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"ALL MUST COMBINE IN THE STRUGGLE AGAINST THE MICROBES" GLOBAL BIOPOLITICS AND TWENTIETH-CENTURY HEALTH ORGANIZATIONS

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ABSTRACT OF THESIS

“ALL MUST COMBINE IN THE STRUGGLE AGAINST THE MICROBES” GLOBAL BIOPOLITICS AND TWENTIETH-CENTURY HEALTH ORGANIZATIONS

The following paper explores the rise of global biopolitics by focusing on the League of Nations Health Organization (LNHO) and the World Health Organization (WHO) as pivot points around which an international system transitioned into a global system. The central thesis of the paper is that the LNHO served as the first true site of deployment for global discourses on health and hygiene, not as recent scholarship has suggested, the WHO. The purpose of the paper, however, is to provide an overview of the larger transformation of public health in the twentieth century, beginning with the proliferation of nineteenth-century international health organizations and culminating in the WHO. Central to this argument is the belief that population control is the ultimate end of the modern state, firmly placing discourses on health and hygiene at the nexus of modern politics. At its heart, this paper is about the nature of the modern state in relation to an increasingly global world.

KEYWORDS: Global Health, League of Nations Health Organization, World Health Organization, Biopolitics, Public Health

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THESIS

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“ALL MUST COMBINE IN THE STRUGGLE AGAINST THE MICROBES”
GLOBAL BIOPOLITICS AND TWENTIETH-CENTURY HEALTH ORGANIZATIONS

THESIS

A thesis submitted in partial fulfillment of the requirements
for the degree of Master of Arts in the College of Arts & Sciences
at the University of Kentucky

By

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2010

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For Dr. Ellen Furlough,
Who takes history seriously.

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Chapter One: “The Duty of Each and the Objective of All”

In 2004, the World Health Organization (WHO), under the auspices of the United Nations (UN), released a report entitled “World Report on Knowledge for Better Health.” The aim of this report, according to Director-General Lee Jong-Wook, was to close the gap between “what we know and what is actually being done.”¹ The contention of the report, that too many people in the world do not have access to “modern” health care, is neither a new one nor a particularly controversial one. The belief that every human *should* have—that is, has a *right* to—the most advanced health care has become ubiquitous, particularly in Western societies. A 2007 *New York Times* poll, for example, found that nearly half of Americans believed that the U.S. government should *guarantee* health insurance for every citizen.² Nearly all believe that every American should have access to doctors, drugs, and hospitals. The WHO report, of course, extends such sentiments the world over, striving for a global system equipped and willing to export to every corner of the planet a uniformity of health and happiness. Even science, ironically, must not stand in its way: “Is science,” ponders the report, “being increasingly driven by economic forces and ignoring its ethical, moral and social responsibility to give entire populations more equitable access to health care?”³ To what is the WHO referring when it chastises “science,” and why should it be *ethically*, *morally*, and *socially* responsible for the well-being of the entire globe? More

¹United Nations, World Health Organization, *World Report on Knowledge for Better Health* (Geneva: World Health Organization, 2004), xi.

² Robin Toner and Janet Elder, “Most Support U.S. Guarantee of Health Care,” *New York Times*, 2 March 2007, <http://www.nytimes.com/2007/03/02/washington/02poll.html>.

³ *WHO Report*, 4.

importantly: what does it mean to be “healthy” in a 21st-century sense and why is it “good” to be “healthy?”

To discern viable answers to these questions, one must first understand the fundamental role public health has played in the history of the modern state. Rudolf Virchow (1821-1902), the “father of modern pathology,” probably did not suspect the full extent of his accuracy when he made the following observation in the middle of the nineteenth century: “Medicine is a social science...anthropology in its widest sense, whose greatest task is to build up society on a physiological foundation...*Politics is nothing but medicine on a large scale.*”⁴ The marriage between health and the modern state has a polymorphic history, but if we understand “public health” to refer to collective action in relation to the health of populations, it is possible to view the striking desire of the modern state to increase and control its own population through public health as its fundamentally “modern” characteristic. Put another way, the relentless administration of health may be a key ingredient to the modernity of the modern state.

Early twentieth-century historians did not imagine such a strong connection between health and state, regarding eighteenth and nineteenth-century sanitization and quarantine efforts as by-products of technological and social advancements. The Columbia and Yale professor George Rosen’s *History of Public Health* (1958) operated as the definitive textbook on the subject for much of the latter twentieth century and its teleological understanding of health continues to dominate popular consciousness. In it, Rosen traced transformations in health care from Pre-Socratic times to the period

⁴ Qtd. In George Rosen, *History of Public Health*, (New York: MD Publications, 1958), 13.

between the two twentieth-century world wars, arguing that health should be understood as a communal story stretching back to humanity's origins and culminating in "development achieved at present in the economically and technologically advanced countries of the world."⁵ After all, if sanitary reforms and efforts to control infectious diseases were the *bona fide* parameters of public health history, then public health was not truly invented in the nineteenth century. It was preconfigured in any and all technological advancements made through time, connected in some way to the rudimentary drainage systems excavated among the ruins of the earliest Indus Valley civilizations.⁶ While advancements in health are certainly vital to the growth of modern civilizations, it is impossible from this perspective to understand public health as co-extensive with the modern state. Instead, it is an operational consideration on which the ultimate efficiency of states may rely, not a central *raison d'État*.

In the 1960s, 70s, and 80s, however, some historians began to question the heroization of public health as a great achievement of Enlightenment rationalism. Many began to glimpse ways in which the impact of epidemics helped shape modern society that did not reconcile with existing paradigms. This new historiography focused on the differential experiences of epidemics by social classes, professionals, scientific and religious communities and political states and oligarchies.⁷ They discovered that not

⁵ Rosen, 18.

⁶ Rosen, 25.

⁷ See Charles Rosenberg, *The Cholera Years 1832, 1849, and 1866* (Chicago: University of Chicago Press, 1962), R.J. Morris, *Cholera 1832. The Social Response to an Epidemic* (London: Croon Helm, 1976), Margaret Pelling, *Cholera Fever and English Medicine 1825-1865* (Oxford: Oxford University Press, 1978), Carlo M. Cipolla, *Faith, Reason, and the Plague. A Tuscan Story of the Seventeenth Century* (Brighton: Harvester, 1979), William Coleman, *Death is a Social Disease* (Madison: University of Wisconsin Press, 1982), Paul Slack, *The Impact of Plague in Tudor and Stuart England* (London: Routledge and Kegan Paul,

only is the experience of “healthiness” not shared across different social groups, but that its subjectivity often gives shape to social patterns. Over the next four decades, such scholarship all but destroyed the progressive “rise of civilization” epitomized by Rosen. Many began to regard public health as a tool often used by modern states to exclude segments of the population, a perspective evident in Alfred Crosby’s and William McNeill’s writings on the processes of colonization and imperialism.⁸ Above all, these historians understood definitions of health to be infused with meaning by the machinations of the state, drawing on a philosophical heritage that dated to the 1930s but found its champion in the French ‘archaeologist of knowledge,’ Michel Foucault.

Following the lead of Hegel and Wittgenstein, Foucault highlighted the contradictions of Enlightenment thought and, through his early investigations of prisons, hospitals, and sanitariums, enumerated a ‘disciplinary culture’ which he argued was the defining characteristic of modern society.⁹ The aim of the modern state, according to this perspective, is the optimization of populations which constitute it. To be able to utilize concepts such as biopolitics and governmentality in one’s analysis first requires

1985), R.J. Evans, *Death in Hamburg. Society and Politics in the Cholera Year 1830-1910* (Oxford: Clarendon Press, 1987), James C. Riley, *Sickness, Recovery, and Death: A History and Forecast of Ill-Health* (London: Macmillan, 1989).

⁸ Alfred Crosby, *Ecological Imperialism: The Biological Expansion of Europe 900-1900* (Cambridge University Press, 1986), William McNeill, *Plagues and Peoples* (New York: Doubleday, 1976).

⁹ Foucault is widely considered a father of the post-modern movement and his opus constitutes what has proven to be one the most lasting and influential de-constructions of Enlightenment thought. While *The Order of Things* (1966) and *The Archaeology of Knowledge* (1969) marked his arrival on the international stage, his most important works, *Discipline and Punish: The Birth of the Prison* (1975) and the incomplete *The History of Sexuality* (1976-1984) were written near the end of his career. His identification in modern society of what he termed “biopolitics” was laid out among a series of lectures delivered between 1970-1984 at the Collège de France, particularly in two lectures respectively entitled “Security, Territory, Population” (1977-1978) and “The Birth of Biopolitics” (1978-1979). The concepts “biopower” and “biopolitics” are imperative to an understanding of the role of public health in the modern state.

an understanding of Foucault's fundamental conception of power. Though the appellation was applied by subsequent scholars, it is useful to regard the power on which Foucault rests his worldview as the "fourth face of power," conveniently shortened to power₄. The first face of power represents the traditional view: "A has power over B to the extent that he can get B to do something that B would not otherwise do."¹⁰ In 1962, Peter Bachrach and Morton S. Baratz argued that a second face of power exists wherein B is *prevented* from doing what it wants to do by the power of A. Finally, in 1974, Steven Lukes contended that a third, or radical, face of power can be exerted during which the very wants and desires of B are manipulated so that B willingly acts against his own interests in the interest of A.¹¹ This is a form of intrusion that is not captured by liberal conceptions of power.

Power₄, conversely, departs from more traditional conceptions of power by calling into question the presumption of A and B. "The fourth face of power," writes Peter Digeser, "does not take as presupposed the subjects of the other three faces. Power₄ postulates that subjectivity or individuality is not biologically given. Subjects are understood as social constructions, whose formation can be historically described."¹² Subjects are thus *produced* by power₄, not preexisting entities upon which it acts. Power₄ is not something that can be owned, not something one can *have*. Instead, power₄ is the relations, often extensively coordinated, among the subjects that it incessantly creates and modifies, so that one should not speak of the *substance* of

¹⁰ Robert Dahl, "The Concept of Power," *Behavioral Science* 2 (July 1957): 202-203.

¹¹ Steven Lukes, *Power: A Radical View* (Houndmills: Macmillan, 1974), 23.

¹² Peter Digeser, "The Fourth Face of Power," *The Journal of Politics* 54, 4 (November 1992): 980.

power (which does not exist), but instead the *relations* of power and the grids of power analysis, or analytics.

Power₄ in this sense is understood as the producer of truth in the form of knowledge which then in turn *empowers* subjects into existence. These subjects, though in constant flux, then reinforce the existence of the knowledge upon which they were founded. “‘Truth’,” Foucault explains, “is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extend it. A ‘regime’ of truth.”¹³ It is easy to see how this analysis bears out in social conceptions like sexuality and mental illness, but, according to Foucault, it is active in every social relationship. Because power₄ is the producer of subjects, it necessarily lies at the bottom of all social practices and in every social relationship.¹⁴ Power₄ is everywhere, co-extensive with the social body: “It seems to me,” writes Foucault, “that power *is* ‘always already there’, that one is never ‘outside’ it, that there are no ‘margins’ for those who break with the system to gambol in.”¹⁵ This ‘regime’ serves as the basis for all modern capitalist (and socialist) societies, so that production of knowledges (truth) concerning the human body—*who* we are, *what* we are—begin to emanate from an increasing number of points in society, many beyond the tentacles of the state. By the twentieth century, in short, biopolitics is the only game in town.

Central to this control is the creation of the concept of “population,” which became a quantifiable category in the eighteenth century with an explosion of statistics

¹³ Foucault, *Power/Knowledge: Selected Interviews and Writings, 1972-1977*, Ed. Colin Gordon (New York: Pantheon Books, 1980), 133.

¹⁴ Digeser, 980.

¹⁵ Foucault, *Power/Knowledge*, 141.

which monitored and tracked it: demographic tables, life expectancy charts, mortality rates, and studies of the reciprocal relations of growth of wealth and growth of population. Tracking populations had existed for centuries, but it was not until the second half of the nineteenth century that demography can be said to have separated itself as its own statistical science.¹⁶ The first international congresses on demography, small though they were, began to be called for in 1840s. Populations became separate “bodies” that, like their individual counterparts, must be controlled: “The biological traits of a population,” writes Foucault, “become relevant factors for economic management, and it becomes necessary to organize around them an apparatus which will ensure not only their subjection but the constant increase of their utility.”¹⁷

But because Foucault conceived of power as both a ubiquitous and *creative* force, “these relations,” he states, “don’t take the sole form of prohibition and punishment, but are of multiple forms.”¹⁸ While a number of power apparatuses are called upon to take charge of “bodies,” not all of them (in fact, an increasingly small percentage) do so by “exacting blood service” or levying biological dues.¹⁹ Of much greater importance to the evolution of the modern state is the converse strategy: helping and, if necessary, constraining individuals for the benefit of their own good health. “The imperative of health,” declares Foucault in a famous passage, “at once the

¹⁶ See Philip Abrams, *The Origins of British Sociology: 1834-1914* (Chicago University Press, 1968), M.J. Cullen, *The Statistical Movement in Early Victorian Britain. The Foundation of Empirical Social Research* (New York: Harvester, 1975), P.E. Razel, “An Interpretation of the Modern Rise of Population: A Critique” *Population Studies* 28 (1964): 5-17., and especially Thomas McKeown, *The Modern Rise of Population* (London: Edward Arnold, 1976).

¹⁷ Foucault, *Power/Knowledge*, 172.

¹⁸ Foucault, *Power/Knowledge*, 142.

¹⁹ *Ibid*, 172.

duty of each and the objective of all.”²⁰ In this way the predominant rationale of the modern state becomes not one of violence but care, the care for individual life. “It is precisely care,” explains Mika Ojakangas, “the Christian power of love (*agape*), as the opposite of all violence that is at issue in biopower.”²¹ Death, central to the question of power in a society built upon sovereignty, becomes an “object of taboo” in a post-sovereign world.²² One should not, however, conceive of biopolitics as simply a method used by liberal states. “Global health,” anthropologist Mike Nichter explains, “is biopolitical whether it is envisioned as an end worked toward in the name of human rights or a means toward larger diplomatic ends such as biosecurity, protecting trade relations, and so on.”²³

As a result, the proliferation of knowledge stipulating what was “healthy” and “unhealthy” behavior (biopower) became what politically, economically, and institutionally drove the rationale of the modern state (governmentality). Biopolitics, then, is the deployment of strategies and techniques aimed to control and manipulate knowledge production. An example: in 1936 the Hygiene Commission of the League of Nations established, through scientific and medical analysis, a dietary standard of 2,400 daily calories necessary for the well-being of sedentary people. In 1950, a dietary subcommission in the French ministry of Health cited this resolution while undertaking an extensive endeavor to standardize a nationwide *minimum vital* for all French

²⁰ Ibid.

²¹ Mika Ojakangas, “Impossible Dialogue on Bio-Power,” *Foucault Studies* 2 (May 2005): 20.

²² Foucault, “*Society Must Be Defended*”: *Lectures at the College de France 1975-1976* (New York: Picador, 2003), 254.

²³ Mark Nichter, *Global Health: Why Cultural Perceptions, Social Representations, and Biopolitics Matter* (University of Arizona Press, 2003): 176.

workers, the “basic need” any generic human being required to fulfill his or her labors.²⁴ The commission examined all aspects of the worker’s life in its assessment: nutrition, clothing, running water rations (one cubic meter per month), even the amount of leisure time (and wine) each needed to maintain a proper well-being. They arrived, despite the arguments of most employers, at the figure of 2,890 daily calories per worker.²⁵ No more, no less.

Subsequent scholars have explored the concept of biopolitics almost exclusively through the prism of the modern state. In the field of public health and hygiene, for example, recent studies have utilized biopolitics to examine racialized nation-building in the U.S²⁶, Australia²⁷, and Canada²⁸, to name a few. Conversely, as Alison Bashford has noted, scholarship of global or “world” health has lacked an adequate biopolitical appraisal: “If biopolitical health and hygiene have been explored as constitutive of modern nationalism and colonialism, what about the field of *world* health, which represented the great 20th-century reach of national 19th-century health and hygiene projects? What about the possibility and imperative of health as it was figured internationally, transnationally and even globally over the 20th century?”²⁹ In *Empire*, their manifesto on globalization, Antonio Negri and Michael Hardt argue that the formation of the United Nations was the pivot point around which an international

²⁴ Dana Simmons, “Wages and Politics of Life in Postwar France,” *The Journal of Modern History* 81 (September 2009): 593.

²⁵ *Ibid*, 594-595.

²⁶ Stern 1999 and 2005, Shah 2002, Fairchild 2003.

²⁷ Anderson 2002, Bashford 2004.

²⁸ Mawani 2003.

²⁹ Alison Bashford, “Global Biopolitics and the History of World Health,” *History of Human Sciences* 19, 1 (2006): 68.

system transitioned into a global system, with the World Health Organization (WHO) serving as the first true site of deployment for global discourses on health and hygiene.³⁰ Recently, some scholars have argued that the League of Nations (LON), not the UN, should be considered the true hinge in the genealogy of globalization. As Susan Pedersen observes: “If one notes its efforts to regulate cross-border traffics or problems of all kinds, it emerges rather as a harbinger of global governance.”³¹

The work and writings of the LNHO support Pedersen’s claims. The period between the creation of the LNHO in 1921 and that of the WHO in 1948 was crucial to the rise of global biopolitics. It is important to note at this point that the terms *global* and *transnational* have been used interchangeably by some scholars and by others fiercely differentiated. For the purposes of this paper, it is not necessary to dwell on the possible differences between the two; both imply a transcendence of the nation-state in ways that enlarge existing grids of power, continually de-centralizing various national bodies. It seems to me that the difference in the terms relies on the factor of de-centralization—at some point the nation-state is far enough removed from the center that the word *transnational* becomes inadequate and the relations of power are better described as *global* in nature. The League of Nations, no doubt, is best understood as transnational in this sense, though it not only predicts but at times realizes a more global dynamic, particularly in the case of the LNHO.

³⁰ Hardt and Negri, *Empire* (Cambridge: Harvard University Press, 2000), 4-5.

³¹ Susan Pedersen, “Back to the League of Nations,” *American Historical Review* (October 2007): 1092.

Chapter Two: “All must combine in the struggle against the microbes.”

In an attempt to resurrect the League of Nations from historiographical oblivion, recent scholarship has re-evaluated its numerous bodies through the prism of transnationalism. In 2005, Patricia Clavin, who has written extensively on the LON, authored with Jens-Wilhelm Wessels a treatise on the subject, arguing that over time “League officials sought to prioritise League interests over those of the nation-states from which they originated,” so that eventually the League’s Secretariat developed its own policy agenda for international cooperation that “sometimes ran counter to the interests of its major national sponsors.”³² Such literature has ably demonstrated that to regard the LON simply as an ineffective hodgepodge of national actors misses both the nuances of its operations and the historical implications of its existence.

How is it possible to conceive of the LNHO as a global apparatus? Certainly its actors viewed themselves in largely national terms, despite the general agreement among them that international cooperation was the only avenue through which to secure lasting peace. The key to understanding the global nature of the LNHO lies in Foucauldian analytics: by proliferating discourses on the body through hygiene and epidemiology standards, the LNHO created a new “world view” of how the health of large populations should be managed—and manage itself. While it may have lacked in many instances the teeth to put into practice its recommendations, the production of the discourse, the sheer cataloguing of numerous population statistics, can be seen as a turning point in the genealogy of global health. The LNHO, writes Martin Dubin, “served

³² Patricia Clavin and Jens-Wilhelm Wessels, “Transnationalism and the League of Nations: Understanding the Work of its Economic and Financial Organisation,” *Contemporary European History* 14 4 (2005): 467.

as a coordinating body—a sort of executive committee—for a worldwide biomedical/public health episteme...and had the unusual quality of being largely self-transforming in response to new scientific knowledge developed within the episteme.”³³

U.S. based philanthropies are also crucial to understanding the vast network of the LNHO. It would be almost impossible to overstate the importance of the decidedly transnational involvement of the Rockefeller Foundation, which was initially created to combat hookworm and yellow fever in the U.S in 1913. By the interwar period, the Foundation was financing health-related projects in South America and Europe, including funding for hygiene institutes in Yugoslavia, an anti-tuberculosis campaign in France, and numerous health programmes in Poland, Hungary, Bulgaria and other Eastern European countries.³⁴ It developed a special relationship with the LNHO, donating annually to the coffers of the Health Organization, sometimes in large sums. After granting millions of dollars to overseas relief just after WWI, the foundation began to regard such specialized humanitarian efforts as wasteful, confident that only through long-term investments in public health could there be significant advancements in what one Foundation official identified as “the health of the people of all lands.”³⁵ The involvement of the Rockefeller Foundation also served as another avenue through which U.S. influence could be felt within the LNHO.

³³ Martin David Dubin, “The League of Nations Health Organisation,” in *International Health Organisations and Movements, 1918-1939*, Ed. Paul Weindling (Cambridge University Press, 1995) 56.

³⁴ Paul Weindling, “Public Health and Political Stabilisation: The Rockefeller Foundation in Central and Eastern Europe between the Two World Wars,” *Minerva* 31, 3 (July 1993): 256-259.

³⁵ Qtd. In Paul Weindling, “Philanthropy and World Health: The Rockefeller Foundation and the League of Nations Health Organisation,” *Minerva* 35, 3 (September 1997): 271.

In many ways, international health efforts in the early twentieth century can be seen as a continuation on a larger scale of the “quarantine” efforts by nineteenth-century states enacted to “sanitize” problematized places within their own borders. Following the great cholera epidemics of the mid-nineteenth century, international epidemiological meetings occurred with greater frequency, beginning with the International Sanitary Conference of 1851, in Paris, followed a year later with the first International Congress of Hygiene and Demography in Brussels. Over the next eighty years, this congress met 19 times in a dozen countries, meeting for the last time on the eve of WWII.³⁶ Each session dealt primarily with containing the spread of various epidemics—cholera, typhus, and tuberculosis in particular. In 1907, the International Office of Public Hygiene was established in Paris and within five years had 41 members, only half of them European states. A network of regional health bureaus (Singapore, Washington, Alexandria) helped the Paris office compile vast reports and statistics on epidemiological outbreaks and trends across the globe.³⁷ The work of the Paris office was not simply to gather information, but to regulate the quarantine efforts of major European cities, borders, and ports. When a typhus epidemic raged along the ruins of the Eastern Front in 1920, the LON was called upon to investigate. Fear that the epidemic would spread across a vulnerable Europe concerned the minds of many. “The necessity for establishing an international organization of this kind,” wrote the Argentinian delegate to the LON in 1920, “has long been felt...In such circumstances there are no longer allied and associated, neutral or belligerent Powers—all must

³⁶ *International Conferences and Congresses, 1840-1937* (The H.W. Wilson Company: 1938), 97-99.

³⁷ *The Palgrave Transnational Dictionary*, 343.

combine in the struggle against the microbes.”³⁸ As the imperative of health spread, then, quarantine logic evolved into the need for a global governance of subjects, which in turn necessitated a centralized body to direct such efforts.

In September of 1921, the LON officially ratified the Health Organization of the League of Nations. In its inaugural manifesto on the purpose of this new body, an unnamed official wrote: “Hitherto it was nobody’s business to suggest that the time was ripe for a definite international understanding and, what is more, to facilitate and partially finance actual laboratory work leading to the practical realisation of a generally acknowledged need.”³⁹ The reference here is to the standardization of serological tests, vital for the treatment of tetanus, diphtheria, dysentery, and other ailments. The LNHO convened two congresses to discuss this “all-important question” over the period of a year, during which a number of subcommittees were formed to interview various medical experts and make recommendations.⁴⁰ In seeking a global knowledge of health and disease, the LNHO required a noso-politics of classification. It succeeded in regularizing medical nomenclatures, symbols, morbidity categories, drug definitions, and communication and intelligence systems through its Permanent Commission on Standardization. The LNHO established methods for measuring x-rays, classifications for blood types, and categorized definitions of Vitamins A, B, C, and D. It also standardized

³⁸ *Draft Proposals of the Argentine Delegation for the establishment of an International organization of health and demography*, Assembly Documents, 1920, microfilm.

³⁹ *Report of the Health Section of the Secretariat on its duties and work during the period from Oct. 1921 to Sept. 1922*, Health Section of the Secretariat, Sept. 6th, 1922.

⁴⁰ *Report of the Health Section of the Secretariat on its duties and work during the period from Oct. 1921 to Sept. 1922*, Health Section of the Secretariat, Sept. 6th, 1922.

certain drugs, including insulin, digitalis, and pituitary extracts, and then distributed to laboratories around the world.

Other efforts by the LNHO included the expansion of the list of official causes of death, which became more particular in an attempt to combat statistical confusion. This was accomplished by “the hierarchization of causes, so that the choice of the cause to which a death should be assigned in the statistics in the case of more than one cause being indicated on the death certificate would be clear.”⁴¹ As a result, the establishment of age-groups in which it was appropriate to classify deaths became necessary, as well as the refinement and augmentation of “population categories” to make mortality statistics “intelligible.”⁴² This new rubric first placed the deceased in one of 16 categories, ranging from smallpox to suicide, or even (ironically) “ill-defined causes.”⁴³ Further classification followed. Tumors needed to be categorized first as either sarcoma or carcinoma, then specified anatomically (lip, ovary, subcutaneous, etc). One of the organizational missions was even to amass information on the various processes and categories of data-collection itself: part of the LNHO’s 1936 Epidemiological Report was a table setting out “The International Lists of Causes of Death: Extent of their Adoption in the Various Countries.”⁴⁴ Such activity supports

⁴¹ “International List of Causes of Death,” *Bulletin of the Health Organization*, Vol. 7, 1938: 944.

⁴² *Ibid.*

⁴³ *Revision of the International List of Causes of Death*, letter by the Secretary General, July 13th, 1927, microfilm.

⁴⁴ “The International Lists of Causes of Death: Extent of their Adoption in the Various Countries,” *Bulletin of the Health Organization*, Vol. 6, 1937: 111.

Bashford's contention that "extensive standardization both *was* biopolitics, and was one of the preconditions *for* biopolitical practice on a new kind of global field."⁴⁵

The same manifesto summarizes a second and more important ambition of the LNHO: the concentration of epidemiological statistics in a particular place. "Likewise," it continues, "no institution is undertaking at present the publication of a comprehensive survey of the epidemiological situation of the world."⁴⁶ Despite the efforts of the Parisian Office, communication between different regions was often unreliable, sometimes disconnected entirely. Over the next 25 years of operation, the LNHO obsessively accrued, processed, and published thousands of incidents of illness taken from all corners of the globe, in such striking detail that on July 5th, 1931, it was reported that an "Egyptian, 12 years of age, living in a house situated at the intersection of Ibrahim Tewfick and Kisra Streets, 2nd kism, native quarter, at about 1 mile from the port and 530 yards from case No. 2," contracted the plague.⁴⁷ The contacts, at the time of the report, remained under close observation.

This emphasis on vital statistics, "so crucial for the intelligibility of populations in 19th-century national public health," began to be inscribed within a global paradigm.⁴⁸ The initiative would not be restricted only to participating League countries—it was to be a study of current epidemics affecting "the whole world."⁴⁹ The national origin of each report became a subheading beneath large regional swaths of coverage. These

⁴⁵ Bashford, 75.

⁴⁶ Ibid.

⁴⁷ *Weekly Epidemiological Record of the Health Section of the Secretariat*, 6th Year, 1931: 414.

⁴⁸ Bashford, 70.

⁴⁹ *Report of the Health Section of the Secretariat on its duties on its duties and work during the period from Oct. 1921 to Sept. 1922*, Health Section of the Secretariat, Sept. 6th, 1922.

ambitions reoriented lines of communication around the LNHO, the medium through which nearly all public health decisions would flow and from which all standards would originate. Information flowed through several media, including telegraphs, wireless broadcasts, and weekly tabled publications. The LNHO even developed a special new AA cable code (telegraphic), which could be transmitted in English and French and was used exclusively for the purposes of the Health Bureau. Offices in Paris and Brussels were connected to those in Washington in a more efficient, more coordinated manner; the Far Eastern Bureau in Singapore transmitted dozens of statistics daily to its western counterparts, continuously collecting reports from hundreds of pacific ports. By the mid-1920s, the LNHO had offices in Paris, Geneva, London, Warsaw, and Hong Kong, with bureaucratic and research outposts in the United States, Canada, Mexico, Japan, Australia, Fiji, Philippines, Siam, Borneo, numerous island chains, Peru, Iraq, Nigeria, Russia, British India, French India, Portuguese India, French West Africa, Kenya, Madagascar, Uganda, French Indo-China, Egypt, Morocco, Tunis, Union of South Africa, Federated Malay States, Ceylon, Algeria, Belgian Congo, Nyasaland, Sudan, Palestine, Southern Rhodesia, Ecuador, and Honduras. By 1937, according to Weindling, an estimated 72 percent of the world's population was covered by the vital statistics of the LNHO, encompassing a sufficiently large enough area that for the first time one can speak of the existence of global vital statistics.⁵⁰

In what ways, then, can we view the global ambitions of the League as an extension of national biopolitical aims? “[The LNHO],” writes Rubin, “penetrated deeply

⁵⁰ Qtd. In Paul Weindling, “Philanthropy and World Health: The Rockefeller Foundation and the League of Nations Health Organisation,” *Minerva* 35 (1997): 276.

into national societies drawing domestic administrative, research and educational agencies into a transboundary biomedical/public health infrastructure.”⁵¹ The technical ambition towards the hygienic governance of “each and all” is unmistakable. Health was now a mode of “being,” subject to management of individual conduct if necessary (and it was always necessary). With the creation of a “General Programme of Research into Biological Measurements and Tests for the Definition of States of Malnutrition,” states were designated as either properly cognizant of this knowledge or substandard.⁵² Those who did not pass the test were regarded as a common danger. As a result, missions were sent to (and requested by) countries around the world to standardize, in effect, the proper responses to epidemics and, more importantly, educate the “people” about personal hygiene.

“Hygiene,” the LNHO declared in 1931, “is primarily a matter of education.”⁵³

Across the globe, League officials worked towards an individual internalization of new bodily practices and dispositions, discourses on personal hygiene proliferating from the LNHO, by peoples on a local level. The aim was to bring about individual recognition by each person of the need for personal hygienic responsibility. Medical inspections of schools in the United States came under scrutiny of the LNHO after doubts were raised as to “whether our common schools will ever become what they ought to be as places for the promotion of health.”⁵⁴ The League closely scrutinized maternal hygiene, maternal mortality, and infant welfare in the U.S., Australia, and the U.K., resulting in

⁵¹ Dubin, 73.

⁵² Ibid, 505.

⁵³ *Health*, Assembly Documents, 1931, microfilm: 13.

⁵⁴ James Frederick Rogers, “School Medical Inspection in the United States of America,” *Quarterly Bulletin of the Health Organisation*, Vol. 4, 1935: 708.

extensive reports which recommended “prenatal supervision” and “popular education...instruction of all women in the rules of maternal hygiene...a vigorous campaign in favour of breast-feeding, frequent attendance at infant welfare centers...reform of habits...and improvement of health conditions.”⁵⁵

A 1934 LNHO document entitled “The Perilous Threshold of Life” demonstrates the aims of the organization most clearly.⁵⁶ Written by the Chief Statistician of the LNHO, K. Stouman, the document explored the fall of the infant mortality rate and the subsequent demographic effects such a rapid transformation had across the globe. Comparative categories of analysis included the birth rate, the size of the family, age distribution, geographical distribution, gender discrepancies, consecutive births, and ante-natal mortality, wherein an official definition of “still-birth,” a term standardized by the LNHO, could be found. “The gateway to life,” he wrote, “has been—and must continue to be—rendered less perilous.”⁵⁷ This problematization of the health of the “international” infant as a precipitate of large-scale demographic trends reveals the “politics of life” that are at the heart of biopolitics. Stouman’s concern was not with the individuals who constitute each family, but the “well-being” of the productive force of the family as a whole. “The rapid scientific and social developments described within this study,” he continued, “enable us to foresee the possibility of a directed demography as counterpart of a directed economy.”⁵⁸

⁵⁵ “Report for the Period January 1931 to September 1932,” *Quarterly Bulletin of the Health Organisation*, Vol. 3, 1932: 11.

⁵⁶ K. Stouman, “The Perilous Threshold of Life,” *Quarterly Bulletin of the Health Organization*, Vol. 3, 1934: 531-612.

⁵⁷ *Ibid*, 611.

⁵⁸ *Ibid*, 532.

Biopolitics can also be seen at work beneath the rubric of “rural hygiene,” a broad initiative which engaged international health workers in South America, China and south-east Asia. For more than ten years, the LNHO undertook an extensive and unprecedented effort to “modernize” the public health system of China, throughout which “a close technical collaboration [had] been continuously maintained in regard to quarantine services, cholera control, general public health services, medical education, hospital administration, etc.”⁵⁹ The LNHO sent eleven League-appointed doctors, along with countless other personnel, were sent to Sian, Changsha, and Nanning. While there, the teams were “chiefly devoted” not only to the establishment of various medical services, but also to the “dissemination of health propaganda,” without which their efforts might prove to be in vain.⁶⁰ The LNHO explicitly exported systems of practice by establishing local schools of hygiene under its own logic. It trained public health field practitioners and exchanged engineers, so that workers in “non-advanced” countries were brought to “sanitized” countries to be educated on “port health administration, industrial hygiene, rural hygiene, sanitary engineering, vital statistics, and school hygiene,” among others.⁶¹ Nutrition in Chile, for example, was studied closely over a multi-year period, with the diets of “everyday Chileans” intensely scrutinized.⁶² In one report on the subject, Dr. E. Burnet wrote that, “should the Chilean government decide upon a long-term nutrition policy, [the LNHO] would be prepared to co-operate with any central technical body the Government might appoint to co-ordinate the appropriate

⁵⁹ Stouman, 247.

⁶⁰ Ibid, 250.

⁶¹ *Report on the Permanent Standardisation Commission*, Council Document, August 6th, 1930, microfilm.

⁶² Dr. Et. Burnet, “Report on Popular Nutrition in Chile,” *Bulletin of the Health Organization*, Vol. 6, 1937: 296.

measures, including in the organization of clinics, schools, and other public health centers.”⁶³

I have touched above on only a fragment of the global efforts of the LNHO, which of course undertook many other projects analyzable through a biopolitical lens. Problems of a “humanitarian character” necessitated intervention in Spain in 1937⁶⁴, officials penned extensive reports on the density of flies in Hungary in 1938⁶⁵, while others reported on health conditions of the “Greek population” repeatedly over a two-year period from 1925-26. In 1941, the LNHO carried out a detailed study of the diets of Indian workers and concluded that “no reason why a new and rigorous attack on the rice problem should not be made,” spear-headed, of course, by the expertise of League officials.⁶⁶ The “rice problem” would eventually be investigated in Thailand, as well.⁶⁷ Wherever one looks, the work of the LNHO is marked by a preoccupation with questions of population, defined in both broad and meticulous terms. In this sense, the League of Nations Health Organization illuminates how global health during the early twentieth century was understood through questions of demography and migration, and was as much statistically driven (towards a mathematically ideal balance) as it was medically rooted.

⁶³ Ibid, 300.

⁶⁴ “Report on the Health Mission in Spain,” *Bulletin of the Health Organization*, Vol. 6, 1937: 56-92.

⁶⁵ George Makara, “Investigations into the Fly Density in Hungary in the years 1934 and 1935,” *Quarterly Bulletin of the Health Organization*, Vol. 5, 1936: 219-236.

⁶⁶ W.R. Aykroyd, “The Poor Rice-Eater’s Diet,” *Bulletin of the Health Organization*, Vol. 9, 1940-41: 342-360.

⁶⁷ “The Rice Problem in Thailand,” *Bulletin of the Health Organization*, Vol. 9, 1940-41: 361-369.

Chapter Three: “It is an Economic Disease”

The regular publication of the LNHO’s *Chronicle of the Health Organisation*, a monthly propaganda pamphlet disseminated to numerous locations around the world, was suspended in May 1940 because of impending conflict. Over the next five years, only two issues were released. In December of 1945, the *Chronicle’s* editor, left anonymous, published a 16-page reflection on his beloved institution, the last words ever officially printed by an organization that had set to paper millions of statistics, opinions, research findings, and proposals during its 24-year existence. “Health,” he wrote, “is something more than the absence of disease, and although curative and preventive medicine have not said their last word, they cannot endow the individual with that physical perfection which ensures joy of living.”⁶⁸

League administrators dreamed in the early 1920s of a health organization that would bring under its umbrella all existing public health projects, medical experts, and hygiene institutions. The LNHO never fully realized this ambition, dissolving, despite some intrepid officials who continued their work into the 1940s, with the arrival of the Second World War. Many of its schemes were abandoned unfinished and its records became, for a short period, chronicles of a lost cause. But through its global re-imagining of the role of international health organizations, the LNHO had pioneered the transition from “international hygiene” to “world health,” a paradigmatic shift culminating with the creation of the WHO in 1948. The new institution inherited the

⁶⁸ *Chronicle of the Health Organisation*, Special Number, Geneva, December 1945: 3.

mandate, resources, and much of the staff of its progenitor, which was brought under its auspices along with other pre-existing health organizations like the International Office of Public Hygiene. The Pan American Sanitary Bureau retained its autonomy as part of a larger regionalization scheme laid out by the WHO.

The WHO began with a concerted effort to effectively broaden its geographic influence that would allow for a future expansion of objectives. Whereas its predecessor had often been maligned (sometimes fairly, sometimes not) for a lack of effective organization, the WHO emphasized early the importance of a smoothly operating bureaucracy. It immediately split the world into more manageable regions (the Americas, Southeast Asia, Europe, Eastern Mediterranean, Western Pacific, and Africa), each of which by the mid-1950s had its own headquarters and numerous satellite offices. Moreover, argues medical historians Theodore Brown, Marcos Cueto, and Elizabeth Fee, the very act of “naming the new organization the *World Health Organization* also raised sights to a worldwide, “global” perspective.”⁶⁹

This section will address three aspects of the WHO from 1950-2000 that best illustrate its maturation into a global operator. The first is the attempt by the WHO in the 1950s and 1960s to secure the worldwide eradication of malaria, the boldest and most expansive epidemiological effort up until this point. Following the ultimate failure of this agenda and the WHO’s 1969 declaration that such eradication would be impossible, the organization turned instead to questions of Primary Health Care, the

⁶⁹ 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 (January 2006): 64.

second topic. Over the next two decades, the WHO rebuked technological and disease-oriented strategies in favor of social and economic approaches, which emphasized long-term socio-economic growth and diversified the activities of the organization. Partly as a logical progression of previous policies and partly in response to an economic crisis in the late 1980s, the WHO refashioned itself in the 1990s as a coordinator and leader in the self-proclaimed field of “global health.”

As one might imagine, an intergovernmental organization like the WHO has always been particularly sensitive to political upheaval. Early on, the slow ratification of the U.N. inhibited the WHO’s activities, as did the tension between the U.S., its main financial contributor, and other countries at the dawn of the Cold War. During the years between the 1949 departure of the Soviet Union and other communist countries from the U.N. until their return in 1956, the WHO was strongly beholden to U.S. interests. The reinstatement of the U.S.S.R. again shifted power relations within the WHO, as the Soviets, eager to make their mark on global health, donated (along with Cuba) 27 million doses of freeze-dried smallpox vaccine. Thus, the interplay between the two great competing powers of the 1950s and 60s provide the context for the WHO’s eradication efforts in that era.

In 1953, the Brazilian Marcolino Candau replaced Canadian Brock Chisolm as director-general of the WHO. Candau, who had previously worked on the problem of malaria in Brazil, was associated with the “vertical” disease control programs of the Rockefeller Foundation and the Pan American Sanitary Bureau. In 1955, the World

Health Assembly of the U.N. charged Candau with overseeing the worldwide eradication of malaria, an ambitious goal “conceived and promoted in the context of great enthusiasm and optimism about the ability of widespread DDT spraying to kill mosquitoes.”⁷⁰ Because eradication in a single country was difficult as long as neighboring countries remained infected, worldwide eradication was viewed as the only option worth the effort.

Medical historian Randall Packard has argued that the WHO’s program of eradication formed out of larger desires by Western countries, particularly the U.S., to foster “friendly” development in newly independent countries or those undergoing decolonization. “It was within the context of efforts to ‘modernize’ the economies and political structures of tropical countries,” Packard writes, “that ideas and strategies concerning the eradication of malaria and other diseases were developed and implemented.”⁷¹ In the early 1950s, Western powers not only perceived third world countries as potential points of production but viewed them as a critical weapon in the war against international Communism.

By 1955, the benefits of malaria eradication were clear. During the 1955 proceedings that led to the program of eradication, the Director General to the Eight World Health Assembly declared:

⁷⁰ Brown, Cueto, Fee, 64.

⁷¹ Randall M. Packard, “Malaria Dreams: Postwar visions of health and development in the third world,” *Medical Anthropology* 17 (1997): 281.

There can be no doubt about the general economic and social benefits that malaria eradication brings to the countries cleared of the disease... As regards non-malarious countries, obviously they will share in the benefits if they have import or export business with countries once malarious and now freed of this burden.⁷²

Later that year, the Director of the Pan American Sanitary Board made the same point to representatives of UNICEF arguing for its support of malaria eradication in the Americas: “Malaria is a serious burden on the economy of every malarious country. It has been well said that, where malaria fails to kill, it enslaves. It is an **economic disease.**”⁷³ Once the malaria mandate passed the World Health Assembly, the WHO assumed responsibility for its structure and implementation.

Over the following decade, the WHO oversaw the implementation of a program that brought to malarious countries outside technology and administered “eradication” without making any serious efforts to enlist the assistance of local populations. This “vertical” approach “fit neatly into U.S. Cold War efforts to promote modernization without social reform.”⁷⁴ Eradication was meant to be achieved swiftly and decisively. The sixth report of the Expert Committee on Malaria, which convened in Athens in June 1956, laid out the argument in favor of malaria eradication as opposed to malaria control, the former entailing a definite suppression of the disease while the latter entailed long-term reduction of its prevalence among the population. Eradication “needs special finance for a limited time only—when its necessity can be understood by the people and by their representatives in the legislature—whereas continuance of

⁷² World Health Organization, Proposal by the Director-General to the Eighth World Health Assembly (3 May 1955): 9.

⁷³ Ibid, 25-26.

⁷⁴ Brown, Cueto, Fee, 65.

successful control would still call for continued financial support long after the disease had become largely a memory.”⁷⁵

As the years wore on, however, it became increasingly clear that eradication could not be achieved through technology alone. Even the return of Soviet resources and participation had not dramatically affected the success of the program. By 1966, only 4% of people living in the malarious regions of Africa had been helped by the program. The numbers were higher in the Eastern Mediterranean Region (56%) and the Western Pacific Region (39%), though still far below the total eradication hopes of the program’s engineers. Upwards of 80% of those benefitting from the program lived in Europe and the Americas, regions that were least affected by malaria to begin with.⁷⁶ In 1969, the World Health Assembly admitted that it was not feasible to eradicate malaria worldwide under current conditions and initially returned to an older agenda of malaria control.

It should be noted, in contrast to the failure of malaria eradication, that the WHO experienced enormous success in the late 1960s with the eradication of small-pox. Due to technical improvements such as jet injectors and bifurcated needles, the process of vaccination had become much cheaper and more viable. In 1967, the disease was still endemic in more than 30 countries when the WHO launched its Intensified Smallpox Eradication Program, led by U.S. support. In 1980, the thirty-third World Health Assembly adopted a resolution affirming the report of the Global Commission for the

⁷⁵ World Health Organization, *Expert Committee on Malaria, Sixth Report* (Athens: June 1956): 5-6.

⁷⁶ World Health Organization, *Expert Committee on Malaria, Thirteenth Report* (Geneva: 1966): 8.

Certification of Smallpox Eradication that the “once-universal” disease had been eradicated worldwide.⁷⁷

Nonetheless, the failure of malaria eradication had convinced many health officials of the need for a more comprehensive, bottom-up approach to disease control. “Difficulties now being experienced in a number of countries,” the final WHO Expert Committee on Malaria had concluded in 1967, “[are] believed to be due to the fact that they were not sufficiently well-prepared before starting eradication measures.”⁷⁸ Other voices had been raising doubts about the experiment as early as 1960, when an Expert Malaria Panel of the International Cooperation Administration had declared:

Many of the areas where malaria is now a problem are areas where the authorities have had little experience in the application of the modern scientific method; they therefore lack both the scientific background and administrative experience essential to success. Furthermore, the challenge of unfriendly, i.e., ignorant populations has at times been met by the dedicated individuals and government personnel who have contrived to make the hostile populations aware of the benefits of eradication.⁷⁹

The 1969 Assembly thus placed particular emphasis on the need to develop rural health systems of which malaria control would be but an aspect.⁸⁰ In this way, the work of the WHO returned over the next two decades to the rubric of rural health and hygiene that had characterized the interwar efforts of the LNHO. During the 1960s and 1970s, these changes in the WHO were significantly influenced by political events, primarily by the

⁷⁷ William H. Foege, “Commentary: Small-pox Eradication in West and Central Africa Revisited,” *Bulletin of the World Health Organization* 76 (1998).

⁷⁸ World Health Organization, *Expert Committee on Malaria, Fourteenth Report* (Geneva: 1967): 5.

⁷⁹ International Cooperation Administration, Expert Panel on Malaria, “Report and Recommendations on Malaria: A Summary,” *American Journal of Tropical Medicine and Hygiene* 10 (1961): 471.

⁸⁰ World Health Organization, *Re-examination of the Global Strategy of Malaria Eradication: A Report by the Director General to the 22nd World Health Assembly* (Geneva: 30 May 1969).

emergence of decolonized African nations, but also by the spread of nationalist and socialist movements.⁸¹ Theories of development that emphasized long-term socio-economic growth rather than short-term technological intervention gained prominence.

In 1967, a new division was created in the WHO: Research in Epidemiology and Communications Science. Among the research projects it developed, one addressed the research in the organization and strategy of health services. Its purpose, according to Dr. Socrates Listios in a paper presented to the WHO Director General's Conference in 1969, was "the development and demonstration of methods to show that a rational approach to the formulation of health strategies is desirable, possible, and effective."⁸² By "rational approach" was meant the incorporation of epidemiological, ecological, and behavioral perspectives into the health services planning process.⁸³

In 1968, Candau called for an inclusive and integrated plan for curative and preventive care services. In 1971, the Executive Board of the World Health Assembly chose the subject of methodology of promoting basic health services for its next organizational study. In introducing the document to the board, Dr. Halfdan T. Mahler, director of the Epidemiology and Communications Division, noted that "there were sufficient financial and intellectual resources available in the world to meet the basic health aspirations of all peoples," and announced the need "for an aggressive plan for

⁸¹ Brown et. al, 66.

⁸² Qtd. In Socrates Listios, "The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach," *American Journal of Public Health* 94 (November 2004): 1885.

⁸³ Ibid.

world-wide action to improve this unsatisfactory situation.”⁸⁴ In 1972, the WHO fused a number of its divisions, including Mahler’s, into the new Organization of Health Services, with Dr. Kenneth Newell as director. The division drafted a final report to be presented to the full executive board in January 1973.

Over the next five years, tension among communist countries played a significant role in shaping the future of primary care efforts. The Chinese delegation initially proposed to the WHO the idea of an international conference on primary health care, but the proposal was rebuked by the Soviet Union, which defended the “vertical” approach to third-world countries. By 1974, however, the Soviet Union admitted the growing influence of the primary care movement and declared its commitment to hosting a convention on the subject. The Soviets offered to fund the conference at the cost of \$US 2 million. Despite protests from a number of other members, particularly the Chinese delegation, and a search for other potential sites that included Iran, Egypt, and Costa Rica, the Assembly eventually agreed that the Soviet offer was unlikely to be matched. In accepting the offer, the WHO asked only that a provincial location be chosen instead of Moscow, fearing the potential public conflation of primary health care and communism. In response, the Soviets agreed to hold the conference in Alma-Ata, capital of the Soviet Republic of Kazakhstan, partly because of remarkable health improvements experienced in what was considered a backward area during Tsarist

⁸⁴ World Health Organization, *Executive Board 49th Session* (Geneva: 1973).

Russia. As Marcos Cueto argues, “The event was a small Soviet victory in the Cold War.”⁸⁵

Thus, in 1978 the International Conference on Primary Health Care convened in Alma-Ata, U.S.S.R., with the express endorsement of both the World Health Assembly and United Nations General Assembly. More than 3000 delegates from 134 governments and 67 international organizations attended the conference. UN and international agencies such as the International Labor Organization, the Food and Agricultural Organization, and the Agency for International Development attended, as did non-governmental organizations, religious movements (including the Christian Medical Commission), the Red Cross, Medicus Mundi, and political movements such as the Palestine Liberation Organization and the South West Africa People’s Organization. China, however, was conspicuously absent in response to worsening Sino-Soviet relations.

The resulting “Declaration of Alma-Ata,” which was called by some contemporaries the “twentieth-century Magna Carta for health,” represented the culmination of previous efforts to cast a global net over the problem of health. As admitted by Mahler, by this time the Director-General of the World Health Assembly, “Its technical content, its demand for social justice in health matters, and its plea for urgent national and international action for health might not be startlingly new.” To the contrary, as this paper has demonstrated, the language of the Alma-Ata declaration was

⁸⁵ Marcos Cueto, “The Origins of Primary Health Care and Selective Primary Health Care,” *American Journal of Public Health* 94 (November 2004): 1867.

preconceived by earlier international organizations, particularly the LNHO. “But taken together,” Mahler continues, “in the worldwide political and social context in which they crystallized they manifest an unusual degree of international consensus on the need for cooperation among countries ...to attain an acceptable level of health for all the peoples of the world.”⁸⁶

The language of the declaration demands a thorough assessment. It began by reaffirming verbatim the quintessentially biopolitical belief which had previously inaugurated the constituting document of the WHO itself: “Health is a state of complete physical, mental and social well-being and not merely the absence of infirmity or disease.”⁸⁷ Furthermore, the conference concluded that health “is a fundamental human right and that the attainment of the highest possible level of health is a most-important world-wide social goal.”⁸⁸ The document, couched in the language of *development*, decried the “gross inequality” existing between developed and developing countries. Health was once again presented as an economic problem, as enumerated by the declaration’s third clause:

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.⁸⁹

⁸⁶ World Health Organization, *The Work of the WHO: 1978-1979, Biennial Report of the Director-General to the World Health Assembly and to the United Nations* (Geneva: 1980): xi.

⁸⁷ *The Constitution of the World Health Organization*, http://www.who.int/governance/eb/who_constitution_en.pdf, accessed on 23 April 2010: 2.

⁸⁸ World Health Organization, *The Work of the WHO*, vii.

⁸⁹ *Ibid.*

Health work was perceived not as a temporary intervention but as a permanent, on-going process by which health conditions across the globe would be progressively improved. “Primary health care,” explains Cueto, “was designed as the new center of the public health system.”⁹⁰ This necessitated an “intersectorial approach” between public and private institutions (e.g. on health education, adequate housing, safe water, and basic sanitation). Such a stance had powerful political implications. Indeed, clause five avers that “Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures.”⁹¹

The declaration was also more than that. As Mahler had indicated a few years earlier, health should be an instrument for development and not merely a byproduct of economic progress (though in what ways this could occur were never exactly clear). The leaders of world health, he argued, “could...become the *avant garde* of an international conscience for social development.”⁹² By the year 2000, the declaration avowed, “all peoples of the world [should have attained] a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target.”⁹³

The new focus also aimed to stretch the jurisdiction of world health organizations beyond the confines of epidemiology and standardization. The population problem had, for LNHO predecessors, been one of mostly world migration: birth and

⁹⁰ Cueto, 1868.

⁹¹ World Health Organization, *The Work of the WHO*, viii.

⁹² H.T. Mahler, *WHO's Mission Revisited: Address in Presenting His Report for 1974 to the 28th World Health Assembly* (Geneva: WHO, 1976).

⁹³ World Health Organization, *The Work of the WHO*, viii.

death rates, emigration trends, natural resources per capita, etc. The LNHO had focused on optimizing population density, which it hoped would, in turn, optimize the standard of living. But the League had always been better at charting demographic trends than managing them, in part because it had little ambition or desire to govern reproductive sexual conduct. Any regulation of population phenomena to do with sex or reproduction—contraception, abortion, sterilization, family planning—was “firmly and consistently placed beyond its remit.”⁹⁴ By the 1970s, however, these aspects of population control had been included in the mantra of the WHO. Family planning and birth control became problematized subjects, a regulation of sexual conduct and reproduction that had been absent from the LNHO proceedings (though in many ways the LNHO’s interest in maternal and infant welfare helped lay the groundwork for these pursuits).

The 32nd World Health Assembly that took place in Geneva in 1979 enthusiastically endorsed the conference’s declaration, approving a resolution championing the importance of primary health care. Mahler became one of the movement’s outspoken advocates, writing papers and giving speeches, including one delivered in 1982 entitled “Eighteen Years to Go to Health for All.” Yet despite initial enthusiasm, the program was often bogged down by criticism that it was too broad or too idealistic. Even while papers were being drawn on the subject in Geneva, other world health advocates were meeting to discuss alternative strategies.

94 Bashford, 78.

In 1979, at its Bellagio Conference Center in Italy, the Rockefeller Foundation sponsored a small conference entitled “Health and Population in Development.” The goal of the meeting was to examine the status and interrelations of health and population programs during a time when the organizers acknowledged “disturbing signs of declining interest in population issues.”⁹⁵ The conference attracted some major players: Robert S. McNamara, former secretary of defense under Kennedy and Johnson and, since 1968, president of the World Bank; Maurice Strong, chairman of the Canadian International Research Center; David Bell, vice president of the Ford Foundation; and John J. Gillian, administrator of the US Agency for International Development, among others.

The conference was predicated on the idea of “selective primary health care” put forth in a published paper by Julia Walsh and Kenneth S. Warren in the *New England Journal of Medicine* in 1979. The article, entitled “Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries,” began by declaring the goals of the Alma-Ata declaration laudable but unattainable. It then asks: “How then, in an age of diminishing resources, can we best attempt to secure the health and well-being of those trapped at the bottom of the scale long before the year 2000 arrives?”⁹⁶

The paper sought specific causes of death, paying special attention to the most common

⁹⁵ Qtd. In Cueto, 1868.

⁹⁶ Julia Walsh and Kenneth Warren, “Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries,” *Social Science in Medicine* 14C (1980): 145. Though originally published in a 1979 issue of the *New England Journal of Medicine*, this paper was re-produced in a post-conference issue of *Social Science and Medicine* largely concerned with the Bellagio proceedings. Other article titles in this issue stress the importance of population control: “Health, Population and Development” by Knowles, “Population: Current Status and Policy Options” by Berelson, Mauldin and Segal, “Interrelation Between Health and Population” by Grosse, and “Planning Primary Health Services From a Body Count?” by Habicht and Berman, to name a few.

diseases of infants in developing countries such as diarrhea and those produced by lack of immunization. In a subtle rebuke of Alma-Ata, Walsh and Warren re-centralized public health around the question of population, arguing that in focusing on the ideal of “health for all” the WHO had lost its bearing on the true purpose of large-scale public health: “The concomitant disability [of disease and poverty] has an adverse effect on agricultural and industrial development, and the infant and child mortality *inhibits attempts to control population growth.*”⁹⁷

The debate between proponents of the two primary health care factions characterized efforts of international health organizations throughout the 1980s. Mahler reluctantly attended the Bellagio conference and, despite misgivings about its direction, did ask a WHO assistant director to nourish good relations between the WHO and UNICEF, which strongly supported programs of selective primary health care. To counter claims that the Alma-Ata program had no clear targets, the Executive Board of the World Health Assembly urgently requested a template for progress, which came in the form of a paper entitled “Indicators for Monitoring Progress Towards Health For All” followed five years later by one which provided specific “Health for All” goals: 5% of gross national product devoted to health; more than 90% of newborn infants weighing 2500 g; an infant mortality rate of less than 50 per 1000 live births; a life expectancy over 60 years; and local health care units with at least 20 essential drugs.⁹⁸

⁹⁷ Walsh and Warren, 145. Emphasis added.

⁹⁸ World Health Organization, “Primary Health: A First Assessment,” *People Report on Primary Health Care* (Geneva: 1985): 6-9.

Despite such attempts, it was clear by the mid-1980s that the WHO had lost some of its prestige—in 1982 the World Health Assembly voted to freeze its budget due to economic instability. In 1985, the U.S. decided to withhold its contribution to the WHO’s regular budget in protest against its “Essential Drug Program” which had drawn the ire of leading U.S.-based pharmaceutical companies. Concurrent with the diminishing role of the WHO was the rising influence of the World Bank, which had been a supporter of selective primary health care from the beginning. Created in 1946 to assist in the reconstruction of Europe, by the 1970s the World Bank had shifted its focus to population control. The World Bank approved its first loan for family planning in 1970. In 1979 it created a Population, Health, and Nutrition Department that funded both stand-alone health programs and health components of other projects. The Bank favored free markets and a diminished role for national governments, though it continued to work with the WHO and the UN, co-sponsoring conferences and programs. The World Bank is now the world’s largest external funder of health, committing more than \$1 billion annually in new lending to finance health, nutrition, and population programs in developing countries.⁹⁹

The debate between comprehensive and selective primary health care came to a head in 1988 with an acrimonious public debate in *Social Science and Medicine*. Newell, the WHO’s leading proponent of comprehensive health care behind Mahler, asked:

⁹⁹ For an excellent overview of the World Bank’s involvement in global health, see Jennifer Prah Ruger, “The Changing Role of the World Bank in Global Health,” *American Journal of Public Health* 95 (January 2005): 60-70.

If health is not definable except in a fluffy way, can never be completely attainable by individuals or groups, and will always involve a play off between risks and aspirations, then why do we continue to act as if disease and death control equals health?...The primary health care failures may need to be ruthlessly destroyed but the movements towards workable forms have to be protected and encouraged. Selective primary health care is a threat and can be thought of as a counter revolution. Rather than an alternative, it is a form of health service feudalism which can be destructive. Its attractions to the professionals and to funding agencies and governments looking for short-term goals are very apparent. It has to be rejected, but for the right reasons.¹⁰⁰

Separate responses by Warren and Walsh in the same issue, while not nearly as apocalyptic, stressed that comprehensive primary health care, despite its admirable vision, simply never worked, and never would.¹⁰¹

In 1988, Mahler's 15-year tenure as Director-General of the WHO came to an end. His replacement, an unexpected Japanese researcher Hiroshi Nakajima whose nomination was not supported by the U.S., took the reins of an organization with severe budgetary concerns and an identity crisis. By the beginning of the 1990s, "extrabudgetary" funding had overtaken the regular budget by \$21 million (54% of the overall budget), so that multilateral agencies and "donor" nations, each with agendas of their own, now strongly influenced the direction of the organization's efforts. "Wealthy donor nations," explains Brown, "and multilateral agencies like the World Bank could largely call the shots on the use of the extrabudgetary funds they contributed. Thus,

¹⁰⁰ Kenneth Newell, "Selective Primary Health Care: The Counter Revolution, *Social Science and Medicine* 26 (1988): 906.

¹⁰¹ Julia Walsh, "Selectivity Within Primary Health Care" and Kenneth Warren, "The Evolution of Selective Primary Health Care in *Social Science and Medicine* 26 (1988).

they created, in effect, a series of “vertical” programs more or less independent of the rest of the WHO’s programs and decision-making structure.”¹⁰²

This is the context in which the WHO began to refashion itself as a coordinator, strategic planner, and leader of “global health” initiatives. In January 1992, the Executive Board of the World Health Assembly decided to appoint a “working group” to recommend how the WHO could be more effective in international health work in light of the “global change” that was swiftly transforming world networks.¹⁰³ William Muraskin has shown how this initiative was at least partly in response to the Children’s Vaccine Initiative, which was perceived within the WHO as an attempted “coup” by UNICEF, the World Bank, the UN Development Program, the Rockefeller Foundation, and other players to gain control of vaccine development.¹⁰⁴ The working group’s final report of May 1993 recommended that the WHO, if it was to maintain prominence in the health sector, must overhaul its fractured management of global, regional, and local programs, address the adverse effects of “extrabudgetary” influence, and above all increase the emphasis within its ranks on global health issues.

Though this paper has demonstrated that efforts to control the discourse on health had long since “gone global,” the term “global health” had until this time been only sporadically used in an official capacity. In the 1990s, however, the rising recognition of a “global community” across many sectors brought about the same

¹⁰² Brown et. al, 68.

¹⁰³ Ibid, 69.

¹⁰⁴ For more on the struggle for vaccination development rights, see William Muraskin, *The Politics of International Health: The Children’s Vaccine Initiative and the Struggle to Develop Vaccines for the Third World* (Albany: State University of New York Press, 1998).

linguistic awareness within the WHO as well. The connection between the environment and the health of human populations may have been particularly influential.¹⁰⁵

The considerable literature being produced in mid-1990s on global health threats further augmented the perception that health was a global phenomenon. In the U.S., the Centers for Disease Control and Prevention (CDC) began publication of its journal, *Emerging Infectious Diseases*, and “global infectious disease threats” became a self-contained subject. In 1994, Richard Preston’s *The Hot Zone*, a bio-thriller about an outbreak of the Ebola virus in Washington D.C., became a #1 best-seller. In 1997, the Institute of Medicine’s Board of International Health released a report entitled: *America’s Vital Interest in Global Health: Protecting Our People, Enhancing Our Economy, and Advancing Our International Interests*.¹⁰⁶ “The message was clear,” explains Brown et. al, “There was a palpable global disease health threat.”¹⁰⁷

In 1998, the World Health Assembly replaced Director-General Nakajima with Gro Harlem Brundtland, a former prime minister of Norway and a public health professional. As chair of the UN World Commission on Environment and Development in the 1980s, her well-known “Brundtland Report” had led to the Earth Summit of 1992. Her self-declared objective was to refashion the WHO as a “department of

¹⁰⁵ See, for example, Andrew J. Haines, “Global Warming and Health,” *British Medical Journal* 302 (1991): 669-670, Anthony J. McMichael, “Global Environmental Change and Human Population Health: A Conceptual and Scientific Challenge for Epidemiology,” *International Journal of Epidemiology* 22 (1993): 1-8, and John M. Last, “Global Change: Ozone Depletion, Greenhouse Warming, and Public Health,” *Annual Review of Public Health* 14 (1993): 115-136.

¹⁰⁶ Institute of Medicine, *America’s Vital Interest in Global Health: Protecting Our People, Enhancing Our Economy, and Advancing Our International Interests* (Washington D.C.: National Academy Press, 1997).

¹⁰⁷ Brown et al., 69.

consequence,” in the network of global activity.¹⁰⁸ Her initial wooing of the partnership of the Bill and Melinda Gates Foundation, which committed more than \$1.7 billion between 1998 and 2000, had a significant impact on the WHO’s ability to create “global health partnerships” with the world’s poorest nations. By 2000, some 70 of these programs were fully-funded and underway. Today the WHO firmly considers itself a “global” institution.

¹⁰⁸ Gro Brundtland, qtd. In Ilona Kickbusch, “The Development of International Health Priorities—Accountability Intact,” *Social Science and Medicine* 51 (2000): 985.

Chapter Four: Conclusion

In describing his own efforts to understand the function of the modern state, Foucault once declared: “I will try to show how the central core of all the problems that I am presently trying to identify is what is called population.”¹⁰⁹ I equally have endeavored to explicate the notion that the question of populations—how one defines them, their uses, and the methods through which they are both created and managed—lies at the heart of modern health. But this idea is ultimately not meant to be contained by questions of health or, at least, the traditional understanding of health as having to do with physical sickness alone. Instead, it places health at the nexus of the modern state and so colors state efforts that do not specifically deal with public health. Questions of gender, sexuality, age, and identity are not commonly understood to be health-related, yet a subject’s behavior conceptualized in reference to each of those categories is routinely assessed between the extremes of “perfectly unhealthy” and “perfectly healthy.” The administration of public health is not the only way the modern state has aimed to manage populations since the eighteenth century, but it is the method which has perhaps had the greatest impact. This viewpoint is not revolutionary, though it has gone largely unappreciated by historians who do not specifically deal with health and disease.

“People’s ideas about health and illness,” Nichter explains, “are emergent, ad hoc, and subject to change through time in accordance with the processual nature of illness and the response of illness to different therapeutic modalities both used and

¹⁰⁹ Foucault, *The Birth of Biopolitics*, 21.

imagined.”¹¹⁰ In order to treat an illness an illness must first be defined. In this way, the activities of international health institutions like the LNHO and WHO have enormous influence over cultural perceptions of healthy behavior. This is not to suggest that diseases like malaria and smallpox are somehow “created” by political institutions. Instead, it shows how the treatment of those conditions has been, from the start, politicized. It also helps explain why countries with incidents of malaria are perceived to be “third-world” while those with rampant obesity, alcoholism, or homicide retain first-rate status.

I will conclude by addressing some of the questions and criticisms that tend to accompany this type of analysis. I have been asked, by more than one observer, about the moral implications of such a system; whether, to be plain, I believe the actions of states and state-based organizations concerning public health to be “good” or “bad.” Some observers have gleaned something sinister in the behaviors I have described in this paper and to a certain extent, not believing their modern state system to be fundamentally base, reject the analysis as fatalistic or, worse, as that which disregards human agency. On the contrary, this analysis is acutely aware of the significance of human agency to governing bodies described herein. Indeed, I have gone to great lengths to demonstrate the human debates that drive all efforts of international health.

At the same time, however, this analysis recognizes the overwhelming importance of *the institution*. Its aim is to demonstrate how the modern state system

¹¹⁰ Mark Nichter, *Global Health: Why Cultural Perceptions, Social Representations, and Biopolitics Matter* (University of Arizona Press, 2003): 9.

works. It attempts to do so by utilizing multi-state institutions as sites of analysis. As such, it does not attribute a morality to that which cannot have it; it recognizes neither “good” nor “bad” in the function of institutions. Instead, it regards the state for what it is: a self-justifying ethos continuously created and reinforced over time to control the populations which are alone its constitution. A state without its requisite population ceases to exist. Efforts to define and protect the health of a certain group of people, therefore, should be placed in the context of *the health of the state*, not the health of the individual, who is necessarily of secondary importance. There exists a direct link between what is considered to be “healthy” for the state and that which is professed to be “healthy” for the individual.

Going forward, social scientists must continue their investigation of the new “world space” outlined in this paper and historians must continue to trace its genealogy backwards through time. Greater cooperation between disciplines will be required. The demarcations between social science, history, and public health studies must continue to blur, so that future students will not be forced to choose between them. Students of health must not be afraid to leave the Humanities for answers; evolutionary biologists, neuroscientists, and population experts are equally vital to fleshing out the story. Historians in particular need to pay better attention to questions of health and the body. We must be careful not to perpetuate the social machines we mean to investigate. “Too often,” Bashford notes, “scholarship on world health leaves sex and population to one side, replicating rather than interrogating the parameters of the

official organizations themselves.”¹¹¹ In the end, such scholarship aims to unravel the aspect of society that governs the way modern humans regard their own bodies. What could be more fundamental?

¹¹¹ Bashford, 82.

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