN Archives (UNICEF).

30 Proceedings of the 'Scandinavian Coordination Committee', 16. December 1950, 4. Private Archive no. 7369, Box 2 (C), DNA. English in original.

connection with the three Indian Tuberculosis Centres to be established and they do not constitute plans either for a mass campaign in the real sense or for demonstration work on a scale such as ITC has been conducting it'.³¹ Holm's protest is not surprising as the WHO plans constituted a challenge to a campaign infrastructure of which he had been one of the main architects. Not surprisingly UNICEF agreed with Holm and the ITC and the former's liaison officer described the WHO plans as a system that did not 'augur well, either for economy or success in general'.³² In October 1950 it seemed that the ITC and UNICEF would lose the contest with WHO, which seemed unprepared to compromise.³³

In the spring of 1951 the issue remained unsettled because the WHO could not proceed without UNICEF funding. UNICEF planned a conference in Bangkok to discuss the fate of BCG vaccination in Asia and the ITC expressed the hope that the WHO would be convinced to actively support a 'real' mass vaccination campaign in India.³⁴ The WHO obstructed the Bangkok conference, so negotiations between the WHO, UNICEF and the ITC took place in New Delhi in March. Holm reiterated that he preferred the training of new BCG teams be done in the field rather than at the demonstration centres and UNICEF's Regional Director, Sam Keeny, pressurised WHO to 'clarify' whether the organisation 'would support an extended mass vaccination scheme in India developed on the existing structure'. He further suggested that the issue of the relation between the campaign and the demonstration centres could be left open. Another UNICEF representative at the meeting was more assertive and hinted that the UNICEF Board 'was not convinced that the money involved in Diagnostic Centres was a good investment because it was their impression that anti-Tuberculosis measures had not been devised on a scale which was economically possible for a country like India to support'. In other words UNICEF did not believe that India could afford the type of programme advocated by WHO and as mass vaccination was cheaper it was preferable. E. J. T. McWeeney from the WHO admitted that the three planned centres were inadequate, but opted for time 'to digest the lessons of the present set up from every possible angle'. Moving fast forward with BCG vaccination was clearly much more urgent for the UNICEF representatives, on whose behalf Keeny urged that the vaccine 'should be pushed

31 Letter from Holm to Dr. Eliot of WHO, quoted in B. Fraser (Copenhagen) to Karl Borders (New York) 26. October 1950. Box CF/RA/BX/PD/1947/T016, folder A137, UN Archives (UNICEF).

32 B. Fraser (Copenhagen) to Karl Borders (New York) 26. October 1950.

33 In November Fraser wrote that Holm appeared to have given up the struggle to save 'his' approach to BCG vaccination. B. Fraser (Paris) to Karl Borders (New York) 3. November 1950.

34 Proceedings of the 'Scandinavian Coordination Committee', 16. December 1950, 4. Private Archive no. 7369, Box 2 (C), DNA. English in original.

forward and it should not be treated by Government as of lesser importance than other TB services'.³⁵

Meanwhile Holm acted in the field. He made a lengthy trip to India in the spring of 1951 during which he attended the March meeting in New Delhi. He saw the main purpose of this trip to determine whether India was ready for mass vaccination. In a report to the co-ordination committee of the ITC he explained: 'Before starting out on this trip, I realized that there were only two alternatives open to ITC either to extend the BCG vaccination to a real mass campaign in India as in the rest of the ITC countries, or to abandon the campaign completely and withdraw from India as soon as possible'.³⁶ During the trip Holm took the opportunity to transform the ITC campaign from demonstrations to travel as widely as possible in India, to localized mass vaccination of entire populations. Chosen for this 'experimental mass vaccination' were the cities of Meerut and Gwalior and the rural areas of Ambala district in the Punjab and Indore in Madhya Pradesh. Seeing that the number of tests and vaccinations went significantly up, Holm was quick to conclude that 'the ITC organization of mass campaigns can be used also in India'.³⁷ There can be little doubt that Holm and the ITC tried their best to ensure that the UNICEF inspired supply oriented approach prevailed.

The disagreement over the future design of the BCG campaign was a third manifestation of the general tension between approaches to international health taken by the WHO and UNICEF. The WHO proposal was an attempt to make BCG vaccination an integral part of a more diversified and less 'vertical' tuberculosis control scheme.³⁸ The ITC and UNICEF, on the other hand, preferred to contain BCG within a single-purpose and focused mass vaccination campaign. Rather than integrating BCG with other tuberculosis control measures, they aimed to vaccinate as many as possible as quickly as possible.

Conclusion

Without knowing the exact outcome of the negotiations in New Delhi in March 1951 it seems clear that in the end the ITC and UNICEF also won this contest. In

35 'Minutes of a meeting held in the UNICEF India Mission House ... on March 21, 1951, to consider the future requirements and organisation of a BCG campaign in India', 3–5. Box CF/RA/BX/PD/1947/T016, folder A137, UN Archives (UNICEF).

36 'Report on Visit to India, February-April 1951', 2. Private Archive no. 7369, Box 4 (F.i/J. Holm), DNA.

37 Brimnes, "Vikings", p. 428

38 'Report of the Meeting of the Medical Subcommittee', 4. January 1950, 4. E/ICEF/R.10. See also 'Report of the Meeting of the Medical Subcommittee', 25–26. August 1950, 9. E/ICEF/R.78. Both in UN Archives (UNICEF).

a report on the three tuberculosis demonstration centres written around 1955 BCG-related activities were only referred to as ‘planned’ and among nearly 900 people trained at the centres before that year only seven were BCG vaccinators.³⁹ By contrast, after the WHO and UNICEF had taken over from the ITC as international partners to the Government of India the BCG vaccination effort developed into the largest vaccination campaign the world had seen. In late 1953 the number of monthly tests surpassed one million and it reached nearly two million in late 1958, by which time one hundred and sixty-one vaccination teams operated throughout India. At times the optimism of the WHO senior medical officer Halfdan Mahler knew no limits. In a report from 1954 he cheered

What most of people denied and a few wishfully hoped has proved to be possible. The past years’ experience has shown that it is a realistic economically and technically proposal to tuberculin test the total young population in India within a five to seven year period and to vaccinate the non-reactors. BCG should therefore, potentially be able to influence the epidemiology of tuberculosis in India.⁴⁰

Mahler’s elation was premature. The campaign ran out of steam in the 1960s and coverage rates became frustratingly low.⁴¹ Later evidence was to raise questions about the efficacy of BCG vaccination altogether, as a large controlled trial in Chingleput in South India conducted from 1968 to 1978 suggested that BCG was in fact worthless as a preventive against pulmonary tuberculosis.⁴² But whatever the eventual outcomes of this massive programme, I have attempted to demonstrate that the campaign was not the result of the congenial cooperation between the WHO and UNICEF. Instead the nature of the efforts to control tuberculosis in India during the 1950s was to a large extent the result of the goals and the immediate financial power of UNICEF overriding the long-term public health strategy of the WHO.

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39 ‘Report on India TB-project UNICEF FEP-32’. Box CF/RA/BX/PD/1962/T009, folder A136, UN Archives (UNICEF).

40 H. Mahler, ‘Quarterly field Report’, 2nd quarter 1954, 25. July 1954, 9. Box CF/RA/BX/PD/1962/T008, folder A123, UN Archives (UNICEF).

41 For the development of BCG vaccination in India after 1960, see Brimnes, *Languished Hopes*, 210–76.

42 For details, see Brimnes, “BCG Vaccination”.

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The IHO as Actor

The case of cannabis and the Single Convention on Narcotic Drugs 1961

James H. Mills

The early years of the CND

The Commission on Narcotic Drugs (CND) was appointed at the first meeting of the United Nations Economic and Social Council in New York in 1946¹ and one of its first actions was to broaden its remit; the Paris Protocol of 1948 brought the wide range of new synthetic drugs that had emerged during the 1940s under existing controls on the advice of the WHO. The Commission did not neglect more longstanding interests, however, and quickly attempted to impose a world-wide monopoly on opium.² This met with some resistance on the part of the world's opium producers and was eventually watered down in the 1953 Protocol on Opium, which never actually came into force.³ The chief concern of the Commission throughout the 1950s was to come up with a simplified system to replace the various treaties devised in the 1920s and 1930s and the Single Convention on Narcotic Drugs of 1961 was eventually to satisfy this ambition.

The confusion and curiosity in international policy circles about cannabis in the inter-War period was replicated early in the 1950s. The sub-Committee on Cannabis established by the League of Nations in the 1930s had petered out due to the outbreak of hostilities.⁴ During its six years of collecting information and opinions the sub-Committee only managed to conclude that 'certain points still require clarification, especially in connection with the physiological and psychological and psychopathic effects of cannabis and with the relationships between hashish

1 British Library (BL), UN Documents Collection (UN), E/34 27th February 1946.

2 *The UN and Narcotic Drugs: Half a century of successful struggle against crime, disease and social affliction*, (New York, 1960), pp. 12–17.

3 A. Lande, "The Single Convention on Narcotic Drugs, 1961", *International Organization*, 16, (1962), 782.

4 See chapter 2 of J. Mills, *Cannabis Nation: Control and consumption in Britain, 1928–2008*, (Oxford, 2012).

addiction and insanity and between cannabis addiction and addiction to other drugs especially heroin'.⁵ Perhaps because so little progress had been made in the 1930s towards a clear and agreed approach to the drug, the issue of cannabis remained largely neglected at the United Nations in its early years. The Progress Report on the Work of the Division of Narcotic Drugs for the period between May 1949 and March 1950 noted that 'the Division's preoccupations with the many matters with which the present report deals, coupled with the absence of its officials on missions, have made it impossible to give the studies on cannabis as much attention as would have been desirable'. It noted that Professor Bouquet, who had sat on the sub-Committee on Cannabis in the 1930s, had been contacted by the Division and that it had also been at pains to collect much of the information of the previous decade on the chemical nature of cannabis. It also noted a recent report in the *Lancet* on withdrawal symptoms in Cannabis addicts. However, it gave the sense that matters related to the drug were proceeding much as they had in the 1930s, at a leisurely pace in which the collection of information seemed to be the central objective.⁶

The Secretary-General of the United Nations quickly changed the pace of action on cannabis with the first draft of the proposed single convention on narcotic drugs which was unveiled in 1950. It had been agreed that his office should prepare this to get the ball rolling on the process of agreeing a single convention.⁷ When the Secretariat presented its ideas on 27th February 1950 the proposals for cannabis were radical. Two alternative approaches to the substance were on offer. Both assumed that recreational consumption was bad and ought to be rigorously discouraged. However, the first alternative also worked on the assumption that cannabis had no legitimate medical use that could not be met by other 'less dangerous substances'. It proposed that the production of Indian hemp be entirely prohibited save for those small amounts necessary for scientific experimentation.

The second alternative worked on the assumption that cannabis did have legitimate medical uses. In this case each national state would have to establish a monopoly which had the exclusive right to produce cannabis and trade in it. Each government would be expected to select from a range of measures to ensure that no cannabis leaked out of the system into 'illicit traffic', measures that included starting state-run cannabis farms and the systematic uprooting of wild plants. In countries

5 British Library (BL), League of Nations Collection (LN), Advisory Committee on Traffic in Opium and other Dangerous Drugs (AC), S.P.R. Mic. B 23/12, C.237.M.136.1938.XI. AC, report to the council on the work of the twenty-third session June 7th to June 24th 1938, pp. 9 and 26–27.

6 BL, United Nations collection (UN), E/CN.7/196. UN Economic and Social Council 21st June 1950, Progress report on the work of the division of narcotic drugs for the period 16th May 1949 to 31st March 1950, p. 43.

7 BL, UN, E/1673. UN Economic and Social Council 27th April 1950, Procedure regarding draft single convention on narcotic drugs, p. 1.

where there was significant consumption of cannabis products for recreational purposes, it was proposed that ‘a reservation’ be made that allowed the continued production of cannabis for this market. However, this was on the strict condition that this reservation would ‘cease to be effective unless renewed by annual notification made to this effect and accompanied by a description of the progress in the preceding year towards the abolition of such non-medical use and by an explanation of the continued reasons for the temporary retention of such use’.⁸ In other words, the starting-point for discussions had cut through the patient dithering over voluminous and contradictory evidence which had marked the League of Nations approach and that of the early United Nations. It boldly asserted that all non-medical consumption of cannabis was harmful and proposed that countries where recreational use was common should be obliged to tackle the habit among their people. Indeed, the possibility that cannabis was entirely useless as a medicine had also been formally recognised in the draft treaty, although only as an option. This draft was considered at the 5th session of the Commission on Narcotic Drugs at New York on Friday December 1st 1950.

It is not difficult to explain why this firm stance on cannabis was taken as William McAllister has argued that an ‘inner circle’ of control-advocates was in the ascendant at the UN in the late 1940s and early 1950s and was determined to set a ‘radical’ agenda on questions related to narcotics.⁹ However, the report of the 5th session of the Commission on Narcotic Drugs which discussed the draft convention shows that national delegates did not immediately agree on which of the two options to back, ‘many members of the Commission thought that Indian hemp drugs have no medical value and, consequently, expressed themselves in favour of the first alternative ... other members did not share this view and gave preference to the second alternative’. The records of this meeting show that the representative of the USSR took the initiative to secure the first alternative which was for total prohibition. He was supported by Egypt, Turkey and Mexico among others but France and the Netherlands were chief among those that resisted. The latter argued that it preferred to leave to its physicians the freedom to choose between medicines, and so therefore favoured control rather than prohibition. The former was also concerned about prohibiting a therapeutic which was currently recommended by the French Academy of Medicine. Iran and India voiced their opinion that ‘the question should be thoroughly studied before any decision was taken’ and the representative of the USA concurred.¹⁰ The attempt to take decisive action on cannabis by the

8 BL, UN, E/CN.7/AC.3/3. Draft of the Single Convention, 27th February 1950, pp. 32–35.

9 W. McAllister, *Drug Diplomacy in the twentieth-century: An international history*, (London, 2000), pp. 156–157.

10 BL, UN, E/CN.7/SR.117. Commission on Narcotic Drugs Fifth Session Summary Record of the Hundred and Seventeenth Meeting 10th December 1950, pp. 7–9.

Secretariat stalled, as the Commission concluded that before agreement was likely, 'it would be necessary to undertake more studies in order to determine whether the control measures proposed in the second version of Section 33 or any other measures would, in practice, prove effective'.¹¹ Indeed, the misgiving that 'a rigid limitation of the use of drugs under control to exclusively medical and scientific needs does not sufficiently take into consideration long established customs and traditions which persist in particular in territories of the Middle and Far East and which it is impossible to abolish by a simple degree of prohibition' seemed to suggest that even the attempt to impose consensus on recreational, non-medical use was to be challenged.¹²

With the issue of cannabis once again deferred for more information, the Secretary-General of the Commission on Narcotic Drugs wearily reported in 1953 that 'there are a number of major difficulties inherent in the problem of Indian hemp which makes it very hard to decide what measures would be most effective in leading to its solution'.¹³ It noted among these the lack of agreement on its medical value, the traditions of recreational and ritual use in parts of the world, the industrial use of the plant and its ready availability in wild and remote areas. The Secretariat proposed a number of new studies and it is interesting to glimpse the ways in which the Secretariat's call for more information carried within it a presumption about the outcome of this gathering process. The Secretary-General's note was prepared for the consideration of the Commission as follows:

The Commission may wish to give the Secretariat instructions on the scope of these studies and to formulate more precisely the subject-matter which they should include. It is thought that the studies fall naturally into two categories as follows:

1. Those that address themselves to the factual situation;
2. Those that aim at evaluating and interpreting that situation with a view to adjusting the present control regime for Indian hemp which has become outmoded by changing circumstances to present day condition.

So that everyone was clear that the 'present day condition' was an unhappy one, the Secretariat included in its note a couple of statements. It began with the observation that seizures in 1951 were over ten times that of 1945. The UK was then used as an example of a country that was experiencing 'increased use of Indian hemp as a pleasure drug' and the government's report to the UN was quoted as showing 'there

11 BL, UN, E/CN.7/216. Report of the Commission on Narcotic Drugs (Fifth Session), p. 38.

12 Ibid., p. 25.

13 BL, UN, E/CN.7/256. The Problem of Indian Hemp, Note by the Secretary-General 19th March 1953, p. 3.

has been a considerable increase in the traffic in Indian hemp in recent years, so that this drug now accounts for more than half the seizures made by H.M. Customs'. This was a particularly selective reading of the cannabis situation in the UK at this time, as Home Office officials had observed in an internal review of 1952 that 'the picture is as before, a small drug problem kept within narrow bounds by a rigid system of control ... there is still no sign of a widespread, organised traffic, of violent crime arising from the habit, or of the white inhabitants taking to the habit to any degree'.¹⁴ Indeed, at the next meeting of the Commission the UK delegate made a point of protesting that 'the smoking of Indian hemp was still a new and relatively minor problem in his country'.¹⁵ Nevertheless, the selective reading of the situation in the UK, when taken together with the tone of the Secretariat's note, leaves the impression that the proposal to seek more information about cannabis was not driven by a sense that the issue was an open one, but rather was based on a feeling that more evidence was needed for the prosecution. The Secretariat's proposed call for information was approved by the Commission at its meeting in 1953, which was particularly keen for data on the 'physical and mental effects of the use of Indian hemp' and which agreed that the term 'cannabis' ought to replace Indian hemp in all future discussions and regulations.¹⁶

In gathering the research on cannabis the Secretariat decided to target countries where cannabis use was common. The WHO was given the responsibility of tackling the survey of the physical and mental health issues. This recognised the previous efforts of the WHO's Expert Committee on Habit Forming Drugs to cut through the confusion on cannabis. Established in 1949, this Committee met for only five days in that year and for the same in 1950 and 1952 before declaring that

It was of opinion that cannabis preparations are practically obsolete. So far as it can see, there is no justification for the medical use of cannabis preparations.¹⁷

The vice-Chair of the 1952 meeting was R.N. Chopra, the expert who had represented British India at the League of Nations meetings before the Second World War and who now represented independent India as the Director of the Drug

¹⁴ UK National Archives (NA), Home Office (HO) 45/24948. Note by J.H. Walker, 3rd July 1952. It is worth noting that the only other evidence of an urgent problem with cannabis consumption produced by the Secretariat in its report was the annual reports of the USA for 1936 and 1937 and P. Wolff's book *Marihuana in Latin America: The threat it constitutes* (Washington, 1949). The reliability of this volume was called into question at the trial of Backary Manneh discussed in chapter 3 of Mills, *Cannabis Nation*.

¹⁵ BL, UN, E/CN.7/262. Commission on Narcotic Drugs Report of the Eight Session, p. 16.

¹⁶ BL, UN, E/CN.7/276. The Problem of Cannabis, Note by the Secretary-General 22nd March 1954, p. 1.

¹⁷ Expert Committee on Drugs Liable To Produce Addiction, Third Report (Geneva: WHO Technical Report Series no. 57, 1952), p. 11.

Research Laboratory at Srinagar in Kashmir. Among the other members was the British expert J.R. Nicholls of the Government Laboratory in London and the American, N.B. Eddy of the National Institutes of Health in Bethesda. This group had provided a clear and definitive position on the therapeutic use of cannabis, and this was as negative as could be. It was also on the advice of this committee that the term 'cannabis' came to replace 'Indian hemp' in UN discussions and regulations.¹⁸

The Commission returned to the issue of cannabis on 22nd April 1954 as the Secretariat was keen to draw attention to the WHO's 'clear-cut position in the matter [that] there was no justification for the medical use of cannabis preparations'. The representative of the Secretariat did concede that preparations of the plant remained in the pharmacopoeia of a number of countries, but was quick to confirm that it was not mentioned in many others. The WHO representative at the meeting piped up to point out that presence in the pharmacopoeia was not evidence of actual usage.¹⁹ He reiterated that 'from a medical point of view it could be said that cannabis preparations no longer served any useful purpose'. The British representative returned to the issue of corn plasters that had haunted the country's position on cannabis since the 1920s, before Harry Anslinger²⁰ of the USA made his nation's position plain 'stocks held by pharmacies in the United States had been turned over to the public authorities upon enactment of the Cannabis Tax Act. Cannabis was no longer used in the country'. It only remained for Mr Yates of the Secretariat to confirm that he agreed with the WHO representative that for all practical purposes cannabis preparations were no longer necessary. The mention in various pharmacopoeia showed, however, that there was still a residual situation to clear up, including the use of cannabis for veterinary purposes.

The Chairman, the French representative, proposed that a resolution be drawn up to recognise the emerging consensus at the Commission that cannabis had no legitimate medical use. Those present endorsed the proposal. The Commission now had a clear position on the medical use of cannabis which it had taken straight from the WHO's work in the previous year. It was a position taken by the Commission without any clear sense of what evidence the WHO had used, and without recourse to any scientific data of its own.²¹

South Africa was the first to respond to the Secretariat's earlier call for more information from countries where cannabis use was common. It sent in an extended

18 BL, UN, E/CN.7/262. Commission on Narcotic Drugs Report of the Eight Session, p. 16.

19 The WHO representative was Pablo Osvaldo Wolff. See footnote 14.

20 Anslinger remains a controversial figure in the history of drugs. See McAllister, *Drug Diplomacy*, p. 89.

21 This account taken from BL, UN E/CN.7/SR231 Commission on Narcotic Drugs Summary of the 231st Meeting on 22nd April 1954, pp. 5–6.

version of a report it had previously submitted in 1952 to the WHO.²² The authorities in South Africa had a long history that stretched back into the nineteenth century of concern about cannabis consumption among both the Asian and African communities there. Indeed, it was a report from the Union of South Africa in 1923 that had placed cannabis for the first time on the League of Nations drug control agenda.²³ As such it was not surprising to find that their position was a negative one. Delegates at the meeting who discussed the document were especially struck by reports of cannabis users who were as young as seven, and by the fact that a staggering two hundred and twenty-nine tons of cannabis had been seized in 1952. Harry Anslinger launched into an attack on the South African government for being too lenient in its approach, claiming that ‘it was regrettable that the police did not pay more attention to drug addiction and illicit traffic and that there was not a special narcotics police division in the Union’. This despite the fact that eighteen thousand prosecutions for cannabis offences had been made there in 1952. Only the Indian delegate was intrigued by reports of use of preparations of the plant in South Africa’s indigenous medical systems and he asked for more information about consumption of the drug there at social and ceremonial occasions.²⁴

Cannabis and non-Western medicines

When the Commission met in 1955 it was greeted with new evidence on cannabis from the WHO and others. The Greek representative submitted a statement to the Commission on the question of cannabis that included the following assertions; ‘there is a relation between the degree of unemployment and the use of charas, especially in the case of the eastern peoples’ and ‘apart from the permanent disturbance of their mental faculties, charas users have a propensity to crime and rapidly become dangerous criminals’.²⁵ He included no evidence to support his statements and provided no evidence of citations to studies that had formed his position. His document was accompanied by something rather more significant. The WHO submitted its definitive statement on The Physical and Mental Effects of Cannabis for consideration. It was authored by Pablo Osvaldo Wolff, a former Secretary of the Expert Committee on Addiction Producing Drugs of the WHO. It

22 Union of South Africa, Report of the Inter-Departmental Committee on the Abuse of Dagga (Pretoria: Government Printer, 1952).

23 See J. Mills, *Cannabis Britannica: Empire, trade and prohibition 1800–1928*, (Oxford, 2003), pp. 160–2.

24 This account taken from BL, UN, E/CN.7/SR231. Commission on Narcotic Drugs Summary of the 231st Meeting on 22nd April 1954, pp. 7–12.

25 BL, UN, E.CN/7/L.92. The Question of Cannabis, Note by the representative of Greece.

was damning in its revelations and in its tone, and drew on over fifty publications and scientific papers to support its argument. He was scarcely interested in its physical effects, referring readers to previous publications by Bouquet that made it clear that ‘among cannabis smokers diseases of the respiratory tract are frequent, bilharsiasis and circulatory as well as alimentary diseases become refractory etc’. It was with its mental effects that he was most concerned. He ranged widely across the work of others and lifted their observations on varied conditions such as ‘transitory intoxication’, ‘mania from hasheesh’, ‘acute psychosis associated with the withdrawal of cannabis indica from addicts’ or ‘a certain link between chronic cannabis consumption and the atypical schizophrenic picture’. He made it clear that he had no time for those who would ‘minimise the importance of smoking marihuana’. As such he went beyond his remit to outline the social impacts of cannabis use, quoting reports from Greece, South Africa, Puerto Rico and Mexico which insisted that ‘cannabis apparently brings to the surface of the subconscious vices and tendencies which have been submerged by education and environment’.

As these reports were thin on actual examples and instances, Wolff drew on his collection of ‘clippings from newspapers from South American countries which suffer particularly from the consequences of marihuana abuse, and which the writer has been collecting for years’. Clearly conscious of how tenuous this looked, he was forced to admit that these were ‘somewhat sensational’ in character, but he made a point of insisting that the recurrence of such stories, as well as the police statements referred to within them ‘show that there must be much truth in them’. Having done this, he did not hesitate to select the most startling of the stories, including a case where the murder of a petrol station attendant by a group of sixteen year olds had been blamed on their cannabis consumption. Despite acknowledging the weakness of such evidence he left colleagues in no doubt about the ‘criminogenic influence of the cannabis resin’ and he concluded that ‘cannabis constitutes a dangerous drug from every point of view, whether physical, mental, social or criminological’.²⁶

The document is remarkable in its relentless insistence on that conclusion. Various criticisms have been made of the report and of the author. His reliance on data from newspapers was regarded as sufficient to dismiss his views by a British doctor in a court of law who was asked to comment on his conclusions at a murder trial in the early 1950s.²⁷ At least some of the work that he refers to is problematic, not least of all that by Anslinger, and by Warnock.²⁸ Whatever the shortcomings of

26 BL, WHO/APD/56. The Physical and Mental Effects of Cannabis, Additional Study, 17th March 1955, p. 32.

27 See chapter 3 of Mills, *Cannabis Nation*.

28 See R. Bonnie and C. Whitebread, *The Marihuana Conviction: a history of marihuana prohibition in the United States*, (Charlottesville, 1974), pp. 154–174; J. Mills, “Colonial Africa and the international politics of cannabis: Egypt, South Africa and the origins of global control” in J.

Wolff's WHO document, it is important for this study as it shows that by the middle of the 1950s it was opponents of cannabis use who had control of its agenda, however outlandish their statements and dubious their evidence. When the Commission turned to the WHO for a definitive expert position from the medical authorities, it received a statement from one of most firmly established critics of the drug of the period. Mr Yates of the Secretariat commended Wolff's report to the Commission as he felt that it 'embodied not only a statement of the facts, but also a number of critical evaluations'.²⁹ The Chair of the Commission, the French representative Charles Vaille, and Harry Anslinger were careful to publicly record their appreciation of Wolff's efforts. It was agreed that his account should be forwarded with the report of the Commission to its parent body, the UN's Economic and Social Council.³⁰

The Commission had endorsed the WHO's position in 1954 that 'from a medical point of view it could be said that cannabis preparations no longer served any useful purpose'. With Wolff's report from the WHO at hand in 1955 the Secretariat was finally able to move the Commission to accept the first alternative of the draft single convention on cannabis that had been presented in 1950. Based on the premise that cannabis had no legitimate medical use that could not be met by other 'less dangerous substances', the Commission approved the proposal that the production of the plant for purposes of manufacturing drugs should be entirely prohibited save for those small amounts necessary for scientific experimentation.³¹

That was not quite the whole story, however, as the agreement included controversial exceptions for India. In 1955 that country's representative had arrived at the meeting to declare that

his Government was unable at present to comply with [the] Council resolution ... as cannabis was used in both the unani and ayurvedic systems of indigenous medicine, by which a very large proportion of the Indian population was treated. Unless the possibility of discontinuing the use of cannabis in these systems had been studied by the Indian medical faculties- and there had not been sufficient time for this since the Council issued its recommendation- immediate implementation of the recommendation was not possible. He wondered whether the World Health

H. Mills and P. Barton, eds, *Drugs and Empires: Essays in modern imperialism and intoxication, c. 1500-c. 1930*, (Basingstok 2007), pp. 178–182.

29 BL, UN, E/CN.7/SR 266. Commission on Narcotic Drugs Tenth Session Summary of the Two Hundred and Sixty-Sixth Meeting 20th April 1955, p. 14.

30 BL, UN, E/CN.7/SR 267. Commission on Narcotic Drugs Tenth Session Summary of the Two Hundred and Sixty-Seventh Meeting 21st April 1955, p. 4.

31 Commission on Narcotic Drugs, Report of the tenth session, (New York 1955), p. 12.

Organization or any other expert body had given consideration to the question of the utilization of cannabis in indigenous systems of medicine.³²

The WHO's representative was caught on the hop. He replied that 'he was unable to state the position of his organization with regard to the use of cannabis in indigenous medicine' and contented himself by repeating the doctrine that 'cannabis should be abolished from all legitimate medical practice'. The Indian delegation insisted that the use of cannabis in non-Western systems of medicine should be acknowledged as legitimate and that exceptions would be required to allow for this. This position echoed that of the delegation's British predecessors at the Hague Opium Conference in 1924/5. Any agreement on cannabis would have to work around south Asia's long experience of using preparations of the plant.³³

The Indian effort to have practices in south Asia validated by the UN caused consternation. The Yugoslavian representative was worried about the effect of entering reservations, and the Mexican delegate insisted that 'his delegation in principle favoured total prohibition' as he was anxious that 'the danger that production permitted in exceptional cases might be exported to other countries must be avoided'. The representative of the USA was adamant that Asian therapeutic traditions should be dismissed as 'quasi-medical uses'. This provoked a fierce rebuke from Saldanha of the Government of India;

Indigenous systems of medicine such as the Ayurvedic and Unani systems which had been in existence in India on an organized basis for hundreds of years, and on which large sections of the population continue to depend for medical treatment, were just as much entitled to be called medical, and not quasi-medical, as the allopathic and homeopathic systems were. They did not become quasi-medical merely because they were not Western systems.³⁴

Eventually the Government of India succeeded in forcing the UN to recognise as legitimate the production of cannabis for non-Western medical systems. In 1957 'the Commission adopted a compromise proposal whereby the abolition of the medical use of these substances, except in three indigenous medical systems- the Ayurvedic, Unani and Tibbi systems, was recommended to Governments'.³⁵ This was a significant achievement. The Indian delegates had frustrated the efforts of the Secretariat and the WHO to declare that cannabis was of no medical value

32 BL, UN, E/CN.7/SR 267. Commission on Narcotic Drugs Tenth Session Summary of the Two Hundred and Sixty-Seventh Meeting 21st April 1955, p. 6.

33 See Mills, *Cannabis Britannica*, p. 174

34 BL, UN, E/CN.7/SR 270. Commission on Narcotic Drugs Tenth Session Summary of the Two Hundred and Seventieth Meeting 22nd April 1955, pp. 3–5.

35 BL, UN, E/CN.7/333. Report to the Economic and Social Council on the twelfth session of the Commission on Narcotic Drugs, p. 81.

whatsoever. It had also challenged the hegemonic assumptions of the Western-trained doctors of the WHO about the legitimacy of south Asian medical systems. It should be emphasised, however, that it was the interests of ‘large firms which produced indigenous medicines’³⁶ that were being protected in India rather than those of the humble bazaar herbalist.

By 1957 the Commission had also moved on to consider the surveys of the cannabis situation that had been commissioned by the WHO back in 1953 and which had focused on the most important centres of consumption such as South Africa, India, Brazil and Morocco.³⁷ Each of these reports conformed to a set format, so that data was collected from different contexts in order to be readily compared. The first set of questions related to the plant itself, the second to the industrial outputs from the plant. The third looked at the legal uses to which psycho-active preparations were put, the fourth to any international trade in cannabis plants, the fifth to medicinal use which was followed by details of non-medical use. The rest of the questionnaire focused on matters relating to illegal traffic, including surveillance and police measures. The surveys were designed to give a sense of what the existing legitimate interests were in the plant, and of the difficulties that were being experienced in controlling its illegitimate use.

As such most of the reports simply repeated the common mantra that possession and consumption of cannabis were illegal, that the police worked hard to arrest consumers and peddlers, and that traffic in the drug was troublesome. For example, the report from Brazil noted that ‘cultivation of the cannabis plant is most prevalent in the northern and northeastern parts of the country’ and that the traffic flowed from ‘the backlander who cultivates the cannabis plant through the middleman to the ultimate users ... Braganca, a city in Northern Brazil ... is one of the largest centres of the cannabis traffic in that part of the country’. It assured readers that ‘as the State and Federal authorities are fully aware of the existence of the illicit traffic in and use of cannabis in Brazil and as they know the places where these mainly occur, their concerted drive against the spread of the traffic in and use of the drug has not slackened’. However, the report was forced to admit that such was the extent of consumption that it was ‘not possible to give even a rough estimate of the number of maconha smokers in Brazil’.³⁸ The report from Southern Rhodesia similarly intoned that ‘police patrol all native areas regularly, and any cannabis plants are

36 BL, UN, E/CN.7/SR.286, p. 12.

37 By 1960 replies were circulated from the Union of South Africa, Basutoland, Bechuanaland, Swaziland, Northern Rhodesia, Southern Rhodesia, Brazil, Angola, Mozambique, Morocco, India, Pakistan, Italy, Egypt, Costa Rica, Burma, Lebanon, Mexico, USA, Jamaica, Cuba, the Dominican Republic, Haiti and Greece.

38 BL, UN, E/CN.7/286/Add.8. Survey of the situation in Brazil, 19th April 1955, pp. 8–17.

destroyed and the grower prosecuted'³⁹ and at the opposite end of the continent, the authorities lamented that 'at one time packets of kif were found in family parcels sent to Moroccan soldiers serving in Europe by their families'.⁴⁰ These glimpses of obstinate consumers and persistent markets suggest that there was ongoing resistance to, or ignorance of, attempts to prohibit use of a favourite intoxicant in many parts of the world;

Group smoking is general ... the pleasure seems to lie not only in the use of the drug but also in the collective euphoria it produces. This they smoke in cafes, sometimes in a private house, very often on a small shopkeeper's premises. This small shopkeeper is very often a barber or tailor. The master craftsman smokes with his staff or forms groups with his customers, to whom, it is said, he gives the drug and equipment free of charge solely for the pleasure of smoking in company ... kif addicts only incur the half-hearted disapproval of the healthy members of the population. The fact that the use of kif is so widespread and taken for granted most certainly influences their views: a practice as common and as widely tolerated as this could not be regarded as a very serious offence or the drug a very harmful product.⁴¹

While the above report from French Morocco pointed to the place of cannabis consumption in the routine social life of the region, the survey of Brazil identified the place of the drugs in the country's cultural practices,

In Alagoas the drug is used during sambas and batuques, dances introduced by Negroes: it is also consumed by those who *porfiam na colcheia* i.e. contend with semi-breves, which among country folk is a rhymed and sung dialogue in which each reply (usually in quatrains) begins with the challenger's cue or last words. It is claimed that the cannabis gives contestants great inspiration and facility in rhyming and leads them to issue the challenges for the *desafio* or poetic duel.⁴²

This contrasted somewhat with the picture in Southern Rhodesia where 'it was used before going into battle, and more recently before hunting expeditions and sporting events'.⁴³ Similar applications were encountered in India where it 'is still sometimes used by contestants in wrestling contests and other athletic sports as well as in games requiring great effort and endurance'. In that country it was reported 'that to meet

39 BL, UN, E/CN.7/286 Add.7. Survey of the situation in Southern Rhodesia, 30th March 1955, p. 4.

40 BL, UN, E/CN.7/286/Add.11. The cannabis situation in the Scherifian Empire (French Zone), 20th April 1956, p. 12.

41 Ibid., pp. 10–11.

42 BL, UN, E/CN.7/286/Add.8. Survey of the situation in Brazil, 19th April 1955, p. 14.

43 BL, UN, E/CN.7/286 Add.7. Survey of the situation in Southern Rhodesia, 30th March 1955, p. 9.

a man carrying bhang was regarded as an omen of success; similarly to think of the cannabis plant in a dream was considered lucky'. This was because the cannabis plant was represented in Hindu holy texts as sacred.⁴⁴ Such glimpses add to the sense that the picture presented in these reports was of a police problem rather than a social problem. In other words, the regulations on cannabis since the 1920s had imposed a new set of obligations on the authorities rather than it being the case that the behaviour of cannabis consumers had forced officials to act. Poetry contests, folk dances, sporting events and afternoon gatherings at the local shop hardly look like the stuff of social mayhem given the wider history of the 1950s. Needless to say none of these glimpses of routine cannabis consumption were singled out for discussion by the Commission. Delegates had reports from eighteen countries in front of them and lingered for little more than an hour and a half in chewing them over. Much of this limited deliberation was taken up by the Indian delegate's report on a meeting in his country of that year and some excitement about mixtures of hashish and chocolate available in Arab countries.

That the glimpses of routine users of cannabis engaged in harmless activities were not discussed and were disregarded as evidence may well be down to another of the documents that accompanied the national surveys for consideration in 1957. The Secretariat presented its summary of where the Commission had reached on cannabis as it entered the final phase of re-drafting the Single Convention. It quoted Wolff's conclusion that cannabis drugs were dangerous from 'every point of view' and added its own assertion that 'they are used for euphoric purposes in many parts of the world where their consumption constitutes a traditional and widespread habit and often a serious social evil'.⁴⁵ The same report was forced to admit that

While cannabis drugs are addiction producing within the meaning of this term as defined by the WHO, it is agreed that they do not cause physical dependence in the same way as morphine, i.e. that there are no physical abstinence symptoms equivalent to those which occur in the case of withdrawal of morphine

The issue of addiction was yet to be discussed by the Commission and as such it recommended that further attention be paid to the 'special character of addiction to cannabis drugs'. The only reference to this point in the Commission's thoughts on their report was the observation by Harry Anslinger that 'medical officials of the United States Air Force had held that, contrary to the assertion ... cannabis caused

⁴⁴ BL, UN, E/CN.7/286 Add.12. Survey of the situation in India, 30th April 1956, pp. 26–29.

⁴⁵ BL, UN, E/CN.7/324. The Question of Cannabis, Note by the Secretary-General, 26th April 1957, p. 11.

physical dependence'. He had to acknowledge, however, that 'their theory had been challenged'.⁴⁶

Cannabis and the Single Convention

The uneasy consensus on the medical obsolescence of cannabis that the WHO and colleagues in the UN had worked so hard to establish in the 1950s faced a final challenge late in the decade, this time from the microbial world. British delegates, together with those from the US, Canada and France, tabled a draft resolution in April 1959 which pointed to recent reports of the antibiotic properties of certain extracts of the cannabis plant. They were mindful of the fact that these antibiotic properties could undermine the WHO's insistence that cannabis was no longer a useful source of medicine and therefore requested the organisation to prepare an account of antibiotic properties in cannabis as a matter of urgency.⁴⁷ The French delegate acted as a spokesman for the group that had introduced the resolution and he asserted that new techniques, such as ionising radiation, meant that cannabis might now be used to produce useful drugs. He pointed to reports of experiments in Hungary which suggested that cannabis was the source of substances that were effective against staphylococcus aureus and various gram-positive bacilli. The American delegate was insistent that 'the door should not be closed to further research on any natural material which might be of use to the medical profession' and in a rare show of unity the USSR and China supported the draft resolution of the US, the UK, Canada and France, as did others including India and Iran.

While governments such as the US and the USSR had been entirely convinced that the plant had no legitimate medical uses throughout the 1950s it is striking that the mention of antibiotics had rapidly caused them to reconsider. This was because, since the development of mass production techniques for penicillin in the 1940s, such products had been widely regarded as the wonder-drugs of their generation which were capable of controlling an array of infectious diseases for the first time. The economic and political power that such control could confer was highly attractive to national governments and the development of new and improved pharmaceutical products, particularly antibiotics, was high on the scientific agendas of many modern states in this period.⁴⁸ This context explains the readiness of so many nations to back the draft resolution asking the WHO to investigate reports of antibiotic properties in cannabis more closely.

46 BL, UN, E/CN.7/SR.342. Commission on Narcotic Drugs Twelfth Session Summary of the Three Hundred and Forty-Second Meeting, 6th May 1957, p. 5.

47 BL, UN, E/CN.7/L.212. The Question of Cannabis, 30th April 1959.

48 For more on the origins and impact of antibiotics in this period see R. Bud, *Penicillin: Triumph and Tragedy*, (Oxford, 2007).

The WHO response to this sudden show of unity on the part of the Commission's members reads as one of piqued professional pride. Dr Halbach, the representative of the organisation at the Commission, blustered that 'he was convinced that the Expert Committee's statement on the obsolescence [sic] of cannabis as a therapeutic agent would remain unchanged' and pointedly asserted that 'it was not easy to imagine, in the present state of knowledge, the reintroduction of cannabis as a means of rational therapy based on modern conditions'. His reluctance comes across in the minutes, as he conceded that 'he felt that the WHO would have to carry out the study desired by the Commission'.⁴⁹ Halbach was the chief medical officer of the addiction-producing drugs section of the WHO and evidently did not take kindly to diplomats challenging statements on medicines that were designed by his fellow scientists to be final and authoritative.

The WHO response finally appeared late in 1960 as a paper with the title 'The Merits of Antibiotic Substances Obtainable from Cannabis Sativa'. The report noted that results published between 1957 and 1959 from experiments with extracts of cannabis had indeed suggested antibacterial activity. These results supported the theory that such extracts inhibited the growth of staphylococci, streptococci and other Gram-positive organisms and actively destroyed the tubercle bacillus. However, the WHO paper went out of its way to problematise these results. It questioned the validity of the experiments and argued that 'none of the available reports on clinical use appears to refer to a properly conducted trial with adequate controls'. It pointed out that 'no experiments are reported on its effects on isolated mammalian cells'. It noted that 'it would appear that these studies, which have been going on for several years, have not carried enough conviction to induce a material production of this substance on a commercial scale'. Finally it speculated that

Even if the clinical reports in the publications under survey are to be fully credited, it still remains to be decided whether they illustrate a curative action not obtainable by other and more orthodox means ... it would be very surprising if a direct comparison between them [neomycin and bacitracin] and the cannabis substances in question did not show that their action, especially if they were used together, was superior.

The report reads as a hatchet job as it questioned the legitimacy of the science behind the positive reports with no good reason, inferred that lack of a corporate backer was evidence of ineffectiveness on the part of a substance, and speculated on the likely results of an imaginary trial of cannabis antibiotics against those already available to conclude that the latter were superior to the former. Any chance that the imaginary trial would take place was denied by the report's assertion that 'the case has not been

49 BL, UN, E.CN/7/SR.422. Commission on Narcotic Drugs, Fourteenth Session, Summary of 421st Meeting, 4th May 1959, pp. 3–13.

proved in favour of making cannabis available for the extraction of therapeutic substances, particularly with antibiotic properties equal of superior to those obtainable otherwise'. It finished by referring the reader back to the report of the WHO Expert Committee of 1952 and confirming that 'cannabis preparations are practically obsolete and there is no justification for their medical use'.⁵⁰

At the same time as the WHO was producing this report the Secretariat authored a final survey of the cannabis issue designed to inform delegates as they began to work on the agreement that would become the 1961 Single Convention. This was largely a compilation of observations from the country surveys on the subject conducted since 1952. It is instructive to read the summary against the originals, as the selective nature of the document seems obvious. Consumers from across the continents were lumped together in the following brief description;

Apart from unemployed persons who generally figure prominently among consumers, there are also mentioned traffickers who also consume the drug, labourers, odd-jobbers, vagrants, criminals, seamen and a few students and cabaret artists.

Nowhere was there mention of the shopkeepers and craftsmen who smoked in the Moroccan afternoon, of the Brazilian country-festivals where cannabis was inhaled to encourage dancing and poetry, or of the Indian and African sports for which contestants prepared with a dose of the drug.⁵¹ Instead, the Secretariat's survey carried details of an ambitious new development that neatly summarises the position of the UN on cannabis by this time. As part of its Mediterranean Development Project scheme \$703000 had been provided to 'assist the Government of Morocco with two concurrent phases of its plans to develop the Rif region ... which includes a large part of the lands traditionally cultivated for kif (the chopped up parts of the flowering or fruiting tops of the cannabis plant)'.⁵² For the first time the organisation was involving itself in a hands-on programme of eradicating cannabis production, through replacing it with 'forest and fruit-tree planting, livestock raising, and field crops'.

Finally, a Plenipotentiary Conference was convened at which delegates were expected to thrash out the details of the Single Convention. The WHO and the Secretariat of the UN had made their positions on cannabis clear. The 1950 proposal to entirely prohibit the production of cannabis save for the small amounts necessary

50 BL, UN, E/CONF/34/5. The Merits of Antibiotic Substances obtainable from Cannabis Sativa, pp. 2–3,

51 BL, UN, E/CN.7/399. Annex The Question of Cannabis, Note by the Secretary-General 5th December 1960, p. 9.

52 BL, UN, E/CN.7/399. The Question of Cannabis, Note by the Secretary-General, 5th December 1960, p. 7.

for scientific experimentation was presented as article 39.⁵³ At this stage a number of governments acted to prevent this position being adopted in the final draft, and one of these was the UK. The British position was not taken out of any great concern about cannabis and the preparations of the plant, but rather was driven by suspicion of the political principles that lay behind the proposals. It was not alone, as a number of governments were outraged at the suggestion that the UN had the power to determine the domestic affairs of national states, or as the UK's delegate pointed out:

It is, in her Majesty's Government's view, wrong in principle, in a matter which affects the treatment of the sick, to require governments, if they wish to adhere to the Convention, to consent to the prohibition of whatever drugs a majority at a plenipotentiaries' conference may decide to include ... a mandatory prohibition of internal manufacture and use such as is contained in paragraph 1 of Article 2 seems to Her Majesty's Government to be quite unjustifiable.⁵⁴

The British position was that, unless modifications were made which gave the final decision on the scientific and medical use of any drug to individual national governments, the UK would not agree to the Convention.

The proposals on cannabis were also a sticking point for the Government of India for the simple reason that they entirely ignored the earlier discussions about Asian medicines. The Indian delegates there opposed Article 39, insisting again that 'cannabis drugs are used in indigenous systems of medicine in India and it has not yet been proved that these drugs are as dangerous as the other drugs listed in the Schedule or total prohibition of these drugs is absolutely necessary'.⁵⁵ Iran backed this position and submitted an amendment to the cannabis section of the treaty that read 'the parties shall prohibit the production of cannabis and cannabis resin, except for purposes of their use in indigenous medicine or of scientific research'.⁵⁶ Harry Anslinger of the US government even contributed on the side of cannabis, stating that 'a product derived from the cannabis plant was thought to have possibilities for the treatment of certain mental diseases'.⁵⁷ On the other hand many nations held an unblinking view of the drug and the representative of Egypt 'urged countries in

53 BL, UN, E.CN.7/AC.3/9. The Single Convention on Narcotic Drugs (Third Draft), 11th September 1958, p. 55.

54 BL, UN, E/CONF.34/1. Compilation of comments on the single convention (Third draft), p. 40.

55 BL, UN, E/CONF.34/1. Compilation of comments on the single convention (Third draft), India on Schedule IV.

56 BL, UN, E/CONF.34/1. Compilation of comments on the single convention (Third draft), Iran: amendment to the redraft of article 39.

57 BL, UN, E/CONF.34/24. UN Conference for the Adoption of a Single Convention on Narcotic Drugs, Summary Records of Plenary Meetings, Thirty-Third Plenary Meeting 20th March 1961, p. 154.

which the cannabis plant was cultivated to assume the obligations set forth in article 39' while the Brazilian made it clear that 'his delegation was ... in full agreement with article 39 as it stood'.⁵⁸ The Commission's response to this divided position on the issue of cannabis was to send it to an Ad Hoc Committee which included representatives from India, Pakistan, the US, the UK and Canada.⁵⁹

In advance of the meeting of this Committee the British and Canadian delegates drafted a much simplified version of the article on cannabis. Their intention was to place preparations of the plant alongside opium in the convention as a substance that could be prohibited in domestic medicine by national governments if they so wished. Most were satisfied with this but the Government of India insisted that the leaves of the cannabis plant should be excepted from any provisions on cannabis whatsoever, stating once again that they were 'far less harmful than alcohol and ... used by the poorer people of India to make a mildly intoxicating drink or as a substitute for analgesics and tranquillizers'.⁶⁰ Once this was accepted by everyone it was agreed that 'cannabis leaves should be subject to a less rigid regime than the fruiting or flowering tops or the resin of the cannabis plant ... it was proposed to this end [that] the leaves may be omitted from the definition of cannabis and that a separate provision may provide for their control'.⁶¹ The British had seen off the ambition of the UN to dictate policies to national governments on medicines, and the Indians had ensured that cannabis leaves would be treated differently from other parts of the plant. The Conference finally agreed on cannabis in the afternoon of 20th March 1961.⁶²

The Single Convention on Narcotic Drugs 1961 remains the basis of international laws on cannabis to this day and its key intention was to 'limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs'. Specific measures included prohibiting in the name of public health the cultivation of cannabis plants for anything but scientific and medical use, annual reporting on the area of cultivation of cannabis for these purposes, and establishing national agencies to control the cultivation of crops for medicinal and scientific purposes. Modern medicines that contained cannabis were in Schedule I of the Convention and their prohibition was not recommended.

58 BL, UN, E/CONF.34/24. UN Conference for the Adoption of a Single Convention on Narcotic Drugs, Summary Records of Plenary Meetings, Thirteenth Plenary Meeting, 8th February 1961, pp. 58–62.

59 BL, UN, E/CONF.34/12. UN Conference for the adoption of a single convention on narcotic drugs, ad hoc committee to deal with article 39, 23rd February 1961, p. 2.

60 BL, UN, E/CONF.34/24/ADD.1. Ad Hoc Committee on Article 39 of the Third Draft, Tuesday 21st February 1961, p. 274.

61 BL, UN, E/CONF.34/12. UN Conference for the adoption of a single convention on narcotic drugs, ad hoc committee to deal with article 39, 23rd February 1961, p. 2.

62 BL, UN, E/CONF.34/24. UN Conference for the Adoption of a Single Convention on Narcotic Drugs, Summary Records of Plenary Meetings, Thirty-Fourth Plenary Meeting 20th March 1961, p. 156.

Cannabis and cannabis resin, however, were included in Schedule IV of the Convention, which meant that the prohibition of their medical use was recommended. Significantly, the definition for the sake of the treaty was as follows:

"Cannabis" means the flowering or fruiting tops of the cannabis plant (excluding the seeds and leaves when not accompanied by the tops) from which the resin has not been extracted, by whatever name they may be designated.

This was the section that meant that India's reservations about cannabis leaves had been respected and that the only stipulation regarding these was the vague assertion that 'The Parties shall adopt such measures as may be necessary to prevent the misuse of, and illicit traffic in, the leaves of the cannabis plant'.

Conclusion

Different governments held various positions on cannabis throughout the 1950s, and the actions of the Indian delegation show how a specific national interest could shape the final version of the 1961 Single Convention. However, the Indian intervention draws attention to a further feature of the international context in this period, one that was more pronounced in the 1950s than previously. This was the place of trans-national bodies such as the UN and the WHO in driving the agenda on drugs, and in particular on cannabis. Bodies such as the Expert Committee on Habit Forming Drugs at the WHO and the Secretariat at the United Nations were determined to assert the darkest picture possible of cannabis in this period and to force through the strictest possible control mechanisms.

The reasons that the UN and the WHO took such a dark view of cannabis are various. In the first place, the position of control-advocates in key roles and on important committees in these organisations ensured that negative views of a whole range of substances were the starting position for international discussions throughout the 1940s and 1950s. Moreover, both the UN and the WHO were nascent bodies that were engaged in carving out positions for themselves in the post-war world. Their interest in cannabis can be seen as just one instance of a wider project of empire-building and territory-claiming by the staff of ambitious organisations at a time when a growing remit for these bodies ensured their significance and survival. In the 1920s cannabis had first been caught up in the international regulatory system because of the competing interests of national and colonial governments such as the UK, the US, Egypt and India. In the 1950s cannabis was located closer to the heart of the international drugs agenda than ever before, and it was put there not by national governments, but by the UN and the

WHO, trans-national bodies seeking to widen their spheres of interest by finding new problems that they claimed it was their responsibility to fix.⁶³

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63 Perhaps the high point of this 'empire-building and territory-claiming' came in the early 1950s when Leon Steinig, head of the UN's Division of Narcotic Drugs, proposed that he would head up a world monopoly on opium, which he later sought to extend to cover nuclear material too. He was removed in 1952. For more on this, and for a full account of the politics of the international drugs bureaucracies in this period see McAllister, *Drug Diplomacy*, pp. 156–211.

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From Charity to Development: Christian International Health Organizations, 1945–1978

Walter Bruchhausen

Introduction

With the exception of the Red Cross, the history of non-governmental international organizations in the field of health has found far less attention than intergovernmental organizations and national non-governmental organizations (NGOs). Globally acting non-governmental organizations used to be initiated by transnational movements constituted of such nationally organized social groups as trade unions, political parties, academic societies or religious bodies. This article will demonstrate how national NGOs like the Christian organizations Misereor and Bread for the World (*Brot für die Welt*) that were founded in Germany in 1958/59 could impact and even trigger the development of international NGOs working in health. It is argued that between the late 1950s and the 1970s these German organizations led the way in re-conceptualizing faith-based aid work as a developmental issue, rather than a matter of charity and missionary activity. These organisations became models for similar organizations in other European and North American countries.¹ Their example was also followed by organizations at the international level devoted to health and development, namely *Medicus Mundi* (International Organization for Medical Cooperation) in 1963, CIDSE (*Coopération internationale pour le développement socio-economique*) in 1967 and the CMC (Christian Medical Commission of the World Council of Churches in Geneva) in 1968. The article concludes that the place of national and international Christian organisations may have been neglected in accounts of the processes that culminated in the Alma-Ata Declaration of 1978.

1 For example *Fastenopfer* and *Brot für Brüder* in Switzerland in 1961 and Catholic Relief Services in the USA, which was founded in 1943 but reshaped in this period. For the latter see Eileen Egan, *Catholic Relief Services: The Beginning Years* (New York: Catholic Relief Services, 1988).

The History of Christian Health Care Worldwide before 1945

In early historical research Christian missions, when they were mentioned, were simply treated as part of the colonial health care system. Those who looked at disease control campaigns saw the role of missions as negligible² while those who conducted research into the place of medicine as a 'tool of empire' simply conflated missions with the colonial authorities.³ The exception was the work of Terence Ranger in his seminal study of Southern Rhodesia⁴ and later studies followed his lead in looking at differing aspects of missionary medicine, including its geographical spread beyond the centres of colonial administration, its often difficult relationships with colonial and local authorities, how far it focused on individual care rather than public health and its emphasis on education and training.⁵ Similarities and oppositions between colonial and missionary medicine were highlighted and disputed, as the majority of research work consisted of case studies of single hospitals or mission societies with their own peculiar conditions. A monograph on the medical missionary movement in general⁶ and a collected volume on medical missions⁷ have been published, but nearly all of the studies cover the time before 1945. The history of the medical missions after the Second World War has yet to be written. The few studies of mission hospitals for the period after the end of the Second World War generally take the form of microstudies that integrate the larger context of altered international and national conditions in their analysis, but do not focus on them.⁸ Therefore any historical approach to this international level of Christian health work can only be a first attempt to sketch some major changes brought by decolonization and the

2 Cf. e.g. the contributions in *Epidemics and Ideas: Essays on the Historical Perception of Pestilence*, ed. Terence O. Ranger and Paul A. Slack (Cambridge: Cambridge University Press, 1992).

3 E.g. Megan Vaughan, *Curing their Ills. Colonial Power and African Illness* (Cambridge: Polity Press, 1991).

4 Terence O. Ranger, "Godly Medicine: The Ambiguities of Medical Mission in Southeastern Tanzania, 1900-1945," *Social Science & Medicine* 15B (1981): 262. Abbreviated version in *The Social basis of health and healing in Africa*, ed. Steve Feierman and John M. Janzen (Berkeley: University of California Press, 1992), pp. 256-82.

5 Nancy R. Hunt, *Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham: Duke University Press 1999); Mike Jennings, "'This Mysterious and Intangible Enemy': Health and Disease Amongst the Early UMCA Missionaries," *Social History of Medicine* 15 (2002): 65-87; Walter Bruchhausen, "Medicine between Religious Worlds. The Mission Hospitals of South-East Tanzania during the 20th Century," in *From Western Medicine to Global Medicine. The Hospital Beyond the West*, ed. Mark Harrison, Margaret Jones, and Helen Sweet (Hyderabad: Orient Black Swan, 2009), 262-93.

6 Christoffer Grundmann, *Sent to heal: Emergence and development of medical missions* (Lanham/Md: University Press of America, 2005).

7 David Hardiman, ed., *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, (Amsterdam: Rhodopi, 2006).

8 E.g. Pascal Schmid, "Medicine, faith and politics in Agogo. A history of rural health care in Ghana, ca 1925 to 1980" (PhD diss., Basel, 2013).

emergence of the development discourse. As will be shown, the recent WHO-related historiography of the pathways to Primary Health Care contains more on the role of the Christian Medical Commission, its experts and the projects of its institutional members than the historiography of mission medicine so far.

The changes in the twentieth-century to be analysed here must be seen against the background of the long and complex history of Christian health care. Since – different from Greek and Roman antiquity where the medical profession was a profitable business – helping the sick is an explicit obligation of the New Testament institutionalised services for this group in need became a characteristic feature of Christian organisations from late antiquity onwards. Bishops, religious orders, brotherhoods and devote individuals founded hospitals that – like similar institutions in the contemporary Islamic world – cared for the diseased poor, too. Contributing to legitimizing European expansion, health care also became part of the modern evangelizing mission to countries outside Europe and America to the extent that sometimes the medical mission became increasingly separated from the religious one.⁹ Mission doctors, by their professional standing, were far less subordinate to mission societies and religious congregations than nursing sisters had been.¹⁰ In the China mission of the late nineteenth-century, for example, doctors often received more financial support from the local population than from the mission society at home.¹¹ Local interest in Western medicine, science and education was often greater than curiosity about Western religion, and this made health care the most respected part of Christian missions.

It was certainly the case that for many towns in Southern China and rural areas in South Asia and Africa, Christian institutions were the main entry point for Western medicine. The missions began with medical education and even medical schools for Chinese students, sent West Africans for medical studies to Europe and opened training facilities for nurses and paramedics in all parts of the world. These activities gave rise to international societies and journals and increasingly influenced the medical and public understanding of health care worldwide.¹²

9 Edward V. Gulick, *Peter Parker and the Opening of China* (Cambridge/MA: Harvard University Press, 1973).

10 Chi-Min Wang and K. Chimin Wong, *Lancet and Cross. Biographical Sketches of fifty Pioneer Medical Missionaries in China* (Shanghai: Council on Christian Medical Work, 1950).

11 Cf. the annual financial reports in *Report of the Tungkun Medical Missionary Hospital in connection with The Rhenish Missionary Society for the year 1893 [-1898]*, ed. Tungkun Medical Missionary Hospital (Hongkong: “China Mail“ Office, 1894 [-1899]).

12 E.g. *The China medical missionary journal* (Shanghai) since 1887 and *Medical Missionary* (Philadelphia) since 1927.

Christian Health Care and Decolonization after 1945

This pattern of health care by Christian institutions was dominant until decolonization began after 1945 and picked up pace in the 1950s. Christian medical care in colonized regions had been mainly provided by missionary societies from a range of Western countries, was usually (though not exclusively) focused on individual therapy, and routinely kept a distance from colonial administrations. Even where missionary doctors participated in some governmental health care activities such as training of health workers, disease control campaigns, vaccination schemes or mother and child health programmes they did not regard themselves as part of the colonial health care system. In 1919 Pope Benedict XV cautioned Catholic missionaries not to engage in overly close relationships with colonial administrations which might lead to their pursuing ‘the interests of their terrestrial homeland [patria] instead of with those of their homeland in heaven’. His admonition ended with the order that they ‘Remember that your duty is not the extension of a human realm [imperium], but of Christ's!’¹³

The period of the 1950s and early 1960s brought several major changes to this established pattern of expatriate mission doctors and nurses running mission hospitals with support from their own congregations and friends at home. These changes can be understood under four distinct headings; churches and the secular world; aid organizations and the development discourse; local staff and independence movements; government budgets for development aid.

Churches and the Secular World

The years after 1945 were a time of major transformation for the Christian churches, worldwide and especially in Germany. The experiences of common enemies such as national socialism, communism and anti-religious forms of liberalism encouraged interdenominational and interreligious contacts as well as greater cooperation with those governments that were not hostile to religion or Christianity. Within the churches the growing influence of members who did not belong to the clergy, and renewed theological ideas led to changes in doctrine and discipline which improved the opportunities for an active role for Christian actors in many sectors of the modern world. The social sciences, which had often been regarded by both social scientists and theologians as attacks on religious authority, were now used as tools for reflection and re-organization in the churches, especially for long-term planning and provision of social services. Scientific medicine, modern education, democracy and liberal

13 Benedictus XV, “Maximum illud”, [Apostolic Letter of 30 November 1919]. *Acta Apostolicae Sedis* 11 (1919): 440-55, here 446, quoted after the translation on http://www.who.int/global_health_histories/seminars/nairobi03.pdf (7 August 2014).

economics were no longer regarded with scepticism or as threatening Christian order and tradition. Thus the 'civilizing mission' of Western societies, which had sometimes been seen as at odds with the 'proselytizing mission' of the churches, was now fully accepted in the modernization paradigm by missionaries.¹⁴ Humanizing societies, understood as introducing a mix of traditional Christian and modern values, not the head count of baptisms, became the dominant calling for Christian overseas work.

Aid Organizations and the Development Discourse

The very recent European experience of hunger and international relief, the Christian revival after the Second World War, and the ample flow of information about the seemingly devastating situation in many non-Western countries combined by the end of the 1950s to drive a sense in the churches of Europe that a key role for them was in tackling want. This seems to have been particularly acute in West Germany which, having itself been rescued from starvation and devastation by charity parcels from Care and the European Recovery Program (Marshall Plan), was by this time enjoying a new wealth as well as the liberty to organize church life denied under the Nazi regime. The first nationwide collections in both the Catholic and in the Protestant churches of Germany for the explicit intention of relieving 'hunger and disease' were made during lent and advent, respectively, in 1959. They resulted in the unexpectedly large sum of more than 50 million Marks, an amount that exceeded the recently introduced budget for international aid granted by the West German parliament. As a result, two new aid organizations were created to deploy these resources, Catholic Misereor and Protestant Bread for the World.

The distribution of these enormous funds immediately became a contested issue. On the Catholic side a debate took place in print between the clerical proponents of a classical evangelising mission and charitable work for the hungry and sick and those more influenced by the social science theories of the period who advocated a new type of support for investment in development.¹⁵ Led by a prelate, the head of Misereor Monsignore Gottfried Dossing (1906–1997), the latter started to dominate the debate. In 1959 the bishops' commission for distributing the donations had outlined the distinction it now made between 'direct aid by buying and donating medicines and medical equipment and sending doctors and nurses' and 'aid for self-aid comprising a) direct improvement of the health situation by educating and advising the population for better and more hygienic ways of living and eating, b)

14 Klaus Fiedler, *Christianity and African culture. Conservative German Protestant missionaries in Tanzania, 1900-1940* (Cologne: Brill, 1996).

15 Sylvie Toscer, *Les catholiques allemands à la conquête du développement* (Paris: Édition L'Harmattan, 1997).

direct improvement of health care by constructing and enlarging hospitals, dispensaries, maternities etc., c) indirect improvement of health care by educating and training doctors and nurses (courses for nurses, constructing and enlarging nursing schools)'.¹⁶ The contested questions were whether 'structural aid' instead of 'direct aid' complied with the wording of the call for donations and thus the intentions of the donors and how the warning of pope Pius XII was to be interpreted. The pope had insisted that missionaries should only take on such tasks which are 'easy to perform and directly effective'.¹⁷ Dossing stuck to his option for 'structural aid' and argued the pope's warning meant that other tasks, i.e. more difficult and long-term ones, should be fulfilled by lay members of the church, not the missionaries belonging to the clergy.

Misereor therefore became a developmental organization for 'structural aid' and not one for immediate assistance such as delivering medicines and food. This broader focus on relieving poverty, which was shared by the Protestant organization, Bread for the World, tried to make health care part of integrated developmental schemes. Epidemiological statistics replaced the missionaries' perception of local illness as the starting point of aid in health care. Non-medical factors for improved health, such as education and agriculture, were emphasised. This broad integrative development approach meant a greater focus on the prevention of ill-health and a new role for institutes for medical mission as technical agencies in health care.

Local Staff and Independence Movements

From the late nineteenth-century onwards locals trained in western medicine had taken on roles in Chinese and Indian hospitals and increasingly came to dominate their staff, but they were usually in subordinate positions to Europeans who tended to monopolise senior roles. In Africa this process only really gathered pace by the middle of the twentieth-century and was given fresh impetus as the continent's nations emerged in the post-colonial period, particularly when the new governments of these nations saw the permanent presence of Western health personnel as a nuisance and an embarrassing reminder of the recent past. These changes had two major consequences for Christian aid as well as for foreign governmental aid. First, Western medical personnel were only welcomed in Asia and Africa where they had special skills or particularly high qualifications e.g. in public health, health education, midwifery or anaesthesia. Secondly, the need for high quality local graduates to take

16 Anhang 4 zum Protokoll der Sitzung der Bischöflichen Kommission [Attachment 4 to the minutes of the meeting of the episcopal commission], 11.12.1959, MAA (Misereor Archive Aachen) Bischöfliche Kommission Sitzungen Protokolle 1959-1963.

17 Protokoll der 2. Sitzung des Beirats [Minutes of the 2nd meeting of the advisory board], 18.1.1960 in Köln (Cologne), MAA Misereor Beirat Sitzungen, Protokolle 1959 bis 1974.

on medical degrees in order to populate the medical services of post-colonial nations became urgent.

The German Catholics' initiative for foreign students, the Katholischer Akademischer Ausländerdienst/KAAD [Catholic Service to Academic Foreigners] founded in 1958, immediately focused on this need. Three quarters of its first batch of students that were supported by grants from Misereor consisted of future health professionals, the others being social and agricultural scientists.¹⁸ The first institution of higher education financed by Misereor was the Christian Medical College in Bangalore/India.¹⁹ Subsequently a medical college in Liberia was discussed, funding to support a university hospital in Congo was agreed and proposals were drawn up to do the same in Vietnam.²⁰ Provisions were also made for European medical faculties, first in Pamplona and later in Rome, that were devoted to the medical education of students from overseas.²¹ Medical education became a major part of Christian 'development aid' which ensured that a considerable number of senior health professionals in post-colonial nations were trained in ways that were tinged with Christian messages.

Government Budgets for Development Aid

Another major change for church work in health was the introduction of budgets for development aid in all the Western states many of which had not been colonial powers before. Part of the motive for this was the fight against communism for which the churches were seen as likely allies.²² As the Western governments themselves did not have sufficient foreign partners for projects on the ground, the Christian organizations' turn from charity to development made them suitable partners for spending the funds. In West Germany the new Ministry of Development Cooperation, founded in 1961, used resources previously received from the Marshall Plan for development aid, as repeatedly demanded by Eisenhower and MacMillan since 1958.²³ Soon grants from this budget were also given to both major German

18 Bewilligung [Approval] 6.11.1959, MAA 510-0/1 Stipendien KAAD.

19 Protokoll der Sitzung der Bischöflichen Kommission [Minutes of the meeting of the episcopal commission], 11.12.1959, MAA Bischöfliche Kommission Sitzungen Protokolle 1959-1963.

20 Protokolle der 23. und 29. Sitzung des Beirats [Minutes of the 23rd und 29th meeting of the advisory board], 5.7.1963 und 18.2.1965, MAA Misereor Beirat Sitzungen, Protokolle 1959 bis 1974.

21 Protokolle der 16. und 31.-33. Sitzung des Beirats [Minutes of the 16th and 31st to 33rd meeting of the advisory board], 11.1.1962, 14.10.1965, 8.2.1966 bzw. 16.5.1966, MAA Misereor Beirat Sitzungen, Protokolle 1959 bis 1974.

22 Friedhelm Raden, *Christliche Hilfswerke im Kalten Krieg* (Herbolzheim: Centaurus, 2000).

23 Wolfgang Rieger, *Wirtschaftswunder für farbige Völker? Deutschland und die Entwicklungshilfe* (Hamburg: Rütten & Loening, 1961), 16.

churches which made up 50% of their aid in these projects.²⁴ Internal and external communications of the Ministry emphasised that health was addressed in a third of the development projects of the churches and thus the churches came only second to the state in German international health work.²⁵ This financial cooperation, however, was much contested inside and outside the churches as clerics were concerned about compromising their independence in development work, and opponents of Christianity feared an increased influence of religion.²⁶

In responding to these changes and new opportunities Christian churches in Europe began to see the advantages in, and need for new, international organizations to coordinate activities among the religious institutions of the continent in the sectors of health and development. The outcome of these processes was the foundation of Medicus Mundi Internationalis, CIDSE, and the World Council of Churches Christian Medical Commission in the 1960s..

The Christian IHOS

On the Catholic side Medicus Mundi Internationalis (International Organisation for Medical Cooperation) was founded by West European organizations and individuals engaged in health care within 'developing countries'. Set up in 1962 at the headquarters of Misereor in Aachen, its first president was the German medical doctor and specialist in tuberculosis Heinrich Jentgens.²⁷ Its member organisations or national branches had been founded by quite different individuals and bodies. In the Netherlands, where Catholics were a large minority distrusted by Calvinist government circles, it was started by doctors' associations working in international health since 1957. In Belgium, where at the time Catholicism came close to a national religion, Caritas Catholica Belgica (the national Catholic humanitarian organization)

24 Karl Osner, *Die entwicklungspolitische Zusammenarbeit der Bundesregierung mit den christlichen Kirchen in der Bundesrepublik Deutschland*. Vortrag im Campo Santo, Rom April 1979 (Rom: KAEF, 1979).

25 Der Bundesminister für Jugend, Familie und Gesundheit, *Gesundheitsbericht* (Bonn: Kohlhammer, 1971), 170; Scheiber, BMZ Referat I B 6, Anlage zum Vermerk vom 6.8.1970, BArch (Bundesarchiv/Federal Archive Koblenz) B213/4960 1970/71 Fragen des Gesundheitswesens, III A/7-T9010 Gesundheitspolitik in der BRD (Gesundheitsbericht); Entwurf für den AwZ [Ausschuss für wirtschaftliche Zusammenarbeit] Vermerk „Veränderungen in der Projektpolitik im Bereich der Gesundheitshilfe“ (Februar 1975), BArch B213/4990 Allg. und Grundsatzfragen der Gesundheitshilfe [305/T9000], AwZ-305T9000 Heft 1.

26 Gerhard Brenneke, „Hier gibt es nur ein klares Nein“, in: Christian Berg (ed.), *Brot für die Welt. Dokumente, Berichte, Rufe* (Berlin: Lettner, 1962), 179-183 Rieger, *Wirtschaftswunder*, 137-38.

27 Bericht über die Sitzung des Sonderausschusses am 17.12.1963 im Missionsärztlichen Institut Würzburg [Report on the meeting of the special commission 17.12.1963 in the Medical Missionary Institut Würzburg], MAA 1991/1 HGF Missionsärztliches Institut 1963-1969.

founded the branch with the director of an institute of tropical medicine as its head. The French branch counted a national minister and a number of professors among its founders while in mainly Catholic Austria former mission doctors organised *Medicus Mundi*. In the Rhineland of Germany, a Catholic doctors guild in close collaboration with the new ‘development aid’ experts in Catholic aid organizations, especially *Misereor*, combined with the federal ministry for development cooperation to set up the organization. In Spain medical specialists together with Jesuit priests founded *Medicus Mundi* in several largely independent regional branches, each with health projects of their own. The Irish organization was established at the initiative of the Medical Missionaries of Mary, a congregation of religious sisters.²⁸ Pre-existing associations in other countries, some founded as early as the 1920s, joined as national or associate members. The Medical Mission Sisters (the Society of Catholic Medical Missions) and the Catholic Medical Mission Board (CMMB) in New York represented the USA. The Swiss medical missionary society (*Schweizerischer Katholischer Missionsärztlicher Verein*) joined in 1970 by founding the Swiss branch of *Medicus Mundi* as a non-denominational body. Doctors from Italy, Algeria and later Poland were represented as well.

During their first years the national branches and the international annual general assembly were busy in sending hundreds of health workers into Asia, Africa, Latin America and Oceania for between three and five years at a time. By 1966, however, the Secretary General Dobers was complaining that *Medicus Mundi* was mostly an office for recruiting these workers, while other ‘goals, namely improving health [and the problem of] the dependence of medico-social assistance on the economic and cultural development of the countries [have been] largely neglected.’²⁹ According to the Secretary General there were too many hospitals and too much curative care. In response, by the late 1960s the annual general assembly began exploring options for more wide-ranging health strategies.³⁰

28 Heinrich Jentgens, *Kleiner geschichtlicher Überblick auf den Beginn von Medicus Mundi* [Short historical overview on the beginnings of *Medicus Mundi*], in *Medicus Mundi/International Organisation for Medical Cooperation*, Profil, 7-11, MAA Box 1996/15 GW *Medicus Mundi Internationalis* 1972-1987.

29 GS Dobers at the 3rd International General Assembly, 21.5.1966, Monserrat, according to E. Widmer and M. Manciaux, *Die Aktivitäten von MMI*, in *Medicus Mundi/International Organisation for Medical Cooperation*, Profil, 12-19, here 14, MAA Box 1996/15 GW *Medicus Mundi Internationalis* 1972-1987.

30 Edgar Widmer, *MMI history and philosophy* [Reprint from 2003 of the address to the conference “40 years of fighting global poverty by promoting health“, Berlin, 24 October 2003], in: 50 years of *Medicus Mundi* International Network, 1963-2013 Looking back and ahead. Memories and insights by MMI presidents (Annex to the Annual Report 2012 of the *Medicus Mundi* International Network), 12-14; *Medicus Mundi/International Organisation for Medical cooperation*, ed. Documentation of the General Assembly, Amsterdam, 20-22 May 1977 (Aachen: General Secretariate of *Medicus Mundi*

International, n.d. [ca. 1977]), see: List of participants and Table I-III.

But Medicus Mundi was not alone as an international organization established to coordinate European Catholic intervention in the health care of 'developing countries'. In 1965, at the end of the Second Vatican Council in Rome, the Catholic Church opened the way for cooperation with other churches and religions as well as secular institutions. The German Archbishop of Cologne Josef Cardinal Frings, who had played a key role in founding Misereor, initiated a meeting with the bishops of eight other national Catholic developmental organizations which were mostly financed by lent donations. This meeting paved the way for the foundation in 1967 of CIDSE (International cooperation for socio-economic development, since 1981 International cooperation for development and solidarity). This was designed to be distinct from Caritas Internationalis, the Catholic Church's humanitarian organization which was also active in the international health sector, but mainly for emergency aid.³¹ As with Medicus Mundi, the key health issue in the international meetings of CIDSE in the late 1960s became the departure from hospital-based curative care which was regarded as old-fashioned and an obstacle to comprehensive health services.

On the Protestant side two international consultations on international Christian health care took place in 1964 and 1967 in Tübingen, the old seat of the Deutsches Institut für Ärztliche Mission (German Institute for Medical Mission) which had been set up in 1906.³² These consultations stated that the churches' health care hitherto had not been sufficiently oriented towards the needs of the poor and the majority of the populations. The traditional idea that illness was a consequence of individual sin and a sign of the presence of evil in the person was rejected in favour of a new view that the social or structural sin of gross inequality marginalised parts of the population and caused most ill-health.³³ These theological, ethical and medical reflections lead to the foundation of the World Council of Churches Christian Medical Commission (CMC) with its headquarters in Geneva. The Christian Medical Commission was to become the most politically influential of the

31 Josef Teusch, „Zuerst: Eine Äußerung des Glaubens. Das Bischöfliche Werk ‚Misereor‘, seine Anfänge und seine Initialwirkung in die Weltkirche“, in *Die Ortskirche im Dienst der Weltkirche. Das Erzbistum Köln seit seiner Wiedererrichtung im Jahre 1825*, ed. Norbert Trippen and Wilhelm Mogge (Cologne: J. P. Bachem, 1976), 200.

32 World Council of Churches, ed., *The Healing Church: The Tübingen Consultation 1964* (Geneva: World Council of Churches, 1965); World Council of Churches, ed., *Health: Medical-theological Perspectives. Preliminary Report of a Consultation held in Tübingen, Germany, Sept. 1-8, 1967* (Geneva: World Council of Churches, 1967).

33 Rainward Bastian, „Kirchliche Gesundheitsarbeit auf evangelischer Seite,“ in *Entwicklungsziel Gesundheit. Zeitzeugen der Entwicklungszusammenarbeit blicken zurück*, ed. Walter Bruchhausen, Helmut Görden, and Oliver Razum (Frankfurt/M.: Peter Lang, 2009), 28-29.

international Christian health organizations, in part through its contacts in the USA.³⁴

The Shift to ‘Community-Centred Health’

By the end of the 1960s both Catholic and Protestant IHOs were well established, and grappling with similar issues. At the annual international general assembly of *Medicus Mundi* in 1969 a German Professor of Tropical Medicine Hermann Knüttgen, director of the university institute in Tübingen, challenged ‘modern medicine’ and complained about its interference with ‘indigenous continuous development’. He was sure that ‘markedly environment-conditioned diseases’ could ‘be reduced without special measures’ by better preventive programmes and education.³⁵ Moreover, he argued that ‘the professional education of students from young nations at European medical faculties is far from ideal for the health service of their own countries’ and was an advocate of a model from Tanzania for the ‘formation and training of local assistants’ in situ. In the same year John Harland Bryant published the seminal book *Health & the Developing World* which made similar arguments, and he was soon to become chairman of the CMC and director of Columbia University’s school of public health, and later serve as a member of the US delegation in Alma Ata.³⁶ The Director of the CMC, James McGilvray, also echoed these arguments in 1969 to a conference of the American Medical Association,³⁷ as did the chairman of the Department of International Health at the

34 Carl E. Taylor, “What is different now?: A Christian Medical Commission’s Role in Health Planning” (presentation at Johns Hopkins University, 2003). http://www.ccih.org/Christian_Medical_Commission's_Role_in_Health_Planning_Taylor.ppt Accessed 23 August, 2013; Socrates Litsios, “The Christian Medical Commission and the Development of the World Health Organization’s Primary Health Care Approach”. *American Journal of Public Health* 94 (2004): 1884–93; Marcos Cueto, “The Origins of Primary Health Care and Selective Primary Health Care.” *American Journal of Public Health* 94 (2004): 1864–74; Dan Kaseje, “The contribution of the Christian Medical Commission to health care in Africa in the post colonial era” (presentation at the WHO’s initiative on Global Health Histories Meeting in Nairobi, February 6-8, 2006). Accessed 23 August, 2013. http://www.who.int/global_health_histories/seminars/nairobi03.pdf.

35 Hermann Knüttgen, „Die Bedeutung der Medizin in der Entwicklungshilfe“ [Place and Importance of Medicine in Development Aid], 6th International General Assembly of MM Bensberg 7-8 June 1969, MAA 1991/1 HGF *Medicus Mundi* Sitzungen bis 1965, Generalvers. bis 1973.

36 John H. Bryant, *Health & the Developing World* (Ithaca/NY: Cornell University Press, 1969).

37 Cited from China Health Care Study Group, ed., *Health care in China. An Introduction* (Geneva: Christian Medical Commission, 1978) 12.

Johns Hopkins School of Public Health, Carl E. Taylor in an influential article on the future of the CMC.³⁸

If the move away from hospital based personal care appeared to be the way forwards, the challenge of working out exactly what would replace it remained. Christian IHOs closely observed pioneering initiatives around the world. Perhaps the most famous and influential was set up in 1970 by Raj and Mabelle Arole in Jamkhed, Maharashtra.³⁹ The CMC followed this project which sought to introduce new methods of communication, training, identifying and solving problems and which drew on methods pioneered by WHO and UNICEF. But the responses of certain national governments also drew the attention of the Christian IHOs in seeking the way forwards from the rejection of hospital based medicine. In 1972 the Christian Medical Commission appointed a group of medical and social scientists in Hong Kong to study the question ‘What in the Chinese experience of rebuilding a health care system might be of value to communities in other cultures and social systems?’⁴⁰ The study group was composed of both Chinese and Anglophone experts from medical and non-medical disciplines and financed by the German Arbeitsgemeinschaft für Weltmission (Working Association for World Mission). It concentrated on China’s experience of setting health-related national goals, reorganizing health care systems, tackling epidemic disease, controlling population size, approaching traditional and Western practices, and dealing with mental illness. This focus on national experiences grew throughout the 1970s. The annual general assemblies of Medicus Mundi discussed Putina/Peru, Gabon and Korea in 1973; Nepal, Malawi and Algeria in 1974; Niger, Panama and Zaire in 1975 and so on.⁴¹ They complemented these reports with speakers who had experience in the field. Ali Hassan Mwinyi appeared in 1974 as Health Minister for Tanzania (he would later serve as president), as did Dr A. Eberwein of the WHO. Another member of the latter, Dr D. Flahault spoke in 1975 and in the following year the then Health Minister of Tanzania, Leader Dominic Stirling, presented. He had been first an Anglican, and then a Catholic mission doctor.

The Christian IHOs seem to have concluded that centre and starting point were ‘communities’, as their mobilisation and participation were regarded as indispensable for sustainable success. The ‘Concepts 1’ document produced by Medicus Mundi in 1968 and edited by the Dutch professor H.A.P.C. Oomen stated that fundamental

38 Carl E. Taylor, “A Christian Medical Commission’s Role in Health Planning”. *International Review of Mission* 58 (1969): 181-94.

39 Pai D. Malgavkar, *Rural health care: The Jamkhed Project* (New Delhi: Centre for Policy Research, 1981).

40 John H. Bryant, Foreword to *Health Care in China. An Introduction*, by China Health Care Study Group (Geneva: Christian Medical Commission 1978), 7.

41 MAA 1991/1 HGF Medicus Mundi Sitzungen bis 1965, Generalvers. bis 1973; Medicus Mundi Internationalis Kommissionssitzungen 1974-1975; 1976-1977.

to the mission in ‘developing countries’ was a commitment to ‘improving [the] health of the community with its own co-operation’.⁴² Yet the word ‘community’ could be ambiguous and was as often used to name the target rather than the agent of health care. For several academic medical experts advising the churches, the terms ‘community health’ or ‘community medicine’ were better than ‘public health, preventive medicine, or social medicine’ for describing the necessary approach, defined as ‘medicine of man in the aggregate’.⁴³ According to William Foege, a director from the National Communicable Disease Center in Atlanta/Georgia, this approach went ‘beyond the discussions of care of total man to care of total men’. Maximum care for the individual should be replaced by providing for ‘the health needs of groups, communities, areas, countries, and regions’.

But by the early 1970s it was also clear that some engagement with national administrations and other IHOs was necessary too. In 1972 the ‘First Asian Ecumenical Conference on the Role of Health in the Development of Nations’ in Bangkok declared that ‘As part of the health development program, we of the Church should strive to influence Governments and other interested medical bodies to provide better health care facilities and better conditions of living.’⁴⁴ As the headquarters of the World Council of Churches was located in Geneva the opportunities for the CMC to influence the WHO were especially frequent. Member church organizations also discussed appropriate strategies with senior civil servants and government officials back in Europe. The CMC had members from East and West Germany so it could even broker some exchange of experiences rare during the late Cold War.⁴⁵

While Christian IHOs consulted widely on experiences elsewhere and were keen to draw on the successes and failures of others, they also acted. The CMC ‘sponsored ... several experimental projects in health care delivery’, the first of which was the ‘Kojé Do Project’ in South Korea.⁴⁶ This was conceived as ‘a six-point project: a broad, community-centred health programme consisting of family planning, public health, and a scientifically controlled, sub-maximal curative medicine’ coordinated with other local activities.⁴⁷ This commitment was not uncontroversial as critics

42 3rd international general assembly of Medicus Mundi, 4./5.5. 1968, Viller la Ville/Belgium.

43 William H. Foege, “Community Medicine”. *Contact* 2 (1971): 1.

44 “First Asian Ecumenical Conference on the Role of Health in the Development of Nations”, Bangkok December 1972 (Bangkok 1973), cited from L.K. Ding, preface to *Health Care in China. An Introduction*, by China Health Care Study Group (Geneva: Christian Medical Commission 1978), 10-11.

45 Anonymous, “Meeting of the CMC in Bad Saarow, German Democratic Republic, 1-8 April 1979,” *Contact* 51 (1979): 9-14.

46 James C. McGilvray, “Short introductory note on J. R. Sibley, ‘The Kojé Do Project – Progress and Problems’”. *Contact Occasional Paper* No. 5. (1971).

47 Sibley (1971) as in the previous FN, 2.

argued that providing the best possible care for individuals in need and for the sick was a Christian duty too. Nevertheless it was clear that a direction had been set. Resources were to be focused on 'community' health and curative medicines were not to be the priority.

Conclusion

This article has explored some of the drivers of change in the approach to providing healthcare of European Christian organisations in the period after the Second World War. They moved from a hospital-based focus on curative medicine to community-focused primary healthcare in the three decades or so after 1945. The reasons for this lay in their recent experiences both in Europe and also in decolonizing regions. As parts of Asia, Africa and elsewhere decolonized, the national states that emerged sought to assert their authority over the populations under their control. In this context, foreign missions that set their own agendas and delivered medical care to groups of their choice looked dangerously like the colonial past even where the missions had distanced themselves from administrators of the former European empires. Besides the preoccupation with sovereignty, priorities in these new nations tended towards ideas of development brought up in late colonialism.⁴⁸ What had been on offer from many European mission societies earlier in the century was no longer welcomed in regions that were decolonizing. Asian and African governments no longer accepted charitably hospital work supervised by Europeans but demanded integration into the national health care system. Responsibility had to be handed over to nationals who often first needed to study or get further qualification. Due to the initial lack of academically educated staff and medical schools this had to be done by grants for Europe or supporting new colleges.

At the same time there was change in Europe. Christian churches in Germany were revitalized after the traumas of National Socialism and the Second World War and as the continent grew economically in the 1950s. The experience of recovery from starvation and the traumas of oppression and war in Europe bred an optimism that similar improvements could be achieved elsewhere. Rejection of the old missionary models led to a nationalisation of Christian overseas health work as responsibility for delivery shifted from foreign mission societies to national churches. It also meant searching for alternatives to the mission models of charitable services, and collaboration in development became the spirit of the age. Churches worked together in the West to pool ideas, resources and personnel and Christian IHOs were

48 Walter Bruchhausen, "From precondition to goal of development. Health and medicine in the planning and political conflicts of British Tanganyika Territory". In *Developing Africa: Concepts and practices in twentieth century colonialism*, edited by Joseph Hodge, Gerhard Hödl, and Martina Kopf, 207-221. Manchester: Manchester University Press, 2014.

established as part of this phenomenon. European governments that had difficulties in finding suitable partners for their new 'development aid' in health granted considerable funds to the established services of the churches for developing health care. Soon and in most places, European mission societies no longer ran hospitals and other health services themselves but they and their Christian IHOs supported local churches and initiatives instead. These local actors were increasingly seen more as partners in development than as objects for aid. The result was a closer connection of the churches with local congregations and action groups. The outcome of these processes was not just a move to 'working for the people' on the part of European Christian organisations in delivering healthcare but also to 'working with the people' to do so.

By the end of the 1970s the emphasis on community participation in delivering healthcare, and also in assessing the effectiveness of that delivery, was enshrined in the Alma Ata Declaration made at the International conference on primary health care organised by WHO and the United Nations Children's Fund (UNICEF) in 1978. The shift from strongly paternalistic, even authoritarian sanitation policies of states, and particularly colonial states, to rights-based and participative health action became the official international programme. Histories that explore the origins of this declaration have recently pointed to the influence of Christian IHOs on Alma Ata in addition to national actors and UN agencies.⁴⁹ The reasons, however, why and how they were engaged in the same debates and were concerned about similar issues, in the decades immediately before 1978, are not yet sufficiently understood. Future research might usefully explore what precisely Christian organisations like the CMC and Medicus Mundi had to offer to the origins of the Alma Ata Declaration.⁵⁰

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49 Litsios (2004) as in FN 34.

50 A good place to start would be "Non-governmental organizations and primary health care" (Position paper for the Conference of Alma Ata, Reprint). *Contact* 48 (1978): 8-10.

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Endocrine Disruptors: An Evolving Health Concern in International Organizations

Iris Borowy

Introduction

In a complicated world full of risks that appear especially menacing for often being invisible, indirect and difficult to assess for the non-expert, people need experts to give them credible advice on the extent and the nature of risks and on reasonable ways to react. In the twentieth century risk assessment has become an integral component of political and public life.¹ In a complicated world full of experts, who often come to different conclusions using different methods and different criteria of evaluation, people need credible recommendations based on authoritative analysis of existing expertise. International organizations, supposedly standing above special national interests, are expected to act as experts of the experts. In more detailed terms this role has been described as defining concerns and framing questions for research, offering a forum for communication between experts and stakeholders, establishing state of the art understanding of an issue at hand and, as far as possible, creating consensus about it, and providing guidelines for suitable corrective and preventive action.² By all means this is a tall order. Faced with incomplete and often contradictory knowledge, international organizations have to strike a balance between too much and too little caution. They also have to manoeuvre between vested interests as well as between the contradictory demands of science and politics, requiring on the one hand, scientific precision, using cautious language and providing adequate representation of doubts, and, on the other hand,

1 Ulrich Beck, *Risikogesellschaft* (Berlin: Suhrkamp, 1986).

2 Michael Barnett and Martha Finnemore, 'The Politics, Power, and Pathologies of International Organizations', *International Organization*, 53: 4 (1999), 699-732; Per-Olof Busch, 'The OECD Environment Directorate. The Art of Persuasion and its Limitations', Working Paper 20, *The Global Governance Project*, (2006). <http://www.glogov.org/images/doc/wp20.pdf>; Ernst Haas, *When Knowledge is Power. Three Models of Change in International Organizations* (Berkeley, 1990);

unequivocal statements, which are sufficiently clear to be useful for policy recommendation.

Expectations are especially strong and began particularly early with regard to health. The need for international decisions on what did or did not constitute health threats and what to do about it can be seen as the origin of international health cooperation, and it was accepted by international health organizations (IHOs) early on.³ From the outset in 1946 the World Health Organization (WHO) has been expected 'to promote and conduct research in the field of health ... to provide information, counsel and assistance in the field of health' and 'to assist in developing an informed public opinion among all peoples on matters of health'.⁴ Several other organizations have also come to issue verdicts on health-related issues, due to the proliferation of public and private organizations engaged in international health since the 1980s and to the multidisciplinary nature of health and its interaction with a broad range of social determinants. Complicated health issues that have no clear or simple cause-effect relation and touch on the responsibilities of several institutions present a special challenge for IHOs. This paper addresses one particularly complicated issue.

Endocrine disrupting chemicals (EDCs) are compounds believed to bring the endocrine system of living beings, including humans, into disorder by mimicking hormones. The endocrine system manages central processes in living organisms including growth, metabolism and reproduction. During fetal development hormones set the 'program' for development of the growing being from birth to maturity so that their influence during gestation may only become visible many years later. It is a complex system, affected by numerous interacting elements, which evade simple cause-effect relations and fall into the areas of expertise of scientists that do not often talk to, let alone cooperate with, one another. The effects of a growing list of substances with possible endocrine disrupting qualities on human health have been the object of discussions and controversy since the 1990s. This list includes numerous substances that had already caused concern before, at a time before there were EDCs.

For scholars of international health EDCs present a fascinating case study since they allow observing in real time how various stake holders negotiate a growing body of data from the first detection of a possible threat to evolving discussions, while possible assessments of its risk range between non-existent to dramatic. The story falls into two distinct periods: a first in which the conditions were set that both facilitated and obstructed the understanding of EDCs, and a second, in which the concept and scale of EDCs were debated. The second phase is far from over. This

3 Neville M. Goodman, *International Health Organizations And Their Work*, (Edinburgh / London, 1952, 2nd extended edition 1971), pp. 46-71; Iris Borowy, *Coming to Terms with World Health* (Berlin, 2009).

4 Constitution of the World Health Organization, art. 2, 22 July 1946, <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>, consulted 23 Jan 2014.

paper aims to be an early effort at disentangling the various actors and their concepts which have shaped the response of IHOs to the challenge of EDCs.

From the 1970s to the 1990s: IHO health work before EDCs

The two most spectacular examples of EDCs, so far, erupted long before this expression existed. Thalidomide was first sold as a sedative by the German pharmaceutical company Chemie Grünenthal in 1957 and was subsequently marketed under approximately sixty trade names in many countries for numerous illnesses, ranging from insomnia and morning sickness to depression, premature ejaculation, tuberculosis, premenstrual symptoms, menopause, stress headaches, alcoholism, anxiety, and emotional instability. After some years doctors noticed a rising number of infants born with congenital deformations to mothers who had taken the drug during pregnancy. In December 1961 an article by the Australian doctor William McBride appeared in *Lancet* and Hamburg medical professor Widukind Lenz publicized his findings about a correlation in Germany, and by the end of the year the drug had been withdrawn from the market in most countries. More than ten thousand children worldwide are believed to have been born with deformed or missing limbs because of the effects of the drug. A large-scale court case against Grünenthal ended in 1970 with a dismissal of the case after a donation by the company to an assistance fund for victims.⁵

The number of affected people and the severity of the deformations made Thalidomide an outstanding case of teratogenic damage, but its impact was limited by its relatively direct connection between cause and effect, since abnormalities were immediately visible at birth. By comparison the case of diethylstilbestrol (DES), a synthetic estrogenic substance, remarkably similar to natural female hormones, was more difficult to establish. Despite early indications of carcinogenic and teratogenic effects in animal tests and an initial rejection of admission in the USA, the drug was accepted for sale in the 1940s, and subsequently millions of women were prescribed DES as therapy during menopause and to prevent miscarriages during pregnancies. Many more people took in smaller quantities through their food when DES was fed to livestock to accelerate weight gain. In 1971 doctors began to note clusters of rare vaginal cancers in women whose mothers had taken DES during pregnancy. By 2008 it appeared that of ‘the 2 million to 5 million children who were exposed to DES prenatally, nearly 95 percent of them have experienced reproductive tract problems,

5 Jerry Avorn, “Learning about the Safety of Drugs – A Half-Century of Evolution”, *New England Journal of Medicine*, 365 (2011), 2151-2153; Carsten Timmermann, “Die Nachtseite des Wirtschaftswunders”, *FAZ*, 25 Nov 2001, <http://www.k-faktor.com/contergan/artikel8.htm>, consulted 27 Jan 2014.

including menstrual irregularities, infertility, and higher risks of a variety of reproductive cancers'.⁶

These two cases established two principles of the future discussions on EDCs: that a substance, which caused no harm to adults, could affect the development of the fetus, including in ways which might only become apparent decades later when the former fetus had reached adulthood, and that its effect did not follow a classical toxicological dose-response mechanism.

Both scandals were viewed as medical and pharmaceutical issues, and the World Health Organization (WHO) was the only IHO that reacted. The thalidomide disaster triggered the establishment of the WHO International Drug Monitoring Programme. First preparations began in 1962 and a pilot project with ten member countries ran from 1968 to 1971, when the program became permanent. It proceeded to grow rapidly and to issue policy guidelines, general publications and safety reviews of specific medicines, acting in response to national reports. In 1968, the Pilot project received 5645 drug reaction reports from ten countries. In 2008, the programme declared having some four million case reports from approximately 100 countries.⁷ It formed a model case of an IHO providing information and guidance on a perceived health threat.

These challenges were constructed as strictly iatrogenic risks, i.e. as a function of monitoring medical drugs. For a long time, few people saw a relation to environmental and occupational hazards related to the explosive growth of the chemical industry. The global production of chemical products surged from 1.5 million tons in 1950 to 50 million tons in 1976 and 100 million tons in 1989. In 2006, it would amount to 246 million tons, still growing.⁸ Large part of chemicals went into the production of plastics whose very plasticity made them useful for a sheer endless number of uses at little cost, ranging from packaging to hospital tubes and car parts. Plastic increased the sensation of growing affluence because it 'promised abundance on the cheap.'⁹ But chemicals also became a substantial part of everyday life as pesticides, cosmetics, packaging, glues, clothes, electronic equipment, food additives and for countless other purposes. It soon became clear that chemicals could represent health risks during production, usage and through their virtually ubiquitous presence in food, clothes, housing etc. and as waste after having been discarded. Therefore substances which, some decades later, would be considered EDCs first gained attention as occupational or environmental health hazards.

6 Nancy Langston, "The Retreat from Precaution. Regulating Diethylstilbestrol (DES), Endocrine Disruptors and Environmental Health", *Environmental History*, 13 (2008), 41-65, 51.

7 Jan Venulet and Margaretha Helling-Borda, "WHO's International Drug Monitoring – The Formative Years, 1968–1975", *Drug Saf*, 33: 7 (2010), e1-e23.

8 http://www.chemgapedia.de/vsengine/media/vsc/de/ch/16/schulmaterial/mac/alltag/grafik/weltproduktion_kunststoffe.jpg, consulted 20 Jan 2014.

9 Susan Freinkel, *Plastic. A Toxic Love Story*, Boston: Houghton Mifflin, 2011, 7.

One of the most notorious and most researched examples involves polychlorinated biphenyls (PCBs). PCBs had been commercially produced since the late 1920s, and it had since been applied in plasticizers, surface coatings, inks, adhesives, flame retardants, pesticide extenders and paints.¹⁰ During the 1920s and 1930s, workers in manufacturing plants repeatedly suffered severe, sometimes fatal chloracne. PCBs also emerged as agents of food poisoning in 1968, when 1,300 residents of Kyushu, Japan, became ill after eating rice-bran oil, which had been contaminated with PCB fluids. Fifty people died.¹¹ Meanwhile, Rachel Carson's *Silent Spring* regarding the consequences of massive use of pesticides in agriculture on birds, published in 1962, established chemicals such as DDT as an environmental rather than a health problem.¹²

IHOs got involved in discussions regarding chemical safety early on and with a rapidly growing number of programs. The International Labour Office (ILO) regularly addressed hazards of toxic substances as an issue of occupational health issues already during the 1920 and 1930s.¹³ After 1945 the ILO, the Food and Agriculture Organization (FAO) and the WHO, individually and jointly, addressed health repercussions of chemicals. The early focus was on pesticides. Prompted by a 1951 World Health Assembly resolution the WHO presented its first report in 1953. It concluded that, when properly used, existing pesticides did not appear to cause imminent health threats, though long-term effects or consequences of new substances needed to be observed. This finding was largely confirmed three years later by a joint ILO-FAO-WHO study group. Their report revealed their profoundly ambivalent view of pesticides: while it was acknowledged that pesticides might, under certain circumstances, present some risks and that it was preferable not to have any residues in milk or water, this was not always possible since the use of pesticides was found indispensable for several purposes such as the production and storage of food and for the fight against vector-borne diseases, notably malaria.¹⁴ This view characterized the position both of joint FAO/WHO and ILO/WHO expert committees on pesticides throughout the 1960s.¹⁵ An FAO/WHO meeting in 1963 resulted in a report that

10 IPCS, Concise International Chemical Assessment Document 55, *Polychlorinated Biphenyls: Human Health Aspects* (Geneva, 2003), p. 4.

11 The History of PCBs, http://www.foxriverwatch.com/monsanto2a_pcb_pcbs.html, consulted 20 Jan 2014; IPCS, *Polychlorinated biphenyls and terphenyls*. Environmental Health Criteria 2 (Geneva, 1976); Eric Francis, "Conspiracy of Silence", *Sierra*, (September/October 1994) <http://www.sierraclub.org/sierra/200103/conspiracy.asp>, consulted 20 Jan 2014.

12 Rachel Carson, *Silent Spring* (Boston, 1962).

13 Aage Grut, "The Work of the International Labour Organization in Occupational Health", *British Journal of Industrial Medicine*, 8 (1951), 199-205.

14 WHO, *Toxic Hazards of Pesticides to Man*. Technical Report Series 114 (Geneva, 1956).

15 WHO, *Principles Governing Consumer Safety in Relation to Pesticide Residues*. Technical Report Series 240 (WHO: 1962); Kingsley Kay, "Organization of Occupational Health Services for Personnel Exposed to Toxic Pesticides", *Ann. Occup. Hyg.*, 7 (1964), 285-297.

addressed 37 pesticides and suggested acceptable daily intakes of fifteen of them (which earlier reports had refused to do). Further meetings expanded this list and specified which fruit, vegetables and cereals the recommendations referred to.¹⁶

Inadvertently, this act of setting standards affected not only domestic health regulations but also questions of international trade. Here, international assessments of chemical safety could help harmonize national health and trade interests if international standards were similar to national standards, and they could do substantial harm if they differed materially in either direction. This connection provoked the involvement of the Organization for Economic Cooperation and Development (OECD), an agency designed to promote economic growth and prosperity through trade in undistorted markets. In 1966 it organized a workshop on 'unintended occurrences of pesticides in the environment,' to which the OECD invited the WHO to send a representative.¹⁷ The meeting started a three-year project.¹⁸ Its final report made clear that the issue required more institutionalized long-term attention, and in 1971, the OECD created a long-term Sector Group on *Unintended Occurrence of Chemicals in the Environment*. This program aimed at the harmonization of testing methods and regulations and at ways to reduce related costs. The main driving force was the US government, which wanted to prevent European countries from using health concerns as trade barriers against the newer and more dynamic US chemical industry.¹⁹

The scenery became even more complex when, in 1972, the UN Conference on the Human Environment in Stockholm raised the international awareness of environmental concerns, including possible health effects of chemicals. As a result, the UN Environment Programme (UNEP) emerged as additional actor and the WHO initiated an *Environmental Health Criteria* (EHC) Programme, designed, among other tasks, to assess information on the relationship between exposure to environmental pollutants and human health, to identify gaps in pertinent knowledge, to provide guidelines for setting exposure limits and for toxicological and epidemiological methods in order to make research results internationally comparable. The first EHC report appeared in 1976, published, like its successors,

16 WHO, *Pesticide Residues in Food*, Technical Report Series No. 370 / FAO Agricultural Studies No. 73 (Geneva, 1967); WHO *Pesticide Residues*, WHO Technical Report Series No. 391 / FAO Meeting Report P: 1967/M/11 (Geneva, 1968). Following reports see <http://www.who.int/foodsafety/chem/jmpr/publications/reports/en/index.html>, consulted 25 Jan 2014.

17 De Groot van Embden to Candau, 19 April 1966, H II/80/2 (A), WHO archive (WHOA).

18 Timmons to Candau, 29 Oct 1970, H II/80/2 (A), WHO archive (WHOA).

19 Peter Carroll and Aynsley Kellow, *The OECD. A Study of Organizational Adaptation* (Cheltenham, 2011), pp. 220-226.

under joint WHO/UNEP sponsorship.²⁰ Health concerns focused on cancer and possible damage to the liver and kidneys. The approach was solidly toxicological. Following the principle that the dose makes the poison, the assumption was that there was a threshold below which exposure to a substance was harmless and that, therefore, the task of an IHO was to provide authoritative information about what this threshold appeared to be and how pertinent studies should be conducted.

In 1974, the WHO established a study group on health hazards from new environmental pollutants. Reviewing information from toxicological data banks, clinical and laboratory work etc. it extended substantially the range of relevant chemicals to be considered, including plastics and plasticizers, fire retardants, metals, photosensitizers and pesticides. As a new feature, a draft on the harmonization of toxicological testing techniques mentioned, among others, risks of teratogenesis.²¹ A 1977 resolution of the World Health Assembly further broadened the perspective. In view of the ubiquitous 'growing use of chemicals' it called for studies on the problem and possible long-term strategies regarding 'the acute and especially the chronic or combined toxic effects, not only on present but on future generations, that may result from exposure to chemicals in air, water, food, consumer products and at the place of work, particularly if combined with exposure to other chemicals, infectious agents and physical factors.'²² Thus, the WHO clearly advanced the approach on the issue from that of mono-substance oriented short-term effects to long-term and multi-substance considerations, including effects on future generations, aspects, which would be crucial to the ECD discourse.

However, this was only one side of what remained an ambivalent and partly contradictory position of the WHO. Chemicals formed part of environmental health, and in the general WHO context, environmental health overwhelmingly referred to risks emanating from natural and organic sources such as infections resulting from bacterial contamination of water or from disease vectors. This perspective saw industrialization and chemicals as a solution rather than as a problem. Tellingly, in late 1969, Director General Candau regarded the upcoming Stockholm Conference on the Human Environment with suspicion, lest emotions on insecticides would obstruct WHO anti-malaria work.²³ In 1972, the WHO Bulletin published a study which demonstrated high levels of chlorinated pesticides, especially

20 WHO/UNEP, Mercury, EHC 1 (Geneva, 1976); WHO Task Group on Environmental Criteria for Carbon Tetrachloride, Published under the joint sponsorship of UNEP, ILO, WHO (Geneva, 1999), ix.

21 Socrates Litsios (WHO), *The Third Ten Years of the World Health Organization, 1968-1977*, (Geneva, 2008), pp. 264-266.

22 WHA30.47 Evaluation of the effects of chemicals on health, 19 May 1977, Handb. Res., Vol. II (2nd ed.), 1.11.3, http://apps.who.int/iris/bitstream/10665/93210/1/WHA30.47_eng.pdf, consulted 25 Jan 2014.

23 Note for the file, Conference on the Human Environment – 1972, 5 Dec 1969, H/II/86/3, WHO archive.

DDT, in the fatty tissues of people living in the Ferrara region, without even mentioning possible health repercussions.²⁴ And as late as 1988, the WHO representative, who interviewed future Director General Gro Harlem Brundtland about the publication of the Commission carrying her name, wondered if the report had not concentrated too much on man-made environmental problems ‘while in reality two-thirds of mankind were struggling against adverse natural conditions such as unsafe water, disease vectors, unfavourable climatic conditions, and so on.’²⁵ This perspective of health hazards of chemicals as a pet complaint of the privileged rich and a potential impediment to satisfying the health needs of the poor would continue to burden considerations at the WHO and may explain why different WHO departments could take tangibly different positions on the assessment of the health hazards of chemicals. Depending on their overall field of work, WHO staff could interpret their task either as highlighting the health risks of chemicals in order to protect populations from potential resulting health burdens, or as downplaying possible health risks of chemicals in order to prevent populations from losing crucial protection against existing health burdens.

This ambivalence showed in the second EHC paper, published in 1976, which reviewed available data in original scientific publications and national overviews on exposure levels and possible effects of PCBs and polychlorinated terphenyls on humans and on the environment. The paper clearly outline the extent of human exposure to the substance, estimating that the cumulative world production of PCBs since 1930 were about one million tons, about half of which were found in dumps and landfills from which they were slowly being released. They were well absorbed by mammals through the gastrointestinal tract, lungs, and skin, stored mainly in adipose tissue, and they passed the placental barrier. Most people tested, had shown PCB levels up to 1 mg/kg body weight, though exposure, notably in work places, could be much higher. But the authors of the text were not overly alarmed by these findings. Man appeared to be the species most sensitive to PCB, and the contamination incident in Japan had suggested that 0.5 g (i.e. 500 mg) over 120 days represented the smallest dose to produce an effect.²⁶ These data suggested that, irrespective of their massive environmental presence, PCBs represented little danger to health, and the paper did not provide any policy recommendation.

The attitude contrasted with the precautionary approach taken by a WHO study group at the same time as well by the OECD three years earlier. Invoking the confirmed presence of PCBs in wildlife in many countries, the OECD had called for

24 L. Prati, R. Pavenello and F. Ghezzi, “Storage of chlorinated pesticides in human organs and tissues in Ferrara Province, Italy”, *Bulletin World Health Organization*, 46 (1972), 363-369.

25 Forum Interview with Gro Harlem Brundtland, ‘Planet Earth – suicide or survival?’, *World Health Forum* vol. 9, 1988, 180

26 IPCS, *Polychlorinated biphenyls and terphenyls*. EHC 2, Geneva: WHO, 1976.

<http://www.inchem.org/documents/ehc/ehc/ehc002.htm#PartNumber:9>, retrieved 4 Dec 2012.

the international control of PCBs with a goal to minimize and – eventually – eliminate their escape into the environment.²⁷ This recommendation was in line with US policy of the time, which had severely restricted the use of PCBs through the Toxic Substances Control Act of 1976 (four years after DDT) and banned its production in 1979. European countries followed suit.²⁸ A WHO Technical Report, also published in 1976, went even further. The meta-study considered a substantially expanded spectrum of possible health risks, reviewing various methods to test mutagenicity, carcinogenicity, teratogenicity and ecological damage. Given the diffuse nature of these effects and the difficulties of experimentation with humans, warning signs were statistical and inherently problematic, since they required extensive and reliable registration of physical burdens and defects and had to consider numerous new synthetic substances in all fields of life. The concluding recommendations were bold: the introduction of new materials should not be permitted until their adverse effects, if any, had been adequately assessed.²⁹ It was the most far-reaching demand with the most unequivocal endorsement of the precautionary principle voiced by an international organization, not paralleled before or later. It was the year when the Icmesa chemical plant, a subsidiary of Hoffman-La Roche, released large amounts of highly toxic tetrachlorodibenzodioxin into the environment at Seveso, Italy, injuring hundreds of people.³⁰ Chemicals were increasingly recognized as potentially serious health threats.

Shortly afterwards, the chemical industry got organized to present their perspective. The European Chemical Industry Ecology and Toxicology Centre was founded in 1978, an agency financed by the who's who of chemical companies, including BASF, Bayer, Shell, ExxonMobil, Honeywell, Procter & Gamble, Merck and others. On its 2014 website, it describes its task as

developing and promoting top quality science in human and environmental risk assessment of chemicals' and presents itself as the scientific forum where member company experts meet and co-operate with government and academic scientists, to evaluate and assess the available data, identify gaps in knowledge and recommend

27 C(73)1(Final), cited in Draft Decision Recommendation of the Council on Further Measures for the Protection of the Environment by Control of Polychlorinated Bisphenyls ENV(86)22, 19 Nov 1986, OECD archive, 7.

28 Theo Colborn, Dianne Dumanoski and John Peterson Myers, *Our Stolen Future* (New York, 1996), p. 91. Francis, Conspiracy.

29 WHO, *Health hazards from new environmental pollutants. Report of a WHO scientific group*. WHO Technical Report Series, No. 586 (Geneva, 1976).

30 Pier Bertazzi et al., 'The Seveso studies on early and long-term effects of dioxin exposure: a review', *Environmental Health Perspectives*, 106 (Supp.2) (1998), 625–633.

research, and publish critical reviews on the ecotoxicology and toxicology of chemicals, biomaterials and pharmaceuticals.³¹

Its methods of work, reports and workshops, mimicked those of academia, and by posing as a forum for international and interdisciplinary exchange of scientific knowledge, the Centre claimed the ground of IHOs. In 1994, it changed its name to European Centre for Ecotoxicology and Toxicology of Chemicals (ECETOC), dropping its ties to industry from its name and thus increasing its impression as an IHO, in charge of providing authoritative information and recommendations.³² Apparently, organizers had decided that the best way to counter negative information coming from IHOs about chemical products was to act like IHOs and hope that some people would not tell the difference.

Meanwhile, international organizations increased their institutionalized cooperation. In 1980, the International Programme on Chemical Safety (IPCS), which had already provided an informal frame to joint WHO-UNEP publications for some time, added ILO to its participants and became firmly institutionalized. Its task was to organize and assess peer review processes to evaluate the risk to human health of (combinations of) chemicals and to develop and review methods for laboratory testing and ecological and epidemiological studies with member states.³³ In the following years, the IPCS became the authoritative voice of risk assessment, issuing a series of metastudies, designed to provide state of the art knowledge about a long and growing list of chemicals, addressing their possible carcinogenic effects as well as possible damage to internal organs, skin and respiratory irritation.³⁴ At the same time, the OECD Chemicals Programme was renamed the Environment, Health and Safety (EHS) Programme moving closer to health-related work developing at the WHO and its cooperative organs with UNEP and ILO.³⁵ Their expertise was acknowledged at the UN Conference on Environment and Development in Rio 1992. Agenda 21, its copious plan of action, described the problem in clear terms: 100.000 chemical substances existed, of which 1.500 represented approximately 95% of world production. Crucial data for risk assessment were missing 'even for a great number of chemicals characterized by high-

31 <http://www.ecetoc.org/overview>, consulted 17 Jan 2014.

32 Timeline, <http://www.ecetoc.org/history>, consulted 17 Jan 2014.

33 WHO, WHO Task Group on Environmental Health Criteria for Carbon Tetrachloride, (Geneva, 1999), ii; WHO: *Action for Environmental Health. WHO Says* (Geneva, 1988), p. 16.

34 See e.g. IPCS studies on Beryllium (1990), on Alpha- and beta- hexachlorocyclohexanes (1992), on Hexachlorocyclopentadiene (1991).

35 OECD, *The OECD Environment, Health and Safety Programme: Achievements, Strengths and Opportunities*, ENV/JM(2011)17, [http://search.oecd.org/officialdocuments/displaydocumentpdf/?cote=ENV/JM\(2011\)17&doclanguage=en](http://search.oecd.org/officialdocuments/displaydocumentpdf/?cote=ENV/JM(2011)17&doclanguage=en), consulted 12 May 2012,

volume production.³⁶ Agenda 21, therefore, strongly underscored the urgent need for more research, calling on IPCS the OECD, FAO and the European Community (EC) in this regard.³⁷

Thus, by 1992, several IHOs were well alerted to chemicals as potential health risks. They had an elaborate infrastructure of joint inter-agency committees in place. This background of institutional collaboration certainly helped coming to terms with the new challenge of EDCs. However, the strict conceptual separation stood in the way of easy inter-sectoral communication: toxicological principle of dose-response was established for occupational and environmental health while a bio-systemic understanding was used in iatrogenic health risks, and the two spheres hardly intersected. These circumstances formed the background for the understanding of the emerging new concept of endocrine disruption.

From the 1990s to Today: IHO health work with EDCs

During the 1980s evidence of disturbing phenomena emerged from a confusing range of seemingly unrelated contexts, ranging from laboratory experiments with uncontrollably multiplying cancer cells to fish of unclear sex caught near discharges of sewage treatment plants, and apparent increases in boys born with deformed genital organs.³⁸ In July 1991, zoologist Theo Colborn gathered a group of interdisciplinary scientists, including wildlife biologists, endocrinologists, immunologists and toxicologists, in Wisconsin, to discuss a series of disconcerting changes in the Great Lakes area. After long discussions they discovered a common theme among the various phenomena and coined the expression of 'endocrine disruption' to mark diverse disorders related to hormone directed physiological processes.³⁹ For the first time, a categorization of a group of diverse substances was based on the presumed type of health damages they provoked. Subsequently, Colborn co-authored a paper, published 1993, which laid out the bases of the new concept:

Convincing evidence exists that a variety of pollutants, some of which can disrupt endocrine development in wildlife and laboratory animals, is found in rain water, well water, lakes, and oceans, as well as freshwater, marine, and terrestrial food products. ... Endocrine-disrupting effects are not currently considered in assessing risks to humans, domestic animals, and wildlife. Taking into consideration what is currently known about chemicals that disrupt the endocrine system, the effects 1)

36 Agenda 21, § 11, <http://habitat.igc.org/agenda21/a21-19.htm>.

37 Agenda 21, § 15, <http://habitat.igc.org/agenda21/a21-19.htm>.

38 Colborn, Dumanoski and Myers, *Our Stolen Future*, pp. 122-135.

39 Freinkel, *Plastic*, pp. 92-93.

may be manifested in an entirely different way, and with permanent consequences, in the early embryo, fetus, and neonate from effects as a result of exposure only in adulthood; 2) can change the course of development and potential of offspring, with the outcome depending on the specific developmental period(s) of exposure; and 3) are often delayed and thus may not be fully or obviously expressed until the offspring reaches maturity or even middle age, even though critical exposure occurred during early embryonic, fetal, or neonatal life.⁴⁰

Drawing the connection to the DES case, the paper suggested a list of health disorders potentially caused by EDCs including preterm births, low birth weight, small skull circumference, cryptorchidism in infants, and cognitive, motoric, visual and behavioral deficits in children, breast and prostatic cancer and low sperm count in adults. In 1996, the book *Our Stolen Future*, also co-authored by Colborn, introduced the concept to the lay world. Virtually non-existent before, the use of expressions of ‘endocrine disruptor’ or ‘endocrine disrupting’ in written texts exploded within just a few years.⁴¹ It was the birth of a new health issue, and as fears of a diffuse danger especially to babies and children spread terror among young parents the need for more information was obvious. Scientists turned to the issue with a vengeance. Pubmed listed merely four papers using the keywords ‘endocrine disruptors’ in 1995. In 2011, there were 551.⁴²

The news about this new type of threat was sufficiently disconcerting for governments of industrialized countries to take note. A 1996 OECD survey showed that almost all member countries had done or were preparing national reports or reviews on the question. Alarmed both by data about wildlife and by toxicological studies, all twenty-two countries, which returned the OECD questionnaire, considered EDCs candidates for regulatory or advisory activities, and half of them considered the issue a major concern. Roughly half the respondent administrations felt well informed about what constituted an ‘endocrine disrupting substance’ while the other half did not. The range of chemicals considered (potentially) hazardous included specific compounds as well as groups of substances as EDC suspects. The list revealed the potential scale of the challenge: phytoestrogens, PCBs and metabolites, phthalates, TBT, chlorinated hydrocarbons, chlorinated dioxins, alkylphenols, DDT and metabolites, organometals, pesticides, pharmaceuticals, food additives, bisphenol A, brominated flame retardants, optical brighteners, detergent

40 Theo Colborn, Frederick S. vom Saal and Ana Soto, “Developmental effects of endocrine-disrupting chemicals in wildlife and humans”, *Environmental Health Perspectives*, 101: 5 (1993), 378-84.

41 https://books.google.com/ngrams/graph?content=endocrine+disruptor%2C+endocrine+disrupting&year_start=1800&year_end=2000&corpus=15&smoothing=3&share=&direct_url=t1%3B%2Cendocrine%20disruptor%3B%2Cc0%3B.t1%3B%2Cendocrine%20disrupting%3B%2Cc0, consulted 15 Jan 2014.

42 <http://www.ncbi.nlm.nih.gov/pubmed/?term=endocrine+disruptors>, consulted 20 Jan 2014.

derivatives and steroid hormones.⁴³ If ever there was a case where IHO guidance was needed, this was one. The challenge was threefold: to assess if there were statistically significant unexplained changes in animal and human health, to determine whether these changes (if they existed) were linked to substances defined as EDCs, and to decide whether these health effects of EDCs (if they existed) were sufficiently serious to warrant specific policies.

IHOs reacted by recommending, commissioning and evaluating studies into the question, each taking different perspectives. Early approaches focused on wildlife, for which more data were available. In 1996 the OECD established a *Special Activity on Endocrine Disrupter Testing and Assessment* which initially addressed the economic repercussions of possible effects of EDCs on aquatic life due to their consequences on commercial fishing.⁴⁴ The WHO was even quicker. Its 1993 EHC update on PCBs, a fat volume of 682 pages, which reviewed the findings of over 1000 original papers and several scientific conferences since 1976, included as a new feature, a very technical chapter, specifically entitled ‘effects on the endocrine system.’ While this chapter dealt exclusively with observations regarding effects on animals, the final conclusions also addressed effects on experimental animals, humans and the environment. The text acknowledged the wide distribution of PCBs in the environment throughout the world, its persistence and its accumulation in food webs. Human exposure continued to be largely from the consumption of contaminated food, especially mother’s milk for babies, but also from inhalation and skin absorption. But firm findings continued to be inhibited by complications: PCBs were frequently found in combination with carcinogenic polychlorinated dibenzofurans (PCDFs), which appeared to exacerbate their toxicity but also made it difficult to establish clear cause and effect chains. Thus, the conclusions of the text acknowledged the degree to which humans had become helpless victims of chemical exposure:

It is clear from available data on polychlorinated biphenyls (PCBs) and polychlorinated terphenyls (PCTs) that, in an ideal situation, it would be preferable not to have these compounds in food at any level. However, it is equally clear that the reduction of PCBs or PCTs exposure from food sources to ‘zero’ or to a level approaching zero, would mean the elimination (prohibition of the consumption) of

43 OECD, *Summary Report of the 1996 OECD Questionnaire on Endocrine Disrupting Substances*, undated, unnumbered, OECD Archive, pp. 1- 4.

44 Endocrine Disrupter Testing and Assessment, <http://www.oecd.org/env/chemicalsafetyandbiosafety/testingofchemicals/endocrinedisruptertestingandassessment.htm>, retrieved 5 Dec 2012.

large amounts of important food items, such as fish, but more importantly breast milk.⁴⁵

The logic of EDCs as unpleasant but unavoidable risk repeated a similar approach regarding pesticides some forty years earlier. Accordingly, recommendations appeared mild: more research, more standardization in research, disposal of the substance only in high-performance incinerators and monitoring sea mammal populations.⁴⁶

Soon after, the topic formed the subject of a remarkably broad-based conference. In late 1996, the European Centre of the WHO, the European Commission, the European Environmental Agency, the OECD and various national administrations co-organized a Workshop on the Impact of Endocrine Disruptors on Human Health and Wildlife in the English town of Weybridge, where experts in various fields pooled their knowledge. Participants were cautious regarding wildlife, where they saw ‘few cases within the EU ... where effects could be clearly ascribed to endocrine disruptors,’ and even more so concerning human health. They agreed that there was sufficient evidence to establish that testicular cancer rates were rising and sperm counts falling in some regions and that ‘existing exposure information was generally insufficient to definitely associate the human changes seen with chemical exposure.’⁴⁷ More research was therefore needed to establish if, to what extent and in what way certain chemicals might interfere with animal and human health. As an important step forward, the workshop proposed a definition of an endocrine disruptor as ‘an exogenous substance that causes adverse health effects in an intact organism, or its progeny, consequent to changes in endocrine function.’⁴⁸ It was an early attempt at giving a more precise meaning to a phenomenon whose effects might be limited to wildlife and whose very existence was in doubt for humans.

This caution was understandable, because for international organizations, this new categorization of health issues was a mixed blessing. On the one hand, it provided a theory for the physiological processes in which chemical compounds might cause the rising incidence in an array of health problems, otherwise difficult to explain. But this theoretical precision made scientifically sound conclusions exceedingly complicated because it required explaining mechanism which contradicted the rules so far assumed to determine the health risks of chemicals. During the preceding

45 WHO, § 1.1.1., IPCS, *Polychlorinated biphenyls and terphenyls*, 2nd ed. Environmental Health Criteria 140, (Geneva, 1993). <http://www.inchem.org/documents/ehc/ehc/ehc140.htm>, retrieved 10 Sept 2013; see also <http://apps.who.int/iris/handle/10665/38678>.

46 IPCS, *Polychlorinated biphenyls and terphenyls*, 2nd ed. Environmental Health Criteria 140 (Geneva, 1993), <http://www.inchem.org/documents/ehc/ehc/ehc140.htm>, retrieved 4 Dec 2012.

47 European Workshop on the impact of endocrine disruptors on human health and wildlife. *Conclusions and recommendations*, 2 -4 Dec 1996. http://ec.europa.eu/environment/chemicals/endocrine/documents/reports_conclusions_en.htm#, retrieved 10 Sept 2013.

48 Ibid.

decades the health repercussions of chemicals had been assessed in toxicological terms: the toxicity of a given substance was a function of the dose of exposure ('dose-response'), and its specification required a reproducible relation between a causative agent and its outcome. Both principles were violated by research regarding EDCs. The concept of endocrine disruption through chemicals assumed that the effects of the substances in question did not depend primarily (or not at all) on its dose but, as with endogenous hormones, on the time and condition of exposure, on possible complex interaction with other substances and on tissue-specific effects such as receptor selectivity. Accordingly, results of exposure tests could vary widely, depending on circumstances.

Although this mechanism was well established for drugs like DES, many toxicologists were unwilling to accept it for environmental exposure. And, since experiments with humans were out of the question for ethical reasons, establishing authoritative expertise was difficult. Initially, the majority of data derived from biologists rather than medical scientists, and it was unclear to what extent findings about deformations in fish and mollusks were relevant to humans. Reliable epidemiological data, especially on long-term development of exposed individuals, were often difficult to establish and even more difficult to correlate to exposure levels regarding any specific example of a long list of chemicals with which people had been surrounded in the course of many years. Laboratory tests with animals raised the question of a suitable model while in vitro tests showed endocrine activity but were unhelpful to determine whether it was beneficial or harmful to the health of an entire organism. Thus, finding robust epidemiological data on humans and creating accepted methods for in vitro and clinical tests formed difficult and time-consuming but essential steps towards establishing reliable information on the effects of EDCs for humans.

A few weeks after the Weybridge conference, a meeting sponsored by the UNDP and the US Environmental Protection Agency (EPA), with participants from the same agencies and from numerous individual countries and of industry, demonstrated the difficulty of placing the issue in a global health context. The workshop largely confirmed the Weybridge conclusions, but participants from low-income countries in the South pointed out that, despite some awareness of possible health hazards resulting from chemical contamination, their governments 'regarded the issue as too ill defined and esoteric to take resources away from other pressing public health problems.'⁴⁹ Understandably, from a global South perspective, the increase of testicular cancer by between two and four men per 100,000 in some Scandinavian countries hardly merited redirecting funds from illnesses which killed millions of people in their countries every year. However, the global and long-term

⁴⁹ International Workshop on Endocrine Disruptors, 22-24 Jan 1997, <http://www.epa.gov/edrlupvx/Pubs/smithrep.html>, retrieved 10 Sept 2013.

perspective differed: if wildlife in remote corners in different continents was affected by any given proportion of the rapidly rising number of chemicals, this hazard was ubiquitous. And if the human endocrine system was, indeed, affected by the same chemicals, this rise in cancer incidence might be just the tip of a gigantic iceberg.

The new challenge appeared to arouse a certain degree of inter-agency competition. A May 1997 WHA resolution called on the Director-General of the WHO to „take the necessary steps to reinforce WHO leadership in undertaking risk assessment’ regarding chemicals to human health, and to promote and coordinate research ‘on potential endocrine-related health effects of exposure to chemicals.’⁵⁰ But in reality, any far-reaching work had to be cooperative. No single agency possessed all the expertise and infrastructure of institutes and people for all fields from which information would have to be pooled: the OECD was strong in chemical testing, the UNDP in environmental information, including on wildlife, and the WHO was obviously the central body regarding human health.

During the following years, the IPCS, itself a multi-agency body, cooperated with the OECD to establish a Steering Group of renowned international experts who adopted the task of establishing the state of global knowledge on the field. The result was a major IPCS report, published under WHO auspices in 2002, which summed up the findings of data collection and research of the last years. Again, they amounted to more questions and doubts than robust findings. For instance, it cited documented correlation between some EDCs and neurological development and behaviour, but it cautioned that similar effects could also result from chemicals inducing neurotoxicity rather than endocrine action.⁵¹ Thus, pending further research, the report was very careful to point out that, so far, there was little evidence pointing to a serious public health issue. It was difficult to draw conclusions about effects on human health from statistical data alone since they were often too patchy and too varied in experimental design to allow comparisons over time or between regions and often crucial data, notably regarding exposure during critical periods of development, were simply non-existent. Besides, the concentration and potencies of endogenous hormones was generally higher than that of exogenous chemicals, adding to complexity of interpretation. A decline of human sperm quality had been observed in several countries, but its relation to ECDs remained unclear, and metastudies were inconsistent. Similarly, connections to observed increases in deformations of male reproductive organs, to precocious puberty, impaired neurological development and immune functions and several cancers remained unclear. Testicular cancer rates in Northern Europe had begun rising at the beginning of the twentieth century before the industrial production of chemicals and, therefore, could not be explained by

⁵⁰ IPCS, *Global Assessment of the State-of-the-Science of Endocrine Disruptors* (Geneva, 2002), p. vii.

⁵¹ *Ibid.*, p. 3.

EDCs alone, if at all.⁵² Thus, in several fields there was sufficient credible evidence to establish changes in human health to raise concern, but not enough to draw a firm connection to EDCs. Yet, as one important result, the report narrowed the definition of EDC down to a more precise form to ‘...an exogenous substance (or mixture) that alters function(s) of the endocrine (hormonal) system and consequently causes adverse health effects in an intact organism, or its progeny, or (sub) populations.’⁵³ It would become the standard definition, accepted by believers as well as skeptics of the phenomenon.

As both epidemiological, laboratory and clinical research continued, though sometimes with contradictory findings, subsequent reports vacillated between different degrees of assertiveness. In 2003, an update on knowledge regarding PCBs, reconstructed the topic as a full-blown endocrine question. Though the text still pointed out the lack of unequivocal results due to the large range of possible confounding factors, it now listed an impressive list of disorders which had been observed in humans exposed to PCBs, alone or in combination with other substances, including reduced sperm mobility, slowed fetal growth and development, seriously impaired neurological functions of children such as reduced reflexes, memory capacities and IQ scores (though some deficiencies appeared to disappear later during childhood), increased incidence of cancers of the digestive system and increased susceptibility to some childhood diseases.⁵⁴ Nine years later, in a WHO report on Endocrine disruptors and child health, conclusions were expressed in more tentative terms. They confirmed that several reproductive and other endocrine disorders had reached epidemic proportions to the extent of warranting a new term of testicular dysgenesis syndrome (TDS), describing cryptorchidism, hypospadias, testicular cancer and failure of spermatogenesis, and these disorders had been linked to exposure to some EDCs in animal experimentation. But evidence was still insufficient for unequivocal conclusions. Nevertheless, as a particularly disconcerting aspect, the text repeated the possible impairment of intelligence in child development.⁵⁵ Another new item emerged in an EU report of 2011, which pointed out possible effects of EDCs on globally rising diabetes and obesity rates, though, as usual, firm assessments was considered to require more research.⁵⁶

ECETOC, the industrial ersatz-IHO founded in 1978, established an ‘Environmental Oestrogens Task Force’ but otherwise remained outside the

⁵² Ibid., p. 3.

⁵³ Ibid., p. 1.

⁵⁴ IPCS, CICAD 55, *Polychlorinated Biphenyls: Human Health Aspects* (Geneva, 2003), pp. 4-5.

⁵⁵ WHO, *Endocrine disruptors and child health* (Geneva, 2012).

⁵⁶ Andreas Kortenkamp et al., *State of the Art Assessment of Endocrine Disruptors*, 2011, http://ec.europa.eu/environment/chemicals/endocrine/pdf/sota_edc_final_report.pdf, consulted 10 Jan 2014.

discussions for years except for an article, published in 2000, which suggested a ‘set of testing and screening tiers’ which integrated natural EDCs into the picture and shifted attention away from epidemiological data.⁵⁷ It became more active after the EU issued regulations in 2009, which introduced considerations of risk of endocrine disruption into its admission criteria for chemical substances.⁵⁸ In response, ECETOC held two workshops and issued resulting reports which acknowledged the specific mode of action of endocrine disruption but, paradoxically, retained the idea of exposure limits. Insisting on the ‘science-based’ character of its recommendations it called for more nuanced classifications depending on the nature of the damage caused by EDCs and between substances of low and of higher concern, depending on threshold values of potency.⁵⁹ A more radical line was taken by ECETOC members in contributions to a special issue to *Toxicology Letters*, published online in October 2013. As a case in point, Gerhard Nohynek (long-time employee at l’Oréal) et al., sought to exonerate personal care products by raising doubts about the entire concept of EDCs. In their arguments the authors contradicted conceptual as well as epidemiological tenets of the EDCs: far higher risks should emanate from substances with much higher potency, such as hormone contraceptives or clover; non-monotonic dose-relationship contradicted centuries of pharmacological and toxicological experience; screenings showing endocrine activities triggered by a substance were irrelevant until harm to health could be demonstrated; there was no scientific evidence for some major reported disturbances like declining sperm count, increased incidence in cryptorchidism and hypospadias, nor for a link between EDCs and increasing testicular cancer rates nor for synergistic effects of several substances. Indeed, the paper flatly denied that any link had been shown between a man-made EDC which posed ‘an identifiable, measurable risk to human health’ adding, somewhat disingenuously, that ‘the adverse effects of iatrogenic DES were long known before the endocrine disruptor was coined.’⁶⁰ Derisively, Nohynek et al. commented that ‘the hypothesis that the negligible exposure of humans to chemicals of negligible hormonal potency could have an effect on human fertility is absurd defying a scientific basis as well as common sense’ and suggested vested interests of scientists working in the field, political correctness, a bias against everything man-

57 Tom Hutchinson et al., “Ecological risk assessment of endocrine disrupters”, *Environmental health perspectives*, 108:11 (2000), 1007-1014.

58 European Union, Regulation (EC) No. 1107/2009 of the European Parliament and of the Council of 21 October 2009, *Official Journal of the European Union*, 24 Nov 2009, L 309/1-309/50, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2009:309:0001:0050:EN:PDF>, consulted 29 Jan 2014.

59 Remi Bars et al., “Risk assessment of endocrine active chemicals: Identifying chemicals of regulatory concern”, *Regulatory Toxicology and Pharmacology*, 64:1 (2012), 143-154. <http://www.sciencedirect.com/science/article/pii/S027323230012001237>

60 Gerhard Nohynek et al., “Endocrine disruption: Fact or urban legend?” *Toxicology Letters*, 223 (2013), 295-305, 301.

made and the excessive sensitivity of male scientists to news about deformations of reproductive organs in male infants as reasons for the emergence of such an unfounded theory.⁶¹ Though the authors contrasted this apparent lack of evidence to the demonstrable relation between smoking and cancer, the strategy of creating doubt by denying or ignoring evidence and by smearing scientists in academia appeared eerily reminiscent of that used by the tobacco industry some decades earlier.⁶²

Such vehement repudiation of the idea of EDCs may have been prompted by the rising evidence in its favor. In 2013, an expert commissioned by UNEP and WHO, published an update on the 2002 report on the state of knowledge on the topic. While still cautious, it presented the issue in much firmer and also more urgent terms.⁶³ While approximately 800 chemicals were known or suspected of interfering with hormone receptors, only a small fraction were tested, and human exposure, especially to interacting combinations of chemicals, was now believed to be substantially higher than formerly assumed. The report qualified as strong evidence the link of some EDCs to non-descended testes in young boys, to breast cancer, prostate cancer and, somewhat less firm evidence to attention deficit/hyperactivity disorder (ADHD), cognitive and behavioral deficits and to decreased bone mineral density, and still insufficient evidence regarding adverse pregnancy outcomes, ovarian and testicular cancer, reduced semen in adult men, early puberty, diabetes and obesity.⁶⁴ The report also underscored in clear terms that EDCs represented a ‘special form of toxicity’ which showed non-linear dose-response curves and depended on a variety of circumstantial factors. Refuting earlier perspectives of EDCs as pet health concerns of rich people, the report underscored the global relevance of the issue by relating it to international commitments to protecting vulnerable populations in the Millennium Development Goals. Despite a necessary attention to traditional environmental health risks such as malnutrition and infectious diseases emerging issues ‘should be prevented from becoming future tradition environmental threats.’⁶⁵ Underscoring the ubiquity and urgency of the issue, the report flatly stated:

Endocrine disruption is no longer limited to estrogenic, androgenic and thyroid pathways. Chemicals also interfere with metabolism, fat storage, bone development and the immune system, and this suggests that all endocrine systems can and will be affected by EDCs. ... It is plausible that chemical exposure in pregnancy will affect

61 Quote *ibid.*, 299.

62 Naomi Oreskes and Michael Conway, *Merchants of Doubt* (New York, 2010).

63 WHO/UNEP, *State of the Science of Endocrine Disrupting Chemicals – 2012* (Geneva, 2013), pp. vii-viii.

64 *Ibid.*, viii-x.

65 *Ibid.*, iii.

the health of several subsequent generations of people and wildlife that are not themselves exposed.⁶⁶

In 2014, the European Commission endorsed the findings of a major German-Danish study providing firm evidence of EDC interference with human sperm function and began a review of its policy on EDCs.⁶⁷ Similarly, a 2014 report on the European Division of WHO, reported the phenomenon of EDCs as a fact, though with varying degrees of certainty regarding different health disorders. Building on the 2012 WHO report, it bolstered its position on cases of perceived certainty and extended the list of suspected health effects, citing growing evidence that EDCs might ‘play a role in the development of chronic diseases (including hormone-related cancers, obesity, diabetes and cardiovascular disease)’, all of which were rising concerns of the global burden of disease.⁶⁸ Within twenty years, the concept of EDCs in IHOs had evolved from virtually non-existent to a serious, potentially major, threat of global health.

Conclusions

For IHOs to establish firm positions regarding EDCs required major transformations of categorization and construction of physiologically active substances. The 1970s saw a shift in the view of chemicals from indispensable and essentially ingredients of a modern and healthful life to important substances of everyday life and potential health threats. This shift was conceptually easy because it could draw on Paracelsus’ toxicological principle that the dose makes the poison so that supposedly it was possible to keep any substance within safe areas of usage if threshold values of safety could be identified and implemented. The main responsibility of IHO, therefore, was to define threshold values as standards of chemical safety. At the same time, a different paradigm was in use for drug safety, which took into account potential long-term mutagenic and teratogenic effects of drugs. Here, safety considerations by IHOs (as well as by national bodies) focused on comprehensive drug testing. Medical drugs were perceived as part of a distinctly defined sphere of medicine and pharmacology, clearly within the field of competence of the WHO. Chemicals, by contrast, were important in industrial production, agriculture, international trade, environment and health, touching on the responsibilities of various organizations, all of which became active in the area.

⁶⁶ Ibid., XV and 15.

⁶⁷ SH/HR Max Planck Society, “Endocrine disruptors impair human sperm function”, <http://www.mpg.de/8201201/chemicals-fertility>, accessed 6 Aug 2014.

⁶⁸ WHO Europe, *Identification of risks from exposure to Endocrine-Disrupting Chemicals at the country levels* (Copenhagen, 2014), p. 17.

Thus, when seemingly unrelated evidence of changes in the environment, wildlife and in humans was reported, different organizations with different agendas began paying attention to different aspects of the phenomenon, and making sense of emerging information required an unusual degree of inter-agency cooperation based on acknowledged inter-dependence. This process risked resembling the group of blind people who try to establish the nature of an elephant by each touching a different part of its body. But such collaboration was greatly facilitated by a pre-existing tradition and infrastructure of inter-agency cooperation. Institutionally, there were a series of programs which could be put to use for the various components of ECD research notably the OECD program on chemical testing, the EHC program within the WHO, the IPCS and programs for inter-agency cooperation, all of which were prepared to assess chemical risks. Thus, being able to unite the environmental knowledge, emanating from UNEP and FAO, the laboratory expertise spurred by OECD, the experience with occupational health collected by ILO and the health competence of WHO, formed an immense benefit in constructing a multi-faceted phenomenon. Indeed, it may be speculated that without such a well-established network of joint commissions, establishing the state of existing knowledge on an international level would have been considerably slower.

But for all agencies, creating this new paradigm required reconstructing the views of chemical substances, including those in which work had been done for many years, shifting attention from toxic qualities to biomedical interference. This process was burdened by the rapidly increasing presence of the substances of concern to near omnipresence. Depending on perspective, this growing ubiquity of chemicals made their potentially dangerous character either highly improbable or highly alarming. In any event, it complicated identifying risks from the rising level of fuzzy noise. It also opened up opportunities for industry to use the working structures and the argumentation that public IHOs had been employing so far. Thus, by using selected epidemiological and laboratory data and insisting on prior toxicological paradigms, industry, through ECETOC, tried to strengthen their efforts to discredit gradually evolving knowledge on EDCs. The question was further complicated by the fact that a lot of relevant expertise was held within the chemical industry which, in turn, had an obvious interest in playing down possible health risks. Thus, research tended to show a 'sharp division between those who report detrimental effects of ED at environmental levels (micro- to picomolar range) – mostly academic experts – and those who appear unable to do so at any concentration – industry corporations.'⁶⁹

The challenge for IHOs was how to react to a situation of risk uncertainty. The idea of the precautionary principle had entered WHO language many years before the words had been coined for this purpose in Rio, and for medication it was

69 André Marques-Pinto and Davide Carvalho, "Human infertility: are endocrine disruptors to blame?" *Endocrine Connections*, 2 (2013), R15-R29, R17.

implemented with a strong emphasis on drug safety. For chemicals, the sheer reality of a world awash in products made from new synthetic materials made this approach impractical, despite occasional declaration to the contrary. Thus, allegiances to the precautionary principle, once writ large, receded to the background. In 1976, a WHO report had demanded that the harmless nature of chemicals be established before they were released, supposedly by manufacturers. Twenty years later, instead of demanding proof of harmlessness from chemical industry, several large international organizations assumed the responsibility of assessing the potentially harmful character of specific chemicals. This strategy was probably inevitable. Man-made material had grown too widespread to be treated according to a strict interpretation of the precautionary principle. But the attitude of IHOs was also a defeat of sorts. Instead of a general policy of industry having to prove the harmlessness of its products, the withdrawal of products from the market had required that independent scientists provide substantial evidence of risk. IHOs appear to have had little influence on these national decision making processes. However, IHOs can be credited for not shying away from stating suspected risks and making clear that careful wording resulted from an absence of evidence regarding risks rather than from evidence of their absence.

Thus, endocrine disruptors have been a global epidemic in the making, whose extent is still impossible to assess. In some ways, the situation is not unlike the first Sanitary Conferences between 1851 and the early twentieth century. The threatening diseases of the time, cholera, plague and yellow fever, may have been more easily defined than the diffuse list of potential EDC related illnesses, but otherwise there is a very similar situation of international bodies expected to provide policy recommendations in the face of scientific uncertainty.⁷⁰ In both periods, negotiations on international health focused on two key areas:

1. The scientific accuracy of cause-effect theories regarding health problems;
2. The suitable balance between precaution and risk in the face of different degrees of uncertainty.

Then as now, scientific disagreement has been affected by competing disciplinary approaches. Just like the outbreak of cholera could be assessed in terms of miasma theory or in terms of contagionism, each calling for different preventive strategies, the possible relation of chemical substances to increased incidence in testicular cancer could be assessed within toxicological or bio-systemic frameworks, each leading to fundamentally different conclusions. And in both phases of international health organization (IHOs), erring on the question of risk could have serious outcomes: too

⁷⁰ Norman Howard-Jones, *The scientific background of the International Sanitary Conferences 1851-1938* (Geneva, 1975); Valeska Huber, "The Unification of the Globe by Disease? The International Sanitary Conferences on Cholera, 1851-1894", *The Historical Journal*, 49:2 (2006), 453-476.

much caution threatened to cause enormous economic losses (through the disruption of trade and/or of production in a major economic sector), too little threatened to cause deaths (through epidemics of infectious diseases or of slowly developing illnesses). Then as now, international cooperation was essential because addressing serious health threats while maintaining trade required agreeing on scientific knowledge and sensible precautionary strategies and regulations.

It is too early for an in-depth appraisal of the role of IHOs, individually and collectively, in the evolution of EDCs as public health issues. Tentatively, it appears that, initially, instead of setting the agenda they were taken by surprise by its rapid onset. They were then simply unable to undertake the necessary massive collection of epidemiological, clinical and laboratory data themselves. Their main function has been to receive, analyze and evaluate evolving knowledge into publications that took stock of the state of the art knowledge and – tentatively – issued recommendation. Given these circumstances, they reacted quite quickly, making use of the existing infrastructure of commissions, experts and inter-agency connections and, some evidence suggests, by some degree of inter-agency rivalry. Initial evaluation of available data was very cautious, apparently more concerned about being accused of alarmism in the face of insufficient evidence than of complacency in the face of sufficient evidence of health risks.

For the WHO, a strong policy has been weakened to some extent by a North-South gradient, whereby chemicals were no priority issue within its overall work program. However, this dichotomy appears to be weakening as the list of possible health effects is lengthening, increasingly including diseases like obesity or diabetes, issues of concern in high- as well as low-income countries. Increasingly, EDCs are being viewed as an issue of global concern. In 2014, 1.115 contributions to a UN crowd-sourcing platform on sustainable development from scientists around the world established a list of 96 issues they would like policy-makers to consider for action. ‘Large-scale increases in genetic mutations in humans due to accumulation of toxic chemicals in our environment and in food chains’ was ranked eleventh.⁷¹ If this momentum continues, findings may well become more threatening to the chemical industry and to everyday life, as we know it. Should this happen, IHO credibility for setting standards, providing recommendations and fora for broad-based stakeholder deliberations will be crucial.

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⁷¹ United Nations. *Prototype Global Sustainable Development Report*. Online unedited edition. United Nations Department of Economic and Social Affairs, Division for Sustainable Development, 1 July 2014, 21-22, <http://sustainabledevelopment.un.org/globalsdreport/>, accessed 6 Aug 2014.

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