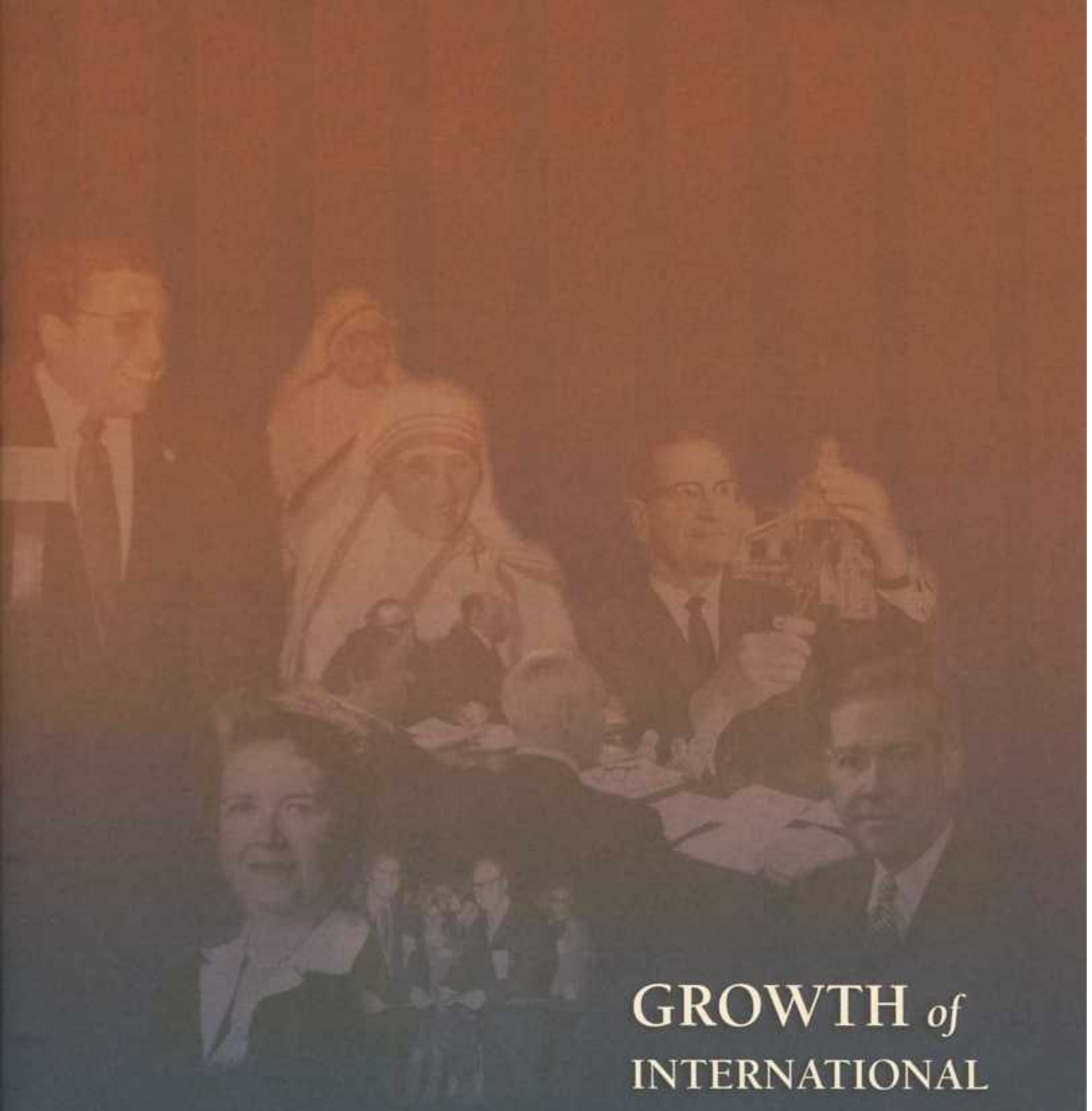

GROWTH *of* INTERNATIONAL HEALTH

American Public Health Association

An Analysis and History

PREFACE

Since its founding more than a century ago, the leadership of the American Public Health Association has recognized the importance of understanding public health from a global perspective. This was not only to protect the health of the public, but also for international humanitarianism and justice, so all people everywhere can achieve the highest levels of health and quality of life.

Ironically, almost exactly one hundred years after its founding, the APHA established a special membership section for International Health. This became the focal point for all of the APHA members who have a professional interest in how APHA can contribute toward the improvement of public health in international or global settings.

The growth and development of the APHA International Health Section is outlined in detail in the following historical document account. As you will discover, APHA itself has gone through many changes as it approached this agenda. This historical review explains how APHA viewed International Health from a professional, scientific, political as well as a financial perspective. The lessons learned from this historical review provide important insights both to APHA leadership, the membership at large, and to those with whom APHA seeks to become partners.

APHA leadership, members, and International Health staff have demonstrated a special ability to tie APHA's public health interests, both domestic and international, into the strategic priorities of the global health community. Through government and private initiatives, bi-lateral as well as multi-lateral efforts, APHA has worked aggressively to promote and protect the health of all citizens of the world. The unique linkage between APHA and the World Federation of Public Health Associations has been a critical partnership ally in this process.

Given all of the changes in our global community since the appearance of SARS, it is woefully apparent that International Health cooperation must be a priority of the public health community. APHA has the opportunity, experience, and capacity to assume a key leadership role in the changed world in which we all live.

As you read this history, I urge you to use these experiences to better identify and support what next steps APHA should take in helping to improve the public health of all of the world's citizens. At the same time, you have the opportunity to decide how you and your skills can contribute to this future agenda. APHA has developed a solid base, a talented and energized membership and staff. We are now ready to move with confidence into our second century of International Health leadership.

On behalf of the Executive Board of APHA I want to personally thank everyone involved in the development of this important documentation of APHA's history. We especially want to thank the Rockefeller Foundation for their enlightened support some four decades ago in helping launch in 1959 APHA's international endeavors, and, now in 2003, for their support enabling us to undertake this timely history documentation.

Finally, a special word of thanks to Frank Lostumbo, APHA member who authored the history, and to the Advisory Committee members—Ray Martin, Russell Morgan and Allen Jones—who assisted in the process.

Georges Benjamin, MD, FACP
Executive Director
September 30, 2003

Foreword

The International Health Section (IHS) of the American Public Health Association (APHA) commissioned the preparation of a history beginning with the Section's inception in 1976. However, to understand properly the evolution of the IHS it is important to include the unfolding of international health as seen from APHA's perspective, including the establishment and growth of its global affiliate the World Federation of Public Health Associations (WFPHA). The history is based on an analysis of available IHS and APHA files, publications, and newsletters supplemented by oral interviews with current and former members. The file information served as a guide and reference point for some 50 interviews, which provided in depth perspective on many key events. An advisory committee guided the process and included Ray Martin, retired USAID/Chair IHS, Allen Jones, Director Education & Global Health Resources, APHA/Secretary General WFPHA, and Russell Morgan Jr., President, SPRY Foundation and formerly senior international health staff at APHA 1970-1979.

Introduction

The origin of the International Health Section was based on the need for an international health constituency within APHA and an international health forum that would encourage dialogue on the interdependence of domestic and international health issues. To understand this evolution the review includes the early vision of APHA leaders during the formative period of APHA's initial agenda for international health. That interest began in the mid-50s with the emergence of APHA leaders wanting to be engaged internationally while the majority of the 13,000 APHA members and many affiliates placed higher priority on domestic public health issues at state, community, and local levels.

Background

The APHA is a membership association with headquarters in Washington, DC. The organization currently has 30,000 members, including 1,600 members from other countries plus state affiliates. The membership is diverse and includes officials and workers from most health and health related professions/organizations across many levels of government, academia, and private entities. The structure of the organization is complex and encompasses the volunteer Executive Board with numerous committees; a Governing Council made up of councilors elected from the sections, special interest groups (SPIGS), and affiliates; 26 autonomous sections each with their own volunteer leadership; and 65 APHA staff organized in functional units headed by an Executive Director. The significance of the multidisciplinary make-up of APHA is reflected in each election cycle as new members ascend to the voluntary leadership levels, bringing their own interests and priorities for the organization. These shifting dynamics also influence and shape communication and interaction among the APHA board, the sections, and the staff. Adequate board representation and communications have been and are continuing issues shared by many sections and their leaders. The International Health Section (IHS) is one of 26 functional interest sections within APHA. It began with 345 members in 1976 and rapidly grew to 1,500 by 1982. The number of section members has remained stable for almost two decades and the overall APHA membership has remained around 30,000 during that same period. There are 1,655 members of the International Health Section as of July 2003.

Early Beginnings

Stephen Smith founded APHA in 1872, and by 1884, his foresight on the importance of securing international cooperation in public health matters led the organization to expand its membership beyond the United States by inviting professionals from Canada, Colombia, Cuba, and Mexico to join. In 1891, the first non-US member elected president of APHA was a Canadian, Frederick Montizambert from Quebec.[1] The ranks of the non-US members increased and international relations or interactions mostly centered on the problems of contagious diseases and the related issues of immigration and quarantine.

However, a broader interest beyond international membership evolved in 1955, when a committee of the Health Education Section composed of Ann Wilson Haynes, Donald Dukelow, Alfred Kessler, Mary Lou Skinner, and Ruth Sumner proposed a resolution to APHA requesting that the section become a member of the International Union for Health Education of Public Health.[2] The Executive Board denied the request on the basis that such membership required a fee of $30 and would set a precedent. In reality, APHA was already considering membership in the International Federation of Public Health Associations and the Confederation of Public Health Associations in the Americas.

As a result of this request and of the growing interest for international outreach by several sections, an international resolution was passed by APHA on November 16, 1955.[3] The resolution included the point that improvement of health throughout the world is a necessary part of the social and economic conditions required for lasting peace. The resolution called for strengthened support and active interest in international health work and recommended that the Public Health Service and the Department of State bring about a freer exchange of information and visitors between countries. Several years passed before any specific international actions were taken within APHA. However, APHA did receive a three-year grant from the International Cooperation Agency (the predecessor of USAID) to cover costs of APHA membership and attendance at annual meetings for 3,568 ICA Fellows from around the world.

APHA took its first step in implementing the resolution on international health in early 1959, when APHA President Leona Baumgartner obtained financial support from the Rockefeller Foundation to facilitate having four distinguished professors from Ghana, India, Japan, and the Soviet Union attend and address the 87th Annual Meeting.[4] She believed that development of international relationships was a responsibility of the APHA and was in favor of establishing an ad hoc committee with this goal.

Leona Baumgartner

The Rockefeller support provided the impetus that led APHA into the broader arena of international health. Baumgartner would later play a key role in strengthening health activities at USAID and setting in motion the eventual evolution of international health activities of APHA.

At the February 20, 1959 Executive Board Meeting, Executive Director Berwyn Mattison presented an initiative for APHA to establish a new Program Area Committee (PAC) on International Health[5] to do the following:

- liaise with public health associations in other countries
- aid in formulation of some kind of international union of public health associations
- be a mechanism for exchanging public health research information
- be a mechanism for relating APHA to the World Health Organization (WHO).

The report of the meeting states that the proposal for another PAC was met with some resistance because of conflicting roles between sections and the various board PACs. A key issue was the fact that many sections were not represented on the board making communication and presentation of their interests difficult. The fact that PACs had staff support while sections did not was also an issue. John Porterfield, chair of the Executive Board, and Malcolm Merrill, APHA president, studied the issue along with a board committee including Herman Hilleboe, Abraham Horowitz, and Estelle Ford Warner. Their findings recommended the establishment of the PAC/IH, which was approved at the October 1959 meeting of the Executive Board. The leaders also believed it was important that this Program Area Committee on International Health be chaired by a person who was vested and experienced in international health activities. Fred Soper, director of the Pan American Health Organization (PAHO), was selected as Chair and committee members included Gaylord Anderson, Jessie Berman, Herbert Bosch, Frank Boudreau, L.T. Coggesshall, Henry Van Zile Hyde, Estella Ford Warner, and John Weir. While the issue of having an international effort was solved, the structural weakness of inadequate representation and difficult communication channels for many APHA sections was not resolved and would continue.

Berwyn Mattison

The Committee on International Health (as the PAC/IH came to be known) reported in 1960 that a potential international partner for APHA was the Inter American Federation of Public Health Associations (IAFPHA) established in 1925 with headquarters in Mexico City, Mexico. As the IAFPHA was meeting December 5-10, 1960, the Board designated Philip Blackerby and Eugene Campbell to attend as representatives of APHA. Soper cautioned that to provide for an effective international network would require resources and an organizational base that was currently absent. Thus this effort was not an initiative that an APHA staff member could carry out. Soper's observation may explain why no action was recorded regarding an official partnership.

Insight on the Links between APHA and USAID

By 1963, Leona Baumgartner had been appointed USAID assistant administrator for Technical Services where she led USAID in broadening international interaction in health. In November 1965, Malcolm Merrill joined USAID as deputy assistant administrator for Health, Population and Nutrition and Lee Howard served as deputy. These two public health officials listened to the concerns of many developing country members of WHO as they cited their urgent needs for rural health systems. In response Howard developed an approach called the DEIDS project (Development and Evaluation of Integrated Delivery Systems) that was endorsed by Merrill. The work of these two pioneers during their three years together at USAID would provide a unique vision of rural health and also have significant impact for APHA.

Lee Howard being sworn in at USAID as director of Malaria Programs by Ed Lapham and witnessed by Assistant Administrator Leona Baumgartner in 1964. Howard would become director of health from 1967 to 1981.

The World Federation of Public Health Associations, WFPHA

APHA continued its efforts through the Committee on International Health to establish and strengthen the various public health associations in other countries. In 1966, at its 94th Annual Meeting in San Francisco, APHA sponsored an initial meeting of delegates from 13 different foreign counterpart associations to discuss and plan for a new international entity.[6] The Executive Board Meeting of February 1967, chaired by Myron Wegman, approved the next step in the process. The first meeting would be in Geneva, Switzerland in May and provided for three delegates from each organization, plus an application fee for membership (just under $2,000). The board voted to send Berwyn Mattison, Malcolm Merrill, and Carl Taylor as APHA delegates. In May 1967, during the occasion of the World Health Assembly in Geneva, Switzerland, a group of delegates representing 32 national public health associations convened and established the World Federation of Public Health Associations (WFPHA) with 16 core member associations. The efforts of Hugh Leavell and Ernest Stebbins were instrumental in this formal establishment of the WFPHA. This new global organization culminated the international vision set in 1959 by Mattison and Baumgartner and APHA celebrated this achievement and acknowledged the efforts of the Committee on International Health at the 95th APHA Conference.

APHA contracted with the Council of International Organizations for Medical Sciences (CIOMS) based in Geneva, to provide temporary space for the new federa-

tion, and the Royal Society for Public Health of the United Kingdom provided funding support for the first year. WFPHA evolved, according to many APHA members, as a predominantly European organization. However, APHA assisted in the growth of WFPHA from the original 16 core members to 67 member associations in 2003, and has provided unwavering support to WFPHA over its 36 year life span. This is also reflected in the numbers of APHA staff who have served as Executive Secretary of WFPHA including Hugh Leavell (1969-1972), Thomas Hood (1972-1974), Russell Morgan Jr. (1974-1979), Susi Kessler (1979-1988), Diane Kuntz (1988-1998), and Allen Jones (1999-present). In November 2002, WFPHA President Theo Abelin, when citing WFPHA accomplishments as a scientific network, indicated that the organization was poised to expand beyond networking, publications, and standard setting and take on a more robust advocacy role to improve health policies nationally and globally.


Malcolm Merrill

In 1968, APHA established the domestic focused Community Health Action Planning Service (CHAPS) and Malcolm Merrill joined APHA staff as its director. Within a year requests for international assistance were received from numerous countries and APHA would begin international activities the following year along with liaison activity in support of the WFPHA.

New Vision for APHA

In April 1969, the two-year study of the APHA Conference on Association Functions, Organizations and Relationships (CAFOR) culminated in the establishment of a new structure and vision for the Association. A sense of the global thinking at that time, particularly of the APHA leaders, is reflected in excerpts from Russell Train's plenary address.[7] He quoted from columnist Russell Baker's article on the moon landing saying "the reason we reach the moon with such efficiency, alacrity, and elan was precisely because the odds were against it. The possible things like cleaning up our air, water, and slums are not challenging enough, such tasks bore us." Train proposed a broader view of public health, a recognition that involves the total public and its habitat, not just a condition or disease. He considered the entire earth as man's home and not just the little piece of turf where you hang your clothes and eat your meals. The winds of change were in the air, and in 1973, Train would become the second Administrator for the new Environmental Protection Agency (EPA) established in December 1970, when the federal government transferred environmental programs out of the Public Health Service. This was an historic point in public health history as it marked the fork in the road where environment and public health took separate paths.

APHA was changing too as evidenced by the remarks of another key visionary, Lester Breslow, in his 1969 presidential address.[8] Breslow spoke of the slow change in the pattern of health conditions during the 19th century but as the rate of change sped up during the 20th century, a whole new set of health problems emerged corresponding to the advances in industrial technology. He cited three elements in the origin of the health crisis at that time:

- Failure to comprehend the long-term adverse health effects that result from the application of certain technological innovations;
- Continuing reliance on industry to find simple technological solutions to problems identified and the danger of emphasis on production and profits regardless of the cost in health;
- Lack of adequate social mechanisms for the control of current health problems.

Breslow used the example of the roles of machine production and the attractive marketing of tobacco that led to expansion of a highly profitable industry that took a toll on the health of millions of consumers. He emphasized that it took four decades to recognize the problem and three decades to educate the public to reach the point of taking action. It took another three decades for action on tobacco at a global scale when on May 20, 2003, the World Health Assembly invoked their treaty authority for the first time and voted unanimously to support an international treaty to combat tobacco use.[9] The treaty, viewed as one of the more important international public health initiatives, is designed to make it more difficult for cigarette companies to promote and sell their products worldwide but especially in poor nations where smoking rates are still relatively low. While implementation of the treaty in different countries will be a challenge, the decision is gratifying to APHA and the health community as it is based on long-range public health impact.

Implementation of the Vision

APHA introduced a streamlined reorganization in 1970 with a new agenda for social action based on the CAFOR Report. This marked a culmination of the vision and long-term guidance under the leadership of Lester Breslow, Paul Cornely, and Berwyn Mattison. APHA began a proactive year to educate the general public and elected officials regarding air, water, and noise pollution, the relationship between housing and health, and concerted action against the environmental crisis. APHA also raised the issue of widespread gun sales and the reduction of the hazards of homicide, suicide, and child violence.

APHA President P. Walter Purdom and President-Elect Myron Wegman led the effort of social activism and the commitment to influence improved health policy at the national level. The reorganization included a relocation of APHA headquarters from New York to Washington, DC. Executive Director Berwyn Mattison, a visionary leader for over 13 years, retired in early 1970. He was succeeded by James R. Kimmey, who took on the daunting task of the move and implementing these structural changes and policies for the new organization. A labor problem ensued as 70% of the staff declined to relocate to Washington, D.C. This delayed the actual move, which eventually took place in the summer of 1971.

Kimmey described the move and implementation of a new agenda as a "period of unfreezing of the organization

James Kimmey and Myron Wegman — cutting ribbon for new quarters in DC

in an effort to become more influential in health policy." It was also a time of concentration on specific issues such as national health insurance and tobacco. APHA followed a model whereby providing good technical information, APHA could drive a change in policy. Kimmey commented, "We learned in the long haul that it didn't! I was fortunate to have Malcolm Merrill and appointed him head of the Division of International Health Programs (DIHP) in 1970. As a past president of APHA (1959-1960) and former Sedgewick award winner, he brought great distinction to APHA's health efforts abroad. At a critical time he became a venture capitalist who brought in needed resources for APHA while building a successful field activity that also utilized over 500 APHA members as consultants and advisors."

The move to Washington, D.C. turned out to be more costly than originally projected and by 1972, APHA had encountered a severe budgetary deficit. Dues income had dropped to around 50% of budgeted projections and accounting problems revealed a shortfall in financial reserves. Facing a financial crisis, the board initiated a fund-raising campaign to raise $300,000. At the same time Kimmey and Merrill developed a strategy to increase external funding by seeking support from government sources. An historical parallel here is the similar experience of the National Council for International Health (NCIH) community some two decades later. Periods of severe financial stress were problems common to many health organizations and their successful resolution requires the cooperative effort of board and staff.

The Division of International Health Programs (DIHP)

In 1968, Mattison hired Malcolm Merrill from USAID and Hugh R. Leavell, also a former president of APHA and recently retired from Harvard School of Public Health. APHA had received its first research grant in International Health in 1969 from the Milbank Memorial Fund to assess "The Role of National Voluntary Health Organizations in Supporting National Health Objectives." It would become a five-year research project co-sponsored by WFPHA and was first located in the New York City headquarters of APHA. Leavell served as director of the project and Russell E. Morgan, Jr, was hired as the senior health specialist on the project and represented the first full-time staff person hired by APHA exclusively for international health activities. The Milbank project was designed to study and assess the potential of non-governmental organizations, such as traditional voluntary health agencies, to help newly emerging developing country ministries of health in developing and implementing national public health, nutrition and family planning programs. It had become clear in the early days of independence in many developing countries that government resources were extremely limited, particularly those designated to improve "the health of the people" in their broadest context. Community-based organizations that linked local people and resources to development were seen as a complimentary approach to government health services that needed to be strengthened. An interesting note here is that the Milbank Foundation credits this study as helping to launch the broader non-governmental movement in health care delivery in developing countries. Thus APHA played an important role as much foreign assistance is channeled through NGOs in US to NGOs in developing countries.

Hugh Leavell

However, on July 6, 1970, at the request of the new APHA executive director, the office relocated to Washington, DC along with Malcolm Merrill and the staff of the CHAPS project. This began the establishment of the first Washington base for APHA, with the new Division of International Health Programs (DIHP), the CHAPS program, and WFPHA. In the midst of this changing environment there were protracted staff negotiations and loss of experienced people as Kimmey and remaining staff did not depart from New York until the following year.

Russell Morgan

Merrill obtained a grant from the US Agency for International Development (USAID) to supplement the funding from Milbank for the research project on Voluntary Health Organizations. Leavell and Morgan initiated the country studies in collaboration with the national voluntary organizations. Staff analyzed the role of voluntary health organizations in 25 developing countries and established two model demonstration projects in Costa Rica and the Philippines. The project also provided an opportunity for the WFPHA and APHA to work collaboratively with the World Health Organization, and it was during the ensuing period that the WFPHA received "official relations designation" with WHO and several other UN agencies. This official designation allowed the WFPHA to co-sponsor the project with WHO—Geneva and its regional offices. This was an important step for the WFPHA, as it would lead to a future leadership role with the non-governmental community and with the WHO.

Under Merrill's guidance, the division received additional funding for projects in Africa, Asia, and Latin America. The largest long-term contract received by the Division of International Health was for the USAID Development and Evaluation of an Integrated Health Delivery System (DEIDS) project in 1972. The large-scale endorsement of low cost primary health programs by USAID was based on project designs by the developing countries themselves with technical guidance by public health consultants. Lee Howard and USAID looked to APHA as the best vehicle to provide the technical guidance, as APHA was the only professional organization in the US with comprehensive national representation. APHA represented a unique asset that justified USAID doing sole source contracting with it. As a result of his experience within and outside USAID, Merrill was aware of the stringent federal regulations regarding contracts and grants.

USAID policy required a competitive re-examination process prior to each renewal period for contracts/grants. As the funding increased, staff recruitment efforts increased as well to handle such activities as health education programs, promoting voluntary agencies, infectious disease control, population and family planning, maternal and child health, nutrition, and environmental health studies and assessments. APHA also organized numerous study tours for people interested in learning about public health in countries such as Costa Rica, Guatemala, Panama, Japan, the Philippines, and Thailand.

In 1972, Kimmey assigned Thomas Hood, deputy executive director to the division to assist Merrill in the effort to increase the level of external resources. Merrill added Donald Rice, Dale C. Gibb, and Herbert Dalmat to the DEIDS project. Rice would later be assigned to head the CHAPS program. A major achievement, according to Kimmey, was renegotiating the government overhead rate to 86% which eventually generated sufficient resources to ease APHA out of its financial crisis. The USAID support for international activities increased significantly from approximately $500,000 in 1971 to $1.2 million by 1973. A 1972 proposed contract for APHA to evaluate the USAID Population Programs was discussed and the board decided against the project and instead established a subcommittee to review APHA contractual obligations to USAID. Leavell retired in 1972 after three decades of service to APHA.

It is important to describe the pressures of the period as APHA embarked on implementation of the new social advocacy policy that would move the organization into a constructive, confrontational role with the government regarding improvements in health policies. Changes in the health hierarchy of the federal government attracted APHA attention in 1971. In an editorial by Kimmey[10] on the subject of the ouster of Roger Egeberg, assistant secretary for Health and Scientific Affairs at the Department of Health Education and Welfare (DHEW), a key point was that HEW policy formulation and decision-making in health matters passed from professional hands into those of "the grey legion of business men" brought in to manage the federal government's health affairs. Kimmey's editorial reflected the growing concern of many public health professionals that in the areas of environment and health, the federal government was on a path that would weaken and eventually displace trained public health leadership. Additional observations indicated that the American Medical Association (AMA) was opposed to the national initiatives on Medicaid and Medicare spearheaded by DHEW and supported by APHA. As many of the Public Health Service (PHS) leaders were professionally affiliated with the AMA, the differences over this issue created a tension between the DHEW and the PHS leadership. In 1967 HEW Secretary John Gardner established a new position of Assistant Secretary for Health as an organizational layer above the Surgeon General of the PHS. This ultimately changed the decision-making process in public health and was a major concern for APHA. This was the background for Kimmey's editorial and APHA's close monitoring and continued advocacy on the importance of trained public health leaders for these important posts affecting the nations health. The history of that action reveals an evolution over three decades that shifts the operational responsibility of the Public Health Service from the Surgeon General to the Secretary of Health and Human Services.

The Founding of the National Council for International Health, NCIH

As in 1967 with the establishment of the WFPHA, the 1970 World Health Assembly (WHA) was the setting for informal discussions that were the precursor of another interesting initiative. The US delegation included Paul Ehrlich, DHEW, Lee Howard, State Department/AID and Norman W. Hoover, a representative of the American Medical Association (AMA). Hoover, an orthopedic surgeon from Chicago, had recently headed a two and one half year medical school project in Saigon, Vietnam. As a newcomer to the WHA, Hoover inquired about the interest of WHO and the US in sponsoring American doctors for short-term assignments overseas. The discussions during the WHA struck a sympathetic cord and convinced Hoover that there was a far greater public health need in the countries beyond the assignment of doctors. Hoover subsequently obtained approval from the AMA Board in May 1970 to establish a Task Force on International Health to assess the problems of international health and to propose a mechanism by which common approaches could be defined, joint efforts undertaken and limited resources used most effectively.

The twelve member Task Force was chaired by M. Alfred Haynes, Drew Medical School and included many APHA members such as Henry van Zile Hyde, Association of American Medical Colleges; Dieter Koch-Weser, Harvard University; Carl Taylor, Johns Hopkins University; John Weir, Rockefeller Foundation; Leroy E. Burney, Milbank Memorial Fund; and ex-officio members S. Paul Ehrlich and Lee M. Howard. The Task Force met four times during an eight-month period and presented their findings at the Fifth AMA Conference on International Health held in Chicago, Illinois in September 1971. The AMA Board approved the recommendation establishing the National Council for International Health (NCIH) and a General Assembly of International Health Agencies to provide a regular meeting place of all interested organizations and individuals. The latter became the NCIH Annual Conference with its emphasis on achieving an open forum and finding a basis for consensus on international health issues. The AMA also approved funding and provided secretarial support for a three-year period to allow NCIH to become viable. While NCIH was not Norman Hoover's idea, his leadership brought about AMA support for the study group that culminated in NCIH.

Ten organizations were invited to be founding members and to have permanent seats on the Board of Directors. Through the efforts of Carl Taylor and Malcolm Merrill, APHA was one of the ten founding members. The original board members were American Dental Association (ADA), Victor H. Frank; American Hospital Association (AHA), Robert M. Farrier; American Medical Association (AMA), Burt L. Davis; American Nurses Association (ANA), Hildegard E. Peplau; American Public Health

Association (APHA), Malcolm H.Merrill; American Society of Tropical Medicine and Hygiene (ASTMH) Franklin A. Neva; Association of American Medical Colleges (AAMC), Henry van Zile Hyde; Association of Schools of Public Health (ASPH), Carl E. Taylor; National Council of Churches(NCC), William L. Nute and the National Medical Association (NMA), George Tolbert Ex-officio governmental agency members and representatives included Office of Assistant Secretary of Defense, Health and Environment (DOD), Bedford H. Berrey; Office of International Health (DHEW), S. Paul Ehrlich; Office of Health Technical Assistance Bureau, (Department of State), AID Lee M. Howard and Deputy Assistant Secretary of State for Medical Services, George I. Mishtowt. General members, who also served on the board with the founding group were: Leroy E. Burney, Milbank Memorial Fund; James P. Hughes, Kaiser Foundation International and Wilfred Malenbaum, Wharton School, University of Pennsylvania. APHA sponsorship of NCIH was announced in the August 1971 issue of *The Nation's Health*.

Carl E.Taylor served as the first volunteer chair of the NCIH from 1972 to 1974 with Malcolm Merrill as Vice Chair and Henry van Zile Hyde as Secretary Treasurer thus establishing a strong early link between NCIH and APHA. Henry Feffer became volunteer chair in 1975 and obtained funding and partnership support for NCIH from the Institute of Medicine (IOM), USAID and others. Joe Perpich, IOM, provided administrative and secretarial support to NCIH and Lee Howard, USAID, was instrumental in obtaining longer term grant funding for the fledgling organization. As a result of this early support, the NCIH was able to begin work on the gathering of information on non-governmental organizations in the US and to search for sources of funding to support the organization.

The organizational structure of NCIH was patterned after the AMA House of Delegates and included a 21-member board with ten slots permanently reserved for the founding organizations. Later the board would expand to a total of 32. Most of the key individuals saw a need to maximize the effectiveness of the many organizations working in international health. The group particularly promoted active communication, partnerships, and cooperation. Feffer and others recall that a few members of the core group still saw things in terms of the interests of their own academic or professional institutions rather than the bigger picture. This point provides a key insight to differences in perspectives between boards and staffs that both APHA and NCIH encountered from time to time. The first NCIH conference on "Health Care Systems and Human Values" was held April 25-27, 1973 and was chaired by Taylor. Feffer, would serve as facilitator, host and keeper of the annual minutes until 1979 when NCIH became incorporated and would appoint a salaried President. At the same time the DIHP at APHA was in full swing and the creation of a section on international health had not yet crystallized.

APHA Leadership Shift

From 1972-73, Kimmey encountered resistance and policy differences with board members over priority issues. The State Affiliates were concerned with local domestic issues and were not as interested in federal policy as were the leaders of APHA. Kimmey described this intensive period as leaving little time for interaction with board members. He believed that the external backdrop of the Vietnam War and the nation's Watergate crisis served to undermine confidence in the federal government and its policies and this influenced the thinking of some new board members. Kimmey observed that this growing concern with government policies and the organization's acceptance of government funds would trouble some board members for decades. On February 1, 1973 James Kimmey would leave APHA for a state government position in Wisconsin and he would also assume the presidency of the WFPHA for 1973.[11]

On June 1, 1973, William McBeath became the executive director of APHA, a position he would hold until November 1993. In the Executive Director's report to the board in the fall of 1973, McBeath reported that the DIHP activities had grown rapidly under the impetus of several contracts from USAID. He further noted that while the contracts supported a wide variety of DIHP activities, the funding was mostly out of the AID population accounts. This revelation generated significant board discussion and interest regarding the USAID contracts. Some board members were concerned over the use of population funds for health activities and others wanted an internal policy review process for prior approval of contracts and grants. Despite the fact that these activities had been developed under the aegis of the Committee for International Health and provided needed overhead income, members of the APHA Program Development Board and its Population Council believed the review process within APHA for screening contract proposals was inadequate. A decision was made that the Executive Committee serve as a review committee for all contracts undertaken by the association.[12]


William McBeath

In the meantime USAID officials were pleased with the success of APHA activities under DEIDS and staff additions included Alberta Brasfield, Jason Calhoun, Eileen Crawford, and Robert Lennox. An observation by Lee Howard was that APHA / DEIDS activities were unique at that time as no other international organizations, including WHO, had proposed or funded such activities. For example, in 1974, APHA started a demonstration project in the Lampang province of Thailand, which was an early model of community participation later applied to all of Thailand and was used as a teaching model for WHO member countries in South East Asia for sustainable development. A cadre of trained local health workers, with the support of the Thai government, were able to assume the delivery of integrated services in maternal and child health, family planning, and nutrition to a community of 650,000 people. Similarly many members of the APHA Medical Care Section were initially supportive of the division's activities because of their interest in the way medical care was organized in the countries and the different ways countries structured and financed their health systems. However, their interest and support waned over time as the division

became more involved with primary care public health projects. There were fewer advocates for the public health practice activities of DIHP on the board who saw the value of different approaches to specific medical interventions. The success of the APHA projects resulted in continuing increases in government funds through USAID. Merrill and the DIHP staff increased efforts to diversify funding from other sources for APHA.

This transition from Mattison to Kimmey to McBeath marked a shift in the dynamics, relationships, and interests of the Executive Board with the APHA/DIHP staff. Previous board members, supportive of the division's work, rotated off the Executive Board and the Committee on International Health (CIH). New voices on the board raised concerns and more detailed interest in APHA procedures for screening and approval of the contract/grant application process for DIHP. This perspective may have reflected the competing pressures for dwindling resources among the specialty professions within public health. However, from a management perspective such detailed involvement of board members, even in the best of circumstances, can severely impede an organization's ability to actually obtain a grant/contract. Over the next few years, the framing of debates at board level would change with board rotation leaving fewer advocates for the division's international field activities. By 1974, APHA membership growth was low and dues represented 43% of income. The Membership retention rate was down to 68%. This drop in core income magnified by the exceptional growth of USAID funding to the Division of International Health Programs drew board attention as these funds dwarfed the APHA membership income by a factor of 3 to 1.

The External Environment

A July 1974 editorial by McBeath in *The Nation's Health* provides insight to the external environment of this troubled period. The editorial cites a series of surveys conducted by the Center for Political Studies from 1958 to 1974 indicating that Americans' trust in government has fallen sharply with striking evidence of lost faith in the political system as well as an erosion of confidence in social institutions. Also an Opinion Research Corporation survey for the American Society of Association Executives indicated that only 53% of association members polled indicated favorable attitude toward their associations. Large associations such as APHA and others classified as professional received the most member criticism. The prolonged effects of the Vietnam War from 1961 to 1970, the Watergate incident in 1972, followed by the OPEC Oil Embargo in October 1973 and the resulting energy crisis were some of the external distractions that had a significant impact on the country. The resignation of President Richard Nixon in 1974 added to the prevailing mood of the nation that would deeply affect the health professionals and their views toward government. This would influence the introduction of political aspects to board debates and strong rhetoric regarding government policies.

The Executive Board

The International Health Activities Report to the board in November 1975[13] describes APHA efforts to develop a program for diversifying the sources of funds for international health. APHA had arranged a conference of representatives of US private sector organizations that included corporate executives. The subsequent report to the board in 1976 included the exciting news that a private sector group of CEOs from that previous conference in 1975, had already responded by coming together again to create an inter-organizational task force called the International Health Resources Consortium (IHRC). From an historical perspective this was a momentous coming together of the private and corporate sectors with APHA and represented a seminal opportunity for a unique public health partnership. The group included: Ambassador True Davis; Paul Entmacher (Vice President Metropolitan Life Insurance Company); Virginia Gordon (Vice President, Celanese Corporation); James Grant (Director, Overseas Development Council); Howard Hiatt (Dean, Harvard); Morton Hilbert (President, APHA); Van Holden (President, Rockefeller University); Leon Marion (Executive Director, International Association of Voluntary Organizations, IAVC) Frank Pace (President, International Executive Service Corps, IESC); Frank Picker (Dean, Columbia University); Ormsby Robinson (Vice President, IBM); Frank Stanton (President, CBS); and conveners Clarence Pearson and Russell Morgan.

APHA was invited by IHRC to become a member and George Silver (CIH Chair) and Morton Hilbert were asked to serve as co-chairs. The role of the IHRC was to educate corporate leaders on the value of investing in the public health infrastructure for developing countries. An initial project was developed by APHA in cooperation with Alcoa in Jamaica. The IHRC was ready to move quickly to solicit funds and had proposed that APHA be the official recipient of any monies received. This was a moment in time where APHA could have facilitated a different path for national and international cooperation and financing for public health. The innovative approach had significant potential for the future of international public health. It presented APHA with an opportunity to assume a prominent role in assisting struggling Health Ministries around the globe with a mechanism for diversified resources and just as importantly balanced partnerships in delivering health services.

Russell Morgan presented a staff recommendation that an APHA foundation be established for the purpose of receiving the IHRC funds. Some board members simply rejected the idea of establishing corporate partnerships as suggested by the IHRC. One board member referred to the proposal as "cultural imperialism." McBeath reminded the board that APHA initiated this activity when they facilitated the formation of the inter-organizational task force in 1975. The task force was viewed as a mechanism to continue joint activity among those interested and the formation of the IHRC was an unplanned result of bringing these corporate leaders together. Merrill assured the board that the IHRC was not intended to encourage provision of medical care by the voluntary sector in developing countries. Rather it was developing cooperative mechanisms for supporting people in general and voluntary groups to par-

ticipate more responsibly in public health program development. Although not formally rejected, the board deferred and requested that APHA restudy the proposal and clarify purposes and processes. Despite the support of APHA President Hilbert, this cool reception by various vocal board members was a huge disappointment and major setback for the DIHP, WFPHA and ultimately international health.

This was a lost opportunity for APHA to explore a global vision through a truly unique partnership with organizations that could really help the Association's mission on a global scale. The board constraints in effect placed a governor on the creativity of APHA/DIHP in exploring private sector partnerships and seriously limited further proactive efforts for alternative funding. Other board members and staff realized at this point that without a constituency to demonstrate the presence of significant support within APHA for international health, it was very possible that the international health programs operated by APHA would be in serious jeopardy and possibly eliminated. An interesting point here is that within two decades the Public Health Service Centers for Disease Control (CDC) would utilize the same strategy of establishing a foundation as a mechanism to accept funding from private and corporate sources.

International Health Research Consortium Meeting in 1976. From left Frank Pace, IESC; Clarence Pearson, Metropolitan Life Insurance; Howard Hiatt, Harvard University; True Davis, Ambassador; Russ Morgan, APHA; Virginia Gordon, Celenese Corporation; Frank Picker, Columbia University; Van Holden, Rockefeller University; Leon Marion, IAVO.

USAID support for the work of the Division of International Health Programs continued as the four main contracts were for multi-year terms. DIHP activities and staff continued to grow and Barry Karlin was added to head the education and health promotion activities. In January 1977, APHA published the results of a two-year study on 180 primary health care projects in 54 countries, called "State of the Art Delivering Low Cost Health Services in Developing Countries." APHA staff assisting Karlin in this effort included Alberta Brasfield, Shelley Buckwalter, Eileen Crawford, Cecelia Doak, Robert Emry, Kenneth Farr, Dale Gibb, Reginald Gibson, and Carol Pewanick. Many of these staff members would move on to become key leaders in government and private sector organizations. This led to the creation of a computerized database of some 500 projects in developing countries. Other activities of the division included a computerized roster of professional resources, two popular newsletters, and a series of cutting edge monographs. The newsletters included *Salubritas*, focusing on sharing innovative country systems for delivering health services that had a distribution of 10,000 copies per issue in English, Spanish, and French, and *Mothers and Children*, covering infant feeding and maternal nutrition. Topics in the monograph series produced by the division, included health economics, health auxiliaries, pharmaceuticals, water and sanitation. A contract from the Peace Corps provided funds for publication of a manual for starting Community Health Education Projects in Developing Countries. Consultants contributing to the manual included Pam Straley, Uyen Nyoc Luong, Diane Hoffman, and Mary Jo Kraft. These innovative publications were based on field projects and activities of health workers in their own countries, a concept that was new. Previously universities active in the countries published their research under their own banners. APHA published field-based activities highlighting local country nationals as a service important to people working in the field. The DIHP practice arm of public health was thus highly regarded by many countries and served as a model for the international community. APHA developed an international based network and deployed an estimated 750 consultants.

APHA's external funding for international activities continued to grow significantly from 1975-1977, compared to the relatively sluggish dues income. This caused some angst and displeasure among representatives who ascended to the APHA Board. New voices on the board were more vocal in opposing USAID funding for APHA while others were simply opposed to APHA receiving any government funding. Political issues entered the discussions as board members raised concerns regarding US government international policies and others were conflicted by the pressures of their own organizations competing for funding.

These discussions introduced new debates at the board level. Section leaders continually raised concerns over their lack of adequate representation on the board and the difficulty of communications with the board over various section issues and priorities. The problem of external funds being out of equilibrium with core funds was a legitimate management concern as was the importance to APHA of the overhead income from the government funding and the value of the activities. However, these facts appeared overshadowed in board discussions as voices that opposed government funds lobbied that they compromised the independence of APHA and tainted the organization.

One member of the board, Vicente Navarro, raised objections to what he perceived as the close working relationship between APHA division staff and staff at the State Department (USAID) because it reflected poorly on APHA. His position was that to be a leader in international health APHA could not receive funds from the US government. Navarro proposed closer supervision over the division by the Executive Board or the outright discontinuance of the division's international activities.[14] His interventions introduced a difficult and stressful period for APHA decision makers. The increased numbers of members from new and evolving professional disciplines presented an array of new and different ideas. The record also reveals part of this change included a significant loss of old members, particularly those who supported the international activities of APHA, as retention rates were poor. The lingering debate, contained in fascinating accounts in the minutes of board meetings and committee reports from 1975 through 1976, diverted board attention from a sub-

stantive discussion of the innovative and seminal ideas proposed by the Division for International Public Health. Instead of supporting the international health leaders, the board deferred and initiated several studies and evaluations involving special committees examining the division's activities and reviewing the appropriateness of APHA relationships and independence from USAID. The outcome of all these evaluations supported the work, the relationships and funding sources for the division and concluded that they were very valuable and that APHA should continue to support them.

The Executive Board moved to continue support of the Division through the CIH.15 However, the after effects of this controversial experience would ultimately undermine the APHA's international health activities and staff for the future. The passage from APHA member through the portal of APHA board official did not always result in a change to a broader orientation or perspective for APHA.

During this period there were legitimate external stresses as APHA leaders were involved in an important international human rights effort to free six health workers who had been detained, jailed, and persecuted in Chile. Hugo Behm, APHA vice president for Latin America, was released from prison in October 1975, due to APHA's extensive advocacy efforts. A special board task force chaired by Paul Cornely continued pressuring both the Chilean and US governments regarding human rights of the remaining health workers. It was these differences and concerns over US policy that led to questioning the appropriateness of APHA accepting any funding from government.[16]

Formation of the International Health Section (IHS)

Merrill together with staff recognized this changing perspective on the board and determined that a supporting constituency was necessary for the future of the division. Merrill requested Morgan to form a working group to develop such a constituency within APHA. The group included Eugene Campbell, USAID; Mary Jo Kraft, HHS: Russell Morgan Jr., DIHP; and Clarence Pearson, Metropolitan Life Insurance Company. The group's effort included a survey instrument for determining member interest and support for a new section. Met Life provided funding to underwrite costs for printing and mailing the survey to several thousand APHA members. The resultant database of over 700 potential members demonstrated significant interest in international health, providing a basis to take the necessary steps for creation of an international health section.

The effort was reinforced by a number of APHA members including Janet K.Anderson, Robert Bowers, Leslie Corsa, Paul Ehrlich, Elizabeth Hilborn, Helen Martikainen, Lee Howard, Clifford Pease, Hildrus A. Poindexter, and Virginia Worsley, and the board approved an International Health Section in late 1976.[17] Carl Taylor, who had chaired the Board Committee on International Health from 1967 to 1970, and who had served as the first chair for NCIH in 1971, was elected as the first chair of the new section. IHS initiated their first newsletter in early 1977 and developed a logo for the section. The IHS initiated an effort within APHA to influence an awareness of the importance of international health to domestic health and this mission would be reflected in the program of the 1977 Annual Meeting, the first in which IHS would participate. One of the presentations by the IHS was "What America Can Learn From Other Countries About Shaping National Health Policies," that would become a staple for many future international sessions and reflects the basis for an IHS.

Photo Carl Taylor, APHA and James Grant, UNICEF during a field visit in China in 1984.

At the same 1977 Annual Meeting, Peter Bourne, special assistant to President Carter, spoke to the new International Health Section members on "US Global Health Strategies in an Age of Interdependence." Bourne stated that a national health policy for the United States would not be fully effective unless coupled with development of a strong US international health policy. He stressed the need to reorient government and multilateral development strategies to affect health needs, to dispel the welfare image of international health assistance, and to reinforce and emphasize economic development. His comments were based on a draft White House Report that his office was preparing that analyzed how the full potential of diverse programs and resources in biomedicine, food, population, trade, and related foreign policy areas might be brought to bear on improving the health status of US citizens and foreign nationals. At that time 22 agencies were involved in international health and their efforts were only marginally related to one another. The comprehensive 350-page report was introduced in 1978, as the plan for international health during the Carter Administration.[18] The plan was not fully implemented as a change of administration occurred in 1981. While most IHS members present at this kickoff session of the section were very much in tune with the Bourne approach, they were a minority within APHA.

Initially, other section leaders were concerned that the new IHS would compete with their own global interests as a number of sections had members who were active international experts. Paul Ehrlich states that the international attention within the APHA membership continued to be minimal and that the section worked diligently to urge the APHA members to look beyond domestic issues and to develop a more international outlook. There were many other sections in APHA that had members who were involved in specific international activities such as communicable diseases, population, medical care, maternal health, and nutrition. Initially the IHS leadership was able to interact with these sections and gain their support but this required a continuing effort that ebbed and flowed over the ensuing years. Since then most other sections have developed an international unit or competency on their own. From the proliferation of specialty areas in health amid dwindling resources a pattern of competition emerges

rather than one of reinforcement of all the various components to the health system. None-the-less, the new section began with 345 members and would grow to over 600 the following year.

Oversight Role for the Committee on International Health

At the time the Executive Board approved the creation of IHS, it did not reassess the role of the Committee on International Health (CIH) but rather increased its powers by giving it broad oversight of the Division of International Health Programs. This marked a more formal relationship as the Board assumed a monitoring and operational role over the DIHP staff. The division had grown to a 33 person staff and developed a strong image and reputation that was reflected in the field programs. APHA received substantial overhead income as the division achieved a significant record of success under Merrill and USAID funding grew to $3.8 million by 1977. This also provided APHA's public health practice activities a significant comparative advantage over other organizations in international development. Malcolm Merrill retired from APHA in July 1977 and was succeeded by Susi Kessler. Under the new arrangement, CIH Chair Milton Roemer worked closely with Susi Kessler over the next five years until he stepped down as chair.

WFPHA

Change was occurring at the global level as well. The multinational agencies were looking with renewed interest at the role of voluntary organizations in health. As a result of the Milbank/USAID funded project for voluntary agencies it became clear that non-governmental organizations were critical to the development process and needed to be strengthened in developing countries. They were seen as core elements of democracy and thus were an alternative to providing support to national governments who were in constant transition. This new development assistance direction became accelerated in the family planning field and in the areas of child health, nutrition, and environmental health. The research work led to WFPHA and its members, particularly APHA and the Canadian Public Health Association (CPHA), being recognized as leaders in the field of NGOs in public health.

In May 1977, WHO and the United Nations International Childrens Fund (UNICEF) invited WFPHA to take the leadership in coordinating the views of the non-governmental community and develop a position paper on primary health care for presentation at the UN International Conference on Primary Health Care in Alma Ata, Kazakh SSR, in September 1978. The Milbank/USAID project provided APHA/WFPHA a solid base for writing the position paper. To develop this consensus the WFPHA organized its second triennial congress in Halifax, Nova Scotia in May 1978. The congress report, "Non-Governmental Organizations and Primary Health Care," was finalized and printed in six languages (Arabic, Chinese, English, French, Russian, and Spanish). WFPHA President Gerry Dafoe was invited to make a formal presentation of the final paper to all of the government and non-government delegates attending the Alma Ata Conference. This was major recognition for both APHA and the WFPHA and it represented the first time that a non-governmental organization representative was permitted to make a formal presentation to the WHO/UNICEF government delegates. Linda Vogel (HHS), commented that Alma Ata established APHA as an important player in international health and the APHA/WFPHA partnership changed the direction of global health. It was also a testament to the dedication and effort of the APHA staff of Merrill, Leavell, and Morgan nine years earlier. Another outcome of the Milbank/USAID funded effort provided the WFPHA/APHA staff to establish new contacts and relationships that helped strengthen national public health associations in many countries around the world.

NCIH

In 1978, the NCIH Board of Directors determined that they needed to hire a full time president in order to move from being a totally volunteer and networking group with an annual conference to a professional association. In April 1979, Russell Morgan left APHA and became the first paid president of NCIH, serving for 14 years. The Pan American Health Organization (PAHO) initially provided office space for the organization and USAID provided a grant to help US private voluntary organizations (PVO) become more effective in primary health care. NCIH started with a budget of $8,000 that would increase to over $ 1.5 million during Morgan's tenure. Over the next ten years, NCIH would play a unique role in international development building a base of 122 member organizations into an effective coalition. Lee Howard relates that the NCIH was effective in mobilizing and developing financing mechanisms for the PVOs. The annual conference would become a premier event in international health involving world and national leaders from congress, governments, and the PVO community. It would develop an "Action Agenda" around a specific health issue and generate coalition action through education, advocacy, and follow up to improve policy and increase international funding for child survival, communicable diseases population, environment, and women's health.

NCIH, supported by funding from USAID, developed an AIDS initiative that mobilized an informed global network of advocacy organizations that helped to raise awareness and international funding for AIDS activities. It also diversified its funding, which brought in base grants from a number of private foundations. Taking the concept of "Bringing International Health Back Home," the NCIH network with partners in the various regions of the US documented and incorporated many "Lessons Without Borders" in a publication entitled "Global Learning for Health." Clifford Pease and Jack Geiger introduced the "Lessons Without Borders" concept at an NCIH brown bag lunch in 1983. During this period many IHS members also joined NCIH as members and the relationships at this membership level were excellent as evidenced by the IHS regularly scheduling sessions during the NCIH Conference. The first international challenge faced by the fledgling NCIH was a result of the Cambodian crisis.

NCIH was asked to mobilize health volunteers to be assigned for short term stays in Cambodia. Graham Fralick managed the NCIH project for its duration.

A short time later, James Cobey, director of the volunteer organization Orthopedics Overseas (OO), contacted Curtis Swezy of the NCIH staff and an administrative contract was arranged to enhance the capacity of the voluntary NGO in deploying teams of orthopedic physicians, who paid their own way in providing six-week rotational services to countries such as Peru, Bangladesh, and Vietnam.

Russell Morgan and Mother Theresa at an NCIH Conference in 1989.

Nancy Kelly was hired as an intern to support the project, allowing NCIH to expand the program to other disciplines by developing a database of physicians, nurses, laboratory staff, and various health practitioners for this purpose. After several years of continuing growth and expansion to other countries, this program became a separate country-oriented entity called "Health Volunteers Overseas."

Challenge for DIHP

Kessler describes her Division of International Health Programs role with the Committee on International Health and the International Health Section as an organizational challenge because the roles and functions of each were fuzzy. With the creative tension between the CIH and the IHS, she saw her role as a buffer among the three to facilitate communication because there was no direct linkage between the board committee and section. She stated that her primary task beginning in 1979 was supporting WFPHA, as there was an APHA budget allocation for that activity. During her ten-year tenure she reported that APHA did not allocate an annual budget for the international projects or project development. Thus the activities of the division were severely limited to those activities supported by the external grants and multi-year contracts. This left no funding available for project development. She indicated there was a real hesitancy by APHA leaders to invest core resources in program development. Further, by 1980, a number of key staff had departed from the division leaving experience voids in a number of key areas. In 1981, CIH Chair Roemer recommended that APHA add a badly needed position to the 1982 proposed budget to address the division's lack of expertise in project development. The board deferred on adding a staff position and the result created a gap that left the DIHP staff ill equipped to successfully compete for project grant funding. A final evaluation of the division in 1982 indicated dwindling staff morale that eroded the division's capacity to maintain its momentum and to cope with future changes. Some funding was obtained from the Aga Khan Foundation and UNICEF provided for a series of issues papers in July 1983 on Health Education and Training of Community Health Workers. A number of IHS stalwarts who provided consultant services to the division included Julius Bud Prince, Dory Storms, and Curtis Swezy.

J. Henry Montes, a member of the board, describes the years from 1976 through 1988 as a roller coaster period for APHA leaders as changes of government administrations brought about dramatic philosophical shifts. As an example of the growing angst with government policies, he cited the fact that Eugene Babb and Steve Joseph, chair elect of the IHS, resigned their government positions at USAID on principle in 1981. The issue was that the US government cast the lone negative vote against the *WHO Code on Marketing Infant Formula*. APHA had actively supported the code during its 1979 to 1981 involvement in the committee review process with WHO. The last minute turnabout by the Reagan administration created serious dissatisfaction within the health community and further affected relationships with the government. Montes, chair of the APHA Equal Health Opportunity Committee, was particularly concerned with the Reagan administration's position on affirmative action and dedicated his efforts within the committee to improving the program in APHA.

Expressing concern about the significant drop in staff and resources in 1983, IHS Chair Dieter Koch-Weser raised the question of viability of the Division of International Health Programs.[16] Was it a viable entity or should it be changed? The response by Kessler was that it would be difficult to remain viable, as its largest AID contract, DEIDS, had been extended 15 months through April 1984, but with a substantially reduced budget. It was noted that the Association of Schools of Public Health (ASPH) was competing for the renewal of the same contract and there was concern that if APHA was awarded the contract that they would be required to sub-contract with the ASPH. Kessler reported that the Caribbean activities, Infant and Maternal Nutrition Newsletter, UNICEF activities, and water sanitation projects in Swaziland had sufficient funding to be maintained. The IHS leaders expressed their concerns about the future of the division with APHA Executive Director McBeath. The Chair and IHS team were reminded that the Committee (CIH) had a watchdog role over the division activities while IHS did not. It was pointed out that while a member of a section may be on the committee or board, sections are not responsible for the activities of APHA. This response made it clear that without IHS representation on the board, IHS views, particularly those supportive of the DIHP, had little impact on APHA leaders and their decisions. After working diligently to establish an international health constituency within APHA there was a sense of powerlessness among the IHS members.

Similar comments from various people in leadership positions at that time indicate there was a desire to keep APHA independent of the government. This, along with the lack of representation of IHS at the board level, was believed to have precluded a fair and open hearing on the importance of the division and its extension of public health practice to the countries. Added to the stress and strain of the time, the rules of the government grants had changed in 1982 from national categorical grants to block grants for states with reductions in available national allo-

History Timeline

1955
APHA Health Education Council requests approval to join the International Union of Health Education for Public Health-Board Denies request.

First Resolution on International Health passed by APHA

1959
Rockefeller Grant awarded to APHA

APHA Program Action Board establishes Committee on International Health (CIH)

1961-1973
Vietnam War

1967
APHA provides impetus for establishment of World Federation of Public Health Associations (WFPHA)

50's

1968
APHA establishes Community Health Action Planning Service (CHAPS)

Malcolm Merrill hired as Director of CHAPS

Hugh Leavell becomes Executive Secretary of WFPHA

1969
Milbank Memorial Fund awards grant to APHA to study the role of Non Governmental Organizations in health

1970
APHA reorganization-social action strategy adopted

Division of International Health Programs (DIHP) created

First USAID contract awarded to DIHP

60's

1971
National Council for International Health (NCIH) established with key role played by APHA members

1972–1974
Watergate Scandal

1973
OPEC Oil Embargo

Board Subcommittee reviews APHA-USAID relationships and recommends development of international programs

1974
Energy crisis and resignation of President Nixon

70's

1975
APHA Board Members voice growing concern over USAID government funding—CIH Program Review recommends larger APHA role in International Health Policy—Board instructs Executive Board conduct a thorough review of international activities

1976
Board defers International Health Resource Consortium invitation for partnership

Opportunity to establish an APHA Foundation to receive resources proposed—Minority recommendation of special committee on IH recommends abolishment of DIHP—not accepted by board but need for a supporting IH constituency apparent.

International Health Section (IHS) approved by APHA Board to provide an IH constituency

1978
WFPHA/APHA lead NGO participation at UNICEF/WHO Alma Ata "Health for All" Conference

1979
NCIH hires full time President and receives funding from USAID

80's

1981
US veto at WHO on marketing code for infant formula criticized by APHA

90's

1983–1987
USAID grants to DIH decline precipitously during period when DIHP lacks project development expertise

1988–1989
IHS redefined and develops active advocacy and strategic planning efforts

00's

1997
APHA initiates fundraising and partnerships with private and corporate entities

2000
WFPHA—leads a reassessment of Alma Ata and a Call to Action re-primary care strategy

2003
New opportunity for APHA to assume leadership role in global health

cations. The competitive process for winning grants favored aggressive coalitions and partnerships with experience in writing project proposals and understanding the rules and regulations of government grants and contracts.

At the November 1983 Annual Meeting in Dallas, Texas, APHA reported a dismal fiscal picture with a decline in book sales, decline in membership to 29,268, and a decline in attendance for the meeting. The Executive Director's report stated that a joint bid by APHA and Harvard for a successor activity to the Accelerated Delivery Systems Support (ADSS) project was lost to Management Sciences for Health (MSH) which was awarded the international contract. IHS then turned to what it could control by urging its members to contact their congressional representatives to advocate for increases in the budget allocations for USAID international development assistance. IHS promoted the concept of the interdependence of the United States and other countries in the practice of international health. The IHS section during 1983 aggressively engaged in advocacy dialogue supporting increasing government allocations in international assistance and collaborated with NCIH for their annual conference on Traditional Healing and Contemporary Medicine.

It was not surprising when McBeath reported a 55% reduction of USAID contract extensions. APHA could no longer rely on its accomplishments and sole source provider status quo with USAID. By 1983, the Division of International Health Program's support from USAID fell sharply to under $3 million and in July the Executive Board requested a review on the future of International Health Programs and a working group provided a plan of action.[19]

External funding support for the division was in free fall by 1984.[20] An IHS report during the November 11-15, 1984 Annual Meeting in Anaheim, California, indicated that $100,000 was allocated from core association funds to DIHP, however without project development expertise APHA was at a disadvantage. The rise of competing non-governmental and for-profit entities and the interest of government agencies to disperse their funds to different organizations simply raised the bar for APHA. Although CIH, chaired by Diane Hedgecock, supported DIHP, the board debate continued as some stated that the international health projects activity was atypical of APHA endeavors as it did not relate to the entire membership. Continued CIH support may have helped as the 1986 Executive Board Minutes reveal an allocation from core funds of $99,000 for the Division's activities. However, this allocation was rather late as the USAID funding to DIHP had already trickled to less than $1M and extensions of remaining contracts were through 1987. APHA reduced the staff to one professional position and maintained sup-

port to WFPHA. A number of APHA leaders reacted strongly to the loss of USAID contracts, including the executive director who said that "never again will we accept project funds" from the federal government.

By contrast, one of the many non-profit organizations that seized the opportunity was the Association of Schools of Public Health (ASPH)). It was successful in winning the competition for USAID funding and maintaining their independence. An insight offered by Lee Howard was that perhaps it was not easy for all board members to appreciate the onerous federal and congressional regulations that USAID was required to follow regarding contract rules and project approvals. Several members remarked that since the APHA programs (DEIDS, immunization, and MCH) were so successful in the countries, it appears as an historical puzzle that members of the Executive Board would focus on the magnitude of USAID funding rather than the substantive contributions of the APHA extension of public health practice activities globally.

Perhaps another perspective on the historical puzzle lies in the extreme specialization of health professions that has evolved along with a strong protective zeal within each specialty and the competition for resources. As APHA funding from USAID continued to increase, the angst of some board members may also have increased regarding the competing needs of their own organizations. While researching the IHS files, a fascinating historical chart was discovered which helps to shed further light on the historical puzzle. The updated 1985 chart was entitled "Milestones of Public Health in America" and was originally published by APHA in 1926. A remarkable aspect of the chart, which begins with the *Colonial Birth and Death Registration Law* in 1639 and ends with the discovery of antitoxin for scarlet fever in 1926, is the subtle way in which nine different components of public health at that time are depicted separately yet are linked together thus reinforcing an overall perspective of public health.

These separate components or specialties listed in the chart include: Laboratory, Tuberculosis, Organization, Sanitation, Vital Statistics, Communicable Diseases, Foods and Drugs, Public Health Nursing and Prenatal Infant and Child Hygiene. Today it would be extremely difficult to prepare a similar chart due to the exponential growth in the number of specialty areas and the difficulties in depicting the same types of linkages among various public health specialties. The unending stress of competing for diminishing resources by the many different health specialties over the past few decades often has overshadowed and dimmed the importance of the fact that all the specialties are interlinked and very essential for an improved public health system.

Thus the task of IHS in advocating and educating APHA internally on the importance of international health and on broad public health issues has been extremely difficult. The experience with private sector foundation funding in the US also reflects a primary interest in supporting very specific endeavors or issues such as onchocerchiasis, trachoma, population, and AIDS. This also contributed to the diminishing of general public health resources and to the difficult transition of organizational or specialty representatives elected to board status with concerns about these competitive funding pressures for their specialty interests and perhaps less so for APHA.

Activities and Contribution of IHS

With the loss of government funding, the Executive Board set about to clarify APHA's role in international health work. Susi Kessler left APHA for UNICEF and Diane Kuntz was hired in 1988 for the sole position remaining in the International Health unit. A working group consisting of John B. Walker, Ruth Roemer, and Diane Hedgecock developed a new mission statement for IHS that was adopted by the Executive Board in November 1988. An excerpt from the mission statement provides some insight as to the tension of the time.

> *"The international health mission of the American Public Health Association is first and foremost to do everything in its power to advance the health of all people in the world, especially those in the developing countries. Another international mission of APHA is to maintain friendly relationships and to exchange ideas with the health workers of all countries, so as to learn lessons that may improve the health of Americans and transmit knowledge that may help others. In order to carry out this double mission, APHA must serve as an independent organization, representing its members; it is not an instrument of the U.S. Government."*

The last sentence perhaps best reflects the impact of the issues and the prevailing perspectives that affected APHA for several decades and depicts the stresses and strains of the politics of public health.

APHA President Ruth Roemer expressed concern that while the association was not discontinuing activities in the international area, it had discontinued dedicating staff for international health activities as reflected in the 1988 proposed budget. APHA would continue the *Clearinghouse on Maternal Nutrition* and its newsletter as the only major AID funded activity in 1988. Roemer stated that in addition to the importance of the activities and programs to association members and to world populations, the international activities uniquely apply to every section of APHA. She described that significant shifting of the emphasis of international activities from projects to the various sections had been made under Kessler's leadership and that the emphasis needed to be continued. Perhaps this insight explains the erosion of critical mass for the international health activities.

Redefining IHS

Diane Hedgecock, former deputy director NCIH, became chair of the International Health Section for the 1987-1988 period. Having served as chair of the Committee on International Health from 1983-1984, she was familiar with many of the issues faced by the IHS and had knowledge of how the Executive Board worked and its various complexities. This experience helped her to initiate

several cooperative activities with other sections and encourage broader involvement by members. Her NCIH background provided a strong sense of partnership and coalition building. She forged a partnership between IHS and the Alcohol and Drug Abuse Section. That partnership resulted in winning a challenge grant from APHA for an anti-tobacco marketing campaign in developing countries.

This was also a period when APHA leaders showed a new interest in international public health concerns as reflected in the President's column in January and February articles in *The Nations Health*. Section membership grew to 1,433 and more members became active as APHA joined a consortium that took on the US Government's budget cuts and contribution deferrals to the World Health Organization. The section developed resolutions on the US contribution to WHO, universal childhood immunization and exportation of tobacco products. A new student committee was formed and submitted plans for a student award in recognition of contributions to international health work at their meeting in New Orleans.

John Wyon established a Community Based Group (CBG) within the IHS that included Carl Taylor, Gretchen and Warren Berggren, and Joseph Valdez and the CBG has grown significantly since then. This new period of increased activity led to an exploration by the IHS membership to redefine the role and responsibility of the section. In 1988, some forward thinking members of IHS established an AIDS Task Force headed by Ron Waldman. This initiative is an example of the section's responsiveness to global health issues and would evolve over time into a Special Primary Interest group achieving section status in 2001. IHS participated in the 40th Anniversary Celebration of WHO by sponsoring a dinner during the 116th APHA Annual Meeting in Boston honoring Halfdan Mahler former Director General. NCIH and the American Association of World Health (AAWH) were co-sponsors along with IHS.

Ken Bart and Dory Storms drafted a position paper in 1989 on key health problems and issues of concern to APHA's international health constituency. The provocative document generated discussion within IHS resulting two years later in a policy paper on the *Role and Opportunities of the American Public Health Association International Health Section*. This was a defining moment for the section and much of it was due to Hedgecock's leadership and commitment in guiding the section and the initiative of members, particularly Bart and Storms. IHS membership peaked at 1589 for 1990 and then dropped to 1551 in 1991. Over the next decade the section would miss the extensive support that had been provided by the DIHP and the useful lessons and country experiences that were invaluable to the advocacy efforts of the section. Perhaps this partially explains the fact that the membership levels remained fairly stable for the next decade. However, the recurring problem of difficulty in communication continued between the section and various levels of leadership.

An interesting point here is that the term "international health" had been used for several decades and for the most part meant "over there" or defined countries other than the US. Around 1989, the change in nomenclature from international to global began and provides a more inclusive term that includes the US in the definition of global public health. It remains to be seen if this achieves a more inclusive modus operandi for US interactions in global health. Hopes for achieving a global public health perspective may be tempered by the impacts of global economics.

In 1991, the IHS continued its efforts by forming a Task Force on Child Survival headed by Dory Storms and a Task Force on Tobacco led by Reed Wulsin. In efforts to widen student participation, IHS added 1-2 student slots for all working committees and task forces. Deborah Bender served as chair of the Student Participation Committee. APHA's 119th Annual Meeting in Atlanta Georgia November 10-14, was marked by the concurrent scheduling of the WFPHA's 6th International Congress.

During 1993-1994 Chair Samir Banoob reorganized all the committees and task forces of IHS by adding co-chairs to strengthen communications. He also reintroduced the annual Distinguished Service Award for the IHS, as there had been no awards granted since 1986. Membership in IHS peaked to 1611 during his tenure. A list of the various IHS awards and their recipients are attached.

John Bryant, chair IHS 1995-1996, although based in Pakistan, initiated an effort to incorporate IHS global thinking to the APHA Strategic Planning Process. An IHS position paper on "Strengthening the Role of the United States in the Field of International Health" was submitted to the APHA. Its prophetic preamble warns of threats to health for the world including new and re-emerging diseases, increasing violence, threats of bio-warfare and bio-terrorism, and unconstrained movement across geographical boundaries. Accompanying these are increasing health problems arising from individual behavior—smoking, drug abuse, vehicular injuries, inappropriate diet, and environmental degradation, increasing poverty, and population all of which weave their web of social decay and destruction. All of these contribute to diseases and hazards well beyond the realm of health to endanger the very stability of societies and global security. The message to APHA and the public was that the US was not immune and could not distance itself from these problems without increasing its own vulnerability. Bryant also attempted to re-establish cooperative relationships with NCIH, Institute of Medicine, National Academy of Sciences, and other entities. An insight to this period is shared in a 1996 memo sent by Bryant to Diane Kuntz. Bryant writes, "The APHA and its IHS is a curious mix. Instead of saying the work is never done, I would say that much of what we would like to do is never begun. The field is so vast and complex and interlinked with national policy issues and international problems that getting hold of the issues is difficult. We see an agenda that is hard to shape and actions that are hard to take. Nevertheless we are all in it because we sense its importance and we look for ways in which whatever we can do might help a bit." His perception perhaps best captures the resiliency, perseverance, and intermittent frustration of the international health community.

Henri Migala, chair of IHS from 1998-1999, provided a penetrating perspective of his term of office. He cited the

nature and complexity of the APHA organizational structure. When one first becomes the chair, one is faced with what appears to be a replication of duties between governing board, nominating board, committees, and the complications of how all that information flows. His experience was that it almost takes the full two-year period of office to fathom and understand how to guide the section. He recommends the section develop a primer on how to interact with the APHA political structure and how to make things happen internally. He also believes that in transitioning to new officers, IHS needs to provide more opportunities for overlapping with incumbent officers. Migala actually instituted such a transition process. He also shared that members in the International Health Section travel frequently, are geographically dispersed, and as volunteers have other responsibilities making it difficult to hold productive follow-up meetings and posing challenges in getting things done or providing continuity. The problem of scheduling an active group of practitioners for voluntary meetings may be difficult, but does not appear to be insurmountable.

Other members also reaffirmed the key challenge for IHS involves the problem of successfully navigating the complex APHA organization to allow the section an opportunity to influence policy. They state that there is a need to establish a system for documenting previous experiences as a tool for future chairs. Each chair starts a two-year term with a handicap because there is no primer or body of lessons and guidelines to reduce the learning curve and allow a smooth transition. The cyclical repetition of the slow learning curve impacts on available time for all volunteer section officers leaving them splitting time between focusing on the needs or expectations of the members while attempting to learn the complexities of the organization. All members interviewed stressed that IHS could represent a strong political force if it could be focused and obtain APHA support. This cyclical dilemma also impacts effectiveness in determining how the section can be more influential and which key issues to tackle. Alleviating some of these hurdles for the volunteer leadership positions could improve their effectiveness in determining the most productive way to interact with APHA leadership

Ahmed Moen, former membership chair, Julius Prince, consultant and mentor, Dory Storms, former IHS chair, and other members affirm that despite these problems and difficulties the section has provided a gateway for women into the international arena and provided valuable mentoring and guidance to many students and new entries to the field while maintaining a continuous advocacy effort for international health. The student sections have been cyclical in terms of activity that is related to the differences in students and the extent of their involvement for each successive class.

Many former members recommend that IHS needs to better utilize the resolutions process to get APHA members supporting international health initiatives. Although the process takes a year or more, other sections have successfully used the resolution mechanism to get things done. In reviewing all the IHS resolutions during those powerless days, the majority centered on various political reactions: i.e., protests to ban bombing or in response to a refugee crisis in Central America. In reality none of those resolutions were a prescription for working on programs and the IHS was thus seen as a moral conscience or prod but not a program builder. Some members tried to get IHS to think about more substantive issues that would result in implementing good programs. However, to use the resolution process successfully takes extensive planning rather than trying to initiate an issue at the Annual Meeting with a flurry of effort at the last minute.

Members state that the section lost its links to key mentors such as Merrill, Ehrlich, Howard, and Leavell who were interested in both public health practice and understanding policy. This meant that people entering the field of international health lost the benefit of the mentoring and wisdom of the experienced international visionaries. Members interviewed believe this was an important transition for newcomers into the field as the insights of these former leaders linked policy and public health practice and provided an important understanding of global health for the new members.

In the fall of 1996, APHA's new Executive Director Mohammad Akhter brought a strong global health focus to the organization reminiscent of the 1970s. Akhter believed there was a shift in how people looked at international health and public health. He saw an opportunity to utilize global health as a platform to unify APHA within a broad arena in which all members could participate. He also pursued a strategy to create a revenue stream from other organizations and develop partnerships to help APHA carry out its missions and goals. Primary revenue sources for APHA were from three areas: publications 36%, membership 33%, and conventions 26%. Akhter pledged to improve three main areas for the organization:

1) Maintain the scientific base of the association.

2) Put forth an educational effort to provide practitioners with scientific based information to improve the health of citizens of the US and the world.

3) Promote grass roots advocacy.

Through the WFPHA, a study tour sponsored by APHA was organized in December 1996 to learn about the health system in Vietnam. This was reminiscent of the study tours conducted in the early '70s to involve more of the members in global interaction and to Nicaragua and Cuba in the late 1980s and 1990s.

CHANGE FOR NCIH Advocacy

1996 marked a milestone for the NCIH community. Led by President Frank Lostumbo and Board Chair Barry H. Smith, NCIH completed a successful three-year advocacy effort to prevent severe budget cuts to the foreign assistance program. Describing the USAID Sustainable Development Program as a "Fragile Shield" that helps to improve health throughout the world including the US, the NCIH network, joined by a broad coalition of agencies, was successful in staving off elimination of the program by Congress. At the NCIH 23rd Annual Conference on June 12, 1996, Vice President Al Gore announced a major policy to safe-

guard the world from the threat of new and re-emerging diseases. This success was attributed to a number of key NCIH officials, members, and supporters including Sir George Alleyne, Jose Barzelatto, James Hughes, Anthony Fauci, Rosalia Rodriguez-Garcia, Janet Gottschalk, Tony Hall, Norbert Hirschorn, Gordon Perkin, Adel Mahmoud, Miriam Labbok, Joshua Lederberg, Elaine Murphy, David Newberry, Waafas Ofosu-Amah, James Sarn, David Satcher, Nils Daulaire, Linda Vogel, and Karl Western.

Left to right-Donna Shalala, Secretary HHS, Vice President Al Gore and Frank Lostumbo at the NCIH Conference in 1996.

This achievement and the announced retirement of Lostumbo stimulated a strategic initiative for developing the future role of the NCIH. A special consultative group headed by C. Everett Koop recommended a more global focus and streamlining of the organization's cumbersome board structure from 32 to 7. The re-structured successor, Global Health Council (GHC) was launched in early 1998, with Nils Daulaire, former USAID deputy director, as president.

In 1997, IHS Chair Dory Storms led networking efforts resulting in three regional meetings of section members being established. Chicago area members convened at Wheaton College and were organized by Gretchen Berggren. Steven Schensul at the University of Connecticut hosted a Northeast meeting, and Mary Ann Mercer organized the Northwest International Health Action Coalition, a Seattle area group based at the University of Washington.

Also in 1997, APHA conducted a feasibility study that found corporations were interested in contributing to APHA. APHA members who worked for corporations commented that they saw opportunities to advance the cause of public health from within those settings. Those interviewed were interested in contributing to APHA but noted that the Association appeared to keep them at arms length. This was not surprising as a few voices continued to believe such funds were tainted, while many board members believed it was time to re-examine this issue. The executive director believed that APHA was at a pivotal juncture and needed to define partnerships that would advance public health and healthy communities into the 21st century. This time, a decision was made by the Board to pursue a strategy that was reminiscent of the foresight and vision of the international staff and their innovative partnership recommendations to the 1976 Board.

As a result of the feasibility study, the Executive Board in January 1998 endorsed the idea of fund raising and a Development Campaign for APHA under the leadership of William Foege. While the stimulus for this was the construction of an APHA owned building, this opened the door to a more open policy regarding external funds for the association. This led to the next major change as APHA developed an internal policy in April 1998 for the association receiving corporate support or donations. APHA had come full circle after deferring to accept an offer of partnership from the International Health Resource Consortium two decades earlier. This reaching out to government and non-government entities helped APHA build a new headquarters building in Washington D.C. and establish new cooperative relationships and partnerships with other organizations to strengthen public health advocacy efforts.

It was also in 1997, that APHA's Executive Board reassessed the organization's interest and commitment to global health. In reviewing the organization's four goals, there was some discussion that a fifth goal be added on global health. However, after debate, the decision was made that instead of adding a new goal, it was more appropriate to add language that included a global dimension to each of the four existing goals, making global health an important component of its overall vision and mission.

In 1998, APHA partnered with the American Cancer Society, the National Center for Tobacco-Free Kids, and US Senators Richard Durbin, Ron Wyden, and Susan Collins to plan an international policy conference on children and tobacco for March 1999 in Washington, D.C. This conference brought together health ministers and key policymakers from around the world to fashion a legislative strategy to curb the use of tobacco as it affects children. The WFPHA took the tobacco issue to its 8th International Congress in Arusha, Tanzania in October 1997, and later adopted a policy paper on tobacco and established a Task Force on Tobacco at its annual meeting in May 1998. This effort assisted the process of global recognition of the tobacco issue. The Federation also adopted resolutions on global free trade and other leading public health issues. The WFPHA's trade resolution urged that trade agreements incorporate "social clauses" that protect the environment, promote the rights of children, and advance workers rights.

Akhter re-established working relationships with the federal government and after an absence of several decades APHA was included as a member of US delegations to the World Health Assembly, from 1997 through 2001. The Association invited members to participate in providing input for the proposed strategic plan for 1999-2002, and strategic priorities for 2000-2003. Henri Migala and Ray Martin initiated a brainstorming and dialogue process within the IHS seeking to incorporate some recognition of global health into APHA's priorities. Pioneering APHA's "broadcast email" facility, the section was able to solicit input from 700 members for a June 18, 1999, memo to APHA drafted by Bart Burkhalter, Ray Martin, and Allen Jones. The IHS recommended that APHA's goals express explicitly an interest in international and global health and urged that APHA expand its advocacy and research, especially in priority areas, the top four of which were identified as HIV/AIDS prevention and control, child survival and children's health in developing countries, public health impact of violence and war, and women's health. Despite the executive director's invitation to the IH Section to help the association as a whole define its objectives, agenda, and priorities in global and international health, none of the section's recommendations found their way into the final strategic plan and priorities eventually submitted by the

Executive Board to the Governing Council. This fact led to some disillusionment in the IHS about how seriously the APHA values section input. An observation by staff indicated that the IHS contribution would have received greater attention and had more impact had IHS efforts been in closer sync with the APHA's overall planning process. After two decades of frustration for the IHS, the section did note some positive progress regarding section representation on the board.

An interesting example of the growing relevance of global health issues to the US public was an incident in 1999 when officials from New York's Health Department attended an IHS business meeting during the APHA Annual Meeting in Chicago to request assistance from the International Health Section as a result of the outbreak of West Nile virus in Brooklyn. While section members shared their experiences and views, there was no resource capability to provide assistance. Yet educating and convincing the total APHA membership of the global aspects of public health continues to be elusive and predicated on a specific crisis.

WFPHA Growth

WFPHA's role further evolved as a global NGO at its 9th International Congress, held in Beijing, China in early September 2000. The Federation organized a Leadership Forum in Beijing that included representation and participation from such global public health figures as WHO Directors Halfdan Mahler and Gro Harlem Brundtland, PAHO Director Sir George Alleyne, US Surgeon General David Satcher, and others. The Leadership Forum participants reviewed the quarter century that had passed since the 1978 adoption of the Alma Ata Declaration that forged an international commitment to primary health care. During this 25- year period, this commitment has ebbed and flowed and been uncertain at times, partly as a result of competing global initiatives in such areas as human rights, children's health, food and nutrition, and the environment.

Based on the forum and congress proceedings, the Federation revisited the Alma Ata declaration and reaffirmed its commitment to primary health care by issuing a Call to Action in Beijing. This Call appealed to public health leaders throughout the world to consolidate efforts around the common cause of social justice and to advance the goal of "Health for All" in the 21st century. The Call to Action renewed commitment to primary care and took up the challenge to translate current knowledge and skills into specific actions for the better health of all the people of the world.

At the conclusion of the Beijing Congress, the Call was sent to the UN Secretary General Kofi Annan, who was meeting in New York with World leaders to discuss the challenges for the new millennium and the targets and pledges necessary to meet those challenges. The Federation utilized this theme to plan its next congress. The 10th WFPHA International Congress: "Sustaining Public Health in a Changing World—Vision to Action" will meet in Brighton, England in April 2004.

Perhaps Executive Director Akhter's global perspective stimulated a glimmer of interest within APHA of the importance of global public health issues as well as recognition of the increasing importance of these issues to the US public. This was reflected in the theme "One World, Global Health" for APHA's 129th Annual Meeting in Atlanta, October 21-25, 2001. Another IHS regional unit took flight as Tom Hall organized a San Francisco International Health Interest Group.

In 2002, APHA combined its education and international staffs in a new unit, Education and Global Health Resources. This was undertaken in part for budgetary considerations and resulted in some reduction of staff resources. However, this consolidation provides an opportunity to create an integrated and comprehensive platform for addressing global needs in public health education and training. These issues are of key importance for countries involved in health sector reform and such crises as the HIV/AIDS pandemic, which indicate a critical need for adequate numbers of trained public health manpower.

A new collaboration between APHA and the American Medical Association may provide a benefit to the aims of the International Health Section. The collaboration aims to create a stronger link between medicine and public health. The effort is championed by APHA President Jay Glasser with support from AMA Presidents Hank Coble and Roy Schwarz and recognizes that the two professions have in recent history acted more often in competition with one another rather than in collaboration or cooperation. As this weakness has also been observed within APHA, perhaps this initiative will help to bring about a spirit of mutual reinforcement among the specialty areas of public health. Health care costs have increased dramatically while resources have not kept pace. This suggests that a new commitment across the professional lines and specialty areas to develop mutually reinforcing strategies that can strengthen public health in the US and globally.

Mohammad Akhter, Georges Benjamin and Allen Jones.

History Presentation at 130th Annual Meeting

"International Health Where are We? Where are We Going?" was the topic of a panel session at the APHA Annual Meeting in Philadelphia, Pennsylvania, on November 11, 2002. Panelist Frank Lostumbo provided an overview of the history based on his research and extensive oral interviews. Panelist Russell Morgan, a member of APHA's Division of International Health from 1969-1979, described his experiences working with Malcolm Merrill, Hugh Leavell, Dale Gibb, and others in DIHP when they received the initial Milbank Foundation grant to jumpstart the division. He also shared events from his term as WFPHA Executive Secretary and cooperative activities with then President of WFPHA Gerry Dafoe. A highlight from that period was presenting the position paper on the *Role of NGOs* at the Alma Ata Conference in 1978 at the

Russell Morgan, Gerry Dafoe and Jay Glasser

request of WHO and UNICEF.

Panelist Dory Storms shared her recollections from early years as a student and new member of the IHS to later becoming a key leader and chair of the Section. She pointed out that her experience during those years was enriched by members of the section being outgoing and inclusive during meetings while presenting many diverse interests and ideas. A valuable contribution of the section members was the fact that the IHS had served as a gateway for women to enter international health careers. In addition the section provided many opportunities for students and new members. Other key points she made were the value of the mentoring role of the early leaders and the importance of IHS inviting retired and former members to serve as volunteer mentors and recapturing the broad vision of the early leaders. She observed that IHS needed to increase and broaden efforts for new members.

Panelist Carl Taylor shared remembrances and insights of his 26 years of IHS advocacy and his involvement with CIH, WFPHA, and NCIH. Carl closed his remarks by stating that he believed it was time for everyone in international health to pause and review the basic assumptions of IHS and look at the changing environment in which the global health arena is functioning. While events in the world in 2002 are quite different, there are similar parallels with the challenges of 30 years ago. Reviewing the history of the IHS provides an opportunity to take a fresh and broader look at today's challenges and to redefine the section. He asked that the group reassess the reasons why there should be an International Health Section and asked John Bryant to assist in posting four questions to the audience:

1) Does the start of the International Health Section in the Vietnam era give us any lessons to guide us in our concern for terrorism and the war pending in Iraq?

2) What is the current justification for the International Health Section?

3) What kinds of functions have we been performing and need to perform for the next generation of leaders?

4) Do we need a change in our approach toward recognizing the importance of a community-based approach?

These questions invoked a provocative discussion and precipitated other questions and ideas from the audience. Although a Strategic Plan for IHS had been developed in 1999, it was obvious from the discussion that it needs updating and reorientation to the new and different global challenges before us. Some of the key points of the discussion include:

- Should the role of the APHA IH Section be tied closely with current international political events impacting the US? For example, should the public health impact of bio-terrorism be an important niche for the IHS?
- Should IHS/APHA pursue a project for the development of mechanisms and support for training future leaders for global public health activities?
- Should IHS/APHA expand by creating a geographic network of both student chapters and regional chapters of international health that could provide strong grass roots support that would address local priorities, national priorities and global issues. An IHS Chapter for the District of Colombia was actually in the planning stage and being organized by IHS members Curtis Swezy and Julie Hantman.
- The role of mentoring was a small endeavor done well by IHS in previous eras, but which requires staff continuity and the coordination of a cadre of volunteer members. This is an activity that could strengthen all sections and provide additional human resource support for APHA

Such initiatives require assessments of the level of support available within APHA including budget priorities, and availability of leaders and active volunteer support from the members.

Allen Jones, Russell Morgan, Frank Lostumbo and Ray Martin

Ray Martin and Allen Jones incorporated the essence of the panel discussion to reshape a series of questions to be circulated via e-mail to the full IHS membership and to other Section Chairs. The results of that process will be included in the strategic planning process and utilized for future initiatives.

Conclusions, Lessons and Insights from the History of International Health

This history of International Health covers some four decades and provides an interesting lesson on leadership that can occur in many different ways and at many different levels. An obvious observation is that a few key leaders such as Leona Baumgartner, Hugh Leavell, Berwyn Mattison, and Malcolm Merrill had international perspective and foresight. The strong international vision of a few led a movement that made a significant difference and influenced the whole of APHA. This is also the story of a subsequent group of dedicated leaders and members who steadfastly attempted to follow the global roadmap while the organization as a whole had difficulty envisioning the importance of global links to their domestic interests. APHA exhibited moments of global foresight that resulted in seminal actions and decisions in the early years. Some of the key events and lessons are as follows:

- A Rockefeller Foundation grant in 1959 launched APHA's initial involvement in international health

activities. The participation of four international health leaders (Ghana, India, Japan and the Soviet Union) began the process of global interaction as envisioned by Baumgartner and Mattison

- A Milbank Memorial Foundation Grant in 1969 to APHA provided the first program grant to study the role of non-governmental organizations in health was important to APHA and international health. This five-year study helped launch the non-government involvement in health services delivery in developing countries. This seminal effort stimulated the channeling of US foreign assistance funding through US based NGOs and to NGOs throughout the world. It also served to increase the validity of the non-governmental community to WHO, UNICEF, UNFPA and other multinationals as envisioned by Merrill and Leavell.
- APHA's unwavering investment in strengthening national non-governmental associations and supporting the establishment of WFPHA as an independent global entity continues to be a significant contribution to public health.
- Leadership in international health was exhibited by a relatively small corps of officials and dedicated members whose foresight and steadfast commitment to international health led to the establishment of:

  World Federation of Public Health Associations (1967 to present)

  Division of International Health Programs (1970 to 1988)

  The International Health Section (1976 to present)

  National Council for International Health (NCIH 1971 to 1997) / Global Health Council (1998 to present)

- The International Health Resource Consortium in 1976 presented a unique opportunity for APHA to assume a leadership role in establishing partnerships with private sector organizations. Unfortunately, this concept was too innovative for some APHA Governing Board members who successfully achieved a no-decision position by the APHA Board. This concept was partially implemented in early 1990 when Public Health Service/Centers for Disease Control established a CDC Foundation allowing a mechanism for a government agency to raise private sector funds and corporate donations. Efforts between the government and non-government sectors for partnerships in health are still evolving.
- The need for an international health constituency within APHA was the driving force for establishing the IHS. However, it would be a number of years before adequate IHS representation could be achieved on the APHA Board. Nonetheless, many international health section members continued to provide significant contributions to improving health in poor and underserved areas of the world.
- Changes in external environments at both national and global levels significantly influenced APHA leaders as they struggled with how to address international health issues. These forces included the Vietnam War from 1961 to 1970, the Watergate scandal in 1972, and the polarizing trauma that followed, and the OPEC Oil Embargo in late 1973 that precipitated an energy crisis through 1974, and generated mistrust in government policies. In addition US foreign policy in Central and South America further frustrated the public health community and moved them to action in response to the Human Rights Abuses in Chile in 1975 and 1976. These events provided a chaotic backdrop of polarizing views that affected decisions by APHA officials and framed their outlook regarding the importance of the international activities.
- The lack of consistent follow-through by the board on the early vision of the role of international health within APHA was described as an historical puzzle. Perhaps it has more to do with differences in behavior and expectations of members regarding their perspectives and the role on the board. The board structure is complex. The increase of public health specialties led to growth of many different sections and special interest groups within APHA. As these representatives ascended from member status and passed through the portal to become board members, a wider range of narrower paradigms were introduced pulling APHA in different directions. While some changed their focus to a broader APHA vision, others maintained uncompromising views creating polarization that shrouded the value of the association's international activities and obscured the global vision of the charismatic early visionaries. Perhaps the bold organizational transition experience of 1970 when a few APHA leaders were willing to take risks with a clear vision could provide some options for meeting the challenges of the future.
- The founding and evolution of WFPHA, NCIH/GHC, and IHS are reflected in the common link between many of the early leaders whose interests intersected and who believed in cooperative partnerships as critical for improving health. The overlap of many individuals being members to both NCIH / GHC and IHS has continued to the present. GHC is an independent organization with a streamlined board that allows rapid response and the ability to act quickly and mobilize coalitions or organizational partnerships as needed. IHS is a section made up of individual members within an APHA organizational structure that often inhibits communications and slows response capability.
- Recent consolidation of the education and international health functions within APHA provides a platform for a leadership role in identifying and facilitating the education and training skills neces-

sary for health sector reform. Realistically, connecting these two program components has significant potential that is worthy of a re-evaluation of resources and staff necessary to achieve an APHA prominence and leadership effort in these areas.

- The history reveals that irrespective of the cyclical problems of budget deficits and internal differences, the IHS continually maintained a significant amount of energy, resources, and focus for an international program at each APHA Annual Meeting and often influenced a global theme. The Annual Meeting provides excellent cutting-edge presentations to attendees already active in the field and has kept the IHS true to its education and advocacy for the importance of global health.
- With APHA providing the Secretariat support, the WFPHA assumed a leadership role for the non-governmental community in global health with the presentation of the Background Paper on the Role of Non-Governmental Organizations at the 1978 WHO/UNICEF-sponsored Conference on Primary Health Care at Alma Ata—A significant action that helped to change the direction of WHO and UNICEF regarding the role of non-governmental organizations in global health.
- APHA/DIHP in partnership with national and non-governmental organizations working for the poor successfully extended public health practice to improve conditions in basic health and environmental services. It contributed to building community-based public health innovations from 1970 to 1987, and disseminated information about effective country experiences important for public health advocacy and education.
- The accomplishments of a few committed people with global foresight provides a proud legacy for APHA. Their dedication in promoting communication and cooperation among key players in international health serves as a valuable lesson and guideline for the future, particularly the importance of maintaining dialogue with all sectors irrespective of policy differences. This concept needs to be re-affirmed to address communication and organizational barriers among sections and between the sections and the governing board, to change the emphasis from competition among public health specialties to a mutually reinforcing public health coalition..
- The synergy created among the leaders of APHA, Rockefeller Foundation and the Milbank Memorial Fund launched major initiatives in international health, including the formation and strengthening of WFPHA and creation of NCIH/GHC, and should serve as a model to advance further development of international health organizations.

Comment on Where We Have Been and Where We are Going!

APHA, as a pre-eminent non-governmental organization with a mission dedicated to the public's health, has a potentially crucial role in the future health of the nation and in the interconnected globe. The recent threats of West Nile virus and SARS have demonstrated clearly that public health cannot be confined to just local, state, or national levels, as it requires a global scope to be effective. Many dedicated APHA pioneers and workers in international health have continually advocated for this global context as an integral part of all APHA's public health activities, often during periods of inconsistent support from the APHA board. This analysis of the history and evolution of the International Health Section is the story of where the section has been and the path that was taken. This retrospective reflection was based on a review of available files enhanced by oral interviews and has provided a unique window to those visionary leaders who were able to lift the organization's efforts at various times. In addition the history provides glimpses of other types of leadership and resolve demonstrated by the many individual members of the International Health Section.

NCIH/GHC & APHA/IHS share the common link provided by the international health perspective of a few leaders and the value of board support providing political will that allows the organization to accomplish much more.

Advocacy for public health takes time and requires cooperation, partnership and mutual reinforcement among the many different health professions. The challenge for APHA and WFPHA is to focus the coalition of organizations to improve the conditions of poverty so that advocacy efforts can influence improved public health policy and practice in the countries.

References

1. Excerpts from Nancy R. Bernstein's History of Public Health from The Nations Health 1-12/72
2. June 1955 Executive Board Minutes
3. APHA Annual Meeting Kansas City, November 1955 Executive Board Minutes
4. June 1959 Executive Board Minutes
5. February 20, 1959 Executive Board Meeting
6. Argentina, Australia, Brazil, Chile, India, Israel, Japan, Mexico, Netherlands, Nigeria, Philippines, Venezuela and United Kingdom
7. "Prescription for a Planet" at the 9th Bronfman Lecture November 13, 1969 Philadelphia published in AJPH Vol.60 NO. 3 pg. 433.
8. The Urgency for Social Action for Health. 1970 Vol. 60, NO. 1 AJPH.
9. 56th World Health Assembly Framework Convention for Tobacco Control (FCTC) May2003
10. Nations Health April 1971 page one
11. July 1971 Nations Health page three
12. Agenda Item 3.32 International Health program Report 1973
13. Minutes of the Executive Board November 15, 1975 Chicago, Illinois Agenda Item 12.07
14. Report of the International Activities Subcommittee to the Executive Board A Dissenting View pages 233-234, September 1976 Governing Council Minutes.
15. The Nations Health August 1976 page 5
16. Executive Board Report on International Agenda Item 6.3 pages 22-25
17. Agenda Item 7.20 Establishment of International Health Section October 1976 page 25, EB Minutes
18. White House Report New Directions in International Health Cooperation Spring 1978
19. Minutes of the Executive Meeting of the International Health Section, APHA February 16, 1983 pages 4-6
20. Executive Board Minutes June 2-3, 1984, Washington, DC Agenda Item 6.00 International Health Program Review, pages 130-136.

Attachments

Individuals interviewed for the history

Mohammad Akhter, Tim Baker, Samir N.Banoob, James E. Banta, Rose Belmont, Georges Benjamin, Peter Bourne, John Bryant, Eliese Cutler, John C. Cutler, Rosemary Donley, Gerry Dafoe, S. Paul Ehrlich Jr., Caswell Evans, Henry Feffer, Jay Glasser, Janet Gottschalk, Diane Hedgecock, Lee Howard, Allen Jones, Barry Karlin, Susi Kessler, James R. Kimmey, Lani Marquez, Ray Martin, William McBeath, Jerold Michael, Henri Migala, Ahmed A. Moen, J. Henry Montes, Roscoe M. Moore Jr., Russell Morgan Jr., Julius S. (Bud) Prince, Vicente Navarro, Clarence Pearson, Jean Pease, Lorraine Pease, Olive Roen, Rose Schneider, Josefa Ippolito-Shepherd, George Silver, Dory Storms, Curtis Swezy, Carl E. Taylor, Ann Tinker, Linda Vogel, Ronald Waldman, Ned Wallace, Myron E. Wegman, Charles L. Williams Jr., Chuck Woolery, Joe Wray, and John Wyon.

Awards and Recognition

Recipients of the International Health Section Lifetime Achievement Award for Excellence in International Health:
Dr. Stanley O. Foster, 2002
Dr. Joe Wray, 2001
Dr. Jack Bryant, 2000
Drs. Warren and Gretchen Berggren, 1999
Ms. Veronica Elliott, 1998
Dr. Milton Roemer and Dr. Moye Freymann*, 1997
Dr. Julius "Bud" Prince and Dr. Jeanne Sumner Newman*, 1996
Dr. John Wyon, 1995
Dr. Timothy Baker, 1994
Dr. Cicely Williams*, 1993
Dr. Derrick Jelliffe*, 1992
Dr. Carl Taylor, 1991

*Awarded posthumously

Recipients of the International Health Section Mid-Career Award:

Dr. Adnan Hyder, 2001
(No Mid-Career award in 2000)
Dr. Stephen Gloyd, 1999
Dr. Luis Tam, 1998
Dr. Marty Makinen, 1997
Ms. Colleen Conroy, 1996
Dr. Mary Ann Mercer, 1995
Dr. Irwin Shorr, 1994
Dr. Walter K. Patrick, 1993
Dr. Dory Storms 1990

Recipients of the International Health Section Distinguished Service Award:

Dr. Marty Makinen, 2002
Ms. Lani Marquez, 2001
Dr. Dory Storms, 2000
Dr. Samir Banoob and Dr. Susi Kessler, 1997
Dr. Henri Migala, 1996
Dr. Ahmed Moen, 1995
Dr. Olive Roen and Mr. H. Pennington Whiteside, 1994 (the award was re-introduced)
Dr. Raymond B.Isely*, 1986
Dr. Diane Hedgecock 1985
Dr. Kathleen A. Parker—initial award 1984

Other Awards

Special Recognition
Dikembe Mutombo, 2002

International Health Section Chairs/Newsletter Editors

1976	Carl Taylor		
1977	Malcolm Merrill	Janet Anderson	
1978	Hildrus Poindexter	Naomi H. Chamberlain	
1979	Jeanne Sumner Newman	Jason Calhoun	
1980	Jeanne Sumner Newman	Harold Royaltey	
1981	Carlos H. Daza	Charles L. Williams Jr.	
1982	John Karefa-Smart	Charles L. Williams Jr.	
1983–1984	Dieter Koch-Weser-	Frank I. Gauldfeldt	
1985–1986	William A. Reinke	Harold H. Royaltey	
1987–1988	Diane Hedgecock	Marty Pipp / Pennington Whiteside	
1989–1990	Richard Cash	Cynthia MacCormac / Olive Roen	
1991–1992	Susi Kessler	Olive Roen	
1993–1994	Samir N. Banoob	Olive Roen	
1995–1996	John H. Bryant	Vishnu-Priya Sneller	
1997–1998	Dory Storms	Vishnu-Priya Sneller	
1999–2000	Henry Migala	Josefa Ippolito-Shepherd	
2001–2002	Ronald Waldman	Josefa Ippolito-Shepherd	
2003–2004	Ray Martin	Josefa Ippolito-Shepherd	