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WHO: Past, Present and Future

Backstage: the relationship between the Rockefeller Foundation and the World Health Organization, Part I: 1940s–1960s

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ABSTRACT

In recent years, there has been a growing debate about what role foundations should play in global health governance generally, and particularly vis-à-vis the World Health Organization (WHO). Much of this discussion revolves around today's gargantuan philanthropy, the Bill and Melinda Gates Foundation, and its sway over the agenda and modus operandi of global health. Yet such pre-occupations are not new. The Rockefeller Foundation (RF), the unparalleled 20th century health philanthropy heavyweight, both profoundly shaped WHO and maintained long and complex relations with it, even as both institutions changed over time. This article examines the WHO–RF relationship from the 1940s to the 1960s, tracing its ebbs and flows, key moments, challenges, and quandaries, concluding with a reflection on the role of the Cold War in both fully institutionalizing the RF's dominant disease-control approach and limiting its smaller social medicine efforts, even as the RF's quotidian influence at WHO diminished.

In recent years, there has been a growing debate about the role of foundations and private sector interests in global health governance generally,[1–4] and particularly at the World Health Organization (WHO).[5–7] Yet such pre-occupations are not new.[8–10] The Rockefeller Foundation (RF), the unparalleled 20th century health philanthropy heavyweight, both profoundly shaped WHO, directly and indirectly, and maintained long and complex interactions with it, even as both institutions changed over time. This article is the first in a two-part series that examines the WHO–RF relationship from the 1940s to the 1980s, tracing its ebbs and flows, key episodes, power struggles, and enduring challenges and dilemmas.

An obvious preliminary question is whether 'relationship' is even the right descriptor: after all, the launching of WHO in 1948 coincided with and helped stimulate the disbanding of the RF's International Health Division (IHD) and the waning of the RF's <grand moment> in international health. But, as we shall see, because the RF's influence on international health's institutions, ideologies, practices, and personnel was so pervasive from the 1910s through the 1940s, the WHO's early years were imbued not only with the RF's dominant technically-oriented disease-eradication model but also with its far more subordinate forays into social medicine, an approach grounded in political, economic, and social terms as much as the biomedical.

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The International Health Division's ending and the WHO's beginning

The IHD (and its predecessor Board) had been involved in international health efforts since the RF's founding in 1913 by US oil magnate John D. Rockefeller. One of the most notorious capitalists of his day, Rockefeller turned to philanthropy as a means of harnessing science and education to the profit-oriented industrial modernization of society, and of maintaining stability in an era of tumultuous social and political uprisings (as well as, purportedly, to ensure his personal salvation). Public health, at home and abroad, proved an ideal vehicle for these ends, imparting scientific knowhow and garnering popular support for social melioration, while upping labour productivity and investment prospects. In addition to dozens of large-scale hookworm, yellow fever, and malaria campaigns, and more circumscribed efforts against tuberculosis, yaws, influenza, rabies, schistosomiasis, malnutrition, and other health problems in almost 100 countries and colonies (to the tune of billions of dollars in current-day equivalency), it was also involved in institutionalizing public health, country by country, through support for both local health units and national ministries. To shepherd these initiatives, the IHD helped establish 25 schools and institutes of public health across the world and sponsored 2500 nurses, doctors, and engineers to pursue graduate public health study, mostly in the US.[11]

In its trademark public health efforts, the RF pursued a narrow, biological approach to disease based on short-term, technical solutions, with a larger aim of preparing vast 'backward' regions (as it referred to much of Asia, Africa, Latin America, and the Southern US) for integration into the capitalist world of production, trade, and consumption. The RF drove the agenda of cooperation with national governments, set its temporal and geographical parameters (often with the accompanying aim of fending off radical political movements), relied on efficient 'magic bullets' against disease, and placed disease eradication and education campaigns under the direction of its own officers (or local experts trained at RF-funded public health schools such as Johns Hopkins and Harvard), even as governments were expected eventually to foot most of the bill for cooperative activities. To be sure, a range of in-country actors reshaped and at times rejected these endeavours; the RF modus operandi of crediting local authorities without drawing excessive attention to itself, developed through decades of experience, helped mitigate resistance and reinforced its model.[12]

For example, in Mexico in the 1920s, the RF operated major campaigns against yellow fever in the region around the country's leading port in the oil production state of Veracruz, and against hookworm disease in key agricultural areas, several of which were also hotbeds of agrarian rebellion. Neither of these diseases was considered a priority by Mexican authorities (yellow fever was more a menace for US ports receiving Mexican exports), who requested instead campaigns against malaria and tuberculosis. The RF did not heed these requests, however, for neither malaria, nor tuberculosis could offer an effective demonstration of its disease-control model of public health: at the time, the RF-selected diseases had ready technical tools (insecticides and larvicides in the case of yellow fever, and anti-helminthic drugs for hookworm), whereas tuberculosis, for example, required significant long-term social investments in housing and nutrition.[13]

Yet despite its principal focus on technically-based disease campaigns and related training initiatives, the RF, especially from the 1930s into the early 1950s, also gave unofficial, occasional latitude to a handful of individual officers to engage in contemporary 'social medicine' approaches that embedded modern medicine within a critical social and political framing of health and disease. Among these small-scale efforts was research and travel funding for several prominent leftwing 'health internationalists' including famed Yugoslavian public health leader Andrija Štampar and Swiss historian of medicine Henry Sigerist, both leading proponents of social medicine. On several occasions in the 1930s, RF Director of Medical Sciences Alan Gregg secured RF sponsorship for Štampar to tour the United States and relay his understanding and experience of international health solidarity and social medicine. Štampar had received major funding from the RF to create a school of public health in Zagreb in 1926, building on his work with the Croatian Peasant Party to establish a network of rural health stations; in the 1930s, now in exile, he travelled alongside the RF's John Black Grant to assess developments in rural China amidst the country's revolutionary unrest.[14] Gregg also orchestrated the recruitment and support of the esteemed Sigerist to lead the Johns Hopkins Institute for the History of Medicine, which Sigerist used as a platform for lobbying for national health insurance in the US and drawing incisive attention to Soviet developments in health and medicine. These men, and their RF champions, would prove important players in the early relationship between the RF and WHO.

Alongside its in-country work, the RF was backing an emerging multilateral framework for international health, initially through the Geneva-based League of Nations Health Organisation (LNHO), founded after World War I. The LNHO partially modelled itself after IHD efforts, drawing from its personnel, practices, and agenda to institutionalize international health through a transnational network of experts, expanded epidemiological surveillance, and the setting of worldwide standards for vaccines and medications. Several Americans were LNHO advisors but since the United States never joined the League, the RF served as an ersatz US emissary. Under its skilled leader, Polishman Ludwik Rajchman, the LNHO advocated a social medicine approach, incorporating living, working, and political conditions as key factors in addressing health. Even though few IHD staff shared Rajchman's views, the RF remained the LNHO's lifeline, eventually funding almost half its personnel.[15–18]

During World War II, the LNHO was denuded of resources and staff (maintaining neutrality, while its rival, Paris-based Office International d'Hygiène Publique, in charge of sanitary conventions and surveillance, was accused of collaborating with the Nazis).[19] In 1943 the new US-sponsored and generously funded United Nations Relief and Rehabilitation Administration (UNRRA) largely absorbed and expanded upon the LNHO's functions through the massive provision of medical relief, sanitary services, and supplies in war-torn countries, with a staff of almost 1400 health professionals from

some 40 countries and expenditures of up to $US80 million/year.[20] UNRRA, too, had a deep RF imprint: it was devised and planned by IHD veteran Selskar Gunn, while IHD director Wilbur Sawyer became head of UNRRA health operations following his retirement from the RF in 1944.[21] Not only were the LNHO and UNRRA the immediate precursors to WHO, they acted as a pipeline for WHO's first generation of personnel.[22–24] However, the hoped-for full transfer of funds to WHO upon UNRRA's closing in 1947 consisted of a far more modest sum ~under five million dollars.[25]

The RF had a third, even closer connection to the new WHO: Dr. Fred Soper, who had spent almost two decades at the helm of the IHD's large-scale campaigns against yellow fever and the malaria vector *Anopheles gambiae* in Brazil[26] before becoming head of the Pan American Sanitary Bureau (PASB, renamed the Pan American Health Organization in 1958) from 1947 to 1958. Whether PASB, the world's oldest international health agency – founded in 1902 – would remain independent or be collapsed into WHO would prove a significant thorn in WHO's side, and this situation was indirectly linked to the RF.

Soper's election marked the passing of PASB leadership away from a string of US Surgeon-Generals. (The last of these, Hugh Cumming, had served as PASB director since 1920, continuing after he retired from the US Public Health Service in 1936.) Soper's appointment implied that PASB would be independent of US foreign policy interests; instead, it was the RF that now had a direct conduit to an international health organization. The RF paid Soper's salary the first year,[27] and he remained an RF staff member during his first four years at PASB, considering his assignment 'not one of abandonment of the Rockefeller Foundation but rather of fulfilling its program. It was quite in keeping with Foundation policy to make my services available to PASB.'[28] The RF did not wish to be perceived as undercutting WHO through further PASB support, but at Soper's behest, in 1947–48 it furnished $US8500 as an interim measure to cover salary and travel for a staff nurse.[29] Soper was no pawn, but RF President Chester Barnard undoubtedly felt justified in asserting in 1950 that PASB was designed to 'cover most of the purposes which the IHD pursued in Latin America. Under [Soper] IHD policies and philosophies have been adopted. The PASB will eventually take over our functions.'[30]

Upon assuming office, the self-confident Soper embarked on an ambitious plan to expand PASB's reach: he scanned PASB's finances and quickly amassed a nest egg of one million dollars in voluntary contributions and higher dues from member countries throughout the region (with Brazil and the US leading the pack). PASB's hefty budget impeded WHO from fully absorbing it since WHO could not secure the same level of replacement funds. Consequently, WHO's 1949 agreement with PASB allowed it considerable independence as a regional office, soon compounded by its separate identity as a specialized agency of the Organization of American States. Soper was not opposed to WHO like his adamant predecessor,[31] but the cards he played forced WHO into a decentralized structure, based on geographically-organized regional offices (with PASB remaining the largest and most independent of these), thereby strengthening Soper's hand and power.

Mindful of these developments, the RF was initially cautious about its formal relationship with WHO, wanting to be supportive, while downplaying its influence. Already at the International Health Conference held in New York in July 1946 to organize WHO, a 'large number of the representatives of the countries present were IHD fellows in public health.'[32] But the RF did not intervene directly, instead following the behind-the-scenes work style it had instituted over several decades.

During WHO's Interim Commission (1946–8) before its formal inauguration, RF staff members began testing a relationship. In 1947 senior RF officer John Grant eagerly sent the proceedings of a preventive medicine and health economics conference to the Commission's Executive Secretary, psychiatrist and Canada's deputy health minister Brock Chisholm. Claiming little knowledge of WHO's future goals, Chisholm, who had had negligible prior dealings with the RF, nonetheless sought Grant's input, whether officially or privately.[33] With US membership in WHO uncertain, Grant began feeding ideas to Chisholm, for example endorsing the American Public Health Association's recommendation that WHO establish a Bureau of Health Care.[34] Even as an informal suggestion this was daring, given the acerbic struggles over national health insurance in the United States at the time.[35] To be sure, Grant, who would go on to become an important liaison between the RF and WHO, had staked his ground as a staunch supporter of both universal health insurance and integrated community medicine in China.[36]

The RF was also invoked in the bitter US Congressional debate over joining WHO. Fearing that the country would repeat the error of not having joined the League of Nations, respected US Surgeon-General Thomas Parran (a presumed candidate for WHO director) gave impassioned testimony at the Senate on June 17, 1947: 'Health has been termed by [RF President] Mr Raymond Fosdick as a 'rallying point of unity' in international affairs. Cooperation … in the interest of health represents one of the most fruitful fields for international action. When one nation gains more of health it takes nothing away from any other nation. By learning how to work together in the interest of health, the lesson will be of value in other and more difficult fields.'[37,38]

By this time the RF was busy mobilizing backstage in the context of unfolding Cold War rivalries. Rolf Struthers, Associate Director of the RF's Medical Sciences Division, reported on his reconnaissance: 'If U.S. insists on Parran … Russia will not join and it will not be a World Health Organization.'[39] This problem, together with the perception that Parran 'does not enjoy wide support' despite his distinction as a public health leader, led IHD Director George Strode to suggest backing Chisholm 'because he is thoroughly honest, understanding and deeply interested,' although questions remained about his leadership effectiveness.[40]

As late as March 12, 1948, the US Senate tabled a vote on WHO membership, leaving American public health leaders angry and embarrassed. The US finally joined WHO in July 1948 (almost three months after WHO's April 7, 1948 'birthday') following a compromise Joint Congressional resolution allowing the US to withdraw unilaterally from WHO on one year's notice. Ironically, the USSR delegate formally proposed US acceptance into WHO, but it would be the USSR and Soviet bloc, not the US, that would later pull out of WHO (1949–1956).[41]

With US membership settled, the RF began to judge the new organization's first steps. At the first World Health

Assembly (WHA) in July 1948, Chisholm was elected director-general.[42] Fred Soper relayed his impression that the WHA 'left a good deal to be desired.' As director of PASB, Soper noted that discussions about WHO's regional offices were lacking, stymied by European colonial powers.[43] This seems a disingenuous observation, given Soper's and the US's role in forcing regionalization on WHO and Soper's evident satisfaction with this outcome.[44,45] Soon Strode became concerned that, unlike IHD men, WHO leadership had 'little grassroots knowledge of the field.'[46] Notwithstanding his repeated misgivings about Chisholm's lack of public health training and background,[47] Soper privately defended him: 'Chisholm has stood out pretty well against political influence.'[48]

Intertwined with RF scrutiny of the new WHO was the future of the IHD. Early on, John Grant pointed out that WHO's major emphasis on malaria, tuberculosis, venereal diseases, maternal and child health, nutrition, and environmental hygiene were 'all fields in which the IHD is or has been actively interested. Consequently, one anticipates gradual transfer to WHO of IHD activities in these fields.'[49] Widely-respected RF malariologist Paul Russell agreed that because WHO was giving top priority to malaria, 'Overlapping and duplication are therefore possible.' WHO's field demonstration approach offered 'an opportunity' for transfer, with Russell keen to provide backup support.[50]

At a pivotal October 1948 IHD Scientific Directors meeting, Strode more pointedly raised the question of the effect of WHO's founding on the IHD: trustees would want justification for preserving the RF's public health program. WHO's apparent focus on application of existing knowledge left IHD with the companion interest of acquiring new knowledge: WHO 'will aim to aid governments so that their peoples may enjoy the same public health benefits as those of the most advanced countries.' Strode argued, 'It is therefore clear that the [RF] officers must maintain intimate relationship with [WHO] officials so that the respective programs will be complementary rather than competitive.' Rejecting concerns of conflict, Strode welcomed WHO 'wholeheartedly,' looking forward to withdrawing from some activities and enabling IHD to cultivate 'certain new fields of interest.' For the most part, however, he held it was 'inadvisable to change' most IHD activity. The Scientific Directors concurred, stressing that WHO 'could not have come into existence' without the IHD, which 'had the original concept and blazed the trail.'[51]

But Strode's optimism would not bear out. By 1951 the IHD was dismantled, its activities partially absorbed into the RF's new Division of Medicine and Public Health (DMPH).[52] Headed by IHD career man Andrew Warren until 1954, the DMPH was to focus on professional education, medical care policy, and health sciences development, with residual support for disease control efforts (such as against schistosomiasis, which entailed joint work with WHO[53]). WHO's establishment as an independent agency was undoubtedly the significant impetus: the IHD's 'turf was increasingly threatened' by WHO as well as other new UN organizations, American Point IV development programs, and the expanding British colonial system of welfare.[54] The RF's own interests were also shifting from public health towards agriculture (Green Revolution) and population concerns, which it circumspectly framed in the Cold War terms now defining US foreign policy.[55,56] For his part, Soper held that global campaigns against malaria and other diseases required bona fide international cooperation PASB/WHO-style, while the RF only worked bilaterally.[57] Of course, Soper knew from experience that his malaria vector eradication ambitions demanded the large-scale resources and coordination that only a multilateral organization could provide, and he would be an essential figure in orchestrating WHO's global malaria eradication campaign launched in 1955.[26,58,59]

Many staff disagreed with shuttering the IHD, some even advising that the RF return to its roots in hookworm control.[60] Others fretted that senior RF observers were misguided in recommending friendly but distant relations with WHO. Perennial IHD officer Marshall Balfour opined: 'I do not believe that a stand-offish attitude toward WHO is wise or justified. Without endorsing all their activities or policies, we should support them morally and seek to increase their effectiveness and prestige,' even as the RF's policy of dealing directly with governments or institutions rather than other agencies, remained in place.[61]

Yet the RF was still there. As Lewis Hackett, who oversaw IHD programs in South America and Italy for over three decades, noted, 'To a greater or lesser degree, all the international organizations have adopted the policies and activities in which the IHD has pioneered,' through inheritance of personnel, fellows, approaches, and even equipment.[30] Others agreed: 'The things they [the IHD] did are now the basis of WHO work.'[62] Ultimately, as the RF's 1950 annual report pronounced, the waning of the IHD was a kind of self-fulfilling prophecy: 'today the task of health promotion has been taken over on a global scale' by WHO, 'supplemented by numerous regional and national agencies.'[63]

The RF as consigliere

Well into the 1950s the RF served in a retired emperor's role, no longer the quotidian wielder of power but playing a crucial part behind the scenes in various ways. With the IHD's impending demise, senior WHO administrators were keen that the RF's Struthers spend a week in Geneva to get to know WHO technical staff, 'learning both of their personalities and their fields of competence.' Struthers found Chisholm 'particularly anxious that the close association between the WHO and the RF' continue, 'both with the object of avoiding duplication of effort, and also that the RF was able to do some things which WHO could not do, and that our long experience, and objective and independent outlook were of value to the personnel of WHO.'[64]

A parade of RF officers was invited to serve on WHO expert committees, intensively so in the 1950s, and more sporadically in subsequent decades. After the IHD folded, RF staff wondered whether they should sit on WHO expert panels in areas that were no longer RF priorities, but DMPH director Warren assured them that such positions were useful for maintaining contacts, for example in malariology.[65] Several RF nurses were asked to serve on the Expert Advisory Panel on Nursing,[66,67] another colleague on the yellow fever panel in 1954,[68] and so on. The RF was also involved in joint WHO/RF

seminars in the early 1950s, supporting mostly travel costs to garner the interest of scientists in such areas as sanitary engineering.[69]

Certain requests for RF expertise were dealt with more gingerly. In 1948 RF malariologist Paul Russell 'hesitate[d]' to suggest a Latin American country for a WHO malaria demonstration progam, insisting that Soper be consulted to avoid 'difficulties.'[70] Within a few years, WHO asked Russell to serve as a Malaria Consultant and advisor to WHO for two years,[71] an assignment DMPH director Warren made willingly, provided the invitation came from WHO's director-general.[72]

A subset of RF men also became involved in WHO work in the areas of medical education, healthcare policy, and community health and development (the first two being major foci of the RF's new DMPH). Launched with vigour under Chisholm, this back door support for social medicine, even as WHO's disease campaigns were proliferating, included: RF officer John Grant participating as 'observer' to the 1952 Expert Committee on Professional and Technical Education and various public health expert meetings through the 1950s;[73] RF Vice President Alan Gregg serving on the Expert Panel on Medical Education in 1952;[74] and panel membership of several leftwing social medicine experts who had been supported by the RF, such as Štampar and Sigerist. The reports produced by these panels made powerful recommendations about the need to incorporate comprehensive, community-based social welfare approaches rather than a narrow focus on clinical care.

In this regard, John Maier, a DMPH staff member, noted that WHO and the RF were facing similar dilemmas. At a WHO European study conference of Undergraduate Training in Hygiene, Preventive Medicine and Social Medicine, for example, Štampar—although far more politically radical than his patrons—outlined the difficulties caused by a 'separation and antagonism between preventive and curative medicine' and suggested calling medical schools 'schools of health.'[75] The RF's effort to undo its longstanding compartmentalization of medicine and public health was partially linked to WHO, involving for example, RF support for several medical schools in Colombia, which in the 1960s informed WHO's call for the teaching of community-based, preventive, social and occupational medicine as part of internationally accepted standards.[76]

In the early 1950s, Grant was at the fulcrum of RF-WHO collaborative social medicine efforts. His commissioned paper on the 'International Planning of Organization for Medical Care,' was presented before WHO's Department of Advisory Services in 1951, informing the recommendations of related expert panels.[77] This work emphasized the importance of regionalized health systems and village health committees. Later that year he was nominated by WHO to be a member (funded by the RF) of a three-person UN survey mission on community organization and development in India, Ceylon (now Sri Lanka), Thailand, and the Philippines. The survey, building on Grant's prior scouting of inter-agency cooperation possibilities among WHO, UNICEF, and the US government to 'rebuild' Southeast Asia,[78] highlighted the economic and social aspects of community programs, again stressing self-help efforts, in part as a means of fending off communism.[79] WHO's European office was also keen to have Grant's participation, inviting him on a study tour of Sweden, Scotland, and Belgium,[80] and receiving almost $US50,000 from the RF over three years to study personnel needs under Europe's new health and social welfare laws.[81] Grant wryly observed that some believed that they were so far advanced, there was little room for improvement, with Norway and Sweden serving as paradoxical 'exceptions to this attitude.'[82]

By the mid-1950s, RF leaders believed that the RF need no longer be represented at every WHO meeting and 'should maintain good relations and reasonably close contact. But a nice balance seems called for –not too intimate and not too distant relationship.'[83] Soon enough, WHO invitations for RF participation were turned down: 'As we have no one with special knowledge of the problem of onchocerciasis, I am sure that our failure to be represented will not detract from the productiveness of the conference.'[84]

With its resources now focused elsewhere, the RF sought to rally other philanthropic players. It had already tested these waters in 1949, suggesting that WHO approach the Ford Foundation for a subsidy towards a new building,[85] and in early 1951, the RF and the Kellogg Foundation each provided PASB with $US150,000 interest free loans to purchase a building to serve as headquarters.[86] Kellogg also joined the RF in providing fellowships.[87]

The role of the RF's flagship fellowship program was an important ongoing issue.[88] At first, the IHD sought to retain public health fellowships 'in significant fields which are not major interests of WHO' because of WHO's tendency to let member countries select fields and individuals for fellowships, which might 'preclude senior men who may be developing newer areas.'[49] The RF also questioned WHO's preference for fellowships to be held at non-US schools, a policy WHO justified by the large number of foreign students attending these institutions.[89] Another problem was due to WHO's poaching of fellows who had been trained specifically for RF projects. The RF called for mutual 'consideration and unusual courtesies,' meaning that WHO should 'refrain from offering attractive employment' to men destined for RF work.[90] Chisholm was so alarmed by these personnel-raiding accusations that he sought RF permission to use the RF fellowship directory to recruit candidates for field projects.[91]

The RF was careful not to bankroll WHO projects without participating in their design. DMPH director Warren was particularly troubled by a request that it work *with* WHO to support Manila's Institute of Hygiene, declaring, 'the only categorical statement I can make is that we will not operate through WHO or any other intermediary.'[92] The DMPH ultimately granted $US20,000 but only to support visiting Johns Hopkins faculty.[93] By 1952 it was mutually decided that there would be 'no further joint projects, but that we will maintain a relatively close liaison' in training courses in insect control and biological testing of insecticides.[94] On the other hand, the RF sought to take advantage of WHO demonstration projects to organize particular studies.[95]

Despite these changes, the RF remained on the pulse of WHO politics. Numerous Americans involved in WHO confided to RF staff about developments under Chisholm. Some were concerned with decentralized regionalization; others believed that Henry Sigerist, self-exiled from Johns Hopkins back to Switzerland, was exerting 'undue influence'

on Chisholm in regards to both national health insurance and medical education reform.[96] Grant, meanwhile, kept a close eye on social medicine developments[97] and praised WHO's increasing emphasis on program evaluation.[98] But his critique of technical assistance in Thailand was met by defensive WHO staff intent on gaining RF understanding and approval.[99]

The annual WHA was also an important touchstone for RF assessments. Struthers sought to attend the contentious 1952 Assembly as the RF observer, but Chisholm felt that given the large number of nongovernmental organizations (NGOs) that maintained official relations with WHO, the RF could not be offered this status. Instead Chisholm invited him as a private citizen and confided in him at lunch during the conference.[100] Struthers was 'extremely disappointed' in speeches by luminaries Gunnar Myrdal and CEA Winslow on the economics of prevention, but the big storm was around Norwegian Executive Board chair Karl Evang's speech and motion on WHO's recognition of and involvement in population studies and control of reproduction.[101] A 'highly emotional controversy' ensued over the following days, with France, Belgium, Ireland, and Italy threatening to resign from WHO. Following a 'tense debate,' these countries, facing 'religious political pressure,' defeated attempts at any technical discussions: Evang's motion was not brought to a vote but advisory birth control work in India was allowed to continue.[102] This incident, which nearly broke WHO apart,[103] also delineated an area for RF work that would not overlap with WHO efforts. Just a month later, John D Rockefeller III convened an invitation-only 'Conference on Population Problems' with top experts.[104] He founded the Population Council shortly thereafter, separately from the RF because its own board was divided, thus partially (though not intentionally) shielding WHO from this problematic arena.

Another difficulty faced by the young WHO was financial. In both 1953 and 1954, the US paid only $US8 million of $US12 million pledged, even while the UN had asked WHO to increase its technical assistance to member countries. With a $US30 million shortfall, WHO was forced to freeze spending. One RF officer berated, 'The WHO is just learning the wisdom of setting aside all funds for each project out of current budget.'[105] RF staff also learned that WHO was fearful of the 'empire-building aspects' of UNICEF, which was more solidly (largely US) funded and 'will tend to use its stronger autonomous position' to build its own technical staff rather than rely on WHO as per the original agreement.[106]

Concerns about the urgency of US support for WHO were so great that advocates approached the RF for help from all angles. Esteemed US public health man Frank Boudreau (who rose to deputy director of the LNHO and then executive director of the Milbank Memorial Fund), chair of the National Citizens Committee for World Health, appealed to Nelson Rockefeller[107] to attend the National Conference on World Health in 1953. The Committee, set up in 1951 to generate public interest and support for international health and save the United Nations from the fate of the League of Nations, already had Chisholm, Eleanor Roosevelt, the US Surgeon-General, and RF President Dean Rusk lined up as speakers at its conference, but the presence of a Rockefeller family member was deemed essential.[108]

Distance despite familiarity

The RF's stamp on WHO was reinforced with the May 1953 election of Dr. Marcolino Candau as its director-general. Candau had been an RF fellow and had worked with Soper in IHD's *Anopheles gambiae* campaign in Brazil, then briefly served as his deputy at PASB. Initially there were close interactions. Grant learned early that Chisholm would be resigning in June 1953, after a single term.[109] Because of Soper's continued relations with former colleagues, the RF was privy to the internal battles and 'considerable hard feelings' over Chisholm's successor. With British support for a Pakistani candidate and Vatican support for an Italian, 'through Chisholm's intervention, and after very close voting, Candau of Brazil was nominated, and presumably will be elected.'[110] Soper 'has confidence' that Candau would 'bring strong leadership to WHO Secretariat.'[111]

Notwithstanding his pedigree, the RF did not take Candau's perspective on international health for granted, and he was subject to prolonged scrutiny. Certainly his election elicited wide congratulations from RF staff, returned by Candau's gracious thanks as he faced this 'exciting and challenging task.... indeed I shall need the help you offer and the knowledge and training that I was fortunate enough to be given by the Rockefeller Foundation years ago.'[112]

Despite Candau's long association with the IHD, there remained questions about whether future relations between WHO and the RF would entail dependence, independence, or a mix of these. For example, newly-elected Candau told Struthers that he was interested in employing social scientists, especially social anthropologists in public health. Struthers 'surmised that [this] was an attempt to learn of RF thinking in this area.'[113] More likely, Candau was seeking to revisit Chisholm's efforts around these issues, based on the WHO consultancy of famed psychological anthropologist Cora Du Bois in 1950–1. Meanwhile, RF nursing expert Mary Tennant learned that Candau 'says he will stay only one 5-year term as DG, then return to Brazil,'[114] perhaps an indication of his early doubts, but ultimately completely erroneous 'intelligence.' Robert Morison, RF Director for Biological and Medical Research, was 'impressed by the ability and sincerity' of Candau, his principal aides, and section chiefs. Noting that Candau gave a much better impression at headquarters than at 'peripheral field points,' he 'is certainly trying to do a good job although they are obviously attempting to do too many things at once and satisfy too many national pressures.'[115]

RF reconnaissance went beyond its own staff members to include the opinion of US delegate Henry van Zile Hyde, US President Harry S. Truman's chief international health advisor in a variety of capacities and the US representative on WHO's Executive Board from 1948 to 1952. Zile Hyde reported a 'much improved atmosphere in Geneva under Candau,' with budgets 'realistically based on quotas from countries actually attending the assembly' rather than counting the dues from the (absent) Soviet bloc.[116] An RF fellow who worked at WHO reported that Candau's practice of personally interviewing each staff member about their work and future projects had facilitated the transfer of leadership and was

'adequate to get rid of the nostalgia' for Chisholm, even inspiring some cynics.[106]

Candau's grilling continued in New York in October 1954: new RF President Dean Rusk invited Candau for lunch and a 'relaxed discussion' about WHO programs and 'what a private organization might do in the world today in the field of medical education and medical care.' Candau suggested RF support for education, research, and training in strong regional institutions such as Mexico's Institute of Cardiology, the São Paulo and Santiago schools of public health, and the new Central American Institute of Nutrition. Rusk saved the 'Mars bars' question for after dessert—Candau's position on birth control. After pretending he had to leave, Candau explained that he had been instructed to keep mum on this issue, though he was well aware of the 'population-food problem' and that other UN agencies were accusing WHO of 'creating more problems than it was solving.' As such, Candau argued, birth control work was well-suited to private organizations.[117]

Once the RF became satisfied with Candau's agenda for WHO, more routine matters resumed. Tensions over fellowships resurfaced under Candau because the RF was getting growing numbers of WHO staff applications for fellowships that had not been approved institutionally.[118] Candau lobbied several RF men, hoping for 'sympathetic consideration' so that a few outstanding fellows could become key personnel for permanent WHO positions, both at headquarters and regional offices.[119] He also wrote DMPH director Warren, promising to screen all candidates, and hoping for continued support: 'It is fully realized that you cannot envisage continuing the granting of fellowships for an indefinite period. We are, however, most grateful for your agreeing to assist WHO in the development of its staff during these early critical years.'[120] RF staff suspected Candau wanted much of WHO staff trained at RF expense and 'is now trying to hedge a bit on his agreement in the hope that he can wangle more fellowships than you had in mind….Hence, the training program would seem to be a more or less continuous process.'[121] Warren concluded the discussion by promising: 'As you know, we are anxious to do all we can to help you and your colleagues … develop a sound corps of well-trained people for permanent and long term work… [but] Because of limited funds, and need to train personnel closer to home, [we] will not support operating field personnel.[122] For a few years, new RF-WHO fellowships again rose, going from 2 in 1953 to 8 in 1959, but by 1963 there was only 1, in 1964 2, and only 1 new RF fellow from WHO in 1968.[123] By this time the WHA had approved major funding for fellowships,[124] and the RF was no longer needed.

In 1955 another conflict brewed around WHO's job offer to the director of an RF-funded community health centre in France.[125] John Maier, now an assistant RF division director, wanted to draft a harsh letter to Candau about the matter but was told this was 'inadvisable,' and he would 'simply have to grin and bear it.'[126] Further confidential, high level discussions about the case called for informal approaches: 'It was decided that the RF was not justified in taking such a stand…on the basis that we should not try to play God.'[127]

Around this juncture, the RF-WHO relationship began to grow more distant. The New York meeting with Rusk led to unofficial RF approval of Candau's indefinite posting as director-general, which lasted until 1973. Candau oversaw the establishment of WHO's global malaria and smallpox eradication campaigns, a growing WHO bureaucracy, and a massive effort to provide public health training fellowships to over 50,000 health personnel from across the world.[128]

Ironically, or perhaps due to this connection, the late 1950s and 1960s was the period of least interaction between the RF and WHO. To be sure, Soper was a central shaper of its malaria campaign, and Paul Russell and other RF men were involved.[26,59] But the growth in membership of WHO following the liberation struggles of dozens of new nations in Africa and Asia (and later, the Caribbean), accompanied by increasing bureaucratization, and the malaria effort – significantly financed by the US government (and a few others) through 'voluntary' contributions rather than regular member country dues[58] – moved the RF further away from WHO's centre stage. The RF's period as prime advisor was over—and WHO went from being swayed by the priorities and agenda of the foundation to becoming subject to powerful, far larger donors, most notably the United States, in the context of Cold War exigencies.

Certain collaborations did continue. In 1958 the RF granted $US25,000 for a WHO manual of operations.[129] Joint efforts, such as $US250,000 in RF support for research to combat protein malnutrition carried out in 12 countries, involved WHO in an advisory capacity, among other agencies.[130] In 1960 the RF's new Division of Medical and Natural Sciences joined WHO to support a rural public health centre in Kenya and a School of Nursing in Congo Republic,[131] as well as various efforts in medical education. As in the past, numerous RF-trained and supported experts from around the world rose to prominent positions at WHO.

But the RF began to turn down WHO requests as often as it accepted them,[132] and focused on narrowly targeted efforts such as funding a WHO bibliography on hookworm.[133] For its part, WHO was also reluctant to commit to co-sponsoring RF projects. When USAID administrator Leona Baumgartner suggested in 1963 that USAID, the RF, and WHO carry out a joint study on training of ancillary health personnel and staffing needs, Candau offered support of a WHO statistician but insisted 'WHO cannot be considered as a Sponsoring Agency.'[134]

Meanwhile, the RF had also changed—tolerance of social medicine on the margins of its main efforts dwindled with Alan Gregg's and John Grant's respective retirement and death and amidst the continued red-baiting of the McCarthy era. For example, since his posting by the RF to Puerto Rico in 1954 to set up a coordinated medical and public health system of research and practice,[36] Grant had been keen to make WHO aware 'that their present categorical activities must be replaced by polyvalent permanent local organizations.'[135] After four years, a possibility finally materialized only circuitously when the National Citizens Committee for the World Health Organization obtained grants from the RF, as well as the Milbank, Kellogg, and Avalon foundations and various industrial concerns, to fund key public health delegates to the 1958 WHA (held in Minneapolis) to travel to Puerto Rico to attend a series of professional sessions arranged by Grant and see the island's 'progressive public health and medical services.'[136] But this was an anomalous episode: after 1954, the RF's European office (a vital link to WHO) shrank by 90% and

RF programming moved even further away from public and international health (though support for bench research on arboviruses and other tropical diseases, and some community medicine efforts, continued apace).

From backstage to backdrop

It is not surprising that the RF left such a deep impression on WHO, for the IHD was the most influential international health actor of the era. Before WWII, European powers were focused on their colonial networks, with inter-imperial commercial rivalries impeding strong international agencies, while the US government was testing its own international health leadership in the Americas. Thus by default and through its own protagonism, the RF was the *de facto* international health leader.

Even after the IHD closed down shortly after WHO was founded, this was no disappearing act. The RF's disease control ideology and approach to international health were infused into the agenda and practices of WHO. This took place both directly, through the discreet advice it purveyed and the generations of RF personnel and numerous RF fellows and grantees WHO employed and consulted, and indirectly, through the RF having shaped the international health scene via scores of in-country cooperative efforts over almost forty years and through its hand in designing and supporting major multilateral health institutions over several decades.

What is remarkable is that not only was the RF's predominant technobiological paradigm adopted by WHO, but so was its modest entrée into social medicine, advanced by a small contingent of left-leaning longtime IHD officers. This was particularly marked during WHO's early years, when Chisholm, himself not an RF man, opened the organization to this alternative perspective even as the RF's main approach bore down on his administration. In those years, the RF was subtly everpresent—conveying both of its legacies, albeit at different scales.

How and why the RF subsequently became less visible at WHO also illuminates the constraints of shifting power blocs at WHO. The bulk of Candau's period would mark a distancing between WHO and the RF, even as the RF's disease control model had become fully entrenched at WHO, most visibly through the launching of the global malaria eradication campaign. On one level, this paradox—Candau's rise coinciding with the RF's demise at WHO—indicated that because its approach was firmly in place at WHO, the RF's presence was superfluous.

On another level, this estrangement meant that some openings to social medicine enabled by the RF–WHO relationship now faded. While RF-sponsored advocates of social medicine remained on certain expert committees, the hard line of McCarthyism wiped out many American health leftists in particular. A notable target was health systems and policy expert Milton Roemer, who left the repressive context of the United States to work at WHO in 1950, only to lose his WHO appointment in 1953 after the US government revoked his passport due to his refusal to sign a loyalty oath.[137] In the late 1950s and 1960s, some social medicine advocates involved in WHO came from other quarters, including Latin America and Africa. Sidney and Emily Kark, for example, who had innovated a successful community health centre model in South Africa (in part thanks to RF officer John Grant's backing), participated in various WHO activities. But under Candau and with heightened Cold War rivalries at WHO sparked by the return to active membership of the Soviet bloc in the mid-1950s, this health internationalist tenor was marginalized at WHO, only to resurface, as we shall see in Part II, starting in the late 1960s and early 1970s.

The RF became but a backdrop not only at WHO but also on the international health scene writ large. Indeed, the subtitle of a 1959 US Senate report about the US and WHO, 'Teamwork for Mankind's Well-Being,'[130] echoed, perhaps inadvertently, the RF's 1913 motto: 'For the Well-Being of Mankind throughout the World.' This 150-page document cited the RF's link to WHO on just two pages and only in regards to inter-agency research collaboration, with no mention of the RF's pivotal prior role in setting the international health agenda.

The importance of the RF's advocacy, legitimacy, and seed funding for projects diminished considerably after the US's financial support of WHO efforts soared starting in 1956–7, in the wake of the influenza pandemic, the Soviet bloc rejoining WHO, and US recognition of the potential of the malaria eradication campaign to combat communism. As such, the RF's organizational power was waning even as its ideological approach to international health had become solidly institutionalized within WHO.

In sum, the RF had enormous bearing on WHO, just as it did on the overall international health arena: WHO's very configuration was unthinkable without the RF. Yet as WHO found firm ground in the 1950s and the RF abandoned its primordial international health role, there was a tacit understanding that the RF would not interfere in day-to-day operations, even as WHO leaders and champions remained conscious of the RF's underlying influence. After the US government brashly moved onto WHO's turf at the height of the Cold War, particularly through its role in the global malaria eradication campaign,[58,59] there was a further distancing between the RF and WHO.

As will be discussed in Part II, it was only in the 1970s that the relationship resumed, just when WHO began to question the RF's disease campaign model, and, backed by the bulk of its member countries, it pursued a more community-grounded approach to primary health care amidst calls for a new anti-hegemonic economic order. By this time, the RF's support for such social justice-oriented efforts was much narrowed in the context of the dominant ideological shift towards neoliberalism, and it played what many perceived as an antagonistic role in seeking to resurrect its disease control paradigm.

The RF–WHO relationship was complex, with moments of paternalism, scoffing, frustration, dependency and mutual manipulation, but also of real collaboration. In some ways, the timing was off: in the 1950s, when the RF still retained remnants of a social medicine approach that was never at its core, WHO had little room to manoeuver in this direction; paradoxically, this mismatch would repeat itself in the 1970s and 1980s but in reverse guise. Just as WHO was adopting a more socio-political approach to health, the RF was retrenching in the other direction, through its backing of 'neglected' diseases, 'child survival,' and transdisease vaccinology. Through these

vicissitudes, the powerful presence of health philanthropy, at certain times quietly, at others blatantly, raises important and enduring quandaries about the role of unelected, unrepresentative entities in international/global health.

Author statements

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