

A Study on Australia's Cooperation with the World Health Organization during the Cold War Period

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Abstract

During the Cold War era, Australia's need for collaboration with the World Health Organization (WHO) arose from domestic pressures to control infectious diseases and the risks posed by transnational disease transmission. At the same time, Australia's robust national public health system and advanced medical technologies equipped it with the capacity to engage in global health partnerships. The establishment of the WHO provided an ideal international platform for such cooperation. Australia not only actively aligned with the WHO's global health agenda but also took proactive steps in regional health governance and international aid efforts, evolving from a mere participant in collaborations to a key regional coordinator. This progression ultimately helped transform the WHO from a Euro-American-centric health institution into a more inclusive and dynamic platform for global health governance.

Keywords

Cold War, Australia, World Health Organization, health governance, infectious diseases

1 Introduction

During the Cold War, global health governance took shape amid the intricate interplay of great-power rivalries and international cooperation. The World Health Organization (WHO), as the central institution of this governance framework, relied heavily on partnerships with sovereign states to function effectively. Since its founding in 1948, the WHO has championed transnational health collaboration, and its exchanges and cooperative efforts with countries worldwide remain essential to comprehending the evolution of global health governance. Australia's partnership with the WHO held implications that transcended mere domestic infectious disease control. By aligning with the WHO, Australia could draw on international resources to counter the post-World War II surge in infectious diseases, driven by mass population displacements and sluggish economic recovery. At the same time, it leveraged its advanced medical infrastructure and deep talent pool, bolstered by waves of immigrants and professionals, to engage actively in the organization, thereby amplifying its voice on the global stage. The geopolitical dynamics of the Cold War, meanwhile, profoundly shaped the trajectory of this collaboration. Australia's pro-U.S. foreign policy aligned seamlessly with the WHO's dominant influence, the United States, spurring it not only to embrace the organization's global health agenda but also to take the lead in regional health governance, evolving from a passive participant into a pivotal regional coordinator.

This article follows a chronological framework, drawing on World Health Assembly documents as its primary source material. Using Australia's cooperation with the WHO as the focal lens, it methodically traces

the nation's evolving role in the Western Pacific region and broader global health security efforts, with particular emphasis on infectious disease prevention and control. In doing so, it offers deeper insights into how middle powers engaged with the WHO to propel global health governance forward during the Cold War era.

2 Background of Australia's Cooperation with the WHO

Since the 20th century, alongside economic development, Australia's domestic quality of life and medical and health standards have improved markedly, leading to significant enhancements in the overall health of its population. The historical trend in individual life expectancy (the expected remaining years of life at birth or a specific age) has risen accordingly. However, during the early Cold War period from 1946 to the 1960s, the rate of increase in life expectancy slowed (averaging just 2.6 years), a decline of 1.65 years compared to the early 20th century (1901-1922) (Pei et al., 2009). From the 19th century to the early 20th century, infectious diseases were the primary cause of death in Australia, accounting for around 20% of total annual deaths (Pei et al., 2009). This was particularly evident during World War II, when Australian forces fighting the Japanese in New Guinea suffered substantial non-combat casualties from malaria, which also resulted in the spread of the outbreak to the mainland (Xu and Zeng, 2023). Ancient infectious diseases such as plague and cholera had not been fully eradicated domestically, posing ongoing challenges to public health.

Postwar population growth and accelerated urbanization further amplified the demand for public health services. The rise of nation-states after the war intensified transnational population movements, and as the White Australia Policy gave way to more inclusive immigration policies, the influx of new immigrants to Australia increased (Wang, 2003). This facilitated the cross-border spread of infectious diseases, elevating health issues to the realm of diplomacy (Kickbusch, 2023) and significantly heightening the risks of transnational transmission. No single nation's control measures could adequately address the shocks of global pandemics. The Australian government fully recognized that controlling many infectious diseases required not only national coordination but also indispensable international cooperation (Pei et al., 2009), as improvements in global public health were closely linked to its national security and economic development. Domestically, during the Cold War (1947-1991), the government steadily increased investments in public health, with public health funding comprising approximately 2% of total health expenditures, of which infectious disease control accounted for 16.6% of public health funding (Pei et al., 2009). This ensured Australia's technological leadership in multiple fields of modern medicine, the construction of public hospitals, and the gradual formation of a medical service network centered on public hospitals. Internationally, the establishment of the WHO in 1948 provided a platform for Australia to participate in global health governance.

3 Australia's Cooperation with the WHO

3.1 The 1950s: Initiation of Cooperation and Exploration in Regional Foundational Areas

3.1.1 Participation in the Early Institutional Building of the WHO

In 1948, Australia was elected as one of the 18 members of the Interim Commission of the World Health Assembly (World Health Organization, 2013a), tasked with preparing for the First World Health Assembly. Motivated by its own security concerns and a vision for global public health governance, Australia, along with other countries, actively advocated for the inclusion of infectious diseases such as malaria, cholera, yellow fever, and smallpox in the WHO's priority control agenda (World Health Organization, 2013b). In 1949, the WHO established a regular broadcasting service, commissioning over 200 audio recordings from medical experts and consultants, which were broadcast for promotional purposes in seven countries, including the United Kingdom, the United States, Switzerland, Australia, and France (World Health Organization, 2013c). At the Second World Health Assembly, Australia also served as one of the eight nations on the General Committee. Its chief delegate offered comments on the budget review and, drawing from the experience of the Second Assembly, urged the Executive Board to expedite deliberations on the budget and working capital at the Third World Health Assembly through procedural channels. This would allow member governments to provide input before major commitments were made, and the proposal garnered support from the U.S. representative (World Health Organization, 2013k). As a WHO training center, Australia focused on specialized areas of public health, assisting relevant countries and regions with medical training and aid (World Health Organization, 2013k). Australian representatives opposed launching large-scale mental health projects

or addressing public health nursing issues with the limited available donation income from the WHO (World Health Organization, 2013k), but they supported efforts to control leprosy, particularly in Asia (World Health Organization, 2013k). They also proposed that contributions to the WHO should be considered within the framework of the overall United Nations apportionment policy, a view endorsed by the French government. In 1950, regarding the financial arrangements for the WHO's working capital fund, the Australian delegation at the Third World Health Assembly suggested payments to the WHO based on the proportion of each member state's budget for the following year, as approved by the Assembly (World Health Organization, 2013l). In 1951, Dr. D. A. Dowling from Australia was elected Vice-Chairman of the Fourth World Health Assembly (World Health Organization, 2013m), representing the country in advancing the WHO's early institutional development.

3.1.2 Regional Public Health Construction

In 1950, the WHO arranged for Western Pacific fellows to study in Australia and New Zealand (World Health Organization, 2013d), exploring the potential use of these countries' training facilities for staff from other nations in the region. Subsequently, with WHO funding support, Australia sent its own physicians to study social pediatrics in Canada, the United States, Finland, Sweden, and Norway. WHO expert advisors visited Melbourne, Australia, to inspect BCG vaccine production, as the country sought WHO approval to incorporate it into regional tuberculosis programs (World Health Organization, 2013d). In 1951, Australia joined other Commonwealth members in participating in the Colombo Plan, with a focus on health development in the Western Pacific region (World Health Organization, 2013m). In 1952, new regional offices were established in the Western Pacific, Europe, and Africa, completing the six regional offices planned at the First World Health Assembly (World Health Organization, 2013n). In line with the International Sanitary Regulations stipulating that yellow fever vaccines must be WHO-approved, Australia promoted the involvement of the Commonwealth Serum Laboratories (CSL) in Melbourne in yellow fever vaccine production. In April 1952, the laboratory received official approval for manufacturing yellow fever vaccines, positioning it as a key supplier in the region (World Health Organization, 2013e). As a non-endemic country for yellow fever, Australia's proactive push for global control reflected its forward-thinking strategic approach to epidemic prevention. Australia actively engaged in Western Pacific regional seminars, such as the 1958 session where its representative joined 17 others from Western Pacific countries and seven government observers to discuss regional environmental sanitation (World Health Organization, 2013f).

3.1.3 Cooperation from Zoonoses and Yellow Fever to Smallpox and Tuberculosis

On April 27, 1951, the WHO Executive Board held its Eighth Session (Document EB8/2 (World Health Organization, 2014a), which noted that from 1950 to early 1951, 12 countries, including Greece, Denmark, Italy, and France, were designated as centers for brucellosis research under the FAO/WHO collaboration. Among them was Australia's Commonwealth Serum Laboratory in the Parkville N.2 district, marking the beginning of cooperation in the field of zoonoses. By the late 1950s, collaborative efforts expanded from lower-impact diseases like yellow fever to higher-risk ones. In May 1958, the Soviet representative at the Eleventh World Health Assembly proposed a smallpox eradication plan. Citing the slow global decline in smallpox cases over the past decade, the risk of the virus being carried into disease-free countries, and high mortality rates, the Soviet delegate argued that eradication could be achieved through vaccination and effective isolation measures, though it would require resolute commitment from governments and the WHO (World Health Organization, 2013o). The Australian representative endorsed the Soviet draft resolution but emphasized that the plan's success depended on the willingness and capacity of endemic countries, and that vaccination campaigns would demand systematic efforts (World Health Organization, 2013o). In the realm of tuberculosis research, in May 1959, Australia applied for funding for a tuberculosis research project at the Twelfth World Health Assembly (World Health Organization, 2013p). In September 1960, the WHO Western Pacific Regional Committee provisionally approved an application to host a seminar on tuberculosis public health and control for Western Pacific scholars in Australia, with costs covered by the Australian government and the National Association for the Prevention of Tuberculosis (World Health Organization, 2016b).

3.2 The 1960s: Deepening Cooperation and Expansion into International Domains

3.2.1 Governance of High-Risk Infectious Diseases

In 1960, the WHO approved the budget for Australia to host a tuberculosis seminar. Held in Sydney from

May 23 to June 3, 1960, the seminar brought together medical officials engaged in tuberculosis research from 22 Asia-Pacific countries, along with several international experts. It also invited representatives from Australia's National Association for the Prevention of Tuberculosis, the South Pacific Commission, and the U.S. Agency for International Development in China (Taiwan) and the Philippines. Discussions covered the latest advancements in tuberculosis control, as well as public health and prevention strategies for ongoing projects. Following the event, Australia's National Association for the Prevention of Tuberculosis and the government arranged for some participants to visit the country's tuberculosis control initiatives (World Health Organization, 2013g). This marked the entry of Australia-WHO cooperation in high-risk infectious diseases into a substantive phase.

In 1965, Australian antigen was discovered in the serum of Indigenous Australians, providing a foundation for further exploration of the disease's etiology and epidemiology, as well as for preventive measures (World Health Organization, 2013h). 错误!未找到引用源。 By the 1960s, infectious diseases were no longer a severe health issue in Australia, though certain ones remained concerning. From July 1, 1967 to June 30, 1968, the most frequently reported infectious diseases in Australia were infectious hepatitis and tuberculosis (World Health Organization, 2013h).

3.2.2 Engagement in Global Public Health Affairs

During the 1960s, Australia began engaging in global health governance issues. At the 16th World Health Assembly in 1963, Australia took the lead in drafting a resolution on African matters, emphasizing that the WHO should adhere to its non-political and humanitarian principles, as outlined in the WHO Constitution, particularly in controlling infectious diseases that transcend borders. The resolution aimed to safeguard the health rights of all affected African populations and to address restrictions on population movements between African member states, thereby enhancing the effectiveness of cross-border infectious disease prevention (World Health Organization, 2014b). 错误!未找到引用源。 In malaria control efforts, as of April 30, 1962, Australia had donated \$106,082, ranking second only to the United States, the Soviet Union, Germany, Sweden, and Denmark (World Health Organization, 2013q). Following approval at the 19th World Health Assembly in 1966, the WHO launched its smallpox eradication program in January 1967. Australia actively responded to the global health governance needs amid U.S.-Soviet Cold War dynamics, further integrating into the international health cooperation network (World Health Organization, 2013h). As Australia's involvement in international health affairs grew, its Department of Health established an International Health Division to manage these matters, accelerating the country's participation in global health initiatives (World Health Organization, 2013h).

3.3 The 1970s: Expansion into Non-Traditional Areas and Strengthening Regional Support

3.3.1 Breakthroughs in Non-Traditional Health Domains

From the 1970s onward, cooperation extended from traditional infectious diseases to non-traditional areas such as drug dependency and mental health (World Health Organization, 2013s). In drug dependency governance, Australia collaborated with the WHO to issue a statement calling for reduced global illicit drug demand and strengthened treatment and rehabilitation services for those affected, to address the public health challenges posed by drug proliferation. At the 32nd World Health Assembly in 1979, it was decided to host the first Pan-Pacific Conference on Drugs and Alcohol in Canberra, Australia, in February 1980 (World Health Organization, 2015c).

Beyond infectious disease control, Australia focused on mental health and intellectual disabilities. In 1977, at the 30th World Health Assembly, Australia proposed prioritizing the prevention and support of intellectual disabilities in national policies, along with promoting relevant interventions among children (World Health Organization, 2014c). At the 31st World Health Assembly, it supported Resolution EB61.R28 to advance the implementation and monitoring of mental health programs (World Health Organization, 2013v).

In 1979, breakthroughs in malaria control vaccines were announced through human genetics research in Australia and 10 other countries (World Health Organization, 2013j).

3.3.2 Enhancing Regional Organizational Capacity

As the WHO's coordinator for health affairs in the South Pacific, Australian experts actively participated in regional malaria control, such as assessing the status of malaria eradication in Papua New Guinea. Their evaluation highlighted obstacles to the national malaria eradication program, including rugged terrain, communication and transportation challenges, funding shortages, and cultural patterns (World Health Organization, 2013r). In 1972, at the 25th World Health Assembly, Australia assisted Papua New Guinea in applying for associate membership in the WHO, promoting the integration of regional countries into the global health system (World Health Organization, 2013u). In the Western Pacific region, from 1972 to 1976, the Regional Education and Training Center in Sydney, Australia, organized courses and workshops for 250 individuals from 120 institutions in the region (World Health Organization, 2013i). In 1978, Australia led a proposal to launch the WHO's mid-term plan for health personnel training, urging member states to leverage existing health resources to bolster regional health workforce reserves and further solidify its leadership in regional health capacity building (World Health Organization, 2015b). At the 32nd World Health Assembly in 1979, the Australian representative affirmed support for the WHO's "Health for All by the Year 2000" (HFA/2000) goal, introduced at the 30th World Health Assembly in 1977. Australia pledged continued technical assistance in areas such as eradicating infectious diseases, improving water supply and sewage systems, enhancing nutrition and family planning programs, and conducting health training. Such cooperation could bridge divides among people with differing social, economic, and political backgrounds, while opposing the introduction of political divisions into the WHO. The representative emphasized that medical care was a vital means to achieve health goals for all Australians by 2000, with primary health care serving as the key (World Health Organization, 2015c).

To control the cross-border spread of infectious diseases, Australia enforced strict regulations on international travelers regarding vaccination certificates upon entry. At the 30th World Health Assembly in 1977, the Australian government reported a steady increase in recent years of overseas airline passengers entering the country with invalid or missing international vaccination certificates. Statistics from 1973 showed that 4,805 individuals received smallpox vaccinations upon arrival by air, while 13,808 received cholera vaccinations; additionally, 338 people who arrived without vaccinations and refused them upon entry were quarantined and detained. The Australian government established mechanisms for tracing, tracking, and testing susceptible populations exposed to infectious disease carriers. For instance, in 1969, a passenger who flew from Mumbai, India, to Sydney fell ill with cholera in Melbourne, Australia. All fellow passengers on the flight were traced and subjected to epidemiological surveillance, with no secondary cases reported (World Health Organization, 2013t).

3.4 The 1980s-1990s: Enhancing Discourse Power and Addressing Emerging Challenges

3.4.1 Strengthening Discourse Power in Regional Health Governance

In the 1980s, as the number of member states and population size in the Western Pacific region grew, Australia advocated for a resolution at the 38th World Health Assembly that increased representation on the WHO Executive Board by adding one seat for a Western Pacific country. This expanded the board from 31 to 32 members, directly elevating the region's voice in global health governance and underscoring Australia's regional influence (World Health Organization, 2013w).

3.4.2 Regional Collaboration on Emerging Infectious Disease Control

In the 1980s, emerging infectious diseases like AIDS posed major global health challenges (World Health Organization, 2015e). Australia, in collaboration with the WHO Western Pacific Regional Committee, promoted Resolution WPR/RC39.R4, urging member states to develop short- and medium-term AIDS control plans, with the regional director coordinating information sharing and project evaluations (World Health Organization, 2016a). By January 1990, technical assessments had been conducted in 23 of the 35 Western Pacific countries. Through WHO cooperation with regional nations, 17 short-term plans and 8 medium-term plans were formulated. Despite pressures from doubling HIV infection rates and high incidences of sexually transmitted diseases, Australia played a central coordinating role in regional control efforts (World Health Organization, 2015a). By June 1, 1993, the WHO continued providing technical support in this area, further enhancing skills access for Western Pacific countries including Australia. Technical assessments had reached 31 countries, with short-term plans developed in collaboration with 21 and medium-term plans in 19—a

substantial increase from 1990 levels (World Health Organization, 2015f).

From the 1950s to the 1990s, Australia's health governance cooperation with the WHO not only mirrored the evolution of the global health governance system but also illustrated how middle powers could enhance regional infectious disease control capabilities through international organizations, yielding benefits for Australia itself. Starting in the 1970s, the rate of life expectancy increase accelerated, reaching an average of 77.45 years at birth by 1992, a gain of 6.4 years from the early 1960s (Pei et al., 2009). From the 1980s to the early 1990s, mortality rates due to infectious diseases remained stable at around 4% (Pei et al., 2009).

4 Australia's Paths to Participation in WHO Cooperation

4.1 Participation in the WHO as a Middle Power

4.1.1 Economic and Political Foundations Supporting Domestic Health System Development

Leveraging its abundant resources, a political system combining federalism with local autonomy, and a highly centralized fiscal regime, Australia ensured stable economic growth during the Cold War. In the 1950s and 1960s, rapid economic development drove up federal government expenditures on medical and health services. In the 1966/67 fiscal year, spending on health care provision accounted for 11.6% of general government consumption expenditures (World Health Organization, 2013h). Total health expenditures as a share of gross domestic product increased year by year, reaching 7.9% by 1994 in the post-Cold War period—slightly above the average for OECD member countries (Pei et al., 2009). This laid the groundwork for a mature domestic public health system, such as vaccine development and accumulated expertise in infectious disease control, and endowed Australia with the “output capacity” to engage in international health cooperation, underpinned by its domestic economic strength.

4.1.2 The U.S.-Australia Alliance Strategy Shaping Diplomatic Orientation

On one hand, the signing of the Australia, New Zealand, and United States Security Treaty (ANZUS) in 1951 anchored Australia's foreign and defense policies to the U.S. alliance. This choice alleviated its defense and security concerns, allowing it to redirect more energy and resources toward domestic economic development and participation in international affairs. On the other hand, given the profound U.S. influence on the WHO during its early years, Australia's pro-U.S. diplomatic stance aligned closely with the organization's dominant force, facilitating greater support for its positions within the international health agenda.

4.1.3 Australia's Paths to Participation in the WHO

4.1.3.1 Postwar Engagement as a Builder of Multilateralism, Actively Integrating into Global Health Governance

As a founding member of both the United Nations and the WHO, Australia played a key role in constructing the postwar multilateral health governance system. In 1946, it participated in signing the WHO Constitution. After the WHO's establishment in 1948, Australia actively engaged in its core affairs, with a focus on institutionalizing global health governance: supporting the organization's aim to ensure “the attainment by all peoples of the highest possible level of health”, responding to the Alma-Ata Declaration's call for “health for all”, adjusting its own health policies, such as establishing a community-based primary health care system, and participating in World Health Assembly decisions on budget planning and assessed contributions. Over time, Australia transitioned from a “rule-taker” to a “rule-maker”.

4.1.3.2 Actively Responding to WHO Infectious Disease Control through Technical and Resource Outputs

During the Cold War, global infectious disease threats, such as smallpox, malaria, and brucellosis, provided the premise for Australia-WHO cooperation, with its focus shifting from early “technical reception” to “technical output and resource support”. In the 1950s, as noted earlier, Australia joined the WHO's disease control network as a collaborative participant in the Western Pacific region. For instance, the Commonwealth Serum Laboratory in Parkville N.2, Australia, served as a brucellosis research center, undertaking regional pathogen studies and technology dissemination; it also provided international technical references for BCG

vaccines in the Asia-Pacific. From the 1960s to 1980s, Australia demonstrated leadership in the WHO-led “Smallpox Eradication Program”. For example, it dispatched expert Frank Fenner to WHO headquarters, promoting domestic control experiences to the Asia-Pacific region and making key contributions to the global eradication of smallpox in 1980. In malaria control, drawing on military research accumulated during World War II, such as antimalarial drugs and mosquito control technologies, Australia supported the “Pacific Malaria Eradication Program” by helping Papua New Guinea, the Solomon Islands, and other countries build health systems. It promoted technologies like insecticide-treated bed nets and rapid diagnostic tests (RDTs), significantly reducing local malaria incidence rates. In the 1950s and 1960s, the Australian government addressed kuru disease in Papua New Guinea through education, legal measures, and cultural guidance, gradually prohibiting cannibalistic practices among local tribes.

4.1.3.3 Maintaining Policy Alignment in International Health Affairs

Within the WHO framework, Australia aligned its health policies with allies like the United States, positioning itself as a “strategic coordinator for the Western bloc”. For example, at the Seventh World Health Assembly in 1954, Australia supported the U.S.-proposed amendments to the 1955 budget, balancing international contributions with domestic fiscal constraints. In discussions on assessed contribution scales, it advocated for differentiated assessments between “active” and “inactive” member states—a stance that echoed the U.S. position while accommodating middle-power interests—allowing it to serve as a “bridge” in international health financing matters. This coordination not only aligned with its diplomatic orientation but also secured greater discourse power for Australia within the WHO.

4.1.3.4 Conducting Health Aid to Bolster Geopolitical Regional Influence

Australia viewed health cooperation as a tool to consolidate its regional influence. Through multilateral platforms like the WHO, it intensified health aid to Pacific island countries, serving Cold War geopolitical strategies, such as countering Soviet or leftist infiltration. Aid priorities focused on primary health care system projects, including training for medical and nursing personnel in primary health care, rural and suburban water supply and sanitation facilities, community health research, international infectious disease control, and maternal and child health among 11 key areas. From 1978 to 1979, Australia’s aid to the United Nations, regional organizations, and other international bodies totaled 40.54 million Australian dollars, with health projects targeting tropical disease research (WHO/UNDP/IBRD), the WHO dengue research project, WHO epidemiological surveillance and disease control services in the South Pacific, and acute respiratory infections and diarrheal disease projects (World Health Organization, 2012). Through bilateral and multilateral aid, it disbursed 454.955 million U.S. dollars. By 1979, 52 countries and regions received Australian development aid, prioritizing the South Pacific, ASEAN, and South and Southeast Asian nations, with bilateral aid to Papua New Guinea reaching 236.26 million Australian dollars (World Health Organization, 2012). For many years, the Australian government has been a primary provider of development aid funds to Pacific island countries in the South Pacific region. In 1975, it ranked third among donors to the region; by 1982-1983, contributions had risen to 120 million Australian dollars, making Australia the largest donor to the South Pacific. These efforts are seen as direct responses by the Fraser government to foreign powers’ infiltration of Pacific island countries (Ni, 2022).

5 The Impact of Australia’s Cooperation with the WHO during the Cold War on Health Governance

5.1 Impacts on Australia Itself

First, Australia’s active participation in the WHO’s formulation of global health standards, such as disease surveillance and vaccine specifications, allowed it to incorporate international experiences into its domestic practices, directly advancing the modernization of its public health system. Second, during the Cold War, Australia’s activities within the WHO served as an important supplement to its diplomatic strategy. In particular, by promoting WHO health aid projects in the Asia-Pacific region, it consolidated its “peripheral security sphere” during the Cold War era and expanded its soft power in the region. Third, against the backdrop of East-West confrontation during the Cold War, Australia’s engagement in global health cooperation through the WHO demonstrated the agency of a “middle power”: it proactively participated in WHO-led global

initiatives, such as child immunization programs and public health emergency mechanisms, shaping an image as a “responsible international actor” distinct from its purely military alliance role in the Cold War. On issues involving health resource allocation and disease control priorities, Australia emphasized tropical diseases and the needs of developing countries, aligning with its own and its neighbors’ interests while garnering support from developing nations, thereby indirectly enhancing its weight in voicing concerns within the international system. Fourth, Australia’s medical technology and pharmaceutical industries also advanced through participation in the WHO’s international cooperation.

5.2 Impacts on the WHO

5.2.1 Promoting the Regional Implementation of the WHO’s Global Health Agenda

Leveraging its geographical advantage in the Western Pacific region, Australia translated the WHO’s global objectives into regional action frameworks, thereby strengthening the organization’s governance effectiveness in the Asia-Pacific. For example, in 1952, the Commonwealth Serum Laboratories (CSL) in Melbourne, Australia, integrated the WHO’s yellow fever vaccine technical standards into the regional health system. In the 1970s, by integrating WHO technical resources, Australia incorporated the “Pacific Malaria Control Program” into basic health services. Through vector control, such as widespread DDT spraying, and drug treatment, such as free distribution of chloroquine, it reduced malaria incidence rates in countries like Papua New Guinea (World Health Organization, 2016c).

5.2.2 Strengthening the WHO’s Regional Governance

At the 39th World Health Assembly in 1986, the Western Pacific region secured four seats on the Executive Board, accounting for 12.5% of the total 32 seats (World Health Organization, 2015d). This significantly enhanced the region’s influence in key decisions on budget allocation and project priorities, while bolstering the global health governance capacities of small and medium-sized countries and indirectly optimizing the WHO’s decision-making distribution.

5.2.3 Coordinating Cooperation between Eastern and Western Blocs in Health Affairs

In the Cold War context, Australia, as a member of the Western bloc, built bridges for East-West communication through health cooperation, thereby safeguarding the WHO’s neutrality and operational capacity. For instance, in the 1960s, Australia collaborated with the Soviet Union under the WHO framework on smallpox virus research. This model of “technical cooperation transcending political differences” provided assurance for the continuity of the WHO’s global health network during the Cold War.

5.2.4 Expanding the Boundaries of the WHO’s Health Governance

Australia combined its domestic public health experiences with the WHO’s global objectives, propelling the organization to extend from infectious disease control to broader social health issues. For example, in non-traditional health domains, during the 1970s, Australia partnered with the WHO on regional research into “drug dependency and mental health”, pioneering the inclusion of addiction treatment and community psychological interventions within the WHO’s technical assistance scope. Through the WHO, Australia advocated the concept of linking “health with economic development”, emphasizing that improving public health was a prerequisite for poverty alleviation.

5.3 Advancing International Health Governance

5.3.1 Technical Leadership in Global Health Governance

During the Cold War, the U.S. and Soviet blocs created a certain degree of impasse within the WHO, which in turn created space for middle powers to exercise technical leadership. Australia held a world-leading position in tropical medicine and entomology research. Through the WHO platform, it provided crucial technical guidance, expert training, and field trial experiences to Asian and Pacific countries. Australia’s efficient vaccination systems and disease surveillance networks served as models for the Western Pacific region. Its laboratories also supported the WHO’s smallpox virus research. These actions reinforced the WHO’s identity as a “science-based technical institution”.

5.3.2 Serving as a “Health Bridge” between the Western Bloc and the Asia-Pacific Region

First, Australia became an important channel for transferring Western medical technology, knowledge, and resources to Southeast Asia and Pacific island countries. Many WHO training programs, expert dispatches, and medical supply aids in the region were coordinated or implemented through Australia. This, to some extent, alleviated the wariness of some newly independent countries toward direct aid from former colonial powers or superpowers. Second, it voiced regional concerns: as a key member of the Western Pacific Regional Committee, Australia leveraged its Western connections to advocate for greater attention and resources for the region, especially resource-poor Pacific island countries. It helped integrate regional health needs, such as infectious disease control and basic health infrastructure development, into the WHO’s global agenda. It also assisted the WHO in implementing health projects in politically fragmented “Asian Cold War” frontline areas, like Southeast Asia, preventing regional health governance from collapsing entirely due to geopolitical tensions.

5.3.3 Promoting a New Paradigm Centered on Primary Health Care

In the later Cold War period, international health governance underwent a major conceptual shift, from technology-driven “vertical programs”, such as single-disease eradication, to more comprehensive, equity-focused “horizontal approaches”, primary health care (PHC). The Alma-Ata Conference in 1978 marked a milestone in the history of international health governance. The Alma-Ata Declaration established the goal of “Health for All by the Year 2000” and the PHC pathway. Although the declaration was spearheaded by the Soviet Union, it received support from many Western countries, including Australia. Australia viewed it as more suitable for developing countries than expensive, technology-centric Western medical models. Through the WHO, Australia supported the rollout of community-based health worker training, essential drug distribution, and health education initiatives in Pacific island countries. This support provided valuable practical cases and legitimacy for the PHC concept from within the Western bloc.

6 Conclusion

Australia’s participation in cooperation with the World Health Organization during the Cold War essentially embodied a dynamic balance of “capability and willingness” for a middle power within global health governance. This process exhibited three core characteristics: first, pragmatism, with health cooperation consistently serving its domestic and foreign strategies; second, gradualism, evolving from passive participation to active leadership, which underscored the incremental accumulation required for middle powers to build influence; and third, duality, as it responded to global public health needs while implicitly incorporating the geopolitical logic of the Cold War.

The aforementioned health diplomacy reflects a behavioral logic distinctive to a middle power. First, advancing health diplomacy through alliances. As a middle power, Australia sought alliances with great powers to secure safety assurances, while its geopolitical position and military capabilities provided exploitable strategic value to those powers. Thus, such alliances were both a subjective necessity and objectively feasible, for instance, the signing of the Australia, New Zealand, and United States Security Treaty in 1951. Leveraging these military alliances, Australia conducted humanitarian aid, supported non-communist countries, and shared relevant medical intelligence and infectious disease control experiences on the basis of alliance relations.

Second, regional diplomacy. As a middle power, Australia could not assume a mainstream role in international affairs akin to that of the United States, the former Soviet Union, or China. Constrained by its relative strength, it had to prioritize its diplomatic actions across the global arena and various domains. Consequently, it concentrated its foreign policy objectives more heavily on its own region, such as the Western Pacific, striving to play a unique role in constructing regional order. Through implementing the Colombo Plan, it pursued international cooperation and development aid programs in the Asia-Pacific region, particularly Southeast Asia and South Asia, thereby realizing its “forward defense” diplomatic strategy. However, in Africa, driven by strategic interests, Australia maintained low-level cooperation with the continent, donating medicines and engaging in disease control through bilateral or multilateral channels to promote therapeutic drugs (Chen, 2016).

Third, multilateral diplomacy. On the platform of the WHO, Australia possessed both the capability and

willingness to serve as a catalyst, facilitator, or even manager in international affairs. Multilateral diplomacy proved to be a vital avenue for Australia to exert its influence.

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