The World Health Organization and Global Health: Toward a New World Order?

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Columbia School *of* Public Health

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The Frank A. Calderone Lecture

The World Health Organization and Global Health: Toward a New World Order?

delivered by

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It is scandalous that today global health is adrift, without stewardship, and without coherence. The agency that should be held principally responsible for this critical deficit is the World Health Organization (WHO), established in 1946 with the fundamental objective of helping all peoples attain the highest possible level of health.

The gap between global realities and needs and WHO's current capacity and approach can be illustrated with reference to four topics: global protection from epidemic disease; the strategic foundation for advancing health; the operational basis of health promotion and protection; and organizational accountability. In each of these areas, WHO is demonstrably inactive, outdated, or ineffective. This analysis will also suggest the critical requirements for a reform of WHO, through which it could regain its lost position of global health leadership, or, if it proves incapable of major restructuring and revitalization, why another organization or entity will need to be created to promote and protect global health.

The recent outbreak of pneumonic plague in India has demonstrated once again that, rhetoric aside, no one assumes active responsibility for protecting against the global spread of epidemic disease. On August 26, human plague cases were first reported in Bir district, about 200 miles from Bombay; within a month, not only were several hundred pneumonic plague cases reported from the city of Surat, the 12th-largest city in India, but cases of suspected or confirmed plague were also reported from over 20 other cities in India, including Bombay, Calcutta, and New Delhi. Panic, so typical when plague is involved, led to closure of public places such as schools and movie theaters in New

Delhi, and by late September, many countries restricted travel to India and even commercial trade. The news about plague coincided with the start of the peak tourist season, bookings plummeted, and in desperation, the government offered 500 free trips to India to influential journalists and travel agents. Both within and outside the country, India's reputation was considered sullied.

Thus far, there is no evidence that plague has spread to neighboring or distant countries. Yet this episode was merely the latest instance in which the world may have escaped a major international health crisis, despite the absence of any coordinated international response or action to protect it. WHO was on the sidelines, offering technical advice and hastening to reassure everyone. Yet, given the speed of international travel, it would have been entirely possible for someone to have been exposed to pneumonic plague in New Delhi, travel to New York and arrive feeling well, then develop a severe pneumonia with fever in a small town in upstate New York or in Boston. Having had experience with human plague in New Mexico, I can assure you that before pneumonic plague would have been diagnosed, the patient would almost certainly have died, and one, possibly two or more generations of person-to-person spread may well have occurred, and, finally, at least one person already incubating the disease would likely be traveling elsewhere.

I am not suggesting that in this instance the United States was facing an uncontrollable epidemic; clearly, at a high cost in resources and dysfunctional behavior, any plague outbreak in this country would be brought under control. Yet most countries, even in the industrialized world, lack an effective Centers for Disease Control (CDC), and most

do not have readily available a reliable laboratory capacity to make the (relatively easy) confirmatory diagnosis. The potential for plague to become pandemic has been well demonstrated; indeed, it is often used as a historical illustration of the close connection between movements of people and spread of disease: the plague of Justinian; the Black Death; plague in London in the mid 1600s, and the late-nineteenth-century pandemic that brought plague to a new home in the western United States.

There could be, there must be, an alternative scenario. We can imagine a global institution or network — a global pathogen watch — relentlessly searching for the appearance of threatening health events: new spread of old diseases, outbreaks of new diseases. Then, when human plague is reported in an unexpected area (apparently the last case of reported plague from India was about 20 years ago), the global organization does for the world what a state health department or the CDC does in this country: a rapid initial investigation is carried out, using, in this instance, a combined national and global team. Diagnosis is rapidly confirmed or excluded; expert guidance is given regarding prevention and control measures. (The closing of schools and cinemas was a classic piece of public health theater, designed, like the U.S. law preventing entry of HIV-infected travelers, to pander to the public and delude people into believing that something useful is being done to protect them.) Through collaboration with the national government, the public and health authorities in other countries are provided with accurate information about the evolving situation. Delay and denial, the deadly enemies, are kept to a minimum; globally coordinated control efforts are mobilized for the sake of all.

What makes this scenario impossible today, thereby increasing global vulnerability to epidemic diseases, is the old-fashioned way that international collaboration is conceived and carried out. National officials may still deny and conceal the existence of even large-scale epidemics with impunity. Meanwhile, WHO waits to be asked for help; it stands on the sideline offering technical support, which countries may reject out of a desire not to acknowledge their own deficiencies, and issues guidelines about control, which may be freely ignored or which may be beyond local or national capability to carry out. In such situations, diplomacy rules and responses to health crises are delayed, sometimes endlessly.

The International Health Regulations were adopted by the World Health Assembly in 1969, superseding a long series of agreements designed to prevent the international spread of disease, starting with the International Sanitary Convention of 1903. The Regulations are designed "to ensure maximum security against the international spread of diseases with a minimum interference with world traffic." Yet the Regulations, with only slight revisions in 1973 and 1981 regarding cholera and smallpox, are relics of a bygone era — the persistence of an obsolete world defined by ships and the telex in an era of satellites and 747s. For since the Regulations were promulgated, the pace, scope, intensity, and diversity of international movements of people and goods has increased so dramatically that a qualitatively new global reality has emerged.

It must now be recognized — as the HIV/AIDS pandemic teaches us, and pneumonic plague in India reminds us — that a health problem in any community or country can

so rapidly become a health crisis around the world that new approaches and new measures are needed. The unit of reference and analysis must be resolutely global, National pride cannot be allowed to stand in the way of effective protection of global health, and an early-detection-and-response capacity, able to cross all borders, must be developed.

Fortunately, the HIV/AIDS pandemic has stimulated a rethinking of this problem of new and emerging diseases, and work at the Institutes of Medicine and the CDC and some preliminary discussions at WHO have taken place. Whether the needed global pathogen watch will become a reality, capable of detecting and responding to the new spread of old diseases like plague, cholera, and tuberculosis, as well as emerging and "new" diseases, is still unclear. Then, even beyond rapid detection and response, true global thinking should seek to predict where and how new diseases might emerge, so they can be anticipated, sought for, and perhaps even prevented. Global risk areas might include the frontier zones where human settlements penetrate previously uninhabited lands; wherever large population movements occur, in war or peacetime; and where major environmental changes provide new avenues for disease spread. In short, a modern, flexible, creative approach is needed, not a static Maginot Line; no country can rely upon its borders for defense against disease. This great lesson of the modern world, of global interdependence, must be applied, and not only regarding microbial threats to health; this requires a capacity for global thinking and translation of these ideas into responsive and innovative organizations.

Yet to be responsible for global health requires more than global thinking in geographical terms. A coherent strategic approach to "attaining the highest possible level of health" depends on a coherent analysis of the nature of health and its critical determinants. For how a problem is defined will determine what we do about it.

The current WHO global AIDS strategy can be used to illustrate the obsolete nature of the WHO approach to health and the lack of essential strategic coherence. Using AIDS to illustrate WHO's current unfitness for global health leadership may seem paradoxical, for two reasons. First, WHO has promulgated an excellent, official definition of health. Second, the WHO AIDS program, the largest program in WHO, directed and coordinated an unprecedented global mobilization, helped virtually every country to develop its national AIDS program, and was instrumental in developing common policies on HIV/AIDS prevention and control. Thus, if any part of WHO deserves to be considered global, it would be the AIDS program.

However, it was the very success of the WHO AIDS program in traditional public health terms that helped reveal its strategic inadequacy, raising in turn serious questions about WHO's capacity to provide effective global health leadership.

In the mid 1980s, WHO developed its first global AIDS strategy, based on what was known at the time, both about AIDS and about public health. The problem of prevention was defined as follows: AIDS is a new, serious global health threat; since HIV spreads through personal behaviors, individuals must change their behaviors; accordingly, programs are needed to help people accomplish this task.

The programs developed to support behavior change were based on a three-part model: two parts were from traditional public health practice and one part was new. The standard parts of this "prevention triad" were (1) information/education and (2) health and social services. The third element, not part of the standard lexicon of public health, was the need — discovered through practical experience — to prevent discrimination toward HIV-infected people and people with AIDS. Programs at the community level, based on this three-part model, were often highly successful in preventing HIV spread. Indeed, many such pilot or local programs were as successful as any other public health program based on behavior change or even more so.

Global mobilization occurred; national AIDS programs were developed in virtually every country; common policies were promulgated. Yet while this approach and model for prevention were very good public health and highly internationalized, they essentially represented a new and improved global expression of the traditional public health paradigm, what may be considered the "useful, necessary and important but not sufficient" approach.

For despite global and most national efforts, experience taught that the first WHO global strategy was inadequate and incomplete. The gap between the expanding pandemic and the global response continued to grow, rapidly and dangerously; successful pilot projects were neither sustained nor disseminated; the lessons painfully learned from hard global experience were ignored and not widely applied; community and political commitment to AIDS plateaued or declined; the disparity between rich and poor, within and between nations increased; and AIDS remained disconnected and isolated from broader health concerns.

Yet, during this time, even as the pandemic intensified and continued to spread inexorably around the world, and as the inherent limits of public health programs became evident, a critical discovery that illuminated a much more profound and fundamental understanding of the nature of the HIV/AIDS pandemic. Reviewing the evolution of the epidemic in different countries, industrialized and developing, a societal risk factor for HIV infection became evident. To the extent that people belonged to populations already marginalized, stigmatized, and discriminated against, their vulnerability to becoming HIV infected increased. For example, in this country, the HIV epidemic is moving increasingly into the African-American and Latino communities and the inner cities and is also increasing among women. In Brazil, an epidemic that started among upper-class, internationally connected gay men is now a vast heterosexual epidemic in the slums of Rio and São Paulo. In India and Thailand, the poor, the dispossessed, the young women sold into prostitution — these are most affected. And, taking the analysis one step further, in East Africa, women who are married and monogamous are increasingly becoming infected with HIV: it has even been said that marriage is a major risk factor for HIV infection among Ugandan women! The women know about AIDS; condoms are available in the marketplace. Yet even if their husband is known to be HIV infected, they cannot refuse unwanted or unprotected sexual intercourse, out of fear of being beaten and without legal recourse or divorce, which is equivalent to social and economic death. In short, discrimination — women's unequal rights, roles, and status — creates an environment of increased vulnerability to HIV infection.

To frame the analysis somewhat differently, the failure to realize human rights and respect human dignity has now been recognized as a major cause — actually, as the root cause — of vulnerability to the HIV/AIDS epidemic. This understanding resulted from concrete and practical experience, not from simply theoretical considerations; it was discovered in communities, not in governmental bureaucracies or universities. Field experience has led to a critical insight of importance beyond AIDS, for a careful analysis of the other major health problems of the world, including cancer, heart disease, injuries, individual and collective violence, and other infectious diseases, shows that they are all closely linked with the status of respect for human rights and dignity. In this manner, the struggle against a new global epidemic has led to the threshold of a new understanding of health and society.

The modern concept of health is best expressed in the WHO's excellent definition: health is a state of physical, mental, and social well-being. Modern public health was then defined most cogently by the U.S. Institute of Medicine in 1988 as "ensuring the conditions in which people can be healthy," Or, to blend both definitions, public health seeks to ensure the conditions in which people can achieve physical, mental, and social well-being. Yet what are these essential conditions for health?

Let's get right to the point: in contrast to the prevailing myth, medical care accounts for only a small part of health. Some recent studies suggest, for example, that in this country, only about one sixth of the increase in life expectancy during this century has resulted from medical

care. Medical care is not, and should never be, considered synonymous with "health"; we all recognize its importance, but by far the most important determinant of health status are the so-called social factors.

The next, obvious question involves the specific nature of these societal determinants of health, and here the paucity of research efforts, compared with the enormous investment in biomedical research, is simply stunning.

Socioeconomic status has been the best-studied relationship and potential explanatory factor. And indeed, throughout the world and over time, the rich and well-educated live longer and have less illness and disability than the poor. Yet the socioeconomic status analysis has three major limitations. First, there are an increasing number of discordant observations: why do married Canadian women and men live substantially longer than their single fellow citizens? Why does the health status of Mexican immigrants to Los Angeles decline as their socioeconomic status rises? Why is the health of those Germans living in former East Germany declining precipitously while their socioeconomic status is improving? Why are obese women in this country more likely to live in poverty and to have less education than non-obese women?

The second problem with the socioeconomic explanation is related to the variables taken into account in the analysis. In most studies, socioeconomic status is determined by considering a few simple issues: income, highest educational attainment, and job category. In this country, race, rather than social class, has often been the only variable measured. Yet the size of the gap between the rich and poor, the magnitude of societal inequality, is also relevant, and psychological characteristics such as hostility and depression are also clearly important, as are other social features such as "connectedness" and integration in the social fabric.

The third problem with the traditional socioeconomic status argument is that it leads to paralysis and inaction. For once health professionals have identified poverty and low socioeconomic status as the critical determinants of health status, what concrete and practical steps can they take? The overwhelming nature of the problem leads to professional disempowerment and to the common situation in which so-called social factors are readily identified as the most important determinants of health by professionals whose work does not directly address these root causes of ill-health, disability, and premature death. We have all heard countless talks about health problems acknowledge, in a throw-away line at the end of the biomedical talk, the "vital social, economic, and other factors," which are then never actually discussed!

The modern perspective of health as well-being, the modern appreciation for the overwhelming importance of the societal determinants of health status, and the insights generated by experience with HIV/AIDS prevention and care must now be brought together to catalyze a new and broader approach to understanding what is required to promote and protect individual, community, and global health.

The promotion and protection of health are now understood to be inextricably linked with the promotion and protection of human rights. In other words, health

promotion and protection depend upon the extent to which human rights are realized and dignity is respected. From this viewpoint, the human rights framework may be a better one for analysis of health and for action to promote and protect health than the existing biomedically based, pathology-based approaches that have been developed by the health professions. For the human rights framework addresses the requirements for physical, mental, and social well-being, or, to put this in health language, it identifies and addresses the "conditions in which people can be healthy." This analysis does not minimize the value of biomedically derived and traditional public health approaches, but it directly addresses the distinction between the societal root causes and the surface manifestations — the expression of these causes in the form of ill-health, disability, and premature death. Thus, when the World Bank, not known primarily as a human rights organization, states that increasing the educational attainment of women in developing countries would be a powerful and effective intervention for improving health status, it is not abandoning the need for health services, or safe water, or prevention of epidemic disease. Rather, the analysis recognizes that health clinics, pumps, and immunization programs will ultimately be most successful in promoting and protecting health when women have the education that is so critical to realizing other human rights.

The practical implications of this analysis are enormous and can be illustrated in the following thought experiment. Take any specific component of HIV prevention — for example, control of other sexually transmitted diseases. If we ask what should be done to control STDs in the community, the experts can readily provide us with a list of activities that together constitute the public health approach, such as establishing STD clinics, training clinicians, ensuring accurate and rapid diagnosis, making treatment readily accessible, providing information through media and pamphlets, and educating in the schools. All of these activities are important, must be taken seriously, and must be performed conscientiously. Yet, curiously, if we then ask these same experts — our colleagues, ourselves — whether doing all these things will control STD in the community, the answer is a quiet but honest "no"! If we then ask what would be required to achieve control, a short list of deep societal issues will be identified, such as gender inequality, cultural barriers to open discussion of sexuality, and economic inequity.

Then, if we repeat this process for each of the specific elements of HIV prevention — condoms, a safe blood supply, injecting and other drug use — the result is the same. For each specific problem there will be a list of traditional public health activities, different for each, along with a shorter list of deeper, underlying societal issues. Each time, we will conclude that our public health—based work is useful but not sufficient to get to the heart of the problem. Then, we discover that the short list of deeper societal problems is remarkably constant and similar; the specifics vary widely, yet the deeper issues are common denominators.

Of course, this is actually a rediscovery. For public health has long recognized the fundamental importance of societal factors for health. The new advantage comes from linking health with the concepts, language, and action-oriented framework of human rights. The central challenge is the difference between recognizing and responding; we have been trained to see but not how to act.

New forms of action, including collaboration between health professionals and others in society seeking to promote and protect human rights, will be required. Unfortunately, by adhering to a narrow biomedical framework of analysis and by refusing to learn from the vast global experience in HIV/AIDS prevention, WHO has marginalized itself from the real struggle to "ensure the conditions in which people can be healthy." When the WHO AIDS program realized that discrimination was not only a tragic effect, but was actually a root cause of the pandemic, it was leading WHO inexorably to the brink of a substantially new understanding of the work required to promote and protect health. Seeking refuge in the medical and technical issues in which WHO's formal expertise can be unchallenged, Dr. Hiroshi Nakajima, the current Director-General, has led the organization back into the past, affirming: "Let us remember that AIDS is a health issue, not a human rights issue."

A third requirement for global health leadership focuses on the operational question of who is responsible for health at the community and national level. WHO, as a specialized agency of the United Nations (UN), is an organization of nation-states. WHO's sole interlocutor at the national level is the Minister of Health, just as UNESCO has a privileged relationship with Ministers of Education. This leads WHO to act, always, as if the government — and indeed the Minister and Ministry of Health — is the key actor in health.

In turn, this creates two problems. First, Ministries of Health are not generally prepared for, or capable of, playing a major role in the governmental decisions that affect "personal, mental, and social well-being," nor are they able to act directly on most of the "conditions in which people

can be healthy." Other sectors of government, such as budget, planning, labor, transportation, justice and defense have a much more substantial impact on health. In addition, Ministries of Health are notoriously weak and underfunded. To be concrete, at the large cabinet table, the Minister of Health is likely to be seated at the distant end, near the Minister of Education, barely seen and rarely heard. Finally, Ministries of Health, commonly dominated by physicians, often tend to perpetuate the medical model rather than a public health approach. Thus, from both a conceptual and pragmatic viewpoint, putting all the "health eggs" into the Minister's basket is a mistake.

In addition, for health, the community-based and nongovernmental organizations (NGO) are often "where the action is." The number of international and national/local NGOs, emerging largely since 1945, has grown enormously. NGO work in health involves three broad areas: service delivery, innovation, and advocacy. The special quality of NGOs, a source of both their particular strengths and specific limitations, is their generally close and participatory relationship to the community to be served or affected. For NGOs generally emerge in response to specific, concrete problems faced by specific groups. Population and family planning offer a particularly rich, diverse, and extraordinary example of nongovernmental capacity. Or to take the example of AIDS, the first NGO in this country was formed in 1982, yet by 1990, over 16,000 AIDS-related NGOs had been created.

WHO's relationship to nongovernmental organizations is narrow, for it is designed to be explicitly respectful of national governments. NGOs can monitor, irritate, or even

oppose official governmental health policies and programs; accordingly, WHO deals with national or community-based NGOs only through the Ministry of Health and with its full approval.

Not surprisingly, therefore, interactions between WHO and NGOs are stilted and constrained. WHO is inherently reluctant to go beyond declarations of the importance of community-based organizations. Concepts of personal and community "empowerment" are expressed and promoted, yet when these collide with national policy or politics, WHO is studiously mute. WHO's rhetoric is actually revolutionary, yet WHO remains locked into a relationship with nation-states that deprives it of flexibility and responsiveness, but also insulates it from public accountability.

The fourth issue to be raised regarding WHO's capacity for global health leadership involves the question of accountability. Should the global public be informed about the major global health challenges and threats to health? To be bolder still, should that public be able to hold an organization like WHO accountable for its actions and its effectiveness? Of course, these are truly revolutionary concepts for any part of the UN system. For the sanctity of national sovereignty is enshrined in the UN Charter, expressing the view (of governments) that they represent the will and needs of the people living within their borders. This seems reasonable, for short of divine election, what other source of legitimacy might a government possibly possess?

Yet the relationship between an organization with WHO's mandate and the interests of its constitutent nation-states

must be inherently uneasy, just as in the UN, a constant struggle exists between the fundamental organizational principle of respect for national sovereignty and the fundamental organizational purpose of promoting universal human rights.

Unfortunately, WHO has surrendered abjectly to the nation-state principle. In WHO meetings, with rare exceptions, countries are never named, and thus officials might speak about a cholera epidemic in the Eastern Mediterranean Region, or, when referring to one's own country, they speak of "the country I know best." This curious circumlocution is symbolic of the great fear of embarrassing a country or offending its political leadership. For in strictly organizational terms, such offenses can have several serious consequences. First, even though the regular budget involves dues, countries may express displeasure by withholding their assessed contributions, as the United States has done. Second, such offenses may result in WHO being excluded or not invited to work with the country concerned. Third, the elections for Director-General and for the six Regional Directors are entirely political events. So the cardinal sin of the WHO secretariat would be to point the finger or to embarrass a government.

What about organizational accountability? The recent reelection of Dr. Nakajima provides an excellent case study. The position of Director-General of WHO is the single most important post in global health. The key event in the election process is the nomination of a candidate by the Executive Board of WHO, composed of 31 individuals ostensibly chosen for their personal qualities, yet actually selected by their governments. The medical journal *Lancet*

called the reelection of Dr. Nakajima last year "an undignified scuffle" and noted that for the voting members of the Executive Committee, in addition to all-expense-paid trips to international conferences, "it is clear that many... 'incentives' were on offer."

Yet perhaps of greater importance, there was a total absence of discussion about global health priorities and strategies. It is scandalous that no one, including the governments that voted for him, can tell us what Dr. Nakajima's vision, priorities, or plans may be. This complete silence — the absence of any public debate or information — is tragic. The entire outcome of the election, the single most determining factor for the work of WHO during a five-year term, was based on global power politics and influence.

The lack of transparency and accountability operates at many levels. Example: The Director-General has the authority to violate any and all staff rules. Example: Immediately on leaving a position on a WHO governing body, such as the Executive Board, a health expert may be employed, with generous remuneration, by the Organization. Example: International health experts can be excluded from (not invited to) meetings in which they have demonstrated competence and leadership, because they disagree with WHO secretariat attitudes or positions. Example: No nongovernmental organization has yet been able to successfully monitor or "watchdog" the internal operation of WHO.

This total lack of transparency and accountability, even to governments, has a high cost. Again to cite *Lancet:* "WHO {now} wallows rudderless amid a sea of adverse rumors,

offensive press reports, and staff disaffection." Both the words of Peter Drucker and a proverb are apt. Drucker noted that when an organization is infused with a clear and common sense of purpose, it doesn't matter what the organizational chart looks like and that when an organization lacks a clear and coherent understanding of its mission, it also doesn't matter what the organizational chart looks like! The proverb is more direct: "When the leaders lack vision, the people suffer."

Thus, in at least four critical areas — global thinking, coherence of strategic analysis and approach to health, capacity to work with society to promote health, and organizational accountability — WHO is clearly obsolete and out of step with modern realities and needs.

Revitalization and renewal of WHO — or creation of the capacity to provide leadership in health, and global health leadership — is essential. The next pandemic may already be incubating, and it will not wait. Without a coherent strategic approach, health promotion and protection will be inherently limited, for no matter how hard we try, traditional public health programs cannot compensate for the vulnerability to disease, disability and premature death created by society. The powerful community and nongovernmental movement for health needs to be linked and to be able to link its local action with global vision. Disaffection with and distrust of WHO cannot be managed with "spin doctors" and declarations.

Yet the seeds of renewal are already present — in the preamble to the WHO Constitution! This preamble was truly visionary and remains as vibrant, fresh and inspiring today

as when it was written. It points an accusatory finger at those who have led the Organization astray.

For it declares firmly that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." WHO's inextricable linkage with the modern human rights movement can therefore never be questioned.

Then, it identifies health status and global equity as prerequisites for peace and common security, stating boldly that "the health of all peoples is fundamental to the attainment of peace and security" and that "unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger." Global interdependence is explicitly recognized, for "the achievement of any State in the promotion and protection of health is" understood to be "of value to all."

Next, it declares its universalist aspiration, not only by referring to health as a right, but by insisting that "the extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health."

While giving great importance to nation-states, the preamble reminds governments that they "have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures," and it declares unequivocally that "informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of... health."

This was, and remains, a global declaration of great power that, if taken seriously today, indicates how, why, and when an old order must give way to the new.

The challenge to global health, and therefore the challenge to WHO, is profound. A new relationship between national sovereignty and global health interdependence must be negotiated; a "new public health" must be championed, linking traditional public health strengths with new insights into the major determinants of health status and with a commitment to action; public and community participation must be welcomed and enhanced; and institutional reforms to reduce corruption and inefficiency are overdue.

Just as a personal crisis is sometimes needed to bring us back to our true selves, so a health crisis, or series of shocks to the status quo, may be needed to remind the world that the vigilance and vision are needed to protect our global health and to shake WHO from its complacency, bringing it back to its first principles.

Fortunately, the history of individuals and institutions provides many examples of rebirth, of renaissance. Yet we cannot only await these changes. Let us assume our own responsibilities. For to be engaged in public health, to "ensure the conditions in which people can be healthy," inevitably leads us to challenge the status quo — of institutions, of societies, and of ourselves. And we recall that the proverb which begins in sadness, "when the leaders lack vision, the people suffer", concludes with hope — "yet there is confidence and strength in the councils of the people" — and we are the people.

Reflecting on history, Jorge Luis Borges wrote that, in contrast to the history of kings, battles and treaties, the real history was very deep, hidden below the surface. Thus, two key historical moments, according to Borges, occurred when Greek theater moved from a single voice to two voices, opening all the potential for human dialogue and exchange, or when, in a Nordic epic poem, the courage of the enemy was celebrated, so that for the first time, the "other" was also seen as human — a giant step toward tolerance. In such a way, we now possess an image — the single most important photograph or picture in history — that may also mark a deep change in human consciousness; the picture of our Earth, seen from outer space — irrefutable evidence that we are destined to travel together.

FRANK A. CALDERONE, MD

Dr. Frank A. Calderone (1901-1987) was born on the Lower East Side of the New York City. He attended Columbia University as an undergraduate, and obtained his MD in 1924 at New York University Medical School. He was an Instructor in Pharmacology there until 1936, and was immensely popular with his students, who elected him to membership in Alpha Omega Alpha. In 1936, he attended Johns Hopkins University to pursue a Masters of Public Health. In 1938, he was appointed District Health Officer of the Lower East Side for the New York City Department of Health.

In 1942, Dr. Calderone was appointed Secretary of the Department of Health, and First Deputy Commissioner of Health a year later. He held this position until 1946, saving the City of New York over a million dollars through careful planning, operations management, and negotiation.

In 1946, Dr. Calderone became Director of the Headquarters Office of the United Nations Interim Commission of the World Health Organization (WHO). He was instrumental in shaping WHO's policies and structure, and in raising funds to support its continued operations. In 1948, when WHO became a permanent organization, he was awarded a five-year contract as Chief Technical Liaison Officer and New York Office Director. He was later appointed Medical Director of the United Nations Secretariat health service.

Dr. Calderone was a Fellow of the American Public Health Association. In addition to his numerous public health responsibilities, he also managed a family business of eight theatres and extensive real estate holdings, and enjoyed music, sailing, and family.

THE FRANK A. CALDERONE MEDAL AND PRIZE

In the early part of this century, Salvatore Calderone, immigrant father of Dr. Frank Calderone, commissioned the renowned firm if Dieges and Clust to design and strike a "medal of merit" in solid gold. Only a few of these beautiful medals were ever made and, of those few, only one medal is still in existence. It was used by Tiffany & Company as the model for the creation of the Calderone Medal. Along with a $10,000 prize, the Calderone Medal is awarded by the Columbia School of Public Health every two years to recognize and honor individuals who have made significant contributions to the field of public health and public health research.

Recipients

1994	Jonathan Mann, MD, MPH
1992	C. Everett Koop, MD