

Global Health Governance

HISTORICAL DIMENSIONS OF GLOBAL GOVERNANCE

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Preface

WHO's work in the area of Globalization and Health focuses on assisting countries to assess and act on cross border risks to public health security. Recognising that domestic action alone is not sufficient to ensure health locally the work programme also supports necessary collective action to address cross border risks and improve health outcomes.

In carrying out this work there was an increasing recognition that the existing rules, institutional mechanisms and forms of organization need to evolve to better respond to the emerging challenges of globalization and ensure that globalization benefits those currently left behind in the development process.

Consequently, as part of WHO's research programme on Globalization and Health, global governance for health was identified as an issue that required more detailed analysis to better inform policy makers interested in shaping the future "architecture" for global health.

Working in partnership with the Centre on Global Change and Health at the London School of Hygiene and Tropical Medicine, WHO's Department of Health and Development commissioned a series of discussion papers as a starting point to explore the different dimensions of global governance for health. The papers have been written from varying disciplinary perspectives including international relations, international law, history and public health. We hope these papers will stimulate interest in the central importance of global health governance, and encourage reflection and debate among all those concerned with building a more inclusive and "healthier" form of globalization.

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ABBREVIATIONS

AFRO	African Regional Office (WHO)
AMRO	American Regional Office (WHO)
EMRO	Eastern Mediterranean Regional Office (WHO)
EURO	European Regional Office (WHO)
FCTC	Framework Convention on Tobacco Control
GHG	global health governance
GPA	Global Programme on AIDS
IHG	international health governance
INFANT	Infant Formula Action Coalition
ILO	International Labour Office
IMF	International Monetary Fund
INGO	international nongovernmental organization
LN	League of Nations
LNHO	League of Nations Health Organization
LRCS	League of Red Cross Societies
NGO	nongovernmental organization
OIHP	Organization Internationale d'Hygiène Publique
PASB	Pan American Sanitary Bureau
PHC	primary health care
RF	Rockefeller Foundation
ROs	regional organizations
SEARO	South East Asian Regional Office (WHO)
TNC	transnational corporation
UIA	Union of International Associations
UN	United Nations
WPRO	Western Pacific Regional Office (WHO)
WHA	World Health Assembly
WHO	World Health Organization

HISTORICAL DIMENSIONS OF GLOBAL HEALTH GOVERNANCE

1. INTRODUCTION

The analyses presented in this series constitute a multidisciplinary engagement with a new area of study *global health governance* (GHG). This chapter aims to highlight the potential of historical analysis as a means to clarify and possibly strengthen the concepts and definition of global health governance mobilised in discussion of this emerging area. Given the recency of the phenomenon of GHG and the still formative nature of its conceptualisation, there has been little or no historical engagement with this topic per se. However, longer traditions of international health co-operation have been subject to historical investigation, and the published literature in this field forms the backbone of the analysis presented here. A list of archival holdings that would support future research is provided in Appendix A.

The paper begins by outlining some of the key themes and issues mobilised in contemporary debates about GHG, highlighting the way historical analysis challenges ideas of the 'newness' of some of these developments. The bulk of the paper presents an overview of developments in international health since the nineteenth century and argues that assumptions about contemporary patterns and relationships need to be tested against this longer history. Significant gaps in the available historical literature are thrown into relief by some of the questions and concerns raised in debates about GHG. These gaps are discussed at the end of the paper, and complement the archival sources also listed. Sustained empirical research is clearly needed to support and/or challenge some of the claims associated with GHG. Alongside this, however, is the equally important task of clarifying the conceptual history of cross-border and international health activities, especially in the postwar period.

2. HISTORY AND GLOBAL HEALTH GOVERNANCE

As a phenomenon and as an emerging area of study GHG is by definition formative, in-process. Initially, this fugitive aspect may seem at odds with historical research, a practice inevitably framed by the availability of hindsight. However, GHG's formative quality opens up a certain amount of common ground with historical practice. This commonality is evident in Discussion Paper No. 1¹, which maps out the territory of GHG – the concepts that are drawn upon and being developed, and the identification of mechanisms seen as significant or constitutive. In mapping this process, Dodgson and Lee demonstrate the importance and the necessity of re-examining the familiar and taken-for-granted once they are placed in new or seemingly incongruous relationships e.g. global public/private partnerships. Dislodging our assumptions about the present is a key feature of historical accounts, whereby the self-evident and seemingly natural is rendered curious and problematic through an emphasis on contingency and change over time. This emphasis underpins the importance of an historical perspective in the *questioning of the present* raised in debates about GHG.

In terms of this paper the ideas and claims embedded in the concept of GHG can be usefully broken down, initially, into *globalization* and *global health governance*. Globalization is relatively straightforward in the sense that it

¹ A conceptual review on global health governance can be seen in Dodgson, R., Lee, K. & Drager, N. (2002), "Global Health Governance: A Conceptual Review" Discussion Paper No. 1.

refers to a long-standing, though geographically and culturally uneven *process* of change over time. The change in question relates to the growth and development of global interconnectedness: technological developments in transport and communications; economic developments such as multinational and transnational corporations; and the emergence of globally dominant cultural and organizational forms e.g. the standards, measures and nomenclature of science (on periodization see Held, McGrew, Goldblatt and Perraton 1999; Buzan and Little 2000). However, globalization as a *construct* is more problematic. This relates to a perceived intensification of globalizing processes, located in the second half of the twentieth century. Developments in this period underpin the rise of globalization as an analytic construct addressed to understanding the consequences and implications of this intensification, whereby:

... the world is rapidly being moulded into a shared social space by economic and technological forces ... [and] ... that developments in one region of the world can have profound consequences for the life chances of individuals or communities on the other side of the globe. For many globalization is also associated with a sense of political fatalism and chronic insecurity in that the sheer scale of contemporary social and economic change appears to outstrip the capacity of national governments or citizens to control, contest or resist that change. The limits of national politics, in other words, are forcefully suggested by globalization

Held, McGrew, Goldblatt and Perraton (1999: 1)

It is this phenomenon that debates on *global health governance* are most directly concerned with, in that the process of globalization is seen to have specific health consequences that existing forms of health governance cannot effectively address. Here, the emergence or intensification of trans-border health risks (e.g. global climate change) is seen to challenge existing forms of international health governance (IHG) which are defined by national borders and thereby considered state-centric. Global health issues, it is argued, may be partially or wholly beyond the control of governments (Lee (2000): Background Paper for the UK. White Paper on Globalization and Human Development). The potential weakness associated with forms of governance anchored around the co-operation of nation states points to another aspect of the globalization phenomenon – the growth in number and influence of nonstate actors in the national, international and global arena e.g. civil society groups, non-governmental organizations, social movements, private companies. Emerging mechanisms of GHG, such as those identified in other chapters in this volume e.g. Medicines for Malaria Venture, are distinguished by the mix of public/private in their organizational forms and participating actors.

As the above discussion suggests, GHG is a broad construct predicated on a number of claims and ideas, some of which are more amenable than others to historical analysis. The term *health governance* is particularly weak. It refers to, “the actions and means adopted by a society to organise itself in the promotion and protection of the health of its population” (Discussion Paper 1). Interestingly, such organization can be formal or informal, the mechanisms of governance can be local, regional, national or international, and health governance can be public or private or a combination of the two. Here it should be noted that this description of health governance is difficult to operationalise historically, due largely to its expansive, almost boundless nature. The associated idea of *good governance*, which emphasises the need

for governance mechanisms and organizations that are appropriate, representative, accountable and transparent, is more specific and clearly located in an historical trajectory – the emergence and expansion of concepts of liberal democracy. Historically speaking these concepts are associated with the development of European nation states, a feature implicit within the above definition of health governance (the way a society organises itself to protect its population). And herein lies a key element in the emerging paradigm of GHG, and an important claim concerning its distinction from existing forms of IHG.

Ideas of good governance fit well with the nation state, and with forms of IHG that are anchored in the co-operation of states; and therefore still serve discrete constituencies. However, are such concepts applicable to the kind of social and political spaces that now exist between and beyond states? According to the literature on GHG, the proliferation of such spaces is a recent phenomenon, both a consequence of and a response to the process of globalization. The increased number and influence of nonstate actors operating in these spaces, individually or in association with a range of other state and nonstate actors, is considered a defining feature of the transition from international to global health governance; and one requiring the implementation or adaptation of recognised concepts of good governance. In this paper, this transition is explored by outlining the historical development of IHG in light of key aspects associated with the emergence of GHG: the mix of public and private in international health; the influence of groups and organizations not formally associated with the state; and the health consequences of globalization per se.

3. THE DEVELOPMENT OF INTERNATIONAL HEALTH GOVERNANCE

The development of international health co-operation is commonly considered in relation to three periods, as reflected in the existing literature:

- (1) the nineteenth century, characterised in particular by the first international sanitary conferences;
- (2) the interwar period, distinguished by the establishment of international organizations, such as The League of Nations, and the rise of American Foundations;
- (3) the post-war era - dominated by the history of the World Health Organization.

Interestingly, the key aspects of GHG mentioned above are not at the forefront in the historical literature on international health. This is understandable, as conceptualisations of the state, of public and private have changed over time. Indeed, historically speaking the state, as such, was a relative latecomer in terms of providing for the health needs of its domestic population (Barry and Jones 1991). Nevertheless, the presence and role of non-state actors in the field of international health and welfare is well documented, in varying degrees of detail, throughout the three periods.

3.1. The International Sanitary Conferences, 1851-1903

The beginnings of international health co-operation as we know it today i.e. co-operation between two or more states, is located in the series of international sanitary conferences that took place between 1851 and 1903. The most detailed accounts of the conferences are contained in the two editions of Neville Goodman's *International Health Organizations and their*

Work, and Howard-Jones' *The Scientific Background to the International Sanitary Conferences*; and subsequent summaries of these events draw extensively on these texts (Goodman 1952, 1971, Howard-Jones 1975). The principle engine behind this series of conferences was the spread of epidemic diseases, especially cholera and yellow fever. The two cholera pandemics that engulfed Europe between 1830 and 1847 were facilitated by the increased movement of goods and people between East and West, which accompanied developments in international commerce: steamships, rail and later the construction of the Suez Canal. The long established response to epidemic disease such as plague - quarantine and the closing of ports² - proved difficult to sustain in the age of international commerce. Quarantine measures and disruption to shipping served to undermine the maritime economies of nations like Britain and France, whereas the new speed achieved by steam ships meant that people and goods could be disembarked before the disease declared itself: outstripping even the relatively short incubation period of cholera. The international sanitary conferences emerged as a mechanism for responding to the political and economic threat a new epidemic disease like cholera posed to the European powers.

Political and commercial interests were the primary concern of the first conference, which was convened in Paris in 1851 and attended by diplomatic and medical representatives of twelve governments. The decision to exclude discussion of the vexed question of etiology from the conference strikes some commentators as 'peculiar for a health conference' (Siddiqi 1995: 15). However, it would be inappropriate to think of the Paris meeting as a health conference, given that its stated intention was 'to regulate in a uniform way the quarantine and lazarettos in the Mediterranean' (Goodman 1971: 22). Commerce, trade and economic competition were high on the agenda. The 'Middle East' was not only an area through which epidemics reached Europe, it was also a key strategic area where European imperialist powers jostled for position from the 1830s onward. Indeed, economic and political conflicts surfaced at regular intervals during subsequent conferences convened in Paris (1859), Constantinople (1866), Vienna (1874), Washington (1881), Rome (1885), Venice (1892), Dresden (1893), Paris (1894), Venice (1897) and Paris (1903). For example, the sixth conference convened by the Italian government in 1885 was provoked largely by Franco-British tensions in Egypt. Britain occupied Egypt in 1881 and dominated the 'sanitary council' of Alexandria³. Italy and France resented Britain's anti-quarantine stance when cholera broke out in Egypt in 1883. Britain retaliated by threatening to divert shipping away from the French-run Suez Canal in light of French claims that cholera was introduced from British India. Suez was on the agenda again at the seventh and ninth conferences. The sanitary regulation of westbound shipping through the Canal occupied the 1892 conference in Venice, and the role of the Canal and the Red Sea as routes for epidemics associated with the Mecca and Medina pilgrimages was the main issue at Paris in 1894.

Because of high-level disagreement over what measures were needed and acceptable, the conventions and regulations that emerged from the majority of these conferences were never successfully ratified by participating governments, until the eleventh conference in Paris (1903) produced what Goodman describes as 'the first effective convention' (Goodman 1971: 23). The fruits of 1903 formed the basics of the convention governing quarantine on land and sea until World War II, although 1903 was in effect the consolidation

² Venice introduced quarantine in 1348, closely followed by Genoa and Marseilles.

³ This was one of a series of regional councils that developed ad hoc in the course of the century, others included the 'sanitary councils' of Tangier, Teheran and Constantinople. See Afkhami (1999).

of four earlier conventions: Convention on Sanitary Measures to Regulate Westbound Shipping through Suez Canal (1892); Convention on Notification of Epidemic Disease (1893); Convention on Hygiene Measures for Pilgrim Ships (1894); Convention on Obligatory Notification of Plague (1897). Indeed, the constitution of an international committee to consolidate the existing four conventions was agreed unanimously by the 1897 conference. However, the idea of an international committee was taken further in 1903, when the representatives of twenty governments including Brazil, Persia, Egypt and the US, as well as European countries recommended the establishment of an International Office of Public Health. The *Office International d'Hygiène Publique* (OIHP) was established at a further meeting in Rome (1907). The OIHP was located in Paris but maintained close communication with the 'sanitary councils' in Alexandria and elsewhere. The primary function of the OIHP was the collation and dissemination of epidemiological intelligence through a monthly bulletin. Governments were obliged to inform the Office of the steps they were taking to implement the sanitary conventions and the Office had the right to suggest modifications. The 'Paris Office' as it became known, was under the control of a committee consisting of one delegate from each state, although voting power was related to the amount subscribed, and states could choose to belong to one of a number of categories. The OIHP's co-ordination with regional 'councils' and its focus on the health authorities of states pre-figures the organizational emphasis of later bodies, such as the World Health Organization.

The establishment of the OIHP marks the point of transition, from the era of international conferences to permanent international health organizations, of which the Pan American Sanitary Bureau (PASB) (created in 1903) was the first. Interestingly, the idea of an international commission or organization, for the notification and exchange of information on epidemics had been proposed as early as the Vienna conference (1874) and again at the Washington conference (1881). The consensus that began to emerge at the close of the century is best understood in relation to a range of forces, the most immediate of which were the severe cholera epidemics that again struck in 1893 and 1897. However, the development signalled by the emergence of the first international health organizations was part of a broader movement toward international co-operation, which had been growing in range and complexity throughout the nineteenth century. And it is in this broader movement that key aspects of the debate on GHG have some resonance.

3.1.1 The broader context of International co-operation

The period from the Congress of Vienna (1815) to the outbreak of WWI in 1914 saw the emergence of wide-ranging international co-operation in many areas: law, economics, labour, religious and intellectual movements, social and welfare organizations, and humanitarian causes. According to Lyons (1963:12), there were nearly 3000 international gatherings in this period, and the creation of more than 450 private or international nongovernmental organizations (INGOs) and over 30 governmental organizations. Developments in transport and communication facilitated this level of international activity. Many of these gatherings and organizations addressed health issues, broadly defined and, as the figures in Table 1. suggest, nonstate actors played an important role in the development of nineteenth century internationalism (see Table 1.).

TABLE 1: THE DEVELOPMENT OF INTERNATIONAL ORGANIZATIONS 1815-1914

Year	International Non-Governmental Organizations Created	Still Active at mid-20 th century	International Governmental Organizations Created	Still Active at mid-20 th century
1815-49	4	4	1	1
1850-54	1	1	0	0
1855-59	4	1	2	0
1860-64	6	3	1	0
1865-69	9	4	5	3
1870-74	8	6	3	1
1875-79	17	9	2	2
1880-84	11	6	3	2
1885-89	29	16	2	1
1890-94	35	19	3	3
1895-99	38	20	2	1
1900-04	61	22	5	2
1905-09	131	42	4	1
1910-14	112	38	4	3
	466	191	37	20

Source: Lyons, F.S.L. (1963), *Internationalism in Europe, 1815-1914* (Leyden: A.W. Sythoff).

Developments that can be considered as having a broadly defined health dimension can be broken down into two fields: (a) intellectual co-operation and consensus in science, and (b) social, religious and humanitarian movements.

Disputes concerning the etiology of diseases such as cholera bedevilled many of the early international sanitary conferences. Scientific developments, such as John Snow's work in London (1859) and Robert Koch's work in Germany (1885), had no immediate impact on the conferences that followed these discoveries. Indeed, Goodman (1971:60) highlights the *Lancet's* attitude to a proposal international commission, arising from the Vienna conference (1874), 'we must confess to want of faith in the value of international scientific work'. However, effective co-operation in areas of science and medicine developed and progressed outside of the sanitary conferences (Crawford 1992). Initially this took the form of international congresses on specialist areas such as the first statistical congress (1853), first congress of ophthalmologists (1857), first congress of chemists (1860), and many of these went on to form international committees and associations. The statistical congress of 1853 for example initiated the preparation of a nomenclature for causes of death that would be applicable to all countries. This was adopted and revised at subsequent meetings and taken forward by the International Statistical Institute that was formed in 1891. International associations that cut across different areas of specialisation also began to emerge, such as the Association of Academics (1900) which brought together leading national scientific associations. Intergovernmental co-operation in areas such as measurement and mapping developed largely from these international initiatives i.e. International Geodetic

Association (1867), International Association of Seismology (1903), International Committee for the Map of the World (1909), International Electro-Technical Commission (1904) and the International Agreement on the Unification of Pharmacopoeical Formulas for Potent Drugs (1906).

At the close of the century the momentum for co-operation between nonstate actors, and later between states, focussed on the exchange of information, and represented the first moves towards an international vocabulary (i.e. standards, classification) in medicine and science. The social, religious and humanitarian movements that emerged in the nineteenth century were more complex and diverse in their development, in that many were characterised by popular and even mass support; although the pattern of conferences leading to more permanent committees or organizations is also evident. A burgeoning middle class and the spread of evangelical religion supported many of these activities, whereas the shared experience of industrialisation and urbanisation spawned common social problems across a number of states. The first of four International Congresses of Charities, Correction and Philanthropy met in Brussels in 1865. These were followed in 1889 by a new series of international congresses on public and private charity that met at irregular intervals up to 1914. According to Lyons, these meetings were attended by representatives of a wide range of philanthropic organizations and the discussions covered a broad spectrum of issues: food production, alcoholism, prison conditions, medical assistance to the poor, rehabilitation, infant mortality and the protection of women and girls (Lyons 1963: 264). In 1900 an international committee was formed and a bureau of information and studies followed in 1907. This 'umbrella' association emphasised the need for information exchange and an increasing number of governments sent representatives to its conferences.

A number of international 'single issue' reform movements also came to the fore, a development seen as early as 1840 with the International Anti-Slavery Conference and later the International Committee of the Red Cross (1864). In the health and welfare field these associations could be popular in orientation or focussed on specialist expertise. Some, such as the congresses on alcohol, and the resultant International Temperance Bureau (1906), mingled both moral activism and science (Bruun, Pan and Rexed, 1975), as did the International Central Bureau for the Campaign against Tuberculosis (1902), which emerged from a series of international conferences dating from the 1860s. The pattern here seems to be one of activity by nonstate actors in the international arena leading to greater intergovernmental involvement, although the operation of these international movements and campaigns is given only sparse definition in the available literature. The relationship between national associations and national governments would need to be explored in greater detail to understand the mechanisms involved. Interestingly, it seems that many of these movements were characterised by a mixture of governmental, voluntary and local activity, such as the policing of conventions around the 'white slave trade', which stemmed from the 1899 International Bureau for the Suppression of Traffic in Women and Children (Lyons 1963: 274-285).

A significant development at the close of the period was the establishment of a Central Office of International Associations in Brussels (1907), an organization that changed to the Union of International Associations (UIA) at the first World Congress of International Organizations in 1910. This co-ordinating centre for international activity produced a wealth of documentation, including annual indices, which evolved into the *Yearbook of International Organizations*. The

documentation produced by the UIA, and its forerunners⁴, provides the most comprehensive guide to international activity at the turn of the century, although it has yet to receive sustained historical investigation. Indeed, the only text that covers the UIA in any detail is Seary's article (Seary 1996). Nevertheless, the appearance of platform organizations for the activity of international NGOs, such as the UIA, point to an interesting development that was largely sidelined in the following era.

3.2 THE INTERWAR PERIOD

The interwar period (1919 – 1939) is characterised by two interrelated developments, the rise of a new style of international corporate philanthropy, such as that undertaken by the Rockefeller Foundation, and the establishment of permanent international organs epitomised by the League of Nations. Unlike the nineteenth century context of international health outlined above, and the post 1945 period discussed below, interwar developments have received more detailed historical investigation. Indeed, the bulk of the available historical literature on international health concentrates on this period. This concentration parallels more general medical-historical concern with the early-twentieth century, which saw greater state involvement with medical provision throughout industrialised countries and the emergence of welfare states. Detailed studies of developments at the national level provided the basis for comparative analyses and brought a greater focus on the international arena. Interestingly, this emphasis on comparing the health and medical provision of different states and political systems was an important theme in the research undertaken by international health organizations in the interwar period: a natural spin off from international data collection and standard setting activities.

In discussing the key developments of the interwar period, namely corporate philanthropy and the League of Nations, the depth and degree of their inter-linking should be noted, both in terms of financial support and personnel. For example, the League of Nations Health Organization (LNHO) drew between a third and a half of its budget from the Rockefeller Foundation (RF) (Weindling 1995b: 137). Such, relationships are described by Dubin (1995:72) as symbiotic, leading to the creation of a world-wide public health/biomedical episteme, centred around a core of health specialists:

The RF helped Rajchman [the League's medical director] recruit staff; awarded travel grants to individuals visiting Geneva; recommended persons for expert bodies; made its own staff available for special purposes; helped assess requests for technical assistance; provided additional help to governments receiving LN assistance; and funded its own schools, laboratories and institutes of persons engaged in the LNHO.

Historians continue to debate meaning and consequences of the RF's involvement with inter-governmental mechanisms at this time. Interpretations of the scale of RF involvement during a period of US political isolationism can be read as benign philanthropy or American imperialism by private means. Likewise, the emergence of a recognised group of international public health experts and the call for 'social medicine' can be read as a movement to place

⁴ Institut International de la Paix (1903), Central Office of International Associations (1907).

medicine on a socio-economic and humanitarian basis, or the spearhead of professional imperialism.

These debates echo concerns raised in the current literature on GHG, especially in relation to the contemporary role of corporate philanthropy and public/private partnerships. For example, in discussing recently established foundations, (e.g. Bill and Melinda Gates), Lee (2000) notes the role of interwar foundations and points to the potential problems of such funding, 'Reliance on philanthropy to fund global health causes risks placing decision making in a small number of hands, therefore, and thus a neglect of less popular and populist causes' Lee (2000), Background Paper for the UK White Paper on Globalization and Human Development 4. However, there is no consensus amongst historians that interwar foundations were more inclined to support projects and health issues which had popular and political mileage. Indeed, the role of American foundations in international health needs considerable historical unpacking.

3.2.1 The role of American Foundations

According to Bulmer, the years between 1901 and 1913 witnessed the coming into being of a new form of philanthropy, characterised by the RF and other largely American institutions – Milbank Memorial Fund, Commonwealth Fund, Sage Foundation (Bulmer 1995). This new form developed a research-oriented view of social improvement and introduced a wider, international dimension to research and sponsorship activities, especially in the area of science and medicine. The scale of the RF's financial input into the LNHO has already been noted, but the foundation also developed its own initiatives through its International Health Commission (1913) and through support for clinics, training schemes, school's of public health and laboratory services throughout the world (Berliner, 1985, Farley, 1995). Importantly, the RF pursued a much more interventionist and ameliorative programme than the American government was willing to contemplate at the time (i.e. the RF backed the LNHO although the US was not a member state of the LN). To some historians, the RF is seen as a stalking horse for wider American political interests, and even as a central agent of biomedical imperialism by exporting a US model of public health across the world (Arnove 1980).

Undoubtedly, US political interests were furthered by RF involvement with the LN and through its programmes in the Far East (Manderson 1995) and Latin America (Cueto 1995, 1997). More recent analysis, however, recognises the complexity of the RF, its degree of autonomy and how its programmes changed over time in the Far East. According to Gillespie's work on Australia and the Pacific Islands, 'There was no simple imposition of an American model on compliant local populations' but 'a complicated process of bargaining and compromise [that] led to local interests dominating the implementation of the Rockefeller programme' (Gillespie 1995). Moreover, Weindling emphasises the relative freedom of the American foundations, from public or political constraints, and from the need to placate the interests of the medical profession (Weindling forthcoming). For example, in the aftermath of the First World War, RF support helped develop a system of socialised primary health care in Serbia, and contributed to primary health initiatives in the US and abroad. This relative freedom also enabled the foundations to support 'unpopular' health issues i.e. the RF provided backing for child guidance and mental hygiene, and the Commonwealth Fund targeted mental health during the interwar period (Thomson 1995).

Through its focus on training and institution building the RF was fundamental in creating an international network of public health experts, contributing to biomedical/public health episteme described above. Drawing on the universalism of science, the RF emphasised technology transfer and the exchange of personnel. This approach is seen by some to accompany the scientisation of social policy on one hand and the primacy of professionalised, increasingly technocratic solutions to public health problems on the other. For example the RF's disease eradication campaigns in Latin America became increasingly laboratory based, and Gillespie notes a similar trajectory in Australia and the Pacific Islands (see Farley 1995 for this transition).

3.2.2 International Health and the League of Nations

The technical agencies of the League of Nations, the Health Organization (LNHO) and the International Labour Office (ILO) followed a similar pattern of narrowing their focus to that noted in the RF programmes. Initially the ILO had an expansive vision of its role in health and welfare, legitimised by the Treaty of Versailles (1919) which assigned it the role of protecting 'the worker against sickness, disease and injury arising out of his (sic) employment' (Weindling 1995b: 139). Weindling (1995b: 139) sees a basic dilemma in the strategy developed by the ILO, which restricted its medical programme at such an early stage:

...in seeking to justify its reformist demands in the universalist terms of science, it had to devolve initiatives to scientific experts whose empirically based approaches were necessarily limited to what could be proven in the laboratory.

Consequently, its focus became overly technical, anchored around the production of scientific evidence of the health effects of particular hazards. Moreover, despite its overall premise that welfare was determined by socio-economic conditions, no attempt was made to correlate economic trends with the mortality and morbidity data present in its labour statistics.

The LNHO, the agency with responsibility for public health and social medicine, shows a similar narrowing of its focus, signalled by its separation from the Social Section in 1920 (Miller 1995).⁵ The primary concern of the LNHO in the 1920s was the scientific universalism of standard setting, in terms of biologicals and morbidity/mortality statistics (Sizaret 1988, Cockburn 1991). Indeed, by 1937 approximately 72 per cent of the world's population was covered by the LNHO statistics. This emphasis on international standards did however, provide leverage for broader health debates during the Great Depression of the 1930s. The LNHO developed co-operative programmes with the ILO that focused on developing social medicine on an economic base – how diet, housing, and economic conditions shaped health were key areas of research. Scientific expertise served radical reform in areas like nutrition, as British scientists criticised their government by invoking nutrition standards endorsed by the LNHO/ILO – forcing them to raise the minimum standards used in calculating unemployment and maternity benefits.

⁵ The Social Section was responsible for the traffic in women and children, the traffic in opium and other dangerous drugs and from 1924 the residual aspects of child welfare not covered by LNHO and ILO. A separate Opium Section was created in 1930.

The LNHO, like its successor the WHO, was anchored around the health ministries of member states. However, through the 1930s the LNHO sought greater autonomy, aided by RF money. In moving towards independent research initiatives and the setting of optimum standards for health it hinted at the kind of autonomy condemned by some contemporaries. For example, in 1934 Sir George Buchanan of Britain's Ministry of Health warned that the LNHO should not presume to 'constitute itself a super-health authority which supervises or criticises the public health administrations of the world' (quoted in Weindling 1995b: 143). The autonomy of the LNHO is interesting, as it relates to the issue of corporate philanthropy and its role in supporting popular or unpopular causes. This is a complex area. It has already been noted that the RF and others did provide support for mental health initiatives, whereas the ILO focused primarily on economically productive sectors of the population (i.e. not the elderly, disabled or mentally ill). Moreover, the LNHO avoided the politically controversial issue of birth control in the interwar years. Issues deemed unpopular obviously change over time (i.e. sexually transmitted infections, Weindling 1993) but generally speaking such issues were often championed by voluntary initiatives before they became respectable in arenas dominated by state actors. In one case, illicit drugs, a separate system emphasising control of trade, all be it in the interests of health, was set up in the interwar period. A series of international conventions following the Geneva Convention of 1925 established and extended an import certificate system together with limitation of manufacture (Berridge, 2001).

Historically, a particularly interesting aspect of international health in the early twentieth century is that there were initially voluntaristic models for a world health authority, lead by the League of Red Cross Societies (LRCS). In line with the new form of philanthropy epitomised by the RF, the LRCS (an offshoot of the American Red Cross), sought to move away from sporadic relief towards securing community based welfare (Hutchinson 1995, 1996). In relation to the LN and its technical agencies, the LRCS enjoyed early involvement, however, as Seary (1996: 23) documents:

...the interaction between the League and international NGOs changed from one of NGOs supporting and contributing to the policy work of the League to one where the League was less interested in the opinions of NGOs but more willing to provide information for and about them.

This distancing process can also be seen in the reorganization of the LN's Committee on Social Questions which became entirely governmental in 1936. The UIA, mentioned above, was also sidelined by the development of the LN which moved the focus of INGOs to Geneva and away from Brussels (the home of the UIA). In 1929 the Federation of International Institutions came into being in Geneva, and by 1938 it grouped together 42 INGOs, addressing technical matters on the running of INGOs (taxes) but was far less ambitious than the UIA.

In terms of contemporary debates on GHG, two further features of the inter-war period are worthy of note. First, it was the 1930s that witnessed the first single-issue co-operation between INGOs. In 1932 around 30 international peace and disarmament organizations formed an International Consultative Group to promote 'cooperative action and coordinated policies' (Seary 1996: 21-22). Moreover, as Dubin (1995: 73) has argued in his work on the LNHO and the RF, which he describes as 'a public-private partnership': 'They penetrated deeply into national societies drawing domestic administrative, research and educational agencies into a transboundary biomedical/public

health infrastructure'. The technocratic, elitist form of social medicine that came to the fore at this time resonates with Lee's concerns about contemporary forms of cooperation: 'The growing importance of public/private partnerships in health, for example, is raising concerns that global forms of elitism are emerging to accompany more familiar forms of exclusivity (e.g. rich versus poor countries)' (Lee, Background Paper for the UK. White Paper on Globalization and Human Development: 4 2000 London).

3.3 WAR, THE UNITED NATIONS AND THE WORLD HEALTH ORGANIZATION

The history of international health in the second half of the twentieth century represents the largest and the most organizationally complex era of developments in this field. The key difference in the postwar context concerns the scale of participation, with a significant rise in the number of states, the number of intergovernmental organs, specialised agencies, and nongovernmental organizations. This rise in scale and complexity has been intimately related to fundamental shifts in geo-politics, such as the dismantling of nineteenth century colonial empires, the onset of Cold War and the collapse of the Soviet Union. Other significant developments, more specifically related to health and medicine have also marked the postwar period, such as the rise of the pharmaceutical and biotechnology sectors, and new health threats posed by nuclear technologies, water and atmospheric pollution. Core concepts and discourses have also shaped the understanding of international health since 1945, international human rights and international development are particularly important in this respect. Unlike the interwar period however, international health in the postwar context has yet to attract the sustained attention of medical/health historians. The available, and largely non-historical literature that touches on this area forms the basis of a necessarily selective summary of some of the key themes and issues in postwar international health. Particular aspects are also highlighted as ripe for historical analysis and/or revisiting.

The most significant event in the organization of postwar international health was the establishment of the World Health Organization (WHO) as a specialised agency of the United Nations (UN) in 1948. The origins and development of WHO are covered in a series of 'in-house' or 'insider' histories covering the headquarters and regional offices (WHO 1958, WHO 1967, WHO 1968, Howard-Jones 1981, Manuila 1991, WHO 1998). A comprehensive account, which takes the story up to the 1990s, is the historical dictionary of WHO provided by Lee (1998). More explicitly critical reflections on the history of WHO are those provided by Siddiqi and Lee (Siddiqi 1995, Lee 1997). From the wealth of detail provided in these texts a number of key interrelated themes emerge namely regionalisation, emergence of political blocs, issues of politicisation and shifting paradigms of disease eradication, primary health care and health sector reform. The issues raised in the literature thus focus largely on the role of international health development. However, it is arguable that international organizations have also been of great policy importance in relation to the policy agendas of high-income countries as well. Some examples of this process of policy transfer are given below.

The regional structure of WHO is largely an historical legacy, in that pre-existing regional organizations (ROs), the Pan American Sanitary Organization and the Eastern Bureau of the LNHO, were absorbed into the new specialised health agency. New ROs were created to balance this structure, resulting in the six regions: Eastern Mediterranean (EMRO), Western Pacific (WPRO), Europe (EURO), Americas (AMRO), Africa (AFRO), South East Asia (SEARO).

Siddiqi (1995: 73 – 76) argues that this decentralised structure, which delineated broad areas and assigned countries to particular regions, was problematic from the start. At the foundation of WHO there was no discussion of potential problems, such as the fact that the tasks to be dealt with might not follow this peculiar delineation of geographical boundaries, or the possibility that regional organizations could come under the influence of politicized regional blocs. For example, Pakistan chose to be in the EMRO rather than SEARO with India and Afghanistan. Colonial legacies and political disputes over the mismatch between sovereignty and geographical area also affected regular membership. France proposed that Morocco be assigned to the European region, followed by a proposal from Spain that the part of Morocco known as the Spanish Protectorate Zone be assigned to Africa. This split identity was further complicated by unsuccessful Arab requests that French Morocco be assigned to the EMRO. The newly independent Morocco became a full member of WHO in 1956 and was allowed to choose its region. Having accepted provisional membership of the EURO it moved to the Eastern Mediterranean in 1986 after Israel joined EURO in 1985 (Siddiqi 1995: 73-76).

Independence movements and the political nature of regional alliances have been fundamental forces operating in the UN system and its agencies since their inception. For example, WHO had 48 full members in 1948, this had risen to 183 full and 2 associate members by 1993. Although the action of political blocs was not new, i.e. the mass withdrawal of socialist states in 1949-50, the structural and political inability of WHO to absorb the newly emerging post-colonial nations meant that new formations, based on differences in wealth, joined established Cold War distinctions of ideology. In response to what was seen as a disparity between voting strength and financial contribution between rich and poor nations (Talbot 1994, Siddiqi 1995) the 1960s and 1970s saw the emergence of blocs, such as the Geneva Group (made up of states that contribute the majority of funds to UN/WHO) and the Group of 77 (international interest group representing developing countries). With regard to the relationship between WHO and such blocs, Siddiqi notes that, '[some] senior WHO officials do not consider them as undesirable' (page 85). As these help dilute the political or extremist content of motions put from the floor at the World Health Assembly (WHA). North-South (donor/recipient of aid) became a new axis of political and ideological conflict in postwar international health.

This axis structured ensuing debates around the alleged 'politicization' of WHO during the 1970s and 1980s, such as the 1985 WHA resolutions on Arab health in the territories occupied by Israel, and the health impacts of economic sanctions (e.g. Nicaragua). The alignment of developed – developing countries was clear in the passing of resolutions WHA38.15 and WHA38.17, as the US, Israel and most western countries voted against (Siddiqi 1995: 8-9). Clearly, 'politicization' was not something that emerged in the 1970s but has been present throughout the history of WHO. However, another aspect of the 'politicization' debate has less historical precedent, the criticism of the marketing practices of transnational corporations like Nestlé. In 1981, amidst protest from the US government and industry representatives, the WHA adopted an International Code for the Marketing of Breast Milk Substitutes. This was the culmination of international protest on the issue, including a boycott of Nestlé products by the Infant Formula Action Coalition (INFAC) in 1977 and followed an earlier WHA resolution (1974). NGO led activism of this kind was an extension of nineteenth century developments that focussed on single-issue concerns. However, the ability to generate an effective world-wide consumer boycott of a globally marketed product on the basis of a health development issue was new (Walt 1993). The current moves to develop a

Framework Convention on Tobacco Control (FCTC) can also be located in the history of international moral and scientific health activism.

A broadly based philosophy of health, which was more sensitive to local requirements and distinctions, and anchored around the provision of primary health care (PHC), gained ground at WHO during the 1970s. The clearest expressions of this development were the Declaration of Alma Ata (1978) which emerged from the International Conference on Primary Health Care, and 'Health for All by the Year 2000', a global strategy emphasising social justice, equity and the link between health service provision and a country's socioeconomic development (Koivusalo and Ollila 1997: 109-136). Historically, one can see echoes of the LNHO's work in the 1930s (Siddiqi 1995: 193-195). In the 1930s and the 1970s international health organization began to emphasise PHC and an understanding of the economic underpinnings of health. Economic crisis formed the backdrop to developments in both decades, although the postwar division of North-South and the greater representation of poor nations in the machinery of international government led developing countries to demand a New International Economic Order (supported by the Alma Ata Declaration). Moreover, as Weindling (1995b: 148) points out, the social medicine approach developed at the LNHO in the 1930s was technocratic and elitist, '...driven by the scientific preoccupations of the laboratory'.

PHC also followed from critiques of vertical (disease specific) programmes developed by WHO in the 1950s and 1960s, such as the Malaria Eradication Programme (Siddiqi 1995: 123-183, Lee 1998: 11-14). One of the engines behind PHC was the evidence of successful, low-technology community health care provided by China's experience of 'barefoot doctors'. China gained membership of WHO in 1973. According to Lee (1997) the examples of China and Cuba, which were successfully mobilised by the Soviet Union, challenged the prevailing biomedical/public health episteme at WHO. This challenge also encouraged a renewed interest in traditional medical practices and personnel, and during the WHA in 1974 delegates from a range of developing countries began speaking of traditional medicine as a positive affirmation of their native cultures. Moreover, the renewed interest in horizontal programmes (i.e. health concerns as a whole, rather than disease specific), and the emphasis on appropriateness and community involvement pointed to a more inclusive disciplinary mix in international health. As a former WHO official noted in 1975, in reference to the Malaria Eradication Programme, 'money, time and effort has been unstintingly spent in the belief, seemingly, that the basic laws of ecology and social anthropology would be lifted to allow a magical disappearance of the disease' (quoted in Lee 1997: 29). However, to counter this somewhat romantic account of WHO's ideological reorientation it should be noted that while the organizations regular budget was frozen in the early 1980s, the majority of extrabudgetary funds were directed to disease or technology specific programmes (Koivusalo and Ollila 1997: 115-119, Lee 1998: 14-16).

Although 'Health for All' may have provided a new ideological touchstone for international health, Alma Ata was still based largely on the assumption that states would play the major role in health care provision and health development. For example, the original Alma Ata document did not highlight the role of NGOs. The primacy accorded to NGOs from the 1980s emerged during a period when many major donor countries pursued anti-statist policies in their domestic health sectors. At the international level this found echoes in the policies of Structural Adjustment pursued by the World Bank and International Monetary Fund. Downsizing and sustainability climbed

policy agendas in the 1980s, along with Health Sector Reform. Green and Mathias (1997) emphasise the rise of NGOs in a climate where public sector health provision was often being characterised as inefficient, centralised and unaccountable. In this context there was a growing awareness of the financial capacity of NGOs and their experience in funding systems at a local level. Sollis (1992) also points to the heightened media profile of NGOs through their involvement in emergency and disaster relief from the 1980s (see also Philo 1993, Philo 1999: section 5 'International development, disasters and crisis reporting').

NGOs have also attracted the attention of donors in relation to concepts of good governance. These concepts have begun to shape the willingness of donor countries to criticise not only the efficiency of recipient state, but also to question their legitimacy on grounds of a lack of democracy. These are recent developments, but have highlighted the need for a fuller understanding of NGOs. As Green and Mathias (1997:15) note, there is little historical analysis of the growth of INGOs and of their activities in developing countries, on which to base claims of improved greater accountability:

Whilst it is evident that in some countries, notably those in parts of Latin America, many NGOs (including the church) have provided an important alternative to government through links with popular political movements ... it is difficult to sustain an argument that international NGOs (still the ones predominantly supported by donors) have clear systems of accountability to local communities.

The function of international health organizations in transferring policies or policy 'cultures' from national to international, and back to national levels, should also not be forgotten. Primary Health Care as a concept was strengthened by WHO initiatives in **developed** countries as well as **developing**. The role of WHO in disseminating distinctive conceptual approaches – as for example disease theories of alcohol and drug use and later formulations with concomitant policy and practice implications – has been considerable (Room, 1984). This function of 'international policy transfer' is seen at its clearest in recent history through the impact of HIV/AIDS, where the (GPA) Global Programme on AIDS was of key importance in achieving international acceptance of HIV/AIDS as a 'human rights' consensual issue (Berridge, 1996).

4. CONCLUSIONS: STRENGTHENING OUR UNDERSTANDING OF GHG

This brief outline of the history of international health governance hints at the longevity of some of the patterns of cooperation associated with GHG, especially the role of the voluntary sector and public-private financing. This longevity is routinely acknowledged in analyses of GHG, but the relationship between past and present forms, and a sense of the particular differences needs greater specification. A contributing factor here is that there are obvious gaps in the historical literature. The interwar period has attracted the most detailed historical scholarship, evidenced by the empirical strength of Weindling's edited collection (1995) and Löwy's special issue (2000), which provide studies of individual NGOs, private foundations and the implementation of policies in specific countries. This concentration on the interwar period has already been noted, along with the fact that it parallels more general medical-historical concern with the early twentieth century, which saw greater state involvement with medical provision throughout the

industrialised world and the emergence of welfare states. Detailed studies of developments at the national level provided the basis for comparative analyses, and brought a greater focus on the international arena. Unfortunately the same has yet to happen with regard to the nineteenth century and the postwar period, although the same pattern of detailed national studies leading to international comparison is clearly the way forward.

The creation of the Union of International Associations, a body that generated a wealth of primary historical data, offers clear opportunities for exploring the informal, international dimensions of health cooperation in the late nineteenth and early twentieth centuries. Unfortunately, there appears to be a tendency (among historians and contemporary advocates of GHG) to view events prior to the founding of international health organizations through a particular prism – that of biomedicine and states (the international sanitary conferences). Sustained historical research on the archives and publications of the UIA could begin to transform our image of cross border health activities and exchanges in the late nineteenth and early twentieth centuries. Such work would help to dismantle a trajectory that seems implicit in much of the literature on GHG, namely a progression from a narrow to a more expansive conceptualisation of *health*, and a corresponding progress from state involvement to a more pluralistic and potentially less easily governed mix of state and non-state actors. This largely industrialised world focus finds its clearest resonance in the relatively recent emergence of welfare states. However, this image needs to be matched by an awareness that patterns of voluntarism did not disappear with the advent of state provision in high-income countries, and it overlooks the essential role of nonstate actors in providing health care to colonised territories.

With regard to the postwar period, it has already been noted that the sheer scale and complexity of developments preclude any easy synthesis. Historical accounts of specific initiatives or particular aspects of health are beginning to appear such as Ruxin (1996) on postwar international nutrition and Muraskin (1998) on the children's vaccine initiative. The continuing interest in international drug control has led to a recent proliferation of research interest, which draws attention to the impact of US influenced political imperatives in the international dissemination of initiatives such as 'crop substitution' (Berridge, 2001). Histories of agencies and the organization and financing of programmes need to be enhanced by histories of the experience of communities in which these programmes were implemented, like Cueto (1997) on the RF's involvement in Latin America (Cueto 1997). Available studies that explore the development/implementation of services in low-income countries usually focus on events prior to the Second World War, such as the range of detailed histories on colonial or mission medicine (Patterson 1981, MacLeod and Lewis 1988, Vaughan 1991, Manderson 1996, Sadowsky 1999, Pati and Harrison 2001). Work that focuses on such experience within postwar developing countries is considerably rarer (Hopwood 1980, Greenough 1995).

The changing roles of local, national and international NGOs is a central theme in the development of postwar health cooperation, and in the claims made about GHG. According to Green and Mathias (1997), the change in donor attitudes to NGOs during the 1980s was linked to shifts in their domestic social and economic policies. The shape and complexity of this 'new' view of NGOs in international health has yet to be documented in any detail. However, there is now a substantial body of work on NGOs in the US that explores their relationship with government, their impact on domestic policy and their work with communities. Moreover, questions of accountability,

transparency and the role of NGOs within patterns of elitism and democratic representation are key issues in this literature (Daedalus 1987, Minerva 1997, Critchlow and Parker 1998, Condliffe Lagemann 1999). Studies of this kind beg questions about how, and to what extent, did changing attitudes to NGOs at the national level feed into the international arena - or vice versa. Indeed, national as well as international NGOs were an important voice in the 1945 UN Conference on International Organization, at which the shape of the new postwar machinery of intergovernmental organization was discussed. For example, as Seary (1996: 25) notes, the US government invited 42 American NGOs to send representatives to the conference to act as consultants to the US delegation, and a further 160 US NGOs attended the conference as observers. Moreover, US desire to avoid the possibility of a major domestic lobby turning against the UN (e.g. American Federation of Labour) was a key factor in allowing for national as well as international organizations to have a role in the UN system.

The national-international dynamic is an important area that needs further study, both in relation to changing attitudes towards NGOs among donor countries and in relation to issues of policy transfer, which include both **developed** and **developing** countries. Debate about the accountability or effectiveness of NGOs in developing countries needs to be underpinned by an empirical understanding of the pattern of NGO activity over time. Figures on the development of NGOs in Zimbabwe, provided by Green and Mathias, show a complex pattern:

TABLE 2: GROWTH OF NGOS IN ZIMBABWE: DATES OF COMMENCEMENT

Commencement	Church	Secular	Local	Local/ International	International
Pre-1900	7	-	7	-	-
1900-1949	15	3	16	1	1
1950-1979	17	16	29	3	1
post-1979	-	24	11	-	13

Source: Adapted from Green and Mathias (1997) page 17.

These figures are by no means comprehensive, although they do suggest a rise in secular and international NGOs following independence in 1979, and point to a steady rise in local NGO activity as the colonial period came to an end. Primary historical research would flesh out the kinds of changes suggested by these figures. Oral histories taken from participants, along with archival documents held by colonial authorities, church and mission societies, and the records of international NGOs like the Red Cross, offer the potential to build detailed case studies of NGO activity over time.

Contemporary discussion on the relative merits of NGOs, states and the private sector, in providing appropriate, sustainable health care, especially in developing countries, point inevitably to 'the past'. Unfortunately, in many respects this *past* has yet to be documented. In order to understand what is new in developments in international health we need a stronger sense of the complex history of this field: in national arenas (developed and developing); in the formal and informal arenas that developed between and across states (networks as well as intergovernmental organizations). Historical analysis also suggests that other issues are germane to GHG. The issue of policy transfer at different levels facilitated by international organizations is one such; the growing internationalisation of activist agendas underpinned by science is another. 'Development' is also an aspect that is seldom remarked upon in contemporary debate about GHG. However, 'development' is the

unacknowledged backdrop to postwar international health and the claimed transition towards something new. Historically, we know little of its intellectual or institutional origins, or the forces that sustained its rise to prominence. Studies that focus specifically on the rise of 'development' are notable in their absence. Indeed, only one study was identified during the course of this review (Rist 1997).

The 'past' is an essential resource for challenging or strengthening ideas about what's distinctive in contemporary developments. Archival sources and the systematic collection of personal testimonies could begin to close some of the gaps in our present understanding of cross border health activities in the past. A range of archival holdings are listed in Appendix A. However, what emerges from this review is the need to ask new questions and challenge assumptions, and to be more open in where we look when trying to answer these questions.

APPENDIX A

Archive Resources

The archive holdings included here relate mainly to postwar developments in international or transborder health. The list is suggestive rather than comprehensive, and corresponds to the further research possibilities mentioned in the text.

1. **WHO/UN:** WHO, in association with the Institut Louis Jeantet d'Histoire de la Médecine of the University of Geneva, a WHO collaborating centre for the history of public health, established an historical collection in 1995. Selected works and rare books within the collection are undergoing a process of optical scanning to provide printed and online copies (the latter will appear on the WHO website). The collection includes material relating to the nineteenth century Sanitary Conventions, the Office International d'Hygiène Publique and the League of Nations Health Organisation. Administrative documents and the official records of the WHO also form part of the collection. A particular strength of the collection is its comprehensive coverage of all international classifications and nomenclatures of disease. A useful reference guide to UN/WHO archives is *Guide to the Archives of International Organizations: 1. The UN System* (Paris: UNESCO) 1984. This guide lists material from agencies like WHO, FAO, ILO and from organisations such as the International Agency for Research into Cancer. It also details the rule governing deposit and access within the UN system.
2. **UIA:** Since 1948, The Union of International Associations does not maintain an archive as such. Records relating to the early organisation may be located in the Mundaneum – a museum created by Paul Otlet (co-founder of the UIA) and located in Mons Belgium. More recent material has been donated to the Royal Library, Belgium.
3. **Mission Medicine:** Records of the Church Mission Society, include full runs of publications and annual reports, other material subject to 40 year closure rule (material from 1950s became available in 1999) – contact University of Birmingham Library. Records of the World Development Movement (est.1970), contains committee minutes, correspondence files, newspaper cuttings – contact 25 Beehive Place, London SW9 7QR. Records of Christian Aid include full run of annual reports from 1960, other material relating mainly to the 1960s is boxed according to country or region of work e.g. Africa, Asia – contact the Library of the London School of Oriental and African Studies. A useful reference guide to the range of missionary records located at SOAS is R. Seaton and E. Naish's *A Preliminary Guide to the Archives of British Missionary Societies* (London: SOAS) 1992.
4. **Development:** Records of relevant British Government Departments are listed on the website of the Public Records Office <http://catalogue.pro.gov.uk/>. Records of the Colonial Social Science Research Council (1943-1963), a forerunner of the ODC, include minutes, correspondence, research proposals and reports, and miscellaneous records of related bodies – contact London University, British Library of Political and Economic Science.
5. **Activist organisations:** Records of Baby Milk Action, a British based consumer pressure group (originally the Baby Milk Action Coalition created in 1979 to boycott Nestlé) and part of International Baby Food Action Network, includes minutes of national and international committee meetings, directories, annual reports, financial records, correspondence, newspaper clippings – contact National Co-ordinator at 32 St Andrew's Street, Cambridge, CB2 3AX. Records relating to the International Bureau for the Suppression of Traffic in Persons (1899-1971) are available at the London Guildhall University, The Women's Library. Records of the International Bureau of the National Vigilance Association (1899-1969) are also available at the London Guildhall University, The Women's Library.
6. **Personal papers:** A good UK source for the personal papers of those involved in international health is the Contemporary Medical Archives Centre at The Wellcome Library for the History and Public Understanding of Medicine, Euston Road, London. Examples are the papers of Cicely Williams, nutritionist and paediatrician, head of WHO maternal and child health (1950s-1960s); Carlos Paton Blacker papers relating to his involvement with International Medical Group for the Investigation of Birth Control and other populations groups (1920s-1970s). Of equal interest of records of medics who worked in developing countries, such as Edward Hammond Williams' papers relating to his time as medical superintendent, Kuluva Hospital, Uganda (1940s-1970s) and his work with the Leprosy Research Fund (1952-1980).

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