

Rural hygiene in the early years of the World Health Organization: another casualty of the Cold War?

A higiene rural nos primórdios da Organização Mundial de Saúde: outra vítima da Guerra Fria?

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Abstract

Rural hygiene was a major program in the League of Nation's Health Organization (LNHO). During WHO's early years steps were taken to develop rural hygiene programs in several countries and to incorporate it as part of WHO's priority program of environmental sanitation. Nevertheless, by the early 1950s these initiatives failed to move forward for various reasons, one of which was the growing importance of the Cold War in America's foreign policy.

Key Words:

Rural hygiene, public health, environmental sanitation, Cold War, World Health Organization.

Resumo

A higiene rural constituiu um grande projeto da Organização de Saúde da Liga das Nações. Os primeiros anos da Organização Mundial de Saúde foram canalizados para o desenvolvimento de programas de higiene rural em vários países e para os incorporar como parte do programa prioritário do saneamento ambiental da OMS. Todavia, nos primeiros anos de 1950, estas iniciativas não conseguiram avançar por vários motivos, entre os quais se situa a importância crescente da Guerra Fria, na política externa dos Estados Unidos.

Palavras Chave:

Higiene rural, saúde pública, saneamento ambiental, Guerra Fria, Organização Mundial de Saúde.

Introduction

Much has been written about the early years of WHO and the impact of the Cold War on its programs. John Farley's book *Brock Chisholm, the World Health Organization & the Cold War*, provides a comprehensive account of the trials and tribulations encountered in the creation of the Organization and in its early development [1]. Randall Packard, in his various works, has described how Cold War politics played an important role in forcing WHO away from its original vision. In particular, Cold War "tensions limited the ability of the postwar international organizations to carry out their early commitments to broad based integrated approaches to health and development, and encouraged instead reliance on narrow technical programs, made possible by advances in technology and science during the war" [2: 112].

Particular attention has been given to how the Cold War affected WHO's global malaria control/eradication campaign. Prior to the advent of DDT, it was believed that successful control would require attention being given to broader approaches to health and development; with the arrival of DDT, "the association of rural malaria control with rural economic (agricultural) development radically diminished" [3: 256].

Rural hygiene, as such, is not discussed in Farley's book, which in some ways is not surprising as he paid little attention to the legacy of the League of Nations Health Organization (LNHO), where rural hygiene had developed into a major program before the onset of World War II. The lack of attention to the work of the LNHO is also understandable as Farley published his book in 2008, one year before Iris Borowy's authoritative and detailed account of the work of the LNHO was published [4].

One purpose of this paper is to make more complete Farley's history, first by summarizing the LNHO program on rural hygiene before looking at how it fared during WHO's early years. What emerges does not contest the general view of the negative impact of the Cold War on WHO's work. On the contrary, by focusing on rural hygiene, we get to see in greater detail the obstacles that WHO faced at that time, ones that severely limited and narrowed its immediate development. Given the fact that the LNHO rural hygiene policy was resurrected as part of the primary health care movement that enveloped the organization some 20 years later, one can only lament what was lost.

LNHO heritage

Rural hygiene was a major program in the League of Nations' Health Organization (LNHO). It emerged in the late 1920's following a comparison of model areas in Western Europe, "where problems of rural hygiene had been satisfactorily solved", with areas of in Southern and Eastern Europe, "where problems were still acute" [4: 200].

Subjects addressed were healthful living (nutrition, drinking water, sewage and waste disposal, milk and housing) and sanitary administration (district level organization of medical services, school health, infant welfare, anti-TB campaign, etc.). A European Conference on Rural Hygiene, held in 1931, was followed by the gathering of information on these conditions using study tours and interchanges.

Steps were taken almost immediately to organize conferences on rural hygiene in Africa and in Asia. Two Pan-African Conferences were held in South Africa in 1932 and 1935. That of Asia was held in 1937 in Bandoeng, Indonesia. Its scope was broadened to include elements of rural reconstruction, particularly agriculture, education, and cooperative movements.

The Bandoeng Conference approached the problems of rural hygiene from an "intersectoral and interagency perspective and focused not only on the need to improve access to modern medicine and public health but also on the fundamental challenges of educational uplift, economic development, and social advancement" [5: 42]. The subjects addressed were health and medical services; rural reconstruction and collaboration of the population; sanitation and sanitary engineering (housing, water supply, disposal of house refuse and other wastes, and fly control); nutrition, and measures for combatting certain diseases in rural districts (malaria as well as plague, hookworm, tuberculosis, pneumonia, yaws, leprosy and mental diseases). Each subject was dealt with by a Commission or sub-Commission. Given its scope, no attempt is made to even summarize its outcome, especially as much had been written about its importance [2,4]. Nevertheless, note is taken of some recommendations, especially those that pertain to poor rural areas of the world, least covered by any form of organized health services, i.e. the problematic faced by WHO at its creation.

Concerning health and medical services, the Conference concluded that:

- 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.
- It is absolutely necessary to bring medical and health services as near to the population as possible, but the decentralization of activities should be guided and supervised by a central body in order to maintain efficiency and ensure a uniform policy.

Concerning the use of auxiliary staff, emphasis was placed on the necessity for ensuring that all members of the auxiliary staff receive adequate training in hygiene and preventive medicine (training to be as simple and practical as possible, care to be taken that training does not make them lose touch with the people, etc.), while concluding that the composition of the auxiliary staff relative to the kind of work they are called upon to do will vary in different areas.

Also:

- A large body of adequately trained auxiliary personnel is important to ensure that the connecting link between the rural inhabitant and the medical men may be as efficient as possible.
- It is essential to the proper functioning of a health service that the emoluments offered be fully adequate so that the right type of man with proper training may be attracted and retained, and enabled to devote his full time to the service.

The Commission dealing with rural reconstruction called for the planning and execution of Government services to be coordinated so as to be integrated, comprehensive and effective. Each village or group of villages should have an organization of its own – namely, a committee for conducting its affairs and promoting its welfare in all directions. These committees in turn should be advised by a committee of management consisting of Government experts, representatives of villages and other non-officials. The village committees may be entrusted with duties relating to water supply; sanitation, house improvement and village-planning; construction and maintenance of village roads and waterways; social and recreational activities including playgrounds; and education of adults, both men and women.

Also, in a much quoted conclusion, given its political implications, the Conference judged that “without land reform . . . rural reconstruction will not rest on a permanent basis; serious consideration of this problem and the study of methods best adapted to local conditions is urgently recommended to Governments” [6:26].

While the Conference did not identify any country as having satisfied these recommendations, even in part, several of the background papers as well as on-going programs illustrated certain positive experiences. These included the training of ‘native medical practitioners’ (NMPs), who have “undoubtedly played the largest part in arousing the confidence of the native in western methods of treating disease . . .” [7:9]. China’s rural health program in Tingsien county led by CC Chen, which is considered to be the precursor of the bare-foot doctor that gained global prominence in the 1970s, in which lay workers, selected by village leaders and drawn from the farming population, carried out essential health promotion activities [8] and the program of Dr John L Hydrick, an Rockefeller Foundation staff member stationed in nearby Bandoeng, which “aimed to communicate the usefulness of hygiene measures to the population by simple and practical demonstration, films and public lectures, home visits, etc.” [9: 67].

Hydrick’s 60-page book, from which this last quote was taken, is essentially a ‘do-it-yourself’ manual, largely dedicated to environmental sanitation: latrine building, boiling of water, making houses safe, bringing clean water into the schools, protecting food from flies, et al. Health education was a central theme in Hydrick’s program. Educational methods and materials used elsewhere were altered to make them suitable for use under local conditions. Campaigns were begun “on a small scale in order to keep the cost of work and the cost of necessary changes within

reasonable limits”; work was extended “slowly and only as results justified extension” [9:3].

The detailed activities of each of the field stations that Hydrick established were carried out by hygiene mantris, midwives, and other members of the subordinate personnel. Mantris were health workers who initially were concerned with educating the public about hookworm before moving on to other problems. They were all males (at first), were literate, spoke well and inspired confidence. Midwives entered the program at a later date. Hydrick arranged for their training to be conducted by experienced midwives

The diseases that were most widespread where Hydrick worked were “those that belong to the great group of intestinal diseases or filth borne diseases. In the ordinary living habits of the people of the rural areas, the pollution of surface soil and streams is far more common than the use of latrines. Of all the diseases which are spread by soil and water pollution, the worm diseases are not only the easiest to explain and demonstrate, but are also the most widespread over the East Indian Islands” [9: 4]. Activities carried out concerning the prevention of soil and water pollution “were so organized that they could be used as a basis for building up small health services” [9:24].

The Bandoeng Conference represented the last major initiative on the part of the LNHO concerning rural health.

Post-war carryover

The threat of war dramatically reduced the activities of the LNHO; it did not survive World War II. Country programs were equally affected. None of the programs cited above (China, Indonesia and Suva) survived the war. What remained was in the form of written accounts and personal awareness.

Hydrick’s book was favorably reviewed in the *AJPH*: This book is much more than a delightful report of outstanding public health work; it is a philosophy of public health expressed in terms of successful experience [10:885]. Dorolle, who became WHO’s Deputy Director General in 1950, translated it into French in 1938 and also arranged for its translation into Spanish in 1944. In his extensive introductory commentary to the French version, Dorolle expressed his admiration for Hydrick’s book in multiple ways: its simplicity, the progressive manner in which Hydrick carried out his work, his experimental and realistic spirit, his meticulous care to detail, his concern for educating health workers, to name just a few. There was much to be learned in Hydrick’s school and much to be gained by following certain of his principles concluded Dorolle.

John B Grant, a Rockefeller Foundation staff member, who helped shape the pre-WWII program in China, played an important role in promoting similar ideas after the war, as discussed below. China’s experience, as well as that of Hydrick’s, was witnessed firsthand by Harry Gear, “who was largely responsible for the establishment of the health centre at Pholela [South Africa] and selecting Sidney Kark as its Director” [11]. Gear played an

important part in WHO's early history, first as South Africa's representative in WHO's Executive Board, and then as a senior staff member.

New experiences

Grant visited Kark's program in 1947, which had been initiated several years earlier. He found it to be "one of the most forward looking and comprehensive health plans of any country" [12: 181]. Its essential features included "care of the sick and prevention of illness by the doctor and nurse, associated with a programme of health education carried out by specially trained 'health assistants' acting under the direction of the doctor". The result was "a very closely integrated curative, preventive and promotive health service in which there is an ever-increasing appreciation of the community's health needs and an understanding of the various families served" [13: 101]. Each health center served a defined area within which staff conducted home visits. Center staff helped local people with simple environmental sanitation and stimulated the establishment of school feeding schemes, nursery schools, recreation clubs, gardening clubs and discussion groups.

Another early post-WWII experience is that of Ethiopia. Ironically, it was due to Ethiopia having been attacked by Italy that led to United Nations Relief and Rehabilitation Agency (UNRRA) heavily supporting health work there. UNRRA first assisted in "a rapid training course for sanitary inspectors, dressers, and health visitors" [14: 577]. This was followed by a joint US/WHO program consisting of three successive stages, the first covering very simple training for nursing and sanitary aides, the second for nurses and medical assistants, and the third, covering university training. Attention was first on the airborne diseases, principally malaria and dysentery, followed by waterborne diseases. Clinics and health centers were set up "as fast as you could train Ethiopians to run them" [15: 66]. It very quickly developed into "one of the finest health programs in the whole of Africa" [15: 65].

WHO's chaotic beginning

It was Brock Chisholm, WHO's first Director General, who used the term "chaotic" when referring to the first years during which the Interim Commission (IC) worked to develop the early program of WHO [16:11]. While he did not specify his reasons for describing it as such, a brief account of some of the discussions that took place concerning the selection of priority subjects is suggestive of chaos. Also, it must be taken into account that Chisholm associated himself with those visionaries who were proponents of social medicine and who believed that "any improvement in the public health would require social and economic measures as well as strictly medical ones" [1:3]. In other words, he looked to the IC and WHO's governing bodies to develop programs that promoted similar ideas; that they weakly did

so, might also have led him to judge their work as chaotic.

Rural hygiene appeared in several contexts in the 'chaotic' period of the IC, sometimes on its own, other times in the guise of rural health and/or tropical hygiene/health. In a draft list of activities that WHO was currently engaged in, written in December 1947, i.e. just before the last session of the Interim Commission that had been established in 1946 to guide the development of WHO's program, rural health was listed under the section 'social medicine' along with housing, town planning and sanitation, tropical hygiene, industrial hygiene, sanitary engineering, hospitals and clinics, nutrition, medical care, natural resources, school hygiene, and recreation [17]!

When presenting this list to the 5th session of the IC, Chisholm suggested that for the purpose of the 1st WHA, which was scheduled to take place in 1948, these items could be grouped under five headings: (a) an action program that included specific activities; (b) study and analysis of a problem with a view of developing recommendations for future years' activities; (c) central staff assigned of a minimum of one medical officer, one research assistant and one stenographer; (d) a central staff of a minimum of one medical officer and one stenographer; and (e) no action to be taken during the first year. The first category implied "the provision of field services, an expert committee, demonstration teams, central staff and any other specific activities recommended", while the second category implied the provision of "an expert committee and central staff" [18:37].

Despite the fact that the budget had not yet been discussed, the IC accepted Chisholm's challenge to place the items under discussion in one of these headings. Henry van Zile Hyde, who earlier had been Chief, Health Division, UNRRA, and later Director of the Point IV Health Program within the US State Department, and was then Chief, Division of International Health, USPHS, took the lead. He placed malaria, TB, MCH and venereal diseases in category (a), while indicating that the specific activities would include field missions, fellowships, and visiting lectureships and tours. He then indicated that public health administration "should be placed in category (a)", given that "one of the main objects of the WHO was to help to develop efficient national and local health administrations in all countries" [18:38]. To this he would attach tropical hygiene, rural hygiene, industrial hygiene, sanitary engineering, hospitals and clinics and medical care, as well as public health nursing.

While the Commission went along with almost all of his suggestions, public health administration was placed in category (c), along with most of the other items with which Hyde had grouped it, with no discussion! Tropical and rural hygiene were placed in category (b), along with nutrition, since it was indicated that joint committees with the FAO on both subjects had already been agreed to.

The only solid priorities decided upon were those of malaria, MCH, TB and venereal diseases, which had already been agreed upon earlier. In the IC's final report to the WHA, it was noted that "the fundamental importance of rural hygiene in the health of the populations of vast areas of the world is generally recog-

nized, and the environment and character of life of rural populations call for a special approach". It was also noted that such an approach had been developed by the LNHO for Europe in 1931 and for the Far Eastern countries in 1937. Sanitary engineering was cited as being of importance to "all public health activities" [18:11]. It is difficult to judge which IC members were aware of LNHO's approach as the only other reference to it is to be found in a background paper prepared by Andrija Stampar. Another person who likely knew of the LNHO's history is Hyde, who in 1975 read to a group discussing community medicine "a document and asked them how they liked that; if that seemed to cover what they had in mind. They all agreed it did, and at least one of them thought this was something I'd just written and was testing on them" [19:74]; it was an excerpt from the Bandoeng report, a policy direction that Hyde pursued when he was with the USPHS.

Environmental sanitation joins list of priorities

When the 1st WHA took place, Martha Eliot, US delegate, took the occasion to suggest "adding to the four priority items the major category of environmental hygiene, to include the diseases borne by water, food and insects, such as typhoid fever, cholera and dysentery", adding that such diseases "could be effectively and promptly controlled and their elimination was fundamental to any progress in health" [20:116]. Another member of the US delegation, Dr Halverson, "pressed for the inclusion of environmental hygiene in the first priority items, as many diseases arose from unsafe water, faulty sewage-disposal, poor food-protection and failure to eliminate flies. The related subjects of rural hygiene and tropical hygiene "could be amalgamated with environmental hygiene" [20:165].

The new priority granted to environmental sanitation was generally welcomed by the delegates to the 2nd WHA. When Dr MacCormack, the delegate from Ireland, suggested that "environmental sanitation be coordinated with work for the extermination of endemic diseases and should form a necessary part of the follow-up programme in any such scheme, Hyde, who was chairing the committee, indicated that MacCormack had "expressed very clearly what was, in fact, the view of the Director-General" [21:169].

As outlined by the first WHO Expert Committee responsible for Environmental Sanitation that took place in September 1949, environmental sanitation referred to the control of a long list of items, including methods for the disposal of excreta, sewage, and community wastes to ensure they are adequate and safe; water-supplies, to ensure that they are pure and wholesome; housing, to ensure that it is of a character likely to provide as few opportunities as possible for the direct transmission of disease, especially respiratory infections, and encourage healthful habits in the occupants; arthropod, rodent, mollusk, or other alternative hosts of human disease;

and infections commonly acquired or transmitted by the alimentary route, especially the enteric group; infections commonly acquired by the respiratory route; infections commonly acquired by surface contamination, which included yaws, leprosy and hookworm disease; and infections transmitted through the agency of an alternative host, which included malaria, yellow fever, leishmaniasis, bilharziasis, plague and epidemic typhus.

The Committee thought it evident that the sanitation of the environment is "literally the foundation upon which a sound public health structure must be built". Without it the superstructure "will be costly, weak, and insubstantial." If all of its constituents are not firmly designed, the "structure will still totter" [22:5-6]. One is tempted to add 'amen'.

The committee met again in 1951, when it was asked Chisholm to "devote its attention ... to the specific problem of education, training, and utilization of personnel for environmental sanitation [23: 3]. It remained at pains to provide specific guidance for "underdeveloped or emergent countries" due to "the wide variety and complexity of the systems presently in use", and to the "many different ways" in which the systems of local and central government exercise their control of the environment [23: 5]. However, it did identify the categories of personnel involved which ranged from sanitary engineers "to serve as true professionals at the various levels of responsibility relating to the environment in public health and associated organizations", to sanitarians who were grouped under the titles health inspector, health assistant, and health aid [23:9]. Health inspectors were "the backbone of the sanitary service" and were expected to have sufficient education to matriculate at a university. Also included were voluntary leaders for the mobilization of self-help, who it was hoped would include local leaders, village school-masters and "young men with enthusiasm who work or own property in the village..." [23:12].

The 3rd session of this Committee, which met in 1953, addressed the sanitation problems of small communities in under-developed countries and methods of solving these problems. Dr Marcolino Candau, WHO's Director-General (1953-1973), in his opening comments, stressed two points: a program of rural sanitation cannot be successful without the active participation of the local community, and it is necessary for all health workers at every level to participate in well-designed programs of health education of the rural population [24: 3].

The Committee stressed the fact that "sanitation was fundamental and basic to individual and community existence" [24: 4]. Furthermore, "it should be considered axiomatic that environmental sanitation programmes in underdeveloped areas should be integrated with general community development, and particularly with agricultural progress" [24: 5].

The administrative structure should provide the "simplest possible mechanism for the local health worker to obtain technical guidance from and consultation with staff at the next

higher administrative level of government. Other technical services, such as laboratories, health education, and investigations, should be correlated with the needs of the rural sanitation program” [24: 13].

The committee emphasized “the essential value of sanitation personnel who can enter into people’s homes”. Health aids should be able to do so. Employing women at this level was judged to be of “considerable value” as “many countries” had been successful in using “trained women in both domestic and community sanitation programs” [24: 16].

Given the global importance assigned to malaria at the time, it is of note that the Committee, chaired by George Macdonald, a leading figure in the global malaria eradication campaign, recommended that “in every area in which vector control is a primary need, suitable measures should be taken, but as an integral part of the general programme of environmental sanitation. It is emphasized that this activity should not take such precedence in the programme as to exclude action in the safe disposal of excreta and in the provision of safe water-supplies” [24: 14].

Taken as a whole, this report is the closest in spirit and in content to the Bandoeng report of all WHO papers produced around that time.

Promising initiatives

President Truman’s Point IV program, initiated in 1949, opened the door to America providing technical assistance to underdeveloped areas. Stanley Andrews was asked to take charge of this program, which he did until Eisenhower’s election in November 1952. His oral history account of his term as director provides ample evidence of how difficult it was to overcome Congressional opposition (mostly on the part of the Republicans) and bureaucratic opposition (mostly in the form of different agencies within the Administration competing with each other or simply reluctant to take technical assistance seriously). Nevertheless, he tells of how Hyde “did a marvelous job “of mapping out a world health program” and where Point IV fit into it (15, p120). What is clear from this testimony is that there were elements in the Administration that were favorable to the kinds of programs that Hyde approved of, which included rural hygiene. It was one of these elements that led to Grant being engaged in 1950 to develop “an emergency program . . . of assistance to southeast Asia” [25].

Grant undertook a tour to explore possibilities for inter-agency cooperation (America’s Economic Cooperation Administration (ECA), WHO and UNICEF). Hopes were high as the ECA had “secured the release of \$63,000,000 of China Area ECA funds for allocation to southeast Asia” for which 6 million were available for public health in the coming 15 months [26].

Grant proposed two “immediate measures” – every country becoming self-contained in the production of vaccines and sera for the common immunisable diseases, and measures directed towards the building up of the services required for nation-wide

prevention of uncontrolled major preventable diseases. Concerning the latter point, he stressed two steps: the institution and extension of environmental sanitation services, particularly rural, and the institution and extension of the personal health services, both of which were “now practically non-existent” [26].

He identified a number of elements to be covered by environmental services: insect control through residual DDT spraying, and provision of potable water supplies and adequate night soil disposal in the villages. In as much as labor is a major factor of cost in undertaking these measures “it is important that the principle of ‘village self-help’ be instituted. This would entail the establishment of village health committees who would be responsible for procuring the non-technical labor when the insect control and sanitation teams reach each village” [26].

Chisholm engaged Cora Du Bois, an American cultural anthropologist, to explore “the possible value of anthropology in public health” [27]. Grant paid careful attention to her work, using each of his visits to Geneva to find out how she was progressing. They seemed only to have met once when they both participated in a meeting held in the UNICEF office in Bangkok in August 1950 to discuss the implications of a ‘tentative budget’ by the US ECA for Thailand of an amount of nearly 3 million US\$. A few days later another meeting was organized specifically to discuss with “Dr Cora Du Bois . . . some of the basic questions regarding operational planning” that had arisen from the previous operational discussions” [28]. Mr Keeney, UNICEF officer in charge of the Bangkok office, indicated that there was no disagreement as to the principle that Du Bois was advocating, but he pointed out that UNICEF “was not a very powerful force in the situation because the ‘big money’ does not come from us”. He further pointed out that “UNICEF has to wait till it is invited to join in wider conferences, such as with ECA or else make arrangements to be invited” [28].

Milton Roemer was hired in 1950 to visit two countries, Ceylon and El Salvador, to spell out what shape a demonstration project might take in each of those countries. Before taking up this assignment, Roemer was a member of the commissioned corps of the US Public Health Service. He was also co-author of a book on rural health and a student of rural health programs in different nations. Perhaps in anticipation of his eventually working for WHO, he had already indicated in 1947 that WHO would “devote much of its efforts to the advancement of rural public health services throughout the world [29: 63-64].

Both reports prepared by Roemer concerning demonstration areas are substantial documents; that of El Salvador was 233 pages long! Roemer identified the important objectives of such an area in the following terms: 1. to demonstrate a unit of well-balanced health services (including medical and dental care) within the economic resources of a community; 2. to demonstrate the modern methods and techniques in medical science as applied to a community for the prevention of diseases and promotion of health of the people; and 3. to demonstrate that health is the determining factor in an organized effort in social and economic development of an area. By organizing the simultaneous multiple

approaches, the social and economic development of a community can be achieved more efficiently and effectively.

Recognizing that the USPHS did not have enough personnel “to do it alone”, Willard Thorp, Assistant Secretary of State for Economic Affairs, called upon US public health workers to “volunteer to go out and take their places in this unique enterprise in building a healthier world” [30: 1483]. Hyde soon added his voice to this call, specifically aiming it at America’s public health engineering staff. Since “health is one of the roots of social and economic progress, it is incumbent on us”, said Hyde, “to press forward its development throughout the world as rapidly and effectively as possible.” The “problem is in the first instance one of sanitation. The key to it is held, in almost unique fashion, by the sanitary engineers of America” [31: 1].

When Dr Daubenton took over as Regional Director of the newly established African Regional Office in the early 1950s, he expressed the opinion that “it was impossible to consider health and disease in Africa as isolated factors; the environment, sanitary engineering problems, and social and anthropological conditions had also to be taken into account” [32: 7]. Dorolle went further; he wrote of the “absolute necessity to associate ethnological studies with all health actions” [33: 315]. Dorolle managed to engage Jean-Paul Lebeuf, a very eminent French ethnologist, to work for WHO’s African regional office for several years. Dorolle was one of the very few individuals still engaged in international health work who had participated in the 1937 Bandoeng Conference.

Public health problems in rural areas was the subject for the technical discussions at the Seventh World Health Assembly held in May 1954, under the chairmanship of Andrija Stampar. A list of references on rural hygiene was compiled by the WHO Secretariat to assist participants in their discussions. Some 309 references were cited, including five LNHO publications, Hydrick’s book, six of Roemer’s papers, 4 on South Africa and 2 on China. Again rural sanitation was recognized as being of vital importance; “in less developed countries it is of first importance” [34: 5].

America’s politics undermines global rural hygiene initiatives

This brief section is confined to examples related to the initiatives described above.

UNRAA was essentially an American funded and run organization. Republican members in the US Congress viewed UNRAA primarily as a solution to the problem of large agricultural surpluses; they opposed any efforts at institution building since it did nothing to advance food exports. Lacking congressional support, UNRAA was closed down just as WHO was being created.

Matters seriously deteriorated following Eisenhower taking over the presidency in January 1953. The ECA was replaced in 1951 by the Mutual Security Agency (MSA), which was replaced in 1953 by the Foreign Operations Administration. These shifts “hampered US development assistance in significant ways and

tied it ever more strongly to often uncoordinated economic, political, and social objectives and programs, while an increasing amount of aid went to military purposes” [35: 31]. Harold Stassen, who was made Director of the MSA, was “convinced that not all that had gone beforehand was acceptable to the new administration”. He “and Company” were suspicious of “far left organizations” and of anyone that had any association with such organizations [36: 39]. What had been favored earlier was now objected to, as Andrews remarked concerning the program in Ethiopia – he got “hell for it” because he was “putting some of our materials and some of our money in a United Nations deal and also our technicians” [15: 65]. It was Andrews who judged the Ethiopian program to be the best in Africa, as noted above.

Grant witnessed the collapse of promising initiatives due to the retreat of American support to broad integrated development projects whose development he was pursuing. None of the projects that he proposed were initiated.

Efforts to encourage American public health workers to get involved in international health were undermined by the right-wing elements in America, led by J Edgar Hoover, targeting progressive Americans. When Du Bois applied for a position at the WHO, “J Edgar Hoover ordered the Washington [FBI] to conduct a full time investigation on her” [37: 297]. On leaving WHO she joined the ranks of academia, where she continued to be harassed by the FBI. She was but one among many American anthropologists that were greatly affected by the political atmosphere in America; as noted by Margaret Mead: “the Joseph McCarthy era and the Korean War, when everybody inside the government who could have used material or insights that anthropologists could have produced, went home or got fired” [38: 258]. As well, hundreds of university professors were dismissed; medical schools “divested themselves of left-leaning faculty members” [39: 434].

A major loss was Milton Roemer being forced to resign from WHO in 1953, after the State Department revoked his passport for refusing to sign a loyalty oath, which the US required of all Americans working for the UN. The State Department went so far as to threaten any organization that employed ‘suspect’ Americans.

The pullback of American funding and the retreat of American expertise to assist in the development of rural hygiene programs effectively cut short all of the promising initiatives identified above and many more.

Concluding comments

None of the above impacted negatively on WHO’s malaria control/eradication program. If anything, America’s Cold War politics greatly augmented the importance of malaria control, as it was believed that malaria control would contribute to agricultural productivity and that the rapid progress achieved would contribute to winning the “hearts and minds” of rural populations threatened by communism [40: 283]. On the other hand,

it seems clear that, given the extraordinary promise of DDT and the rapidity with which it impacted the presence of malaria, malaria control would have been a priority even if the times had been less antagonistic.

The same cannot be said concerning rural hygiene, which is why the title of this paper has been formulated in an interrogative manner. Rural hygiene, especially its environmental sanitation component, is a long-term affair. Great patience is required to alter traditional ways of life that interfere with local hygienic conditions. It was precisely for this reason that the contribution of cultural anthropologists was called for. However, there is little

in the literature to suggest that anthropologists would have accepted to play the educational role demanded of them, or even that they were capable of fulfilling this role.

Also, third-world governments had their own priorities, ones that did not necessarily include rural hygiene. Thus, it would be unrealistic to suggest that had there been no Cold War matters would have turned out differently.

Rural hygiene remains today as much of a challenge as it did then. However, had greater attention been given to it earlier on, valuable experience would have been gained that may have provided a basis for more rapid and wide-spread successes.

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