At the Roots of The World Health Organization's Challenges: Politics and Regionalization

The World Health Organization's (WHO's) leadership challenges can be traced to its first decades of existence. Central to its governance and practice is regionalization: the division of its member countries into regions, each representing 1 geographical or cultural area.

The particular composition of each region has varied over time—reflecting political divisions and especially decolonization. Currently, the 194 member countries belong to 6 regions: the Americas (35 countries), Europe (53 countries), the Eastern Mediterranean (21 countries), South-East Asia (11 countries), the Western Pacific (27 countries), and Africa (47 countries). The regions have considerable autonomy with their own leadership, budget, and priorities. This regional organization has been controversial since its beginnings in the first days of WHO, when representatives of the European countries believed that each country should have a direct relationship with the headquarters in Geneva, Switzerland, whereas others (especially the United States) argued in favor of the regionalization plan.

Over time, regional directors have inevitably challenged the WHO directors-general over their degree of autonomy, responsibilities and duties, budgets, and national composition; similar tensions have occurred within regions. This article traces the historical roots of these challenges. (*Am J Public Health*. 2016; 106:1912–1917. doi:10.2105/AJPH.2016.303480)

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Created in 1948, the World Health Organization (WHO) faced a number of challenges in its early years. The agency had to come to terms with the escalating Cold War and the consolidation of a bipolar world, and also needed to deal with the anxieties of British, French, Dutch, Belgian, and Portuguese governments trying to hold on to, or rebuild, their colonial empires as these began to crumble. Like other United Nations (UN) agencies, the WHO quietly abandoned its dreams of a collaborative community of nations and instead began to come to terms with new international political realities. The agency moved closer to US foreign policy and became partially captive to US resources and priorities. It pursued a pragmatic course of limited objectives, settled upon an institutional structure of regionalization—incorporating compromises over decolonization—and initiated several disease control programs.

POLITICS

A direct result of Cold War tensions at the WHO was the withdrawal of the Soviet Union along with the Ukrainian and Byelorussian Soviet Republics (which initially had independent seats in the World Health Assembly) in 1949. The Geneva, Switzerland, secretariat was informed of these decisions by telegram in February of that year, a few months before the Second World Health Assembly was to meet in Rome, Italy. Just before and after the Assembly meeting, Bulgaria, Romania, Albania, Poland, Czechoslovakia, and Hungary also sent notifications of withdrawal. They declared themselves dissatisfied with the work of the agency, and were angry with WHO and the United States for withholding medical resources from Eastern Europe. The Soviets felt that they had paid a very high price in human and material terms during World War II, but had received little help after the war from the Marshall Plan, US bilateral agencies, or multilateral organizations. Believing, for good reason, that the Americans dominated the WHO and the UN, the Soviets simply decided to boycott the agencies.

Contributing to the boycott decision was a growing conviction on the part of the Soviets and their allies that there were 2 dramatically opposing views of public health: that of capitalism and that of communism. The Soviets argued that the United States did not recognize the inseparable connections between social, economic, and health problems. They denounced poor working conditions and exploitation under capitalism as the roots of disease and argued the need to nationalize medical services. In 1949, a communist delegate to the World Health Assembly declared that WHO was the battleground of

> two opposing points of view . . . [that of the Soviet Union] standing for the interest of humanity, which demands that the attainment of medical science should serve the whole human race . . . while the capitalist camp represents the interest of a minority who consider science as a source of income and as a weapon of war.[1]

The Polish Minister of Health said that the WHO had "surrendered to the imperialistic States and in particular to the United States."[2]

Many others in WHO, including Brock Chisholm, the first director-general, hoped that it would still stand by the social medicine principles embodied in its constitution. A key founding member, Andrija Stampar, argued that the WHO should concentrate on 4 principles: "social and economic security, education, nutrition, and housing."[3] Taken seriously, however, the social medicine perspective

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required questioning the inequality of land ownership in rural areas and the striking inequities, poor housing, misery, and illness in urban areas. The United States was not particularly interested in this approach and instead promoted the concept of "technical assistance." The framework of "technical assistance" conveyed the idea that assistance to developing countries was best provided through the transference of a knowledge of science and technology, thus avoiding any preoccupation with the economic interests and social realities that led to underdevelopment.[4] The Second World Health Assembly voted to provide funds and design technical health programs for developing countries, making WHO one of the first UN agencies to offer specific assistance to these countries, and also reinforcing the impression and reality of powerful US influence.

On a practical level, the decision by the Soviet Union and its allies to leave WHO had an impact on WHO's finances, as the absent countries (and several others) did not pay their assessed contributions. Director-General Brock Chisholm, from Canada, insisted that WHO was the international health organization of all nations and, knowing that there were Russian physicians and health officials who did not want the USSR to pull out of WHO, offered to visit the Soviet Union to dispel any "misunderstandings." Chisholm pointed out that WHO's constitution made no provision for withdrawal from membership. He therefore asserted that the 9 communist countries were "inactive" rather than "withdrawn" and announced that he would wait for their return (a decision that later created a path for their smooth reentry). C. E. A. Winslow, in an *American Journal of Public Health* article, endorsed Chisholm's conciliatory stance: "The erring brothers have their seats waiting for them when they desire to mend their ways."[5] Several WHO leaders also tried to help. For example, Rajkumari Amrit Kaur, a Minister of Health from India and President of the World Health Assembly, privately tried to persuade Molotov, the Soviet foreign minister, that the United States was "not running WHO."[6]

In 1950, US Senator Joseph McCarthy accused the US federal government and the UN of being infiltrated by communists. One result was that the US State Department and the Federal Bureau of Investigation strengthened their already rigorous "clearance" regulations for Americans working at the UN and its agencies. One notable early WHO staff member who had a difficult time with these regulations was left-leaning physician and sociologist Milton I. Roemer who worked as an officer in social and occupational health between 1950 and 1951, admired Soviet public health, and believed that the United States needed a national health insurance system. In Geneva, the US Consulate seized his passport and informed him that it could only be used to return to the United States.[7] Reinforcing Soviet perceptions, the UN and WHO were perceived as essentially supporting the US side in the Korean War (1950–1953). Some WHO officers tried to distance their agency from this perception, but others tolerated or embraced it.

For its part, the US State Department in a May 1953 memorandum to the White House bluntly stated that "In the Cold War the UN has become a major means for diplomacy and propaganda in combating the political warfare of the Soviet Union and in rallying the strength of the free world through a wide variety of measures."[8] Willard L. Thorp, Assistant Secretary of State for Economic Affairs, at the 1950 annual meeting of the American Public Health Association said that a clear relationship existed between national security and the worldwide struggle against disease and poverty. Disease and poverty must be fought, he suggested, because they "feed communism" and thus threaten the "very survival of our democracy."[9] As Congressman Frances P. Bolton explained the US government support for WHO,

> In our global struggle against communism, one of our principal endeavors is to keep the free world strong. Disease breeds poverty and poverty breeds further disease. International communism thrives on both.[10]

International health could help keep the world safe from communism.

The tension between the superpowers and the relationship of the Soviet Union with the UN and WHO changed in 1953 with the death of Joseph Stalin. An incipient de-Stalinization came with the rise of Nikita Khrushchev, who emphasized "peaceful coexistence" and "friendly" competition with the United States, both within and outside the UN system. In July 1955, the Soviet Union formally stated its intention to rejoin WHO and fully participate in the UN. WHO welcomed the reentry of the USSR and Soviet allied countries, and asked for payment of only a small percentage of their back dues. All the communist countries—with the exception of China—returned to the WHO in 1956.[11]

Initially, Europeans, many of them experienced in colonial medicine, were the majority of WHO's staff. The recruitment of a few medical experts from developing countries to WHO's staff was criticized for depleting precarious health systems of valuable individuals. In response, WHO decided to hire international public health workers for no more than 3 years. However, this regulation was hard to enforce: many WHO officers enjoyed much higher salaries than they had received in their home countries and were reluctant to return home.

By the early 1950s, the WHO had developed and approved a 4-year plan for fellowships, and by 1956 had provided more than 5000 of them to health professionals from 149 countries, thus helping to build or reconstruct public health systems.[12] It had also completed important work in standardization, such as in the Sixth Revised List of Diseases, Injuries and Causes of Death, the International Pharmacopoeia, the list of biological standards for drugs, and International Sanitary Regulations (1952). These new regulations standardized quarantine and, thus, the control of smallpox, plague, cholera, yellow fever, louse-borne typhus, and louse-borne relapsing fever, all defined as subject to quarantine.

FINANCES

Not all went smoothly for the WHO in terms of finances. The Second World Health Assembly approved a budget for

1950 of USD 7.5 million, but owing to several countries not paying their contributions, it had to be reduced to USD 6.3 million. The Third World Health Assembly passed a budget for 1951 which, owing to the same circumstances as in 1950, was reduced to USD 6.15 million. In 1954, the World Health Assembly rejected a US proposal for a more limited budget and approved a total assessment of over USD 10 million for the 1955 calendar year. The American delegation made a strong case to cut the budget to USD 9 million and objected to any increase that would entail a rise in the American assessment.[13] The US contribution amounted to 33.3% of the total budget of the WHO. American officials were worried that this figure was in excess of the cap of 30% that Congress had set for contributions to multilateral agencies.[14] WHO officials thought that exceeding the 30% limit was reasonable because the US had the highest per capita income in the world. The final budget for 1955, which was approved by a 28 to 24 vote of the World Health Assembly, was halfway between the US proposal and the initial figure proposed by the Executive Board of more than USD 11 million. The Board argued that it had exercised restraint for the past 3 years, partly because it took into consideration American concerns over the growing budget. It was now imperative for the agency's expenditures to increase if its programs were to be developed and the organizational structure sustained. The US Congress eventually agreed to maintain its financial support for the WHO. The United States, as the main fiscal underwriter of WHO, bought a considerable amount of influence with its financial support.

THE DIRECTORS-GENERAL

In 1953, Brock Chisholm formally announced that he was uninterested in a second term, declaring that WHO should regularly renew its leadership during the early years of its history. Likely contributing to his decision were his objections to the United States' heavy hand in the organization and his own constant conflicts with the Catholic Church over family planning. Chisholm was probably also sensitive to the political reality that a conservative US government would not support the socio-medical orientation he preferred.

Brazilian Marcelino Candau became the second director-general of the WHO at the age of 42 years. After he received the nomination of WHO´s Executive Board, he was elected at the 1953 World Health Assembly where he was victorious over candidates from Pakistan and Italy who were supported, respectively, by the British and the Italians. Candau's candidacy was endorsed by the US delegation as well as by a bloc of Latin American countries and some European nations.

Candau was a graduate of Rio de Janeiro's Medical School and held a master's degree in public health from the Johns Hopkins University. He had worked under Fred Soper's supervision during Rockefeller International Health Division's fight against *Anopheles Gambiae* in the Brazilian northeast and, later, in programs sponsored by US bilateral assistance. In 1952, he moved to Washington as the Pan-American Sanitary Bureau's Assistant Director, to work briefly under Soper again. Candau was WHO's longest-serving director-general, being reelected 3 times and directing the agency from 1953 to 1973. The US government supported Candau not least because the State Department believed that with Candau it would be possible to negotiate a "reasonable" WHO scale of assessments and raise the "minuscule" contribution paid by the USSR.

Under Candau, the WHO increased its visibility, financial stability, and administrative coherence. He worked closely with the staff in Geneva and developed a reputation for his diplomatic skills, which he used to rally the World Bank, the UN Food and Agriculture Organization, the US State Department, and even the US Congress. By the mid-1950s, WHO administered 120 projects, employed about 900 staff and included 88 member countries. Candau was largely responsible for WHO's regional organization. He also secured a new building in Geneva and built up the resources and staff of the regional offices. He decided that regional directors should be elected by the member countries of each region rather than being appointed by the director-general, and he allowed the regional directors considerable control over their region's programmatic activities.[15]

THE CHALLENGES OF REGIONALIZATION

The development of regional offices was, in fact, one of the most notable features of WHO's organizational evolution in the late 1940s and early 1950s. Initially, 5 regions were envisioned: the Americas, South East Asia, Europe, the Eastern Mediterranean, and the Western Pacific, respectively known as AMRO, SEARO, EURO, EMRO, and the WHO-Western Pacific (no acronym initially used).[16] The creation of the sixth regional office, for Africa, was only accomplished after complex negotiations with the European imperial powers. Each regional office was overseen by a committee consisting of representatives of "full members" (independent countries) and "associate members" (usually European colonies). The regions were meant, at least initially, to aggregate countries sharing geographic proximity and similarity of epidemiological profile. The regional offices were responsible for setting regional policies, hiring staff, supervising and carrying out WHO policies in the regions, and organizing meetings with representatives of the governments of each member country. In the late 1940s and early 1950s, these meetings moved from city to city within the regions until a regional "capital" was agreed upon.

Most of the European officers of the WHO initially resisted the idea of regionalization, believing that countries should join individually—as they had done in the earlier League of Nations Health Organization. But the US and Latin American bloc adamantly insisted that the Pan American Sanitary Bureau (PASB) continue its existence as a quasi-autonomous organization and this stance forced regionalization to prevail across WHO. An agreement between WHO and PASB in 1949 guaranteed that the latter would serve as the regional office of WHO in the Americas and at the same time constitute a specialized agency of the Organization of American States. PASB would have the authority to elect its own director (in loose consultation with the director-general) and the liberty to promote and finance some of its own

programs. Over time, the other regions would gain a similar degree of autonomy. PASB was an important instrument of US foreign policy in Latin America, and no doubt for this reason the US delegation played a heavy-handed role in the regionalization debate.[17] The US State Department had recently established regional bureaus that coincided, approximately, with the geographical areas covered by the regional offices of the WHO, and having multilateral agencies closely attuned to this American vision of the world was considered essential to US foreign policy.

The organization of WHO's regional offices confronted the political challenges posed by a fraying European imperialism and the tensions of the early postwar period. Imperial powers argued that they would take care of the health needs of the populations in their colonies but they also allowed colonial nations to become "associate" members of the WHO regions. In several cases, changes were made to regional configurations to skirt international political antagonisms. One example was Israel, which was originally placed, seemingly naturally, in EMRO. But because of its conflict with Arab nations, it was moved to the European regional office. Another example was Pakistan, which joined the Eastern Mediterranean region and not its geographically "natural" area of SEARO because of the enduring conflict between Pakistan and India. Cold War tensions also intruded. In 1949, the Chinese Communists drove the Nationalists onto the island of Taiwan and proclaimed the People's Republic of China on the mainland. Nevertheless, Taiwan, with a very much smaller population, was included in WHO as the representative of China in the Western Pacific region, while mainland communist China was denied a place in WHO or a seat at the UN.

The EMRO office, under the direction of Aly Tewfik Shousha, the leader of WHO's anticholera campaign, began operations in July 1949 using the resources of the former Alexandria Sanitary Bureau, dating back to the 19th century. One of EMRO's first preoccupations was an old international health concern: the possible spread of cholera with annual pilgrimages to Mecca. At EMRO's first session in Cairo, Egypt, Shousha focused on a broader goal: promoting community participation in health was not something "which can be done to people; it must be done for themselves by themselves."[18]

SEARO, the South East Asian region, at first included Afghanistan, Burma, Ceylon, India, and Thailand, and soon added Nepal and the "trust territories" of French Indochina, French India, Portuguese Goa, and the British Maldive Islands—each represented by governments of their metropoles. SEARO established its headquarters in New Delhi, India, with the full support of the Prime Minister of India, Pandit Jawaharlal Nehru. Its first director, Chandra Mani, a founding member of WHO, was adamant in enlarging the prerogatives of his regional office. In his annual reports, he complained vehemently that Geneva retained the essential functions such as general planning and supervision, technical guidance and budgetary control, while leaving responsibility for operating programs to the regions.

The Western Pacific Regional Office included Australia, Cambodia, China, South Korea, Laos, New Zealand, the Philippines, Vietnam, and provisionally the Malay Peninsula. The beginnings of the regional office were troubled because of the Korean War, and after the war, representation of Korea was given to South Korea while communist North Korea was only recognized as a WHO member in 1973. The governments of Australia and New Zealand were initially opposed to the creation of 1 regional office and suggested, unsuccessfully, the formation of 2 regions, 1 for the north with the less-developed countries and colonies and 1 for the south including Australia, New Zealand, New Guinea and the South Pacific Islands.[19] When the proposal failed, an Australian representative attended the first session of the regional committee but only as an "observer," and New Zealand did not attend at all.[20]

The Philippine government led the opposition to Australia-New Zealand's aggressive position, insisting that the region should be autonomous and defined as broadly as possible. They succeeded in making Manila the regional headquarters, bypassing Australian cities. The first regional director was the Chinese physician I. C. Fang, who had trained at the Peking Union Medical College and received a master's degree in public health from the London School of Hygiene and Tropical Medicine.

The European regional office was promoted by Eastern European countries, while Western European countries generally saw no pressing need for it. The Eastern European countries argued that the office would help them overcome the legacies of World War II, such as destroyed hospitals, nonoperating medical schools, and insufficient medical personnel. But the British, for example, were not convinced of the need to establish a regional office on the continent that already hosted the general headquarters of WHO. Despite these misgivings, in 1951, a European regional office was established in Geneva and, ironically, Great Britain's Norman D. Begg was appointed the first director of EURO and remained in the post until 1957.[21] Five years later, the EURO office moved to Copenhagen, Denmark. Several countries in northern and central Africa–Spanish Morocco and British Zanzibar–were assigned to EURO on the argument that their participation in European commerce was more relevant than their geographic location in Africa. The former Italian colony and newly independent Libya asked, for political and religious reasons, to be part of the Eastern Mediterranean Region and was allowed to join EMRO.

AFRO

Of all the WHO regions, the last to be formed was the one for Africa, a continent that had formerly received scant attention from international health agencies but was, not accidentally, the leading site of European colonization and colonial medicine. The delay in creating a regional office was the direct result of postwar politics. After World War II, all African countries were colonies except Liberia, South Africa, Egypt, and Ethiopia, and the last 2 were made members of the WHO's Eastern Mediterranean Region. The rest of Africa fell into the UN category of "non-self-governing territories" under the UN "trusteeship" system. The debate over trusteeship was vigorous.[22] As a compromise measure, European governments were not forced to give up their colonies but had to report annually to a UN Trusteeship Division on

the living conditions of the colonized people under their jurisdiction. The UN thus sought to *improve* colonial conditions rather than question their legality.

AFRO, with a few exceptions, embraced countries and territories south of the Sahara in an area of about 7 850 000 square miles inhabited by approximately 150 million people. The countries in AFRO were among the poorest on the globe, and were seen to be in dramatic need of help, incapable of rising out of poverty themselves, and thus dependent on Europe and the United States for "development."

The first AFRO committee meeting took place in Geneva in late 1951. It was attended by representatives of the "full" member countries–Belgium, France, Liberia, Portugal, Spain, South Africa, and the United Kingdom—and by a representative of its first associate member, Rhodesia. The Dutch physician François Daubenton was chosen to lead the African Regional Office—to be administered from Geneva. Daubenton had studied at the University of Johannesburg and at the London School of Hygiene and Tropical Medicine and had been medical consultant to mining companies in South Africa.[23] His career and the first meetings of AFRO reflected the attitudes of colonial medicine. At a regional meeting in 1952, WHO Director-General Brock Chisholm warned against a too rapid transfer of modern western techniques to Africa and advised AFRO to emphasize "a series of orderly steps requiring direction, control, and constant thought." For his part, Daubenton urged WHO to promote the participation of "enlightened Africans" capable of winning the understanding and cooperation of the people.[24] Chisholm and Daubenton both believed in a version of colonialism that entailed progressive and orderly changes led by enlightened elites. Daubenton took care to maintain close communications with European colonial medical officers working in London, England; Paris, France; Lisbon, Portugal; and Brussels, Belgium.

In 1953, the regional meeting made the decision, despite the doubts of some European representatives who considered the step "premature," to move AFRO headquarters from Geneva to African soil. Daubenton negotiated with the French government to create a headquarters office in French colonial territory and selected Brazzaville in French Equatorial Africa (later the Republic of Congo). A few years later, the regional staff moved to new and larger quarters in nearby Cité du D'Joué, where they served as an island of modernity in a surrounding sea of poverty.

Daubenton retired in 1953 and was succeeded by the Portuguese physician Francisco J. Cambournac, a skilled public health officer trained in tropical medicine. He never questioned the idea that Europeans had a "civilizing mission" in post–World War II Africa and thought to postpone claims to independence by offering expanded services and political concessions to decolonizing nations. Others in WHO's Geneva headquarters and UN agencies agreed with this approach. The British, for example, increased their recognition of local rights in the colonies because of fears for their crumbling empire. But the British failed in Egypt, where President Nasser nationalized the Suez Canal in 1956. Thus the British began more vigorously to favor indirect rule and the organization of a titular "Commonwealth" under their hegemony because maintaining colonies was getting too expensive and too politically fraught.[25]

Conflicting prospects for colonialism also beset the French government. Most French politicians believed it necessary to grant some power to native elites to retain their loyalty, while others preferred authoritarian control over the colonies.

Calls for a French Union comparable to the British Commonwealth were greeted in some colonies with revolts and rebellions. Social unrest in Morocco, Tunisia, Algeria, and Madagascar—which the French government could not subdue—ultimately led to independence. Elsewhere in the French empire, the war in Indochina begun in 1946 ended in France's humiliating defeat in 1954.

While these major political events played out, AFRO tried to get on with its work. The office initiated surveys, medical personnel training programs, sanitary engineering projects, and studies of infectious diseases, in particular yellow fever. Cambournac also wanted to develop new public health programs in mental health, community development, and medical anthropology (in the United States, called applied anthropology). He made the French ethnologist Jean Paul Lebeuf chief of a new section in the regional office, and asked him to comment on all projects from a sociological perspective because, as he said, learning "the habits and reactions of human beings" was as important as learning the "habits and reactions of insects."[26]

Cambournac urged the WHO to pay more attention to Africa. The 1955 World Health Assembly in Mexico had justified the exclusion of Africa from the "global" malaria eradication program by saying it was "premature" to carry out operations in locations with bad roads, large rural populations, and precarious health systems. The fact that malaria was endemic in Africa allowed many non-AFRO WHO experts believe that there was no great urgency for African malaria eradication programs.

DECOLONIZATION

The African colonies were rapidly obtaining their independence. In 1960, the conservative and pragmatic British Prime Minister Harold Macmillan made a famous "wind of change" speech in South Africa, acknowledging the irreversible growth of African independence. Between 1960 and 1964, independence was granted to all the remaining British possessions in East Africa. The Belgian Congo became independent Zaire in 1960, and Rwanda and Burundi became separate states a year later.

These changes had an impact on the UN, WHO, and AFRO. In October of 1960, 16 new African countries entered the United Nations. Between 1960 and 1965, 24 newly independent African countries joined the United Nations and the WHO. Since the 10th session of the African regional committee held in Accra, Ghana, the chairman or vice-chairman of the meeting was a Black African. In the early 1960s, after violent confrontations in South Africa where police killed demonstrators against apartheid, representatives of former colonies announced that they would not attend AFRO meetings if South African delegates were to participate. (At the 1963 meeting

when South Africa's representative was called to speak the rest of African representatives left the room.) The dramatic change in the African region was reflected in the growth and change of its membership. In 1957, there were only 3 member states and the same number of associate members. Ten years later, the regional office recognized 29 members and only 2 associate members. In 1965, Alfred Comlan Quenum of Benin, with the support of the newly independent African nations, became the first African Regional Director.

NEW POWERFUL COMPETITORS

With the emergence of newly independent states, the spread of nationalist and socialist movements, the break-up of the Soviet Union, and the increasing globalization of capital and markets, the political and economic context of WHO has constantly changed. So has its number of country members: currently, WHO has 194 members. New theories of development have emphasized long-term socioeconomic growth rather that short-term technological interventions. Perhaps of greatest importance is the arrival of new and powerful competitors: among them, the World Bank and the Bill and Melinda Gates Foundation, each with very large financial resources. AJPH

CONTRIBUTORS

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HUMAN PARTICIPANT PROTECTION

Human participant protection was not required because this essay did not involve human participant research.

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