The League of Nations Health Organisation and the Evolution of Transnational Public Health

DISSERTATION

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Abstract

The League of Nations Health Organisation, a technical body created in 1920 to address international health issues, was an unlikely setting for a revolutionary experiment in international relations. Yet the leaders of the organization created an international epidemic control system that not only brought together collaborators across enemy lines, but also garnered political support for a vision of international public health that posited that the well-being of the world’s citizens deserved at least as much attention as the state’s security or economic interests. The leadership of the Health Organisation leveraged the success of the older international epidemic control system, which they expanded with new technologies and information gathering practices, to attempt to manage endemic and non-infectious diseases at a distance.

The experts at the organization went beyond older bacteriological models to posit a social-environmental understanding of health that maintained that social and physical surroundings were more determinative of health and illness than race or heredity alone. Although bacteriological understandings of health dictated certain international epidemic control techniques – most notably quarantine and disinfection – the increasing emphasis on environmental understandings illustrates the dramatic changes underway in international public health work between the world wars.
The previous system, overseen by the Office International d’Hygiène Publique, relied on epidemic notifications sent over diplomatic channels. International public health came into its own at the League, granted its own section and charged to medical professionals rather than diplomats. Although few would argue that health cooperation had no political consequences, governments were more willing to cooperate on “technical matters” and the staff of the League of Nations Health Organisation were happy to feed into this perception and used it to justify their activities.

During World War II this pretense became impossible to uphold. Nations withdrew from the League and its technical bodies, epidemic intelligence was declared as a military secret, and the Office International d’Hygiène Publique was burdened with a Nazi observer. Frustrated by this interference, international public health workers advocated for the separation of their work from the politics, leading in part to the separation of the World Health Organization from the United Nations, and greatly changing the course of post-war international health work. Decolonization and the epidemiological transition sharpened the divide between the West and non-West.

Through an examination of the various strategies employed by the League of Nations Health Organisation – direct attack against epidemics in afflicted states, sanitary conventions, epidemic notifications, statistics, investigative commissions, and the advocacy of social reform – my dissertation charts the negotiation of the new definitions of health and the creation of a sanitary system that was founded on the internationalist and progressive optimism of the interwar period.
Dedication

For Stephen, who made it possible.
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Chapter 1: Introduction

“If there is a field of action in which the League of Nations can bring immediate relief to nations, and one which will affect individuals in their personal and family life, it is the field of social hygiene in the most liberal sense of the word. Health measures are essentially international measures, whether it be a question of adopting preventative or defensive means to combat contagious or epidemic diseases, or of popularising methods of cures and treatments.”


A New Era in Epidemic Control

The League of Nations Health Organisation, housed across the street from the main League of Nations offices for much of its twenty-six-year existence in a purple

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2 The official name of the League of Nations Health Organisation (sometimes called the Health Organisation of the League of Nations) used the British spelling of “organization.” I have endeavored to maintain that spelling in proper names. In the rest of the text, I have preserved the original spelling of quotations, but otherwise use American spellings.
wallpapered apartment that “looked like the boudoir of the kept woman of a Genevois banker,” was an unlikely setting for a revolutionary experiment in international relations.³ Major Greenwood, a British statistician who collaborated on a number of League projects, observed that there were serious doubts about whether the Health Organisation, which he claimed was composed of “a dozen or two miscellaneous joy riders and hardbitten nationalists without an idea or a language in common,” could, in his words, “achieve a big thing.”⁴

Yet the League of Nations Health Organisation, a motley group of doctors, researchers, statisticians, and politicians, did manage to change a big thing. They ushered in a sanitary system that was more comprehensive medically and politically than its predecessor and that shaped international cooperative work through to the present. The nineteenth- and early twentieth- century international sanitary system that had privileged the health concerns of large maritime empires had been centered at the Parisian Office International d’Hygiène Publique.⁵ States relied on the quarantine of infected ship passengers to prevent the spread of diseases through international shipping lines, although they agreed, under the auspices of the international sanitary conventions, to notify other states when any of a small number of infectious diseases occurred near ports.

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⁴ Major Greenwood to Ludwik Rajchman, July 14, 1925, 1, 12B/40376/28785, League of Nations Archives, Geneva, Switzerland (hereafter LON).

The system that the founders of the League of Nations Health Organisation helped to build facilitated freer information exchange and reflected their belief that global health needed to be built on more than the control of infectious disease. In so doing, they expanded the definition of what constituted an epidemic of international concern and adopted new strategies to address this expanded definition of international health.

The leadership of the League of Nations Health Organisation leveraged the success of the older international epidemic control system, which they expanded with new technologies and information gathering practices, to attempt to manage endemic and even non-infectious diseases at a distance. Despite the bacteriological basis of older models of international epidemic control and the increasing global sway of scientific racism and eugenics, the medical professionals who worked with the League of Nations Health Organisation posited a social-environmental understanding of health that maintained that social and physical surroundings were more determinative of health and illness than race or heredity alone. Although bacteriological understandings of health dictated certain international epidemic control techniques – most notably quarantine and disinfection – the increasing emphasis on environmental understandings illustrates the dramatic changes underway in international public health work between the world wars.

These new assumptions about health and disease entailed the use of new strategies of work. The Health Organisation staff adopted two broad types of interventions to control disease and improve health. The staff at the League moved to addressing not merely the social and environmental bases of disease, including programs on nutrition, rural health, and mother and child welfare, but also the techniques of population thinking,
including an increased emphasis on information exchange and statistical analysis and the use of vaccination. In short, they turned to techniques which sought to lower the risk to populations rather than simply control the movement of sick individuals. Neo-quarantinism, which relied on surveillance, notification, and isolation, remained an essential strategy at ports but was no longer the main strategy of official international public health cooperation.³ Inherent in this new emphasis was a move away from predominately bacteriological understandings of disease to bolster public health initiatives and towards an increased reliance on multi-causal conceptions of illness.

The League of Nations Health Organisation staff, led for most of the organization’s existence by the Polish bacteriologist Ludwik Rajchman, managed to garner significant political support for this project. These international workers convinced states that not only were governments responsible for the health of their citizens, a consensus that had been growing over the nineteenth and early twentieth centuries, but that they had an obligation to other states to ensure the health of their citizens. Although early in its history certain members of the League of Nations Health Organisation attempted to undertake direct control of epidemics by proposing international sanitation and disinfection campaigns in other states, this model was rejected by the international community as too costly and too great a violation of sovereignty. Instead, the League of Nations Health Organisation worked through governments and encouraged states to take the last step domestically, that is to look after

³Peter Baldwin, Contagion and the State in Europe, 1830-1930 (Cambridge: Cambridge University Press, 1999), 151.
their own ports and their own populations, for their benefit and the benefit of the rest of the world. This orientation was fundamentally different from that of older regulations, which tried to control bodies in other states and other ports, and from the post-World War II economic development schemes, which tried to improve the health of bodies in other states.7

The supporters of the League of Nations Health Organisation garnered a remarkable level of political support for these efforts by emphasizing that their work was technical and not political. Analysis of the history of the organization suggests, however, that this stance was rhetoric designed to allow states to participate in international efforts that might have appeared suspect at home. In their work on other aspects of the League program, including its economic functions, Patricia Clavin and Jens Wilhelm Wessels have similarly shown that technical and political issues were rarely separated at the League. As they wrote, “while League officials sought to hide behind the distinction, they certainly didn’t believe in it.”8

The delicate balance achieved in the 1920s and 1930s between national and international interests in disease control collapsed after World War II. Although the founders of the World Health Organization paid lip service to promoting health rather than merely controlling disease, in the early years the staff of that organization pursued a

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7 For more on how “development” relates to health, see Sunil Amrith, Decolonizing International Health: India and Southeast Asia, 1930-65 (New York: Palgrave MacMillan, 2006). Development and in its role in postwar international relations will be discussed more in Chapter 7.

limited program of disease eradication in an attempt to avoid political entanglements.

Several factors account for this shift and illustrate the difference between the interwar and postwar international public health environments. The first is the new found ability to control diseases through magic bullets, single technologies such as DDT, smallpox vaccine, and antibiotics that promised to cure, prevent, or eradicate targeted diseases. Additionally, the political and epidemiological separation of the developed from the developing world also made global initiatives difficult. Former colonial states had decreased economic incentive to improve health in the regions they had once colonized, as they no longer benefitted directly. Western states were further separated from the developing world by the control of many infectious and environmental diseases in the West.

Public health specialists domestically and internationally found their positions weakened by their attempts to take on too many disparate areas of work. By the end of the interwar period, the League of Nations Health Organisation had claimed responsibility for disease control, biological standardization, nutrition, housing health, and even mother-and-child welfare. As other scholars have noted, public health efforts tend to collapse whenever their supporters broaden their claims of expertise too far, making it difficult for them to claim legitimacy in any particular area.9 After World War II organizations such as the Food and Agriculture Organization and the United Nations Children’s Fund took up the broad array of health activities advocated by the staff of the

Health Organisation and made nutrition and child welfare their main responsibilities, cutting into the broad field the League of Nations Health Organisation had tried to claim.\(^\text{10}\)

The change was also due in part to the sense among the supporters of the League of Nations Health Organisation that politics had interfered with and failed to support their work, and that their program had unfairly collapsed when the League of Nations did. Consequently, public health professionals were eager to withdraw from the “political” portions of international health work. The main tensions that had defined health work in the interwar period – between environmental and bacteriological understandings of disease and between national and international action – were not resolved by the World Health Organization but shaped into new configurations that were often the opposite of those of the League of Nations Health Organisation.

In this dissertation I chart the development of the international sanitary system in the interwar period. Throughout, I focus on the institutions used to address epidemics, the specific diseases that became the focus of that work, and the strategies the international community used to control the diseases. In so doing, I explore how the conceptualization of these diseases changed, often in response to the local experiences of disease brought to the attention of the international community by cooperative investigations. This study is not merely an institutional history of the League of Nations Health Organisation. Indeed, the system of epidemic control itself transcended that

\(^{10}\) For more on the creation of the United Nations specialized agency and the ethos they embodied, see Amy L. S. Staples, *The Birth of Development: How the World Bank, Food and Agriculture Organization, and World Health Organisation Changed the World, 1945-1965* (Kent, Ohio: Kent State University Press, 2006).
organization and was built on the cooperation, under the auspices of the international sanitary conventions, of the foreign ministries of various states, and of local public health establishments.

This project exposes the tensions amongst different national approaches to public health and between international and national public health. It is the history of the search for a broad yet sustainable definition of health that went beyond attempting to control infectious diseases. It is also the history of the yearning for magic bullets, for inexpensive and focused solutions to particular diseases. This work also yields insights into the early development of epidemiology and population thinking, as the League promoted a number of statistical methods for understanding disease patterns that laid the groundwork for the post-World War II international sanitary system.

The history of the interwar sanitary system also sheds light on the function of international institutions. Studying the League of Nations Health Organisation reveals larger patterns about the role of individuals in large, multi-state organizations, illustrating how programs with patrons do better with programs without an individual or national delegation to champion them. This history shows the development of the relationship between technical expertise and politics and how that relationship can shape the actions of states. It explores the transition from empires to nations and the peculiarity of an organization based on nations in a world ethos that was still unavoidably imperial. This dissertation also charts ongoing discussions about the meaning of reconstruction, relief, and development in a global context. The international sanitary system of the interwar era provided an alternative framework for how international relations could have
developed. Rajchman and his supporters attempted to create an interventionist international public health service, which would have given international organizations unprecedented privileges inside sovereign states. Although the full extent of his program was never realized, his repeated attempts illustrate a model of international cooperation that came surprisingly close to being adopted.

Finally, the dissertation contributes to the history of globalization writ large. According to most work on the history of globalization, the interwar period is a singularly inauspicious period to study international and global trends. This was a period of the turning of states inward, of increasing nationalism, of tariffs and decreasing international trades and capital flows, and even a decrease in international citations in most linguistic groups’ psychiatric journals.\(^\text{11}\) These trends only increased with the Great Depression.\(^\text{12}\) The history of the interwar sanitary system reaffirms the turn inward politically, socially, and scientifically in the 1920s and 1930s. The utter mystification with which American and European malaria experts encountered each other is one example. The reluctance to give up the medical inspection of ships, the fear of leaving something so vital to other states, is another. Indeed, the period is marked largely by the attempt to use international public health projects to promote national ends. But this dissertation is not only interested in the slowdown of transnational linkages in this period,


but the remarkable ways in which global exchanges stabilized or increased in the area of public health, and the acknowledgement by many that international cooperation was essential. The increase in the production and sharing of epidemic intelligence is probably the most prominent example, although the study trips and meetings of the commissions is another. While states reaffirmed their rights in the administration of public health activities within their borders, these rights were often considered to be granted in response to responsibilities the government had both to its own citizens and the international community. I will now consider these bigger issues in turn before introducing the interwar international sanitary system and its antecedents in more detail.

Public Health and Social Medicine

The history of public health is in large part about state interventions to forestall the development of disease based on removing the source of infection. Nineteenth-century public health campaigns in Europe were directed at water sanitation, quarantine, and to a lesser extent vaccination, a project that was bolstered by the germ theory of disease. Although public health specialists continued to use many of the disease control techniques that were based on the germ theory of disease, by the interwar period many doctors began to view the sanitationism that had held sway domestically as too simplistic by the interwar period, and they began to advocate for personal prevention.¹³ By the

1930s, spurred by the Great Depression, national policymakers were increasingly interested in issues of nutrition, chronic disease, mother-and-child welfare, and industrial health, locating the cause of many diseases outside of individual germs or bodies and in the fabric of society. The League of Nations Health Organisation’s staff and guiding Health Committee often emphasized the importance of social and environmental understandings of disease. Therefore their history contributes to our understanding of how different models of disease causality translate into different public health practices.14

As much as the history of public health is a story of competing model of diseases – dirt, germs, heredity, or miasmas – it is also a history of the debate about the proper role of government and the obligations between state and citizen. One of the most curious discoveries in this work is that anyone in the 1920s thought that public health could be separated from politics at all. The history of modern public health, dating from the nineteenth century in Europe and the United States, was intrinsically political, pioneered by men and women of a dizzying array of political persuasions who were convinced that improving health would improve society. What is even more curious is that the World Health Organization has largely succeeded in avoiding entangling itself in the most pressing political issues of the day. Whatever the personal persuasions of the individual staff members at the World Health Organization, the institution as a whole has

retreated from what Joel Oestrich calls the “‘fuzzy’ social issues” of human rights and development. I explore how this shift took place, suggesting that a combination of state disinterest, evinced through lack of funding and lack of follow-through on Health Organisation advice, and state interference, especially the shutting down of data-sharing in World War II, drove the League of Nations Health Organisation workers, at the end of their tenure, away from large scale social interventions and towards limited technical solutions to public health problems.

Although industrialization prompted much of the modern attention to issues of public health, through the creation of industrial pollution and the effects of urbanization and poor factory conditions for workers, the birth of modern public health as a state effort can be traced back to the French revolutionaries who declared health a right of citizenship. The development of public health in France continued in response to competing proposals put forward by statists, liberals, conservatives, and socialists, who settled on a doctrine of hygienism, which was, in the words of historian Ann F. La Berge, “a belief that all areas of life should be medicalized and moralized to prevent disease and promote public health in the interest of social order and national security.”

Across Europe in the 1830s and 1840s physicians and public health advocates became convinced


of the sanitary idea that poverty and disease mutually reinforced each other. The German progressive Rudolf Virchow, alongside socialists, communists, as well as the British freemarket utilitarian Edwin Chadwick, all looked to these social issues. Virchow looked to poverty elimination to address them, while Chadwick put his faith in engineering. Public health proponents believed that their field work could “redress the balance between industrial growth and the preservation of health.”

This attempt by reformers of all political persuasions to mediate between the market and the citizenry has been termed the “social.” Beginning with the French revolutionaries and continuing through the twentieth century, populations told states that they needed laws to protect “their new political dignity” leading to a drive to solidify social legislation that addressed working conditions, women and children, education, morality, and health and protected these areas from the assaults of the free market. The welfare state was one answer to this challenge. Most collaborators of the League of Nations Health Organisation pushed for the intervention of the state in medicine, but not in the service of a particular ideology. Although Rajchman was an avowed socialist, the organization as a whole did not necessarily promote socialism or even socialized medicine. Most League of Nations Health Organisation collaborators were determined to

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20 Fee and Porter, 17.


22 Ibid., 136.
convince states to provide varying levels of medical services in the interest of economic prosperity, national health, and international harmony.

Consequently, many historians have emphasized the importance of social medicine to the development of the League of Nations Health Organisation program.23 Although, as Christopher Hamlin writes, the history of public health and social medicine is written from the perspective of reformers, social medicine, too, had a variety of intellectual foundations.24 George Buchanan and Ludwik Rajchman, always at odds, were both advocates of different forms of social medicine, as were the eugenicists, who were largely excluded from League of Nations Health Organisation activities.25 While the attempt to connect social medicine, still a difficult concept to define, to international health was an important aspect of interwar public health, it was not the only aspect, especially because the social medical model was predominantly European and never well defined. To say that international public health work was “social” or “political” is inadequate. Instead, this dissertation tracks how those who participated in the interwar sanitary system understood their work to be social or political, and how they deployed or downplayed those terms to create support for their projects.


24 Hamlin, 11.

25 For more on the relationship between eugenics, “social hygienists,” and the League of Nations, see Borowy, Coming to Terms with World Health, 21-22.
Although vestiges of the League of Nations Health Organisation’s broad operating definition of health were formalized in the World Health Organization’s charter, interwar public health specialists failed to impart a lasting practical vision of what international public health specialists should do to achieve a high level of health for the world’s population. In Europe and America, the field of public health fragmented after the war because it lacked any conceptual organizing principle.\textsuperscript{26} Having always defined their discipline through their actions more than their philosophy, public health specialists found themselves unmoored when their basic activities of cleaning water and preventing infectious illness, especially childhood illnesses, had been taken care of in the West following infrastructural improvements and the introduction of vaccines for the major childhood diseases.\textsuperscript{27} Primary health care, whether delivered by the government or through private means, focused on sickness more than health, and in Britain, for example, other social and health workers pushed for more autonomy from the medical establishment, mirroring to some extent the situation in the United States.\textsuperscript{28} Public health researchers also became enthralled with science and the medical research funding structure, which pushed them towards more focused, measurable projects that were modeled on scientific research grant funding and moved the field away from some of its


\textsuperscript{28} Jane Lewis, “The Public's Health: Philosophy and Practice in Britain in the Twentieth Century,” 217-218.
coherent ideological roots.\textsuperscript{29} These issues were at play in the international sphere, when there was no coherent way to advocate for health interventions, and several of the ways, such as social medicine, or broad-based state interventions, had become politically untenable in the immediate postwar period.

**International Context**

The history of epidemic control also reveals fundamental shifts in the international system writ large. Earlier configurations of the international sanitary system had relied on the systems of international relations that shaped the diplomatic relations of the period. In the eighteenth century, a loose association of diplomatic letters informed other nations of plague. In the nineteenth century regular diplomatic conferences gave shape to the International Sanitary Conferences and the International Sanitary Conventions they eventually produced. There was no such clear determinant for the interwar sanitary system. By the end of World War I, the old order lay in shambles and the new configuration of the new international system was uncertain. Rather than reviving past practices, the interwar epidemic control system created an environment in which theories of how to reform the international system could be tested. The lack of a settled international political system presented challenges.\textsuperscript{30}


The unsettled atmosphere of the interwar period created space for experiments in all domains of international relations. As Zara Steiner reminds us, the 1920s were a decade that was decidedly post-war, looking forward to rebuilding a system to prevent war.\textsuperscript{31} The structures of the Health Organisation and the sanitary system that surrounded it bear witness to these international attempts to restructure the international system. Several broader trends deeply influenced the development of the League of Nations Health Organisation. The emergence of Japan and the United States as major powers was mirrored in international public health work, creating new or enhanced sanitary power centers outside of Europe.\textsuperscript{32} The League struggled with Britain’s attempt to maintain the old balance of power between Germany and France and France’s attempt to curtail Germany’s power, often preventing delegates from these nations from cooperating in sanitary matters.\textsuperscript{33} The emerging notion of collective security, which found only weak backing, “assumed,” according to Sally Marks “an astonishing amount of agreements and altruism among men and nations” and a preference for war to peace, which was difficult to achieve with the differences in the leading powers. Thus, the League remained weaker than the dominant powers.\textsuperscript{34} Outside of the cluster of Great Powers, nationalist groups from various entries called for their entry as independent states into the international


\textsuperscript{32} Sally Marks, \textit{The Illusion of Peace: International Relations in Europe, 1918-1933}, 2\textsuperscript{nd} edition. (New York: Palgrave MacMillan, 2003), 1.

\textsuperscript{33} Ibid., 9 and 12.

\textsuperscript{34} Ibid., 34 and 68.
system, although their claims went largely unheard.\textsuperscript{35} Growing anti-colonial nationalism, however, threatened to destabilize imperial arrangements.

Consequently, the rebuilding attempts had limited success. Traditionally, historians have viewed the League as, in the words of Sally Marks, “foresdoomed to failure,” destined always to have “founndered on the twin rocks of the unanimity clause and the absence of the United States.”\textsuperscript{36} Ruth Henig concurs in her recent work on the League, arguing that the unstable international environment, the absence of Russia and the United States, and a general shift away from European power brought about by World War I meant that the League of Nations lacked the power to manage effectively the international system.\textsuperscript{37} The League proved, by the end of the 1930s, a dismal failure in preserving peace amongst the Great Powers. But the facilitation or replacement of Great Power politics was never the full extent of the League program, as recent work has revealed. Susan Pedersen has encouraged us to go “back to the League of Nations” to evaluate the organization in its context rather than solely through its failures.\textsuperscript{38}

Despite the challenges facing the organization, supporters of the League of Nations ensured that its staff embarked on serious international work. Interwar internationalists took inspiration from the wave of international organizations founded


\textsuperscript{36} Marks, \textit{The Illusion of Peace: International Relations in Europe, 1918-1933}, 15.


\textsuperscript{38} Susan Pedersen, “Back to the League of Nations,” \textit{The American Historical Review} 112, no. 4 (October 2007), \url{http://www.historycooperative.org/journals/ahr/112.4/pedersen.html}. 18
over the course of the nineteenth century.\textsuperscript{39} The League of Nations brought a new political urgency to this internationalist vision. Sir Eric Drummond, the first secretary general of the League, intentionally set up an international staff that would, in his mind, address the true spirit of the League.\textsuperscript{40} The technical organizations such as the Health Organisation carried out some of the League’s most successful work through the creation of regulations, the material support of certain activities, and the overseeing of study trips, conferences, and exchanges to promote international dialogue and action. They were most successful at making issues such as health, colonial management, and economics that had previously been the purview of states into legitimate international subjects.\textsuperscript{41}

Similarly, this dissertation will illustrate that although the on-the-ground work of the League of Nations Health Organisation was limited by material and political factors, the staff of the League of Nations Health Organisation and their collaborators began to create a system that in its patterns of consultation and concern was truly international. These areas of work had a significant impact on the diseases that international public health specialists chose to address and the techniques that they employed to combat them. In turn, the successful coordination of international action across ideological and international boundaries in the work of the Health Organisation lent political legitimacy to the League of Nations and often provided a non-threatening first site of interaction

\textsuperscript{39} Akira Iriye, \textit{Cultural Internationalism and World Order} (Baltimore: Johns Hopkins University Press, 1997), 3.

\textsuperscript{40} F. P. Walters, \textit{A History of the League of Nations} (London: Oxford University Press, 1952), 75.

between the League of Nations and the states which were reluctant to commit themselves fully to the organization’s vision of international politics.

The Transnational Context

This dissertation is an international history that addresses interactions between states and a transnational history that examines the flows of people, microbes, practices, and ideas across national boundaries. Although events that took place far from the centers of European power in London, Paris, Berlin and Geneva shape the narrative, the story is at heart a European one, heavily focused on central decision-making powers, such as they existed in the field of international public health. This study does not, indeed cannot, take up the stories of many of the League projects on the ground. This choice is not made to devalue League work overseas. The experience of the European policy makers who funded tsetse fly research and campaigns in Africa or leprosy centers in Rio de Janeiro was necessarily different from the people at whom those programs were aimed. Those local stories deserve to be told at length, but will not be found here.42 Instead, this dissertation examines the creation of a transnational core of action at the

League of Nations, and examines how the conversations in Geneva shaped and were shaped by international practices.

At the same time, the local is not entirely absent from this history, and local conditions frequently shaped international efforts. As Francoise Lionnet and Shu-mei Shi write, although globalization is usually understood to make local spaces more alike in response to global norms, international exchanges can also be thought of as a “a space of exchange and participation wherever processes of hybridization occur,” a process at play in the translation of policy to local environments, and the feedback from them to global norm-setters.\(^{43}\) This process, termed “glocalization” by some, is a constant in health work and plays an important part in understanding the dynamics of international cooperative work more broadly. As Jan Nederveen Pieterse observes, at the same time international norms are shaped by local experiences, those international norms can also be applied to refigure the local.\(^{44}\) This interplay between international standards and lived experience on the ground is a key theme of this dissertation.\(^{45}\)

I understand the international sanitary system as a different type of local, building on the work of other scholars who understand international systems through the study of central networks, communities, or groups. The heart of the story is the group of actors at


and surrounding the League of Nations Health Organisation and to a lesser extent the Office International d’Hygiène Publique. As Gregg Mittman, Michelle Murphy and Christopher Sellers remind us, local history need not be geographically defined, but can instead center on a site or sites of interaction. Patricia Clavin describes transnationalism as being “first and foremost about people: the social space that they inhabit, the networks they form, and the ideas they exchange.” Clavin uses the phrase “community” rather than network to describe the League adequately, because it “suggests both a community of interest, a commonality of character, as well as a group of individuals sharing the same locality or organization.” She borrows from Peter Haas the concept of epistemic communities, which are networks of elites that circulate ideas internationally based on some common expertise and worldview. The increased prominence of public health specialists rather than diplomats in the shaping of interwar public health initiatives is illustrative of the growth of the reliance of states on technical experts in this period.

I suggest that the international sanitary system, composed of various individuals, organizations, and states, is one such site of interaction that is best studied from its center out, rather than being seen only as a set of diffusely interpreted local practices. While the implementation of health controls was doubtlessly shaped by local conditions, focusing

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48 Ibid., 425 and 427.

solely on those local conditions ignores the culture and decisions made at the center, which followed their own organization and conceptual logic. It is time to return to the center to see how those programs were constructed and understood at their source.

The Nineteenth-Century International Sanitary System and its Legacies

Most work by historians on the question of international epidemic control has focused on the nineteenth century, particularly the negotiations of the International Sanitary Conferences that were held between 1851 and the founding of the Office International d’Hygiène Publique in 1907. Prior to 1851, states notified other governments and ports of disease outbreaks on an ad hoc basis. Local ports set quarantine regulations, often varying by what epidemics they had heard of and what local populations would tolerate. For instance, following a lengthy quarantine, the Governor of Malta declared in an 1814 letter to other governments that a combination of inspection, quarantine, and isolation, “the most rigid system of Quarantine hitherto observed in any Country,” had freed the island of plague. He did not detail what the economic or political consequences of such a lengthy quarantine might have been, nor did he describe the basis on which the quarantine limits had been set.

The limits of such an ad hoc system are obvious. Propelled by fears of cholera, the desire for freer trade, or a spirit of liberalism, delegates from European states met together for the first time at an International Sanitary Conference in Paris in 1851 to

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50 Thomas Maitland, “Proclamation,” July 1, 1814, F8/24/1, Archives Nationales, Paris, France.
discuss the prospect of regularizing quarantine across the continent.\textsuperscript{51} These conferences were a product of their time, appearing in the wave of international activity of the late nineteenth century.\textsuperscript{52} These agreements set quarantine policy for European countries and their colonies, and made compulsory the notification of plague, yellow fever, and cholera. They focused on keeping dangerous foreign diseases from crossing the borders of Europe without hindering trade routes. Most scholars of this period, such as Valeska Huber, suggest that the pre-World War I international sanitary system was designed to manage the interests of international trade and protect state sovereignty.\textsuperscript{53} Mark Harrison, by contrast, suggests that trade concerns were secondary to political ones. He argues international conferences were an outgrowth of the nineteenth-century international congress system and reflected the new found belief that epidemics were not merely an internal security threat but rather one that involved multiple state actors.\textsuperscript{54} This “Westphalian” system of epidemic control was Eurocentric, decidedly political, and focused on preventing transmission of disease from one part of the world to Europe while preserving state sovereignty within borders.\textsuperscript{55}


\textsuperscript{52} See Iriye, \textit{Cultural Internationalism and World Order} for more on pre-World War I internationalist efforts.


\textsuperscript{54} Harrison, “Disease, diplomacy and international commerce: the origins of international sanitary regulation in the nineteenth century,” 187-198 and 209.

\textsuperscript{55} Zylberman, “Civilizing the State: Borders, Weak States and International Health in Modern Europe,” 24.
The early conferences produced few agreements – the scientific and political differences were too great to allow the delegates to create formal international treaties, although they occasionally came to understandings about what forms of quarantine and other disease control strategies were appropriate. At the earliest conference in Paris in 1851, states each sent one diplomat and one physician, which resulted often in national delegations voting against themselves. The conference ended with a vote against establishing an international quarantine against cholera.\textsuperscript{56} The second conference, held in Paris in 1859, involved only diplomats and again resulted in a narrow vote against establishing an international quarantine against cholera.\textsuperscript{57} The fourth conference held at Constantinople in 1866, following quickly on the heels of the outbreak in Europe of cholera in 1865, agreed in principle that there would be a quarantine imposed on Hajj pilgrimage ships if epidemics broke out along the pilgrimage route. This agreement was a non-binding resolution, not a treaty. Britain responded by introducing public health reforms in India, the source of the outbreak.\textsuperscript{58}

In 1892 delegates finally came to a formal agreement on maritime travel restrictions to control cholera and until 1903 to establish a comprehensive agreement that created the Office International d’Hygiène Publique as a central clearing house, which began its formal existence with the Arrangements of Rome in 1907. The ability to come to agreements seems to have arisen from a combination of a general increase in


\textsuperscript{57} Ibid., 20 and 22.

\textsuperscript{58} Ibid., 23 and 31.
willingness to sign on to international actions, as discussed by Iriye, and greater degree of scientific consensus.\textsuperscript{59} These conventions predominately framed disease as something foreign, something that would be imported to Europe from elsewhere, or at least from Russia, and a maritime problem, despite evidence the contrary.\textsuperscript{60} The framers of the conventions sought to safeguard local populations from the perceived effects of inadequate foreign disease control and to safeguard trade from overly restrictive sanitary regulations that could hamper the flow of goods.\textsuperscript{61} These conventions set maximum limits, not minimum requirements.\textsuperscript{62} By 1903, practices including standardized international notification of infectious diseases, first suggested in 1881, and surveillance at the local level, first suggested in 1885, were codified.\textsuperscript{63} The 1912 revision confirmed many of these principles, and updated the convention based on new scientific knowledge, even though there was still serious debate over matters such as the etiology of cholera, illustrating how far international sanitary regulations often lagged behind state-of-the-art science.\textsuperscript{64} World War I temporary halted further revisions of the international sanitary convention.


\textsuperscript{60} Huber, “The unification of the globe by disease? The international sanitary conferences on cholera, 1851-1894,” 475.


\textsuperscript{62} Ibid., 40.

\textsuperscript{63} Ibid., 44.

\textsuperscript{64} Howard-Jones, \textit{The Scientific Background of the International Sanitary Conferences 1851-1938}, 82.
The Office International d’Hygiène Publique, which was granted the authority to collect disease notifications under the international sanitary conventions, was an international rather than internationalist forum. It was a place for nations to bring their concerns rather than an attempt to create an international culture. Each country had one delegate on its advisory committee, their votes weighted according their national annual contribution. Certain empires, such as the French and eventually the British, received a second delegate spot for their colonies. While some were public health experts, they were equally likely to be career diplomats, such as Camille Barrère, French ambassador to Rome. At meetings delegates discussed potential alterations to the International Sanitary Convention and presented reports on national health information. The tiny permanent staff of the Office International d’Hygiène Publique, located in Paris, collected and distributed the disease notifications required by the International Sanitary Conventions, and put out a monthly bulletin. That was the extent of the organization’s international efforts. Although the membership of the Office International d’Hygiène Publique advisory committee was broader than the League of Nation Health Committee, they focused their energy on predominately European concerns.

The Office International d’Hygiène Publique inspired a variety of responses among onlookers. It was taken as something of a joke initially in France, where one wag remarked in Le Temps that while other countries experimented with a variety of methods to uphold the states’ responsibility to protect its citizens, “in France? In France, my God,

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it’s very simple: they call a conference.”66 Despite the initial skepticism, the Office International d’Hygiène Publique established itself as valuable component of international public health work. Raymond Gautier, of the League of Nations Health Organisation, wrote that it had “indisputable assents” including its universality, “solid political status,” and clear relationship between delegate and government. In his estimation, these strengths did little to counterbalance its ponderous, academic approach that was backed often only by diplomatic rather than technical knowledge.67 The organization was also reflective of pre-World War I assumptions about international cooperation, which many hoped to update in the wake of World War I with the founding of the League of Nations.

Institutions and the Interwar Sanitary System

After Jan Smuts inserted health into the charter of the League of Nations, most of the diplomats and public health specialists involved in setting up the new organization had assumed that the Office International d’Hygiène Publique would be transferred to League auspices in short order. This elegant solution was not to be – the French were anxious not to lose control of the organization, and the Americans, who had withdrawn from the League after Wilson’s loss at the polls, refused to allow the Office International


67 Raymond Gautier, “International Health of the Future - Confidential,” March 15, 1943, 8, Rockefeller Foundation, Record Group 1 (hereafter R F., R. G. 1., Series 100, Box 22, Folder 182, Rockefeller Archive Center, Tarrytown, New York (hereafter RAC).
d’Hygiène Publique, of which it was a member, to become part of the League of Nations, which it was not. Thus the League of Nations Temporary Health Committee, which had been created in 1921 to prepare the way for the Office International d’Hygiène Publique transfer, became the nucleus of the Provisional Health Committee, which met until June of 1924 and then the Permanent Health Committee that met until 1939.68 The Health Committee itself was part, eventually, of the larger Health Organisation, which in addition to the advisory committee also had a secretariat with staff in Geneva and was overseen by Medical Director Ludwik Rajchman. Attempts to combine or differentiate the organizations came to a head at the 1926 International Sanitary Conference, where the Office International d’Hygiène Publique retained official control of many of its traditional responsibilities, but delegated the actual administration of epidemic intelligence in much of the world to the League of Nations Health Organisation. The Office International d’Hygiène Publique also gained the privilege of overseeing and approving the League of Nations Health Organisation program, a right that had limited effect in practice. The Office International d’Hygiène Publique survived until it was disbanded, following a notorious wartime career under the supervision of the Nazis, with the founding of the World Health Organization.69

The institutional cultures of the two organizations and the disagreements between partisans of each over their prerogatives and orientations shaped international health


69 No comprehensive history of the OIHP exists, largely due to the loss of most of their files during and after World War II.
work; the League of Health Organisation, because of its broader mandate and greater openness to new ideas, had a larger effect on the direction of the interwar sanitary system. The program of the League of Nations Health Organisation was so broad that few have been able to get a handle on it. These historical legacies of the League of Nations Health Organisation have been increasingly uncovered in recent years, with Iris Borowy ably illustrating that many of the programs of the World Health Organization have their roots in the experimentation of the League of Nations Health Organisation. Borowy, the author of the only monograph-length study of the League of Nations Health Organisation, calls the organization “multi-faceted, multi-functional and also, in some ways confusing, evading any self-evident, clear-cut interpretative approach.”

Borowy, who believes that social medicine was the greatest achievement of the League of Nations Health Organisation, also argued that the League of Nations Health Organisation got such support from its association with the League, but was given more freedom because it was seen as technical. Lionel Murard argued that the three legacies of the League of Nations Health Organisation were social improvement, a focus on local program and “sensitivities of the peculiarities of local cultures.” Martin David Dubin saw the

70 Borowy, Coming to Terms with World Health, 39.

71 Ibid., 449 and 451.

League of Nations as “a co-ordinating body” that brought together strands from a worldwide community of public health workers.73

Over its two-decade existence, the League of Nations Health Organisation took on a variety of areas of work: the standardization of sera, a massive international undertaking; the collation of health and disease statistics; managing exchange trips; and to a limited extent sponsoring health research. Their standardization work and exchange trips have garnered the most attention, if only because they were perceived at the time as having the most direct effect on the work of the greatest number of medical and public health professionals.74 This dissertation focuses on the areas of disease control because this area of work provides the most direct contrast to the period before and after, and illustrates the medical, technical, and political changes of the interwar period.

The men, and they were almost entirely men, of the League of Nations Health Organisation and the Health Committee that decided its program of work were each in their own way committed to the internationalist vision of the organization, even if they often vehemently disagreed with each other over precisely what that vision should be.75

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74 Iris Borowy devotes substantial space to these committees in her institutional history of the LNHO. See also Paul J. Weindling, “Interwar Morbidity Surveys: Communities as Health Experiments,” in Facing Illness in Troubled Times: Health in Europe in the Interwar Years, 1918-1939, ed. Iris Borowy and Wolf Gruner (Frankfurt Am Main: Peter Lang, 2005), 75-128; Borowy, Coming to Terms with World Health.

75 Some women were involved in Health Organisation work. Alice Hamilton, despite her impressive background in social and industrial health, was intentionally added as a double token—American and female—to the Health Committee but rarely were able to attend meetings, like Carlos Chagas, because of the distance between Geneva and home. Dame Rachel Crowdy was involved in early anti-typhus fundraising efforts, but was ultimately more central to the founding and administration of the Social Section. Janet Lane Claypon, an employee of the British Ministry of Health, was a member of the Cancer Commission.
The men who founded the organization were old enough to have seen and been inspired by the scientific progressivism of the late nineteenth century, but still young enough to desire change.\textsuperscript{76} Most were doctors or bacteriologists, many with additional training or experience in national public health. Some, such as the Brazilian scientist and physician Carlos Chagas, were invited because of their international prominence. Others, such as Thorvald Madsen of Denmark, were continuing work they had begun at the Office International d’Hygiène Publique. Madsen won election as the chair of the Health Committee over George Buchanan because he was seen as more politically astute and the better scientist.\textsuperscript{77} While Madsen drove the program on biological standardization, another important element of Health Organisation’s work, he did not drive the course on epidemics, which largely determined the international political character of the work. The epidemic control program of the organization, and with it the organization’s character, was driven by the often fierce debates between two men: League of Nations Health Organisation Medical Director from 1921-1937 Ludwik Rajchman and long-time Health Committee delegate George Buchanan.

Ludwik Rajchman was an unlikely leader. Born into a Polish Jewish family, he had strong socialist leanings and was significantly more interested in social medicine than the bacteriology in which he was trained.\textsuperscript{78} He represented, however, a generation of

\textsuperscript{76} Anne Hardy, “Actions Not Words: Thorvald Madsen, Denmark, and International Health, 1902-1939,” in Of Medicine and Men: Biographies and Ideas in European Social Medicine between the World Wars (Frankfurt-am-Main: Peter Lang, 2008), 13.

\textsuperscript{77} Ibid., 135-136.

\textsuperscript{78} For a biography of Rajchman, see Marta A. Balinska, For the Good of Humanity: Ludwik Rajchman, Medical Statesman, trans. Rebecca Howell (Budapest: Central European University Press, 1998).
committed internationalists and allies who saw in the League of Nations a possibility for expanding the arena of international agreement and in the process, building an international system that was significantly less nationally bounded, despite the calls of the Wilsonian moment, than that which had preceded it. The fact that he headed a technical organization only aided his quest. Rajchman and his ilk may have encountered barriers to practical, on-the-ground technical cooperation, but ultimately they created a discursive and legal arena in which truly international efforts were more likely to be acknowledged.

If Rajchman was the personification of the new, more open internationalist international sanitary system, Sir George Buchanan, born in 1869 and 12 years Rajchman’s senior, was the personification of the older system Rajchman sought to replace, leading to a great deal of interpersonal tension on the League of Nations Health committee until Buchanan’s retirement and then death in 1933. Although Buchanan’s position was conservative, he did advocate several of the more novel aspects of the League program, such as an expanded global statistical repository and, most notably, the study of cancer. Buchanan was Britain’s primary bureaucratic representative in international public health work, serving as the Vice Chairman of both the League of Nations Health Committee and president of the Office International d’Hygiène Publique. Buchanan was dogged in his defense of the elder organization but remained respected on the Health Committee because of his great skill chairing meetings and his tireless

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79 Buchanan was the son of the great British public servant Sir George Buchanan, a major figure in the predecessor to the Ministry of Health, and no relation to the British ambassador to Russia of the same name. Major Greenwood, “Obituary: Sir George S. Buchanan, C. B., M. D., F. R. C. P.,” British Medical Journal 2 (October 17, 1936): 788.
devotion to international public health.\textsuperscript{80} One of the themes of this work is that individual patrons of particular strategies and understandings can strongly influence the direction of the institutions in which they work.

\textbf{Disease and Health in the Interwar Sanitary System}

One of the most important changes during the interwar period was the expansion of the understanding of what constituted an epidemic of international concern. The nineteenth century sanitary system had settled on only a handful of diseases that required international control – cholera, yellow fever, smallpox and plague. Between the wars, the Health Organisation’s international public health specialists developed an expanded definition of international epidemics, taking note of new diseases that fit into the mold provided by the notifiable diseases of the nineteenth century, in addition to social diseases that had not previously been considered of international import.\textsuperscript{81} In fact, this dissertation, while primarily a study of epidemic control, illustrates how the definitions of epidemic and health shifted dramatically in the interwar period, which required international public health specialists to develop and adopt new strategies of disease control and health promotion to keep pace with their new conceptual framework.

\textsuperscript{80} Ibid., 788-789.

The Health Organisation’s greatest international impact was on pushing for the recognition of social diseases as a matter of international interest. A number of scholars have recognized the work the League undertook in this area. Work on tuberculosis, malaria, and cancer challenged the bacteriological paradigm of older epidemic control and recognized the increasingly important role played by “diseases of civilization” in the twentieth century. The League, with the exception of George Buchanan, had limited interest in several traditional concerns of social medicine, most notably sexual diseases. When the League of Nations Health Organisation was invited to join L’union internationale contre le peril vénérien, Health Committee member Albert Calmette declined the offer in large part because he was unclear what type of international action could stop which he saw as a matter of personal prevention.

Alongside their increased attention to social medicine, the policy makers at the Health Organisation adopted increasingly multi-causal explanations of disease. This new orientation led to new combinations of strategies being deployed to address diseases, such as malaria and tuberculosis, and also helped pave the way for post-war epidemiological research. The League helped steward pioneering research into the epidemiology of cancer, examining environmental, hereditarian, and biological explanations of the disease. Two of their main statistical consultants, Major Greenwood and Janet Lane-Claypon, pursued pioneering statistical techniques that prefigured the


83 Albert Calmette to Ludwik Rajchman, March 23, 1923, 12B/25607/11346, LON.
more complicated statistics of postwar epidemiology. This broad approach to disease was reflected in the strategies recommended by the experts at the Health Organisation.

**Strategies of Disease Control**

The new institutional arrangements of the interwar period as well of the new diseases coming into the international field meant that the League of Nations Health Organisation and the sanitary system in general had to adopt a broad range of strategies. Many of them, including quarantine, epidemic notification, and sanitationism (cleaning up infected environments), would have been familiar to their nineteenth-century predecessors. Others, such as surveillance, expanded epidemic intelligence, social medical approaches, and the hope for a magic bullet medical cure, would have been less so. Despite Rajchman’s campaign for an interventionist service, international public health specialists and their associated diplomats adopted strategies that were based on controlling the flow of information between states rather than intervening directly in them. These controls took the form of collation, of transmission, and of standardization. These techniques were employed to track, prevent, and control diseases in large population groups, not primarily at the individual level. Despite the relative political safety of the information-based approach, a hard-won battle considering that in the nineteenth century most disease data had been regarded as almost a state secret, the

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League of Nations Health Organisation pushed to be involved in on-the-ground medical and prophylactic strategies as well. The League of Nations Health Organisation experience confirms that there was no simple dichotomy between quarantinists who sought to control the movement of people and sanitationists who preferred to clean up environments.  

Older models of disease control, such as quarantinism and, more importantly, what Peter Baldwin calls “neo-quarantinism” – a combination of inspection, disinfection, notification, isolation and reporting of infected passengers on ships, remained a vital part of the interwar international sanitary system. Quarantine – the sequestering of ships or passengers feared to have been exposed to disease – was one of the most effective yet also most controversial disease control strategies of the nineteenth century. Quarantinists hoped to break the chain of transmission of disease by halting movement until it could be assumed to be safe. Quarantines were rarely employed alone; for instance, in Prussia quarantine was combined with sanitationist measures to protect against cholera. In addition to the personal costs associated with quarantine, the economic costs were also very high – ships stuck in quarantine could not generate money, and shipping companies were more likely to deal with ports that were more open.

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85 Baldwin, *Contagion and the State in Europe, 1830-1930*, 563.
86 Ibid., 155.
87 Ibid., 4.
88 Ibid., 53.
89 Ibid., 62.
Debates over quarantine – both its efficacy and cost – had been fierce across Europe in the nineteenth century, and indeed one goal of the International Sanitary Convention was to dictate maximum quarantine periods. The British, despite their shorter relative history of quarantine and relatively lenient rules, were regarded internationally as a nation that imposed strict quarantine regulations on foreign ships entering their ports.\textsuperscript{90} The British, who wanted shorter quarantine abroad, had problems because their colonies were not under uniform quarantine rules, making their international bargaining position weak.\textsuperscript{91}

The British, did, however, lead the way in neo-quarantinism, which relied on quarantine supplemented by reporting, inspection, and disinfection.\textsuperscript{92} Thus borders, which as Allison Bashford notes were never more than “a set of practices on the ground”, began to shift into boundaries made of several types of practices.\textsuperscript{93} Quarantine never really disappeared. What happened, however, in the twentieth century, was the transition from an “absolute (quarantine) border to a relative (surveillance) border.”\textsuperscript{94} In some cases, this approach meant keeping passengers under surveillance: they would be released in their destinations if they promised to check in with health authorities during the course

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\begin{enumerate}
\item Ibid., 92 and 114.
\item Armand Rueffer to Lord Cromer, May 17, 1900, 1-2, MH 19/278, The National Archives, Kew, United Kingdom (hereafter TNA).
\item Baldwin,\textit{ Contagion and the State in Europe, 1830-1930}, 141 and 153-154.
\item Zylberman, “Civilizing the State: Borders, Weak States and International Health in Modern Europe,” 32.
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of the incubation period of the disease to which they had been exposed. More important in the shift away from quarantine, however, was an increased focus on information sharing in order to limit the number of necessary quarantines.

Other older practices remained an important part of epidemic control, and were often reinterpreted for new conditions. In the nineteenth century, sanitation work had been considered to be the purview of national or local governments. At ports, disinfection had been the responsibility of shipping companies, who usually contracted out to companies specializing in either deratinisation or deinsectization or both. These activities became increasingly regulated under the international sanitary conventions. Sanitation work did come into international play after World War I, where the Red Cross and other volunteer relief organizations provided basic care and basic sanitary measures in the wake of war, but only to war-ravaged populations.95 The League of Nations helped convince Western governments to provide sanitary aid to Russia, Poland, and Greece. This represented a new area in international aid, although it caused tension because it involved trespassing onto what had previously been considered the territory of sovereign states. The targeted deployment of disinfection units was never formalized in international agreements, but became an accepted if unusual international intervention in extreme cases. The League oversaw international disinfection teams in Poland, Russia, Greece, and later in China.

Epidemic intelligence was vital to disease control and became the center of the League of Nations’ anti-epidemic efforts for political and practical reasons. The League of Nations Health Organisation hoped to serve as the center of a system in which countries would report on the location and movement of major epidemics and would share that information globally to prevent transmission. The experience in Eastern Europe had illustrated how vital good epidemiological data could be – knowing where disease outbreaks were and how they were moving allowed public health specialists to devise control strategies including setting up quarantines, directing disinfection units, and even vaccinating vulnerable populations. Before the League of Nations Health Organisation created its Epidemic Intelligence Service, there was limited international exchange of epidemic data. National politicians feared sharing internal data that might compromise their trade relationships or reflect poorly on their public health system. Furthermore, there was no comprehensive international agreement on how these data were to be collected. Existing structures only captured data that were of interest to Europe. The Health Committee, Buchanan excluded, wanted to create an organization that would collate global data and be responsive to changing epidemic conditions in a way that the older notification laws never achieved. Over the course of the interwar period, information gathering became less of a means to support international epidemic control measures on the ground and more an end in itself.

Convention-based notification of epidemics remained an important part of the international system. The Office International d’Hygiène Publique collected information on only smallpox, yellow fever, plague, and cholera and did not want to give up its
position as the main purveyor of health information. Officials there were persuaded in 1926 to add typhus to the list of diseases that required official notifications. The League of Nations Health Organisation encouraged the use of new technologies such as radio and the telegraph to become part of the legal structure. They also negotiated for direct notifications between the League of Nations Health Organisation and national health ministries rather than requiring information to be sent through diplomatic channels. They also encouraged local regions to develop a list of additional notifiable diseases based on local epidemiological conditions, which were often included in League bulletins. Thus, the League of Nations Health Organisation also became a clearing house for information about diseases not covered by the conventions, sending weekly updates that often included more diseases and their trajectories than the Office International d’Hygiène Publique notifications. Despite this compromise, the rivalry between the organizations and their differing models of international cooperation hindered cooperation throughout their co-existence.

The League of Nations Health Organisation expanded not only the collection of international epidemic intelligence, but of statistical information on health generally. Disease notifications alone, while important, left international health workers with many questions about the broader patterns inherent in epidemics. While the nineteenth century witnessed the rise of statistical thinking and particularly found itself linked with the rise of the welfare state, the twentieth century saw that avalanche of numbers overflow
national borders and become a matter of international concern. 96 Ian Hacking further elucidates a sharp change between 1820 and 1840 when, in what he calls the avalanche of printed numbers, governments attempted to improve their statistical knowledge of their populations in order to improve social conditions and even the quality of the population. 97 Often these statistics were used to compare international figures not in an attempt to improve conditions locally, but to laud or embarrass the government in charge. 98 The League of Nations Health Organisation embraced this vision wholeheartedly. Advocates of epidemic intelligence at the League of Nations Health Organisation believed they needed better, standardized mortality statistics to fight illnesses, data they hoped would provide them with information about the movement of diseases and their prevalence. 99

The League of Nations Health Organisation took on several responsibilities related to the field. The first was taking over from the Office International d’Hygiène Publique the revision of the international cause of death list, which was supposed to provide standardized, comparable statistics from a variety of countries. The International Causes of Death List was adapted from the Bertillon system in Paris in 1893 and became a cornerstone of international statistical cooperation. 100 Although compliance with the

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98 Ibid., 284.


international cause of death depended both on national infrastructure – for a time the USSR refused to count population centers with fewer than 10,000 people – and personal pride – countries with confidential reporting had higher reporting rates – it provided an international statistical model.\(^{101}\) In addition to the International Cause of Death List, the Health Organisation statisticians produced weekly, monthly, and annual reports that provided a snapshot of world health.\(^{102}\) Statistical analysis at the League also began to lead toward the birth of modern epidemiology postwar. The Epidemic Intelligence Service staff encouraged the collection of statistics and their analysis. They also encouraged the collection and analysis of statistics of non-infectious diseases, allowing for greater international collaboration.

Few attempts had been made by older international organizations to collate disease statistics generally. They lacked the resources to collect more information or to compile statistics. The League of Red Cross Societies had a great interest in compiling statistical data, but also lacked resources. The Belgian health committee representative Otto Velghe believed that the League of Nations Health Organisation would also have to be careful not to infringe on the League’s own statistical service. Velghe further reminded the committee that under current arrangements epidemic notifications had to travel via diplomatic channels and those same diplomatic offices frequently had reasons to hide their information. Velghe suggested the League enquire into attempting to get information directly from ministries of health or through other “semi-official” channels in

\(^{101}\) Ibid., 141.

\(^{102}\) Ibid., 139.
order to track the epidemics. This suggestion was controversial. Italian representative Alberto Lutrario derisively called it unreliable “sanitary espionage.” Buchanan said that such a process would be cumbersome and probably contravene the existing International Sanitary Convention. Characteristically protective of the Office International d’Hygiène Publique privileges, he objected to “bureaucrats in Geneva” collating the data as opposed to experts. Despite Buchanan’s objections, the Epidemic Intelligence Service took on the dual role of collecting epidemic information and more general statistics, which were collected outside of the purview of the international sanitary conventions, for most of its existence. This attention to data gathering illustrates the shift away from controlling individual bodies in international health and towards attempting to manage larger populations.

The public health specialists and diplomats involved in shaping the international sanitary system, building on these population-based techniques, looked to more interventionist ways to prevent disease across broad populations. When vaccination against smallpox became possible in the nineteenth century, the search for other vaccines began. Despite the promise of vaccination, it proved a controversial technology, with many across Europe arguing that vaccination was seen as potentially dangerous and an


104 Ibid., 20-21.

unfair intrusion, when compelled by the government, into the bodies of the citizenry.\textsuperscript{106} Despite the controversies the technique engendered, vaccination seemed to offer the hope of preventing the transmission of disease, and so the subject became a hotly debated topic at international sanitary conventions. As noted above, the discussion centered on cholera vaccines for Hajj pilgrims, perhaps acknowledging the delicate nature of the technology and illustrating a willingness to impose more interventions on non-European travelers. Later typhus and yellow fever vaccines proved controversial, as well as difficult to administer, even as the medical professionals were excited by the possibilities they presented for disease prophylaxis. The efficacy of new vaccines pushed public health specialists worldwide to consider interventions that targeted and prevented specific diseases. Specialists also approved of vaccines because partial vaccination of the population could often provide protection to the rest in certain outbreaks.

To some extent, the League of Nations Health Organisation also advocated medical approaches, including drug therapy and radium therapy, although the members of the Health Committee and the Commissions struggled to find a way to address what often amounted to clinical interactions at the international level. Consequently, many issues related to drugs, such as the standardization of biological sera, were transferred to the Commission on Biological Standardization, and the Health Organisation became a site of standardization and normalization for many drugs, if not a site of actual regulation of them.\textsuperscript{107} The members of the Health Committee and the Malaria Commission became

\textsuperscript{106} Baldwin, \textit{Contagion and the State in Europe, 1830-1930}, 284 and 312.

\textsuperscript{107} For more on the standardization work of the Health Organisation, see Borowy, \textit{Coming to Terms with World Health}, 143-159.
increasingly interested in drugs in the later years, addressing issues of drug cost and availability and even sponsoring research into quinine substitutes. Although the staff of the Health Organisation had difficulty identifying medical projects to control disease in which they could be involved, a desire ran through many of the commissions to locate a simple, targeted, and cost-effective solution to combat specific diseases on the order of Paul Ehrlich’s salvarsan and other emerging therapies. Magic bullets, in the era before antibiotics, remained elusive, which partially explains the multi-strategy approach to public health and disease control that the Health Organisation specialists advocated.

The variety of often-competing strategies that the staff of the League of Nations Health Organisation and their partners explored was a direct response to the variety of disease conditions faced around the world. The League of Nations Health Organisation and its epidemic control program were complex, sprawling, and often internally contradictory. The members of the Health Committee built their program around a series of inherent tensions. Their organization existed because national leaders recognized that technical problems, such as matters of health, required technical solutions, and required the state to turn to experts to guide it. The public health specialists combined, at times uneasily, bacteriological and environmental understandings of disease in their attempts to control epidemics. The leadership of the program and their national partners could never fully decide whether their ultimate purpose was to prevent the spread of diseases internationally or to promote health without regard to national borders. Over the more than twenty-year existence of the League of Nations Health Organisation, its supporters
tried to balance these tensions in response to changing political, technological and epidemiological realities with a relative degree of success.

**Outline**

This dissertation proceeds as a chronological study of the activities of the League of Nations Health Organisation with each chapter focusing on a particular set of diseases and strategies that shaped the development of the institution. Chapter 1 explores the earliest days of the Health Organisation. Faced with the typhus pandemic in Eastern Europe, Rajchman advocated a form of direct attack, in which an international coalition would enter Russia and attack the epidemics using sanitation, vaccination, and delousing at their source. Rajchman’s project failed, causing most practical health work to be undertaken within and not across national borders.

Chapter 2 examines the attempt to revise the International Sanitary Convention in 1926. Although this revision did not undermine the basis of the sanitary system – that international norms had no jurisdiction outside of the ports of a nation – it changed the practices of international epidemic control significantly. The revision integrated new regions and new practices from those reasons, particularly Asia and the Americas. Most importantly, the new convention emphasized the importance of information sharing and led to increased international exchange of disease information.

Chapter 4 examines the history of the League of Nations Health Organisation’s disease commissions. These commissions greatly expanded the number of diseases
subject to international collaborative control and cemented the organization’s interests in the social and environmental roots of health. This chapter explores how the League of Nations Health Organisation confronted the difficulties inherent in combating complicated and regionally construed diseases from the international level.

Chapter 5 illustrates how, spurred on by the Great Depression, national and international public health workers continued to expand their working definition of health in the 1930s. Even in times of tight budgets, national governments accepted many of these new programs in nutrition and housing because policy makers believed they would improve the national health and national economic productivity. Chapter 6 illustrates how World War II made even this limited cooperation untenable, as nations retreated into alliances and decided that the epidemic data they had so freely shared posed a security risk.

Chapter 7 explores the debates that took place over the founding of the World Health Organisation. Two important choices by the organization’s founders changed the path of post-World War II international health. First, the World Health Organisation’s founders consciously removed themselves from political discussions and hence support, and in so doing sacrificed the broad definition of health they had come to promote. Second, they turned increasingly to magic bullet strategies, including vaccines and antibiotics, which limited the scope of the work of the organization and represented the temporary triumph of a bacteriological understanding of disease over the League of Nations Health Organisation’s favored environmentalist approach. The Conclusion examines this development in more detail and explains how the system first dreamed of
Chapter 2: Epidemic Control, Relief, and Direct Attack in Europe, 1920-1924

In August 1920, Ludwik Rajchman, freshly installed as the medical director of the League of Nations Health Organisation and newly returned from Moscow, stood before the assembled Health Committee with an extraordinary map that he hoped revealed the future of health cooperation in Europe. This map of Eastern Europe, particularly Poland and Russia, was filled with information on quarantine stations, migration routes, and the incidence of epidemic typhus. Rajchman reminded the committee that before his exploratory trip to Moscow, the map had been blank beyond the Polish border.¹ Although this map no longer survives, it illustrated the League of Nations Health Organisation’s ambitious epidemic control program. Although epidemic control had previously been seen as a defensive struggle, the League of Nations Health Organisation proposed attacking epidemics at their source, which required foreigners to enter sovereign states to gather data and help control disease.² Despite some initial


² Previously, official foreign intervention had only come in colonial settings, such as when Britain attempted to improve the infrastructure in India following various cholera epidemics in the nineteenth century. Norman Howard-Jones, The Scientific Background of the International Sanitary Conferences 1851-1938, History of Public Health 1 (Geneva: WHO, 1975), 31.
international support for this scheme, future maps would show a different form of
international health cooperation, one based primarily on information exchange, but that
exchange was possible only because of the bold attempts to foster international
cooperation in typhus control.

Many epidemics erupted during the collapse of the Russian Empire, the ensuing
Civil War (1917-1923) and the Russo-Polish War (1919-1921) that collectively displaced
hundreds of thousands.\(^3\) This situation was further complicated by the expansionist
foreign policy of the new Polish state and the tense relationship between Russia and the
rest of Europe.\(^4\) In the wake of this chaos, refugees and prisoners of war carrying
cholera, typhoid (a communicable fever), and most seriously typhus (a louse-borne fever)
poured over the Polish border, testing the limits of the newly formed state. In Russia
alone there were over twenty million cases of typhus between 1918 and 1922. This
outbreak killed as many as three million people in Eastern Europe and threatened to move
westward, provoking acute international concern.\(^5\)

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\(^3\) Marta A. Balinska, “Assistance and Not Mere Relief: the Epidemic Commission of the League of
Weindling (Cambridge: Cambridge University Press), 82. Balinska provides the most in-depth account of
League intervention in the Eastern European typhus epidemic.

\(^4\) For more on the geopolitical situation surrounding these epidemics see Thomas C. Fiddick, *Russia's
Retreat from Poland, 1920: From Permanent Revolution to Peaceful Coexistence* (London: MacMillan,
1990); Piotr S. Wandycz, *France and Her Eastern Allies, 1919-1925: French-Czechoslovak-Polish
Relations from the Paris Peace Conference to Locarno* (Minneapolis: The University of Minnesota Press,
1962).

\(^5\) Patrick Zylberman, “Civilizing the State: Borders, Weak States and International Health in Modern
Europe,” in *Medicine at the Border: Disease, Globalization and Security, 1850 to the Present*, ed. Alison
The epidemiological crisis in Eastern Europe provided a laboratory for experiments in international cooperation. Supporters of the League of Nations, sensing both an international threat and an opportunity to illustrate the value of their new institution, adopted the epidemics of Eastern Europe as a project that would demonstrate the benefits of practical internationalism. They advocated a coordinated, official, and government-funded international response that differed from older models of charitable relief. In 1920 the League Council approved the creation of the Typhus Commission, later renamed the Epidemic Commission. Between 1920 and 1924, when the League of Nations Epidemic Commission operated in Poland, Russia, and Greece, the commissioners and their superiors in Geneva faced problems of finances, obstructive governments, and feuding among non-governmental organizations. This state of organizational flux nonetheless allowed the Epidemics Commission a freedom of action that was not sanctioned later.

The dire conditions in Russia allowed an interventionist agenda to take hold temporarily. The League of Nations Epidemic Commission pushed for states to provide funds for work in at the root of the problem in Russia. This “direct attack” on epidemics was new in international disease control efforts. Although the full interventionist program was never funded and carried out, the fact that European diplomats came so close to doing so illustrates how unsettled the direction of the international system was in this period. As the crisis passed, the international epidemic control system normalized into one that emphasized international consultation and cooperation over on-the-ground interventions.
The fervent debate over the existence of the League of Nations Epidemic Commission is surprising given that most of the funds for relief were actually provided by other organizations that were operating in Poland before the League of Nations Epidemic Commission was created. Even Rajchman called the material contributions of the League of Nations Epidemic Commission “insignificant” next to the American Relief Administration’s millions of dollars of laboratory supplies, hospitals, and food. This fact suggests that debates about the League of Nations Epidemic Commission were as much over international entanglements as they were about typhus control itself, and about whether international intervention should be economic, political, social, nutritional, or medical.

The League of Nations Epidemic Commission demanded a new model of international relief funded by unconditional government grants. The epidemic control efforts that the commission advocated were caught between older models, which attempted to control individuals, and new population level controls, which focused on sharing data and trying to attack epidemics at the source through improved social conditions. This program succeeded only partially in the tense international atmosphere of the early 1920s. The partial success of the program is attributable to the rhetoric Rajchman and many of his supporters used to convince states to participate. By publically casting work on epidemics as a technical and humanitarian issue, governments

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were able to work across political lines with greater freedom. Despite the rhetoric, all of the participating powers used their cooperation in relief to achieve political and economic ends.

The Epidemics Commission and Eastern Europe

After World War I, Eastern Europe was in crisis. World War I, the Russian Civil War and the Russo-Polish war continued to disrupt agriculture, economic activity, and settlement in the region, resulting in a humanitarian disaster. The American Relief Administration’s annual report included the observation that there were actually “four entirely different relief problems in Russia,” which included famine relief, diseases due “in part to famine condition and in part to the general deterioration and lack of medical and sanitary work,” poverty, and reconstruction. A drought in 1921, compounded by the retreat of occupying armies, who had maintained some relief efforts, made the situation even more dire. Refugees crowded across the Polish border, often in numbers that exceeded agreements between the two states. The crisis was so acute that some observers, among them Rajchman following his Moscow visit, feared that the new Soviet

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government would collapse in the face of the disorder caused by the disasters.\textsuperscript{11} In fact, during 1921 and 22, more people died of disease and famine than had died during World War I and the Civil War combined.\textsuperscript{12}

Disease was a particular problem; historian Patrick Zylberman estimates that between 1914 and 1923 there were 30 million cases of typhus, dysentery, malaria, tuberculosis, and cholera in Russia, which resulted in 3 million deaths.\textsuperscript{13} David K. Patterson estimates that 2-3 million deaths were caused by typhus alone.\textsuperscript{14} Typhus, a fever disease, caused by a bacterium carried by lice, caused special concern because of how easily it was transmitted and how virulent it could be. Typhus causes high fevers, respiratory problems, body pains, a rash, and, in severe cases, delirium.\textsuperscript{15} Poor sanitation bred the disease, which usually appeared in crowded railways, prisons, or hospitals.\textsuperscript{16}

Typhus, like the armies and refugees that carried it, did not respect national boundaries. Serbia experienced a particularly severe outbreak during World War I. German-controlled areas fared slightly better, but most of Eastern Europe had significant outbreaks.\textsuperscript{17} These epidemics continued into the 1920s, especially in Poland and Russia.

\textsuperscript{11} Balinska, \textit{For the Good of Humanity: Ludwik Rajchman, Medical Statesman}, 59.
\textsuperscript{13} Zylberman, “Civilizing the State: Borders, Weak States and International Health in Modern Europe,” 31.
\textsuperscript{14} David K. Patterson, “Typhus and its Control in Russia,” \textit{Medical History} 37 (1993): 361.
\textsuperscript{15} Ibid., 372.
\textsuperscript{17} Balinska, “Assistance and Not Mere Relief: the Epidemic Commission of the League of Nations, 1920-1923,” 81-82.
(in the process of forming the Soviet Union). As late as 1923, the author of one League report somberly advised readers that “several millions of this population cannot be saved because, even if funds were available, the transport facilities of Russia would not permit of sufficient grain being distributed throughout the area.” 18 The situation was complicated by infrastructural and administrative failings, which allowed the epidemic to spill beyond Russia’s borders into neighboring countries.

Both the Russian and Polish governments took steps to control the epidemic. The Soviets focused on lice control techniques, including shaving the heads of people exposed and treating their belongings and bodies with kerosene and benzene to kill the lice. They also isolated patients. 19 The Warsaw government took a number of aggressive steps to attempt to control the epidemic and prevent it from further entering Poland. The Polish government founded the State Institute of Hygiene under Ludwik Rajchman in 1918. 20 In addition to delousing those entering the country, in 1920 the Polish government created a special epidemic section that focused on typhus but also addressed dysentery and cholera. Rajchman and his team pushed a policy that combined border defense, education, and vaccination against cholera and enteric fever. 21 Despite their best efforts, typhus continued to enter the country, causing the Polish government to seek

19 Patterson, “Typhus and its Control in Russia,” 380.
external aid, warning that if typhus was not stopped there, the disease would spread to Western Europe.\textsuperscript{22} The outbreak activated older fears in Western Europe about the importation of pestilential diseases from Russia, especially plague and influenza, making policy makers in the west anxious.\textsuperscript{23}

Typhus was not the only contagion against which a \textit{cordon sanitaire} was erected in the East. Many viewed Poland as the last line of defense against Bolshevism, which affected how the Polish request was received. Such rhetoric rarely appeared in official publications, but it did appear in private correspondence. T.C. Fitzhugh, one of the League of Red Cross Societies’ commissioners, told Dame Rachel Crowdy he wanted to continue his part in the anti-epidemic work to further British interests. He wrote that “Bolshevism cannot last, and that British interests in the Russia of the future are so vital, possibly ending in an alliance to stretch from Lands Ends to Vladivostok and so with France to paralyze Germany, that anything one can do to counteract the impression prevalent in so many Russian minds that England has ‘let them down’ is all to the good.”\textsuperscript{24} The association lingered between communism and typhus in the minds of many Western diplomats, adding another layer of conflict to the negotiations over typhus control.


\textsuperscript{23} For more on fears of Russian contagion, see David K. Patterson, \textit{Pandemic Influenza 1700-1900: A Study in Historical Epidemiology} (Totowa, NJ: Rowman and Littlefield, 1986), 84-84; Peter Baldwin, \textit{Contagion and the State in Europe, 1830-1930} (Cambridge: Cambridge University Press, 1999).

\textsuperscript{24} T.C. Fitzhugh to Rachel Crowdy, July 3, 1921, 1, 45/13989/6037, LON,
The West was therefore sympathetic to Polish requests because of the desire to stem the tide of communism and the fear of an invasion of typhus. Initial international attempts to aid the Polish government attempt to control typhus took place in the context of broader relief efforts. Relief was a growing international obligation, one that was being debated within governments and non-governmental organizations. While benevolent societies had originally stepped forward to care for refugees, prisoners of war, and war victims, government and international agencies became increasingly important in the interwar period. These bodies had their own models for international relief, many of which were hotly contested. These organizations differed on whether aid should come from public or private sources, and which of the myriad humanitarian issues – migration, disease, famine, or economic turmoil – should be addressed in the future, foreshadowing debates in the 1940s and 1950s about the proper scope of development. The radical nature of the League of Nations Epidemic Commission program is best understood within the context of this experimentation in international relief.

The League of Red Cross Societies, the American-led offshoot of the older Comité International de la Croix Rouge, was the first international body to address the epidemics directly. The leadership of the League of Red Cross Societies was embroiled in conflict over the proper scope of relief with the leadership of their parent organization, the Comité Internationale de la Croix Rouge, the original Swiss-founded umbrella for Red Cross societies, whose leaders wanted to continue to limit the organization’s purview

to the aid of prisoners of war and the preparation of ambulance services for the next armed conflict. Supporters of the League of Red Cross Societies put forward the view that the extensive nature of modern warfare made all humanitarian consequences of conflict, for civilians and military personnel alike, the proper purview of relief organizations. Therefore, the organization interested itself in coordinating national Red Cross societies in broader humanitarian efforts. The Red Cross societies relied on private donations and remained strictly neutral.

As part of this expanding mission, the League of Red Cross Societies had sent a Commission of Enquiry to Poland in 1920, but any plans the commissioners had to manage epidemic control measures were thwarted by the Polish response. The League of Red Cross Societies had expected to enter Poland and impose their agenda. The Poles were convinced of their own abilities, and, in the words of Colonel Henry A. Shaw, adjunct commissioner of the League of Red Cross Societies mission to Poland, “wanted material assistance and not advice.” Coupled with the continuing Russo-Polish war, Shaw was skeptical of the prospects for a successful anti-epidemic campaign until the war was over, because Poland lacked the fuel to properly run delousing centers and basic sanitation had been disrupted by the conflict. The mission also faced international problems in Poland, because the staff of the Office International d’Hygiène Publique

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26 Ibid., 23.

27 Henry A. Shaw to Linsly R. Williams, May 4, 1920, 2, RF, RG 1.1, Series 789, Box 2, folder 11, RAC.
objected to other organizations’ involvement in quarantine activities.\textsuperscript{28} Faced with these institutional pressures in addition to the scale of the epidemics, the leadership of League of Red Cross Societies, despite their attempts to expand the organization’s relief efforts, ultimately decided that the epidemic situation in Poland was beyond the ability of their organization to manage.

Different organizations attempted to address various aspects of the crisis, convinced that stabilizing other basic aspects of social and political life would improve the general situation. Food shortages, caused by blockade, occupation, and agricultural disruption, had been common in Europe during and after the war, and Russia experienced a serious famine starting in 1920. Woodrow Wilson and Herbert Hoover “put their faith in food” to provide stabilization to the region and improve general wellbeing. Hoover’s American Relief Administration was the largest supplier of aid to Eastern Europe, after tense and protracted negotiations with the Bolshevik government. The American Relief Administration, although it benefitted from preferential US government treatment and large amounts of government loans, was officially run as a private charitable organization, modeled on Hoover’s earlier food relief work in Belgium.\textsuperscript{29} Hoover himself believed that the scale of the disaster required government involvement but that the political situation in the United States would not allow that involvement to be overt or


\textsuperscript{29} Weissman, \textit{Herbert Hoover and Famine Relief to Soviet Russia: 1921-1923}, xi and 192.
without promises of repayment.\textsuperscript{30} In Poland after World War I, the American Relief Administration’s food program provided food for 400,000 children daily and secured some sanitary aid but had limited impact on epidemics, in part because they failed to establish a sanitary cordon.\textsuperscript{31}

The refugee crisis, intimately connected to problems of famine, dislocation, and disease, birthed a third model through the work of Norwegian explorer turned humanitarian Fridtjof Nansen. Hoover, who wanted a separate commission to address refugees specifically, proposed the commission for which Nansen would ultimately receive a Nobel Peace Prize.\textsuperscript{32} Nansen Help, his organization, negotiated for the return of prisoners of war as well as participating in general relief activities. Nansen took the title of League of Nations High Commissioner for refugees and like the League of Red Cross Societies relied heavily on private donations, although he and his staff availed themselves of the League of Nations’ name and some administrative support from the secretariat.\textsuperscript{33} In this way, the organization was nearly the opposite of Hoover’s, which distanced itself in name from official bodies, while courting effective government sponsorship.

Although Nansen was keenly aware of the health problems created by mass migrations, and frequently alerted the League to their dangers, his staff could not


\textsuperscript{31} Balinska, “Assistance and Not Mere Relief: the Epidemic Commission of the League of Nations, 1920-1923,” 93; W. T. Layton to Eric Drummond, April 20, 1920, 12B/4070/1719, LON.

\textsuperscript{32} Michael Marrus, \textit{The Unwanted: European Refugees in the Twentieth Century} (New York: Oxford University Press, 1985), 85.

\textsuperscript{33} Ibid., 88.
undertake health work on top of their already challenging mandate. Nansen’s project attracted inconsistent League support because he, like Rajchman, proposed, in the words of Michael Marrus “grandiose plans” that seemed to over-reach the young organization’s purview, even though his Nansen passport for refugees stands as one of the great international inventions of the interwar period.  

Older and newer models of international aid seemed inadequate to the challenge posed by the epidemics. Charitable donations were not able to cover the costs involved, while no existing non-governmental organization had the resources or legitimacy to oversee the sensitive negotiations required by the international epidemics. A small international conference on general European health took place at the British Ministry of Health in July 1919, but the assembled experts drew no general conclusions. At the League of Nations Assembly’s first session, Rajchman and Polish Prime Minister Ignacy Paderewski appealed to the international community for aid on the grounds that the epidemic was worsening. The international threat of the typhus epidemic led the British to convene a second conference at the Ministry of Health in London on April 14, 1920 that aimed to develop a plan to address the epidemic and to set a course for the health program of the League of Nations, which had been envisioned since before the League’s founding. The conference ultimately declared that the nascent League’s Health Organisation, so far only discussed in general terms, should take responsibility for

34 Ibid., 90.
treating the typhus epidemic.\textsuperscript{36} The League of Red Cross Societies and the Office International d’Hygiène Publique thought that the problem went beyond the capabilities of voluntary action, and that the League of Nations was the “sole organization sufficiently strong and authoritative to secure that the measures required are taken.”\textsuperscript{37}

The program that the conference delegates suggested the new organization undertake was conservative. The conference suggested that the League support the Polish government’s “elastic” efforts at hospital building, disinfection, and quarantine through the supply of £3.25 million in the form of materials, personnel, and the extension of the systems to surrounding areas and the creation of the League of Nations Epidemic Commission. The Council confirmed these motions on May 19\textsuperscript{th}, appointing British officials John Kenyon Vaughan-Morgan as the Chief Commissioner and Norman White as Medical Commissioner, along with Rajchman. The League asked its members to supply at least £2 million in aid, with the remainder coming from voluntary organizations.\textsuperscript{38} Rajchman was a controversial pick. The League of Red Cross Societies commissioner Sir David Henderson complained of Rajchman’s “disturbing” attitude early on, complaining that Rajchman claimed authority over relief workers, hospitals, and to be a commissioner of the League of Nations prior to his official appointment.\textsuperscript{39} Despite the early friction over Rajchman, the growing epidemiological crisis and his


\textsuperscript{37} Ibid., 4.

\textsuperscript{38} Ibid., 5.

\textsuperscript{39} Henderson to Drummond, 12th July 1920 (telegraph), 1, 12B/5479/1719, LON.
intense involvement in local public health meant that he greatly shaped the League mission to Eastern Europe. In recognition of the work, and his ongoing connection to many in the West, was named Director of the League of Nations Health Section in August 1921, adding to his ability to shape international health policy.\(^{40}\)

Outside intervention remained controversial even after the conference. Although the staff of the major international relief organizations acknowledged that typhus was present, they debated whether the outbreak represented a foreign invasion or the worsening of an endemic menace. Building on past international sanitary practice, a consensus developed that the foreign invasion of disease was a cause of international concern, while an endemic disease would not require international action. These beliefs dictated the policies of the institutions toward providing aid to Eastern Europe.\(^{41}\) Those who labeled typhus an external threat occasioned by wartime migrations called for international involvement. The staff of League of Nations Health Organisation, which firmly advocated outside aid, claimed that “the war on Polish territories since 1914 is responsible for epidemics.”\(^{42}\) Representing the other side was Edwin R. Embree, a Rockefeller Foundation representative who wrote that typhus was endemic to Poland and the disease was therefore no more serious than measles in England and the United States. Because of typhus’ relationship to the poor economic conditions and ongoing war in


Poland, any attempt to destroy the reservoir of typhus was “doomed to disappointment and failure” because Poland’s major need was for medical infrastructure.\footnote{Edwin R. Embree, “Typhus in Poland: Memorandum prepared by Edwin R. Embree in Consultation with Colonel Shaw and Colonel Long of the League of Red Cross Societies and Colonel F.F. Russell of the International Health Board After a Ten Day Visit to Craw, Lemberg and Warsaw and a rapid motor-tour of South and East Poland,” October 26, 1920, 1, RF, RG 1.1, Series 789, Box 2, folder 11, RAC.} In reality, the situation on the ground seems to have fallen between the two extremes. Typhus became more prevalent and deadly over the course of World War I and the Russo-Polish wars. In a confidential letter to Wickliffe Rose, head of the Rockefeller Foundation’s International Health Board, even Rajchman acknowledged that if the epidemic program was not carried out that the “‘black death’ will not indeed over-run Europe,” but he also maintained the risk that such “endemics” (an interesting choice of term) would run out of control and economic problems would worsen.\footnote{Ludwik Rajchman to Wickliffe Rose, February 18, 1922, 3, RF, R.G. 1.1, Series 100, Box 20, Folder 164, RAC.}

In this unsettled international atmosphere, League supporters feared that the political costs of intervening might be too high for the fledgling organization to bear. The British representative to the Health Committee, George Buchanan, worried that if the actions proved unpopular, they could harm the League as whole. He was also concerned that any appeal to members for funds would have no grounding principle behind it. While he called the desire to help Eastern Europe “noble”, he was not sure that either humanitarian grounds or the idea of providing international insurance could justify the request to fund “so great an innovation in international practice.”\footnote{George Buchanan, “International Assistance to Poland,” May 5, 1920, 12B/4456/1719, LON.} Dame Rachel Crowdy, a fervent advocate of League involvement and eventual head of the League’s
Social Section, attempted to dissuade Buchanan of his fear that the action would establish a difficult precedent because the actions contemplated were “so obviously the direct outcome of a worldwide war.” Others, such as the French representative, advocated that the League take action, although the Directors of the League of Nations worried that the League would need a great power mandate to act and should not undertake anything that was not adequately materially supported.

Despite the concerns over the project, the League began to solicit funds. In June 1920, Lord Balfour, Britain’s council delegate, in response to the report of the London Health Conference, wrote to the governments of the League of Nations, apprising them of this situation and stressed the need for “adequate help to be forthcoming from the Family of Nations.” Adequate help, he estimated, would cost £1,750,000, of which Great Britain had already offered £50,000 if the League could garner other contributors Balfour based his appeal on the “geographical proximity…commercial interests… [and] humanitarian motives of member nations.” Later, the Health Committee would boast that the Epidemic Commission was “the first instance of international effort in public health” that was fundamentally different from private relief organizations because it received its funding from governments instead of voluntary organizations or individuals. However

46 Crowdy to Buchanan, November 5, 1920, 12B/7900/7900, LON.
47 Minutes of the Directors’ Meeting Held on Wednesday, August 3, 1921 at 3.30 pm., 1921. No. 22, 6. LON.
this assertion obscures the contentious and often inefficient mechanisms for funding the League of Nations Epidemic Commission.

In practice, the representatives of the League courted voluntary organizations in an attempt to fund the anti-epidemic activities. Balfour contacted the League of Red Cross Societies well before he contacted member governments. He urged the League of Red Cross Societies to coordinate aid efforts before the League stepped up to attempt it. In 1921, the League’s Secretary-General Sir Eric Drummond again contacted the Director General of the League of Red Cross Societies to ask for them to issue an appeal for supplies. The American Children’s Relief, the American Red Cross, the Save the Children Fund, the Vienna Relief Fund, and the Jewish Relief Committee, among others, had already assured basic food supplies had through the harvest. A plethora of organizations thus supported the League efforts, despite Balfour and Rajchman’s hopes to secure government funding.

The League’s quest for funds faltered. The response to Balfour’s June 1920 appeal was poor. Balfour’s earnest second appeal, that no country, including islands like his own England, would be safe if Poland “were allowed to succumb,” failed to make an impression. Even promised subscriptions were slow to materialize. In March 1921,


the Secretary General reported that many of the countries that had promised monies had not provided them, putting the League of Nations Epidemic Commission in danger of over-drafting its account. Many countries had difficulty directing money to the funds. The Italian government declined to contribute, and its delegate cited the high cost of living domestically and the depreciation of the Italian currency. The High Commissioner from New Zealand reported that his government had attempted to use private funds to fulfill its League obligations, but the donors had insisted the money go to Save the Children instead. The Danish Foreign Minister claimed to have asked his Parliament for £10,000 pounds, but was granted only £5000 cash and anti-tetanus and anti-diphtheria serum in the amount of the remaining £5000. Some countries, including Siam and Peru, gave what amounted to token amounts, perhaps to help cement their legitimacy as active members of the international community. Australia, New Zealand, and Japan responded that they were not directly enough affected, but might consider offering funds in return for promises of aid in the case of Asian epidemics. The German government offered one million paper marks if German experts could be


55 Tittonia to Drummond, June 24, 1921, 1,12B/5085/1719, LON.


59 “International Health Conference, April 17-17, 1920, Report and Minutes,” 50, 12B/4124/126, LON.
involved, but the senior administration of the League of Nations did not accept those terms. In September 1921 the League decided to issue one last general appeal, which also turned up short. The budget woes did not end there. In January 1922, the French representative urged the Council to keep the League of Nations Epidemic Commission budget line separate from the League of Nations Health Organisation’s so that the commission’s funding would end as soon as the epidemics did.

Despite these funding difficulties, the League of Nations Epidemic Commission oversaw an ambitious, historically-distinctive program. The Epidemic Commission helped the Polish government obtain scarce materials such as clothes, soap, drugs, ambulances and equipments, as well as food for epidemic hospitals. Shipments began in February 1921, shortly after the League had approved the provisional health organization, seven months after Rajchman had begun as medical director, and nearly a year after international discussions had begun. These League commissioners administered the intricate system of sanitary defenses in Poland, involving hospital beds, delousing, and food camps that often carefully sorted from refugees and prisoners of war.

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60 Stlamer to Drummond, July 27th, 1920, 1, 12B/5785/1719, LON.


64 Iris Borowy, Coming to Terms with World Health: The League of Nations Health Organisation 1921-1946 (Frankfurt-am-Main: Peter Lang, 2009), 50.
who came on foot, in carts, or by train. They oversaw a 1000-km-long sanitary zone that divided Poland from Russia and included 20 sanitary disinfection stations and over 100 hospitals. With some of the friction overcome with the appointment of Rajchman, the League of Nations Health Organisation worked through existing government and public health structures, hoping that such a method would allow them to effect immediate change and also to strengthen the government in the process. Local staff was less expensive than foreigners who were unwilling to expose themselves to risk. The use of local staff, who reported only incidentally to the commissioners, may in part account for the few on-the-spot reports the anti-epidemic personnel in Poland and later Russia sent back to Geneva.

Ultimately, the work in Poland proved inadequate because many cases of typhus originated in Russia. Despite improved sanitary conditions in Poland, migrants from Russia still flooded into Poland at a rate that frequently exceeded the capacity of Polish disinfection and quarantine centers. The Polish government urgently required Russian data in order to implement an effective sanitary cordon, because at least 130,000 refugees had already entered Poland. In order to facilitate this flow of information, Rajchman

68 Ibid., 6-8.
proposed going to Russia. The committee approved the fact finding mission.\textsuperscript{70} The Soviet government also approved the mission, despite having rejected a proposed Commission of Enquiry on labor conditions the year before.\textsuperscript{71}

White and Rajchman traveled to Russia in the fall of 1921 to investigate and attempt to open communication with the Russian government. On their return, White gave a rosy report: although there were not enough supplies he commended the “admirable” and “remarkable” work of the Russian medical professionals. He believed that the epidemic situation was improving.\textsuperscript{72} When Rajchman took the floor, he produced the dramatic map discussed above. While the mission had to his mind produced valuable data, much of that information was troubling. The data he had received from the Soviet Ministry of Health led him to doubt that the Soviets had adequately vaccinated civilians. He also doubted that typhus was decreasing as much as White claimed.\textsuperscript{73} Nonetheless, the mission had done some good. Rajchman also strongly advocated a sanitary agreement between Poland and Russia, which the commissary was ready to do.\textsuperscript{74} Rajchman, who had negotiated an exchange of epidemiological information with the People’s Commissariat, had also obtained a report by Professor Lev Tarassevitch, a Moscow public health official, detailing the rates of typhus and other

\begin{footnotes}
\item[Ib\textit{id.}, 13.]
\item[73]Ibid., 13-14.
\item[74] Ibid., 18.
\end{footnotes}
diseases in Russia. This was the first such report available publicly in the West, and Rajchman had obtained permission to publish a longer version.\textsuperscript{75}

The White-Rajchman mission illustrates the importance of the Russian epidemic situation to the rest of Europe and confirmed Rajchman’s intense desire to bring Russia into contact with the League of Nations Health Organisation. His plan partially succeeded. Tarassevitch’s data, although suspect, were better than nothing.\textsuperscript{76} The Soviet health authorities were more cooperative than other parts of the Soviet administration. Even the French delegate to the League Council, Gabriel Hanotaux, a frequent critic of the League of Nations Health Organisation, was impressed by the overtures to the Soviet Union.\textsuperscript{77} After these tentative steps, the Soviet Union’s integration into the rest of the sanitary system and eventually into Europe’s political order seemed more likely. To hasten this process, Rajchman organized a conference that was open to all European governments, including the Russians. With these early successes, Rajchman’s dreams of a sanitary system that crossed political boundaries seemed possible.


\textsuperscript{76} Tarassevitch’s numbers are still accepted as the broadly accurate, although debate remains over how many of the cases are attributable to the conflict. Patterson, “Typhus and its Control in Russia,” 379.

The Warsaw Conference: Setting the International Course

Like the more famous Genoa Economic Conference, the Warsaw Health Conference of 1922 was pivotal in setting the shape of European interwar international politics. The technical nature of public health concerns gave the participants more freedom in their negotiations. Despite the assurances that League officials and their national partners made that health work was technical and not political, all the conference participants remained aware of the political stakes from the beginning. Rajchman, at a League of Nations Directors’ meeting, admitted that there was no evidence to justify the conference on the grounds that the epidemics threatened most of Western Europe, but deemed the meeting necessary because reconstruction and east-west trade “would be indefinitely postponed” by the epidemics.\(^7^8\)

Early indications suggested that the conference would prove an admirable testing ground for international cooperation. The Soviets and Germans attended, although the United States, Portugal, and Albania did not. Rajchman was enthused by German involvement, claiming with some pleasure that delegates spoke German together more than French.\(^7^9\) This attempt at diplomacy highlighted the ambitions of the League’s technical organizations – theoretically these opportunities allowed nations to come together to discuss a common problem without reference to politics. The urgency of the

\(^7^8\) Minutes of the Directors’ Meetings 1922, Minutes of the Directors’ Meeting Held on Wednesday, February 1st, 1922. No. 35. Geneva, February 3, 1922, 5

\(^7^9\) Ludwik Rajchman, “The League of Nations: What it is and How it Works,” Memo, November 18, 1921, 5, RF, R.G. 1.1 Series 100, Box 20, Folder 165, RAC.
need meant that the meeting could take place with muted reference to broader strategic concerns, and therefore, outsider states, such as Germany and Russia, could be invited as vital part of disease control systems if not political systems.

The Warsaw Health Conference reflected Rajchman’s vision of cooperation between governments mediated by the League. Despite limited response to the epidemic subscription campaigns, Rajchman remained firm in his desire to elicit government funds rather than charitable donations. The conference was not a relief conference in the traditional sense, because only states were invited, not the philanthropic organizations that even during the Eastern European crisis had provided most of the relief funds.\(^{80}\) In so arranging the guest list, Rajchman hoped to force national governments to provide funding and support. The Conference bore an ambiguous relationship to the League. Although the Council had declined the Polish government’s request that the League convene the conference, the League supplied technical experts and supported the Polish plan. In private correspondence, Rajchman called the conference a “semi-League affair.”\(^{81}\) The members of the Health Committee distinguished the aim of their organization from that of voluntary organizations, which were interested in “the immediate alleviation of suffering… with the result that, when assistance is withdrawn, former conditions again prevail,” by aiming for “strengthening the sanitary organizations


of the countries as the most effective and lasting means of choking the spread of epidemics.”82

Several people outside of the Health Committee, including Polish diplomat Szymon Askenazy, advocated for the invitation of “a few prominent men like Lord Robert Cecil” to help bring attention to the cause.83 Drummond disagreed, writing that “to give it the aspect of a political demonstration by securing men of prominent political position would entirely defeat its object.”84 The French foreign ministry later used the technical character of the conference to try to discredit the recommendations. The Quai d’Orsay challenged the international standing of the conference because the League Council had not convened it and because many of the delegates were public health specialists, the French argued that they could not assume that delegates had been given full plenipotentiary powers.85 Thus, while Rajchman had hoped to use the technical nature of the conference to force governments to cooperate in medical relief, certain governments were laying the groundwork to treat the conclusions of the conference as technical advice rather than binding international obligations

Rajchman drove the conference agenda. He hoped to use the meeting to negotiate a Polish-Russian sanitary treaty and to gain material and political support for League and

82 League of Nations, “European Health Conference held at Warsaw from March 20th to 28th, 1922,” in 

83 Rajchman to Attolico, February 28, 1922, 1, 12B/18972x/18972, LON.

84 Drummond to Attolico, March 3, 1922, 1, 12B/18972x/18972, LON.

Polish activities to counteract the epidemics. He proposed the establishment of a sanitary defense system in Poland and Romania on one side and Russia and the Ukraine on the other, consisting of a 1500 km chain of hospitals, quarantine stations, baths, and delousing facilities. He also proposed a new strategy: he wanted to engage in direct attack on the epidemics, to undertake activities at the seat of the epidemics in Russia. Direct attack was rare in the history of disease control; countries did not interfere, as a rule, in the internal sanitary affairs of other states. They protected their own health through quarantine, or sanitation efforts, or vaccination. Rajchman wanted an international commission to supply and oversee these campaigns within Soviet borders.

Other attendees had their own aims. The Western powers hoped to see how the inclusion of the Soviets would affect international negotiations before the start of the Genoa Conference. The Germans hoped to maneuver for more involvement in the international system, and used Soviet resistance to demonstrate their greater willingness to abide by international standards. The Soviet delegation, once they agreed to come, hoped that the conference would help remove the stigmatization of the east, until they realized there were no epidemics in Western Europe worth discussing. They also insisted that the conference remove all symbols of the League from the conference hall.

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87 For a history of nineteenth century epidemic control policy on the national level, and the reasons why these policies varied country by country, see Baldwin, Contagion and the State in Europe, 1830-1930.

88 Balinska, For the Good of Humanity: Ludwik Rajchman, Medical Statesman, 57-58.


90 Weindling, Epidemics and Genocide in Eastern Europe, 1890-1945, 168.
and refused to deal with the League delegation. This demand was complicated by the fact that there was no “League delegation” per se, only League support staff.\(^91\) The French delegate, deeply skeptical of the conference, thought that most important outcome of the meeting would be to document in a technical manner the conditions on the Polish-Russian border.\(^92\)

The conference, which was held March 20-28, 1922, led to three major conclusions. The first two, concerning economics and sanitary conventions, only modified older models of epidemic control. The third, advocating direct attack within Soviet borders, was novel. A resolution of the plenary session declared that “unless much greater efforts than have hitherto been possible are made – and without delay – the present epidemiological situation will cause much more serious suffering and death among the populations of the infected areas, will impede reconstruction, will hamper trade, and will constitute a real and imminent danger to the whole continent of Europe.”\(^93\) This resolution set the tone for discussion and denied any international legitimacy to the claim that the epidemics were not serious. The participants’ faith in economic reconstruction as a consequence of and not a precondition for health created an opportunity for the League of Nations Epidemic Commission.

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\(^92\) “Rapport sur la conférence sanitaire européenne de Varsovie par le docteur Louis Cruveilhier, délégué officiel du gouvernement de la République Française,” 30, SDN/ IL/1585, AMAE.

\(^93\) League of Nations, “European Health Conference held at Warsaw from March 20th to 28th, 1922,” 5-6.
The delegates to the Warsaw conference ultimately recommended major changes to the sanitary convention system and approved a program that mixed new beliefs about international connection with older commitments to economic liberalism and state sovereignty. The report of the conference began with the suggestion to expand the list of notifiable diseases to include typhus, relapsing fever, and cholera. However, the conference participants did not advocate changes in the underlying principles of international epidemic control, stating that their plan “firmly adheres to the fundamental principle laid down by the Paris Convention that the campaign against infectious diseases should interfere as little as possible with traffic and trade.” The costs for inspection and delousing were to be borne by public funds to avoid burdening river and land traffic with taxes, which might harm business. These fundamentals were accepted in the conventions negotiated during the conference between Poland, Russia, White Russia and the Ukraine as well as between Latvia and Estonia.

The conference delegates decided that the League of Nations Epidemic Commission should oversee a Russian-focused anti-epidemic campaign. The Russian and the Ukrainian delegations opposed granting the League of Nations Epidemic Commission that power, but their proposal for a special non-League international

94 Ibid., 29.
95 Ibid., 30.
96 Ibid., 32.
97 Ibid., 6.
commission be set up to control the contributions was defeated. The Warsaw Conference approved an offensive campaign targeted at the Donetz Basin because of the area’s dual role as epidemic and famine centre and economic centre with rich coal and iron ore mines. The conference proposed moving into Russia in three ways – to extend the sanitary zone in and to the Black Sea, strengthen the existing zone, and concentrate direct attack using vaccination and basic sanitation measures on the Donetz basin. In response to this decision, Rajchman emphasized that the delegates had based their reasoning on economic fears and that their realization although only part of Europe was directly affected, all of Europe had a moral and economic responsibility to help with the program.

Europe had a second chance to consider the issue at the Genoa Conference. The most contentious issue there was the debate between the desire to extend the *cordon sanitaire* and the Polish-British proposal for direct attack. Responses at that conference tended to reflect security concerns about Poland. The French advocated a strong quarantine and border defense policy. They advocated the use of international staff and organizations to oversee all Genoa-related projects in Russia, just as they had with the health projects. The British were more eager to integrate Russia and Germany economically and politically.

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98 Ibid., 8-9.

99 Ibid., 12.

The conference, after serious negotiation with the German and Soviet delegations, granted responsibility for implementing their decisions to the Health Committee. In so doing, the Genoa conference provided the Health Committee with both far more and far less than they had hoped. Rajchman’s activist agenda received a boost from the international approval for some of the controversial Russian interventions. These endorsements came with no funds. This mismatch presented a problem for all members of the committee. Some members of the assembly were mildly supportive of the Epidemics Commission. The Assembly passed resolutions that acknowledged that the program needed funding and that the current subscription procedure, in which “only certain States” funded work that was of interest to all of Europe, was unfair. At Warsaw the delegates had agreed to beseech their governments for funding. There was limited response. The British government agreed to give £100,000 if the rest of the world would provide £200,000. This amount did not nearly meet the £1.5 million estimate for the full Warsaw program. Despite Rajchman’s preference for government


102 Ibid., 304.


sponsorship, the League of Red Cross Societies also gave £5000 for Warsaw-related activities.  

The Health Committee had other problems with the resolution. Buchanan believed the reputation of the Health Organisation and the success of the mission would be risked if the Health committee endorsed financially unfeasible resolutions. Buchanan and French representative Léon Bernard objected to the speed with which Rajchman wanted to communicate the Committee’s eagerness to the Council. Neither trusted that Rajchman handled the political considerations of the Warsaw resolutions deftly enough in his report. The Committee passed a resolution “taking note” of Rajchman’s report, although the resolution acknowledged the Health Committee’s approval for international attention and action on the issue of the eastern European epidemics and encouraged the Council to seek financial and political support for the endeavor. Rajchman was never sure how to take such objections. On the one hand, representatives, as technical experts, were supposed to discuss technical matters from their own perspective. On the other, they unofficially represented their governments. Rajchman was convinced that Calmette represented the views of the French government,


108 Ibid., 18.
and received directions from the Foreign Office, but was “doubtful” that Buchanan represented the official British views.\textsuperscript{109}

Political problems ensued beyond the committee as well. Polish public health official and Health Committee delegate Witold Chodzko heard other troubling news from the East. The Soviets refused to accept Article 8 of the Polish-Soviet health convention, which regulated the movements of population in territories caused by war or famine and called for international action. The Russian government claimed that the measure violated its sovereignty.\textsuperscript{110} Almost as soon as the ink was dry on the Warsaw and Genoa resolutions, nations began to withdraw from the ambitious program. The rhetoric of international cooperation and concern remained, but the political momentum slowed.

\textbf{Intervention after Warsaw}

Although the Warsaw conference delegates had ratified an ambitious program, the funds to support the work did not follow. Many diplomats believed that the plans overstepped the League’s mandate. A 1922 report on the Health Section summarized the struggle eloquently: “The League of Nations cannot create anything in the nature of its own Public Health Service, but the organization should regard as its duty the initiation of

\textsuperscript{109} Minutes of the Directors’ Meeting Held on Wednesday, May 24th, 1922, No. 11, LON.

action which, at the present time, no single administration can undertake.\textsuperscript{111} As League member governments became even less inclined to provide relief aid in the difficult economic climate of the early 1920s, the more expansive and interventionist aspects of the League program were allowed, or sometimes encouraged, to wither. This position conflicted with Rajchman’s desire for an interventionist section and did not meet the needs of the epidemic stricken populations in Eastern Europe and the burgeoning refugee crisis in the Near East.

Although typhus, relapsing fever, and cholera still threatened Europe, governments began to tire of funding the Warsaw initiatives.\textsuperscript{112} The Japanese, for instance, “found [it] difficult to make a contribution toward the funding of this campaign” because of worsening epidemics in Manchuria and Siberia.\textsuperscript{113} The French objected, in part because attempts to create a payment scheme at Warsaw were based on a broader Second Assembly plan to rethink League funding more broadly. These broader changes would have doubled the French contribution.\textsuperscript{114} Seeking to limit their contribution, the French government blocked the application of funds to the Warsaw program, although the Assembly preserved the funding for older projects.\textsuperscript{115} The direct attack on the Donetz basin never took place.

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\textsuperscript{113} Baron Hyashi to Dominicio da Gama, September 21, 1922, 12B/8101/1719, LON.
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\textsuperscript{114} J. G., “Note pour la Direction des Affaires Administratives et Techniques: Resolutions de la Conférence sanitaire Européenne à Varsovie (20-28 Mars 1922),” 1922, 4, SDN/ IL/1585, AMAE.
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Despite the financial uncertainty, the epidemic commissioners continued their work distributing sanitation supplies and assisting in vaccination programs through the summer of 1922, a task made easier by the end of the Russo-Polish war and the dying down of the Russian Civil War. Rajchman expressed his belief that the Warsaw resolutions had created “a new basis” for the work of the Epidemic Commission. He tried to capitalize on his interpretation of the Warsaw agreements, that the international community had evinced a willingness to regard epidemic interventions as a continuing international responsibility, by petitioning for new funds. Backed by the Health Committee, he approached the Council to fund the Commission on an ongoing basis, because the problems seemed ongoing, but to little avail.¹¹⁶ Rajchman’s position was boosted when in 1923 the Second Committee of the Assembly, which dealt with League projects, adopted a resolution that would have allowed the Epidemic Commission “to intervene immediately on the outbreak of exceptional importance” with funding authorized by the Council. The proposal did not become League policy. The Assembly’s Fourth Committee, in charge of the budget, maintained that its members did not want to risk subjecting the Assembly to contingent expenditures and proposed instead that the Assembly be required to vote to approve Epidemic Commission work, even in cases with immediate danger. The Assembly took the Fourth Committee’s advice and adopted a resolution that acknowledged the problem of relying on voluntary funds and


recommended the Council study the problem of how to fund the Epidemics Commission so the organization could intervene quickly in “sudden epidemic outbreaks of exceptional importance which might involve political consequences.”\textsuperscript{117}

This program was never actually funded, and the American Relief Administration, which had a budget of $7-8 million, had a substantially greater impact. As the biggest epidemic threat seemed to be related to the Russian infrastructure problems, claims that the epidemics were an international problem, which had been the basis of Balfour and Rajchman’s campaigns for funds, became difficult to maintain and the Epidemic Commission could do little beyond act as public health advisors to the Russian administration.\textsuperscript{118}

During this period of transition, the League of Nations Epidemic Commission expanded its operations to other regions. The collapse of the Ottoman Empire and the signing of the Treaty of Lausanne created a major humanitarian crisis in the region as refugees from the former Ottoman Empire threatened to overwhelm Greece. The migration of the Greek population from Anatolia produced more than a million refugees who entered Greece by 1923.\textsuperscript{119} Nansen had been one of the first to raise the alarm about the epidemic conditions in Greece and Turkey. After visiting Constantinople and Athens, Nansen reported in November 1922, that refugee camps were breeding smallpox,


\textsuperscript{118} Balinska, \textit{For the Good of Humanity: Ludwik Rajchman, Medical Statesman}, 90.

typhoid, typhus, and cholera outbreaks. League staff in the region also took notice of the precarious health situation. L. Lawford Childs, the Deputy Assistant Commission of the League of Nations in Constantinople described the 27,000 Greek Ottoman refugees held at Constantinople because the Greek government was too overwhelmed to accept them as “huddled in dark and noisome barracks, something without even a roof to cover their heads” and according to him the refugees “speedily became the prey of typhus and smallpox.”

The Health Committee responded by sending a Commission of Enquiry under the auspices of the Epidemic Commission to Greece. The Commission agreed with Nansen’s report. After some persuasion, Fridtjof Nansen himself provided most of the funds from his own Nobel Peace Prize monies. After the award, upon hearing Nansen was considering allocating some of his winnings to refugee relief in either Russia or the Near East, P. J. Baker wrote tirelessly to Nansen to convince him to earmark some of his money for the Near East relief, on the grounds that the Greek situation was nearly as desperate as the Russian and there a small amount of money could make a significant difference. Baker also informed Nansen that the British would double any League contributions. The £3000 sum was less than the League had hoped, but nonetheless funded substantial interventions.

120 L. Lawford Childs to F. Johnson, June 18, 1923, 12B/28679/26426, LON.


122 P. J. Baker to F. Nansen, January 3, 1923, 1-2, 48/25543/22543, LON.
The members of the Health Committee faced relatively little resistance in extending the League of Nations Epidemic Commission mandate to the Near East in 1922, even before Nansen had agreed to his donation, perhaps because the Epidemics Commission had proved a viable model and because the League was already involved in the crisis in the Near East. The Epidemic Commission’s program began when Raymond Gauthier and W.E. Haigh established quarantine stations and began vaccinations. Through 1924, the Epidemic Commission helped maintain the sanitary cordon on the Russian border.\textsuperscript{124} The commission arranged for the delivery of 1,674,585 doses of smallpox, cholera, and typhus vaccines in the Near East.\textsuperscript{125} The Near East program was less extensive than the Eastern European, but the mission is noteworthy because the work was undertaken during a retrenchment of epidemic control funding and represented the last direct intervention before the members of the Health Committee turned their attention to other epidemic control measures.

The End of the Epidemics Commission

A combination of a lack of political will, troubled finances, and improving health conditions brought an end to the League of Nations Epidemics Commission. Rajchman’s requests for increased or even just continuing funding met with resistance from the

\textsuperscript{123} Johnson to Procter, January 12, 1923, 1, 8/25543/22543, LON.


delegates in both the League Council and Assembly, who had grown increasingly skeptical of supporting an amorphous aid project. In January 1923 the members of the Council deemed a proposed second subscription request futile. The third session of the General Assembly was particularly hostile to sustaining the League of Nations Epidemic Commission. The delegates to that Assembly “insisted rather strongly on the temporary character of the epidemic Commission” in Eastern Europe, refusing to fund expanded activities. 126 The members of that Assembly’s Fourth Committee reduced the credits to the League of Nations Epidemic Commission from 125,000 to 50,000 francs. The debate over the League of Nations Health Organisation’s budget was acrimonious. Hanotaux, on behalf of France, argued that financial pressures on League of Nations Epidemic Commission governments limited what they could offer. 127 While the Epidemics Commission fared poorly, the League of Nations Health Organisation’s budget was substantial. Although the Assembly did not expand work on epidemics, ultimately the League Of Nations Health Organisation’s 1923 budget of 700,500 gold francs was comparable to the 796,250 gold francs given to the Transit Organization and significantly more than the 205,100 francs allotted to the Mandates Commission. 128 The members of the Assembly also considered alternative funding mechanisms for epidemic work, including a universally subscribed Anti-Epidemic Fund that would serve as an insurance


fund. This proposal, which the members of the Assembly viewed as even more amorphous than the Epidemics Commission, failed.\(^\text{129}\)

Improvements in health conditions ironically made the survival of the Epidemic Commission more unlikely. The Health Committee claimed that “the task of the Epidemic Commission was to defend Western Europe against diseases coming from Eastern Europe,” a task that seemed completed with the political and epidemiological stabilization in the East. By winter 1923-24 the Ukrainian and Russian epidemics of cholera, enteric fever, and tuberculosis no longer represented “a danger from [an] international threat” and the wars that had plagued the region had ended.\(^\text{130}\) In response, the French delegation to the League of Nations led increasing support for a definitive end date for the League of Nations Epidemic Commission activities in Greece and Eastern Europe.\(^\text{131}\) By June 1924, even Rajchman wanted to modify the 1922 accord between the League of Nations Health Organisation and the Soviet Union because the latter no longer had unique epidemic needs.\(^\text{132}\)

The League of Nations Epidemic Commission ended with an administrative whimper. In February 1924 the members of the newly permanent Health Committee


\(^{132}\) Ludwik Rajchman to Léon Bernard, June 19, 1924, 1, 12B/32761x/27184, LON.
noted that the work in Greece was “now accomplished” and the Warsaw Office was “being wound up.” Work continued on a port sanitation project at Libau in Latvia, already scaled back from a proposed network of Latvian quarantine stations, but the Committee decided that the activity of the Epidemic Commission could “be considered closed.” Support for the League of Nations Epidemic Commission had waned given the lack of clarity of the commission’s mission and the lack of financial resources the project had gathered. The members of the Health Committee quietly allowed the League of Nations Epidemic Commission to expire over Rajchman’s objections. Rajchman and the Health Committee channeled the organization’s money and energy into other activities that had lower political costs.

Although the work of the League of Nations Epidemic Commission ended, cooperative international health work continued. A succession of League commissioners including Dr. W. E. Haigh, Dr. M. Pantaleoni, and Dr. Henri J. Cazaneuve remained in Russia to advise on the control of endemic diseases, such as malaria. Other nations, including Albania, approached the League for assistance and advice. Although the international community avoided expensive foreign entanglements, the Eastern European actions had created a precedent for substantial international involvement when the situation was dire. In the 1930s, Rajchman traveled to China to advise on quarantine

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135 Borowy, Coming to Terms with World Health, 114.
procedures. He procured for the Chinese many times the funds earmarked for the Eastern European campaign. Despite Rajchman’s successes in Eastern Europe and China, direct intervention in foreign countries remained a rarity. Open communication, another of Rajchman’s victories, became the more important epidemic control strategy.

Conclusion

Governments rarely afforded the League resources to attack problems directly; the political and financial costs were perceived to be too high. Instead, the League became a forum for discussion, mediation, and cooperation. The members of the League shied away from responsibilities that required expensive, local and permanent solutions that might impinge on national sovereignty. The defense force so desired by the French never came into being. Nansen’s refugee organization faced major limitations after his death in 1930. The League of Nations Epidemic Commission suffered as well from this political reluctance and economic scarcity.

Although direct attack represented a failed experiment, the period between 1920 and 1924 was critical in the development of a new international sanitary order. The League brought together large states and small states, some of which were political outsiders, in effective negotiations. The staff of the Health Organisation illustrated


138 Ibid., 189.
through communication with Soviet public health officials the importance of the free exchange of information. Health questions gave the international community a new way to think about international cooperation. Although Balfour may never have fully convinced his colleagues that typhus and other epidemics were “almost worse than war itself,” he and other likeminded international figures convinced major powers to participate in new health endeavors.\(^\text{139}\) Despite the martial metaphors of epidemic control, the threat of epidemics prompted governments to work together through the League of Nations.

Politically, the League of Nations Epidemic Commission suffered from the unwillingness of the Soviet government to cooperate directly with the League. The project suffered also from French frustration with the direction of larger League structures. Despite French overtures to the Polish government, who also attempted to manipulate the project for political prestige, the French were more concerned with limiting the non-security expenditures of the League than in promoting the Epidemics Commission. Most notably, however, the Epidemic Commission suffered from the lack of international consensus on the proper relationship between national governments and international relief. Although states became increasingly interested in relief in this period, they relied on what Benjamin M. Weissman calls in the case of the US government and the American Relief Administration, the “convenient fiction” that governments did not interfere in other states or direct national money away from

\(^{139}\) Balfour, “Letter to the LRCS,” 68.
domestic problems towards international entanglements.\textsuperscript{140} While Rajchman manipulated the public image of the League of Nations Health Organisation to capitalize on its role as a technical rather than political body, he pushed governments too far when he demanded national subscriptions rather than charitable contributions. States were not prepared to fund that style of relief in the unsettled 1920s. Rajchman and the Health Committee were forced to retreat to less overtly political and more technical approaches funded by regular League contributions.

Despite Rajchman’s intentions, direct attack did not become the predominant way of controlling epidemics in Europe. The international community rejected direct attack as too expensive and too intrusive. Despite this curtailment of his vision, many of Rajchman’s goals for epidemic control were adopted. Epidemic control became increasingly cooperative, and the belief that populations rather than individuals were the appropriate level of disease control – through vaccination and sanitation – carried through the interwar sanitary system. The most significant change was the second part of Rajchman’s program – the expansion of epidemiological intelligence. The exchange of epidemic data allowed outsiders to view sensitive national data in a way that had previously been unimaginable. This form of cooperation became increasingly important in the interwar sanitary system.

\textsuperscript{140} Weissman, \textit{Herbert Hoover and Famine Relief to Soviet Russia: 1921-1923}, 192.
Chapter 3: Epidemiological Intelligence and the Creation of the 1926 International Sanitary Convention

Revising the 1912 International Sanitary Convention

At the opening of the International Sanitary Conference held in Paris in May and June 1926, Camille Barrère, French ambassador to Rome and veteran of many sanitary convention negotiations, claimed that in the field of health work, “universal solidarity is unreservedly manifest.”¹ In his welcoming address to the assembled delegates, who planned to revise the 1912 International Sanitary Convention, he praised the scientifically and politically progressive ideals that allowed the world to be bound together in an improving sanitary safety net. Challenges to Barrère’s vision were soon apparent. The framers of the 1926 International Sanitary Convention had to balance the traditional privileges of the Paris-based Office International d’Hygiène Publique and the large, maritime powers against the geopolitical realities of the interwar period. The older agreement focused on measures to control cholera, plague, and yellow fever, which had menaced nineteenth-century imperial trading routes. In short, in the words of Otto Velghe, the old agreement aimed to “safeguard Europe from pestilential disease coming

from the East.”2 In a world that gave lip service to Japan as a rising international partner, such an agreement was no longer tenable. Japan and the United States angled for recognition of their regions in the treaty. Alongside the smaller, often new, states, they pushed for an agreement that was more universalist and less Eurocentric than its predecessor and had already negotiated regional agreements that they expected to be taken into consideration at the global conference.

The advisory committee of the Office International d’Hygiène Publique delayed planned revisions to the 1912 convention during World War I.3 Consequently, in the early 1920s the world operated under a sanitary convention that was according to one expert “absolutely out of date and in disagreement with all modern theory” and increasingly at odds with the global political situation.4 To respond to these technical and political pressures, the framers of the 1926 agreement gave it a new character. Rather than controlling the movement of contagious people with quarantines, the framers of the convention sought to facilitate the flow of information about contagious diseases.5

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5 Fidler argues that this shift was not so much a shift as a way to make quarantine more powerful – states would be more willing to limit quarantine if they believed they had access to good epidemiological data showing when quarantine was and was not required. Neville Goodman by contrast argues that the shift was more fundamental and represented a turn away from quarantine. See Fidler, 43 for more on this debate. For my part, I suggest that epidemic intelligence was as much about regional and global integration as
Recognizing that information now moved faster than most ships or trains and was crucial to disease control, the greatest debates of the conference focused on how to share that information, what information could be shared, and who was to collect it. This shift to information-gathering was part of the broad interwar reorientation towards disease control techniques that attempted to protect large populations by controlling risks rather than controlling microbes. By negotiating a new convention the world decided on two guiding principles for international sanitary control: the first was to codify regional divisions in public health practice and the second was to bind those diverse regions together through information sharing. The agreement was the culmination of an evolutionary process spurred on by the political and technical difficulties encountered in post-World War I epidemic control.

One of the most important early steps in this evolution was the negotiation of regional agreements to control epidemics before the 1926 agreement took shape. These agreements exposed problems in the old sanitary system and provided a framework for a new one. This chapter examines how those early regional agreements came to be, their effect on the 1926 convention, and the institutionalization of the epidemic intelligence system following the 1926 conference.

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Regional Precursors in Asia and the Americas

The regional agreements in the Americas, Asia, and Eastern Europe set the stage for the International Sanitary Convention by illustrating the shortcomings of the 1912 International Sanitary Convention and providing a venue for their discussion. They also illustrated how the previously undisputed European control of the international sanitary system was changing. The older agreements came under attack because they assumed that countries had Europe’s financial, technical, and technological resources to devote to public health. The new agreements highlighted the significant regional variations in health situations. Geoepidemiology and geopolitics combined to make the European models entrenched in the International Sanitary Convention ill-suited to other regions. Even Europe was no longer well served by the 1912 agreement. Many new European states negotiated sanitary conventions that paid attention to land rather than sea based lines of transmission. These treaties were negotiated as part of the postwar normalization of economic and political relations. Asia dealt with a number of diseases known in the West, but the weak infrastructures in many states meant that they were frequently poorly controlled. Japan and China wished to be taken seriously as international actors, while India chafed under colonial health rules that had been designed for the metropole. The

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8 David R. Watson, “The Franco-Soviet Negotiations of 1924-27,” in Locarno Revisited: European Diplomacy 1920-1929, ed. Gaynor Johnson (London: Routledge, 2004), 108. The first of these new sanitary conventions were one of the League of Nations Health Organisation’s greatest victories at the 1922 Warsaw International Health Conference. At that conference, Poland, Russia, Czechoslovakia, Latvia, Romania, and Germany began negotiating sanitary agreements. The geography of the concerned states meant that the agreements contained provisions on both land- and water-based movement of diseases.
Americas were host to different set of diseases than in Eurasia. The United States angled for increasing its global prestige, while Latin America saw health negotiations as an excellent forum for building a voice in continental affairs. These regional concerns had an unprecedented effect on the 1926 International Sanitary Convention.

The most problematic region for the 1926 revision was Asia and its neighbors. The awkwardly named “Far Eastern Area” comprised, variously, Japan, China, the Philippines, Indonesia, India, Australia, and parts of East Africa that had been left out of nineteenth and early twentieth century health agreements. The region was politically uninfluential, and European powers regarded it as a source of disease, not an area that needed to be protected. The mail-based early twentieth century system had moved so slowly that diseases would reach Japan and other eastern countries before the notifications would have. Thus they remained separate from the early international sanitary conventions. Geopolitical realities, combined with new transportation and communication technologies, made Asian health issues a greater international concern, even in the region itself. The Japanese advocated for stronger representation in sanitary law, claiming Japan faced special risks from its neighbors, and sought to revise the International Sanitary Convention, from which the country was excluded, to suit Japanese needs and amend one of the last “unequal treaties.”

Britain remained interested in its dominions in the region, not to mention colonial outposts such as Singapore. By contrast, the United States, despite its naval interest in the region and control of public health in

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the Philippines, remained generally uninterested in Asian sanitary matters, preferring to exert influence closer to its own borders and away from the League of Nations.

European policymakers had long viewed public health in Asia as a colonial and not cooperative venture. Most health efforts undertaken by imperial powers were aimed at directly improving the economic productivity of their colonies, although colonial administrators also emphasized that health interventions as part of the civilizing mission would improve living standards for colonial subjects.¹⁰ Despite those justifications, many colonial public health projects were undertaken by the same colonial governments to protect their interests back in Europe and as part of its obligations to its European neighbors. For example, the British regime in India faced international pressure to combat cholera at its source after the disease had invaded Europe.¹¹ The Chinese government anxiously attempted to retain its sovereignty by administering public health services in port cities to international standards. The Manchurian Plague Prevention Service, set up in 1913 following foreign intervention in the 1911 plague outbreak, was externally funded and used western techniques to maintain port health. Although these activities were carried out in large part by the Chinese government, they were directed by Western states to protect international shipping and not with the goal of increasing national public health in China.¹² This discourse began to change in the 1930s, with

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increased interest in improving health as an end in itself in colonial areas, but colonial governments rarely followed through on their rhetoric.\textsuperscript{13}

In this context, the policymakers of the League of Nations Health Organisation were slow to embrace work in Asia. In 1922 the Japanese delegate to the Health Committee, Mikinosuke Miyajima, proposed a Commission of Enquiry, to investigate the epidemiological situation in Asia as a first step to beginning work in the region. Miyajima made the request in the hope of protecting Japan from its neighbors, which had higher rates of pestilential diseases, particularly plague and cholera.\textsuperscript{14} The other members of the Health Committee attempted to avoid the expense by claiming they could trust colonial governments to send back accurate information on the situation. However, Miyajima triumphed and had a commission struck. In November 1923, health section member Norman F. White was dispatched as a one-man “Commission of Enquiry to the Far Eastern Ports.” White was joined briefly by an American, which would have been a public relations coup if the representative of the United States Public Health Service had not been invited largely because other potential members had backed out. White completed most of the 35,000 mile tour on his own.\textsuperscript{15}


\textsuperscript{13} Sunil Amrith, \textit{Decolonizing International Health: India and Southeast Asia, 1930-65} (New York: Palgrave MacMillan, 2006), 28. The interaction between the League of Nations Health Organisation and colonial administrations will be addressed in greater depth in chapters 2 and 3.

\textsuperscript{14} Mikinosuke Miyajima, “Memorandum on the Need of Epidemic Intelligence in the Far East,” May 1922, 1, 12B/26253x/11346, LON.

\textsuperscript{15} Norman F. White to Ludwik Rajchman, August 23, 1923, 1, 12B/25734\23239, LON.
White’s tour took him through China, Japan, and much of East Asia and culminated in a detailed report. The report encapsulated the challenges facing the international sanitary order in the interwar period: changing scientific beliefs, weak states, new transportation technologies, and inadequate conventions. White combined a universalist vision with a pragmatic localism. He had begun his tour with the goal to study “diseases of international importance,” such as cholera, smallpox and plague, their movement between Eastern Ports, and the quarantine and surveillance measures that were designed to stop them. He intended to develop uniform procedures across the ports to deal with these issues, which would in turn facilitate a new sanitary convention.16

White’s hopes for a universal project were soon dashed. The questionnaire that had been laboriously designed by the Health Committee in order to facilitate his research was soon abandoned because it was not broadly applicable and risked obscuring important data about individual ports. As White wrote, the customs and constitution of the population of the various countries have also a direct bearing on what is possible in the field of public health procedure and disease prevention. Questions of housing, occupation and general sanitation in the ports are likewise matters of extreme importance. The enquiry, in fact, assumed more and more the nature of a general investigation into public health

conditions, with special regard always to the dangers of transmitting infection by
ship from country to country.\textsuperscript{17}

White recognized the challenges in adapting European-style health measures to
Asia. Western medicine had made more inroads in curative rather than preventive
medicine, meaning the assumptions in force in public health there differed from in
Europe. Second, he feared that Asia was especially susceptible to economic problems
and that precarious health advances in the region were threatened in an era where public
health initiatives were attractive targets for cost-savings measures. As Asia modernized,
the trains and “other means of rapid communication” that brought outside ideas and
economic advancement also increased “the rapid transmission of infection” without
necessarily bringing public health infrastructure.\textsuperscript{18}

White’s monograph outlined two international projects to ameliorate conditions in
Asia, both of which would have important implications for the global 1926 agreement.
The first was for a “Central International Epidemiological Intelligence Bureau for the Far
East” that would receive and send information about epidemic diseases.\textsuperscript{19} His suggestion
that the bureau be housed in “the gateway to the Far East,” Singapore, was taken up after
the Rockefeller Foundation agreed to fund the venture developed with Rockefeller money
into what was called the Far Eastern Bureau.\textsuperscript{20} Although both suggestions were grounded

\textsuperscript{17} Ibid., 7.
\textsuperscript{18} Ibid., 8.
\textsuperscript{19} Ibid., 42-43.
in European practices, White advocated that they too be crafted in response to local needs.

The Far Eastern Bureau for epidemiological intelligence generated initial international support more easily. The Health Committee was supportive. The Chinese, Portuguese, British, and Japanese agreed outright, and the Dutch and French in principle, although they expressed concern about the cost. Rajchman approached the Rockefeller Foundation, which had earlier expressed interest in European Epidemic Intelligence, claiming that once the Eastern Bureau demonstrated its effectiveness, governments would be willing to carry the cost. Despite misgivings over whether governments would actually contribute the Rockefeller Foundation’s International Health Board agreed to pay $5000 for a Health Conference in Singapore in December 1924 to help establish the bureau. The board also offered a grant of $50,000 annually for several years, accepting Rajchman’s arguments that the seed money was necessary to convince governments that this new model would work. The conference confirmed the Singapore location. The twelve attending governments agreed they would cooperate administratively. Siam and the Straits Settlements both offered financial support of up to Straits $5000 annually for

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20 Ibid., 41.

21 Ludwik Rajchman to Selskar M. Gunn, March 12, 1924, 1-2, RF, RG 1.1, Series 100, Box 20, Folder 167, RAC.

22 Rockefeller Foundation, “Minutes of the International Health Board,” October 28, 1924, RF, R.G. 1.1 Series 100, Box 20, Folder 164, RAC.

23 Rockefeller Foundation, “Minutes of the International Health Board,” November 6, 1924, RF, R.G. 1.1 Series 100, Box 20, Folder 164, RAC.

24 Norman White to F. F. Russell, November 20, 1924, 2, RF, RG 1.1, Series 100, Box 20, Folder 168, RAC.
three years, while French Indochina and the Netherlands East Indies offered free wireless services. The Bureau opened March 1, 1925.25

White’s second contribution, his proposed Far Eastern sanitary convention, is less well known but no less important. White suggested a regional sanitary convention, to be a separate chapter in the International Sanitary Convention, in order to harmonize and protect Asian countries from each other and to align practices with Europe.26 White suggested several differences from the practices in the 1912 International Sanitary Convention. The most important was a different basis for the sanitary system. In Asia, ports, rather than ships, were to be classified as infected or clean. Rather than inspecting each individual ship, if it came from a port known to be infected, the ship was assumed to have infectious material (people, goods, or rats) on it, and therefore would be subject to quarantine. If the ship came from a clean port, presumably there was no way for it to have become infected, so it was treated as uninfected unless disease appeared en route. This type of system, occasionally in practice in Europe, had been abandoned in the 1912 International Sanitary Convention because it encumbered healthy ships with unnecessary burdens that were more costly than inspecting each ship individually. White and many of the experts thought that port sanitation in Asia meant that the chances of clean ships

25 Rockefeller Foundation, “Minutes of the International Health Board,” November 5, 1925, RF, R.G. 1.1 Series 100, Box 20, Folder 164, RAC.

emerging from infected ports was very unlikely, making the European practice ill-suited to Asia.27

White’s proposed sanitary convention was controversial. U.S. Surgeon-General Hugh Cumming was uneasy about creating a separate convention for Asia; he feared that “separate sanitary conventions for different parts of the world might imperil the international character” of the work, despite his own involvement in the creation of a Pan-American regional sanitary agreement.28 The Japanese disagreed, stating that any universal convention would, paradoxically, require special regional considerations for Asia.29 They preferred a separate regional agreement for Asia, but were willing for the agreement to become part of a revision of the International Sanitary Convention.30 This proposal caused other problems, as many Asian nations, including China, were unsure about whether they wanted to become party to the larger convention.31 Other governments protested that they could be protected only by the International Sanitary Convention. Australia looked to an amended International Sanitary Convention because the government feared the effects of the presumably lower standards in the Asian

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27 Ibid., 31.
31 T. F. Tang, “Reply from Chinese Government. Translation.,” 8, 1924, 12B\38280\30818, LON.
agreement. Likewise, New Zealand claimed to trade so infrequently with countries afflicted with plague, smallpox, or cholera that its interests might be better served by the International Sanitary Convention. Those countries followed most of the other British dominions in their allegiance to the International Sanitary Conventions and the Office International d’Hygiène Publique. Canadian and South African delegates throughout the period worked more closely with Paris and London than with regional bureaus, showing that, for the parts of British Empire at least, imperial ties outweighed geographical and even epidemiological concerns.

The Japanese, who attempted to become the sanitary center of power in the region, pushed for more autonomy under the convention. Their delegation expressed concern that the International Sanitary Convention had too much power to determine which bacteriological examinations had to be used. They wanted each country to be able to define plague- and cholera-suspected cargo individually. They agreed that the Singapore Bureau should be allowed to collect epidemiological reports and suggested that ports that failed to provide adequate information should be considered suspect. Despite these concerns, the agreement was essentially accepted at the same conference that founded the Singapore Bureau. Although the agreement was not ultimately officially

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33 G. H. Villiers to Eric Drummond, October 5, 1924, 12B/35019\30818, LON.


35 Ibid., 3.
incorporated into the text of the 1926 International Sanitary Convention, the proposed Far Eastern convention shaped practices in Asia and around the world.

The Americas presented a different set of challenges. If the East had an undeveloped health infrastructure that had to be built up to join the international sanitary convention, the Americas had too much infrastructure to be smoothly integrated. Although many American states had been party to the older sanitary conventions, they had developed a strong international regional public health structure. Washington’s Pan American Sanitary Bureau was the world’s oldest international health organization. Created in 1902 by the Second International Conference of American States, the Pan American Sanitary Bureau began as an information sharing arrangement but soon took on the additional role of encouraging member states to improve their public health programs.\(^{36}\) By 1924, all of the American states except Canada had joined, and the Pan American Sanitary Bureau had a growing budget: $20,000 in 1920, $50,000 in 1924.\(^ {37}\) The Pan American Sanitary Bureau struggled between the desires of the United States and a larger but less powerful coalition of Latin American pan-Americanists.

The post-World War I era brought about changes in the organization of the Pan American Sanitary Bureau. The sixth Pan American Sanitary Conference in Mexico in 1923 and the Seventh Pan American Sanitary Conference in Havana, Cuba in 1924


\(^{37}\) Neville M. Goodman, *International Health Organizations and their Work*, 2nd ed. (Edinburgh: Churchill Livingstone, 1971), 329-330. Canada, even after the 1926 agreement, continued to work more closely with the Office International d’Hygiène Publique, like the other British Dominions.
revised American quarantine and sanitary control measures.\textsuperscript{38} The new Pan-American Sanitary Code adopted many of the new international standards of the interwar period. The delegates who approved the convention remained committed to the older idea that “there shall be no invasion of the autonomy of any of the signatory Governments” and that they were “left free to apply such additional measures of a local nature as may be required to meet special local conditions or peculiar circumstances.”\textsuperscript{39} The convention added typhus and influenza to the list of notifiable diseases.\textsuperscript{40} Typhus was a special project of the United States, which had tried to make the disease notifiable from the 1881 International Sanitary Convention. The United States feared importing the disease via immigrants from Eastern Europe.\textsuperscript{41}

Information sharing became increasingly important in the Pan American Sanitary Code. Countries had to notify the first case of a list of diseases that went beyond the requirements of the International Sanitary Convention.\textsuperscript{42} Furthermore, the Pan American Sanitary Bureau was to become a central statistical clearing house and, mirroring efforts being undertaken at the League, was to standardize a list of causes of death.\textsuperscript{43}

\begin{itemize}
\item\textsuperscript{39} Ibid., 39.
\item\textsuperscript{40} Ibid., 49.
\item\textsuperscript{43} Ibid., 63.
\end{itemize}
American Sanitary Code adopted a mixed system of whether to declare ports or ships clean.\textsuperscript{44}

The League of Nations sent White to the conference. White approved of the Pan American Sanitary program; the conference took seriously many of the issues that White had identified in Asia, and was oriented towards the practices that the League of Nations Health Organisation regarded as most modern. In a frank report to Geneva, White related that he expected that the code would need to be taken up in the next International Sanitary Convention discussions. Furthermore, he believed that because the Pan American Code “was drawn up and discussed by men with practical experiences of the diseases treated” that it was a “real improvement on the Paris project.”\textsuperscript{45}

Health cooperation between the League and the Americas was not without its complications. White was skeptical of the sustainability of the Pan American sentiment that underlined the Bureau. He sensed a growing disconnect between the United States and the Latin American countries, which were eager to cooperate with the League to compensate for American dominance.\textsuperscript{46} The Americans presented their own difficulties. White was deeply concerned about the Surgeon General, Hugh Cumming. Although White described him personally as “likeable and most kind and helpful,” his assessment of Cumming’s professional work was scathing. White called him “mentally lazy… rather conceited, politically minded in a narrow sense, with no interest in whatever in

\begin{footnotesize}
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\item[44] Ibid., 14.
\item[46] Ibid., 6.
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international public health beyond a constant care that no code or convention should in any way prevent the U.S. doing exactly what he judges necessary to the public health of his country.” Although the Surgeon General’s office had prepared the draft of the Pan American Sanitary Code and the Havana conference’s agenda, he seemed to have a limited grasp of either. White, who wrote that he believed that Cumming’s attitude to international work merely mirrored that of the uninterested American State Department.\textsuperscript{47}

The attitude of Cumming and the State Department towards health work diverged from broader American foreign policy objectives. While at many of the diplomatic efforts of the interwar period, particularly the Washington Naval Conference and the Locarno conference, the US attempted to find a place in the global order, the International Sanitary Convention was of limited interest to the United States, which had also largely sat out of the negotiations in Singapore, despite the great importance of that region to Washington.\textsuperscript{48} Through the Pan American Sanitary Bureau, headquartered at Washington, the United States had dominion over its own sanitary sphere of influence. The existence of the Pan American Sanitary Bureau was a mark of international prestige for the United States, and like the Office International d’Hygiène Publique, allowed a point of international cooperation in health matters that was not the League. The remarks that White made about Cumming’s interest illustrated the sanitary isolationism of the United States. The United States understood immigrants to be the greatest threat to their

\textsuperscript{47} Ibid., 7.

sanitary security and was resistant to any international attempt to limit national prerogatives in sanitary matters. Unlike the French and British, whose large maritime trading empires had made quarantine a vital issue of economics, the United States, buffered by two oceans and its own organization, was able to remain partially aloof from the debates in Singapore and attended Paris in order to preserve that position.

The 1926 International Sanitary Conference

While the regions negotiated their own agreements, the Office International d’Hygiène Publique completed the early work of the revision of the International Sanitary Convention. By 1924, the Office International d’Hygiène Publique had worked out a draft revision at its regular meetings. The draft was notable for the number of times the Office International d’Hygiène Publique appeared specifically as the body to which information should be reported, a change from the 1912 convention and undoubtedly a power play.49 The drafters of the Office International d’Hygiène Publique proposal also tried to keep League of Nations staff, including as White and Rajchman, in the dark in the earliest stages of their redrafting, delivering the draft to governments while Rajchman was en route to Japan.50 Despite these tensions, the League Council offered technical


50 Iris Borowy, Coming to Terms with World Health: The League of Nations Health Organisation 1921-1946 (Frankfurt-am-Main: Peter Lang, 2009), 148.
support, which meant the League would bear some of the costs.⁵¹ The French finally called the conference for the spring of 1926.

At the conference, which convened in Paris in May 1926, delegates discussed the relationship between the Office International d’Hygiène Publique and the League of Nations Health Organisation, the integration of non-European regions into the previously Eurocentric agreement, and the revision of the out-of-date provisions in the 1912 conventions. The conference was well attended by more than sixty delegations including the United States and the USSR, and newer, smaller countries such as Poland, as well as representatives of colonial holdings, often part of their metropolitan contingent. The British delegation represented the colonies but not the dominions, which had separate delegates.⁵² Because most delegates did not have full plenipotentiary powers, there was no expectation that the signatures would be binding before ratification. The League of Nations Health Organisation, the Office International d’Hygiène Publique, and the International Labour Organization also sent delegations.

After a welcome from the French minister of Culture, Hygiene and Labor, the French delegate Camille Barrère thanked both the League of Nations Health Committee and the Office International d’Hygiène Publique for their work preparing the draft convention.⁵³ At the next three sessions delegates gave opening remarks that set out their nations’ positions. Many countries were dissatisfied with the 1912 convention. The

⁵¹ Ludwik Rajchman to Herbert B. Ames, December 1, 1924, 1-2, 12B/26535x/22235, LON.

⁵² Conférence Sanitaire Internationale de Paris 1926, 53.

⁵³ Ibid., 43.
Italian delegation advocated an expanded list of diseases, more definition of surveillance and observation, more emigration rules, and more actions taken at the point of origin.\textsuperscript{54} Matushima of Japan discussed the special challenges the East faced. He repeated claims that Japan had made elsewhere, stating that nations required complete control of definitions of infection, that information requirements needed to take into account infrastructure problems in the east, and that the Singapore Bureau had to be able to accept data required by the convention.\textsuperscript{55} Witold Chodzko noted that it was the first time in a century that Poland had taken part as an independent nation. He pointed to Poland’s post-war health experiences to show the importance of terrestrial as well as maritime agreements.\textsuperscript{56} Nikolai Semashko of the USSR claimed that the goal of the convention should be to determine the least number of restrictions as an aid to international commerce.\textsuperscript{57} The United States wanted to prevent the League from taking control of international sanitary cooperation from the Office International d’Hygiène Publique, despite the extensive, and publically embarrassing, funding of League initiatives by the American Rockefeller Foundation. In his opening address, Hugh Cumming made several requests that attempted to solidify America’s position, including that English become the second official language of the conference and the that the Office maintain and even

\textsuperscript{54} Ibid., 44-45.

\textsuperscript{55} Ibid., 47.

\textsuperscript{56} Ibid., 47-48.

\textsuperscript{57} Ibid., 49.
expand its role as coordinator of international health information.\textsuperscript{58} The US also wanted the Pan American Sanitary Code provision allowing states to create their own local regulations that exceeded the stringency of the International Sanitary Convention to be included in the larger agreement.\textsuperscript{59}

After opening statements, the conference broke into several sub-committees to consider the Office International d’Hygiène Publique’s proposed revisions. Different committees examined quarantine, deratinisation, information exchange, and other key provisions of the draft through June 15, 1926. They debated three of the most important policies in interwar health: quarantine; preventive techniques that would make large-scale quarantine obsolete; and international sanitary information sharing and epidemic intelligence.

Quarantine, the basis of many older international sanitary conventions, was increasingly out of vogue. By the early 1900s, quarantine was divided effectively into two practices: observation and surveillance. Observation meant keeping an infected ship’s passengers, or at least some of them, in public health custody, either on the ship or in port hospital, until a specified period (usually the incubation period of the disease) had passed. In surveillance, passengers were subject to some combination of periodic physical or bacteriological checkups until the incubation period had passed. What seemed logical in theory – keeping people who had been exposed to a dangerous disease away from others until the danger had passed – was difficult in practice. Determining

\textsuperscript{58} Ibid., 80-81.

\textsuperscript{59} Ibid., 81.
who had been exposed on large ships was challenging, especially given that some of the etiologies of the diseases in question were unclear. Even some incubation periods remained uncertain. Quarantine also had emotional resonances. In some countries, quarantine was a relatively routine and expected measure. In others, it was seen as a major intrusion on the part of the government.\footnote{For a history of quarantine practices in Europe, and their political meanings, see Peter Baldwin, \textit{Contagion and the State in Europe, 1830-1930} (Cambridge: Cambridge University Press, 1999). Baldwin shows that while there was no clear connection between political ideology and quarantine practice, these practices were often discussed in political terms.}

The ability to identify healthy carriers of diseases such as cholera complicated the discussion.\footnote{Howard-Jones, \textit{The Scientific Background of the International Sanitary Conferences 1851-1938}, 92.} The Japanese stated from their earliest involvement in the conference that their government wished to conduct bacteriological examinations on those entering the port and to be able to isolate people who carried the cholera vibrio.\footnote{Conférence Sanitaire Internationale de Paris 1926, 46.} Opponents of the proposal raised two objections. The first was that even the Japanese had been unable to explain how large numbers of passengers could be tested at smaller ports without large laboratory facilities or even at larger ports in a timely manner. Buchanan, representing Britain, called the process “perfectly futile.” He objected that quarantining choleras would mean quarantining the apparently healthy, proclaiming to Rajchman that “this is the battle that England fought for twenty years.” His remarks revealed a strong class bias, suggesting that people like him and Rajchman would be ill served and potentially
offended by being quarantined in Asian ports. Bacteriological examination was not mandated as part of quarantine measures in the final agreement.

As a result, the International Sanitary Convention set maximum limits on practices, rather than mandating minimums, to protect people from unnecessary impingement on freedom of movement, and to get support from countries who were not themselves willing to implement the procedures. Quarantine procedures were loosened in the 1926 convention. The text replaced “quarantine” with the word “observation” in most sections. Only in the section concerning the Suez did language referring to quarantine survive. In other parts of the world, in the instance of plague, isolation of the sick and his contacts was still allowed, and the contacts could be quarantined for six days, the length of the incubation period. However, the International Sanitary Convention prevented the creation of true land quarantines under Article 58 of the convention perhaps owing to general reluctance on the part of the International Sanitary Convention to mandate requirements at land crossings, which had long been outside their

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63 George Buchanan to Ludwik Rajchman, October 27, 1925, 3.
64 Fidler, *International Law and Infectious Diseases*, 40.
65 *Conférence Sanitaire Internationale de Paris 1926*, 423.
67 *Conférence Sanitaire Internationale de Paris 1926*, 169.
purview.\textsuperscript{68} Land and rail quarantines were left to local agreements between neighboring states.\textsuperscript{69}

Surveillance, which meant less intrusion into personal liberty or the flow of commerce, was preferred by most of the participants at the conference. Bacteriological investigation, however, was left out of the definition of the tasks involved in surveillance. Those under surveillance were free to travel around the city, but required to present themselves for a set period to a port health official who would screen them for signs of illness until the incubation period passed.\textsuperscript{70}

The authors of the International Sanitary Convention tried to minimize the use of quarantine. The delegates turned to other measures to prevent disease from spreading. One of the most contentious proposals before the International Sanitary Convention was the use of vaccines, particularly anti-cholera vaccines in migrants. Vaccination was expensive, especially in the numbers needed for pilgrims or emigrants. Vaccine also caused distress in some regions – many still viewed it as an invasive procedure which they would prefer that the government not mandate.\textsuperscript{71} Debates centered on the Hajj pilgrimage, the annual movement of observant Muslims to Mecca, which European health officials viewed as a significant cholera risk because of the large movement of

\textsuperscript{68} Ibid., 423.
\textsuperscript{69} Ibid., 179.
\textsuperscript{70} Ibid., 566.
\textsuperscript{71} For more on the logic of vaccine use in public health and objections to the practice, see Alison Bashford, “The Age of Universal Contagion: History, Disease and Globalization,” in Medicine at the Border: Disease, Globalization and Security, 1850 to the Present, ed. Alison Bashford (Houndsmill, Hampshire: Palgrave MacMillan, 2006), 1-17; Baldwin, Contagion and the State in Europe, 1830-1930.
people to a crowded space with limited sanitary facilities en route. The political
sensitivities of the region were mounting, with the Egyptian delegation angling for more
local control of their nation's waterways. The convention declared anti-cholera vaccine
“a method of proven efficacy” to lessen the spread of the disease, but only recommended
the use of the vaccine in endemic regions.\textsuperscript{72}

Even more contentious were regulations on how to fumigate and disinfect ships to
remove vectors of infection, most importantly rats. Deratinization was an essential
process in preventing plague. Fumigation chemicals, the easiest way to deratinize, were
costly and poisonous. Shipping lines resented the time lost in fumigating ships and the
costs associated with it but not as much time as when they were quarantined for having
rat-carried disease. Countries feared that ships deratted in their ports might already have
brought rats with them. Going into the conference, opinions on how best to balance the
needs of commerce with the needs of public health were mixed. Methods varied around
the world prior to the 1926 convention. White’s treatise on Asia emphasized the need to
keep docks as clean as possible of rats. The International Shipping Congress concurred
that to stop rat plague, docks needed to be clean of rats, rats should be prevented from
entering ships as far as possible, and rats on ships should be stopped from breeding.
Fumigation should be rendered relatively rare by good practices.\textsuperscript{73}

How to deratinize was so controversial that the Convention provisions about it
were vague. Under the convention, governments were required “to use all the means in

\textsuperscript{72} Conférence Sanitaire Internationale de Paris 1926, 173.

\textsuperscript{73} International Shipping Conference. Item 8, International Sanitary Convention Resolution," April 16,
1926, 1, 12B/51628/22235, LON.
their power to diminish the danger and to keep informed of the conditions of rats in the ports.” They were supposed to inform others of these conditions, and perform regular bacteriological examinations of captured rats. These requirements were particularly strict for six months following the discovery of the last plague infested rat. Ports were also required to attempt to stop the boarding of rats onto ships. Countries were required to allow the disinfection and destruction of rats on plague infected ships. Rat plague could render a ship infected, which meant that humans on board were subject to isolation, medical visits, and the disinfection of their goods. However, deratinisation was required to take place in the way that the least damage would occur to ship or cargo; the specific measure was not named. Ships were required to have periodic deratinisation, with certificates attesting to its validity for six months. In instances where rats, mosquitoes, or cholera had been found during inspections, ports were allowed to require the disinfection, deratinization, and fumigation of ships.

The port suggestion that had caused White so much grief in the Far Eastern Agreement was even more controversial in Paris. White, who advocated for port classification for the rest of the world as well, was at a loss over what he saw as a perfectly logical suggestion. “This apparently innocuous question,” he wrote, “is

74 Conférence Sanitaire Internationale de Paris 1926, 163.
75 Ibid., 165.
76 Ibid., 166-167.
77 Ibid., 169.
78 Ibid., 170.
79 Ibid., 163.
sometimes debated with all the fervour that one associates with important political and religious discussion.‖

He believed that classifying ports as infected might be a salutary form of stigmatization, encouraging those ports to clean up their acts, as it were. He thought that the focus on ship and port of arrival conditions in the Paris convention did not take into account the importance of rats in disease transmission, or the fact that many ports lacked the disinfection methods for some disease that might be imported. Many others supported the idea that disinfection at the beginning was preferable. Some European nations attempted to create regional arrangements where healthy ships coming from clean ports avoided further inspection to save time. The Dutch spearheaded this effort. At heart, these decisions rested on whether or not countries agreed that the potential of improved processing times and fewer diseases arriving on ships were worth the risk of giving having to trust other countries’ medical staff.

The conference delegates settled on a mix of procedures. Ports of embarkation were required to try to stop ill passengers and all rats from entering ships, and emigrants had to be medically screened by their home country. Hajj ships had to pass through


81 Ibid., 8.

82 Ibid., 10.


additional screenings by Europeans en route. The convention preserved as a counterbalance to the right of countries to make medical visits on all arriving ships. Countries of destination also maintained the right to determine the level of deratinisation required. Canada and the United States signed the treaty with the reservation that they could override the convention when ships were believed to be infected entered their ports, revealing a divide between North America and the rest of the world, and the increased distance between Canada and the rest of the British Empire, which did not request this exemption. Consensus grew that quarantine was best avoided, and could be avoided through communication. Information sharing increasingly became the basis for epidemic control efforts.

Information sharing had always been a vital part of epidemic disease control efforts. The 1912 Convention required that ports with cases of yellow fever, plague, and cholera notify neighboring ports and the Office International d’Hygiène Publique so that brewing epidemics could be tracked. With the advent of ship-based telegraph and radio, the possibilities for sharing information increased. Ships could send ahead their health status. Ports could communicate to each other without the risk of sending messages through intermediaries that might themselves be contaminated. While these notifications rarely were allowed to replace more traditional methods such as the medical visit, they

86 Fidler, *International Law and Infectious Diseases*, 41.
87 *Conférence Sanitaire Internationale de Paris 1926*, 166.
88 Ibid., 167.
89 Ibid., 105, 130-131.
supplemented older methods when the technological and epidemiological conditions allowed.

As the world grappled with the technological possibilities of rapid disease notification, there was great discussion over what to do with the current standard of notification: the bill of health. The bill of health was a certification by the captain, and sometimes a port medical officer at the beginning of the voyage, of the health condition of the ship. Ranging from minimalist to exceedingly detailed depending on the jurisdiction, the bill of health could be time consuming for the captain to fill out, time consuming to have verified and approved, and frequently inaccurate. The form used in the Straits Settlements, praised by Norman White for its simplicity, including the past history of the ship, the number of cases of plague cholera, smallpox, and yellow fever, as well as other diseases, and deaths, a full list of disinfection steps taken, as well as a listing of all infectious diseases at the port in the past week as well as the calendar year, to be certified by the Port Health Officer. The bill of health frustrated many shipping lines. Paying ports for their certification was expensive, but states argued that the work that went into preparing them justified the expense. The British Treasury estimated a loss of £25,000 of revenue if consular visas and bills of health were abolished. In the 1920s, with the new International Sanitary Convention, some hoped to abolish the bill of health while others wanted to revise and standardize it. The British government was in favor of

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91 A. W. A. Leeper to the Secretary to the Treasury, May 3, 1929, T 161/484/ S34444/1, TNA.

92 C. Harrowsmith to the Secretary to the Treasury, December 6, 1929, T 161/484/ S34444/1, 1.
suppression of bills of health, because as the country with the world’s greatest shipping lines, it faced great pressure from shipping companies to ease their burdens. Buchanan wrote that the bill of health’s usefulness had “largely disappeared.”

Not everyone believed bills of health were outdated. Although Britain led the charge against them, their colonies appreciated the extra medical information the bills provided, especially in epidemiologically active areas. The British sanitary administration in Egypt opposed the suppression of bills of health, calling the proposal “very radical.” Even the international shipping conference wanted a bill of health, although they wanted a simplified standardized form. The Shipping Conference and Sanitary Conference both failed to agree to a standardized form.

The International Sanitary Convention kept the requirement for bills of health, but their long-term survival remained unclear. Unable to agree to a single, standardized bill of health, and largely replaced by radio transmissions, bills of health began to be edited out of International Agreements. In 1934, several countries, including Greece, Great Britain, the USSR, as well as South Africa, Australia, and New Zealand, agreed to no longer require bills of health from each other’s ships, although medical inspection was

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93 George Buchanan, “Report by the Delegate of Great Britain (1) on the Session of the Committee of the Office International d’Hygiène Publique, Paris, May, 1923; (2) on the Health Committee of the League of Nations, June 1923; and (3) on the Mixed Commission of the Office International d’Hygiène Publique and of the Health Committee of the League of Nations appointed to Consider the Permanent Health Organisation of the League (Being the Eighth Report of this Series)” (Ministry of Health, 1923), 8, MH 113/50, TNA.

94 Ibid.

95 A. Granville to Madsen, January 29, 1926, 12B/48742/22235, LON.

still allowed.\textsuperscript{97} The 1944 United Nations Relief and Rehabilitation Administration-based sanitary convention abolished consular visas and included more promises to abolish bills of health completely once the war was over.\textsuperscript{98} Bills of health were a manifestation of the need to manage medical information at ports. Careful management of information became an increasingly important issue in the international public health system.

The conference delegates still had to decide who would run the expanded epidemic intelligence and information system. The creation of the Office International d’Hygiène Publique in 1907 had seemed to bring within reach the half-century long attempt to centralize information exchange to give advanced warning of epidemics. The office had only limited authority, and its system was badly interrupted by the war.

Meanwhile, the League, through the Singapore Bureau and the growth of its epidemiological statistics service, called the Epidemiological Intelligence Service, had set itself up as a rival information gathering body, upon the request of its members. The supporters of the Office International d’Hygiène Publique were urged that this body retain the sole function required of it under the terms of the 1912 International Sanitary Convention.

Many delegations advocated that the staff of the Health Organisation take responsibility for epidemic intelligence because of its early successes in the field. Before the conference, Buchanan related, with some trepidation, that international sentiment was


\textsuperscript{98} Goodman, \textit{International Health Organizations and their Work}, 76.
“hardening” in favor of Geneva. At the conference, the Japanese delegation, which believed that the Office International d’Hygiène Publique had excluded Japan from its system, pushed hard for the League to be the new center, and failing that, “insisted” that the League’s Singapore Bureau be allowed to take notifications from Asian nations. The Italian and Polish delegations signaled that their nations would prefer to send notifications through the League. The Brazilian and other Latin American delegations praised the League’s work and wanted to expand it.\textsuperscript{100}

Not everyone agreed. The Soviet delegation studiously ignored the League, reiterating that the Office International d’Hygiène Publique was the only international health organization. Buchanan and the British announced that the Pan American Sanitary Bureau and League of Nations Health Organisation could best serve public health by supporting the Office International d’Hygiène Publique mission. The United States press reported that Hugh Cumming was allowed to sign any agreement that did not transfer these powers to the League, although Cumming’s delegation framed their objections in terms of fears over the duplication of services, eliding the fact that the United States was not a member of the League of Nations.\textsuperscript{101} The pro-Office International d’Hygiène Publique camp carried the day. The agreement was a compromise and amenable to the needs of states that had felt ill served by the old system. The “regional bureaux”


\textsuperscript{100} “The Paris International Sanitary Conference of May and June 1926,” 1926, 6 and 8, RF, R.G 1.1 Series 100, Box 22, Folder 184, RAC.

\textsuperscript{101} Ibid., 7-9.
agreement allowed countries, such as Japan, to send their disease notifications to local bureaus, which would send the notifications on to Paris. Singapore, the Washington Pan-American Sanitary Bureau, and the Alexandria Hajj station were all declared regional bureaus.\(^\text{102}\)

Despite the emphasis placed on information sharing, many of the reservations appended on the convention concerned the practicalities of inter. Most of these reservations were based on geography. China, India, portions of the British Empire, and Japan all included reservations on Article 8, which required nations to notify the international community of all outbreaks of a notifiable disease above a certain threshold. They stated that their internal public health structures were not adequate to the task – there were regions in their territory that lacked the staff, laboratory equipment, and communications infrastructure to make these notifications in a timely manner. They agreed to report internal epidemics as they became international threats, a threshold that varied based on the proximity of the outbreak to international ports, the general health of the region, and the medical facilities available to treat it.\(^\text{103}\) Japan objected to language in the convention that required nations to telegraph information about epidemics, arguing that by the time mail notification of rural, internal epidemics entered the city, the danger had often passed and the cost of the telegram was unnecessary.\(^\text{104}\) Despite these

\(^{102}\) “Report on the Work of the Tenth Extraordinary Session of the Health Committee, Held at Paris on Tuesday and Wednesday April 26th and 27th, 1927,” 1927, 2, 12B/57499/26535, LON.

\(^{103}\) Conférence Sanitaire Internationale de Paris 1926, 139-141.

\(^{104}\) Ibid., 252.
concerns, the Singapore Bureau made Asia one of the most open information-sharing regions during its existence.

By the end of June, the convention was nearly done. White called it “more up to date and somewhat less open to objection” yet still in the end “a not very satisfactory document.” ¹⁰⁵ Even after the convention was signed, ratifications took time; for example, the United States senate did not ratify it until March 1928.¹⁰⁶

The new international sanitary convention could not be called a universal agreement. Non-European regions, particularly the Middle East and Asia, were dealt with in separate chapters or even ancillary agreements that were only hinted at in the main text. Africa, excluding Egypt, was left out. White eloquently summarized the many practical and political impediments to a truly universal agreement, writing that there were “manifold” reasons people are hesitant to start a universal agreement:

some are political in nature; some are engendered of mistrust on the part of certain national administrations of the efficacy of sanitary measures carried out in countries other than their own; some arise from a widespread distrust of the bona fides of certain countries in carrying out the terms of the convention - this applies more particularly to the tendency of certain countries to suppress information regarding the prevalence of serious infectious disease as long as it can be hidden; some arise for the conflicting interests of commerce and public health - there are

¹⁰⁵ Norman F. White to Gilbert Brooke, June 13, 1926, 12B/45195x/34275, LON.

more apparently than real, and lastly, the rivalries of two international health organizations are for the moment a source of embarrassment.\textsuperscript{107}

The acceptance of a model that took into account regional differences allowed for a more universal subscription to the convention.

\section*{Epidemic Intelligence and Regionalization After 1926}

The most important outcome of the 1926 convention was the increased international emphasis on information sharing. Despite the more favourable position granted to the Office International d’Hygiène Publique in the convention, the most important epidemic intelligence work took place at the League of Nations Health Organisation. Rajchman and the other members of the Health Committee and Health Organisation invested the Epidemic Intelligence Service with several ambitious goals. Both the League of Nations and the Rockefeller Foundation viewed the Epidemic Intelligence Service as an integral part of the League’s plan to prove its worth and earn permanent status, as well as to promote international co-operation, in addition to its primary goal of intelligence gathering.\textsuperscript{108} The Epidemic Intelligence Service joined other League of Nations initiatives, such as expert exchange trips in attempting to create an \textit{esprit de corps} among the various national health administrations.\textsuperscript{109} The League of


\textsuperscript{108} Rockefeller Foundation, “Minutes of the International Health Board,” May 23, 1922, RF, R.G. 1.1 Series 100, Box 20, Folder 164, RAC.
Nations Health Organisation also wanted the service to prepare statistical data in addition to the information about the movement of the disease. Although epidemiological data could help plan immediate action, disease statistics could allow for long-term comparison and planning.\footnote{League of Nations, “League of Nations Provisional Health Committee. Minutes of the Third Session Held in Paris May 11th-16th, 1922. C.366 M. 217 1922 III,” in \textit{League of Nations Publications}, III Health (Geneva: League of Nations, 1922), 17.} The role of the Epidemic Intelligence Service was clarified under Edgar Sydenstricker, an American who had worked extensively on epidemic control and statistics for the Tennessee Valley Authority and was brought in by Rajchman to solidify the program of the Epidemic Intelligence Service. He urged caution, and wanted to create a clearing house rather than a “super statistical organization.” He also wanted to start slowly but build from a European base on to South America and Asia.\footnote{League of Nations, “League of Nations Health Committee. Minutes of the Fourth Session Held at Geneva, August 14th-21st, 1922. C.555.M.337.1922.III,” in \textit{League of Nations Publications}, III Health (Geneva: League of Nations, 1922), 10.}

Because the required notifications under the International Sanitary Convention had to be made to the Office International d’Hygiène Publique, the Epidemic Intelligence Service focused on collecting longer term statistics, with the hope of discerning larger patterns in epidemics. They began to publish monthly and yearly compilations of statistics. They also participated in the revision of the International Cause of Death list. Standardizing causes of death allowed the commensurability of death statistics from around the world.\footnote{Edgar Sydenstricker, “Memorandum on the Preliminary Work of the Special Service of Epidemiological Intelligence and Public Health Statistics. C.H. 91.,” in \textit{League of Nations Publications}, III Health, 1923, 91.} Thus the Epidemic Intelligence Service was involved in two \footnote{See Borowy, \textit{Coming to Terms with World Health}, 105-108.}
different projects: collecting statistics to universalize information coming in from diverse parts of the world and managing the League’s epidemic reporting network.

Despite the compromise that left Office International d’Hygiène Publique as the center of the required International Sanitary Convention notifications, the League of Nations Health Organisation became Europe’s most important hub of epidemiological information. The Geneva office had more staff, a larger printing budget, and a wider purview of disease data collection, which meant that the League service could produce more statistics. By January 1926, before the Sanitary Conference, Albania and Portugal were the only large European states not reporting to the League.113 One observer from Germany wrote that these “bulletins can be seen as proof of the increasing harmonious collaboration of all civilized nation in counteracting epidemics, and of the humanitarian aims of that Section, which are being more and more appreciated.”114 As this information became statistically and strategically valuable in Europe, attempts were made to export the model around the world. Adapting the model outside of Europe proved problematic because many regions did not have the capacity to produce comparable statistical notifications.

The Singapore Bureau, the only League bureau that could collect official convention-based notifications rather than international vital statistics, which began operating before the International Sanitary Convention was signed, had a head start on building local information infrastructure. The first years of the Singapore Bureau were

113 E. Roesle, “The Epidemiological Reports of the League of Nations,” January 1926, 3-4, 12B/48822/17928, LON.
114 Ibid., 1.
occupied with establishing its weekly report, called the “fasciculus,” and creating a radio and telegraphic network over which it could transmit its epidemiological intelligence. The Bureau achieved early success. Within a year of the bureau’s opening director Gilbert Brooke reported to Rajchman that “the bureau progresses famously” and that the weekly fasciculus had grown from reporting data from two countries to reporting information received from seven.\footnote{Gilbert Brooke to Ludwik Rajchman, April 1, 1925, 1, 12B/43209x/34275, LON.} This early communication relied on telegraphy. Singapore had been chosen because of its strategic importance as a telegraphic site.\footnote{For more on the development of international telegraphic systems, see Jill Hills, \textit{The Struggle for Control of Global Communication: The Formative Century} (Urbana and Chicago: University of Illinois Press, 2002); Daniel R Headrick, \textit{The Invisible Weapon: Telecommunications and International Politics, 1851-1945} (New York: Oxford University Press, 1991).} But telegraphy had weak points. It could be very expensive. Governments had, under international agreement, preferential rates and priority position on international cable lines. The League, however, was not considered a government. At the 1925 International Telegraph Conference, the League was afforded government privileges for the priority of its messages, but reduced government rates for League correspondences “was never even discussed.”\footnote{Norman F. White to Gilbert Brooke, November 26, 1925, 1, 12B/34665/34275, LON.} Singapore’s work was eased by the development of a telegraphic code, called the AA code, which decreased the length of telegrams and therefore their costs.\footnote{“Eastern Bureau Annual Report for 1925 and Minutes of the Council Meeting held in Singapore, January 4th to 6th, 1926,” 1926, 10, 12B/34665/34275, LON.} The telegraph was not enough to support a worldwide epidemiological intelligence network given the financial restrictions of the 1920s.
The international community continued to debate how to integrate new communications technologies into the international sanitary system. By the mid-1920s, international epidemic control was dependent on a variety of communication methods that struggled to surpass the speed of transportation. Mail remained the backbone of the system. For non-time sensitive information, such as quarterly statistics and lengthy reports, mail remained the most cost effective method of communication. Telegraphy and radio seemed to offer more safety afforded by quicker communication. Adopting these technologies was fraught with technical and political pitfalls. Questions of reliability plagued the adoption of these new technologies, despite pressures to adopt them from shipping companies, which wanted to be able to send ahead their health status. Rajchman agreed that while the data were valuable, they should not be afforded the status of official, legal notification until the technology was accepted as more reliable.  

Radio, or wireless telegraphy, seemed able to solve many problems. Radio transmissions were significantly cheaper than telegrams. Radio did not require a sophisticated infrastructure. The League had ready access to a radio transmitter in Singapore that could reach to Europe, the Indian Ocean and most of Asia, and one at Nauen, Germany that could cover the rest of Europe, Africa, and the Americas. Using radio broadcasts, Singapore would only have to transmit each round once, saving time and money, because other stations would be able to pick up and relay the message further afield. Adding Asian data to the Nauen broadcast illustrated a major difference between

119 Ludwik Rajchman to Albert Lutrario, January 16, 1925, 12B/41753x/41647, LON.
120 White to Brooke, November 26, 1925, 1-2.
how disease information was managed in Asia and in Europe. A.L. Hoope of the British
government feared that Nauen broadcast would open to public scrutiny diseases that
might embarrass eastern governments.\textsuperscript{121} However, in the East, where disease to some
extent was assumed, open sharing of information was regarded as the only way to
maintain the public health. In the West, where public health was seen as a major
responsibility of the state and marker of civilization, there were fears that such data could
cause embarrassment, or give away strategic or economic advantage.\textsuperscript{122}

Even after deciding to use radio in 1925, setting up the broadcast system proved
more difficult than Gilbert Brooke, the director of the Bureau, had anticipated. Although
by June 1925 thirty weekly returns reached the Bureau, most came in via telegram or
letter.\textsuperscript{123} The wireless messages that Saigon sent to the Office International d’Hygiène
Publique under the International Sanitary Convention were sent in clear because Paris
lacked a copy of the code.\textsuperscript{124} Neither India nor Japan could receive the broadcast, which
meant that the League had to revert to the more expensive telegram. In 1925, only
British North Borneo and Java could receive that version of the wireless broadcast.\textsuperscript{125}
Brooke reported in 1926 that attempts to increase the use of radio “proceed[ed] slowly.”
Many ports responded by letter to the League’s telegrams about the possibility of using

\begin{footnotes}
\item[121] A. L. Hoops to Colonial Secretary, Singapore, April 17, 1929, CO 273/555/10, TNA.
\item[122] Joseph Avenol to Under-Secretary of State, Foreign Office, March 1932, 8D/27425/158, LON.
\item[123] Gilbert Brooke to Norman F. White, June 15, 1925, 12B/45195x/34275, LON.
\item[124] White to Brooke, November 26, 1925, 2.
\item[125] Gilbert Brooke to Norman F. White, October 6, 1925, 1, 12B/34665/34275, LON.
\end{footnotes}
In June, months into the experiment, Brooke wrote again to complain that “it has been very hard indeed to stimulate the various Administrations to make an effort to pick up one of the broadcasts of which we have now quite a fair number.”

Not all hope was lost. A complicated relay structure seemed poised to allow ports as far flung as Australia, Shanghai, Aden, Zanzibar, and Madagascar to receive broadcasts. Despite the possibilities for success in the East, broadcast remained at best a regional technology. Wireless had not yet expanded commercially to Africa, and the weather conditions meant that in much of the continent it could not be used between 2 pm and dusk for most of the year. Some transmission was possible between Morocco, Southern Algeria, and Tunisia. The League continued to add wireless sites over the existence of the Singapore Bureau.

Financial problems also plagued the bureau. Although the leadership of the League of Nations Health Organisation had embraced the opportunity to extend its operations to the East, the League hierarchy had understood the expansion as a regional rather than international project. Although the League had considered asking European countries to bear most of the costs of the anti-typhus operation, expenses were shared by all the members of the League. The council justified the shared burden by claiming that the whole world had benefited from preventing a pandemic. When discussions of

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126 Gilbert Brooke to Norman F. White, March 10, 1926, 1, 12B/45195x/34275, LON.

127 Gilbert Brooke to Norman F. White, June 3, 1926, 12B/45195x/34275, LON.

128 Gilbert Brooke to Ludwik Rajchman, June 18, 1926, 12B/45195x/34275, LON.

funding the Singapore bureau arose, the Japanese delegate argued that because “the benefit to be derived from the establishment of the Bureau is not only for the countries situated in the Orient but for other countries as well,” the League of Nations should pay for the Bureau out of regular funds, but the appeal was not accepted.\footnote{130}{“Eastern Bureau Annual Report for 1925 and Minutes of the Council Meeting held in Singapore, January 4th to 6th, 1926,” 40.} By 1926, the Bureau financial struggles reached a critical point, even though the Rockefeller Foundation grant had not yet expired. The Straits Settlements offered to pay contributions earlier than anticipated, but the Japanese government announced it would not plan to pay until the Rockefeller money decreased in 1927 or 1928. Resentment grew. Although many countries in the region were willing to give “small payments” if the League took over financing, regional subscriptions continued to be the most important source of funding for the Bureau.\footnote{131}{Ibid.}

Amidst financial uncertainty, the staff of the Singapore Bureau expanded their work. In addition to sending disease notifications to Paris under the terms of the International Sanitary Convention, the staff conducted studies of indigenous disease and port practices and facilitated exchanges of medical personnel in the east. The success of the Bureau seemed to suggest that the members of the Health Committee and their local partners had discovered a model for regional public health work.
The Failure of Translation to Africa

With the rest of the world covered by regional health arrangements, attention
turned to bringing Africa into the global sanitary system. From early on, the members of
the Health Committee had discussed how to expand the work of the Health Organisation
to Africa. Rajchman had hoped that “the undertaking of this work would convince the
natives of Africa that the European nations had the interests of civilization at heart.”

The Health Committee began its formal work in Africa by collaborating with the
League’s Permanent Mandates Commission. The commission, which conducted an
annual statistical survey of conditions in the Mandates, turned to the Health Committee to
help them develop more sophisticated disease statistics in 1922. The commission wanted
the mandatories to report on the incidence and treatment of sleeping sickness,
tuberculosis, plague, and smallpox, among other diseases.

The Health Committee agreed to compile health data on African mandates to facilitate its entry into African
health issues and to supplement its global epidemic intelligence efforts. The committee
sent letters to the offices responsible for colonial health in Africa, some of which were
actually located in Europe, but received few replies. In 1922 the committee speculated
that the poor response stemmed both from lack of interest in health matters that
concerned the indigenous populations and hesitation to reveal potentially embarrassing


133 William E. Rappard, “Letter from the Director of the Mandates Section Submitted to the Health
Committee on August 14, 1922,” in League of Nations Publications, III Health (Geneva: League of
Nations, 1921), 45.
information. Ambivalent about working through colonial structures and frustrated with the official channels for relaying epidemic intelligence, the committee decided to supplement the official channels with private correspondence and reference materials.\textsuperscript{134}

The effective exclusion of Africa from the 1926 International Sanitary Convention coupled with the success of the Far Eastern Bureau led to calls for the creation of a Singapore-style bureau for Africa. Supporters argued that a bureau was necessary not only for the good of Africans, but also for the good of European powers. Improved health conditions in Africa would lead to improved economic outcomes for colonial powers. Lucien Raynaud, the head of Pasteur Institute’s laboratory in Algiers, was a passionate advocate of the importance of health work to the colonial project. Africa, he believed, was at risk of depopulation through invasion, tribal wars, slavery, famine, and epidemics.\textsuperscript{135} Europe, because of its use of “black labor” and “colored troops” was at risk of importing “diseases which have hitherto been confined to the black races” and consequently, “Europe and all civilized nations are bound, in common humanity, to give a thought to the situation of these backward peoples who are being mown down by so many diseases and afflictions.”\textsuperscript{136} The rhetoric supporting the African bureau mixed economic, humanitarian, and imperial justifications.


\textsuperscript{136} Ibid., 75.
The placement of the proposed bureau raised political and practical problems. Raynaud offered the use of his Pasteur Institute laboratory in Algiers. Raynaud argued that the air, rail, and wireless connections from Algeria to the rest of Africa and across the Mediterranean would allow Algiers to handle the bureau’s heavy communications responsibilities. He estimated the bureau would cost approximately 70,000 French francs a year for a doctor, stenographer, clerical and office support, printing and postage. Although Rajchman supported Raynaud’s suggestion, Britain and its empire favored locating the Bureau in Egypt. Perrier, the Inspecteur General du Service de Santé, claimed that his office would prefer Dakar, another French colony, because it was the natural center of Africa. The Portuguese government supported that position. Other experts advocated a tripartite division of the continent, including a Mediterranean region centered in Algiers, and a Western and Atlantic bureau built at Dakar, with East Africa reporting to Singapore, a process that had already begun. The location of the bureau proved impossible to agree on, and without a strong national advocate, the proposed bureau faltered. Once again, a model created for one part of the world failed to translate to another.

137 Ibid., 79 and 82.
138 Ibid., 84.
139 G. A. Mitchell to Ludwik Rajchman, 1926, 12B/52848/45465, LON.
140 Perrier to Ludwik Rajchman, October 4, 1926, 1, 12B/52846/45465, LON.
Conclusion

Even the most committed interwar medical internationalist had to confront the hard facts of geography and epidemiology. Different regions needed different arrangements. Regionalization was an imperfect reaction to the challenge of creating one international health system. The regions into which the world divided were highly artificial, dependent on a variety of epidemiological, political and technological factors. Politically, these regions replicated traditional spheres of influence, and although Japan in particular lobbied for more independent control of its sanitary sphere of influence, Singapore’s Far Eastern Bureau was more attentive to British and French imperial concerns. Technologically, regions were as apt to be based on radio distances as political or epidemiological coherence. The 1926 Convention was lauded because it covered more territory than previous sanitary conventions. In retrospect, its greatest achievement was not only the areas covered, but how each of those regions shaped the character of the agreement. The convention also illustrated that Europe was no longer the sole driving force in sanitary legislation. Asia and the Americas each offered models as well, influenced though they were by European and imperial concerns.

The 1926 International Sanitary Convention had to catch up with the technological and political changes of the era. The new system allowed ports to use information to keep one step ahead of the diseases they were trying to catch. The relative political and technical ease of setting up information-gathering systems gave the League and the Office International d’Hygiène Publique a way to expand their traditional spheres of operation. While the leaders of these organizations discovered that they could not
adopt a one-size-fits-all policy in dealing with non-European regions of the world, information sharing, easy to scale up or down and almost universally useful, became the most obvious way to create an international system. Over the 1920s and 1930s, information was relatively easy to share, until World War II again made epidemic data a national secret.
Chapter 4: Disease Commissions and Local Advice in a Global Context

In 1927, perhaps frustrated by years of infighting and the immensity of the malaria problem, the authors of the second report of the League of Nations Health Organisation’s Malaria Commission declared each country would have to “work to its own salvation.” The members of the commission had been unable to develop a global prescription for stopping malaria, acknowledging the difficulty the organization faced in producing health advice for the entire world. The diversity of local conditions challenged the attempts of the members of the multinational commissions of the League of Nations Health Organisation to research diseases and recommend solutions on a global scale. Problems including cancer, malaria, and sleeping sickness were too complicated for commissions of even the world’s finest experts. Despite this inescapable limitation, the commissions helped to create an international culture in which public health specialists and their governments understood public health problems in social, structural, and environmental as well as medical terms. Increasingly, international experts took for granted that these issues were best solved through international consultation and cooperation, rather than as zealously guarded national secrets. Although national policy

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makers might have to work out their nation’s salvation based on local conditions, they would do so with significant international support.

The members of the disease commissions used new institutions and strategies to combat diseases newly brought to the attention of international public health workers. These commissions varied in structure: large, consultative bodies of outside experts, small groups of League and non-League experts that met in European capitals, and scientific teams deployed to the field. The experts on the commissions advocated a number of strategies, of which some, such as vaccines, border control, and general sanitation represented a continuation of older techniques, while others, such as the increased emphasis on environmental intervention, were new for the League of Nations Health Organisation and relatively new for the world. Through the work of the commissions, the staff of the Health Organisation and their supporters put forward the view that endemic diseases, previously treated as national problems, were international issues that demanded state involvement. National policymakers accepted this change because the commissions left the choice of intervention up to national governments rather than imposing external solutions.

In this chapter I analyze the three League of Nations Health Organisation disease commissions that best exemplify these trends: the Cancer Commission, the Malaria Commission, and the Sleeping Sickness Commission. Although commissions dealing with rat control, nutrition, and biological standardization were struck and accomplished valuable international work (the sera commission led to the standardization of anti-disease sera worldwide, one of the major international public health victories of the
interwar era), these disease-control based commissions illustrate the changing face of international epidemic control in the late 1920s. The international community became interested in a broader definition of public health that was largely proactive rather than defensive, and focused on internal health issues rather than external threats. They brought nineteenth-century national developments, particularly the increased importance of vital statistics and the articulation of the social responsibilities of governments to their citizens into the international sphere.

The work of the commissions varied based on the exigencies of the disease and available support. Taken together, their work illustrates the increasing attention that the Health Committee paid to diseases that were local problems and not apt to spread via traditional modes of transmission exemplified by cholera or plague. To address this type of epidemic, the commissions experimented with a variety of methods. The Cancer Commission conducted statistical studies, first of cancer rates compared across Italy, Northern Europe, and America, and then statistical comparisons of treatment. This commission struggled under the complexity of the illness and the fact that even state-of-the-art statistical techniques and epidemiological concepts were not adequate to comprehend the causality of the disease or its variations. The Malaria Commission began in the wake of World War I, which had brought especially virulent malaria to Europe. The ambitious commission oversaw research, conferences, and administrative interchanges. The Malaria Commission was the most methodologically fraught, with deep differences developing between those who favored the use of quinine and other

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medical measures while a competing group emphasized the important of environmental
techniques such as drainage and the destruction of other mosquito breeding grounds. The
Sleeping Sickness and Tuberculosis Commission evolved into an African diseases
commission. Despite its limited geographic focus, the commission drew on international
discussions of disease control and disease causality. Taken together, the commissions
articulated an international conception of disease as a social and political problem.

The Increasing Importance of Endemic Diseases

Prior to World War I, endemic diseases were barely matters of official
international concern. International activities took place outside of government-
supported contexts. Interested medical professionals collaborated with colleagues across
state lines. Some international conferences convened on specific diseases, notably
tuberculosis and sleeping sickness. International associations charged with researching
particular diseases, such as the Central Bureau for the Prevention of Tuberculosis, created
another international venue, but received limited state support. Colonial medicine, a field
with political, military, and economic rather than internationalist aims, claimed many
tropical diseases under its purview.³

³ Michael Worboys, “The Emergence of Tropical Medicine: A Study in the Establishment of a Scientific
Specialty,” in Perspectives on the Emergence of Scientific Disciplines, ed. Gerard Lemaine, Maison des
Ehrlich’s Colonial Connections: Scientific Networks and Sleeping Sickness Drug Therapy Research, 1900–
A firm international consensus that endemic diseases were a state’s own affairs developed in order to preserve states’ sovereignty and to avoid entangling the international community in complicated and potentially expensive interventions. Support for international action against the typhus epidemics of the early 1920s ended when the disease became merely a regional epidemic. The International Sanitary Conventions functioned similarly. The only diseases that required international notification of outbreaks, such as cholera, yellow fever, and plague, were those which crossed international boundaries to places where they did not usually occur.

Changing disease patterns shaped the League program. As the political situation became more settled, Europeans became healthier. The beginning of the decline of infectious diseases that had begun in Europe in the late nineteenth century accelerated. Particularly for the Great Powers, who set much of the League of Nations Health Organisation’s policy, infectious diseases were less of a concern than even a decade before. For example, continental notifications of smallpox (excluding Russia and Spain) had declined from 20,000 cases in 1920 to fewer than 700 cases in 1927. To confront the epidemiological transition, the League of Nations Health Organisation began to deal with longer term, chronic diseases, such as cancer. These diseases, combined with the

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aftereffects of World War I, had led to increased national anxiety around Europe about the health of the nation. Fears of degeneration, of decreased fertility, and the attendant weakening of national economic and military strength made health a national priority internationally.⁷ Chronic disorders, such as headache, constipation, toothache and other low level complaints that interfered with happiness and productivity also gained new attention alongside more serious chronic conditions such as heart disease.⁸ The anxiety over these non-infectious health concerns, although strongly nationalistic, helped spur international interest in programs that promoted health in addition to defending against external diseases.

These endemic diseases did not respond well to neo-quarantinist methods of control, and other purely medical approaches, such as vaccines and drugs, were often inadequate or unavailable. Malaria, cancer, and sleeping sickness all challenged the bacteriological model of disease that had gained increasing currency in the late nineteenth-century.⁹ Effective control required social and environmental approaches. As noted already, many participants in the League of Nations Health Organisation’s work had used that perspective in their national work. Léon Bernard was a major proponent of

⁷ See Mark Mazower, *Dark Continent: Europe’s Twentieth Century* (New York: Alfred A. Knopf, 1999), 76-103 for more on this phenomenon.


⁹ The germ theory of disease was never monolithic, and public health professionals frequently cited non-contagionist factors in disease transmission. See for example Michael Worboys, *Spreading Germs: Disease Theories and Medical Practice in Britain, 1865-1900* (Cambridge: Cambridge University Press, 2000). The International Sanitary Conventions found political expediency in mandating quarantine and vaccination and backing a contagionist model by the 1890s rather than in advocating for more extensive internal changes.
social approaches to tuberculosis control in France. 10 Major Greenwood, a British statistician and a member of several League commissions, advocated for an environmentalist, “soil over seed” model of many diseases. 11 This orientation led the League of Nations Health Organisation to be an early champion of social medicine. Rajchman, although trained as a bacteriologist, had a catholic definition of health. Although the World Health Organisation in the post-World War II era would claim credit for pioneering the transition from understanding health as an absence of infectious disease to health as a state of well-being, the Health Committee’s interests and willingness to support a variety of projects illustrates that such an attitude was already taking place in the 1920s at the League of Nations Health Organisation. 12

This shift in orientation led the Health Committee to take an increased interest in multi-strategy approaches to promoting health rather than just strategies to control disease. These multi-strategy approaches, which frequently included environmental management, housing amelioration, nutrition improvement, and education, were often termed broadly “social medicine.” At the League, the main proponents of these approaches, and this environmentalist understanding of diseases, were often on the political left. Rajchman, a major advocate of this way of thinking, was a socialist and

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12 Borowy, Coming to Terms with World Health, 449.
viewed these interventions as part of the progressive responsibilities of the state. Major Greenwood was an international force in environmentalist understandings of disease, and used his statistical modeling to support this understanding, after splitting with his mentor Karl Pearson’s eugenic understanding of health and illness.

But social medicine, along with the multi-strategy approaches its supporters recommended, was not the sole province of those of any one political persuasion. George Buchanan, a lifelong conservative, was a strong advocate of social medical understandings of disease, and often pushed for inquiries into issues such as cancer and venereal disease, although he argued for less government involvement in the solution to these social ills. Alberto Lutrario, a fascist and close advisor to Mussolini, also advocated social medical approaches, coming out of the Italian attempt to build a stronger state. In addition to their positive eugenics programs, known as eugenics, the Italians undertook a multi-strategic approach to malaria approach which included education, environmental management, and quinine distribution.

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Although health experts of various political persuasions looked to broadly-based health programs to improve society, other pressures and paradigms affected how public health programs were designed. The bacteriological paradigm created by germ theory and new therapies led researchers to seek out, in the words of Paul Ehrlich, “magic bullets” that would attack only the causative agent of disease. Ehrlich’s discovery before World War I of Salvarsan, an arsenic-based compound that effectively treated syphilis, set off an increased search for focused cures.\textsuperscript{18} The appeal of this type of method was two-fold. Effective drug treatment seemed both medically more justifiable and poised to limit the costs and hassle of disease control, an appealing prospect in an era of tight budgets and considerable debate over what extent international bodies and even national governments could or should interfere in the lives and bodies of the world’s population.\textsuperscript{19}

The tensions between bacteriological and environmentalist approaches to disease were complicated by the emerging ecological model.\textsuperscript{20} This model, only newly articulated through the work of ecologists such as Charles Elton, attempted to track the relationship between parasites, animals, humans, and the environment. This recognition of complexity went beyond the social-environmental understanding of disease espoused


by those who wanted to investigate nutrition and housing, which attempted to control the healthiness of humans’ immediate environment. The recognition of the role of parasites in sleeping sickness and malaria made ecology a pressing concern for several commissions. The lack of an agreed-upon paradigm for ecology made this a difficult undertaking.²¹ Sometimes, as with proposals for swamp draining and bush burning, the Health Committee and its local partners addressed ecological concerns as purely environmental. In other instances, as in the attempts to control malaria parasites through quinine or the trypanosomes of sleeping sickness through atoxyl, the Health Committee treated the parasite as a bacterium, and approached parasitical diseases with a bacteriological understanding. In this period, ecological understandings were only emerging and often did not offer solutions to the Health Committee, even though the commissions examined in the relationship between human, parasite, host, and environment. This chapter illustrates the tensions amongst these approaches and the challenges posed to them by the diseases the committees studied.

**The Cancer Commission**

In the 1920s, cancer remained a mysterious illness. Doctors found the causes and treatment of the disease obscure. Public health authorities, in the main, were unsure how to approach the issue. The plethora of suggested causes, from hormones, to viruses, to

environmental factors, did not suggest a traditional model of public health intervention.\textsuperscript{22} New treatments, such as surgeries and radiotherapy, led medical professionals to focus on controlling the disease in individual patients, rather than prevention or eradication, further removing cancer from the realm of public health and into the clinic.\textsuperscript{23} Despite the general understanding that cancer was a private problem, it had public consequences in terms of work lost and, because of theories that connected its etiology to working conditions, home life, and morality, cancer played on a number of anxieties about the modern condition of life. Reproductive cancers caused particular concern, tapping into broader cultural anxieties about the birth rate and breastfeeding.\textsuperscript{24} Some viewed cancer as a sign of degeneration. Later, in the 1930s, cancer represented a threat to racial hygiene for the Nazis.\textsuperscript{25} With the increasing interest from the League of Nations Health Organisation and other bodies in issues of long-term health and diseases of civilization, cancer was a prime territory for exploring new issues in international public health. Many governments were eager to participate, because of the fears of degeneration and


\textsuperscript{23} David Cantor, ed., \textit{Cancer in the Twentieth Century} (Baltimore: Johns Hopkins University Press, 2008), 2.


national weakness of which cancer was thought to be emblematic. Consequently, the Cancer Commission explored new terrain for public health.

The Cancer Commission was unlike the other Health Committee commissions. The members of the commission did not engage in study tours and began with no firm plan for their investigations. Their first work began as an exercise in comparing the results of national studies on cancer rates in Italy, the Netherlands, and Great Britain. The area of enquiry arose directly out of the work of Buchanan and Major Greenwood had presented to the Office International d’Hygiène Publique. The Office’s model of international cooperation carried over into the cancer commission’s early work. Despite its traditional beginnings, the Cancer Commission was a progressive public health undertaking. By highlighting the important knowledge that could be gained from large-scale studies, the Cancer Commission developed a new area of international inquiry.

Buchanan modeled the work of the commission on his ideal of international cooperation. The comparative, statistical design of the first study appealed to Buchanan, who maintained that work of international coordination rather than direction was more appropriate for the League of Nations Health Organisation. Others objected. Rajchman expressed his view that this model did not produce results proportional to its cost, but could not easily put an end to the Cancer Commission because it was one of Buchanan’s “pet activities,” and as a fixture on the international public health scene as the

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representative of Great Britain, Buchanan’s projects were difficult to refuse. Buchanan’s affection for the work often blinded him to the principles he propounded so frequently on the committee. The commission frequently had cost over-runs and expanded from its original goals into ever more complicated and costly avenues.

Buchanan’s faith in statistics was shared by many of his public health compatriots. The Health Committee’s own support of epidemic intelligence and statistics is evidence of the growing interest in statistics among health professionals. Outside of League circles, occupation health specialists turned to statistics to locate patterns in occupational disease. The Fascists likewise compiled large numbers of statistics, including the cancer enquiry described below, in order to assess the health of the Italian population as a first step to managing it. Although Buchanan may have advocated statistics because they left the steps taken to address their results up to the government, others viewed statistics as a first step to intensive population management.

The work began modestly in 1923. Major Greenwood’s recent comparisons of international cancer morbidity and mortality revealed dramatic differences in death rates between Britain, the Netherlands, and Italy, with rates significantly lower in Italy as revealed by recent national studies. Buchanan encouraged the Health Committee to urge the countries to investigate certain cancers more closely, in order to determine what

27 Selskar M. Gunn to F. F. Russell, October 19, 1926, 3, R.F., R.G. 1.1, Series 100, Box 20, Folder 170, RAC.


29 Horn, Social Bodies: Science, Reproduction, and Italian Modernity, 11.

caused the differences in death rates. The Health Committee struck a sub-committee on cancer to study cancers of the breast and female genital organs, because they were being studied already and because they were easier to diagnose than other cancers. Several surgeries for gynecological cancers existed as well, allowing the commission to study both causes and treatments.31

The commission first studied the causes of cancer. The etiology of cancer was unclear in the 1920s. Environmental, dietary, occupational, and hereditary causes each had their proponents. The commission cast a broad net in deciding causes of cancer to study, and considered studying the effects of breastfeeding and women’s sexual behavior, as well as trauma, factory work, heredity, and race. Members discussed the “ostensibly trivial” issues of national dress because “it is not unreasonable to suppose that variations in the fashion of constricting the chest of waist by inappropriate clothing are of aetiological importance.” Subcommittee members suggested consulting educated women familiar with the customs of the three countries. No record of such consultations exists.32

31 “Memorandum by Sir George Buchanan and Dr. Major Greenwood on the Work Proposed at the British Ministry of Health to Elucidate the Causes of Mortality from Cancer of the Breast and Female Genital Organs in England for Comparison with the Corresponding Mortality in the Netherlands and Italy; Together with Observations on Similar lines of Enquiry in the Netherlands and Italy. Forwarded in September 1923 by Dr. Jitta, Dr. Deelman, and Dr. Lutrario for consideration by the Sub-Committee,” November 1923, 1, 12B/30416/28874, LON. These so-called “accessible cancers” were the focus of many national health campaigns, including Britain’s. See Ornella Moscucci, “The British Fight against Cancer: Publicity and Education, 1900–1948,” Social History of Medicine, 23 (2010): 356-357.

32 “Memorandum by Sir George Buchanan and Dr. Major Greenwood on the Work proposed at the British Ministry of Health to Elucidate the Causes of Mortality from Cancer of the Breast and Female Genital Organs in England for Comparison with the Corresponding Mortality in the Netherlands and Italy; together with observations on similar lines of Enquiry in the Netherlands and Italy. Forwarded in September 1923 by Dr. Jitta, Dr. Deelman, and Dr. Lutrario for consideration by the Sub-Committee,” 14.
The broad focus of the work created controversy for the commission and the members had difficulty coordinating the national studies in England, Holland, Italy, and the Netherlands. The League attempted to create a questionnaire that would standardize the collection of data and guide the inquiries in the individual nations.33 Despite the distribution of the questionnaires, individual nations went in their own directions. The Italian government chose to study a larger scale of cancer rates, and slowed down the process by foregoing the use of public statistics and looking instead at two million death certificates to compile newer and ostensibly more accurate numbers.34 The team in the Netherlands, a small country, could not find the 500 required cases and had to delay completing the questionnaire.35

Despite these early challenges, Buchanan sought to expand the scope of the statistical studies to include more data and more experts.36 In February 1924 he asked the Health Committee for 82,500 Swiss francs plus travel expenses to fund his expanded program. In the previous year, the Health Committee had been awarded only 79,000 Swiss francs for all of its investigations.37 The request led to a heated confrontation

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33 George Buchanan to Edgar Sydenstricker, November 24, 1923, 1, 12B/31967x/28874, LON.


36 Ibid., 75.

between Buchanan, eager to protect his pet project, and Léon Bernard, who, despite professing a desire for expanded research in cancer, attacked the basis of the commission’s early work. Bernard claimed that breast and uterine cancers were more prone to errors of diagnosis than other cancers, and, affecting only one sex, did not give a good snapshot of the entire cancer situation of a country. With such a potentially limited sample, the cost of the inquiry was out of line with its scientific promise. Buchanan told Bernard that, not having been at the Office International d’Hygiène Publique meeting where cancer was recently discussed, he could not understand the full magnitude of the study’s potential. Buchanan added that the countries involved would continue their individual investigations without further League funds, but it would be a “matter for regret to refuse the grant of a modest sum which would secure what was otherwise not obtainable, namely, the making it certain that the particular investigations decided upon would be conducted in the same manner in all three countries.” The committee gave in to Buchanan, and allowed the matter to be taken up by the League budget committee, which ultimately reduced the amount given, but did provide subventions through 1926 of approximately 15,000 Swiss francs annually.

The commission’s statistical work produced limited results. Even Buchanan was forced to admit that “if the success of a scientific undertaking were to be judged by

38 Ibid., 48 and 50.

39 Ibid., 51. The conflict may have arisen in part because of Buchanan’s attempts to de-fund Bernard’s Tuberculosis Commission.

whether the problem originally proposed has or has not been solved, we should have to say that this investigation has failed.” The commission failed in its ambitious plan to account for the differences in death rates between the relatively stricken England and Holland and the less victimized Italy. Buchanan, surprisingly, advocated increasing the area of enquiry because “it has often, perhaps more often than not, happened in scientific research that the end actually reached by an investigator is not only quite different from but more important than the goal he originally proposed.”

Despite that grim assessment from the committee’s greatest supporter, the commission drew preliminary conclusions in three areas: the role of family structure and the role of race in cancer susceptibility, and the effects of treatment. This early work revealed that unmarried women had higher mortality than married women. Mothers had a higher rate of cervical cancer than women who had never had children. British studies found suggestive links between “marriage, childbearing and suckling” and breast cancer: women with breast cancer were less likely to have breast fed children. The statistical and survey techniques used by the statistical sub-committee, despite their

41 George Buchanan, “Some Notes by Sir George Buchanan on the Position of the Cancer Investigation to be Submitted to the Health Committee. C. H. 366”, October 1925, 3, 12B/46954/28874, LON.

42 Ibid., 3-5.


44 Ibid., 8.

limits, were quite advanced and relied on the pioneering work of Dr. Janet Lane-Claypon, whose work on cancer for the British Ministry of Health has been hailed as paving the way to the postwar models of epidemiological statistics that allowed, for example, for smoking to be accepted as a cause of lung cancer. This model of causality, which used statistical associations like those being developed by the cancer sub-committee rather than direct laboratory evidence, was hotly contested and not yet worked out in the interwar period.46

The second area in which the commission produced tangible results was in the study of the effect of race on cancer rates. Common knowledge held that certain races within Europe and Africa were less prone to cancer. Although Buchanan was skeptical of racial involvement, the sub-committee enlisted several anthropologists to study the question. Buchanan showed his opinion in his summary of the report, writing “When a moment of consideration is given to the facile claims which have been made for individual nations and races that they are especially prone to, or especially exempt from, liability to cancer, this reasoned judgment, though negative in character, is not without practical value.”47 The report, he hoped, would “serve as an example of the caution which it is necessary to employ when handling problems of race.”48


The authors of the report did not agree with Buchanan’s assessment. They claimed that the evidence suggested that the Mediterranean races were less subject to cancer than the alpine, but they did not think there was enough evidence for a definitive conclusion.\textsuperscript{49} For his part, the Italian criminologist and statistician Alfredo Niceforo found that in Italy there seemed to be no susceptibility to cancer in individual races, although mixed race individuals seemed to be more susceptible.\textsuperscript{50} Eugene Pittard, his Swiss anthropologist co-author, saw clearer links between cancer mortality and race in France.\textsuperscript{51}

Niceforo and Pittard used what they described as a purely biological definition of race that was based on the degree of resemblance of physical and morphological characteristics, how stable those characteristics were, and how endogamous or exogamous the groups were that possessed them. They adopted for their analysis categories well-known to nineteenth and twentieth century race scientists, such as head shape, and divided Europe races into familiar categories including Alpine and Mediterranean, among others. They based their categories, which they acknowledged to be imperfect, on features including skin color, type of hair, head shape, face shape, hair color and height.\textsuperscript{52} The anthropologists reasoned that, as these were physical, heritable characteristics that remained stable over generations, perhaps they were tied to other physical, heritable characteristics that remained fairly stable over generations and caused

\textsuperscript{49} Ibid., 323 and 325.

\textsuperscript{50} Ibid., 76.

\textsuperscript{51} Ibid., 173, 239, and 297.

\textsuperscript{52} Ibid., 24-26.
cancer. They acknowledged that these characteristics were not the only features that humans possessed and that therefore there might be perhaps more accurate constellations of characteristics that produced different racial groupings and hence potentially different correlations to cancer.\(^5^3\) Although the report was rooted in a belief in the biological reality of race, the authors showed a substantial skepticism over the implications of that understanding of race.

Despite the suggestion that race might play a role in European cancers, the members of the committee remained unconvinced that race influenced African cancer rates. Although the commission had in their European work looked to modern ills such as factory work to explain certain cancers, they had limited patience for correspondents who presented Africans as free from diseases of civilization by virtue of, according to the authors, being free from civilization. Despite these conclusions, the belief that Africans were free of cancer was widespread, prompting South Africa to study the disease.\(^5^4\) This attitude was even present on the health committee, where Romanian Health Committee member Catacuzène related, towards the beginning of the inquiry, that it “was well known that cancer was almost non-existent among Negro tribes.” He did allow, however, that cancer might be an environmental condition, and proposed studying rates of cancer in Africans and African-Americans to get the information about whether diet or heredity was more at fault for this.\(^5^5\) Despite the work of the committee to challenge this idea,
belief in African immunity to cancer continued, and the League received letters on the subject as late as 1938, reflecting the perceived close relationship between disease and race. They responded with environmentalist explanations, noting that Africans had a shorter life expectancy, which might exempt them from death by cancer at an old age, as well as the predisposition to certain intestinal cancers they suffered, presumably from parasitic infections.  

Maintaining that Africans were susceptible to cancer put them on more equal footing with white Europeans than denying that they had the disease.

The Cancer Commission also produced early results in studying the treatment of cancer. Buchanan too pushed for this enquiry, concerned, like many of his public health compatriots in Britain, with balancing fear of the disease with fears of promoting false hope through new therapies. This study focused on the treatment of reproductive cancers in women, but included analyses of other cancers as well. For example, the British portion of the study found that patients who were operated on for rectal cancer lived an average of 1.8 years longer than those who had no treatment. The authors of the study found further, however, that treating cancer was not only a technically difficult matter. Buchanan wrote bluntly in a confidential report that “in part the women are undoubtedly to blame, and their failure to attend for treatment must be attributed to their apathy, fear or ignorance - probably to all these. It is also to be feared that the practicing

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56 Yves Biraud to Cooke, April 11, 1938, 1, 8A/29011/603, LON.


doctors do not always devote sufficient care to the examination of the patients who attend for advice and treatment.” Consequently, few people who were candidates for cancer surgery got it, and those who did have surgery generally did so too late for the treatment to do any good.\textsuperscript{59} These results were found more generally in all countries, which greatly disturbed the commission. The finding that “in three countries with medical and surgical services of the highest order there was still a great mass of unnecessary and preventable suffering” from lack of cancer treatment justified the expense of the first round of research and suggested the need for more study.\textsuperscript{60}

After these reports, the commission was unclear about how to find a manageable area of work. Buchanan advocated the expansion of the commission into a committee of experts from different countries.\textsuperscript{61} The further work of the cancer commission was more focused than the early statistical studies. Although the commission had had an optimistic and ambitious program in its earliest incarnation, these studies had produced results that were too amorphous and suggested too many correlations and not enough causes. In order to produce more useful results, the commission moved to two more specific problems.

The first new sub-commission investigated occupational cancer and included a member from the International Labor Organization. Occupational health had become an


\textsuperscript{60} “Minutes of the Fifth Session of the Health Committee Held October 8 to October 14, 1925. C.647 M.236 1925 III October 8 to October 14, 1925,” in League of Nations Publications, III Health (Geneva: League of Nations, November 1, 1925), 33.

\textsuperscript{61} “Reply of Professor L. Bernard to Sir G. Buchanan, C.H. Cancer 57,” August 31, 1927, 1, 12B/61083x/28874, LON.
increasingly important concern in the interwar period, when health was of increasing interest and the need for efficient economic production was high. Occupational cancer was also a potential embarrassment, a condition potentially detrimental to the image of nations and their economic growth. U.S. Surgeon-General and Health Committee member Hugh Cumming, for example, was skeptical of the radium workers’ claims of cancer.\textsuperscript{62} And much international work on the question had raised questions about whether they were looking in the right direction: miners had attracted much attention as a group that was potentially susceptible to occupational cancers, but many of the studies concerning them showed no evidence of a causal relationship.\textsuperscript{63} Italy, despite its major statistical cancer study, could only find two cases of occupational cancer in the entire nation.\textsuperscript{64}

The Occupational Cancer Sub-Commission began its work with a review of the literature, in an attempt to limit the scope of the work. One member believed the task “useless and nearly impossible” because he felt that previous occupational cancer articles ignored the chemical compounds of substances they were discussing” The rest of the sub-commission, however, maintained that such a study could prove or disprove “the


\textsuperscript{63} Ibid., 45.

statement that the primary exciting cause of certain industrially localized forms of cancer is a particular chemical product.”

The sub-commission also queried nations about industrial cancer rates. They consulted the British Departmental Committees of Cancer, sending letters to authorities in Czechoslovakia, Norway, Sweden, Romania, France, Italy, Canada, Spain, India, and the USSR about cancer rates in the staff of radium and cobalt mines. The study found some international patterns in aniline dye-workers, cotton-spinning, briquette making, and cobalt mining. These rates varied across countries. This seemed to present a possibility for work, which would shed light on causes of cancer more general and potentially help economically by safeguarding labor and giving a clearer cost of insurance.

Lung cancer in miners was an equally pressing problem. “Radium death” was particularly intriguing because radium seemed to be a substance that “on one side destroys the tumor cells” yet could “on the other side cause cancer by a man working during a long period under its influence.” The situation was complicated by the tendency for many lung-related death in miners to be recorded as tuberculosis, a known occupational disease. The commission struggled to study the sporadically-identified


68 Franic Seborova, “Results of Enquiry into Cancer of the Lung in Mines in Jachymov,” 1934, 1, 8A/7140/7140, LON.
disease. The commission faced similar problems when it made inquiries into the rate of mule spinner’s cancer, or epithelioma of the scrotum, which had recently begun to appear outside of Britain alongside British manufacturing techniques. The commission, however, was unable to determine whether the mineral oil used as a lubricant or the pressure of the spinning mule on the body of its operator was the cause of the disease.\textsuperscript{69}

The lack of conclusive evidence in these investigations shows the limits of the commission and international model to form coordinated research through the League of Nations Health Organisation.

The second area of work was radium therapy. Radium therapy had followed quickly on the heels of Marie Curie’s discovery of radium at the turn of the century.\textsuperscript{70} Buchanan hoped that the League could be essential in setting standards for this new method. Radium, to some, held out the hope of being “cancer’s salvarsan,” and France and Belgium in particular had developed large anti-cancer programs in order to capitalize on it.\textsuperscript{71} Buchanan, recognizing the problems and the potential benefits of radium, pushed hard for a radiological sub-committee to be struck by the League of Nations Health Organisation. Radiotherapy was expensive and required significant investment in


\textsuperscript{70} Charles Hayter, \textit{An Element of Hope: Radium and the Response to Cancer in Canada, 1900-1940} (Montreal & Kingston: McGill-Queen’s University Press), 12.

\textsuperscript{71} Ibid., 70 and 83.
materials and facilities. He also wanted to protect patients, and the therapy, from inflated claims of false cures that could hurt individuals and discredit the field.\textsuperscript{72}

The League of Nations Health Organisation’s focus on radium therapy was at odds with most of its larger medical concerns. Radium was an individual therapy that did not rely on complicated social or environmental infrastructures. Radium therapy looked away from causes to simply treatment or cure on a one-patient basis.\textsuperscript{73} At the same time, many physicians, especially feminist surgeons, viewed radium treatments as a progressive treatment because it was less mutilating than traditional surgical therapy.\textsuperscript{74}

The sub-committee began with the goal “of presenting uniform statistical statements on the results obtained by radio therapeutic methods in the treatment of cancer of the uterine cervix.”\textsuperscript{75} With the cooperation of J. Heyman in Stockholm, A. Lacassagne in Paris, and F. Volts in Munich, they studied the staging of utero-vaginal carcinoma, data needed for statistical summaries, and how to standardize the techniques of treatment. They issued a series of reports in an attempt to standardize these techniques internationally, more like sera standardization than the differences in cure rates across institutions. Brussels had a 14.9\% absolute cure rate using radiotherapy for uterine


\textsuperscript{73} Medina Domenech and Castañeda, “Redefining Cancer During the Interwar Period,” 1568.


\textsuperscript{75} J. Heyman, \textit{Annual Report on the Results of Radiotherapy in Cancer of the Uterine Cervix. First Volume. Statements of Results Obtained in 1930 and Previous Years (collated in 1936)}. (Geneva: League of Nations Health Organisation, 1937), 7.
cancer, while the Marie Curie Center in Paris had a cure rate of 39.4%.76 These reports continued through the late 1930s and recommended what amounts of radium should be used in treatment but could never fully account for the differences across centers. Those involved, however, maintained that the commission had stirred important international work and cooperation.

This slow progress frustrated some members of the committee, even those who understood the limits of the statistical methods. Greenwood, as early as 1927, had suggested the committee move to a correspondence model, saying that at the cost of 4000 Swiss francs for a sub-committee meeting was “an unnecessary expenditure of public money” when the work could have been equally well carried out “in our respective offices at home.”77 He grew increasingly disenchanted with the lack of clinical knowledge in the study, expressing the view that statistical analysis alone was inadequate to answer the most pressing cancer treatment questions.78 In July 1929 Greenwood offered his resignation from the Cancer Commission, which he called “an entirely futile body, having made no contribution to knowledge from the day of its appointment until now” and therefore he did “not choose to have my name retained as the useless chairman of the useless committee.”79

76 Ibid., 29.
77 Major Greenwood to Evald Tomanek, March 28, 1927, 3-4, 12B/56652/28874, LON.
78 Major Greenwood to Evald Tomanek, August 7, 1929, 1, 8A/4313/4313, LON.
79 Major Greenwood to, Evald Tomanek, July 29, 1929, 8A/4313/4313, LON.
By the end of the 1920s, even Buchanan was forced to admit that the results of the Cancer Commission had been limited. This outcome was, he acknowledged, partially a matter of design, caused by the “difficulty” of selecting “some specific concrete question which required international study,” because there was “no point in the Health Organisation endeavoring to compete with cancer research institutions, or to try to substitute itself for the many conferences, publications, journals, etc” that dealt with cancer. By 1930, he admitted that the commission should be retired. The radiology commission met one final time in Zurich in 1934. The International Labor Organization liaison on occupation cancer remained active on paper, but there were few data, which meant the commission had no reason to meet. Nonetheless, Buchanan was unable to admit complete defeat, maintaining that the commission had made valuable contributions: “The ground was cleared of all kinds of misconceptions about the effect of registration systems, age distribution, marital state, racial proclivity and the like - work which wanted doing, and could only have been secured by the special international expert methods of enquiry which were followed.”

Several reasons account for the limited success of the Cancer Commission. First, cancer work was advocated by an individual, not a nation, which meant that the political support for the project was limited. Second, the commission worked without adequate support from national public health systems. Few nations by the 1920s had established

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80 George Buchanan, “Memo on the Position of the Investigations Concerned with Cancer. C. H. 913”, September 27, 1930, 4, 7-8, 8A/22823/454, LON.

81 Ibid., 2.
public health responses to cancer. Third, the commissions did not have a clearly defined goal. There were no obvious recommendations to issue for governments and no obvious treaties to be negotiated. With no clear role for the state in the fight against cancer, studying it within the context of an organization that focused on getting states to work through an international body to their mutual benefit made little sense.

The most profound reason for the struggles of the Cancer Commission lies in the complexity of the disease itself. Even by limiting its scope to certain kinds of cancer, the commission could not discover an adequate model for understanding the causes and course of the illness (indeed, such a model eludes us today). Although malaria and sleeping sickness had strong environmental components, the parasites that actually caused those diseases provided a focus for control work (and the control of the illnesses often attempted to rely on a strongly bacteriological model, and sought preferentially medical answers). No such obvious focus appeared for cancer, and the commission merely managed to elucidate the complexity of the causes of cancer. The disease model was especially poorly suited to an organization that had carved out a niche in collating and standardizing knowledge and policy.

The studies undertaken by the Cancer Commission were representative of the international scientific culture developing at the League of Nations. The Cancer Commission preferred social to biological explanations of disease. They prized information gathering, exchange and comparison as a first step. The commission created a place for scholars to work cooperatively, which many approved of and felt aided their work. The work illustrates, however, the difficulty of handling a complicated disease in
an international context, particularly one that fit neither bacteriological nor environmental explanations.

The Malaria Commission

Today malaria is thought of as a tropical disease. When the League of Nations Malaria Commission began, malaria remained a global problem, afflicting North and South America, Europe, Asia, and Africa. The Malaria Commission began to combat European forms of the disease. War had led to the spread and increase in virulence of malaria in many nations; the problem was particularly serious in South Eastern Europe.\(^{82}\) Albania approached the League of Nations Health Organisation early on about support for developing an anti-malarial work. Its request helped start the Malaria Commission.\(^{83}\) The League deployed experts to various southeastern European countries, where countries and international aid workers were employing a number of strategies already (including enlisting boy scouts to destroy mosquito breeding grounds).\(^{84}\)

The work of the Malaria Commission was at best a qualified success. Although it intended to create a series of guidelines for the control of malaria, the commission found itself caught between national styles of disease control. Many scholars have observed

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\(^{82}\)Selskar M. Gunn, to F. F. Russell “Re: Activity of the Health Section of League of Nations in regard to malaria”, October 12, 1923, R. G. 1.1, Series 100, Box 20, Folder 166, RAC.


\(^{84}\)“A Report on Public Health Conditions in Greece with Special Reference to Malaria. Draft.”, n.d., 11, 12B/32684x/28002, LON.
that the commission experienced a fundamental conflict between those who favored quinine and those who favored methods that controlled mosquitoes. Malaria is a parasitical disease that, in addition to causing fevers, often leaves sufferers weakened in the long-term and prone to periodic recurrences. In the late nineteenth century the vector for the parasite, the anopheles mosquito, was discovered. Whether to attack the parasite or the vector occupied the committee and malaria workers worldwide. Iris Borowy characterizes the conflict as between those on the side of medical approaches and those on the side of social approaches. Others have seen the dispute more as one between European (quinine) and American (mosquito control) experts, with each favoring the methods in which they were more proficient, and mirroring larger splits in bacteriological versus environmental approaches. The Italians split the difference, claiming great success with bonifications, large scale engineering projects to drain swamp land, the showpiece of a multi-tactic strategy that included quinine distribution that Mussolini used to enhance national productivity.

The commission studied both methods, working from what Borowy has described as a “profoundly ambivalent” conceptualization of the disease. On the one hand, the commission recognized the profoundly social and environmental nature of the disease, while, on the other, frequently placed malaria into a bacteriological paradigm through the

85 Borowy, Coming to Terms with World Health, 240.

86 Hughes Evans, “European Malaria Policy in the 1920s and 1930s: The Epidemiology of Minutiae,” Isis 80 (1989): 44.


88 Borowy, Coming to Terms with World Health, 254-255.
use of drug prophylaxis. This central contradiction hampered the development of a coherent international policy. Although no consensus emerged, the interactions of individual scholars during interchanges and various incarnations of the Malaria Commission created an international awareness of different options in Malaria Control. Few individual national policy makers changed their positions, but the experts who supported these efforts often expressed gratitude, and not a little frustration, at the opportunity to share their methods with their international colleagues.

The Malaria Commission was at first unsure how to produce results across the rest of Europe. Tropical models did not seem to apply.\(^89\) Western Europe, which had largely rid itself of the disease, did not provide a clear model, either: in England wartime malaria seemed to disappear as health conditions improved.\(^90\) S. P. James, a top British expert, encouraged the League to begin with a study tour, studying first in Italy and then moving on to Denmark, Holland, France, England, Sweden and Spain in order to study successful partial eradication of malaria, before traveling on to Greece, Albania, and Russia.\(^91\) James concluded that “by this means the League would obtain International rather than National or Individual advice,” expressing the feeling held by many that malaria was a problem that went beyond the powers of a single nation to solve.\(^92\) Although some of James’s analysis was controversial, the commission began his

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\(^{89}\) S. P. James, “Note Suggesting a Line of Action for Dealing with the Malaria Problem in Europe”, n.d., 1, 12B/28051/25944, LON.

\(^{90}\) Ibid., 3.

\(^{91}\) Ibid., 4.

\(^{92}\) Ibid., 5.
proposed study tour after collecting a malaria questionnaire from the affected governments.\textsuperscript{93}

The commission did occasion one important piece of international cooperation. Cooperation between the League of Nations Health Organisation and the USSR represented a new phase in the Soviet-League relationship. The USSR was treated as any other country in the malaria investigation, not merely as a threat to the rest of Europe. Both sides agreed to end the 1922 Santa Margarita agreement that had created the international health commission that had allowed the League of Nations Health Organisation and USSR to cooperate together on typhus control when the USSR refused to acknowledge the validity of the League.\textsuperscript{94} With more normal political and epidemiological conditions in Russia, health work could now proceed through regular diplomatic channels.\textsuperscript{95}

The Malaria Commission’s visit to Russia went relatively smoothly. Rajchman and other members of the League of Nations Health Organisation team were able, with the exception of a Bulgarian member, to obtain diplomatic visas with limited delay.\textsuperscript{96} They entered a country in which there had been minimal attempts at malaria control.


\textsuperscript{94} Ludwik Rajchman, “The Voyage of the Malaria Commission to Russia”, no date given, 4, 12B/367969/15255, LON.

\textsuperscript{95} Ibid., 5. This shift was mirrored in larger USSR participation in international health work – Chicherin had decided to send a representative to the Office International d’Hygiène Publique and to pay Russia’s membership fee. The USSR also attended the 1926 International Sanitary Convention negotiations.

\textsuperscript{96} Ibid., 1-2.
Hydro-technical work did not seem possible in an area that was so large.\textsuperscript{97} Quinine was in short supply.\textsuperscript{98} The 1500 km tour in the Volga region looked at 24 malaria stations, most of which were just beginning to operate. At these stations, public health staff could examine the blood of suspected cases, register cases, treat out-patients, examine the population for signs of infection, examine breeding places, examine dwelling for hibernating mosquitoes, distribute quinine, and do some medical education.\textsuperscript{99}

The commission issued a report on its findings, which were tentative and controversial. They expressed the view that they had not amassed sufficient understanding to issue recommendations beyond their belief in the importance of therapeutic quinine and basic hygienic measures.\textsuperscript{100} The commission “was impressed by the importance of the housing and feeding of the inhabitants of different areas” in susceptibility and mortality. Towns tended to be healthy, whereas in villages homes were “dark, airless, affording ideal conditions for mosquitoes.”\textsuperscript{101} Although the report unequivocally called malaria a social disease, the report recommended quinine as the most important anti-malarial measure, mixing the social and bacteriological understanding of the disease.\textsuperscript{102}

\textsuperscript{97} D. Mackenzie, “Notes on the Epidemiology of Malaria in S. E. Russia”, 1923, 1, 12B/27585/27585x, LON.

\textsuperscript{98} Ibid., 4.

\textsuperscript{99} Ibid., 1, 15-16.

\textsuperscript{100} League of Nations Malaria Commission, “Report on its Tour of Investigation in Certain European Countries in 1924,” 19.

\textsuperscript{101} Ibid., 25.

\textsuperscript{102} Ibid., 50.
The members of the commission were less convinced by anti-mosquito measures.\textsuperscript{103} Anti-mosquito measures in the home were found to be of some value, because some members of the commission believed that people were most likely to be infected by bites in their homes rather than outdoors. Thus, they approved of spraying insecticides in home, training villagers to kill so-called “house mosquitoes,” and adding netting to windows, as had been successful in parts of Italy.\textsuperscript{104} Mosquito nets were rare, because many lay people and even doctors in malaria-infected areas attributed the disease to warm weather rather than mosquitoes.\textsuperscript{105} Anti-larval techniques, ranging from insecticides, to introducing fish that fed on mosquito eggs, to habitat destruction aroused even more skepticism. Although they acknowledged that Herzegovina had an excellent idea for “propaganda purposes” in having schoolchildren remove algae, adequate removal of algae on a large scale, like other techniques of habitat destructions, was prohibitively expensive.\textsuperscript{106}

The League of Nations Health Organisation expressed interest in systematic drainage and land remodeling. Italy credited much of its reduction in malaria to these bonifications. The commission attributed the success of the Italian strategy to the fact that the bonifications improved both the malarial conditions as well as producing better

\textsuperscript{103} Ibid., 51.

\textsuperscript{104} Ibid., 55 and 57.

\textsuperscript{105} I. Emslie Hutton, “Anti-Malarial Mission: Report of Work Done Between the Dates of he 22nd September 1925 and 6th November 1925 (Forty-six days”, 1925, 2, 12B/43586/31303, LON.

\textsuperscript{106} League of Nations Malaria Commission, “Report on its Tour of Investigation in Certain European Countries in 1924,” 55.
agricultural land. One member of the commission, the Dutch expert N. H. Swellengrebel, expressed the contrary view that bonification only improved agricultural productivity and did nothing to disrupt larval development, but that the resulting economic growth improved health to an extent that the population was less menaced by malaria. The members of the commission affirmed the need for bonifications and other engineering solutions, but wrote that they were aware that this strategy was costly and offered at best long term hope.

The commission expanded its work geographically, beginning with a tour of Palestine. Further attempts to extend the work to the Middle East were tragically cut short. In May 1925 three members of the commission were killed and another seriously injured outside of Beirut. Samuel Taylor Darling, Norman Lothian, both distinguished malarialogists, and the commission’s secretary, Anastasie Besson, died when their car rolled on a steep turn as the commission traveled late at night. The study tour in the Middle East was cut short. James, who had avoided the accident because his responsibilities in London had forced him to leave the tour early, completed a report based on drafts left by Darling and Lothian.

Once the loss of the commission members had been mourned, general discontent began to appear. The committee had produced no new “doctrine or any didactic advice,”

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107 Ibid., 58.
108 Ibid., 171.
109 Ibid., 61.
110 General Sarrail to Ministère des Affaires Etrangère- Asie Oceanie, May 29, 1925, SDN/IL/1588, AMAE.
and while the commission might be able to suggest some local improvements, they could not agree to any general principles.\textsuperscript{111} The problem was exacerbated by the fact that James’s initial draft for the report had again provoked controversy. Rockefeller Foundation representative Selskar Gunn described the report thus: “It practically amounted to a profession of faith with regard to the administration of quinine being the only possible thing to do,” and Gunn believed that had it been accepted, the “hopeless document” would have led to the “almost complete stagnation of anti-malarial work in Europe.”\textsuperscript{112} In another letter, Rajchman revealed that “We had a good deal of difficulty in converting him to another text, but this was successfully accomplished by private conversations, and finally with a certain amount of general discussion in the full meeting.” Rajchman’s claims that “the text adopted gives offence to no one, closes no doors and draws no final conclusions” seemed to be tempting fate.\textsuperscript{113}

The authors of the rewritten second report reiterated that their suggestions were for regions where malaria was not the primary public health threat. The authors expressed dismay at the frequency with which expensive measures that did not suit local conditions were employed.\textsuperscript{114} The study group offered as a corrective careful local study of initial conditions plus ongoing study to assess the efficacy of treatment.\textsuperscript{115}

\textsuperscript{111} “Work of the Malaria Commission - Vth Meeting, March 1925 - Interview with Dr. Lutrario.\textquotedblright, 1925, 1, RF, R. G. 1.1 Series 100, Box 20, Folder 169, RAC.

\textsuperscript{112} Selskar M. Gunn to F. F. Russell, March 30, 1925, RF, R. G. 1.1 Series 100, Box 20, Folder 169, RAC.

\textsuperscript{113} Ludwik Rajchman to Thorvald Madsen, April 3, 1925, 2, 12B/35096/28002, LON.


\textsuperscript{115} Ibid., 17.
Despite the committee’s careful negotiations and their stated position that each community “work out its own salvation,” the commission issued a number of recommendations that sided with the medical camp. The report began by referring to the “tyranny” that mosquito-control based methods had “exercised over men’s minds during the last thirty years.” ¹¹⁶ The commission advocated “direct methods” which they defined only as methods that directly killed the parasite in man or mosquitoes, including quinine treatment and the killing of so called “house mosquitoes,” which they believed spread most of the disease by biting infecting people and then spreading the disease to people in the same dwelling. ¹¹⁷ Aside from these basic suggestions, the commission believed that only one or two anti-malaria methods should be tried at a time, what they termed the “minimal effective degree of perfection.” ¹¹⁸ They did allow that landscape improvement was an important initial step, but maintained that the resulting social and economic reorganization rather than the limits on mosquitoes improved health conditions. ¹¹⁹

Even in their sanitized form, many of these suggestions were controversial, so much so that the League of Nations Health Organisation spent the next several years periodically fielding complaints about the commission’s findings. A professor from the Hebrew University of Jerusalem claimed that the report was founded on unproven

¹¹⁶ Ibid., 13.
¹¹⁷ Ibid., 20.
¹¹⁸ Ibid., 19.
¹¹⁹ Ibid., 27 and 29.
“axioms” and that quinine was not nearly as effective as James maintained.\textsuperscript{120} Scientific journals published attacks on the findings. Some of these criticisms focused on questions of method. Others focused on tone, as the report had rejected the idea that malaria could be completely eradicated in most regions.\textsuperscript{121}

To salvage their reputation and some international goodwill from the debacle, the League of Nations Health Organisation hosted a malaria conference in 1928. All members of the commission were invited, plus malariologists, Rockefeller Foundation representatives, and engineers. Thirty-four people attended.\textsuperscript{122} The conference illustrated the limited agreement on any points to do with malaria control, from the effectiveness of quinine to the need for land reform.\textsuperscript{123} One of the Rockefeller representatives sent back a scathing report. The conference divided between American “eradicators” who hoped to destroy the larvae and hence the disease and European “mitigators” who preferred therapeutic methods to improve quality of life and decrease the amount of infection.\textsuperscript{124} The Americans were shocked by the skepticism their “heresy” met from the Europeans. The Rockefeller Foundation representative


\textsuperscript{122} Ibid., 6.

\textsuperscript{123} “Malaria Commission. 1st Sub-Commission. Provisional Minutes. Second Meeting. Held on Tuesday, June 26th, 1928 at 3 p.m. C.H./Malaria/14th Session/S.C.1/P.V.2.” 1928, 8C/5788/5478, LON.

\textsuperscript{124} “Comments on the Conference Held by the Malaria Commission of the League of Nations at Geneva, June 25-29, 1928”, 1928, RF, R. G. 1.1, Series 100, Box 21, Folder 173, RAC.
acknowledged the dividing lines were imperfect; Italy, which achieved substantial success with land drainage, sent a delegation that could not agree amongst itself whether quinine was effective as a preventive.\textsuperscript{125} The Americans had focused on mosquito-destroying techniques, beginning with work in the Panama Canal zone and then moving into the American south, where with the aid of the Rockefeller Foundation they had determined that land reclamation and larval control, combined with quinine where possible, would be less expensive than a mosquito-based strategy. They had found that as a magic bullet quinine was limited: those taking the drug felt stigmatized, and ongoing treatment of most of the population would be impossibly expensive.\textsuperscript{126} There were rumors that some countries, perhaps Bulgaria or Turkey or Russia, none of which attended, might move to a purely larval control strategy and abandon quinine, but those rumors were never substantiated. Even Hackett seemed shocked at the idea of abandoning medical treatment.\textsuperscript{127} The conference illustrated that the malaria commission had, if nothing else, stimulated international discussion.

Far more successful at fostering international dialogue were the malaria interchanges and training schools Rajchman had advocated.\textsuperscript{128} The Rockefeller Foundation supported this work, which its leadership felt would provide invaluable

\textsuperscript{125} Ibid., 7.


\textsuperscript{128} Borowy agrees, calling the Malaria interchanges “the most successful portion of malaria work” Borowy, \textit{Coming to Terms with World Health}, 248.
training as well as promote an *esprit de corps*. These courses took place in Europe and the Far East, and involved local personnel and explored local techniques in both classroom and field settings. These interchanges were considered so crucial that they easily gained funding from the League of Nations Health Organisation and the Rockefeller Foundation. Study tours and exchanges brought together a diverse set of experts. A study tour to the United States brought Europeans into contact with conditions that were less different from their home countries than some of the colonial sites with which they might be more familiar. Americans favored drainage-based solutions and the Europeans to conclude that US malaria control was an engineering rather than public health problem.\(^\text{129}\) Although the League never established a global malaria policy, the activities it sponsored fostered a global perspective among anti-malaria workers.

Despite the Health Committee’s promises that the Malaria Commission would begin its work in Europe and then apply elsewhere what it had learned, work outside of Europe beyond exchanges was minimal.\(^\text{130}\) One exception was a growing interest in Asian malaria. The commission traveled to India in 1929. There, they found a complicated morass of local principalities and colonial British government, not to mention serious variation in the landscape and malaria load. Although the committee found this diversity overwhelming, the politically unsettled conditions gave them, as Iris


Borowy has observed, the freedom to call for more structural changes than they had been comfortable promoting in Europe. They recommended a combination of quinine and the application of the anti-larval chemical Paris green. They also encouraged the continuance of control measures already in place in some tea gardens, railway stations, railway construction, and port work, in an attempt to limit the spread by migrant laborers. Ironically for a commission that had had its share of squabbles along political, national, and scientific lines, it advised Indian officials to put aside their differences: “If the people and the local boards in the city of Bombay could set aside personal feelings, political animosities and religious scruples and could combine to drive out the enemy from a position that has only been tenable though mutual discord in the attacking force, we believe that a moral impetus of no mean value will be given to the rest of India.”

Once again, experts at the League of Nations Health Organisation discovered that the models that had worked with some success in Europe faltered elsewhere. They acknowledged that in the case of India even their report format had to change because of the lack of a systematic program across the subcontinent.

Malaria work continued through the 1930s. Over the 1920s, the commission had ballooned to include many corresponding members in addition to most of the people who

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131 Borowy, *Coming to Terms with World Health*, 249.


133 Ibid., 150.

134 Ibid., 75.

135 Ibid., 73.
had ever been involved with anti-malarial work. For reasons of economy, in 1931 the commission was reduced to twenty members. By 1937, it had 40 titular members, which made even meeting unwieldy. Another reorganization left the commission with a smaller number of active members, plus liaison officers in each country who would be sure to receive malaria correspondence from the League. This structure, which emphasized the communication of information and consultation, differed from the earlier, more active phase of the commission.

The commission focused increasingly on drug therapy, cleaving more strongly to the bacteriological paradigm preferred by many of the European experts. Costs and disagreements over environmental approaches drove this shift. From early on, the staff of the Health Organisation had studied the price of quinine and maintained an interest in the synthetic drugs becoming available in the late 1920s. The cost of procuring and distributing the drugs was prohibitive. This problem was exacerbated by the fact that some of these drugs went unused because “of the difficulties in placing it in the hands of the sufferers, and partly because Governments cannot afford to purchase the amounts

136 George Buchanan to Mihai Ciucu, January 8, 1931, 2, 8A/25720/1311, LON.
138 “Note du Secrétaire de la commission pour le projet du rapport du président de la commission du paludisme”, October 19, 1937, 1, 8C/30982/911, LON.
needed to treat all their sick.”140 One correspondent from South America wrote that “the most practical thing that the League of Nations might be able to do for the people in the Tropics who are suffering from malaria is to endeavor to get the various governments whose territories are malaria ridden to permit the importation of quinine free of charge….“141 Despite the increasing obstacles, the League continued to attempt to hold a conference on quinine, planning as late as May 1939 to prepare to hold one in 1940, which was made impossible by the war.142

The Malaria Commission exposed the difficulty of trying to investigate a disease that crossed regional boundaries, especially a disease with such strong environmental aspects. The commission struggled against two national styles of thought that had had limited contact with each other before the Commission’s work. Although the Malaria Commission became an important consultative body, these difficulties were too great to overcome, and the League turned to its role as an international standards creator for drugs, which relied on a different model of international cooperation. The shift also implicitly validated the school of medical control, while appealing to states that, in the grip of the Depression, were hesitant to undertake costly civil engineering projects. Although throughout its existence the Malaria Commission had illustrated that a multi-

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141 R. C. Conn to E. J. Pampana, March 31, 1932, 1, 8C/36614/833, LON.

strategy approach was necessary, the climate among governments and specialists made that position difficult to maintain.

The Sleeping Sickness Commission

Although the League of Nations challenged the Eurocentrism of the international anti-epidemic system, its Health Organisation was still a European-based organization that responded primarily to the concerns of the European Great Powers and secondarily to the United States and Japan. Purely tropical diseases such as sleeping sickness did not easily fit into the League of Nations Health Organisation’s schemes. These diseases challenged basic assumptions of the committee. The members of the Health Committee were unsure how to think about disease and international health work in regions that were under formal or informal imperial control. This colonial space gave the Health Organisation leadership greater freedom to suggest more extensive interventions than it would usually be allowed to in the European world, in part because the populations of colonized areas were granted fewer political rights, but it also put significant political limitations on the types of interventions that could be suggested. Although states were anxious to protect their sovereignty in their home nations, they had to acknowledge publicly the best interests of their populations. Frequently in the colonial sphere economic interests were primary. When combined with vastly different epidemiological and infrastructural landscapes, plus populations frequently at odds with Western
conceptions of government and medicine, proposing how to handle disease outside of the West was difficult.

The earliest investigations into African health by the League of Nations Health Committee were undertaken by the Commission on Tropical Diseases, which looked mainly at sleeping sickness, although it also discussed malaria. Many colonial medical specialists argued that in their regions tuberculosis, malaria, and other diseases, whether tropical in origin or not, coexisted and fed off each other in a way that meant they could not be separated. The President of the Central Sanitary Board of Sudan, for example, argued that anti-malaria measures there would be effectively anti-tuberculosis measures as well.

The first meeting of the group that would evolve into the Sleeping Sickness Commission took place in London in November of 1922. Several international experts in tropical medicine, Andrew Balfour, E. Van Campenhout, Gustave Martine, and A. G. Bagshawe met to discuss and collect data about disease controls in colonial areas. They proposed that the area of study that needed be taken into account was Equatorial Africa. They noted that the inquiry should be organized by region or the country in charge of the area, in order to compare the methods at use. To gather information, they


144 O. F. H. Attley to Strouman, February 5, 1924, 1, 12B/26511x/17918, LON.


146 Ibid., 7-8.
had sent questionnaires and in some cases medicines to colonial medical outposts in order to learn about the health of the various regions. The best response came from the French colonies, which had access to the results of a survey ordered by Albert Calmette in 1911-1912 and the network of Pasteur Institute researchers in Africa.\textsuperscript{147}

When the committee decided that tuberculosis was relatively unimportant in Africa, or at least not uniquely important to African health, the Commission on Tuberculosis began took-up the League’s limited work on African tuberculosis and the African diseases commission changed its name to the Sleeping Sickness Commission.\textsuperscript{148} This commission, focused on sleeping sickness, or human trypanosomiasis, took on an unusual character. While most commissions addressed problems that had a wide geographic range, its activity was necessarily limited by the biology of sleeping sickness. Sleeping sickness was caused by trypanosomes, parasites that lived in the blood and were spread by tsetse fly bites. The disease, which was often fatal, first caused flu-like symptoms, then, as the parasites reached the brain, incapacitated its victim, causing them to become lethargic before lapsing into a terminal coma.\textsuperscript{149} The parasites were highly dependent on geography and lived only in narrow bands, although they could be spread through the migration of infected humans or animal. The disease was not an intercontinental concern because the parasite was dependent on a peculiar set of

\textsuperscript{147} Ibid., 8.

\textsuperscript{148} “Minutes of the Fifth Session of the Health Committee Held October 8 to October 14, 1925. C.647 M.236 1925 III,” 21.

\textsuperscript{149} Kirk Arden Hoppe, \textit{Lords of the Fly: Sleeping Sickness Control in British East Africa, 1900-1960} (Westport, CT: Prager, 2003), 7.
conditions that existed only in Africa. These facts placed thinking about sleeping sickness somewhere between the bacteriological and environmentalist paradigms. Paul Ehrlich, among others, advocated drug therapy and pre-war encouraged transnational research in this direction. But the obvious geographic limits to sleeping sickness, and the animal reservoir, as well as the difficulty in finding a medical treatment, made an ecological explanation attractive. In the interwar period the environmentalist explanation and environmentalist control measures remained popular.

Despite the importance of environmental control of the disease, many states persisted in sponsoring bacteriologically inspired control measures. Quarantines and health passports were common. With hopes of a medical cure dim, environmental measures were an essential part of the control program. The British in particular were keen on managing the environment – moving villages, deforesting, burning – in order to manage sleeping sickness, while the Portuguese, Germans, and Belgians had focused more on drug interventions and attempting to develop a single drug that could both prevent and treat the disease.


153 By the early 1920s, several arsenic based drugs existed, including atoxyl and suramine, but neither provided an easily distributable, reliable cure for sleeping sickness. Hoppe, Lords of the Fly: Sleeping Sickness Control in British East Africa, 1900-1960, 12.
Gathering information on colonial control activities proved difficult. The British colonies had never collated their data into a single report.\textsuperscript{154} The French reported the most data on the disease, reflecting their wide-reaching and highly networked colonial public health structure. Although the French medical establishment recognized that “nutrition is often inadequate and always defective”, and that “bad living conditions, diseases of the lungs, syphilis, malaria, intestinal parasitism, physical debility and lack of stamina” were major health concerns, “trypanomiasis [sleeping sickness] is the first and most important endemic disease to be contended with.”\textsuperscript{155}

According to the report, treatment varied across the continent depending on local conditions and the colonial government in control. In most places, dispensaries to care for patients through medical and pharmaceutical treatments existed alongside ground clearing, deforestation, and the removal of villages. Some governments used sanitary cordons and isolation stations.\textsuperscript{156} For example, in the Congo, the Belgians had declared sleeping sickness a communicable disease and instituted quarantine measures, while also turning to environmental management through the clearing of villages. The Belgians found permanently moving whole villages impractical, although they did practice “temporary abandonment” in which the population was moved until the flies disappeared and were then allowed to return.\textsuperscript{157} They also instituted border controls and medical

\begin{itemize}
\item \textsuperscript{154} Balfour, Van Campenhout, and Bagshawe, “Interim Report on Tuberculosis and Sleeping-Sickness in Equatorial Africa,” 73.
\item \textsuperscript{155} Ibid., 40.
\item \textsuperscript{156} Ibid., 44.
\item \textsuperscript{157} Ibid., 63-64.
\end{itemize}
passports. Africans could be required to submit to inspections at any time. Europeans were inspected only on leaving.\textsuperscript{158}

The committee’s report illustrated the seriousness of the disease. The authors blamed sleeping sickness “for the dwindling birthrates and decline of population which characterize immense areas with the result that labor is altogether insufficient for the development of the natural resources of potentially rich countries,” stressing humanitarian and economic considerations, both argued for sleeping sickness work.\textsuperscript{159} The commission members recommended periodic conferences, control of population movements, especially at frontiers, and more medical personnel.\textsuperscript{160} They advocated a medical and quarantinist model of control. They believed, however, that it was a truly international problem, “a humanitarian duty incumbent on all civilized nations to give their attention, for there can be no doubt that it is contact with the white races which has caused the spread of tuberculosis and that sleeping sickness has been transmitted outside its original frontiers.” The report continued, “civilization does not bring advantages only; it inevitably causes harm also, and this it should make good.”\textsuperscript{161}

Despite the humanitarian, internationalist tone struck by the tropical disease committee, work on sleeping sickness and tuberculosis had to be negotiated through national governments. The problems were multiplied because the colonies had no direct

\textsuperscript{158} Ibid., 67.
\textsuperscript{159} “Tropical Diseases Experts Ctte, C. H. 226”, September 12, 1924, 1, 12B/39110/26254, LON.
\textsuperscript{160} Ibid., 1-2.
\textsuperscript{161} Ibid., 2.
representation at the League. They were represented through the metropolitan governments in the Assembly, with some oversight by the Permanent Mandates Commission. The League of Nations Health Organisation worked with indigenous populations only at a distance through colonial structures. This structure often meant that the Health Organisation had to deal with a complicated series of negotiations between different departments within governments.

To try to coordinate both the scientific and the administrative responses to sleeping sickness, the staff of the health organization took the information from the commission’s report and began to organize a conference. The British government pushed to have the conference held in London, building on its self-image as the world’s pre-eminent imperial power and leader in research in tropical medicine. That government also had colonial interests in the issue. William Ormsby-Gore, British Under-Secretary of State for the Colonies, related to the League of Nations Health Organisation that he regarded “tropical disease in Africa as the main, if not the only, obstacle to the full utilization of the fertile areas of the country.” Sleeping sickness weakened both African laborers and their cattle.

The politicking began before the conference. The national balance of the sleeping sickness commission proved to be contentious, as in so many other League endeavors. The best work in sleeping sickness had been done by a German, F. H. Kleine. Rajchman wanted Kleine to head the commission, despite tense relations between the League and

162 “Extract from Personal Letter from Dr. L. Rajchman to Sir George Buchanan,” 1925, CO 323/936/1, TNA.

163 “Memorandum of Conversation with Mr. Ormsby-Gore,” May 6, 1925, 1, 12B/41373x/26254, LON.
Germany, Ormsby-Gore thought that question would “have to be carefully considered” and preferred an American instead. That suggestion was purely political, as Rajchman noted there were relatively few American tropical disease experts, and even fewer who studied sleeping sickness.\(^{164}\) Rajchman pushed for a British biochemist, a Belgian medical officer, a French entomologist, Kleine (although not as chair), and at least temporarily Dr. Louisa Pearce of the Rockefeller Institute, which he hoped will balance both the political and practical aims of the mission.\(^{165}\) The Belgians agreed with the British, saying they would never allow a mission including Kleine to enter the Congo, a necessary area of study for sleeping sickness, arguing that as a German he could not be trusted to be respectful of Belgian colonial concerns.\(^{166}\) The French also had concerns about how an international body might interact with their African holdings. A letter to the French commission from the Ministry of Foreign Affairs gave them full scientific control of the French position, but cautioned about the political implications of the work. They were explicitly warned against agreeing to anything that might cost the administration or interfere with their rights in their mandates as set out in the treaty of Versailles.\(^{167}\)

\(^{164}\) Ibid., 3.

\(^{165}\) “Extract from Personal Letter from Dr. L. Rajchman to Sir George Buchanan.”

\(^{166}\) Ludwik Rajchman, “Note sur ma conversation avec M. Van Campenhout à Bruxelles”, May 9, 1925, 1, 12B/41373x/26254, LON.

\(^{167}\) André Hesse, May 15, 1925, 1, Fonds Emile Brumpt, cote BPT.D6, Archives de l’Institut Pasteur.
The meeting took place from May 19 to 22, 1925 in London. The conference built on work done at two international conferences held in 1907 and 1908. Representatives from England, France, Belgium, Spain, and Italy attended. Walter Fletcher, of the British Ministry of Health, wrote that it came close to ending in a “complete fiasco”, although the final agreement was somewhat acceptable to the British and their partners. The conference had to deal with whether it was best to use an international team, which would give it the most control, or to use existing laboratories. There were concerns over whether the use of an international expedition would inspire or retard national work. The conference settled on establishing an international expedition to carry out the work recommended, in essence, by the committee of experts.

The commission not only sponsored study tours, but also scientific research. This research concerned human immunity, the function of animal breeding grounds for the fly, relations between the *gambiensis* and *rhodensiensis* species of parasites, and how to test flies’ blood for the parasite. Kleine issued a memo stating that he wanted to study plant destruction, drug efficacy, the role of wild animals in spreading the disease, immunity in natives, and the different species of parasites that spread the illness in the

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168 “Minutes of the International Conference on Sleeping-Sickness held in London at the Colonial Office from May 19th to 22nd, 1925. C.H. 334,” 1925, 12B/44260/26254, LON. For more on this earlier era of international sleeping sickness work, see Neill, “Paul Ehrlich’s Colonial Connections: Scientific Networks and Sleeping Sickness Drug Therapy Research, 1900–1914.”

169 Walter Fletcher to Ludwik Rajchman, June 5, 1925, 1, 12B/44850/26254, LON.

170 “Minutes of the International Conference on Sleeping-Sickness held in London at the Colonial Office from May 19th to 22nd, 1925. C.H. 334,” 3.

171 League of Nations Health Committee, “Minutes of the Eighth Session Held at Geneva from Wednesday, October 13th to Tuesday, October 19th, 1926,” 89.
region.\textsuperscript{172} Kleine’s memo illustrated the broad approach the committee took to treating sleeping sickness.

The commission began its work in late 1925.\textsuperscript{173} The League of Nations Health Organisation petitioned the British Colonial Office for permission to work directly with African governments. The commission members planned to concentrate their work in Uganda, where they arranged to have access to an entomologist, and were in the process of securing housing.\textsuperscript{174} The commission nearly faltered. Kleine was almost asked to leave over perceived improprieties when Bayer requested he test some of their drugs. Kleine declined, but Rajchman worried that request could have caused an international incident and put the expedition in a bad light.\textsuperscript{175}

In 1928, the League of Nations Health Organisation convened a second international sleeping sickness conference to discuss the early work of the commission. The site of the conference was the first dispute. Belgium and France wanted the conference to convene in Paris, ostensibly because of easier travel. The British, however, wanted it to be held in London, so that Ormsby-Gore could attend, and because they had “the leading part” in the original conference and placed the government laboratory at

\textsuperscript{172} F. H. Kleine, “Programme of the International Sleeping Sickness Commission – Translation,” June 4, 1925, 3, 12B/44848x/25254, LON.

\textsuperscript{173} Norman F. White, “Sleeping Sickness Commission in Central Africa,” November 25, 1925, 1, 12B/47889x/26254, LON.

\textsuperscript{174} Ibid., 2-3.

\textsuperscript{175} F. H. Kleine to Norman F. White, November 13, 1925, 12B/47019x/26254, LON.
Entebbe at the commission’s disposal. The conference, delayed until November 1928, was held in Paris.

The delegates discussed technical matters, ranging from strategies to control the disease to ferreting out animal reservoirs. Attempts to study hippopotamus resistance were stymied when the London zoo remained firm in its refusal to sell a small hippopotamus to the commission. There was disagreement over whether to control the through land clearing, quarantine, or the removal of people from infected areas. Lutrario did not favor the total evacuation of villages, preferring that such an extreme measure be used in only the worst outbreaks. He advocated the control of movement, observation posts, and census gathering to chart the disease. He also wanted governments to be able to compel treatment. Despite Lutrario’s misgivings, evacuation was an increasingly common tactic. In the Yei epidemic in the Sudan, afflicted natives were placed in concentration camps and encouraged to take up communal farming. The Belgian Van Campenhout looked for strategies beyond mass evacuation, because in some regions, such as Tanganyika, there was nowhere to relocate whole villages – surrounding regions

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176 G. H. Villiers to Eric Drummond, March 21, 1928, SDN/ IL/1586, AMAE.


were filled either with other people or tsetse flies. In his report to the Health Committee, Lutrario described the conference discussions as useful. However, the Conference failed to produce concrete plans or the much hoped for sleeping sickness convention. Although the Belgians had drafted a sanitary convention, those assembled had concluded the conditions on the ground were still too varied to adopt a pan-African agreement.

In 1927 and 1928 the commission of experts in Africa disbanded at the end of their funding. The final report, written by H. Lyndhurst Duke because Kleine and Van Hoof were “almost constantly on safari” emphasized the bravery of the commission. He noted that “in spite of all the travelling – and travelling in sleeping-sickness areas is generally anything but comfortable – the general health of the commission has been excellent.” He acknowledged that they had not solved the problem of sleeping sickness, but rather that they had had some small successes. As he concluded, “Fortune plays a part even in such prosaic enterprises as scientific commissions, and we have had our share of luck.”

The commission had made some headway in understanding the causes and control of sleeping sickness. Kleine speculated that sleeping sickness had spread partially from

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180 Ibid., 21-22.


183 Ibid., 5-6.
the collapse of travel restrictions during World War I.\textsuperscript{184} He believed that woodland destruction was important, as it had managed to stop the River Mori epidemic.\textsuperscript{185} Kleine laid much of the blame, however, on Africans whom he claimed refused to bring all but the gravely sick and dying to doctors, not the more easily treatable early cases. He concluded, “the results of sleeping sickness therapy will improve in so far as the infected natives can be kept under permanent medical control.”\textsuperscript{186} Despite his emphasis on the importance of environmental control and quarantine, Kleine focused on medical treatments, true to his past as a pharmaceutical researcher.

The commission members explored animal vectors of the disease in the hopes of learning more about its ecology and control. The experiments to determine which species of animals could host the human trypanosomes succeeded partially, demonstrating that some apes were not carriers. Attempts to infect baboons failed miserably, suggesting that baboons were not reservoir of infection, a valuable scientific insight that led the experimenter to conclude, with some regret, that “at the end of June 1927, the baboon was alive and well, without ever having been shown trypanosomes in the blood.”\textsuperscript{187} This end result showed that the League had never settled on one plan of attack, but instead continued to sponsor a range of work in an attempt to come to grips with the complexity of the disease.

\textsuperscript{184} Ibid., 15.
\textsuperscript{185} Ibid., 16.
\textsuperscript{186} Ibid., 17 and 20.
\textsuperscript{187} Ibid., 121.
The administrative work of the commission was less successful than its scientific undertakings. In 1928 the commission had a cost over-run of 4000 Swiss francs. The project’s local administrator, H. Lyndhurst Duke, had paid the money out of pocket to keep the work running, leaving the League scrambling to pay him. Work continued into 1927, despite the original end date of 1926, which left the League forced to pay for it out of 1929 money. Duke had tried to raise money while wrapping up the commission, but the commission had few goods that could be sold to raise funds. He hoped he might earn £60 for the two Fords, but was stymied by lack of demand for cars and the fact the cars had “been badly driven by people who have learnt on them.” The amount of travel required and the need to create the very buildings and laboratories for their work contributed to the financial problems. In other regions, the commissions were able to partner with local facilities that provided most of these material basics.

Although the third international sleeping sickness conference never took place, the League and its member governments maintained an interest in the disease. After the second conference and the end of the expedition, the Health Organisation continued to collect reports from local governments that revealed that governments continued to use a variety of anti-sleeping sickness strategies. In Tanganyika, the British continued a similar program of research that looked at land reclamation, movement of settlements, fly

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188 “Note by the Secretary General, Expenditure of the Sleeping Sickness Commission - Unpaid Liabilities, C. C. 315”, 1928, 1-3, 12B/48052/26254, LON.

189 H. Lyndhurst Duke to Rajchman, July 4, 1927, 1, 12B/49727/26254, LON.
catching, and grass burning. After the conference, the Portuguese turned to health passports and quarantine, as well as missions to study the spread of the disease.

International cooperation in the control of African diseases remained a difficult proposition through the 1930s. The costs involved in environmental management and the need to build extensive public health infrastructure gave many European governments pause in the face of the Great Depression. These issues came to a head in 1932 when South Africa attempted to organize a regional health conference under the auspices of the League. The French Ministry of Colonies decided not to send a representative because of costs, despite the protests of the French delegation to the League of Nations. The French tried to block other attempts to hold regular health conferences in Africa. African diseases never received the attention that malaria or European diseases did. The limited spread of the diseases undoubtedly played a role, but the political unimportance of the afflicted regions was also to blame. Despite the relatively simple and inexpensive mechanisms needed for basic control, such as quarantine, political infighting and lack of will meant that governments were unable to work together effectively. The Commission illustrated the tensions in international health work between bacteriological and

190 “Annual report on Experimental Reclamation: Department of Tsetse Research Tanganyika Territory for the Year Ended March 31st, 1930. Published on Behalf of Tanganyika Territory by the Crown Agents for the Colonies, London, 1930,” 1930, 1-6, 8A/9379/687, LON.


192 Ministère des Colonies to M. le Président du Conseil, Ministère des Affaires Etrangères, August 22, 1932, SDN/IL/1585, AMAE.

193 Le Ministère des Affaires Étrangères, March 21, 1938, SDN/IL/1585, AMAE.
environmentalist explanations and the desire for focused cures even with the recognition of ecological complexity.

**Conclusion**

Over the course of its existence, the League of Nations Health Organisation struck many commissions. What had begun as an ad hoc method to deal with standardization, typhus, and opium became a vital part of the League program. Commissions allowed the Health Committee to explore areas that expanded the activities of international public health.\(^{194}\) The Great Depression curtailed some of the commissions’ work. The commissions were expensive, with their study tours, meetings, and substantial printing and correspondence. With the Depression’s financial constraints, the Health Committee attempted to create “a lighter and more adaptable machinery” of small committees of experts that gathered information and consulted from afar.\(^{195}\) Despite cutbacks, commissions remained part of the League program until they were interrupted by World War II.

The commission model, despite its flexibility, had mixed results. The commissions revealed several patterns that illustrate the difficulties facing large scale public health work in the interwar period. The Cancer Commission struggled because of a lack of political infrastructure – states had only barely begun to turn national resources

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\(^{195}\) Ibid., 113.
to cancer control – and a lack of a technical focus. The disease was too complex to easily fit into models that could guide the League of Nations Health Organisation’s research. Malaria followed a different course. European nations and the United States understood that malaria had dire consequences, damaging economies and weakening the labor force. Many governments, among them the Italians, the Dutch, and the Americans, had begun large scale anti-malaria interventions in the form of land drainage and quinine distribution. However, while the political will was strong, the technical solutions were lacking. Unable to achieve an international consensus, states could not look to the League for guidance and in many cases used the dispute as proof of the efficacy of their own positions and the futility of international discussion. Finally, the Sleeping Sickness Commission presented the opposite problem. Although a medical solution to the disease remained elusive, a number of strategies including quarantine and environmental management appeared effective in curtailing it. The control of the disease required cooperation across borders, which few colonial governments were willing to do, preferring to continue their past practices. The experiences of the commissions illustrate how much effective international epidemic control relied on the convergence of political will and technical competence.

The members of the commissions struggled to bring new types of diseases into the international sphere, diseases that only partially responded to bacteriological control methods broadly construed. Although all three commissions illustrated that many diseases required social and environmental controls in addition to drug and quarantine based efforts, targeted medical treatments were appealing because of their apparent
efficiency. An effective, targeted treatment seemed easier to build international consensus around, although debates over quinine illustrate that efficacy in individual cases was not enough when the disease was widespread. The debates over multi-strategy versus magic bullet solutions continued and took on a new character as new technologies developed in the 1930s. Over the 1930s, the attention paid to the social and environmental determinants to health only increased in the face of the Great Depression.

The commissions created an international culture, fostering exchange, alerting professionals worldwide to different perspectives and in some cases, challenging conventional wisdom. The commissions’ examinations of endemic diseases pushed the League of Nations Health Organisation towards a broader definition of health as well as social medical techniques. The commissions also helped expand the League of Nations Health Organisation’s role internationally. The 1926 International Sanitary Convention effectively recognized that the League’s epidemiological intelligence network was the backbone of world disease information sharing, making the League of Nations Health Organisation the world’s leading purveyor of health information. With the expert commissions, the League of Nations Health Organisation attempted to become the world’s central body for the distillation and distribution of health knowledge. Despite the frequent political and technical setbacks, countries continued to approach the League for technical assistance in health matters.
Chapter 5: International Health in the Service of the State, 1929-1939

Joseph Avenol, Secretary-General of the League of Nations, opened the 1937 European Rural Health Conference with an address that illustrated the changing face of international public health work in the 1930s. Acknowledging “the essential unity of Europe,” he continued that “modes of life… cannot be segregated into water-tight compartments by frontiers” because populations and problems often transcended political borders.¹ The object of the conference, however, was not to encourage cooperative programming across state boundaries, but only discussion and debate. Avenol told the assembled delegates, “you have not to draw up international conventions, but merely to co-operate with one another and to find, in the common fund of collective experience you are about to create, the strength needed to speed up progress in your own countries. That will be a very valuable international achievement.”² Avenol highlighted an important but subtle shift in the type of international cooperation that took place within the League of Nations Health Organisation. States would now work together for national rather than international ends, putting international health explicitly in the service of the state.


² Ibid., 17.
The 1930s were full of contradictions for the League of Nations Health Organisation, exemplified by the Rural Hygiene program. The work on rural hygiene realized Rajchman’s vision of a multi-strategy health program, but without the international intervention he had long fought for. The conference delegates recommended a mix of strategies, from disease notification and sewer building, to vaccination, education, and nutrition improvements, to combat rural ill health. The combination of these strategies and the blurring of the lines between social and bacteriological medicine was the hallmark of the League of Nations Health Organisation program in the 1930s. This comprehensiveness came at a price. The work proposed was entirely national. The international sphere became an area of conversation and consultation, not action. This model differed greatly from Rajchman’s cherished but abandoned direct attack, and even from the international sanitary conventions. Both of those approaches had attempted to control disease in other nations, either directly or indirectly.

The success of this new model reflects one of the great ironies of the League of Nations in the 1930s. The political functions of the League diminished as Japan then Germany left, and states became less likely to cooperate officially, as the failure of the 1932-33 London economic conference and disarmament efforts illustrated.3 During these “years of struggle,” as Walters call them, nations relied increasingly on protectionism and limited their international involvement.4 A seemingly unending stream of diplomatic crises, including the invasions of Manchuria and Abyssinia and the Spanish Civil War,

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4 Ibid., 467 and 517.
put further stress on the political functions of the League, which often seemed unequal to the task.

Even in the face of these challenges, the social and technical services of the League of Nations became increasingly important and took on new areas of work. Walters describes this trend, of which the Rural Health program was a prime example, as an “unexpected renaissance,” albeit one that forced the leaders of the League organizations to accept that they would be unable to convince national representatives to sign treaties to formalize the work of the many conferences they held. Despite that admittedly serious limitation, the League convened a number of conferences on issues of importance to various states, taking the Health Organisation’s disease commissions and later conferences as a model. These meetings covered issues such as colonial administration, human trafficking and other international problems. Their method of proposing international solutions but leaving their implementation in the hands of individual governments built on the commission model developed by the Health Organisation in the 1920s, which facilitated informal cooperation between states but had rarely succeeded in creating international treaties.

This shift in emphasis had three important consequences for international cooperation. First, work became more transnational than international as delegates discussed problems between and amongst nations, moving away from attempts to create government-to-government agreements. Instead, work came to emphasize the importance of the relationship between states and their populations rather than states to

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6 Walters, A History of the League of Nations, 749-750.
one another. Second, despite this limitation, the staff of the Health Organisation used these transnational platforms to attempt to influence the opinions of the international public health community with their work, an endeavor that had particular success in the case of nutrition. And finally, as Walters notes, the Health Organisation staff members were more able to criticize or cajole governments into more substantial interactions because they had fewer expectations of creating the type of international consensus that could produce treaties. Many members of the Health Organisation’s committees availed themselves of this freedom to advocate more government involvement in health in the face of the Great Depression.7

This chapter explores the effect of the Great Depression on the Health Organisation, the new work undertaken in nutrition, housing, and rural hygiene, and the attempts to reconfigure the international sanitary system in response to the political and economic challenges of the 1930s. Although epidemic control was rarely the primary focus of these activities, the staff of the Health Organisation and their national partners became convinced that improving general health would control epidemics, as certain tactics of epidemic control were believed to improve the general health and wellbeing of the population.

The League of Nations Health Organisation and the Great Depression

The Great Depression changed the financial, political, and medical context in which the staff of the Health Organisation and the League of Nations as a whole operated. The Depression brought smaller budgets, a greater hesitancy to participate in

7 Ibid., 757.
international collaborative efforts, especially those that cost money, and created greater interest in agriculture, food, and housing. The staff at the Health Organisation increasingly took up these issues in collaboration with national partners and with the International Labour Organisation, reflecting the sort of transnational collaboration amongst experts that was the hallmark of the period.

The League of Nations was no stranger to financial adversity. The leaders of the League of Nations had continually worked to convince members that international activities were worth funding ahead of domestic projects. The Great Depression only increased this struggle, increasing the difficulty of convincing governments to spend precious tax dollars on international schemes. Contributions to the League fell by more than 20% in the 1930s. External funders were hesitant to fund an organization with such poor financial backing. The Rockefeller Foundation grant officers, who required beneficiaries to continue to fund any project to the Foundation sponsored, became reluctant to support the Health Organisation because they could not assume that the members of Assembly would or could continue to fund those programs.

In response to these hardships the staff and advisors of the Health Organisation considered a variety of cost cutting measures, from decreasing travel to allowing positions to go unfilled. Rajchman projected a 13.5% savings in the 1933 budget, which Avenol deemed insufficient because the League had only collected between 77% and

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8 Ibid., 751.

9 Seymour Jacklin, “Budget for the Health Organisation for 1933,” December 19, 1932, 1, 8A/749/749, LON.

80% of expected contributions in 1932. The Health Organisation attempted to share costs by planning to hold the September 1931 meeting in Paris at the same time as the Office International d’Hygiène Publique meeting and cancelled the first meeting of 1932 to save money. The secretariat recommended that the organization save more by leaving several vacant posts unfilled and cutting back on study tours and training courses. The staff continued to try to find cost savings by moving the 1933 advisory committee of the Far Eastern Bureau back to Singapore instead of the more comfortable Tokyo and having visitors travel by second class railcar, but, as Frank Boudreau noted to one collaborator required to travel that way, only during the day when the trains were empty. Budget cuts further decreased the size of the League of Nations Health Organisation staff. In 1930, the Epidemiological Intelligence Service alone had 17 staff members – three section members and fourteen clerks and secretaries. By 1939 the staff had decreased to nine, with only 26 people working for the Health Section in total.

The Depression not only changed the administrative structure of the organization. The economic crisis inspired the members of the Health Committee to sponsor additional work on social medicine and the economic, social, and nutritional determinants of health. Most scholars agree that a social perspective had become central to the League’s mission in the 1920s, and Paul Weindling suggests that World War I had encouraged health

12 Frank Boudreau to Eric Drummond, September 17, 1931, 1, 8A/28426/1311, LON.
14 Ludwik Rajchman to Mitsuzo Tsurumi, January 20, 1933, 1, 8A/882/882, LON.
15 Frank Boudreau to P. G. Stock, April 27, 1932, 1, 8A/36583/505, LON.
16 Yves Biraud to W. A. Sawyer, September 1, 1940, 1, R. F., R.G. 1.1 Series 100, Box 22, Folder 181, RAC.
specialists across Europe to explore the relationship amongst health, nutrition, and housing. The Health Organisation’s commissions of the 1920s, particularly the Tuberculosis, Cancer, and Malaria Commissions, paid increasing attention to housing, nutrition, and education. The Depression brought new urgency to this work. Although a minority of medical professionals proposed that the simplification of modern life wrought by the Depression would improve health, most public health professional maintained that widespread poverty would damage health through poor diets and housing conditions, the lack of access to medical care, and even psychological unrest. The members of the Health Committee approved several projects to explore the effects of the economic depression on health.

The investigation into effects of the Depression on health began with statistical analysis. Preliminary work undertaken by the statisticians at the League found no aggregate effect on mortality in 1931, although the experts found the result perplexing based on their anecdotal experience. Some speculated that mortality rates were lower in 1931 because of a serious flu outbreak the previous year, which had raised numbers above normal. As the staff had found in other investigations, statistical analysis, while a powerful tool, often failed to provide clear-cut answers. This statistical uncertainty


19 “The Economic Depression and Public Health: Memorandum Prepared by the Health Section. A II/1.1932”, September 12, 1932, 8A/5908/1409, LON.

remained for several years. The authors of an early publication based on a conference held in Berlin from December 5 to 7, 1932 accepted that there were no clear results or even ways of tracking malnutrition using available statistics. They encouraged national health services to use both field and statistical enquiries to study nutrition in their populations. They proposed the League of Nations Health Organisation collate this data, and indeed, the *Bulletin of the Health Organisation of the League of Nations* regularly included national reports. The committee also found that morbidity statistics were hard to come by – many people stopped going to the doctor, and the committee believed that many people were suffering from mild diseases that would only weaken but not kill them.

The members of the committee were undeterred by these limited statistical results and continued to push for interventions to be taken against economic hardship. By 1932, the president of the health committee reported that the crises had lowered “the level of health among the masses” and produced “serious results.” Due to lack of funds, governments had cut back health funding at the very time that public health had needed a new infusion of money. Many of these interventions, they believed, would best be undertaken by governments, which had a duty to maintain the health of their populations. The president of the Health Committee warned that “excessive economies in the domain of public health must involve, at the moment, increasing danger.”

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22 Ibid., 120-121, 126.


Committee also sponsored a number of reports on how governments should respond to the crisis. Delegates to a joint conference of the Health Organisation and the International Labour Organization held May 5-6, 1933, underscored the need for government attention because “the prevention and the treatment of disease are measures of economy.”25 The suggestions that the conference issued were wide ranging, from installing new water systems to combat typhoid, to stopping quackery and “rationalizing” hospital management and drug prescriptions, in addition to implementing workers’ insurance schemes.26 These suggestions illustrate the broad approaches that the Health Organisation’s collaborators thought would improve health. However, work on the Depression writ large was limited, if only because of the difficulty in producing measurable statistics or results.

Consequently, although affected by the ongoing economic crisis, most social medical work at the League continued to take the form of separate studies. The members of the Health Committee approved a three-year plan in 1934 to study nutrition, housing, and physical fitness. Rural hygiene continued to be an important part of their program, as did mother and child welfare. To study these issues, the Health Organisation workers used procedures it had relied on for its earlier health work – they began with a literature review or survey, moved onto technical study that coordinated research across countries, and then attempted to formulate general recommendations.27 The separation of these


studies into separate areas may also have been to underscore their general importance to health, a consensus that had been growing at the health Organisation since the 1920s, and not merely as an illustration of the current economic crisis. Most of the leadership of the Health Organisation, even after Rajchman’s departure, intensified their public statements that governments take responsibility for the health of their citizens. Increasingly, national public health workers took notice of the League’s calls, especially in the instance of nutrition, where these international pronouncements resonated with changes happening on the ground.

**Nutrition**

The staff of the Health Organisation and their national collaborators had been interested in the role of nutrition in health even before the Great Depression. Europe as a whole had witnessed an increase in interest in nutrition following the hardships of World War I. Work on nutrition intensified at the League of Nations Health Organisation and elsewhere in response to growing fears about adequately feeding populations during the Depression. Hunger, an amorphous concept that once had seemed confined to the poor, became malnutrition, an insidious and measurable problem that concerned states and could afflict any member of the population through either lack of quantity or lack of quality of food.

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28 “Communication from the International Council of Women to the Secretary General with a View to the establishment of an international institute for nutrition. C. H. 903,” September 13, 1920, 2, 8A/21523/1409, LON.

food, such as Australia, to take a special interest in food prices and food distribution. According to Borowy, the Depression was able to spur interest in hunger because no one had to take responsibility for the nutrition crisis – nations could blame the Depression and not poor management. Nutrition was increasingly seen as a state responsibility – food was a way of making and modernizing citizens. From the late nineteenth century in Europe, the regulation of working conditions in factories inaugurated the age of state interest in hunger when governments began to mandate minimum provisions for laborers. The Rockefeller Foundation was particularly interested, and sought to create “an alliance” of farmers, scientists, governments, and teachers to promote proper health. The creation of standards was part of a broader trend to create “arithmetic standards of living.” The staff of the League attempted to continue this work by developing basic standards for nutrition. They attempted to quantify these standards using statistical and laboratory measures, as they had with sera, even though they acknowledged that the standards were out of reach for much of Europe and Asia. They acknowledged, however, that despite any model diets they devised, local famine or other conditions


30 Walters, A History of the League of Nations, 754.

31 Borowy, Coming to Terms with World Health: The League of Nations Health Organisation 1921-1946, (Frankfurt Am Main: Peter Lang, 2009), 392.


33 Ibid., 90.


would determine what could be done, harkening back to the central problem of League policy work.  

The members of Commission on Biological Standardization took the lead in the standardization of vitamin preparations, following a model of international cooperation that the group had successfully employed in the work on the standardization of sera and hormones. Their interest in vitamins was not purely technical, and they emphasized the importance of vitamins in preventing infectious disease in young children. Vitamins had provoked significant international interest in the 1930s, with many nutritional specialists coming to argue that a diet sufficient in quantity might not be of high enough quality to support good health if the foods consumed did not contain the appropriate vitamins. In the early 1930s, the commission issued standards for measuring vitamins A, B1, E, and D. The process was slow and as late as 1939 the committee was still debating how to measure and standardize vitamins, and how to list their standards for consumption. As contentious as some debates over standardization might have been, the members of the committee were able to rely on their history of providing standards for biological preparations, which had been long accepted as an important international venture.

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36 Ibid., 676.
37 Barona, “Nutrition and Health. The International Context During the Inter-war Crisis,” 94.
The members of the nutrition committee also had success setting standards for food consumption, building on international work on the definition of the calorie. In defining standards for consumption, the members of the Health Organisation risked suggesting that states were unable to meet the basic needs of their population. Despite this risk, many public health experts around the world accepted the eventual League calculations as a basis for measuring the adequacy of nourishment of their populations, and the standards became increasingly germane as economic and military conditions became worse in the 1930s, putting larger numbers of people at risk for malnutrition.

The members of the League of Nations and International Labour Organization’s Mixed Committee on Nutrition set a 2500 calorie per day standard for laboring adults. They further recommended 2000 calories per day for sedentary adults, 2400 for the lightly active, and 3000 for those doing harder manual labor. Their standard for a balanced diet called for 50% carbohydrates, 30% fats, and 15% proteins, with 60% of those preferable of animal origin. They debated whether to prescribe this diet in terms of calories and quantifiable food factors or in terms of available foodstuffs – for instance, so many calories compared to so much quantity of milk. They decided to issue it in terms of quantifiable factors, but struggled against lack of consensus on how to measure many components of food, for example, protein. They also were challenged by the variety of foodstuffs consumed around the world and the variety of ways of producing them.

41 Cullather, “The Foreign Policy of the Calorie,” 356.

42 For discussions of these standards in practice, see “Famine Disease and its Treatment in Internment Camps,” Bulletin of the Health Organisation 10 (1944): 743 and 745.

Consequently, as part of its efforts to define standards, the League undertook many studies, mostly inconclusive, into the preparation of cereals and other foods.\textsuperscript{44}

The nutritional experts at the Health Organisation explored further whether the 2500 calorie per day standard was really universal, acknowledging the challenge the organization had long faced in setting global standards. Members of the organization and their correspondents were particularly concerned over whether race or climate would change the caloric requirements of different populations. Echoing much of their earlier work, Etienne Burnet and Walter Akroyd, authors of the League’s most important research into nutrition, claimed that “what we call race has little influence on diet” and any effect could be attributed to climate.\textsuperscript{45} Despite this conviction, the members of the Technical Committee on Nutrition did have special suggestions for various locations, acknowledging regional variations in the availability and quality of food. In Asia, they claimed that diets were “grossly deficient” and so it would do well to set attainable goals for the region to work them up to adequate diets. The League also published work which modified the standards for the Philippines based on the fact that the average Filipino adult was smaller and shorter than the average European, lowering the average daily intake to a recommended 2000 calories for the lightly active adult.\textsuperscript{46} The report did not speculate if the size difference was caused by race, climate, or nutritional deficiency.

\textsuperscript{44} For a detailed discussion of this work, which took place predominately in Asia because of concerns over the nutritional value of rice, see Sunil Amrith, \textit{Decolonizing International Health: India and Southeast Asia, 1930-65} (New York: Palgrave MacMillan, 2006), 34-36.


\textsuperscript{46} Technical Commission on Nutrition, “Report by a Special Committee which Met in Geneva from August 22 to 24, 1938,” 667.
Burnet and Akroyd’s report, “Nutrition and Public Health,” which laid out the
global standards for consumption as well as many of the Health Organisation’s views on
nutrition, became the best selling League of Nations document in either French or
English. This outcome pleased the authors, who had hoped to provide not only a
scientific survey of nutritional science, but to influence public opinion about the
importance of nutrition.\textsuperscript{47} The members of the health committee understood the main
aim of the authors of the report to be “to show the role of adequate nutrition in preventive
medicine.”\textsuperscript{48} This conclusion drove much of the later Health Organisation’s work, which
used nutrition as a key index of health. Concerns over nutrition were a profound part of
its work throughout the Depression and World War II. These later recommendations
built on the pronouncement of the report’s authors that “the general problem of nutrition,
as it presents itself to-day, is that of harmonising economic and public health
development.”\textsuperscript{49} This call echoed the increasing emphasis in League documents on the
role of the state in ensuring the proper development of national economic, housing,
aricultural, and nutritional development.

Early work of the health commission focused on devising healthful diets for
ormal conditions. Later, as political conflicts spread through Europe, food went from
being a subject of social improvement to one of basic sustenance and even a military
tool.\textsuperscript{50} Although the committee had particular concerns about Asia, they admitted in a

\begin{flushright}
\textsuperscript{47} Walters, \textit{A History of the League of Nations}, 755.
\textsuperscript{50} Barona, “Nutrition and Health. The International Context During the Inter-war Crisis,” 99-100.
\end{flushright}
1938 report “that even in Europe there are at the present time, circumstances so critical as to result in a severe shortage of foodstuffs so that the nutrition problem has in this case become of taking emergency measures against famine.”

In response the commission created several model diets that could be cheaply adapted for refugees across Europe. The first diet, which assumed a sufficient supply of dried skimmed milk powder, recommended 2,000 calories per adult per day from 500 grams of wheat, 45 grams of skimmed milk powder, supplemented with cod liver oil, sodium, and any available fresh produce or fat. Children should be given proportionately more milk. In instances where there was only enough milk powder for children, they recommended supplementing the diet with brewer’s yeast and a salt mixture made of sodium chloride and calcium carbonate. Citrus, potatoes, cabbage, vegetable and even sprouted grains or “non-poisonous green leaves” should be added to the diet to insure enough vitamin C; in more favorable circumstances, they estimated that half an orange or lemon twice weekly would provide the necessary amount of vitamin C.

Meat, legumes, and cereals, when available, should be added in place of the wheat. Infants should be fed on whole milk plus cod liver oil and fresh fruit juice. When possible, they recommended adding cocoa

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51 Technical Commission on Nutrition, “Report by a Special Committee which Met in Geneva from August 22 to 24, 1938,” 675.


53 Technical Commission on Nutrition, “Report by a Special Committee which Met in Geneva from August 22 to 24, 1938,” 678.

54 Ibid., 677-678.
and sugar to break the monotony of the diet, especially for children. Emergency nutrition became the order of the day by the late 1930s. Nutrition work continued many of the methods and assumptions of early Health Organisation work, even in the face of increasingly trying conditions.

**Housing**

Housing inquiries had been part of the work sponsored by the Health Committee from early on, usually as part of anti-epidemic work. The Malaria and Tuberculosis Commissions had investigated housing conditions in the areas they visited. This early work illustrates how interest in housing was not spurred by the Depression but rather coincided with it, having come to fruition in the relatively stable late 1920s and reached the international sphere only coincidentally with the Great Depression. National interest in planned economies helped keep housing a priority, but interest in housing conditions was not fundamentally a Depression phenomenon. The commission brought together experts to discuss longstanding efforts to improve national housing conditions and never attempted to create international standards. Rather, the staff of the Health Organisation hoped that the national delegates would use the information they gathered to develop national standards and strategies.

The Hygiene of Housing commission worked through national committees in the America, France, and the Netherlands, as well as Poland, the United Kingdom, and

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55 Ibid., 678.
Czechoslovakia. The reports created by these national committees were mainly statistical. The report sent by the members of the Dutch Commission merely summarized local housing legislation. Many of the authors of the reports emphasized that housing concerns had been an ongoing problem for their respective governments. Each of the authors detailed the approaches local governments and communities had taken to secure adequate housing, which often varied greatly from the actions taken in neighboring states. The Polish author reported that many of the foreign empires that had ruled Poland had not made housing a priority and construction had been essentially halted during World War I, resulting in significant overcrowding in urban centers. Planned improvements had to be halted in the face of the Depression. Infographics depicting coffins, skeletons, and coughing men informed the reader that there were serious health consequences of overcrowding, particularly tuberculosis. For example, individuals who lived in homes where there was less than one occupant per room had a 12% mortality rate from tuberculosis, while those who had two or more per room had 18%.


60 Ibid., 17.
France’s report told a similar story. Housing work there had been delayed because the author believed that “the French worker is certainly less preoccupied than his English or German neighbor with the comfort of his lodgings” owing to the better French climate. Less French capital was also focused on private lodgings. This delay in funds or interest in housing policy had led to overcrowding in many French urban centers. Consequently, cancer and tuberculosis rates were higher in urban than city populations. According to the report, this situation had reached a crisis after the war, but unstable government finances made work slow. A government building campaign that took place in the later 1920s succeeded in creating new “healthy” dwellings but had not yet extended to retrofitting older lodgings. The government also faced problems because in times of economic crisis, it found that workers, who inhabited the majority of the unhealthful dwellings, preferred to cut housing costs before other costs, unlike the middle class. Educational campaigns were undertaken to try to correct this attitude, but, as the report summarized, “it is natural that habits and laws do not always evolve with the same rhythm.” In Italy, the Fascist government undertook a similar program, which used

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62 Ibid., 74.

63 Ibid., 13-14.

64 Ibid., 143.

65 Ibid., 144.
new housing regulations to improve access to water and air circulation. Their ten-year building campaign constructed 72,676 apartments which had 258,429 rooms.

Following these reports, the Housing Committee proceeded to study various issues related to housing health. These issues including hygiene, noise, lighting and “insolation,” population density, open space, smoke abatement, air pollution, water supply, legislation, and the definition of “healthy dwellings” in both cities and the country. Sound was one of the first issues taken up, although the committee was forced to conclude they had limited physiological or psychological understanding of the effect of excess noise on humans. The members of the committee recommended a number of steps that could be taken to ameliorate noise pollution, ranging from the relatively inexpensive, such as hanging cloths in dwellings and using new materials that were soundproof, to more expensive propositions such as more careful town planning and industrial and transportation silencers, as well as full blown insulation of all buildings.

Attempts to bring standards to their work proceeded slowly. In a 1939 report, the committee “noted that certain of the standards, rules or recommendations formulated by it were regarded as provisional.” They wrote that any standards would have to take into account...
account population characteristics and local geography, and therefore issued few specifications recommendations, beyond, for instance, noting that open spaces were important. Instead, they impressed upon their national committees the need to prepare national standards for the 1939 meeting, as well as model plans of housing, that could be discussed.

The work of the Housing Commission is illustrative of the two of the main features of the Health Organisation program in the 1930s. The first is the broad approach to health as an economic, social, and political phenomenon that required the intervention of states and private industry to improve citizens’ health. The second was an increasing reluctance to issue standards on anything that were not purely biological. Rather than attempt to dictate the political and economic action of member states, the League preferred to position itself as a resource for discussion rather than definition.

Rural hygiene

The rural hygiene work recommended by the members of the health committee program took social medicine, which had been born in the slums of industrial cities, and exported it to the countryside. While much of the work of the Housing Commission had cast urban environments as pathological slums, the Rural Hygiene Commission emphasized that rural environments were not naturally healthy, building on an older awareness of the health perils of rural life. A series of surveys conducted by national

73 Ibid., 751.

74 Ibid., 737.
governments in the late nineteenth century as well as a Rockefeller-funded League survey in 1927 had illustrated the serious health problems endemic in rural regions, despite the persistent ideal of the healthy peasant.\textsuperscript{75} At the League, work on rural hygiene took on questions of nutrition, housing, and sanitation as the field developed. The commission did not attempt to solve the problem across borders, but rather brought together experts from across Europe to share information and strategies that could be adapted to their home countries.

The commission was spearheaded by the Spanish and their Health Committee representative, Gustavo Pittaluga, the Director of Madrid’s School of Hygiene. In 1930, Pittaluga proposed a conference on rural hygiene, which was held June 29\textsuperscript{th} to July 7\textsuperscript{th}, 1931.\textsuperscript{76} The program of the conference exemplified the integrated approach of the Health Organisation. The delegates to conference considered sixty reports on rural hygiene prepared by the national delegations that covered medical institutions and personnel, public health services and their organization, mother and child welfare, communicable diseases, sanitation, the milk supply, sewage systems, housing, and land improvements. The conference hosted delegations from twenty-three European countries, including Germany and Italy, and non-European countries, including the United States and Japan,

\textsuperscript{75} Josep L. Barona, “The European Conference of Rural Health (Geneva, 1931) and the Spanish Administration,” in Health and Medicine in Rural Europe (1850-1945), ed. Josep L Barona and Steven Cherry (València: Seminari d'Estudis sobre le Ciencia, Universitat de València, 2005.), 127-128.

sent observers.\textsuperscript{77} These delegates were experienced in sanitation, agricultural economy, and agricultural labor relations.\textsuperscript{78}

The recommendations of the conference delegates, which they achieved with minimal disagreement, reflected this wide-ranging conception of health. They recommended a program that encompassed education of rural populations, financial and technical assistance, and ways to sanction those who did not comply.\textsuperscript{79} They recommended a ratio of one doctor to every one to two thousand people.\textsuperscript{80} These doctors would be employed alongside public health nurses at comprehensive health centers that addressed disease control and prevention, maternal welfare, infant welfare, popular health education, sanitation, and first aid for urgent cases. The delegates also recommended a smaller number of secondary health centers that would do the above work plus carry out campaigns against tuberculosis and venereal disease, increase emphasis on mother and child welfare, while also offering education for doctors and other medical professionals.\textsuperscript{81} They recommended health insurance for workers, but where employer-based schemes did not exist, they suggested the government provide basic social insurance for laborers.\textsuperscript{82} The conference recommended other areas of government intervention as well, including a long list of suggestions for improving sewage and water delivery in rural regions.\textsuperscript{83} They also recommended government intervention in housing through education, the provision

\textsuperscript{77} Ibid., 10.
\textsuperscript{78} Ibid., 9-10.
\textsuperscript{79} Ibid., 12.
\textsuperscript{80} Ibid., 21.
\textsuperscript{81} Ibid., 31, 33, and 36.
\textsuperscript{82} Ibid., 21.
\textsuperscript{83} Ibid., 40.
of cheap credit, and the enforcement of healthful dwelling legislation. Taken together, the recommendations reflect the increasing international emphasis on a holistic understanding of public health, which recognized that epidemic control and the basic social and sanitary system of populations were inter-related problems that were best addressed together.

The conference was such a success that similar conferences were held in Asia and the Americas. In 1932, at the General Assembly, India and China both requested that the League sponsor an Eastern Rural Hygiene conference. They reiterated their request in 1934, and the conference was held in 1937. The conference’s preparatory committee reinforced the integrated version of public health, claiming that public health took into its sphere the “control of infectious and social disease,” mother and child welfare, nutrition, housing, “enforcement of sanitary regulations and quarantine,” sanitation generally, cancer, and probably soon heart and other rheumatic diseases. The committee highlighted the need for better vital statistics and better training in the Far East as well as suggesting that governments work with private relief organizations in order to deliver aid to rural regions.

The delegates at the Bandung Conference, from British North Borneo, French Indo-China, Burma, Ceylon, China, Fiji and the Western Pacific, Hong-Kong, India, Japan, Malaya, the Netherlands Indies, Philippine Islands, and Siam, were less

84 Ibid., 50.


86 Ibid., 8.

87 Ibid., 16 and 35.
unanimous in their recommendations than the European conference had been.88 That
delegates were able to cooperate at all was striking given the geopolitical situation in
Asia: Japan had already withdrawn from the League and the invasion of Shanghai was
just weeks away. Despite these external pressures, the delegates agreed on the major
issues – health and medical services, rural reconstruction, sanitation, nutrition, and
disease, including malaria, plague, hookworm, tuberculosis, pneumonia, yaws, leprosy,
mental diseases and drug addictions – but according to the report “suggestions for their
solution were not so numerous. A definite tone of conservatism prevailed in all
discussions.”89

Debates centered on whether to focus on curative or preventive activities,
although the final resolution was that “in eastern countries more than anywhere else,
preventive medicine is the cheapest means of improving the health conditions of the
population in the rural areas, and it is along preventive lines that the effort should be
principally directed.”90 Some of these measures were straightforward, such as the
improved training of medical personnel.91 Others were more complicated and more
costly. While the conference delegates were not prepared to suggest what the percentage
of budget expenditure on public health should be, they declared “essential” that
governments finance public health “liberally.”92 Rural housing was “largely a social and

88 Ibid., 15.

89 Ibid., 7 and 38.

90 “Report of the Intergovernmental Conference of Far-Eastern Countries on Rural Hygiene. Held at
Bandoeng (Java), August 3 to 13th, 1937. A.19 1937 III,” in League of Nations Publications, III Health
(Geneva: League of Nations Health Organisation, 1937), 38 and 42.

91 Ibid., 44.

92 Ibid., 45.
economic problem and only partly a public health measure,” illustrating the broad need for reforms in Asia.\textsuperscript{93} Malnutrition was also noted as a serious economic and medical problem, the solution to which went beyond the competence of the conference.\textsuperscript{94} The delegates requested that a follow-up conference be held in five years.\textsuperscript{95} The Asian delegates illustrated, even in the face of overwhelming external pressure, the desire for transnational technical collaboration.

Although the follow-up conference was prevented by the war, international work on rural health continued. The Americas also held an intergovernmental conference on rural hygiene in 1938 in Mexico.\textsuperscript{96} European and Asian rural hygiene work continued mainly through reports that expanded earlier conclusions and studied them in a national conference. A planned second conference on European issues was cancelled because of World War II. The conference was to consider health from the perspective of rural life, acknowledging the social and economic determinants of health. Although the conference did not take place, that attitude had been exemplified in the Health Organisation’s cohesive rural hygiene program and pervaded much of the organization’s work during the 1930s. What is more striking is the extent to which nations, which were increasingly in conflict with each other, were willing to buy into a program that at least in theory put so many demands on them and had them sit across the conference table from their enemies.

\textsuperscript{93}Ibid., 58.

\textsuperscript{94} Ibid., 67.

\textsuperscript{95} Ibid., 116.

Refiguring Politics and Health

By the late 1930s, supporters of the League were presented with a paradox. In the face of increasing failures, most notably to contain Italian aggression in Ethiopia, the future for the League of Nations as serious actor in international politics seemed dim.\(^97\) Japan and Germany withdrew from the League. By 1936, according to Richard Veatch, the League’s security functions, and with them, much of its political legitimacy, “were in disarray” after the failure of the League to stop Mussolini’s invasion of Ethiopia.\(^98\) Attempts to keep Italy in the League failed, and the Rome government withdrew from the League.\(^99\) These tensions began to affect the work of the Health Organisation, which had long managed to avoid many of these entanglements. Work with the USSR became strained, and the country began to refuse entry to foreign scholars on League exchange programs.\(^100\) By order of the German government, Frederick Kolle and his colleagues were forced to distance themselves from the work of the tuberculosis commission to be published in 1934, despite their intimate involvement, by order of the German government.\(^101\) Mitsuzo Tsurumi, a long standing member of the health committee, resigned in 1938 because of Japan’s decision to cease all collaboration with the League of Nations. In the obviously pained letter, Tsurumi had thanked Madsen for his “kindness and friendship,” showing that while politics may have interfered with his official

\(^{97}\) Walters, A History of the League of Nations, 699.


\(^{99}\) Ludwik Rajchman, “Memorandum”, February 22, 1933, 8A/2738/549, LON.

\(^{100}\) Ludwik Rajchman to Maxim Litvinoff, “Memorandum,” February 22, 1933, 8A/2738/549, LON.

\(^{101}\) Thorvald Madsen to Griffith, “Re: TB Inquests,” January 27, 1934, 1, 8A/880/880, LON.
involvement with the League of Nations Health Organisation, the sentiment engendered by the Health Committee transcended them.\textsuperscript{102}

As technical work became more difficult and political work impossible, supporters of the League began in 1936 to look for ways to reform the organization to make it more effective or at least sustainable. Several of the proposals were radical, including the separation of the covenant from the peace treaties and making League membership universal. The Assembly sought to reform the function of the League to preserve its few successes.\textsuperscript{103} These changes did not come to pass, and the technical work of the League faced increasing intrusion from global politics.

Politics struck at the head of the League of Nations Health Organisation. In January 1939 Avenol removed Rajchman from his position as Director of the Health Organisation. Officially, Rajchman’s position was eliminated as a cost-saving measure. As the social sections of the League were combined to save money, a Medical Director seemed superfluous.\textsuperscript{104} Unofficially, most acknowledged that Rajchman was asked to leave for political reasons. Rajchman, an avowed socialist, was seen as a political liability. One Rockefeller agent observed that Rajchman’s dismissal “had been forecast for some time.”\textsuperscript{105} Avenol could not even be troubled the inform Rajchman himself – despite the letter in the personnel file from Avenol, Avenol had deputy Secretary General

\textsuperscript{102} Mitsuzo Tsurumi to Thorvald Madsen, November 18, 1938, 8A/4931/985, LON.

\textsuperscript{103} Walters, A History of the League of Nations, 713-14.

\textsuperscript{104} Joseph Avenol to Ludwik Rajchman, January 26, 1939, 1, Series Personnel, Document 2966, LON.

\textsuperscript{105} A. J. Warren, February 3, 1939, R. F., R.G. 1.1 Series 100, Box 22, Folder 181, RAC.
Sean Lester inform Rajchman in person. Much of Rajchman’s day-to-day work was taken over by section member Yves Biraud, who effectively headed the League of Nations Health Organisation through the war years.

Despite Avenol’s strong personal politics, he believed that the best future for the League lay in creating an organization that was separated from high international politics. He hoped this separation would allow countries that had left the League, such as Brazil, to return to the international fold through their participation in ostensibly apolitical matters. Avenol pushed for a separation of the League’s political and technical functions from as early as 1936. In 1937, the Belgian delegation proposed to remove the Council’s prerogative to approve or disprove of economic and social functions. They wanted Germany and Italy to be free to participate in the economic work of the League, as well as to free the League as a whole from the absurdity of the Council’s approving or disapproving of work that was increasingly funded by the United States.

In May 1939, Avenol recruited the Australian Stanley Bruce, former council president, to strike a commission to study the possible reform of the social and economic sections of the League, or even their transfer to a non-political body. In August 1939, Bruce recommended the creation of “an autonomous Central Committee for Economic

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107 Ibid., 5.


109 Ibid., 761.
and Social Questions.”  

The commission would welcome the involvement of non-member states, and would invite Ministers of the appropriate government agencies on social, medical, and economic issues to form its membership. The body would be equal in its sphere to the League Council in politics. Although the Bruce Committee’s recommendations were not followed, at least not at the League of Nations, they spoke to a deeply held anxiety in the 1930s about the interference of politics in international cooperation. This desire to provide a separate sphere for technical cooperation shaped postwar debates over the creation of new institutions to oversee international relations.

**Conclusion**

The ongoing cataclysms of the 1930s brought out the tension at the heart of the League of Nations Health Organisation. On the one hand, many of the programs that the staff of the Health Organisation and their supporters held dear – social medicine, epidemiological intelligence, and international consultation – were vindicated during the Depression. The world turned to these strategies to confront the globe’s mounting health problems. On the other hand, the fiction that these were technical matters beyond the concerns of sovereignty and national security and therefore best left to technicians rather than diplomats was exposed for what it was. The Health Organisation had accomplished what it had through the cooperation of governments, who, while not perhaps universally embracing the internationalist project of the League, at least were willing to play by its

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rules when they would derive benefits from its services. As the international climate became uncertain, those benefits no longer outweighed the risks and the system began to break down, as states struggled to find an institutional infrastructure that would serve their purposes less controversially. The delicate balance negotiated in the 1920s was upset. With the political system that underwrote it in a shambles, the international sanitary regime faltered. How to rebuild the system, by combining or separating politics and health effectively, became the next major challenge that international epidemic control faced.

The difficulty of cooperating internationally in an era of increasing tension frustrated many international actors, causing them to turn away from the integrated methods of the interwar period. This shift had far reaching consequences for the post-1945 world. The holistic model was broken and refigured with new relief and reconstruction agencies under the United Nations, changing the course of international development. In the nineteenth century, through sanitary conventions, states tried to safeguard themselves by imposing rules on their neighbors. In the era of development, they attempted to improve national health in other regions to secure economic and political advantages. In the 1930s, they instead tried to harness international health work for national and ultimately military ends.
Chapter 6: War and the Interruption of International Public Health Cooperation

The League of Nations and World War II

The report to the Council on the thirty-first session of the Health Committee, whose authorship is unclear given the flux in the committee and the organization at that time, noted that the Health Organisation’s “work had been affected only indirectly by the repercussions of the war.”¹ That statement seems rather incredible, given that the president of the Committee, the Frenchman Jacques Parisot, had begun the meeting by noting that no news had been received from their Polish colleague Witold Chodzko, and the committee later agreed that they should strike a smaller emergency sub-committee to direct work on epidemic intelligence and bacteriological standardization in the event of a war time interruption.² This step mirrored the earlier creation of a five-person Supervisory Committee that could act for the League of Nations Council during the war.³ The members of the Health Committee seem, if they indeed shared that sentiment, to have shared in what F. P. Walters describes as “the delusions which persisted in Geneva” early in the war, in which everywhere there was “a refusal to accept the fact that the

² Ibid., 1-2.
existing foundations of national and international life had disappeared on September 1.\textsuperscript{4}

At that committee meeting, the members discussed rather mundane plans to continue their work, even as Europe plunged deeper into conflict.

Whether or not the great changes that would come to the Health Organisation were fully apparent in the fall of 1939, World War II transformed both the environment in which the organisation operated and the types of activities that governments were willing to carry out. By 1939, the remaining staff of the League of Nations Health Organisation and the members of the Health Committee found themselves without many of the supports they had come to rely on in the previous decades of their work. Rajchman was gone, replaced by Raymond Gautier and Yves Biraud, members of the Epidemic Intelligence Section who would effectively head the staff operations for what remained of the Health Organisation’s existence.\textsuperscript{5} Despite this unrest, the members of the Health Organisation and Health Committee continued to try to control epidemics and promote health. The integration of these two goals during conflict was striking, as the remaining staff of the Health Organisation, especially Biraud, attempted to draw international attention to the epidemic and nutritional dangers of wartime. Not allowed to do on-the-ground work, however, the organisation struggled to remain relevant and found itself facing institutional rivals, particularly in the United Nations Relief and Rehabilitation Administration. National governments became increasingly unwilling to cooperate when their national security was at stake, particularly on issues of epidemic intelligence, greatly decreasing the efficacy of the work of the Health Organisation. Many international public health workers became frustrated by what they saw as both the weakening of their

\textsuperscript{4} Ibid., 803.

\textsuperscript{5} Yves Biraud to Sean Lester, November 18, 1943, series personnel, document 357, LON.
position due to the lack of political support as well as political and military interference in their work. This increasing lack of trust of national governments shaped the postwar international public health settlement.

Historians have largely dismissed the history of the League of Nations during the war as irrelevant.6 Walters claims that “the last dying exertions of the League thus merged almost imperceptibly into the prehistory of the United Nations.”7 By this time, the League secretariat was left with a mere hundred or so employees huddling in the heart of the Palais de Nations and the Rockefeller library, moved from the sprawling series of apartment buildings that the League had also occupied during its heyday. Much of their technical staff had left to join either the United Nations Relief and Rehabilitation Administration or national administrations, fearing what the future would hold from them and their organization in Geneva. The Tehran conference had sealed the League’s fate and paved the way for the United Nations.8 This view overlooks the work of the economic and social bodies, which continued to function during the war, albeit from Montreal, in the case of the International Labour Organisation, and Princeton, where the Economic and Financial Section had moved.9 The history of this period remains vital to understanding how states collaborated in times of conflict and the attitudes that shaped the development of the World Health Organization.

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7 Walters, A History of the League of Nations, 810.

8 Ibid., 810.

9 Ibid., 810; Henig, The League of Nations, 176.
The Health Organisation remained, in curtailed form, at Geneva, in part because Switzerland offered a more central location from which to gather epidemic intelligence. These changes were compounded of the larger reorganization of the League in response to the poor economic conditions of the late 1930s and Joseph Avenol’s desire for a more centralized hierarchy in the League, which the expansionist and autonomous Health Organisation challenged. In 1939, after Rajchman had been dismissed, Frank Boudreau was asked to draft a plan for a merger of the Social, Health and Opium sections. As Biraud wrote, “the plans made were applied or rather parodied in February 1940, i.e., under war conditions and with a wholly inadequate staff.” Boudreau did not want to take over the new section, and so the honor went to Rasmus Skylstad, a Norwegian member of the Minorities Questions Sections. Skylstad was not familiar with the Health Organisation’s past work or technical possibilities, which limited work in the first stages of the war and “prevented him from defending and preserving the necessary officials, when League authorities reduced the Secretariat to a mere nucleus.”

Despite these challenges, as this chapter will illustrate, the reduced staff of the Health Organisation, and what remained of their national collaborators, continued to work on issues as diverse as epidemic control, the promotion of health, relief, and epidemic intelligence in difficult political and epidemiological conditions.

**Epidemics and Conflict**

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11 Yves Biraud to W. A. Sawyer, September 1, 1940, 1-2, R. F., R.G. 1.1 Series 100, Box 22, Folder 181, RAC
The return of widespread conflict to European made many public health specialists and their governments fearful of a resurgence of epidemics, including typhus and influenza, as had followed in World War I. The approach taken to epidemic control in World War II varied, due to both the changed political atmosphere, an increased emphasis on prevention, and newly available technologies, such as DDT and typhus vaccine. After a short-lived and partially successful attempt in the late 1930s to revive the strategy of direct attack on epidemics, absent from the international sphere since the last world war, the Health Organisation was limited to consultative measures once most of Europe was engulfed in conflict. The Health Organisation’s anti-epidemic work was also limited by the decreased international importance of epidemics in World War II, owing to new public health interventions as well as differences in migration patterns in Europe. A study of the League’s work in Spain, China, and then globally in World War II illustrates the decreasing willingness of states to participate in collaborative efforts.

An increased interest in epidemics began to emerge in the 1930s alongside the regional conflicts in the period. In the mid-1930s the Health Organisation successfully completed on-the-ground missions in two countries. At first, this work consisted of the League experts advising national governments. This work in general represented an extension of previously articulated principles. The League and the international community agreed to much of the work with striking ease despite an increasingly difficult political climate. This work took a variety of forms, for instance advising on typhus control during the Spanish Civil War. The exploratory mission on typhus control was followed by a mission on nutrition that similarly advised the Spanish government
and reported back to the League of Nations.\textsuperscript{12} League of Nations Health Organisation work in Spain during the civil war was modest. Broader political concerns made interference in the conflict fraught. The League’s political and technical staff worried over the prospect of a Soviet and German participation in the conflict and the repercussions for the League’s international position.\textsuperscript{13} The Spanish delegation did not bring its internal conflict to the Assembly, and the League retained an official policy of non-intervention.\textsuperscript{14} Other League bodies assisted with the refugee crisis in Spain, and voluntary organizations, such as the Quakers, provided relief.\textsuperscript{15} The Spanish interlude illustrates the role of the League as a consultative body, and the willingness of nations to open internal epidemics to international scrutiny.

More noteworthy was the Health Organisation’s involvement in China, which illustrated a willingness on the part of the League to intervene in an area in conflict. Despite the organization’s general reluctance to involve itself on the ground in the 1930s, its work in China was comparable only to their early work in Eastern Europe and frankly even extended it. As Borowy writes, China became a “phantastic testing ground” for the League’s progressive health program.\textsuperscript{16} Rajchman took a personal interest in the Far East beginning with his Far Eastern tour in 1925. He consulted heavily with the Chinese

\textsuperscript{12}Walters, A History of the League of Nations, 724.


\textsuperscript{14}Ibid., 71.

\textsuperscript{15}Borowy, Borowy, \textit{Coming to Terms with World Health: The League of Nations Health Organisation 1921-1946}, (Frankfurt Am Main: Peter Lang, 2009), 422-423.

government over the course of the 1920s and 1930s, eventually becoming one of Chiang Kai-Shek’s main spokespersons in the west, despite his own sympathies for left-wing politics. Rajchman spent a year from 1933-1934 on leave from the League of Nations in the service of the Chinese government. This activity illustrates the increasing comfort the Health Organisation had in serving as an international pool of experts. They would consult, but the final decision and financial responsibility for any actions rested with the host country.

Renewed interest in China, beyond its ongoing collaboration with the Singapore Bureau, began with an inquiry in 1929 into port health, undertaken on the spot by Rajchman and Frank Boudreau. The report recommended that the government worked for better sanitation, better vaccination, more extensive cholera measures, new hospitals, and better medical training. Despite the improved administrative structure in China, a series of epidemics in the late 1930s required international intervention, epidemics which had been exacerbated by the Japanese invasion and the deteriorating domestic situation. At the request of the Chinese, the Health Organisation sent an international team of experts to China. The General Assembly voted to spend 2 million Swiss francs to fund three mobile epidemic units. These three units, headed by League agents but staffed by locals, each had 150 employees and included equipment for diagnosis, isolating,

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17 Borowy, *Coming to Terms with World Health*, 320.


19 Ibid., 3, 9, 15, 18, 19, and 45.


21 Ibid.
vaccinating, and delousing patients. One had a major laboratory and the other had the
equipment to produce enough anti-cholera and anti-typhus vaccines for all three units.\textsuperscript{22}

Armed with 500,000 Swiss francs of medical supplies, the units proceeded to Sian,
Chang-sa, Nanking and Canton.\textsuperscript{23} At Chang-sa, for instance, the unit vaccinated 81,973
people against cholera in July 1938 alone.\textsuperscript{24}

China requested an extension of the mission in 1938, and the League granted the
project an additional 1,500,000 Swiss francs even in the face of tightened budgets.\textsuperscript{25} The
British, despite their general aversion to funding international health initiatives, were
willing to consider it.\textsuperscript{26} The mission continued into 1939, supported by the British,
French, and the Assembly. They hoped to focus increasingly on training the Chinese
staff to take over and then turning over field responsibilities.\textsuperscript{27} Most responsibilities were
handed over to Chinese-created units, while the senior League technical staff became
advisors. The League commissioner Dr. Dorelle credited the shift in responsibility with
making “possible the creation of a more elastic machinery, better adapted to meet the
constantly changing conditions,” which by 1939 included outbreaks of cholera, malaria,

\begin{itemize}
\item \textsuperscript{22} "Report on the Work of the Health Organisation between June 1938 and April 1939 and on its 1939
Program" 8 (1939): 56.
\item \textsuperscript{23} "The League of Nations Anti-Epidemic Work in China in 1939,” 248-249.
\item \textsuperscript{24} "Report on the Work of the Health Organisation between June 1938 and April 1939 and on its 1939
Program,” 57.
\item \textsuperscript{25} "The League of Nations Anti-Epidemic Work in China in 1939,” 250.
\item \textsuperscript{26} Sean Lester, “Technical Cooperation with China,” May 16, 1938, 1, Fonds Ludwik Rajchman, cote
RAJ.C1, Archives de l'Institut Pasteur.
\item \textsuperscript{27} Ludwik Rajchman to Sean Lester, May 16, 1938, 1-3, Fonds Ludwik Rajchman, cote RAJ.C1, Archives
de l'Institut Pasteur.
\end{itemize}
typhus, relapsing fever, and smallpox. Occasionally, because they were located so far from the central government, the League advisors made decisions on their own. Dorelle reflected that the independent units created in 1937 met the requirements of a period of disorganization resulting from military operations which had deprived China of her capital city” but that “lastly, ‘health expeditions’ of this kind, though justifiable in a period of disorder, lost their justification when, after the first shock, the National Government had resumed control over its various organizations and the latter had begun to function fairly normally.” The sphere of action for the independent units was necessarily smaller than national programs would be, and poor communication meant that the units did not always work in the directions the government would prefer. The units illustrated the unity of bacteriological and social medical approaches – combining vaccines with education on personal sanitation. Andrija Stampar, a League commissioner in China and long-time advocate of social approaches, emphasized in a report on his experiences that health work would not have much effect without also raising China’s basic standard of living.

The Chinese program was the height of the League of Nation Health Organisation’s ability to intervene in the work of national governments. The reasons for


29 Ibid., 268.

30 Ibid., 267-268.

31 Ibid., 268.


33 Ibid., 415.
the general willingnes to fund this intervention are obscure, but seem to be related to the
frustration of many members of the League at the disruption of Chinese practices by the
Japanese invasion, Rajchman’s personal interest and ability to persuade, and the fact that
the Chinese asked for the intervention.

Despite this successful mission, the outbreak of World War II in Europe brought
no such renewal of support for international epidemic action. Although several nations
turned to the League to advise on best practices of epidemic control, the League was cut
out of international anti-epidemic work in favor of relief organizations or military
endeavors. With the outbreak of hostilities in September 1939, the Health Committee
prepared to deal with the health problems the war would inevitably cause. Romania
quickly asked for advice in dealing with a wartime increase in infectious diseases. The
committee decided that the Health Section “should at once take stock of the armory of
preventive and curative weapons made available by modern epidemiology, chemotherapy
and sero-therapy and should define the principles to be followed in the control of those
epidemic disease which must be regarded as most important in present circumstances.”

With these fears in mind, the focus of the League of Nations Health Organisation began
to turn from the social issues that had preoccupied it for a decade back to the infectious
diseases it had been founded to contain. In fact, the staff of the League of Nations Health
Organisation considered recreating an epidemic commission if the conditions presented
themselves. This epidemic commission was never struck.

November 20-24, 1939,” in League of Nations Publications, III Health (Geneva: League of Nations,
November 24, 1939), 2.

35 Raymond Gautier to Neville M. Goodman, October 21, 1939, 1, 8A/39095/36619, LON.
Meanwhile, diseases thrived because of the war’s political, economic, and social upheavals, although many outbreaks took place on a national rather than international scale. In Paris in 1944 the incidence of all infectious diseases had increased, including many childhood diseases, polio and venereal disease.\textsuperscript{36} Despite the localized nature of many of these outbreaks, reports of more serious diseases across Europe began to appear, including typhus, enteric fever, and malaria.\textsuperscript{37} These outbreaks increased worries that serious problems would follow in the wake of war. As an ominous \textit{Times} article reminded readers “more individuals died from famine and preventable diseases in the three years after the last war than were killed in the four years of the war itself.”\textsuperscript{38}

Outside of Europe, yellow fever and malaria remained concerns, especially as troop transports threatened to bring the vectors for the diseases to new areas. As dire as the health conditions were in Europe and around the world, the expected postwar epidemics, aside from localized outbreaks of typhus and malaria in regions in which it was endemic, never materialized on the scale of typhus and influenza had after the previous World War.

Wartime conditions brought back familiar diseases, sometimes in unfamiliar places. The Malaria Commission was called upon to provide its expertise as wartime environmental changes increased the prevalence of infected mosquitoes. Larger theatres of combat meant more opportunities for infection. Planes and ships threatened to bring

\begin{itemize}
\item \textsuperscript{36} “État de santé dans la région parisienne - mars 1944. Note émanant des dispensaires d’hygiène sociale de la région de Paris”, 1944, 1-2, 8A/42400/41674, LON.
\item \textsuperscript{37} Ludwik Rajchman to Herbert H. Lehman, March 23, 1944, 1, R. F. 2-1944, 200, box 266, folder 1826, RAC.
\item \textsuperscript{38} “Plans for Medical Relief. Bringing Succor to Liberate Europe. From a Medical Correspondent. Copied from ‘The Times,”’ March 17, 1943, 8A/41764/41764, LON.
\end{itemize}
malaria to new island groups in the southwest Pacific. A mixture of civil and military control of ports complicated control measures. Thus, in the south Pacific, the British advocated not just trying to keep mosquitoes out, but also tried to eliminate breeding places in regions were infected mosquitoes were not yet found in case the quarantine efforts failed. The military, naval, and air forces were willing to consider quarantine because malaria would prove “disastrous” to the war effort.39

A similar role reversal unfolded in India. While most interwar epidemic control attempted to keep the West from becoming infected by diseases from the East, the massive influx of Western troops into Asia, who had often made multiple calls in ports in infected regions, caused Eastern governments to assert their own sanitary integrity. India was particularly concerned with the risk of yellow fever. It refused to lower a fourteen-day waiting period on entry after inoculation and required the vaccines to be given every two years. It asked the Americans and British to comply with their requests, who agreed to quarantine their troops except in cases of military emergency. The India Office acknowledged the inconvenience, but claimed that “the enforcement of quarantine requirements is trifling compared with the disastrous results which might well follow the entry of yellow fever into India.”40 These control measures were negotiated between governments and militaries and did not involve the Health Organisation.

While the war in the Pacific brought new epidemiological challenges, closer to Geneva typhus returned as a serious threat. By October 1939 an estimated 50,000

39 G. A. Mitchell to the Secretary of State for the Colonies, September 23, 1942, 1, DO/350/950/6-233/1, TNA.

refugees had entered Romania, and there were reports of lice-ridden soldiers, making the possibility of a winter epidemic of typhus seem likely. By August 1940, western Poland, under German occupation, had 414 cases and 72 deaths where there had been no typhus before the conflict. It was unclear whether this change was brought by the decrease in health owing to poor conditions in the region, a new importation of lice, or some combination of these factors. Hopes of testing a new vaccine were stymied. Even if the League could negotiate with the Germans, which it politically could not, the Polish population would not trust anything that the Germans approved. Reports from Romania indicated the situation was “every bit as bad as it was in 1919,” with an estimated 70,000 cases between 1942 and 1945. Mihai Ciucă, a long-time health committee member, wrote that he could “foresee a catastrophic spread of the disease” and hoped for the International Epidemics Commission to be reconvened. Typhus presented “the danger of serious interference with the Allies’ prosecution of the war” and the United States and Great Britain needed to control the disease to win the war, but they had few specialists with experience in typhus control more recent than 1921.

Typhus control had changed little, however. Improved vaccines could be given, but border stations and controlling migration remained essential. Yves Biraud published in 1943 a piece in the Bulletin of the Health Organisation in response to the many queries he had received on the subject. As he wrote, “the memory of the innumerable victims of

41 Raymond Gautier to Hugh Cumming, October 24, 1939, 1-2, 8A/39052/39052, LON.
42 “Extract of letter from Biraud to R. E. Dyer, Chief of the Division of Infectious Diseases, National Institute of Health, Geneva,” August 23, 1940, 1, R.F., R.G. 1.1 Series 100, Box 22, Folder 181, RAC.
43 “Extract from a letter written on September 15, 1945 by Dr. M. Ciuca of the Cantacuzène Serum and Vaccine Institute, Bucharest, Romania (translated from the French text),” 1945, 1, 8A/42798/41674, LON.
44 “Memo from J. H., December 19, 1941, R.F., RG 1, Series 100, Box 32, Folder 259, RAC.
typhus fever in Eastern Europe during the first World War gives that disease a place in the forefront of the public mind.”

Biraud indicated that there were many signs that the feared repeat of epidemics might not come to pass – in 1939, during Germany’s initial invasion, Poland did not experience a typhus outbreak, he speculated because the action was of short duration and during the less common time of the year for outbreaks. By 1940, Warsaw, which had swelled in population from 1.3 million to 1.8 million, experienced an outbreak in light of overcrowding with shortages of soap, fuel, and food.

Spain had similarly escaped a typhus epidemic for most of its Civil War, although the collapse of the Republican front in 1939 led to worsening outbreaks over the next three winters, mostly in Madrid and the south.

Although the current situation was not dire, Biraud stressed that even with an immediate end to hostilities, the need to transport prisoners, refugees, and armies back to their points of origin would risk spreading the disease. Biraud suggested that states take proactive measures to prevent epidemics including delousing all vagrants, prisoners, internees, soldiers, before moving on to poor population. He also suggested taking random population samples to check whether delousing measures should be expanded. He also recommended pre-emptive vaccination among high risk groups such as prisoners and soldiers, which would allow the safer killed vaccine to be used. Live vaccines, he

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46 Ibid., 7.

47 Ibid., 12.

48 Ibid., 15.

49 Ibid., 16.
said, were safer than they used to be and provided an acceptable alternative to killed vaccines when epidemics were likely. Europe possessed the facilities to make enough of either type. As he wrote, “lacking the power to influence economic conditions, or to prevent the risks of importation of virus as a result of troop movements … health administrations should strive to make the populations under their care as unreceptive to the diseases and as resistant as possible by preventive delousing and by vaccination,” which he believed would provide “effective protection” against typhus. 51 Despite all of Biraud’s advice, his position, and that of the Health Organisation, was limited to consultation and advice giving.

Diseases, however, were less of a concern. The situation, Biraud wrote, had changed: “exaggerated fears regarding the expansion of epidemic diseases during and after the war that are commonly held by the general public and even the medical profession are based on the tradition of ‘pestilences’ and epidemics during the wars of the past when etiology and prophylaxis of the infectious disease were unknown, and on an imperfect knowledge and understanding of the epidemic situation which prevailed in the USSR and neighboring countries from 1919 to 1923.” 52 The epidemic situation was generally better, and prisoner-of-war and troop movements were not passing through infected areas. Not yet aware of the conditions inside Germany and Poland, Biraud noted that the large concentration of inmates in Germany was not epidemiologically troubling

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50 Ibid., 20-21.

51 Ibid., 54-55.

because in Germany “the essential rules of sanitation are generally enforced.” This retrospectively shocking statement shows the limits of Biraud’s information during the war. Biraud’s report illustrated the increasingly expansive definition of health operating in Europe, as well as the importance of information gathering.

**Health in World War II**

Biraud had illustrated the different dimensions of the health crisis presented by the total war of World War II. He paid particular attention to the needs of civilian populations and viewed it as the duty of the Epidemic Intelligence Service and the Health Organisation to distribute information that might aid scientific study and national policy. Although the statisticians at the League complained they were receiving increasingly poor data about the health of the civilian population in Europe, Biraud attempted to collect the data they did have access to in a report called “Health in Europe: A Survey of the Epidemic and Nutritional Situation,” which included some of the information on typhus discussed above. Although he acknowledged that the full health picture would not emerge until after the war, “then such a study will have only academic interest, and it is now that health authorities and relief organizations need information, even if only preliminary in character, that will be helpful to them in drawing up their plans for remedying the present situation, as regards both nutrition and epidemics.” The reasons for inaccurate information were many: countries tried to hide information for military

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53 Ibid., 696.

54 Yves Biraud, “Health in Europe,” 559.
reasons, mass movements made data difficult to track, errors were made inadvertently, and Biraud believed it was natural for émigrés to exaggerate the conditions in their home countries to “try to enlist the sympathy and help of other nations.”\footnote{Ibid., 570.} Many of the official statistics on which the Health Organisation had relied were not available. Social insurance numbers were inaccurate because the working population had changed since before the war, urban school statistics were impoverished because many children had been evacuated to the country where no records were kept, and worker’s insurance often recorded less illness because workers, acting out of patriotism or compulsion, were less likely to miss work.\footnote{Ibid., 563.} Similarly, rationing statistics were not a good indicator of actual food consumed – many foods were not rationed, official rations were often not obtainable, and they did not take into account foods that were locally obtainable or purchased on the black and grey markets. Ration statistics also failed to account for variations in cooking, spoilage, and digestion.\footnote{Ibid., 577.}

Despite the poor data available, Biraud presented a report that showed the various conditions across Europe. He reported that food supplies were good in Portugal, Sweden, and Switzerland, and satisfactory in Germany, Austria and Italy. Romania, Bulgaria, and Denmark all also had enough locally produced food to feed their populations. Bohemia and Moravia, like the UK and the Baltic, had occasional shortages but could feed most people. Food shortages affected health in Belgium, France, the Netherlands and Norway. Only in Greece was famine a nationwide problem, although many countries faced shortages and famines in jails, internment camps, prisoner of war camps, Jewish ghettos...
and besieged cities. Biraud’s data may reflect the paucity of information he was receiving rather than actual data on the ground. For example, Biraud, in the early days of the war, seemed relatively quick to accept German reports of the health of the citizens and internees. His assessment of the Italian situation also seemed more optimistic than more recent work on conditions in the country would suggest.59

Another population received special if infrequent attention: concentration camp prisoners, considered separately from prisoners of war, who represented a population largely not dealt with before by the Health Organisation. Relatively little information was available at the Health Organisation about internment camps of any kind, and Biraud was anxious about the political implications of publishing this information. In 1943 the League received a report from aid workers working at a camp, later revealed to be in France. The League published the material with “all facts that might incriminate the authorities of Governments responsible for the internment of these persons and for the conditions obtaining in the camps have, as far as possible been eliminated, and the report is confined to the medical aspect of the observations recorded” in order to protect the doctors and their camp patients.60 They described how 12 to 16 months after the internees arrived – at that point, mostly Jews who joined a smaller number of Spanish refugees already present – “famine disease”, which they often described almost in bacteriological terms, “invaded the camp.”61 The doctors began by inspecting inmates

58 Ibid., 693.

59 For more on food conditions in Italy during World War II, see Carol Helstosky, Garlic and Oil: Politics and Food in Italy (Oxford: Berg, 2004), especially 91-126.

60 “Famine Disease and its Treatment in Internment Camps,” 772.

61 Ibid. 723 and 772.
and separating those at risk. They were granted permission to build relief kitchens and bring in relief supplies. The inspectors examined height-to-weight rations, the condition of skin, and muscular tone, as well as looking for signs of edema and taking blood counts. They classified cases into catechetic, the most severe, which included many adults who weighed only 88 lbs despite being of normal height, pre-catechetic, and threatened cases. At one camp, relief doctors inspected 11,000 people, of whom 331 were cachetic, 839 pre-cachetic, and 4,000 threatened.

To quantify the illness, the authors compared the camp’s rations to the League standard. As noted earlier, the League suggested 2,000 calories per day for a sedentary adult male, 2,400 for an adult man who was lightly active, and 3,000 for men engaged in manual labor. Diets below 1,800 calories per day, the report’s author warned, posed serious health risks. At the camp, prisoners got 1,188 calories per day in October 1942, of which the doctors estimated the prisoners absorbed 950 after accounting for loss due to preparation and digestion. By June 1942, the author estimated that the daily ration had fallen to 958 calories per day without taking into account how many might be lost between distribution and absorption. On top of that, the quality of the diet was poor, deficient according to League of Nations standards in fat and protein. Large scale

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62 Ibid., 752.
63 Ibid., 726, 728-729.
64 Ibid., 729.
65 Ibid., 725.
66 Ibid., 744.
67 Ibid., 747.
68 Ibid., 747-748.
purchase of seasonal food made the diet particularly unhealthy. In addition to deteriorating due to poor storage conditions, the variety was harmful. In the fall of 1942, a large scale purchase of pumpkin, which was served midday and evening, caused everyone’s face to turn yellow, illustrating the unbalanced nature of the diet. Vitamin deficiencies were also present. In 1942, relief organizations secured 2,200 to 2,500 calories for the worst off patients and supplemented rations up to 1958 calories per day for most inmates for part of the year, before they were interrupted, possibly, although not stated explicitly, by the deportation of most of the inmates to Poland. Upon the restriction of relief action, according to the author, the ‘epidemic’ character of the disease immediately reappeared.

The authors were able to make several statements about the efficacy of various nutritional supplements. Brewer’s yeast, for example, was effective in improving patient’s conditions and their diarrhea, but had limited effect on nerve problems. Calcium by injection was helpful, but oral calcium was a very efficient diuretic. Glucose could turn advanced cases, and iron got ‘excellent results’, especially in young anemic subjects. Supplements, no matter their value, were not the point, as the report emphasized in its conclusion: “Interned populations cannot long be kept alive in camps if the basic food ration allowed to them does not reach the living minimum allowed to the free civil population and if the elementary rules of collective and individual hygiene are

69 Ibid., 748-749.
70 Ibid., 741.
71 Ibid., 752-753, 772.
72 Ibid., 763.
73 Ibid., 754-755.
not applied to them. Such are the conditions of their survival.” The camp was an unintentional corroboration of many of the League’s statements about nutrition.

Biraud’s attention to the broader health implications of war illustrates how entrenched the broader definition pioneered by the Health Organisation had become. The contents of his reports illustrated the humanitarian crisis which Europe faced. Even in the midst of their limited access to outside information, the staff at the Health Organisation attempted to keep Europe in particular apprised of health conditions, a difficult challenge in the circumstances. The fact that Biraud collated the data nearly on his own illustrates the change in the role of the League. What earlier would have almost certainly been a collaborative, transnational effort had become a single person operation, with the League struggling to maintain some relevance as many of its members no longer collaborated in what had been common international work.

**War Conditions and Relief**

The extent of the growing humanitarian crisis in Europe required new forms of relief work. Although the League of Nations had been founded in the aftermath of World War I, the organization had never been charged with direct relief work beyond Nansen’s semi-autonomous refugee work. Rajchman’s attempts to carry out relief and reconstruction work in Poland had met with significant resistance. Direct government involvement in relief in other nations, with the partial exception of Hoover’s American Relief Administration, remained the exception rather than the rule. This pattern continued into the early days of World War II. Much of the work during the war was

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74 Ibid., 764.
carried out by traditional aid organizations including the American Red Cross and other Red Cross societies, and Save the Children. The League of Nations Health Organisation had a limited role to play. Official collaboration with the League of Red Cross Societies and the International Committee of the Red Cross was impossible because “the League of Nations [was] not considered to be strictly neutral as Germany is no longer a member,” having withdrawn itself in 1933.\footnote{Raymond Gautier to Hugh Cumming, October 24, 1939, 8A/39052/39052/, LON.} Debates over relief work shifted away from the League.

The most novel response to this humanitarian crisis was the United Nations Relief and Rehabilitation Administration.\footnote{For more on the negotiations that lead to the creation of the United Nations Relief and Rehabilitation Administration, see Jessica Reinisch, “Internationalism in Relief: The Birth (and Death) of UNRRA,” \textit{Past and Present}, Supplement 6 (2011): 258-259.} Unlike the voluntary organizations that predated World War I, such as the Red Cross, or the brief League of Nations Health Organisation experiments in postwar relief, the United Nations Relief and Rehabilitation Administration was the creation of a military alliance. To join the United Nations and its relief organization, countries had to declare war on Germany and Japan and offer material support for the war and rehabilitation effort. Planners recognized that liberation would require military, political, and social action.\footnote{This role later expanded to aiding Germans and other civilian occupants of axis nations. William I. Hitchcock, \textit{The Bitter Road to Freedom: A New History of the Liberation of Europe} (New York: Free Press, 2008), 1.} The Organization was called the “Relief and Rehabilitation” administration because American and British planners were loathe to take on the responsibility for the “reconstruction” of large portions of the world.\footnote{Ben Shephard, “‘Becoming Planning Minded’: The Theory and Practice of Relief 1940–1945,” \textit{Journal of Contemporary History} 43, no. 3 (2008): 412.} The United Nations Relief and Rehabilitation Administration represented an experiment in
relief work: it was much bigger than the private post-World War I relief efforts and garnered significantly more government funding. The organization employed 10,000 people from 43 countries. The leaders of the United Nations Relief and Rehabilitation Administration promoted a form of direct intervention that had not proved sustainable earlier, made possible by the fact that initially the organization dealt only incidentally with local governments and was driven by a smaller, top-down military hierarchy that had significant political backing. The organization took responsibility for refugees and displaced persons, attending to their transportation, feeding, and medical care, as well as providing aid to civilian populations across liberated Europe. They shipped $4 billion in relief supplies to Europe over the course of their existence.

The United Nations Relief and Rehabilitation Administration leadership’s broad definition of relief led them to commission medical work in nutrition, public health, sanitation, nursing, and hospital management. One United Nations Relief and Rehabilitation Administration publication described the organization’s work as “the largest international medical operation in history” including 800 United Nations Relief and Rehabilitation Administration physicians and nurses in working in Europe from 29 countries, in addition to the voluntary work of 125 other organizations that they coordinated. Most of their health efforts focused on typhus control, including

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81 Hitchcock, 217

distributing sanitation supplies to displaced persons and delousing them with DDT, dichlorodiphenyltrichloroethane, in order to prevent the spread of typhus.\footnote{Neville M. Goodman, \textit{International Health Organizations and their Work}, 2nd ed. (Edinburgh: Churchill Livingstone, 1971), 141.}

The United Nations Relief and Rehabilitation Administration’s efficacy was debatable, and its relief efforts were plagued with problems. Hitchcock illustrates how the leaders of the states sponsoring the organization were not clear on their goals for its work, perhaps because of the lack of international governmental relief models.\footnote{Ibid., 414.} After the Allied liberation of Italy, the United Nations Relief and Rehabilitation Administration was not prepared to offer on-the-ground relief. Most of the organization’s funds were going to administration.\footnote{Ibid., 415.} Consequently, the American military began many of the relief efforts, distributing vitamins to combat malnutrition in Sicily and spraying DDT, created by the Swiss company Geigy, to combat typhus in Naples.\footnote{Edmund Russell, \textit{War and Nature: Fighting Humans and Insects with Chemicals from World War I to Silent Spring} (Cambridge: Cambridge University Press, 2001), 3. Russell gives a fuller history of the uses of DDT by the American army in this work, as well as the industrial maneuvering that put DDT in the hands of the Allies and the Axis.} When the Army was ready to withdraw, their leaders preferred to hand their relief activities over to the American Red Cross, while the United Nations Relief and Rehabilitation Administration claimed a coordinating role.\footnote{Shephard, “‘Becoming Planning Minded’: The Theory and Practice of Relief 1940–1945,” 416.} The United Nations Relief and Rehabilitation Administration drove another DDT-based campaign against malaria in Greece, but there planners used Rockefeller Foundation infrastructure and even Rockefeller Foundation staff to oversee
This increased attention to chemical solutions had far reaching implications for the postwar public health world. The ability to control diseases effectively and cheaply through the use of single solutions moved the international public away from the comprehensive reconstructive efforts favored by the League of Nations Health Organisation and the early stages of the United Nations Relief and Rehabilitation Administration.

**Epidemic Intelligence and World War II**

The war had a significant effect on the Epidemic Intelligence System. With the international system that had formed the basis of the interwar system in disarray, the international epidemic intelligence system became another battleground in the quest for national prestige and sovereignty and security. Although information sharing in theory continued, in practice it became a political liability as belligerents became concerned about sharing information that might provide their adversaries a strategic advantage. Despite the work of the proponents of epidemic intelligence to convince world governments that information sharing was a good political risk, military operations changed their calculations of risks versus benefits. The position of the Office International d’Hygiène Publique became opaque with the German invasion of France and the installation of the Vichy government. It was partially in response to fears of Axis manipulation of the epidemic intelligence system, and as a result of their own reconstruction plans, that the Allies responded in kind with the creation of the United Nations Relief and Rehabilitation Administration in 1943, which in addition to its on-the-
ground support of refugees and liberated populations, attempted to create its own intelligence gathering organizations. This new configuration of epidemic intelligence organizations complicated the exchange of data over the course of the war, illustrating the deep political stakes in the problem. The League of Nations had attempted to convince participating states that they could trust each other’s data and that the benefit in sharing sensitive national information outweighed any risks. With the war, the pretense that information exchange was an apolitical act had to be dropped.

The initial volley in the battle over epidemic intelligence, which illustrated the breakdown of the older international system, came earlier, with Egyptian attempts to take control of the International Maritime Quarantine and Sanitary Board. The Board, centered at Alexandria with control over the El Tor quarantine station, pre-dated most of the rest of the international sanitary system. Muhammad Ali had invited the Great Powers to form the board in 1831 to oversee pilgrimage traffic. In 1881 the Board split into a domestic service overseen by the Egyptian government, and a continuation of the international board that retained control over international matters. The board had been an awkward creation since its beginning. Imperial powers fought for control, and the board frequently shifted hands as the balance of power shifted in Egypt. The British had effectively headed the board for most of the twentieth century, but that control was weakening under the strained Anglo-Egyptian relationship. Since 1926 the Egyptian government had increasingly angled for more control of the board. The unsettled conditions created by the War gave the Egyptians the chance to negotiate for more control.

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The Egyptian government had “never disguised the fact that they want to get rid of the International Quarantine Board or at least deprive it of its international character – national prestige, of course.”  

Rumors increased in the 1930s that Egypt might act on those ambitions. The members of the Quarantine Board worried that despite the relatively educated Egyptian staff available, a handover to the Egyptian administration “would be prejudicial to the immunity from epidemics.”  

The 1936 Treaty of Alliance with Egypt, which granted the Egyptians more freedom and ended the British occupation, left the Egyptians free to abolish the board.  

Official approval needed to come, however, from an International Sanitary Convention, because the Alexandria quarantine procedures were written into the current convention. As one British foreign office circular put, “the problem…[was]… to reconcile the legitimate aspirations of the Egyptian Government with the legal rights and certain vital natural interests of other countries concerned.”  

In preparation for the conference, British, as well as Italians, Greeks, French, Spanish, Russian, Polish, Dutch, Yugoslavian and Swedish officials were engaged in discussions about how to abolish the International Quarantine Board. The negotiations went slowly, and telegraphic reports from the British negotiators evinced significant frustration with their Egyptian interlocutors. Bedawi Pasha, the main

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90 J. H. B., “Minute”, October 10, 1936, TNA.  
91 C. Heathcote-Smith to the Acting High Commissioner for Egypt and the Sudan, October 7, 1936, 1, FO 141/597/4, TNA.  
93 Devonshire, for the Secretary of State, “Proof of despatch F 7.715/33, Circular B. No. 67,” 1938, 2, DO 35/577/3, TNA. The treaty section on ‘capitulations’ required that legislation limiting Egyptians sovereignty be removed.  
94 “Proposed Abolition of the Egyptian Quarantine Board. Fifth Meeting Held on 20th December, 1937,” 1937, FO 371/21958, TNA.
Egyptian negotiator, objected to everything about the international system, including “the role of France as the convoking Power and to the preponderating position which would be given to the Paris Office.” S. M. Lampson, the British delegate, claimed that under Bedawi Pasha’s leadership the “Egyptian Government are obviously ignoring all practical issues in favour of theoretical considerations inspired only by exaggerated sensitiveness about sovereignty.” 95

Montagu Travers Morgan, former head of the Board, believed that the Egyptians were being unrealistic in the demands they were placing on other nations. He wrote that the Egyptian Government failed to realize that since they were asking “to be given the right to impose highly burdensome measures against foreign shipping,” other nations were justified in demanding” a technical court of appeal or of consultation” to judge the merit of “those measures.” 96 Morgan also complained that the Egyptians did not understand the functioning of the International Sanitary Conference and the resulting International Sanitary Convention that would be required to transfer the Board to Egyptian hands. They sought to move too quickly, while the technical nature of the convention meant that national delegates were generally not given full plenipotentiary powers and the treaty would have to be ratified to make the change permanent. 97 The Egyptians finally accepted Morgan’s contention and the conference planning went ahead

95 “Cypher Telegram from S. M. Lampson”, 1938, FO 371/21958, TNA.

96 “Dr. Morgan’s Comments on the Memorandum of the Council of Ministers on the Draft Heads of Agreement,” 1938, FO 371/21958, TNA.

97 M. T. Morgan to V. F. W Cavendish Bentinck, August 23, 1938, 1, FO 371/21960, TNA.
on the understanding that the treaty would most likely need to be ratified after the conference.\footnote{Ibid.}

Convening the international sanitary conference required to amend the quarantine procedures was tricky in the strained international climate of the late 1930s. The invitation list became a matter of intense debate. Following the Italian invasion of Ethiopia, the Foreign Office advocated against inviting Ethiopia to any negotiations lest the invitation upset Italy, because it would be “a nuisance” if Italy decided not to come.\footnote{V. F. W. Cavendish Bentinck, “Minute”, September 3, 1938, FO 371/21960, TNA.} They advised the French, who were uncomfortable not issuing the invitation, to lay aside any “legal scruples” they might be feeling, because international law could only be put in practice by those in de facto power, which Ethiopia was not.\footnote{V. F. W. Cavendish Bentinck to Louis Roché, October 21, 1938, 1-2, FO 371/21960, TNA.} At the four-day conference, with no Ethiopian representative, the Egyptians were given the right to take over the quarantine board. Much of the resulting 1938 International Sanitary Convention had been pre-negotiated and the convention dealt exclusively with the functioning of the Egyptian Sanitary Board.\footnote{Norman Howard-Jones, \textit{The Scientific Background of the International Sanitary Conferences 1851-1938}, History of Public Health 1 (Geneva: WHO, 1975), 93.}

The transition was rough. Of particular concern was the replacement of experienced staff with less-experienced Egyptians.\footnote{D. V. K., “Minute”, July 27, 1939, FO 371/23354, TNA.} As the transition went on, the former European staff became frustrated. A former British member of the board, Gilmour described the situation as a “proper mess” and wrote that he could “never have
believed it possible that an efficient administration could get into its present state in such a short time.” He claimed that the remaining Europeans faced problems because all of the official correspondence was in Arabic, and the Egyptian officials were negligent and fought among themselves.\textsuperscript{103}

At home, Gilmour’s correspondents were unsure what to make of his report. They agreed that if his descriptions were correct, then the Egyptians were failing both in the responsibilities under the agreement and putting the world at risk of epidemics. They were particularly concerned with the fact that the war had created the potential for more epidemics. The British government felt their greatest fears might be realized: “If the Quarantine Service built up in Egypt, thanks to British initiative and to the sense of responsibility of British officials, is allowed to deteriorate to the level of Egyptian standards, which it will rapidly do in proportion to the extent of the removal of British control, the danger of the invasion of Egypt by epidemic disease and of the carriage of such disease from the East through the Canal and thence to Europe will proportionately increase.”\textsuperscript{104} They feared it was “only a matter of time” until they were faced with plague or some other catastrophe.\textsuperscript{105}

Despite the ongoing concern about the Egyptians’ competence, the disputes over the Quarantine Board were equally about anxieties over waning British imperial control and the changing international order. Gilmour himself served as a focus of this anxiety. Morgan called him a “peculiar personality” who had “a sense of grievance that he has not

\textsuperscript{103} Gilmour to M. T. Morgan, December 21, 1939, 1, FO 371/24596, TNA.
\textsuperscript{104} M. T. Morgan to D. V. Kelley, December 28, 1939, 1, FO 371/24596, TNA.
\textsuperscript{105} S. Thompson, “Minute”, April 30, 1940, FO 371/24597, TNA.
been able once again to squeeze the last drop from the orange,” expressing concern over Gilmour’s ongoing quest to improve his pension. Morgan claimed that Gilmour “has long reached that unfortunate state of Europeans long resident in Egypt, who can find nothing good in things Egyptian, and the memory of the status of the European in the good old days still rankles.”106 Another member of the Foreign Office called him “one of the last relics of that body of British officials who have always regarded the Egyptian Government as a financial milk cow who in pressing their exaggerated claims” often damaged Anglo-Egyptian relations. Gilmour left the Board once he secured his desired pension.107 His personal struggle was illustrative of larger shifts in international relations.

While the political uneasiness of the late 1930s had begun to shift the balance of power in the international sanitary system, the war nearly broke a system that had been so promising in the interwar period. The war severely weakened the position of the Office International d’Hygiène Publique, eventually all but cutting it off from the rest of the world. After the war began, as in 1914, the Office International d’Hygiène Publique suspended its committee meetings, leaving only its tiny permanent staff to manage its affairs. When the Germans broke through the invaded France, the Office evacuated its Paris headquarters to Royat, but despite its efforts, could not sever ties to Paris completely.

106 Morgan to Kelley, December 28, 1939, 1-2.

107 S. Thompson, “Minute”, February 21, 1940, FO 371/24597, TNA.
The newly installed Vichy government required the Office International d’Hygiène Publique to do all of its printing in the occupied zone.\textsuperscript{108} The organization remained in partial contact with the outside world, continuing to send weekly European data to the Pan American Sanitary Bureau and remaining in contact with the American ambassador in France from June 1940 to November 1942. Relationships with European belligerents and even the League of Nations Health Organisation were more strained.\textsuperscript{109} With the departure of the American ambassador to France in November 1942, the relationship between the Office International d’Hygiène Publique and the rest of the international sanitary network cooled. The organization sent some information to the Pan American Sanitary Bureau via the Swiss legation in Vichy, but no longer received American data. They received some Pan American Sanitary Bureau data indirectly from the League of Nations Health Organisation. In 1943 the Germans communicated the decision through the French Ministry of Foreign Affairs that the Office International d’Hygiène Publique would no longer be able to communicate with outside countries, which the Office International d’Hygiène Publique protested to limited avail.\textsuperscript{110} As of April 1944 the \textit{Weekly Epidemiological Record} of the League of Nations Health Organisation included no information from the Office.\textsuperscript{111}

With communication greatly hampered by the war and censorship and shifting political loyalties collaborations between individuals at the various health organizations

\textsuperscript{108} “Report on the situation under which OIHP was compelled to evacuate from its Paris Office to Royat”, 1944, 1, microfiche A62, WHO.

\textsuperscript{109} “Les relations techniques entre l’Office International d’hygiène publique et les Etats-Unis d’Amerique du 10 juin au 4 octobre 1944”, 1944, microfiche A62, WHO.

\textsuperscript{110} J. Pierret to H. Reiter, April 5, 1943, 1, microfiche T71, WHO.

\textsuperscript{111} Raymond Gautier, December 18, 1944, 1, 8D/34880/204, LON.
became strained. The activities of Jacques Pierret, the head of the Office International d’Hygiène Publique, were among the most speculated upon. Biraud was firmly convinced he was “a full-fledged ‘collaborateur’” and did everything possible to inform overseas contacts of his beliefs. Biraud was troubled by the Office’s “strange double life” during the early years, in which the administrative wing of the Office International d’Hygiène Publique, such as the mimeographers, escaped to Royat while Dr. Pierret and a German observer stayed in Paris. That observer was Dr. Olsen, a former colleague of the League of Nations Health Organisation who had worked on nutrition. He had been appointed head of the service of international hygiene at the Reich Health Office and his duties included the ‘observation’ of the Paris office. Despite Biraud’s suspicions, Pierret was officially cleared after the war, and there is no documentation that proves his guilt as a collaborator or exonerates him.

Although the League was not directly taken over by one side of the conflict, its ability to function was also curtailed. The staff of the epidemic intelligence service had to balance their commitment to open information sharing against their need to preserve access to epidemic data. As early as May 1940 Biraud and Park came to the conclusion that “the risk entailed in the publication of information on the movement of ships in Eastern waters, and more particularly of the destination of such ships, may be more harmful than useful.” They decided to suppress all data, not just those from Allied powers, in order to prevent neutrals from feeling unfairly discriminated against.

112 Yves Biraud to C. L. Park, June 17, 1941, 1, 8D/32549/341, LON.
113 Raymond Gautier, “Information concerning the Office International d’Hygiène Publique supplied by Dr. Goodman”, December 1, 1944, 1, 8D/3488/204, LON.
114 Yves Biraud to C. L. Park, May 3, 1940, 1, 8D/33053/341, LON.
Geneva also stopped receiving epidemiological intelligence reports directly from many quarters in Europe and the Americas and was forced to “crib” the Office International d’Hygiène Publique releases and the Pan American Sanitary Bureau weekly bulletin, a situation Biraud called “preposterous” but unavoidable “when military control and stringency are, of necessity, the order of the day.”

In November 1940 India announced that it would stop sending cables to the Singapore Bureau, which would make the bulletin “glaringly incomplete not to say misleading.” Biraud feared that other countries would follow suit “inspired by the belief (shared neither by Gauthier, nor myself) that these epidemiological data are of military significance,” noting that “with the exception of the Philippines, Thailand, and Portuguese colonies, practically all countries in the area served by the Singapore Bureau are de facto or de jure belligerents.”

By February 1941 there were no weekly cables from British possessions, aside from some mailed reports from some British colonies in Africa. Given that epidemiological data could show ship movements, large scale troop movements, and supply lines, it is unlikely that Biraud or Gautier truly believed there was no military application, although they clearly believed that benefits outweighed the risks.

Biraud expressed his view that military planning and politics threatened the League of Nations as a whole. Biraud feared that “powerful forces” who desired the end of the League would bring down the Health Organisation with it. To protect his service, he proposed severing the organization from the League. He was convinced that a “‘freed’

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115 Yves Biraud to C. L. Park, June 11, 1940, 1, 8D/33053/341, LON.

116 Yves Biraud to Sean Lester, November 11, 1940, 1, 8D/33053/341, LON.

117 Ibid., 1-2.
Health Organisation or Epidemiological Intelligence Service” separated from its politically tainted superstructure, and with funding not tied to states, “could continue to function here without hindrance.” He believed this to be possible because the Epidemic Intelligence Service was still in contact with German and Italian authorities.  

Biraud preferred this plan to another possibility: the transfer of the technical bodies of the League to Princeton University, where many other League technical offices had already decamped, because it would mean less disruption to the global flow of information.

The desire to keep the Epidemic Intelligence Service centered in Geneva was shared outside of the League. Neville Goodman at the British ministry of Health was impressed that as late as April 1941 Biraud was still receiving German information, which might cease if the service moved to Princeton or the US entered the war. It still received limited information from Paris, which the British received directly not “at all or only with very great delay.” He also feared that the Pan American Sanitary Bureau would not appreciate a rival at on their home soil.

In the end, the League of Nations Health Organisation remained at Geneva because the Secretary General feared that if the last technical body of the League left Geneva, the Swiss government would ask the League to leave entirely.

The League of Nations Health Organisation and the Office International d’Hygiène Publique both faced a new rival in the United Nations Relief and Rehabilitation Administration’s nascent epidemiological intelligence service. Unlike the

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118 Biraud to Sawyer, September 1, 1940, 2.

119 Ibid., 2-3.

120 Neville M. Goodman to Makins, April 29, 1941, 1, MH 79/430, TNA.

121 S. Deutschman to G. K. Strode, December 27, 1941, R. F., R.G. 1.1 Series 100, Box 22, Folder 181, RAC.
Office International d’Hygiène Publique and the League of Nations Health Organisation which, at least in theory, were neutral organizations that served the public good, the United Nations Relief and Rehabilitation Administration was a creature of a military alliance, aiming to follow in the wake of a liberating army. The leadership of the United Nations Relief and Rehabilitation Administration created a standing technical committee on health staffed by “technically competent” doctors and scientists.\(^{122}\) Although the bulk of United Nations Relief and Rehabilitation Administration’s health work was relief, policymakers took a keen interest in epidemiological intelligence, fearing a repeat of the epidemics that had followed in the wake of World War I. They saw epidemiological intelligence as a means to their end, however, not as part of a cooperative global venture.

These different orientations made cooperation difficult. The League of Nations Health Organisation complained that the United Nations Relief and Rehabilitation Administration benefitted from a one-sided relationship, in which they demanded information for their operations, but rarely reciprocated.\(^{123}\) The communication problem was actually exacerbated by military success: as the allies liberated new nations, those nations stopped transmitting data to protect the war effort, effectively ending the transmission of data “through devious routes” that had sustained the Epidemiological Intelligence Service for much of the war.\(^{124}\) Biraud attempted to have the French and Belgians use diplomatic bags, but the stoppage of mail across France put the transmission

\(^{122}\) UNRRA Standing Technical Committee on Health, “Minutes of the Seventh Meeting. Dec 5, 1944. THE(44)38, St. Tech. Committee on Health Minutes/7”, December 5, 1944, 2, MT 9/4089, TNA.

\(^{123}\) Yves Biraud, December 22, 1944, 1, 8A/42474/42474, LON.

\(^{124}\) Ibid., 3.
of Portuguese, Spanish, Belgian and French data in jeopardy.\textsuperscript{125} Biraud offered to stop transmitting to German occupied regions or even through them, if he were “assured that the Epidemiological Intelligence Service would get compensation from the Allied Side.” Biraud regarded this choice as the lesser of two evils, since the Germans had stopped sending official epidemiological information. Biraud did try to get permission to have access to confidential health information for the League of Nations Health Organisation’s records, hoping that he could create an archive that could be released for research purposes after the war.\textsuperscript{126}

New organizations were not the only problem. The shifting arrangements between the League of Nations Health Organisation, the Office International d’Hygiène Publique, and the United Nations Relief and Rehabilitation Administration meant that the legal structure that oversaw them had to be updated. The 1926 International Sanitary Convention, augmented by the 1933 Aerial Sanitary Convention based on similar principles, remained in effect and had no provisions for dealing with a wide-scale conflict in which powers no longer cooperated. There were various attempts to deal with the resulting mess. The British, deciding that the International Sanitary Convention reporting requirements endangered their war planning because the Office International d’Hygiène Publique was located in enemy territory decided to no longer submit data to offices operating under the International Sanitary Convention, including the League. Instead, the British government planned to submit required information directly to the heads of diplomatic missions, which satisfied, to their understanding, their national obligations

\textsuperscript{125} Ibid., 2-3.

\textsuperscript{126} Ibid., 4.
under the treaty. Separately negotiated arrangements allowed Geneva and Singapore to obtain some information about British ports, although the British claimed they would delay transmission of data about epidemics, for national security purposes, which to some extent defeated the purpose.  

Many of the necessary legal maneuverings took place at the regional bureaus because of their complicated legal connection to the Office International d’Hygiène Publique. The Singapore Bureau found itself in the most awkward position of any of the bureaus. The bureau owed financial and administrative allegiance to the League of Nations Health Organisation, but was specifically named in the agreements with the Office International d’Hygiène Publique. Its director, Charles Park, was a British subject, working in a British colony, and the British government frequently did not accept his claims that he was there as a representative of the League rather than his imperial government. Furthermore, war had come early to Asia, with the invasion of Manchuria in 1931. Earlier conflict had had a limited effect on the Bureau.  

Although Japan withdrew from the League in 1933, the government remained in contact with the Singapore Bureau, presumably because of its commitments under the International Sanitary Convention. Indeed, the advisory committee of the Singapore Bureau intended to hold its meeting at Tokyo in 1939 and only stopped because of budgetary considerations. The staff at the League of Nations Health Organisation were hopeful that the growing discontent in Europe would not spread. Park wrote to Gautier that “it seems

127 C. L. Park to Yves Biraud, July 18, 1941, 8D/33053/341, LON.

reasonable to think that in the event of war in Europe, Far Eastern countries might not be
drawn in.” Indeed, in August 1939 Park’s greatest concern was that the Straits
Settlements would not allow him to transmit in code any longer.\textsuperscript{129}

The war had a greater effect on Park’s operation than he had hoped. Gautier had
to ask that the Singapore broadcast no longer be transmitted to Europe “owing to
circumstances.”\textsuperscript{130} Park also faced problems from Singapore’s Director of Medical
services, who believed that the League’s location in Geneva meant that it must be under
German influence.\textsuperscript{131} The bureau was shut down when Park was forced to flee during the
Japanese invasion of Singapore. Park’s future became even more uncertain than the
Bureau’s: while Gautier wanted to reopen the bureau as soon as was practical, he did not
believe that Park was “the man for the reconstruction work, and this for obvious reasons.”
They needed to fire him formally in order to remove any claim he had on the directorship
of a re-opened bureau.\textsuperscript{132} This decision led to the League’s hounding Park, asking him to
account for books and other materials abandoned at Singapore, and criticizing his
attempts to run some Far Eastern services from his native Australia.\textsuperscript{133}

Managing the international epidemic network in a way that preserved the world’s
safety from epidemics as well as states’ national security was one of the biggest
challenges of the interwar period. The fact that the stakes were so high illustrates the

\textsuperscript{129} C. L. Park to Raymond Gautier, August 31, 1939, 8D/32549/341, LON. For a full history of the
tumultuous later years of the Far Eastern Bureau see Manderson, “Wireless Wars in the Eastern Arena:
Epidemiological Surveillance, Disease Prevention and the Work of the Eastern Bureau of the League of
Nations Health Organisation, 1925-1942.”

\textsuperscript{130} Raymond Gautier to Calume, December 24, 1941, 8D/38994/341, LON.

\textsuperscript{131} C. L. Park to Yves Biraud, November 3, 1941, 2-3, 8D/33053/341, LON.

\textsuperscript{132} Manderson, “Wireless Wars in the Eastern Arena: Epidemiological Surveillance, Disease Prevention

\textsuperscript{133} Raymond Gautier, “Confidential”, August 1, 1942, 1, 8D/41370/341, LON.
general success of the League of Nations Health Organisation and the Office International d’Hygiène Publique’s epidemic intelligence programs. The wartime experience illustrated how epidemiological intelligence had become so entrenched in international relations that nations, particularly new powers, could manipulate the system for political gain. The wartime experience cemented epidemiological intelligence as the cornerstone of international epidemic control, if not international cooperation.

**Conclusion**

During World War II, the Health Organisation faced changing political and medical realities. Older responses to epidemics, including direct attack and epidemic intelligence, proved difficult to maintain as nations withdrew their support from the League of Nations. Biraud’s work, and the work of those who sent him data, illustrated the loyalty the League of Nations had managed to instill in its staff and some of their collaborators. Despite that faith in the Health Organisation’s mission, the international community entrusted health work to military alliances, fearful that sharing epidemic information might make them look weak to their enemies or reveal their troop and supply movements. This increasing disjuncture between national governments and international work led to many of the central features of the postwar international sanitary system.
Chapter 7: Rebuilding the International Sanitary System

According to most accounts, the World Health Organization was started casually over lunch when all three physicians present at the United Nations Conference in San Francisco in March 1945 decided to propose adding health to the United Nations charter. Three physicians - Chinese, Norwegian, and Brazilian - walked into a restaurant and came out with a plan for a new international health agency. This story, repeated in both World Health Organization-produced-histories and scholarly accounts, served a number of purposes of the early World Health Organization.¹ This founding myth positioned the organization as the creation of physicians who understood the objective, scientific need for a centralized health association and also presented its creation as a matter for discussion over a meal rather than the thorny political problem to be subject to high-level diplomatic negotiation. The myth solidified the World Health Organization as the creation of second-tier powers, rhetorically removing the World Health Organization from the Cold War struggles of the superpowers.

Like many origin stories, this particular narrative is both broadly correct – the three men attest to the lunch, and their motion to create a world health organization was

put into the San Francisco version of the United Nations charter – but also deeply inadequate. Even the three men acknowledged that the San Francisco conference delegates placed the health organization in the United Nations Charter rather than in its constitution because a proper organization could not be negotiated in time.² In fact, planning for a world health organization predated the lunch significantly and had preoccupied many international health workers and diplomats since the early days of World War II.

The character of the World Health Organization developed in response to both the long series of conferences that created the United Nations system – Dumbarton Oaks, Atlantic City, and San Francisco – but also out of a multi-year-long exchange among leading public health officials who debated the proper scope of a world health organization as well as the relationship between that organization and any emerging political super-organization.³ Scarred by the frustrations of the previous twenty years and the negative effect of the collapse of the League on the international sanitary system, experts pushed for a more independent health organization. This chapter traces these debates and provides a little-known “on-the-ground” perspective on a story that is often told from the perspective of Cold War and American politics.

In order to avoid the hindering of technical bodies that occurred during the League of Nations’ tenure, the postwar planners separated, as far as possible, technical

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and security planning. Paul Kennedy described how the United Nation’s Economic and Social Council was created to be an equally powerful counterpart to the Security Council, although that strength was never fully realized. Although the Great Powers were given a veto on the Economic and Social Council in order to secure their cooperation, their governments had limited interest in internationally-directed social projects like health work, leaving the social programs of the United Nations without a major defender. With the withdrawal of political support, the World Health Organization turned away from the social medical interventions that had characterized the League of Nations Health Organisation.

The planners at the World Health Organization focused instead on “vertical disease eradication,” which Katerina Gardikas describes as a “full frontal assault on a single disease… rather than a campaign against a broad spectrum of diseases” and, most importantly in tight budgets, by a “minimal amount of public health infrastructure.” Vertical approaches are contrasted to horizontal approaches, which focused on building general health through disease prevention, mother and child welfare, nutrition and other, often socially based, strategies. The League of Nations Health Organisation supporters had only partially succeeded in convincing the world to adopt their horizontal approach, which was made even less appealing by the technological and political changes of the 1940s. This move put the new health community outside of the growing consensus about the importance of broad-based international economic interventions, such as the Marshall

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Plan. This chapter examines how the League of Nations Health Organisation’s expansive program of the 1930s became the more limited program of the World Health Organization in the 1940s and 1950s through this fear of political entanglement, the promise of new technologies, and the transfer of many Health Organisation responsibilities to newer, more specialized agencies.

I begin with an examination of the debates held over the proper scope of the new health organization held amongst public health professionals and diplomats during World War II. The participants in these debates took for granted the broad definition of health developed by the leaders of the League of Nations Health Organisation. However, in the transition to the World Health Organization, many parts of that definition were pared back in order to reach the political compromises that made the creation of the new organization possible. I then explore how these compromises affected the early years of the World Health Organization program, which was scaled back. Support for a broader program was made difficult by the fragmentation of public health as a cohesive field internationally and the increasing health disparity between the developed and developing world. Consequently, international public health in the immediate post-war period had less in common with the developmentalist paradigm of many international agencies than its broad background would have led most to predict.

**Imagining a New International Health Organization**

While relief efforts were still underway, many internationalists, particularly on the Allied side, took part in efforts to plan a new, multilateral approach to international
relations and the organizations that would support them.\textsuperscript{6} What sort of organization
would replace the League of Nations was hotly debated, as was the purview of that
organization. Many of the planners had deep ties to the League of Nations.\textsuperscript{7} As rooted as
many planners were in the League system, new conceptions of international relations and
government responsibility shaped the discussion. The Depression had encouraged many
governments to look towards not just ensuring basic rights of personal security and
political safeguards but also social rights, including housing and economic security.\textsuperscript{8}
American planners saw postwar economic and strategic interests as intertwined post war,
and looked to freer trade to preserve peace. Decolonization, free trade, and development
would create new markets and prevent resource wars.\textsuperscript{9} Experts debated amongst
themselves whether traditional models of relief were adequate or should be replaced by
newer models of reconstruction, or, increasingly, ideas of development – an economically
centered model.

The new international climate and the developing Cold War demanded a new
series of international health arrangements. Many international public health workers
looked with hope to rebuilding the international sanitary system. However, few partisans
of the League of Nations Health Organisation or Office International d’Hygiène Publique

\textsuperscript{6} Borgwardt refers to this era as the “multilateralist moment.” Elizabeth Borgwardt, \textit{A New Deal for the

\textsuperscript{7} Mark Mazower, \textit{No Enchanted Palace: The End of Empire and the Ideological Origins of the United


\textsuperscript{9} Patrick J. Hearden, \textit{Architects of Globalism: Building a New World Order During World War II}
(Fayetteville: University of Arkansas Press, 2002), 313 and 93.
expected their organizations to survive intact. The current system awkwardly had two
organizations at its center – the League of Nations Health Organisation and the Office
International d’Hygiène Publique – and many public health workers thought that the
dramatic political realignment would allow them to streamline international work. I will
now examine several of the most prominent examples of these proposals, in order to
illustrate the main outlines of the debate and how these proposals ultimately differed
from both the League of Nations Health Organisation and the World Health
Organization.

Health Section member Raymond Gautier proposed the creation of an
“International Health Agency” that would unify the international sanitary system under a
single organization. The Office International d’Hygiène Publique he believed was
“doomed” because of its Nazi taint. He believed that likewise the League would not
survive, but that its technical organizations would be salvageable in some form and
would produce better results when freed from the League.10 His proposed International
Health Agency was to continue many of the activities of the older organizations: to
facilitate free flowing epidemic intelligence, international consultation, and International
Sanitary Conventions. But he advocated a more expansive program, writing that the
International Health Agency should have “higher aims, requiring greater power and
involving heavier responsibilities.” He relied on the newer, more expansive definition of
health that the League of Nations Health Organisation had pushed for: “… health is more

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10 Raymond Gautier, “International Health of the Future - Confidential”, March 15, 1943, 1, R. F., R. G. 1.,
Series 100, Box 22, Folder 182, RAC.
than the absence of illness: the word ‘health’ implies something positive, namely
domestic, mental, and moral fitness.’’11 He advocated many of the tactics employed by
the League of Nations Health Organisation, including institutionalizing a more unified
regional structure, where continental epidemiological intelligence and research bodies
could report back to the International Health Agency.’’12 He also advocated a return to
direct attack, and wanted the International Health Agency to be granted the ability to
organize its own on-the-ground relief and anti-epidemic measures without waiting for
international approval.13

Gautier was not the only League of Nations Health Organisation veteran to
develop plans for post-war reorganization. Ludwik Rajchman also offered his vision for
post-war health work. Rajchman spent most of the war a private citizen traveling
between England and the United States.14 He concerned himself with relief efforts,
hoping to aid in Polish reconstruction “when opportunity offers” and consulting formally
and informally with various international organizations.15 Rajchman, who ultimately was
instrumental in the founding of the United Nations International Children’s Emergency
Fund (UNICEF, later the United Nations Children’s Fund), shared his vision for
international health work in his pamphlet “Why not? A United Nations Health Service,”

11 Ibid.
12 Ibid., 2.
13 Ibid., 6.
14 In 1940, his family had been forced to abandon their French farm. Several of Rajchman’s family
members were transported to, and in some cases killed at, Mecklenburg and Auschwitz. Ludwik Rajchman,
December 26, 1944, 2, Fonds Rajchman, cote RAJ.B2, Pasteur Institute.
15 Ibid., 2-3.
originally published in *Free World* in September of 1943. Like many of his counterparts, Rajchman believed that the system that underwrote the League of Nations Health Organisation was broken. He opined that although the League of Nations Health Organisation had undertaken valuable work, it had faltered because it was “directed by experts and controlled by diplomats.” It was too disconnected from the “more than two billion consumers” of medical services, who understood that “health is the greatest commodity in the world” – an economic language that had been absent from his earlier analyses of health matters. Rajchman claimed that medical advances and the promises of the New Deal had created new economic and conceptual bases for international health work. “Freedom from want” would ensure health for the world.

To accomplish these goals, the new international health organization would need a new structure. The organization, which he called the United Nations Public Health and Social Medicine Organization, would need to be an ad hoc organization, rather than one that relied on formal conventions. This structure would put it on similar footing to the other United Nations bodies being developed and give it greater flexibility than the Office International d’Hygiène Publique or League of Nations Health Organisation. He modeled his plan on the existing International Labour Organization. Rajchman identified two factors that he believed allowed the International Labor Organization to survive the political upheavals of the 1930s and the war: the first was the involvement of the United States, but second and most importantly, it had a vested interest from consumers on the

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16 Ludwik Rajchman, “Why Not? A United Nations Health Service” (Free World, September 1943), 1, 8A/42169/41755, LON.

17 Ibid., 2-3.
ground in the form of workers who looked to the International Labor Organization to provide international leadership. The International Labor Organization succeeded in bringing together policy makers and those whom the policy affected. He wanted his new health organization to do the same. The United Nations Public Health and Social Medicine Organization needed to link policy makers to the health workers on the ground and the regular populations of all nations. To that end, he proposed a world “Health Tax” of 1% of all public health spending to fund the new organization, which he believed would engage consumers without costing them too much money and show how their dollars could be returned to their region and to the greater international good. While the United States and Ethiopia may have experienced different health problems, they could both benefit from internationally involved health work, and the tax would make clear that each would contribute and could expect results from their contributions.\(^\text{18}\)

Rajchman proposed four branches for his United Nations Public Health and Social Medicine Organization: an epidemiological intelligence system, a colonial medicine and health system, a central research service, and a social medicine and public health branch. These bodies would continue much of the work of the League of Nations Health Organisation – the epidemic intelligence network, the emphasis on international research, and work in social medicine. Rajchman placed new emphasis on on-the-ground work by the United Nations Public Health and Social Medicine Organization in these issues, and he envisioned that such work would be completed by persons appointed jointly by the United Nations Public Health and Social Medicine Organization and the

\(^{18}\) Ibid., 3.
local staff, preferably drawn from the local population to avoid any complaint that solutions were being imposed from outside. He also wanted the United Nations Public Health and Social Medicine Organization to commit itself to eradicating typhus, cholera, malaria, and smallpox worldwide as they had been in the United States and most of Western Europe, a more ambitious goal than Rajchman had held when he led the League of Nations Health Organisation.¹⁹

Rajchman circulated this pamphlet widely, and he received comments from many international public health figures. Alan Gregg of the Rockefeller Foundation approved of the health tax, but did not believe that most populations would. He also agreed with the separation of the political and technical. He wrote to Rajchman that the service should be located “20 to 30 to 50 miles away [from any political or United Nations capital] - just far enough so that any visiting that was done would have a real purpose and the health workers would at all other times be relieved from the fevers and the futilities of political gossip and uncertainty,” further illustration of the widespread frustration health workers felt about the current embedding of health work in political organizations.²⁰

Others, while broadly sympathetic to Rajchman’s concerns, expressed concern that his solution risked perpetuating some of the problems that he hoped it would fix. Manley O. Hudson, a key American supporter of the League, took issue with the structure that Rajchman proposed. He wrote that he feared that the ad hoc arrangement Rajchman aimed for represented “a return to the 1890s.” He asked, “have we not learned

¹⁹ Ibid., 4.

²⁰ Alan Gregg to Ludwik Rajchman, October 20, 1943, 1, Fonds Rajchman, cote RAJ.C3, Pasteur Institute.
that it is a most useful thing to organizations in most fields to have a constant responsibility of an overall political body?‖ He concluded that he did not see how the United Nations, at this time largely undefined either by the organization or by Rajchman, could avoid becoming political. 

Haven Emerson, of the Columbia College of Physicians and Surgeons’ De Lemar Institute of Public Health also expressed skepticism that Rajchman’s proposal could truly free technicians from politicians. As he wrote, “without ‘diplomacy’ and ‘politics’ scientists could make swifter progress at first, but representative universal suffrage countries will always, and rightly so, have ‘politics.’” Emerson further wrote that he preferred an advisory or consultative organization rather than the regulatory and tax-collecting organization Rajchman proposed.

These proposals remained amorphous through most of the war. While most observers agreed that the system would change, perhaps radically, there seemed to be little use in trying to anticipate the final outcome. Nonetheless, the proposals illustrate widespread faith that things would change. Fear of political interference led many to imagine a system that was at least somewhat separate from any emerging political organization. Their writings on the subject evinced a great deal of frustration with the current organizational structure. But what they described was usually a larger superstructure, with the real debate seeming to come between a health organization that stood on its own or as a part of a technical organization rather than, as Manley put it, a return to

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21 Manley O. Hudson to Ludwik Rajchman, September 20, 1943, 1, Fonds Ludwik Rajchman, cote RAJ.C3, Pasteur Institute.

22 Haven Emerson to Ludwik Rajchman, September 20, 1943, Fonds Ludwik Rajchman, cote RAJ.C3, Pasteur Institute.
the ad hoc alliances and conventions of the 1890s. Few seemed to find the idea of an organization-free world appealing, even though in the World War II context health work had suffered because of its attachment to increasingly illegitimate political institutions. They retained their commitment to broad-based public health interventions.

Negotiating a New International Health Organization

The question, then, was not whether to recreate a world health organization, but how. These negotiations took place against the backdrop of a series of conferences that aimed to decide the postwar settlement. What had begun with the Atlantic Charter and the subsequent Washington meeting to create the United Nations Relief and Rehabilitation Administration continued through meetings at Dumbarton Oaks in 1944 and San Francisco in the spring of 1945. Dumbarton Oaks paved the way both for a formal United Nations organization and for that organization to have a related, although still ambiguous, constellation of technical organizations. Health was not specifically mentioned. At San Francisco, health was inserted into the Charter after the famous physicians’ lunch, but the charter articles included little direction.

This lack of direction led to more confusion in the international public health community, particularly over the futures of the Office International d’Hygiène Publique and League of Nations Health Organisation. The United Nations Relief and Rehabilitation Administration was not intended to survive. James A. Crabtree, Deputy Director of Health for the United Nations Relief and Rehabilitation Administration told

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23 Hudson to Rajchman, September 20, 1943, 1.
the American Public Health Association that United Nations Relief and Rehabilitation Administration was a direct result of the wartime conditions and “its life span cannot be more than a few years.” The United Nations Relief and Rehabilitation Administration’s health work was limited – during the eventual transfer negotiation, Gautier remarked that one United Nations Relief and Rehabilitation Administration’s official admitted that when it came to traditional health work, there was “mighty little to transfer.”

During the war, the responsibilities of these organizations were already being reassigned. In May 1944 there was a push to establish a separate quarantine commission in London to take over from the Office International d’Hygiène Publique, a move impeded by the rules of the International Sanitary Convention. Consequently, the health planners at the United Nations Relief and Rehabilitation Administration decided to try to amend the international sanitary convention. Montague Travers Morgan, of the British Ministry of Health and former president of the Office International d’Hygiène Publique and head of the International Maritime Quarantine and Sanitary Board in Egypt, was particularly concerned because draft United Nations Relief and Rehabilitation Administration provisions would have transferred the control of quarantine regulations “from Whitehall (strictly speaking from Paris but British interests have always been tactfully imposed and accepted in Paris) to Washington, the seat of the Empires’ most serious competitor, if not already, in the near future.”

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24 Raymond Gautier, to W. B. Chisolm August 21, 1946, 2, 8A/44082/44080, LON.
25 M. T. Morgan to Norman, May 17, 1944, 2, MT 9/4089, M. 14782/44, TNA.
26 Ibid., 3.
issues, interest grew in moving the functions to the United Nations. Several signs made that move look possible: Japan and Germany had neglected to pay their office dues, meaning that the Office staff was no longer required to share information with them and the Free French leaders saw no problem removing the Office from public responsibility.\textsuperscript{27}

The Office International d’Hygiène Publique and its supporters proved to be tenacious. The head of the Office, Jacques Pierret, whose personal involvement with the Nazis was never clear, retained his position after he convinced French authorities that during the war “his attitude had been perfectly correct” and that he stopped the Nazis from transferring the Office to Vienna. The re-emergence of the Office International d’Hygiène Publique was negotiated into the United Nations Relief and Rehabilitation Administration proposal. Raymond Gautier, frustrated at the exclusion of the League of Nations Health Organisation, wrote that he believed that the British agreed to the official revival of the Office International d’Hygiène Publique in exchange for French accession to the United Nations Relief and Reconstruction Administration Sanitary convention. He saw the agreement as a cynical attempt by the British and French to concentrate power in their hands through the United Nations Relief and Rehabilitation Administration.\textsuperscript{28}

The British plan worked, and the convention was brought to a vote at a 1944 conference in Montreal. The Axis states were not invited because they had stopped paying their Office International d’Hygiène Publique dues, thereby giving the Allies the legal grounds to exclude them. After hours of deliberation, “during which,” according to

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\textsuperscript{27} Foreign Office, “No. 9681”, November 10, 1944, 1, MT 9/4089, M. 14782/44, TNA.\\
\textsuperscript{28} Raymond Gautier to List, “Information concerning the Office International d’Hygiène Publique supplied by Dr. Goodman,” December 1, 1944, 1, 8D/3488/204, LON.
\end{flushright}
the British delegation, “the Russians successively raised new points of opposition and repeatedly resurrected points previously disposed of,” a compromise was reached. The Office International d’Hygiène Publique would be reopened, but the United Nations Relief and Reconstruction Administration would take temporary control of the international epidemic intelligence system, partially to given the Office International d’Hygiène Publique time to rebuild. The agreement would expire in eighteen months or upon the signing of a new convention, whichever came first.29

Meanwhile, not everyone had given up on the League of Nations Health Organisation. Gautier, whatever he thought the likely outcome of the settlement, saw it as his duty to put the League of Nations in the most advantageous position possible for these negotiations. Gautier proceeded from the assumption that the reopening of the Singapore Bureau would make the best case for the revival of the League of Nations Health Organisation, because the Singapore Bureau showed the variety of types of work the League was able to do. Gautier approached the Rockefeller Foundation once again in May 1944 to resume their funding of the Singapore Bureau, even though they had already stopped in the previous decade because it was a mature program. His Rockefeller contact W. A. Sawyer objected not because of the previous condition, but rather because he thought war conditions would make any work done by the bureau impractical, but also because he thought that the League of Nations Health Organisation should wait for the

29 Foreign Office British Delegation Montreal, “No. 5 of Relief Saving”, September 26, 1944, 2-3, FO 371/41205, TNA.
development of the new international health agency and hand the reins of the Singapore Bureau over to whatever developed.\textsuperscript{30}

Despite this discouraging response, Gautier persisted, calling the Singapore Bureau the League of Nations Health Organisation’s “trump card” in any ongoing transfer proceedings.\textsuperscript{31} Gautier noted that by shutting the bureau down just as the area took on increased military interest, the army risked importing yellow fever into an uninfected region, putting many people at risk. To prevent the spread of disease by air and other health problems, the region was in desperate need of international health work, and the bureau had proven its efficacy at coordinating it.\textsuperscript{32} Much to Gautier’s surprise, he succeeded in convincing the members of the supervisory commission, who oversaw the remaining League of Nations budget in 1946, to fund the Far Eastern Bureau for six months. The United Nations Relief and Rehabilitation Administration had begun the process of opening a bureau in India to attend to the needs of the Pacific and Indian Oceans, although the British government had lobbied for Singapore. Governor Lehman of the United Nations Relief and Rehabilitation Administration was hesitant to pick sides, despite pressure from London to side with United Nations Relief and Rehabilitation

\textsuperscript{30} “W. A. S. Diary Note of May 29, 1944,” May 29, 1944, 1, R. F., R.G. 1.1 Series 100, Box 22, Folder 182, RAC.

\textsuperscript{31} Raymond Gautier to Sean Lester, August 15, 1945, 1, 8D/43551/341, LON.

\textsuperscript{32} Raymond Gautier, “The Reasons for Reopening a Health Bureau in the Far East with a Branch Office in Australia,” May 24, 1944, 1-2, R. F., R. G. 1.1., Series 100, Box 22, Folder 182, RAC.
Consequently, the Bureau was not reopened, and no new bureau emerged at Singapore.

With no new organization in sight in December 1945, US Surgeon-General Hugh Cumming remained president of the Office International d’Hygiène Publique and planned with Gautier to call meetings of both the Permanent Committee of the Office International d’Hygiène Publique and the League of Nations Health committee, despite the fact that the latter organization seems to have “been wiped out for this octopus [the United Nations] which seems to be reaching out for everything.” Although it was unclear whether there would be new business to discuss, or even transfer business yet prepared, Cumming proposed holding the meetings at the same time so that “we could all at least enjoy a ‘wake’ as the Irish do!” and bring a sense of completion to the organization.34

While the most pressing debate was about the structure of the new organization, the slowness of the calling of the health conference meant that a second debate developed: how or whether to extend the 1944 United Nations Relief and Rehabilitation Administration International Sanitary Convention that was due to expire in mid 1946, effectively deciding whether to reinstate the Office International d’Hygiène Publique. Despite French insistence, the US State department did not want to reopen the office, claiming that “to put UNRRA’s present responsibilities back into the hands of a resuscitated ‘office’ would be an entirely retrograde step.” The Americans regarded the French foray “as being connected with reasons of prestige” only and argued that it would

33 Raymond Gautier, confidential telegram, November 30, 1945, 1, 8A/4922/985, LON.
34 Hugh Cumming to Raymond Gautier, December 14, 1945, 1, 8A/4922/985, LON.
serve only to complicate the transfer of functions to the new health organization. The British Foreign Office defended the honor of the Office’s efficiency in internal communications, but ultimately supported the US contentions on the basis that reopening the Office International d’Hygiène Publique fully would only complicate the opening of a new, comprehensive bureau. On March 15, 1946 at Atlantic City, the United Nations Relief and Rehabilitation Administration approved the extension of the 1944 convention until the establishment of the new organization.

**Towards the World Health Organization**

Preparations for the new health organization sped up in spring 1946. The Economic and Social Council of the United Nations commissioned a Technical Preparatory Committee to prepare a draft constitution for the new organization in advance of an International Health Conference. The committee, composed of experts in international public health, met in Paris from March 18 to April 5, 1946. The committee produced a report that they hoped would guide the constitution. The document began with a radical preamble recognizing “the following truths as basic to the harmonious relationships between peoples of the world”; that health was well being, not just the absence of disease; health was a right; “unequal levels” of health protection

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36 G. E. Yates to H. George-Booth, 1946, 1, FO 371/57070, TNA.

37 Raymond Gautier to G. K. Strode, May 11, 1944, 8A/42748/42748, LON.

38 Report of the Technical Preparatory Committee for the International Health Conference, Paris 18 March - 5 April 1946 (ECOSOC, April 23, 1946), 6, 8A/43889/41755, LON.
“represent a common danger”; and finally, and perhaps most radically, that governments were responsible for the health of their population. This language was ultimately entrenched in the World Health Organization constitution and represented a significant shift from the attitude that had been held in the nineteenth century and even during the founding of the League of Nations Health Organisation. The framers of the constitution inserted into the text many of the conclusions reached by the supporters of the Health Organisation over the course of the interwar period, illustrating the effect of its work on the international public health community.

The organization suggested by the committee took many of the responsibilities of the Office International d’Hygiène Publique and League of Nations Health Organisation: coordination of international sanitary conventions, epidemic intelligence, encouraging infrastructure building at the national level, and serving as a link between scientists and clinicians. They also envisioned that the World Health Organization would “contribute to the harmony of human relations.”

They assumed that the World Health Organization would be a technical organization as described in the United Nations charter. However, they recommended that the upcoming conference develop a process by which non-United Nations members could join. The World Health Organization would be run by a Director-General and permanent secretariat, who were advised by a World Health Conference and World

39 Ibid., 6-7.
40 Ibid., 7-8.
41 Ibid., 10.
Health Board. The committee also proposed regional committees and offices to oversee regional matters in health work but did not discuss amalgamation with the Pan American Sanitary Bureau, only the Office International d’Hygiène Publique. The Technical Preparatory Committee recommended a middle path, it seems, with limited acrimony. In fact, its final resolution was in the form of a poem directed to their French hosts, in which they noted “The work has been fun – it has seemed like play/And we’ll never forget the Palais d’Orsay” in addition to the thanks for the wine and champagne.

Difficult work lay ahead to found the organization the Technical Preparatory Committee had envisioned. The broader political steps to make the World Health Organization a reality unfolded slowly. On April 18, 1946, the League of Nations passed a resolution transferring all League functions, including the League of Nations Health Organisation, to the United Nations. In June, the United Nations’ Economic and Social Council, which had temporary custody of health matters, decided to formally take on health activities until the health conference took place and the World Health Organization was finally started. The International Health Conference took place June 19-July 22 in New York, where the constitution was decided upon. An interim Commission took over from the Economic and Social Council while 26 United Nations countries ratified the

\[\text{\footnotesize{\cite{Ibid., 10, 12, 16.}}}\]

\[\text{\footnotesize{\cite{Ibid., 17, 20, 27.}}}\]

\[\text{\footnotesize{\cite{Ibid., unpaginated.}}}\]
constitution of the World Health Organization, the minimum needed to create the organization formally.45

The New York conference delegates were charged with turning the Technical Preparatory Commission’s “conceptual” draft into a legal basis for an international health organization. The delegates at the Henry Hudson Hotel in New York City were mostly medical representatives who had been given plenipotentiary powers concerning a resolution to dissolve the Office International d’Hygiène Publique, as well as observers from related organizations such as the Food and Agriculture Organization and the International Civil Aviation Organization.46 After opening statements, the discussion turned to several issues that would establish the character of the new organization. The first was the name. After the British proposed an amendment to change the name from the World Health Organization to the United Nations Health Organization, several delegates made impassioned pleas to keep the originally proposed name. The World Health Organization, they argued, implied that the world was entering a new “world age” and emphasized the global reach of the organization. After other nations proposed such abominations as The United Nations World Health Organization and the World Health Organization of the United Nations, the British withdrew their amendment.47


47 Ibid., 16.
A second debate over the preamble concerned a similar principle. The Technical Preparatory Committee’s constitution included wording that the World Health Organization would promote the healthy development of children towards “world citizenship.” The Conference wanted to amend it to cover only the healthy development of children. Brock Chisholm, a specialist in child psychiatry who had gained infamy for claiming that the Santa Claus myth promoted discord between children and parents, insisted eloquently on the need for children to be educated for membership in the global community. Although Chisholm and his supporters lobbied hard, the wording changed. The final constitution included the statement that “healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.”

One proposal was more controversial: how to divide the organization into regional work areas. The Technical Preparatory Committee had bequeathed the Interim Commission two possible models: one that absorbed existing regional organizations and one that simply brought them into relation with the World Health Organization. Initial debates took place over the Pan American Sanitary Bureau and the newly founded Health Bureau of the Pan Arab League, which was not part of any international agreements but demanded to be treated the same way as the Pan American Sanitary Bureau. The United States delegate proposed first making it a regional bureau with limited integration into the World Health Organization, with which the delegates of the Latin American republics

48 Ibid., 100.
49 Ibid., 23.
who were part of the Pan American Sanitary Bureau agreed. Most other delegates did not. This debate was controversial enough that it was sent to a “harmonizing sub-committee.” The delegates agreed that the regional bureaus would be gradually fully integrated into the World Health Organization. The Office International d’Hygiène Publique was set to be dissolved as soon as all of its members ratified the World Health Organization constitution and its duties would be transferred. The actual structure of the regional committees and the regional bureaus remained controversial, but that discussion too ended with a compromise, with most decisions lying with a joint decision of the local committee and the secretary general with especially controversial questions, such as the role of non-self governing regions, to be decided on a case by case basis by the World Health Assembly.51

The Interim Commission set up to await the World Health Organization constitution’s official ratification went to work almost immediately, meeting a day after the New York conference ended. The Interim Commission, according to Andrija Stampar’s report, had an “unexpectedly long life” of two years as the ratifications became delayed.52 Funding for the commission came from a combination of United Nations Relief and Rehabilitation Administration grants, monies from the dissolution of the League of Nations Health Organisation, and loans from the United Nations.53 The

50 Ibid., 23.

51 Ibid., 28.

delegates of these countries as well as Biraud and Chisholm met four times.\textsuperscript{54} Chisholm was elected secretary because of his exemplary behavior at the conference, carrying the Commonwealth vote over Biraud.\textsuperscript{55} The Interim Commission, anticipating a brief existence, divided itself into four sub-committees to deal with urgent matters – Epidemiology and Quarantine, Relations, Administration and Finance, and Health Conditions in War-Devastated Areas.\textsuperscript{56}

At their second meeting in November 1946, the members of the Interim Commission settled down to do more concrete work while waiting for the World Health Organization’s constitution to be ratified. They discussed taking up the issue of biological standardization, prepared to take over all Epidemic Intelligence responsibilities, and even struck a malaria commission and a committee on yellow fever.\textsuperscript{57} Although some members objected that the goal of the commission was purely administrative, the delegates who argued that there were too many health issues to be left alone until the World Health Organization was begun won out.\textsuperscript{58} The Commission met twice more to set up the legal and administrative structures for the World Health

\textsuperscript{53} Ibid., 9.


\textsuperscript{55} Ibid., 11.

\textsuperscript{56} Ibid., 16-17.


\textsuperscript{58} Ibid., 65-66.
Organization as well as overseeing work on biological standardization, the updating of the international sanitary convention, and several disease commissions.\textsuperscript{59} During a 1947 cholera outbreak in Egypt, the Interim Commission, in addition to helping clarify quarantine procedures and reporting on the epidemic in its epidemiological report, also helped coordinate the bulk ordering of vaccines to save costs.\textsuperscript{60} The formal beginning of the World Health Organization in 1948 paved the way for more extensive and intensive work.

**The United Nations Specialized Agencies and Development**

The World Health Organization was meant to be part of a new constellation of “specialized agencies” of the United Nations, which also included the Food and Agriculture Organization, the United Nations International Children’s Emergency Fund, the International Monetary Fund and World Bank, and the International Labour Organization. Historian John Farley has described these organizations as “functionalist experiments – as attempt to separate if possible, political from functional issues.”\textsuperscript{61} According to Paul Kennedy, these organizations were meant to be a multi-legged stool,


\textsuperscript{60} Ibid., 33.

\textsuperscript{61} Farley, *Brock Chisholm, the World Health Organization, and the Cold War*, 5.
co-equal to prop up international relations without intertwining security and economic concerns.62

The World Health Organization did not inherit many of the broader programs of the League of Nations Health Organisation. The Food and Agriculture Organization, which a group of agricultural specialists set up at the 1942 Hot Springs, Virginia conference, received the nutrition portfolio. Former Health Organisation staff member Frank Boudreau, who had moved to the Milbank Memorial Fund, was a major proponent of the new organization.63 Political concerns intruded, particularly over proposals that the organization regulate commodity markets or distribute subsidized foods. The official constitution of the organization was a compromise, which committed the organization to improve agricultural production and raise standards of living, but not to eliminate hunger.64 The first director of the Food and Agriculture Organization, Sir John Boyd Orr, was committed to the idea of nutrition as a path to health, but more interested in the economic basis of agriculture as a way to improved rural standards of living and distribute food.65 He sought to stabilize commodity prices and increase lending to the developing world to allow states to improve their agricultural systems in order to create a more efficient and ultimately equitable world food system, which he believed would have

64 Ibid., 77-78.
65 Ibid., 81.
positive effects on the world economy.\textsuperscript{66} Like Hoover before him, he put his faith in food to bind the world together and improve standards of living.

Orr’s program was never fully implemented, as it met resistance from many of the Great Powers, but the logic underlying his plans illustrated how much assumptions about international cooperation were shifting. The direction of the Food and Agriculture Organization changed again when Norris E. Dodd replaced Orr in 1948 and his staff turned their attention to the Third World and away from Europe. During Dodd’s tenure, the organization’s projects focused on local attempts to improve production on a small scale.\textsuperscript{67} More ambitious programs, such as the creation of a World Food Surplus Clearing House, remained out of the organization’s reach.\textsuperscript{68} The Food and Agriculture Organization had a modest budget of only $5 million per year, and in 1960, its flagship program, the Freedom from Hunger Campaign, had a budget internationally of just $25,000, with some funds provided for local campaigns by other organizations.\textsuperscript{69}

The founders of the United Nations International Children’s Emergency Fund, including Rajchman, took up many of the broader social issues related to health. The United Nations International Children’s Emergency Fund was originally intended to be a temporary organization, but its utility led to its continued existence.\textsuperscript{70}

\textsuperscript{66} Ibid., 86.
\textsuperscript{67} Ibid., 96.
\textsuperscript{68} Ibid., 106.
\textsuperscript{69} Ibid., 112.
organization, unlike many of the other specialized agencies, worked extensively in the field.\textsuperscript{71} Staff participated in campaigns to feed and vaccinate children and were heavily involved in the anti-malaria campaigns of the World Health Organization.\textsuperscript{72} They also picked up on work undertaken by the League’s social section and the children’s rights movement welfare charter and work done by the Swiss welfare organization, Save the Children International. Their constitution called for the child’s right to material and spiritual development, to help when hungry or the victim of disasters, to be unexploited, and to be raised to be a useful member of society.\textsuperscript{73} In the 1960s, the newly renamed United Nations Children’s Fund work moved away from trying to guarantee rights and towards the effort to end world poverty.\textsuperscript{74}

This drive to end poverty was the most definitive characteristic of postwar work. After World War I, there was no cohesive anti-poverty program across international organizations. After World War II, there was a growing tendency to look toward economic solutions. This task took on increasing urgency with decolonization, the drive to integrate new states into an international system, and the desire in particular of the United States to prove the efficacy of American capitalism over Soviet communism. While rights-based regimes were discussed following World War II, the organizing principle of many international activities was the alleviation of poverty and, primarily,


\textsuperscript{72} Ibid., 8; Oestrich, \textit{Power and Principle, Human Rights Programming in International Organizations}, 27.


\textsuperscript{74} Ibid., 9.
the raising of so-called “under developed” or “Third World” regions to a higher standard of living. The World Bank was a combination of two lending agencies, the International Bank for Reconstruction and Development, aimed at middle income and creditworthy nations, and the International Development Organization, for the poorest countries. They were designed to create economic conditions to overcome trade inequalities. Although their work directly engaged economic and social issues, they adopted the policy that only economic, and not political or rights-based issues, in their decision making. They did slowly move towards promoting anti-poverty work.

Many policy makers in America and Europe were gripped by the idea of economic development as a potential solution to many of the world’s problems. In Europe, the Marshall Plan presented the opportunity to reconstruct and create new markets. Outside of Europe, according to David Ekbladh, development programs differed from colonialism, which had operated on a logic of “exploitation and subjection,” in contrast to development’s “control and improvement.” Development, an amorphous term I use to encapsulate programs that sought to improve economic conditions in the Third World in order to bring them into economic relations with the First World, appealed to a variety of interests. The United States looked to development

76 Ibid., 68 and 70.
78 French demographer Alfred Sauvy coined the term Third World, “*tier monde*” in 1952, comparing the post-colonial states to the third estate of revolutionary France. M. D. Litonjua, “Third World/Global South: 302
to provide an alternative to empire and secure its place in the international superpower structure. Britain and France, according to Frederick Cooper and Randall Packard, saw development as a way “to reinvigorate and re-legitimate empire as it was being challenged by nationalist movements, labor militancy, and increased questioning of colonial rule” and later as a way to extend the relationship between colonizer and decolonized.\(^79\) Less developed countries used development as a way to improve their domestic and international situations.\(^80\)

Development grew out of domestic state intervention in the 1930s, in such large-scale infrastructure projects like the Tennessee Valley Authority and the German Autobahns, which were designed to increase prosperity, the same logic of state intervention that had briefly propelled the rural health program of the League of Nations Health Organisation.\(^81\) Development planners had particular faith in the power of technology to improve economic problems.\(^82\) Many formal programs can be linked to Truman’s Point Four Assistance program of 1947, which inaugurated a new era in state intervention.

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\(^80\) Cooper and Packard, “Introduction,” 1.

\(^81\) Ekbladh, The Great American Mission: Modernization and the Construction of An American World Order, 42.

\(^82\) Ibid., 4-5.
to state relations. These programs became so pervasive that the United Nations declared the 1960s the “Development Decade.”

Health and development had an uneasy relationship. As Sunil Amrith writes, “development united the worlds of public health and political economy, for example, in a shared rhetoric of equality, a belief in rational planning, and a concern with the post-war relationship between the Western powers and the soon-to-be ‘third’ world.”

Particularly in the developing world, the logic of health care was changing. Asian states viewed improved health as a pathway to modern statehood. There was also an effort to treat the whole population, not just those who lived in areas of economic production.

But, as Randall Packard writes, the vision was difficult for anyone to put into practice “verticality, the focus on disease, the emphasis on technology, the dominance of western institutions in determining health needs and approaches, the lack of investment in local health infrastructure, continue to shape international health efforts today as they did in the past and present obstacles to the construction of effective and sustainable health interventions.”

Targeted campaigns, however, were of limited effect, because non-

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83 Ibid., 3.
84 Litonjua, “Third World/Global South: From Development to Globalization to Imperial Project,” 108.
86 Sunil Amrith, Decolonizing International Health: India and Southeast Asia, 1930-65 (New York: Palgrave MacMillan, 2006), 159.
specific diseases, such as diarrhea, were actually the most deadly across Africa and Asia. The World Health Organization, staffed largely by doctors who had already fought for the horizontal programs of the League of Nations Health Organisation and lost, was left to chart a path between economy and effectiveness.

The Character of the World Health Organization

A full history of the World Health Organization is beyond the scope of this work and largely remains to be written. The early days of the World Health Organization owed much to the League of Nations Health Organisation, despite the attempts by boosters of the World Health Organization to try to distance the new organization from the League’s failures. The World Health Organization continued many of the main activities of the League of Nations Health Organisation and Office International d’Hygiène Publique: intelligence, conventions, and disease investigations. The staff directed programs as diverse as the delivery of food and water supplies and the training of medical professionals. The World Health Organization did continue some of the other work of the League of Nations Health Organisation. Work on standardization remained important, including standardizing drug preparations, the non-proprietary

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88 Ibid., 112.
89 Amrith, Decolonizing International Health: India and Southeast Asia, 1930-65, 184.
90 See Farley, Brock Chisholm, the World Health Organization, and the Cold War; Staples, The Birth of Development; Goodman, International Health Organizations and their Work.
names for pharmaceuticals, and vitamins.  
It expanded on the advisory work of the League by recommending laboratory protocols and serving as a resource for the standardization of certain clinical practices.  
Other changes affected the distribution of World Health Organization activities. The European region had been effectively cleared by the 1930s of major pestilential diseases controlled by the International Sanitary Convention, and other diseases, such as tuberculosis, were reasonably controlled.  
This shift led to an increasing disjuncture between World Health Organization work in the developed and developing worlds.

One central piece of the League of Nations Health Organisation program did all but disappear: the emphasis on social medicine. Despite offering the most comprehensive definition of health yet internationally agreed to in its preamble, the World Health Organization leaders turned quickly to more constrained solutions. New technologies made some of this shift practical: in addition to the new typhus and yellow fever vaccines, antibiotics offered the hope of a magic bullet for many pressing diseases. Similarly, DDT seemed to offer a targeted solution to the malaria problem. One of the most successful of the World Health Organization programs was the eradication of smallpox, which relied on vaccination. Although many involved in the World Health Organization’s work were committed to social medicine, the allure of the magic bullet


was too strong. Combined with these changes was the increasing move internationally away from a cohesive definition of public health. With the League of Nations program too broad to be sustained in the postwar climate, the early leaders of the World Health Organization turned to these new technologies to carve out a niche and increase their credibility. 95

The targeted programs fit well with the ethos of development growing around the world. 96 As Director General Marcolino Candau wrote in his foreword to the World Health Organization’s official history for 1958-1967, “Health is part and parcel of economic and social development and man is the prime mover in that development. Without him development has no meaning. And without health, development has no hope of putting down its roots.” 97 However, the separation of the World Health Organization from the Food and Agriculture Organization, United Nations Development Program, and the United Nations International Children’s Emergency Fund meant that the staff of the health organization only partially adopted this logic. As an overview of several World Health Organization projects illustrates, the staff pursued technological over infrastructural solutions.

Political considerations played into the shift as well. Because many hoped to use World Health Organization projects to sway the Cold War world to the side of the West,

95 For more on the tendency of public health specialists to define their discipline through their activities, and the challenges they faced given the improving health in the West after World War II, see Jane Lewis, What Price Community Medicine? The Philosophy, Practice and Politics of Public Health Since 1919 (Brighton, UK: Wheatsheaf Books, 1986).


simple, easily administered projects with directly measurable and demonstrable results were more appealing than complicated long term multi-strategy approaches. 98 For those less inclined to use the organization for political ends, such limited programs would interfere less in the operations of host countries. Many advocates of social medicine were from communist countries, such as the Romanian Andrija Stampar, or had strong socialist leanings themselves, such as Rajchman, perhaps making intensive social medical activities seem too close to socialism in the increasingly politically-charged environment of the Cold War. This avenue of inquiry remains to be explored.

To reach these goals, the World Health Organization staff pursued several disease eradication programs. One of the earliest was the yaws campaign. Yaws, a syphilis-like bacterial disease that caused sores and bone pain, was prevalent in rural areas and believed to affect up to 50 million people around the world.99 Syphilis had been an early focus of the World Health Organization in Europe because of its prevalence in postwar Eastern Europe and the fact that it was susceptible to penicillin. Proponents of the yaws campaign hoped to extend this success worldwide.100 This disease responded well to penicillin, and by 1948, a single shot of long-acting penicillin could cure most cases.101 The relatively inexpensive fix, coupled with the ease of administration, made many at the World Health Organization believe that it was a surefire way to win the trust of local

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98 For more on this shift, see Farley, Brock Chisholm, the World Health Organization, and the Cold War.


100 Farley, Brock Chisholm, the World Health Organization, and the Cold War, 140 and 157.

101 Four Decades of Achievement: Highlights of the Work of the WHO, 1.
populations in the underdeveloped world by ridding them of an uncomfortable and economically damaging illness.\textsuperscript{102} That the staff of the newly founded World Health Organization pursued a drug-based strategy rather than attempt to effect improved sanitation that would also have cleared up the disease is telling. The strategy was effective, however. By the 1950s, 4 million people had been treated in Indonesia alone. Following on the successful exchange programs of the League of Nations Health Organisation, a series of fellowships to train local practitioners in yaws control resulted in effective control of the disease by the early 1960s. The yaws example, however, was unusually successful for early World Health Organization projects and may have given the organization too much faith in single-method disease control programs. Other attempts to control diseases in this way were less successful.

The early World Health Organization staff also attempted to use new technologies to control tuberculosis. The BCG vaccine, which had been tested on European children in the 1920s and 1930s, combined with penicillin to offer new hope for the prevention and control of the disease.\textsuperscript{103} Fred L. Soper, a major Rockefeller Foundation advocate of the insecticidal control of malaria, was hopeful that these new technologies would eradicate tuberculosis completely.\textsuperscript{104} These technologies offered the possibility of making tuberculosis, long seen as the model social disease in the nineteenth century, into

\textsuperscript{102} Ibid., 2.


\textsuperscript{104} Ibid., 181.
a controllable bacteriological illness. Attempts to transform the paradigm of tuberculosis met local resistance. The major World Health Organization campaign against tuberculosis, which included mass vaccination combined with antibiotic treatment, caused controversy when implemented in India. Objections came not from the Indian state, which believed that improved health conditions would equip it for modern statehood even if it had to rely on outside assistance, but to the imposition of the bacteriological paradigm. Many prominent Indian scientists objected to the use of vaccine as a cheap stopgap measure that was an attempt to allow the government to avoid desperately needed infrastructural improvements. Indeed, the possibility of magic bullet solutions gave international health work a different character than many other development projects – costs dictated the cheapest control of disease rather than the attempt to create more stable infrastructures.

The Malaria Eradication Program illustrated the huge costs and poor results that were often the result of vertical control projects. Malaria, widespread and economically devastating, was an obvious early target for policy makers eager to prove the relevance of the new global health organization. Many involved in the League’s anti-malaria work had hoped that malaria would be susceptible to a single strategy control mechanism. But as noted above, the great problem of the Malaria Commission of the League of Nations

105 Amrith, *Decolonizing International Health: India and Southeast Asia, 1930-65*, 2.


Health Organisation was that they had not been able to agree on a strategy. The
 discovery of DDT offered new hope for malaria control after its success in Italy and Greece during war relief work.

The Interim Commission’s subcommittee on malaria first rejected DDT and instead focused its energy on continuing the League of Nations Health Organisation’s investigations into the drugs atabrine and chloroquine. They assumed that DDT spraying would be too expensive in the quantities required.\(^{108}\) The United States experts argued that DDT would prove less expensive and more effective than long-term therapy.\(^{109}\) The math of the United States experts was proven correct. The World Health Organization analysts estimated that eradication through DDT would have a one-time cost of twenty-five cents per person in the area; ongoing quinine therapy for the population of infected areas would cost 75 cents per person annually.\(^{110}\) The early DDT campaigns showed that DDT produced resistant mosquitoes, meaning that malaria would have to be eradicated rather than controlled to make sure the chemical was effective.\(^{111}\) The organization settled on a joint worldwide campaign. The Pan American Sanitary Bureau launched the version in the Americas in 1954. In 1955 the World Health Organization began its Malaria Eradication Program.\(^{112}\)

\(^{108}\) Ibid., 158.

\(^{109}\) Ibid., 159.

\(^{110}\) Staples, *The Birth of Development*, 166.

\(^{111}\) Ibid., 165-166.

In Europe and the rest of the world the Malaria Eradication Program was given priority assistance and funding by the World Health Organization. The United States provided $5 million initially, which US policy makers hoped would prove the benevolent interest of the United States in the Third World. From 1957 to 1964, the United States gave the World Health Organization program $54.4 million dollars, with $100 million in additional funding coming from the United Nations Children’s Fund and $57 million from the World Health Organization itself. The program failed to eradicate malaria and had a number of negative environmental and social consequences. In addition to killing plants and animals, DDT sprayings increased the number of houseflies, fleas, bedbugs, and lice, which were now DDT-resistant, and killed most of the economically important silkworm crop in Taiwan. The Malaria Eradication Program cost over $200 million, not to mention its ancillary economic damage, while failing to achieve its desired ends. Towards the end of the program, one World Health Organization report concluded that malaria eradication would have to wait for governments to direct their own eradication programs, improve their health services, and create new technical solutions. The problems associated with the program made many at the World Health Organization skeptical of eradication programs.

113 Staples, The Birth of Development, 166.
114 Ibid., 178.
115 Ibid.
Despite the difficulty of controlling yaws, tuberculosis, and malaria, one successful disease eradication took place after the failure of the Malaria Eradication Program: the eradication of smallpox in 1986. Ironically, the leaders of the World Health Organization were reluctant to take on the program. Instead, the organization served as the facilitator of a US-USSR program that each side hoped would increase its global political and scientific prestige.\(^\text{117}\) The 1958 World Health Assembly, which included the first Soviet delegation to the body, adopted the resolution. The proposal was based on a smallpox eradication program carried out with great success inside the Soviet Union.\(^\text{118}\) Starting in 1967, the World Health Organization directed intensive funding and staff support to the project.\(^\text{119}\) The USSR gave 500 million doses of free dried smallpox vaccine to campaigns in India, Asia, and Africa, while the United States also funded the Indian program.\(^\text{120}\) The campaign was successful, and the dream of global disease eradication became in this instance a reality.

Although the most spectacular successes and failures of the World Health Organization program were the magic bullet programs, the staff undertook other disease control efforts. The World Health Assembly was given authority for the updating of quarantine regulations. In 1951 the International Sanitary Conventions were replaced by


\(^{119}\) Manela, “A Pox on Your Narrative: Writing Disease Control into Cold War History,” 300 and 304.

\(^{120}\) The Second Ten Years of the World Health Organization, 1958-1967, 106.
the international sanitary regulations, which regulated travel by air, sea, and land.\textsuperscript{121} Changing epidemiological conditions, and particularly the eradication of smallpox, changed the application of these rules. For example, from 1957, the Mecca pilgrimage required no special regulation even though it had been subject to special regulation for over a century.\textsuperscript{122} The regulations also limited the requirements for maritime reports and health certificates.\textsuperscript{123}

Despite the abolition of bills of health, epidemic intelligence remained an important part of international epidemic control. The World Health Organization staff continued the League of Nations Health Organisation’s \textit{Weekly Epidemiological Record}.\textsuperscript{124} To improve data collection, the World Health Organization opened the Centre for Classification of Diseases in 1951 to expand older international work in the classification of the causes of death, as well as to run training programs for national statistics to improve the commensurability of data.\textsuperscript{125}

The statisticians of the new organization expanded the older intelligence program. In part, this was simply a matter of including new diseases. The epidemiologists at the World Health Organization took increasing interest in influenza, previously dismissed as too amorphous for international tracking. They incorporated the International Influenza Network, an informal system of influenza information sharing developed by concerned

\textsuperscript{121} \textit{The First Ten Years of the World Health Organization, 1947-1958}, 260.

\textsuperscript{122} Ibid., 262.


\textsuperscript{124} \textit{The First Ten Years of the World Health Organization, 1947-1958}, 262.

\textsuperscript{125} Ibid., 279-280.
laboratories after the 1918 influenza outbreak. The epidemiologists also moved to what they called “epidemiological surveillance.” This expanded strategy relied on better reporting, better statistics, and, crucially, more laboratory research. Epidemiologists were expected to reach out for information from various sources, “including personal contacts” instead of “waiting passively for reports to arrive.” They also began to conduct immunological studies of population to examine the actual presence of disease in populations. The program developers at the World Health Organization also sponsored epidemiological studies about the transmission of diseases in support of eradication programs. Epidemiologists examined the conditions of transmission to better target diseases, taking into account the biological and social manifestations of disease, which harkened back to the multi-causal explanations of disease favored in the disease commissions of the League of Nations Health Organisation.

The importance of many of these communicable diseases decreased along with their incidence due to targeted control and vaccination campaigns. After 1953, the


129 Ibid., 96.

130 The Third Ten Years of the World Health Organization, 1968-1977, 94.

131 Ibid., 181.

World Health Organization statisticians increasingly focused on chronic diseases, particularly cancer.\textsuperscript{133} This work built on the type of cutting-edge research in epidemiology that began to attempt to link lung cancer to smoking. In so doing, epidemiologists searched for ways to demonstrate causality without direct laboratory evidence.\textsuperscript{134} The League of Nations Health Organisation’s greatest contribution may have been to epidemiology, which built on its work in multi-causal understandings of disease.

**Conclusion**

The founders of the World Health Organization preserved many of the central assumptions of the supporters of the League of Nations Health Organisation, namely that international cooperation was essential, information sharing necessary, health was more than disease, and dividing programs along regional lines made the work of public health more effective. However, the strong push for social medicine, for combining social and political and medical processes, was gone. Frustration at having budgets and projects cut for twenty-five years drove part of this change. Fear also drove the shift. The founders feared that if the new organization was too closely associated with the new political organization, health work might again collapse if another global war broke out. The early leaders of the World Health Organization continued this orientation through the early


years, bolstered by perceived magic bullets that were politically and economically cheaper. But without the close connection to political power, and working from different premises from other development workers, the staff of the World Health Organization often found themselves without political support. The architects of the postwar sanitary system had purchased themselves stability, but at the cost of some of the essentials of their vision.

The work of the World Health Organization was at times more effective than many League efforts, and World Health Organization staff were frequently able to direct work on the ground, albeit on a limited scale, more effectively than the League of Nations Health Organisation. Several of the vertical programs of the World Health Organization were successful: yaws was substantially reduced, smallpox eradicated, and the general death rate in the areas most targeted dropped by 15% during the most intensive period of the eradication programs. These programs had their costs, which included the sacrifice of the more broadly based social interventions that had flourished under the League of Nations Health Organisation. When the vertical programs failed, the World Health Organization had lost the legitimacy to insist on trying these broader programs.

135 Amrith, Decolonizing International Health: India and Southeast Asia, 1930-65, 159.
Chapter 8: Conclusion

Today in Geneva, the World Health Organization stands up the street from the Palais des Nations, the erstwhile home of the League of Nations and home of the technical bodies of the United Nations since 1945. This physical separation was not an accident of geography, but rather an attempt to separate health concerns from the center of international politics (a line of reasoning that illustrated a certain optimism about Geneva’s role in international relations). This decision was an explicit acknowledgement of the fact that although some may have tried to separate politics from science at the League of Nations Health Organisation, that goal was never achieved. Of course, the physical move was not immediate. Although the World Health Organization staff had outgrown its space alongside the United Stations staff at the Palais de Nations by 1955, the new World Health Organization’s headquarters did not open until 1966.¹ The conceptual separation had taken place much earlier in response to the frustrations of interwar public health specialists with the old system and the pressures international public health specialists faced from Cold War politics. This separation continues today. As Joel Oestrich illustrated in his study of the influence of human rights discourse at major international organizations, the leadership of the World Health Organization has

been especially resistant to taking a stand on human rights issues, seeing them as beyond their purview and perhaps even a threat to their work.²

By contrast, the work of the League of Nations Health Organisation had been more fully integrated into the work of the League of Nations. Rajchman, Madsen, and Biraud, amongst other leaders in the organization and on the Health Committee, were often on the leading edge of advocating international cooperation. In fact, the staff of the League of Nations Health Organisation had created an integrated system of world public health, moving beyond the paradigm of epidemic control that exerted control over ports and the ships, people, and cargos that moved between them, but went no further. In their quest to improve world health, the supporters of the League of Nations Health Organisation recognized the integrated nature of health as a problem with medical, social, and political dimensions and exhorted states to attend to the health of their citizenries for the good of the international community as much as for their nations.

Several of these initiatives were particularly successful in marrying international cooperation with national efforts. One of the most important of these successes was the epidemic intelligence service. The service collected and distributed vital disease information globally in order to prevent the international spread of epidemics. The members of the Health Committee and its commissions also managed to convince states to share strategies of disease and health management, an approach that had particular

² Joel E. Oestrich, Power and Principle, Human Rights Programming in International Organizations (Washington, D. C.: Georgetown University Press, 2007), 118. Oestrich uses the example of the Global AIDS Program, which the WHO leadership worked tirelessly to have transferred to the United Nations, because they feared that work on so socially and politically contentious a disease would compromise their work in other areas.
success in rural health and malaria control. Other commission members supported states in their efforts to come to grips with new public health concerns, such as cancer. Quantifying the number of lives saved by the work of the staff of the Health Organisation is difficult because the League rarely conducted direct programs. The greatest achievement may have been in opening a space for discussion of these matters, which had never been discussed at the international rather than transnational level before, and often spurred individual states to action within their borders.

The League of Nations Health Organisation could function in this manner only because of certain institutional features of the interwar international system. The first was in the structure of the League. Through reviews at the General Assembly and the Council and the weekly directors meeting that put Rajchman and his successors in the same room as the Director General and other section heads, health was an integral part of the function of the League. The organization received more funding than many other League activities and continued to do so until the transfer of League of Nations functions to the United Nations. Indeed, the work of the Health Organisation and other technical agencies became the most important example of the efficacy of the work of the League of Nations as a whole, an observation made in both League publications and by scholars of the period.

Several epidemiological and political peculiarities of the interwar period supported this integrated system. The first was the commonality of diseases between the West on the one hand and the rest on the other. While Europe and North America had begun to benefit from the epidemiological transition and a decrease in infectious diseases,
and were on the whole healthier than people in Latin American, Asia, and Africa, they were still troubled by the same diseases. Diphtheria, tuberculosis, typhus, and even malaria remained worldwide threats. Although the various commissions brought increasing attention to geographically-bounded diseases such as sleeping sickness, most states supported epidemic intelligence work and the Malaria, Cancer, and Tuberculosis Commissions because they could attract direct interest from more developed states that could fund and staff these initiatives. Their push for understanding the multi-causal elements of disease, and of complicated diseases such as cancer, presaged postwar developments in epidemiology. The project-based funding of the Health Organisation seems to have encouraged this breadth, because Rajchman and his successors constantly had to imagine new projects to acquire seed money from the Rockefeller Foundation and governments.

Another connection helped drive work on even more geographically-bounded diseases. While development may have been predicated on a model of improving economic conditions for mutual benefit, colonialism meant that states had a vested interest in improving economic conditions. As Randall Packard points out, under this system empires gave more resources to areas of economic production than other areas. Economic concerns did lead colonial governments to invest in some broadly based health campaigns, as was illustrated by the responses to malaria, rural health, tuberculosis and sleeping sickness.³ While colonial relationships often made it difficult for the League of

Nations to deal directly with colonized people, imperialism provided an impetus for resources to be directed towards these areas. The often explicit tensions between nation and empire in this period are brought into relief by the attempts of the League of Nations, which was really a league of empires and nations, to negotiate the complicated political relationships among their members.

Although the League of Nations Health Organisation successfully provided a forum for national representatives to discuss and compare their national programs of action, the effect of the organization on on-the-ground health and disease control is difficult to measure. While Rajchman and several others had advocated the direct international attack on epidemics early in the League’s history, states were resistant to this potential intrusion, and the leaders of the organization chose to work through and with states rather than around them in order to increase the reach of their programs. The founders and early staff of the World Health Organization, who had been frustrated by what they saw as undue interference and the futility of this message, drew a dual legacy from the League of Nations Health Organisation. On the one hand, the former’s constitution confirmed the broad vision of health which the League of Nations Health Organisation had pioneered. On the other hand, they moved away from that definition in their work. Partially this shift was in reaction to the unsustainable breadth of the League of Nations Health Organisation program, which had been effectively split amongst other organizations. The broader the claim for public health became, the more amorphous its program and the less legitimacy and expertise public health advocates could claim. But they also reacted against the entanglements between politics and health that had ensnared
the League of Nations Health Organisation. This legacy is seen in the repeated attempts of the World Health Organization to avoid responsibility for politically contentious issues such as AIDS and contraception in favor of less contentious although important interventions in areas such as malaria control and oral rehydration therapy for diarrheal disease, and its ongoing work on biological standardization and epidemic intelligence, two programs it inherited from the League of Nations Health Organisation.

The League’s system was an intrinsically interwar phenomenon. The agreements that shaped the interwar sanitary system were born on the typhus-ridden refugee routes in Eastern Europe and died in the malaria-infested fields of World War II Sicily. As much as Rajchman and his supporters used the rhetoric of objective technical expertise to push their agendas, they relied heavily on the financial, infrastructural, and political support of the League of Nations, which their success in turn had helped to legitimate. In the absence of magic bullet solutions that could be easily applied to stop disease, the League of Nations Health Organisation advocated broader interventions into health. These interventions, when framed as national initiatives rather than international obligations, appealed to nations that were concerned about national health in the wake of the demographic upheavals of World War I and the increasing evidence of national ill health brought about by the Great Depression. Consequently, international and national efforts were able to support each other until international cooperation increasingly totally collapsed with World War II. After the war, new technological advances and new political configurations undid many of the agreements effectively made between states and the international community between the world wars.

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When the designers of the post-war sanitary system sat down in London, Paris, Geneva, New York, and San Francisco, they correctly identified the cause of the collapse of the League of Nations Health Organisation and the Office International d’Hygiène Publique: the withdrawal of political support and the attendant loss of legitimacy. They failed, however, to adequately comprehend its corollary – that political support and integration had been necessary for the League of Nations Health Organisation to function as successfully as it had. Consequently, the World Health Organization adopted new, more focused technologies that required less intrusive interventions into the activities of the state, including DDT spraying, vaccination programs, and the distribution of antibiotics.

This trade-off worked to some extent. Targeted programs led to the reduction in yaws and tuberculosis, as well as the eradication of smallpox. But by the 1970s, planners and populations had become disenchanted with these programs. They were expensive, intrusive, and, like all things, had unintended consequences. Direct attack, when actually carried out as against smallpox and malaria, even armed with “magic bullets,” proved disappointing and limiting in attempting to create general health. Part of this was simply a response to numbers: diarrhea and other “non-specific” diseases were actually bigger killers.4

This frustration led to the promulgation of the “health for all” doctrine in 1976 at the Alma-Ata Primary Health Care Conference held in the Soviet Union. Primary health

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care moved away from disease control and the vertical programs of disease eradication to, as it was eventually formulated, as “the place of first contact with a national health care system.”

This conference, although proposed by the Soviets, was part of a broader reorientation of the United Nations program towards health’s social and economic dimensions, part of larger discussions with the United Nations Development Program and the United Nations Children’s Fund undertaken by the new secretary general of the World Health Organization, Halfdan Mahler, who took over in 1973. The conference, chaired by D. V. Petrovski, Minister of Health for the Soviet Union, included 135 national delegations, and the representatives of 67 organizations. Among the delegates were luminaries such as Edward Kennedy. The conference delegates understood primary health care to include efforts that concerned, in the elegant paraphrase of Dmitry Vendiktov, “controlling disease, food supply and nutrition, safe water and basic sanitation, maternal and child health, immunization, prevention of endemics, provision of essential drugs and appropriate treatment of common diseases,” in short, everything the rural health care program had included in the 1930s.

The rural health centers that the European Health Center had recommended, but were largely ignored in the lead-up to war, had been intended to address all of these issues for rural populations as a first step to creating comprehensive national health programs.

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7 Venediktov, “Alma-Ata and After,” 82.

8 Ibid., 83.
The World Health Organization program in this period focused on attempting to increase the access of citizens to national primary care systems. This focus on basic medical care was in essence a personal medical approach to public health care. This campaign too faltered because the United States never developed a satisfactory national health care system and the Soviet system, in many ways the international model for state run health care, fell apart. This shift also reflected a general medicalization of public health, based partially on the fracturing of the discipline. For instance, in Britain, the Medical Officers of Health were relieved of their duties, and control for national public health was granted to the National Health Service, which provided mostly primary care.

By 2000, the “Health for All” program had effectively been replaced by the World Health Organization’s commitment to the United Nations’ Millennium Development Goals, although both two programs pushed the World Health Organization to re-enter the fields of mother-child welfare, nutrition, and HIV/AIDS prevention. The reason that the “health for all” program was doomed to inadequacy is the reason that all international public health efforts, including those of the League of Nations Health Organisation, have been doomed to inadequacy: to create comprehensive health services, or even control major diseases, is a very “big thing,” to use Major Greenwood’s

9 Ibid.

10 Ibid., 84-85.


expression, indeed. Disease and health are biomedically, socially, economically, politically, and infrastructurally complicated problems.

This dissertation has shown how interwar public health officials, diplomats, and local medical professionals attempted to navigate those difficulties. Despite the almost overwhelming challenges before them, they managed in difficult political and financial circumstances to create a space for international discussion and action. Although they often found their programs shaped by technical limitations, underfunding, and even petty personal differences, they persevered and created a basis for discussion of international health that shaped not only interwar international public health efforts, but was instrumental in the creation of a more broadly based international apparatus to address public health, nutritional, and social concerns in the United Nations specialized agencies. Indeed, it was the model of the broadly accepted political and on-the-ground successes of the League’s technical bodies that ensured that the United Nations Economic and Social Council, United Nations Children’s Fund, the Food and Agriculture Organization, and the United Nations Development Program were created alongside the World Health Organization.

Although the current framework for most international cooperation in humanitarian issues is based on a combination of human rights and economic development, two terms that would have meant relatively little to people like Rajchman and Buchanan, the interwar pioneers of international intergovernmental technical cooperation would recognize the legacy of their emphasis on basic human health as a pathway to greater human dignity and greater international harmony, or at least as a way
to mediate the suffering of people in an imperfect international system. What they would most recognize is the assumption in international development work today that no one strategy will fix all problems. Although international public health has been resistant to forming into any cohesive paradigm, the core features that drive today’s system – an emphasis on health as being more than just the absence of disease, on global epidemic intelligence sharing, and on the necessity of international cooperation for health work – coalesced in the interwar period at the League of Nations Health Organisation.

The challenge in the twenty-first century is to attempt to balance various approaches and to continue to navigate the tensions inherent in international health work. The Millennium Development Goals, agreed to by nations at the United Nations in 2000, outline eight approaches to improving the international standard of living and ending poverty by 2015. While in 2011 these goals seem overly optimistic, they represent a multi-organizational and multi-strategy approach to problems of development. Of the eight target areas – ending poverty and hunger, creating universal education, promoting gender equality, ensuring maternal and child health, combating HIV/AIDS, reaching environmental sustainability, and fostering a global economic partnership for development – five would be familiar to Rajchman and his contemporaries.\footnote{For more on these goals, see “United Nations Millennium Development Goals,” United Nations Development Programme, 2011, \url{http://www.un.org/millenniumgoals/} [Accessed April 1, 2011].}

The road from the first international sanitary conference in Paris in 1851 to the agreement on these goals in New York in 2000 has been long. The League of Nations Health Organisation’s epidemic control work, which so obviously expanded from the agreement by nation states to report on several infectious diseases, played a critical role in the transformation of
international cooperation in matters of health and development to the point where the Millennium Development Goals, written nearly sixty years after the Health Organisation ceased to exist, recapitulate the central concerns of the Health Organisation’s most ardent supporters.

As the assumptions of the current system would be familiar to the pioneers of the League of Nations Health Organisation, so too would the challenges faced by today’s global public health workers. They must balance broad economic and social development, which improve health, with the targeted technological interventions such as vaccines and drug therapy that also improve health. They must integrate national goals with international norms and expertise. They must navigate the tricky path between overstepping political boundaries and retreating into irrelevant theoretical technical discussions. And they must do so in a context that is often fragmented politically, infrastructurally and ideologically. For all that the League of Nations Health Organisation and its successors have achieved, the task before today’s international public health experts remains a big thing.
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