

A Study on US Foreign Health Aid to the Developing Countries During the Cold War

Taking Cholera Prevention and Treatment as an Example

Zhiwei Zhang

The Institute of World History
Zhejiang University
Hangzhou, China 310028
College of Humanities
Tarim University
Alar, China 843300

Abstract—The United States carried out medical and health research abroad early. However, only after the foundation of WHO, did the US engage in foreign health aid activities. The motivations of its foreign health aid are to realize its cold war strategy and national security, protect its overseas interests, realize its economic interests and establish its good national image. Taking cholera prevention and treatment as an example, the United States helped Thailand and Pakistan set up two cholera research centers respectively and invested a lot of money in their operation, which played an important role in cholera prevention and treatment. In spite of its humanitarian nature, the US foreign health aid was restricted by political factors, and could not meet the real needs of the developing countries.

Keywords—foreign health aid; developing countries; the Cold War; cholera prevention and treatment

I. INTRODUCTION

The United States has been playing an important role in the field of international health. The US State Department institutes two special offices,¹ which are committed to mobilizing international forces to prevent and response to the global health security threats. The famous American President's Emergency Plan for AIDS Relief (PEPFAR)² has made an outstanding contribution to the AIDS control of the world. The United States has been one of the most important donors in foreign health aid. In the fiscal year 2017, the funds of the State Department on global health program reached \$7,580,120,416.[1] Although the amount of money

¹ The two offices are OGAC (Office of the U.S. Global AIDS Coordinator and Health Diplomacy) and IHB (Office of International Health and Biodefense) respectively.

² PEPFAR (the President's Emergency Plan for AIDS Relief), managed by Office of the U.S. Global AIDS Coordinator and Health Diplomacy the U.S. global AIDS Coordinator and Health (OGAC) lead and manage the implementation of the foreign office since 2003, the program has saved the lives of more than 17million people, prevented millions of new HIV infections, and accelerated the control process of the HIV/AIDS epidemic worldwide in more than 50 countries.
<https://www.state.gov/policy-issues/global-health/>.

is staggering currently, the US's foreign health aid, as a dynamic process, was in a small scale at the beginning. The establishment of WHO in 1946 was a watershed period of American foreign health aid. During the Cold War, health aid, as with other aid, is a tool for the United States to infiltrate and influence the recipient countries while benefiting them. That is why we select US foreign health aid as the research topic.

The origins of US foreign health aid will be described firstly, and the motivations will analyzed secondly. The prevention and treatment of Cholera, as a typical example, will be described and analyzed to reflect the history of US foreign health aid during the Cold War period. Every coin has its two sides, and US foreign health aid is no exception. The developing countries did benefit from it, but US realized its strategic goals and benefited more.

II. EARLY AMERICAN FOREIGN HEALTH RESEARCH AND AID

Before 1946, only a few official health aid activities had been carried out by the US government. Some private organizations of the US took on most of the foreign health aid activities, such as religious groups, business companies or some American private foundations, among which the most famous was the Rockefeller Foundation. The Rockefeller Foundation was devoted to the Hookworm control program in the United States around the year 1910, and the program was expanded to overseas later.

The U.S. military's participation in foreign health activities was comparatively earlier. In 1899, when the U.S. army was involved in overseas medical research, Bailey Ashford investigated anaemia caused by hookworms in Puerto Rico. In 1900, Walter Reed discovered mosquitoes as vectors of yellow fever in Cuba. Lieutenant Charles Craig conducted amoebic dysentery research in the Philippines, and at the same year, the U.S. army's first overseas medical research laboratory was established. [2]

During the Second World War, the US carried out some health activities in the countries where there were US military bases, but these were mainly for the US military activities. After 1946, the US foreign health aid activities gradually warmed up. However, the Marshall Plan was mainly economic aid. It was not until 1949 that "Point Four Program" put forward by President Truman started its foreign health aid to the developing world countries. In 1960, the Public Health Service Act made the US Department of Public Health Services support bilateral agreements, to be used for the communication of science and technology project in many countries. The Act also allows the use of monetary surplus produced by "Public Law 480" in the country to carry out the research activities, part of surplus currency used by health and humanitarian affairs. [3] In 1961, the Kennedy Administration institutionalized the foreign aid, and improved the mechanism of foreign health aid.

III. THE MOTIVATIONS OF US FOREIGN HEALTH AID

The reasons or motivations of the United States' foreign health aid are as follows: the needs of national security, overseas interests, economic interests and national image building of the Country.

A. *The Consideration of US Cold War Strategies and Its National Security*

By providing foreign assistance to the developing countries, the United States could draw them aside by building more friendly relationship with them. That is why more assistance had been provided to the countries which are more vital to American's Cold War Strategies. Some Asia countries or regions, like Thailand, Pakistan and South Vietnam, which were on the front of restraining the Communism, became the key recipients of the US. The developing countries in the tropical area usually need more health assistance, due to the high incidence of infectious diseases caused by climate.

From the perspective of US national security, providing health aid to the developing countries is helping the US itself. With the rapid development of transportation technology, especially the development of civil aviation, it was much easier for international travelers to spread deadly viruses and bacteria to every corner of the world than before. Due to the poverty and malnutrition, poor health awareness of people, and insufficient medical facilities and staff, the developing countries are high frequency area of epidemic disease, which could cause a lot of population loss and economic losses. What's worse, these epidemics could spread to other countries. For example, several cholera pandemics in the nineteenth century devastated international trade and killed numerous people in the West. In 1832, the world's second cholera pandemic spread to the United States and killed 50,000 to 150,000 people in the country. Later, the cholera epidemics killed 100,000 and 50,000 Americans in 1849 and 1846 respectively. [4] As a matter of fact, no country can get out of the harm of epidemics, therefore, providing foreign health aid is protecting the US itself.

B. *To Protect the American's Overseas Interests*

The overseas military bases and troops of the US and its rapid development of the international trade call for the protection of its own interests around the world. American military bases were spotted around the whole world. After the Spanish-American war in 1898, the United States won the Spanish colonies in Cuba, Puerto Rico, the Philippines and Guam. From then on, the United States has been expanding its overseas garrisons. During World War II, the number of military bases increased to more than 2000 in over 100 countries and regions. After WWII, the US had pulled out some of the military bases; however, it was until 1953 that the number was still up to 815. The number of its overseas troops and their relatives with army is over 1 million. [5] The medical and health problems frequently occur in the host countries or regions, most of which are developing countries. The infectious diseases often threaten US personnel's lives and increase the risks of spreading the epidemics to their homeland with the communication of personnel and supplies. Thus, supplying medical and health aid to the developing countries benefit the host countries' controlling the epidemics, and protect its own military bases overseas. Meanwhile, the US citizens working or travelling abroad can enjoy the welfare of their countries' health aid.

C. *To Gain More Economic Interests*

The United States attained huge interests from the sales of medical and health products in the market of the developing countries, while the health market could be broadened by US foreign health aid. Due to the obvious technological advantages, and huge investment in the research and development of health products, the United States has a high share in international medical and health market. The American medical technology and products were exported to the developing countries easily. Some American companies are engaged in health-related activities, such as manufacturing and selling sanitary products and services, and participating in national or community health projects in the developing countries. The medical and health products exported by the United States mainly include drugs and pharmaceutical chemicals, pharmaceutical equipment, medical instruments, X-ray machines and other medical equipment. Taking medical and health products exported to developing countries in 1976 as an example, the trade surplus of the United States with low-and-middle-income countries reached 541 million dollars. [6] Therefore, achieving economic interest is an important factor of supplying health aid to developing countries.

D. *The Need of Shaping Its National Image*

Health aid helps shaping the national image. Originating from the Puritan ideas in the colonial period of North America, the Americans have idealistic responsibilities, regarding themselves as the chosen people of God, who are destined to assume the moral responsibility of leading the world, and saving the world from the pain. [7] The United States has the capacity and resources in the medical world that no other country can match. It has the ability to train large numbers of health care personnel in the United States

or overseas for developing countries. American academic institutions, foundations and the pharmaceutical industry also have the largest concentration of medical research talents in the world. Surpassing national boundaries, races, religious and cultural differences, health aid activities, such as saving people in distress, bringing hope for the patients, can bring warmth and kindness to people who are in great need of medical aid. For example, “DOD (Department of Defense of the United States) Overseas Laboratories have earned a great deal of good will for the United States in developing countries located on three continents. The importance of the work done by Americans in these laboratories is recognized and appreciated by host country governments.”^[8] Therefore, it is much easier for the donor country to build a good international image by foreign health aid, and the recipient country are more inclined to have a better relationship with the United States. The image of American hegemony could be whitewashed to some extent.

IV. THE CASE OF US HEALTH AID: CHOLERA PREVENTION AND TREATMENT

In this part, the researcher set the prevention and treatment of cholera as an example to illustrate American’s foreign health aid. With the help of the US, two cholera research centers, TSCRL(Thailand Southeast Asian Treaty Organization Cholera Research Laboratory) and PSCRL (Pakistan Southeast Asia Treaty Organization Cholera Research Laboratory) were established respectively within the structure of SEATO (Southeast Asia Treaty Organization). The latter was developed into ICDDR/B (Bangladesh International Institute for Diarrhea Diseases) in the late of the 1970s.

A. *US and Cholera*

Cholera is recognized as a disease existing in South Asia for a long time, whose natural home is located in the Delta of the Ganges River in Bengal area. This region has been heavily populated, in poor health conditions, with the vast waters. The annual average temperature is over 17°C, and the air humidity is over 40% most of the year. All of these conditions are conducive to the survival and spread of pathogens, and cholera broke out almost each year in this area for hundreds of years in history. [9] Despite its being so far away from South Asia, the United States was also the victim of the six cholera pandemics around the world in the 19th century. For the first time in history, Cholera attacked New York on June 23, 1832, and later spread to most other cities in 1834. Then the epidemic went across the Rocky Mountains, and ultimately arrived at the Pacific coast region. In total, the death toll is estimated at between 50000 and 150000. From 1849 to 1850, the outbreak of cholera killed 100000 people in America. In 1866, the cholera epidemic plagued the US for the last time, with 50000 people lost their lives. [10] Although the Sixth Cholera Pandemic killed huge amount of people in the Middle East and Southern Russia, the United States was very fortunate that time. Only a few scientists took part in the research of the disease.

B. *The Establishment of Two Cholera Research Centers*

In many regions of the less developed countries, diarrheal diseases exceed all other causes of sickness and death. In some rural areas, half of all children could be killed by them in the children’s first five years of life. Cholera might be the worst and it did great damage to South Asia. The nearby areas of Indo-China Peninsula were more likely to be attacked by the disease. According to the New York Herald Tribune on June 24, 1958, “Since the cholera outbreak on May 23, the number of cholera cases in Thailand has reached 6,291, with 912 deaths.” [11] During the same period, nearly 1,000 U.S. troops and their families are stationed in Thailand,³ and they were exposed the threat of the epidemic disease. On the advice of the Cholera Research Advisory Team, the United States government signed a formal agreement with the government of Thailand in December 1959 to establish TSCRL, which would be funded by both governments. The institute’s first deputy director, Oscar Felsenfeld, was from the U.S. Army Research Institute. U.S. personnel were primarily from NAMRU-2(US Navy Medical Research Unit Number 2), WRAIR (the U.S. Army Research Institute) and Jefferson Medical College. In 1961, the TSCRL was renamed the Southeast Asia Treaty Organization Medical Research Laboratory of Thailand, which was managed by the Thai government in collaboration with WRAIR and the research was much broader. [12]

In October 1960, with the help of WHO, the US government and the Pakistani government signed a formal agreement to build PSCRL in Dhaka, with the US providing most of the fund. From December 5th to 8th, 1960, 55 delegates from eastern western countries took part in the Southeast Asia Treaty Organization Cholera Disease Conference, and PSCRL was established. The Institute, which was basically a bilateral agency between the United States and Pakistan, focused on researching the causes and epidemiological patterns of cholera and other diarrheal diseases, testing cholera vaccines, studying the pathophysiology of diarrhea, and developing appropriate therapeutic interventions. One of the agency’s achievements has been the use of ORT (oral rehydration therapy)⁴ for cholera patients, which is the basis of modern diarrheal disease control programs. Since then, PSCRL operated until the outbreak of the Civil War in East Pakistan.

C. *US’s Funding to Cholera Research*

After the independence of the Bangladesh, the medical and health conditions of the country were no better than before. In 1976, up to 50% of the population was malnourished, the gross mortality rate is about 17%, and the

³ According to the data on March 31, 1957, the United States stationed military assistance advisory group (MAAG) in Bangkok, Thailand, with 430 military personnel, 6 civilians and 318 military families. Appendix to Frank C. Nash’s report on U.S. Overseas Military Bases, Country Studies: Thailand. White House, 1 Nov. 1957. U.S. Declassified Documents Online, <http://link.galegroup.com/apps/doc/CK2349288167/GDCS?u=jiang&sid=GDCS&xid=3ad9efef>. 2019-07-05.

⁴ ORT: oral rehydration therapy, a very common therapy of cholera and other diarrhea diseases in the developing countries.

life expectancy of the population is only 48 years. Most of the deaths are caused by infectious diseases, such as cholera, diarrhea, tuberculosis and measles. Its health conditions were rather bad, with only 7,000 doctors in the whole country, and the proportion between population and doctors is 10,000:1. What's worse, 75% doctors worked in cities and the number of nurses is also insufficient. National health funding is less than 5% of the total budget. [13]

USAID has been the largest bilateral donor to global health, family planning and nutrition programs. USAID/Bangladesh signed an agreement with the Ministry of Health of Bangladesh in May 1974 to fund the operation of the Bangladesh Cholera Research Laboratory (CRL). AID provides the major part of the funds for the Dacca Cholera Research Laboratory for research in cholera and other enteric diseases. AID provides 90 percent of the laboratory's funds in the form of a grant to NIAID/NIH which, in turn, selects the director and key staff and provides program direction and review. The remaining 10 percent of funds are supplied by Bangladesh, Australia, New Zealand, and the United Kingdom. [14]

In US fiscal year 1975, CRL/B received a humanitarian grant of \$1.4 million from the United States to cover the cost of US technicians and laboratory equipment, to develop and improve cholera vaccines and to cover the local costs of the cholera institute's operations, including medical facilities. [15] Up to September 30, 1976, the total funding of USAID/Bangladesh for the cholera institute was \$4.1 million and 1.5 million Bangladeshi taka (US \$243,000). [16]

The development of CRL led to the foundation of the ICDDR (International Centre for Diarrhea Disease Research) in 1979. Since then, ICDDR/B has been a biomedical research center for the treatment and prevention of cholera and other diarrhea diseases. Some governmental organizations and NGOs supplied funds for its operation. "The United States, which was the principal donor in the case of the Cholera Research Laboratory, is maintaining its previous level of financing and is still the largest single donor, but its funds are now more than matched by other participants." [17]

D. Other Us Agencies' Health Aid

A variety of private volunteer organizations or research institutes also participated U.S. foreign health aid. Ford Foundation was a large donor for ICDDR. At the first consultative group meeting in Geneva in June 1980, which was organized by the UNDP, donors and some interested countries and institutions, Dr. O. Harkavy, representative of the Ford Foundation, announced: "our office approved a second grant of \$ 200,000 for support for International Centre; it is our hope that an additional sum will be forthcoming in the next year". [18]

Besides the donors like Ford Foundation, some universities participated in the research of cholera and other diarrhea disease, of which John Hopkins University was a typical representative. JHCMR (Johns Hopkins University Medical Research Centre), originally located in Calcutta of India, moved to Dhaka in 1974. "Four departments of the

Johns Hopkins University have joined in planning and sponsoring activities in Dacca which are housed in building of the National Institute of Public Health of Bangladesh. JHCMR conducted a broad spectrum of research projects in India and nearby countries, but in Dacca the focus is on cholera and on population dynamics." [19]

V. THE BI-NATURE OF US FOREIGN HEALTH AID

A. The Effectiveness of US Foreign Health Aid

From the perspective of the United States, the American government achieved its strategic goals to a large extent. Its national security was achieved; the good national image was set up; and the American companies got their profits from the medical and health market. From the perspective of the developing countries, they did benefit a lot from the health aid. For instance, with the efforts of the cholera research centers and many scientists all over the world, the death toll of cholera had been decreasing steadily. In 1988, ORT was promoted in more than ninety five developing countries. In some nations, it has brought diarrheal mortality down by at least 40 to 50 percent. [20]

B. The Flipside of US Foreign Health Aid

US foreign health aid was often constrained by political factors in spite of its nature of humanitarian. It is usually said that there is no border in the field of medicine. Is it really so? In terms of the nature of the medicine, the conception of saving the dying and healing the wounded concerns no national boundaries or ethnic groups. However, there are many differences in the formation of medicine itself. Some other factors, like geographical conditions, cultural backgrounds, and uneven development of medicine science and so on, may lead to factual borders. US foreign aid was often closely integrated with the sociopolitical and economic aspects of the country. The geostrategic interests of the United States affect its international health aid policies and activities. The Ganges River Delta had long been considered the origin of cholera. However, PSCRL was founded later than TSCRL. Why? It can be illustrated well that the strategic status of Thailand was higher than Pakistan during the Cold War. To prevent the expansion of communism in Southeast Asia, America's strategic focus was Indochina Peninsula, since the Americans had military bases and large numbers of military personnel in Thailand. However, there were no American troops in East Pakistan. Therefore, Thailand was prioritized.

The other obvious drawback is the mismatch between health aid and actual need of developing countries. Usually, developing countries were in urgent need of medical facilities, staff and other direct health services, while US foreign health aid could only meet the demand to a certain extent. Scientific research was paid more attention. In addition, foreign health aid was constrained by some laws. Existing legislation does not allow a Federal agency such as the Department of Defense, which operates a network of health care facilities outside the United States, to provide care to non-eligible individuals, even though less than 40 percent of bed. [21]

VI. CONCLUSION

In spite of its participation of the international health research as early as in the late of the 19th century, the United States did not engage in foreign health aid formally until the end of World War II. Only after the foundation WHO, did US engage more health aid activities. As part of the foreign assistance, health aid concerns about national security of the US, its Cold War strategies, its overseas interests, and the necessity of building its national image. The prevention and treatment of cholera is a typical case of US foreign health aid. Because of the impact upon the geopolitical strategies in Southeast and South Asia, TSCRL and PSCRL were founded with the help of US government.

Great achievements were made in reducing the death of cholera infectors. In total, foreign health aid played an auxiliary role in realizing America's comprehensive Cold War strategies, and it should be concerned by history researchers.

REFERENCES

- [1] U.S. overseas loans and grants: obligations and loan authorizations, July 1, 1945-September 30, 2017. 2018-06-22, [2019-07-05] https://pdf.usaid.gov/pdf_docs/PBAAJ725.pdf, p.4.
- [2] W.E. van Heyningen & John R. Seal. Cholera: The American Scientific Experience, 1947-1980. Westview Press, Inc. Boulder, Colorado. 1983, pp.91-92.
- [3] Pease, Clifford A., Jr. American Public Health Association. US government policy on development of international health. (1986-03-06) [2019-06-21] https://pdf.usaid.gov/pdf_docs/PNAAV675.pdf, p.5.
- [4] W.E. van Heyningen & John R. Seal. Cholera: The American Scientific Experience, 1947-1980. Westview Press, Inc. Boulder, Colorado. 1983, pp.7-9.
- [5] David W. Tarr, The Military Abroad, Annals of the American Academy of Political and Social Science, Vol.368, American Abroad, Nov., 1966, p.33.
- [6] New directions in international health cooperation: a report to the President. White House, U.S. Government Printing Ofc. (GPO) – 1978. https://pdf.usaid.gov/pdf_docs/PBAAH642.pdf, p.131.
- [7] Xiaode Wang. American Culture and Diplomacy. Beijing: World Knowledge Press, 2000, p.18.
- [8] New directions in international health cooperation : a report to the President. White House, U.S. Government Printing Ofc. (GPO) – 1978. https://pdf.usaid.gov/pdf_docs/PBAAH642.pdf, p.169.
- [9] W.E. van Heyningen & John R. Seal. Cholera: The American Scientific Experience, 1947-1980. Westview Press, Inc. Boulder, Colorado. 1983, p.4.
- [10] W.E. van Heyningen & John R. Seal. Cholera: The American Scientific Experience, 1947-1980. Westview Press, Inc. Boulder, Colorado. 1983, pp.7-9.
- [11] "Thai Cholera Kills 912." New York Herald Tribune [European Edition], 25 June 1958, p. 5. International Herald Tribune Historical Archive 1887-2013, (1958-06-25)[2019-07-05] <http://link.galegroup.com/apps/doc/IBDELK170218933/GDCS?u=jiang&sid=GDCS&xid=fdd438cd>.
- [12] W.E. van Heyningen & John R. Seal. Cholera: The American Scientific Experience, 1947-1980. Westview Press, Inc. Boulder, Colorado. 1983, p. 104.
- [13] Loomis, Scott A. U.S. Dept. of Health and Human Services. Syncrisis, the dynamics of health:17. Bangladesh.(1976-03) [2019-05-11]. https://pdf.usaid.gov/pdf_docs/PNAAC135.pdf, p.1.
- [14] New directions in international health cooperation : a report to the President. White House, U.S. Government Printing Ofc. (GPO) – 1978. https://pdf.usaid.gov/pdf_docs/PBAAH642.pdf, p.164.
- [15] USAID. Mission to Bangladesh. U.S. assistance to Bangladesh. https://pdf.usaid.gov/pdf_docs/PDACS834.pdf, p.1
- [16] USAID OIG Audit Report. Audit Report on Cholera Research Laboratory. https://pdf.usaid.gov/pdf_docs/PDAAT109.pdf.
- [17] International Centre for Diarrhoeal Disease Research, Bangladesh : progress report 1979-80, programme and budget 1981-85, construction of new facilities -- material for meeting of the Consultative Group on ICDDR, B, Geneva, June 6, 1980. https://pdf.usaid.gov/pdf_docs/PNABA843.pdf, p.7.
- [18] International Centre for Diarrhoeal Disease Research, Bangladesh. Proceedings of the Consultative Group meeting of the International Centre for Diarrhoeal Disease Research, Bangladesh. (1980-10)(2018-10-24). https://pdf.usaid.gov/pdf_docs/PNABA842.pdf, P34.
- [19] New directions in international health cooperation: a report to the President. White House, U.S. Government Printing Ofc. (GPO) – 1978. https://pdf.usaid.gov/pdf_docs/PBAAH642.pdf, p.160.
- [20] Oelgeschlager, Gunn and Hain. Oral rehydration therapy: a revolution in child survival. https://pdf.usaid.gov/pdf_docs/PNAAZ606.pdf, p.2.
- [21] New directions in international health cooperation: a report to the President. White House, U.S. Government Printing Ofc. (GPO) – 1978. [2019-05-26] https://pdf.usaid.gov/pdf_docs/PBAAH642.pdf, p.10.