

RESEARCH ARTICLE

The politics of medical expertise and substance control: WHO consultants for addiction rehabilitation and pharmacy education in Thailand and India during the Cold War

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Abstract

This paper explores the role of World Health Organization (WHO) medical experts in ambitious projects for substance control during the Cold War in Thailand and India. The circumstances surrounding opium production in these two nations were very different, as were the reasons for requesting expert assistance from the United Nations. Whereas the Thai military regime was concerned with controlling illicit traffic to secure its borders, the Indian government wanted to direct its opium raw materials towards domestic pharmaceutical production. Overlapping and sometimes competing agendas of country governments and international agencies converged upon each project, complicating the consultants' work and requiring careful navigation. In both cases, medicine as a science concerned with human health and well-being was subordinated to more pressing agendas. At the same time, the article argues that WHO consultants left an important impact, though not necessarily due to their skills and training in medicine. Instead, they provided exemplars of sound governance and delivery of public health in a politically stable and economically developed country.

Introduction

The poppy plant, the source of opium, has historically been cultivated in the dry, warm and mountainous regions of South West, Central, South and South East Asia, from Iran and Afghanistan, across north India, all the way to Thailand and Burma. The opium trade was loosely regulated in the early twentieth century, but with the end of the Second World War, a tighter international control regime emerged under the auspices of the United Nations (UN).¹ The UN's post-war approach to substance control aimed for a careful balance between restricting the illicit trade and ensuring that opium alkaloids were supplied for legitimate medical and scientific purposes. While this approach was enforced primarily through the international narcotics treaties, the UN's overarching economic development mandate also provided technical and financial support to less developed countries. This assistance was important for many opium-producing countries, as they had either recently achieved independence, were politically unstable or otherwise resource-poor. The UN's support took a variety of forms, ranging from small-scale

¹ William B. McAllister, *Drug Diplomacy in the Twentieth Century: An International History*, New York: Routledge, 2000.

activities like consultancies for addiction treatment to larger initiatives, such as agricultural crop substitution projects. Specialized agencies within the UN family each contributed their areas of expertise in these substance control field projects, including the World Health Organization (WHO) as the UN's expert on medicine and health.

During the Cold War, control over rapidly expanding opium production in South East Asia was highly contested and the UN and WHO's assistance competed against other priorities. Thailand and India, two major opium-producing countries in the region, represented important locations for the UN's international diplomacy in narcotics control. Conversely, the national governments of Thailand and India had distinct but equally ambitious interests invested in substance control. In Thailand, opium was grown primarily by non-Thai-speaking migrant villagers in the hilly northern and north-eastern areas bordering Laos and Myanmar, particularly the Chiang Mai, Chiang Rai and Tak provinces. With the intensification of the Cold War, the Thai military government was mainly concerned with countering communist and other insurgent movements, launching a series of interventions to convince or force villagers in these areas to grow crops other than opium. On the other hand, India after independence had a robust industrial and legal infrastructure for harvesting opium alkaloids from poppy fields in the northern states of Madhya Pradesh and Uttar Pradesh. As a result, it was one of a few countries recognized as a trusted opium cultivator, and, in terms of volume, was the largest legitimate exporter for medicinal research purposes. At the same time, the Indian government had a national economic development agenda, intending to make use of its own poppy harvests by establishing a domestic pharmaceutical sector, rather than just serving as a supplier for foreign pharmaceutical manufacturers. Thus the two countries had different plans for their opium resources, which clearly influenced their engagement with external parties. Whereas Thailand requested UN support for crop substitution projects and addiction rehabilitation centres, India asked for assistance in training human resources towards a national pharmaceutical sector that would eventually be capable of export. A shared characteristic was that neither country was a passive recipient of international aid.

This article examines the role of medical expertise in internationally advised drug control projects. Paying attention to the differences between the Thai and Indian contexts, it considers the ways in which WHO experts navigated the politics of substance control in each country. With so many interests at stake, most notably the tensions between the respective geopolitical and developmental ambitions of the Thai and the Indian governments, and the UN's goals for multilateral narcotics control, it is not surprising that WHO experts found themselves severely restricted in terms of the advice they could give. A large part of this was because medical matters competed with other priorities deemed more pressing. In both cases, medicine as an applied science concerned with human welfare was subordinated to high-modernist aspirations for substance control, to borrow James C. Scott's phrase.² For these governments, public health was seen as a service or a luxury that they could not afford. The idea of medical treatment for drug addiction also held an awkward place under the UN's mandate for international narcotics control, at times seen as obstructing efforts to control illicit traffic. As international relations scholars such as Robert Putnam might argue, projects for substance control in South East Asia during the Cold War illustrate a classic tension between international 'high' politics (matters vital to the survival of the state) and domestic 'low' politics (socio-economic issues at the grass-roots level).³

² James C. Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed*, New Haven: Yale University Press, 1998.

³ Robert D. Putnam, 'Diplomacy and domestic politics: the logic of two-level games', *International Organization* (1988) 42(3), pp. 427–60.

WHO's consultants ultimately did have an effect in both countries, even if their advice was not welcomed or immediately taken. However, this was not necessarily due to highly technical and discipline-specific proficiency in medicine. Competing with other more forceful and powerful agendas invested in substance control, the experts' recommendations tended to focus on fundamental principles of sound administrative functioning and pragmatic common sense. In Thailand, WHO experts advised continuous and sustained provision of health care as a right of citizenship for the opium-cultivating villagers. In India, WHO experts recommended a teaching system that encouraged medical students to think critically, as well as experiment and innovate in the laboratory. The article finds that the consultants themselves (consciously or not) adhered to and implicitly transmitted certain universal ideals of a peaceful and democratic state that fully and equally cared for its citizens. As they argued for and at times defended local stakeholders – opium-cultivating villagers or pharmacists-in-training – against the Thai and Indian governments' high-modernist aspirations for substance control, the experts inadvertently conveyed their own assumptions of a perfectly structured polity.

This suggests that the transmission of ideas via expert consultancy depends less upon the type or extent of disciplinary knowledge than the scholarship might suggest. In the social-scientific literature, such as the theory of epistemic communities offered by Peter Haas and heterogeneous actor-networks of scholars and policy makers by Christian Bueger, there is a tendency to presume that knowledge and expertise themselves equate to some form of hegemonic power.⁴ This historical article does not contest this notion but explores this idea in situations wherein the key players have multiple competing interests and are directly confronted with the effects of their policy decisions upon local communities.⁵ In doing so, it draws themes from histories of international health, in particular the work of Sanjoy Bhattacharya and Sunil Amrith on WHO's disease control programmes, and critical development studies, such as James Ferguson's concept of the anti-politics machine and James C. Scott's authoritarian high modernism, which point out the shortcomings of highly technical expert knowledge in the field.⁶ Practical problem solving encased in diplomatic language was more useful when project implementers faced difficult terrains, changing political regimes and other problems insurmountable by specialized knowledge. By decentring, or in this case carefully unravelling and teasing apart the interests at stake in the control of substances in Cold War South East Asia, then examining how WHO medical experts behaved in these complicated conditions, the paper paints a richer and more precise picture of how and why certain forms of scientific diplomacy succeed or fail.

A note on methodology: this article uses expert reports from WHO's official archive in Geneva, a familiar genre for historians of international health. There are several reasons for this. First, controlled substances, which by their nature are clandestine, have an elusive archival trace. Official national archives, especially of developing countries ruled by authoritarian governments, have not provided a reliable record for historians to draw from. Second, while told from the point of view of an international health agency,

⁴ Peter M. Haas, 'Epistemic communities and international policy coordination', *International Organization* (1992) 46(1), pp. 1–35; Christian Bueger, 'From expert communities to epistemic arrangements: situating expertise in international relations', in Maximilian Mayer, Mariana Carpes and Ruth Knoblich (eds.), *International Relations and the Global Politics of Science and Technology*, Wiesbaden: Springer VS, 2014, pp. 39–54.

⁵ As per the historian's approach to theories of science diplomacy, proposed by scholars like Sönke Kunkel, context is critical. Sönke Kunkel, 'Science diplomacy in the twentieth century: introduction', *Journal of Contemporary History* (2021) 56(3), pp. 473–84.

⁶ Sanjoy Bhattacharya, *Expunging Variola: The Control and Eradication of Smallpox in India, 1947–1977*, New Delhi: Orient Longman, 2006; Sunil Amrith, *Decolonizing International Health: India and Southeast Asia, 1930–65*, London: Palgrave Macmillan, 2006; James Ferguson, *The Anti-Politics Machine: Development, Depoliticization and Bureaucratic Power in Lesotho*, Minneapolis: University of Minnesota Press, 1994; Scott, *Seeing Like a State*.

WHO records provide unprecedented insight into activities that so far have only been pieced together through news reports or retrospectively recounted by the historical actors involved, such as the use of oral-history interviews in Alfred W. McCoy's *The Politics of Heroin in Southeast Asia*.⁷ Moreover, the WHO expert report as a primary source allows the historian to 'read against the grain' of dominant historical narratives of narcotics control in South East Asia, which paint drug control health interventions as part and parcel of Cold War military activities. Finally, these sources illustrate the experts' navigation of broader overarching politics between the UN, country governments and other stakeholders. They show the experts as individuals, discovering the limits of their training as they tried to understand problems encountered, perhaps for the first time, in tense and unfamiliar circumstances.

Thailand: managing addiction

Opium has been cultivated and consumed for centuries by migratory indigenous populations residing in the hills of northern Thailand, often called the hill tribes. The rapid growth in the illicit trade in the border areas between Thailand, Burma and Laos, often called the Golden Triangle, became a serious concern for the international community during the 1960s. There are disagreements as to the direct cause, but the influx of political refugees and retreating militant groups, including Kuomintang (KMT) troops, into Thailand as a result of the Chinese Civil War in 1949 increased the production and manufacturing of heroin in the region. Scholars such as Alfred McCoy alleged in the early 1970s that US intelligence agencies supported these militant groups to counter communist influence, either turning a blind eye or indirectly participating in the growing illicit trade.⁸ The UN, ostensibly a neutral multilateral party, was unable to outwardly criticize American foreign policy beyond emphasizing a cooperative approach to drug control but in its field activities, tried to separate its work from Cold War politics.

In the mid-1950s, the UN launched a small technical assistance fund, to which the Thai government submitted a request. The core component of the UN's assistance during the late 1950s and throughout the 1960s was to survey poppy production through a project led by Austrian anthropologist Hans Manndorff. Manndorff's research resulted in a 'Report on the socio-economic survey of the Hill Tribes in northern Thailand', published in 1962, which formed the basis for the interdisciplinary Tribal Research Institute (TRI) launched in 1965.⁹ These activities would establish the foundations for the main goal for the UN and Thai government, which was to incentivize villagers to farm crops like coffee or fruit instead of opium, in what is called integrated or alternative development. A secondary side project of an addiction rehabilitation centre was also planned. WHO, as the UN's specialized agency for health, was to facilitate the exchange of experts to advise on the clinical and medical aspects of drug addiction treatment.¹⁰

Key to note is that these internationally-advised field projects were conducted in a tense geopolitical climate. Historically, the Thai royal government maintained a moderate

⁷ Alfred W. McCoy, *The Politics of Heroin: CIA Complicity in the Global Drug Trade*, Brooklyn: Lawrence Hill Books, 1990.

⁸ Works like McCoy's *The Politics of Heroin*, originally published in the 1970s, alleged CIA involvement in the South East Asian illicit drug trade to finance the KMT and other anti-communist insurgent groups.

⁹ Kwanchewan Buadaeng, 'The rise and fall of the Tribal Research Institute (TRI): "Hill Tribe" policy and studies in Thailand', *Southeast Asian Studies* (2006) 44(3), pp. 359–84.

¹⁰ Hjørleifur Jonsson, 'Phantom scandal: on the national uses of the "Thailand controversy"', *SOJOURN: Journal of Social Issues in Southeast Asia* (2014) 29, pp. 263–99; Hans Manndorff, *Report on the Socio-economic Survey of the Hill Tribes in Northern Thailand*, Bangkok: Department of Public Welfare, Ministry of the Interior, 1962.

policy towards opium, allowing cultivation under legal licenses granted by a state monopoly, while consumption was discouraged but not policed. With rising Cold War tensions, Thai military leaders were focused on securing the northern borders with China, Laos and Burma, particularly the Shan States, against communist influence and insurgency. They sought connections with the KMT refugee army that had settled there, which was supported by the US due to its proxy war to contain communism in South East Asia.¹¹ The populace was also aware that the military regime was involved in some capacity in the illicit drug trade.¹² The Thai government had difficult relations, at times hands-off, at others retaliatory, with the villagers who cultivated opium in hilly areas of the northern provinces. Some were engaged in insurgent and secessionist campaigns beyond their links with the KMT.¹³ Referred to as ‘tribal people’, ‘highlanders’ or simply collectively as the ‘hill tribes’, opium-growing non-ethnic Thai were treated gingerly as outsiders, not integrated into the polity as citizens. This complex set of circumstances would result in the Thai government’s inconsistent and frequently fluctuating attitude towards narcotics control.

The political goal of communist containment was the primary determinant driving Thai drug policy. Following a military coup in 1957, army general Sarit Thanarat came to power. Departing from the previous narcotics policy under the monarchy, Thanarat requested UN assistance for narcotics control, which came with consonant conditions for restrictive drug policy. Narcotics law under Thanarat’s autocratic rule became strictly disciplinarian, completely prohibiting opium production, consumption, transport and sale in 1958.¹⁴ An indirect result of the total abolishment of opium consumption was that addiction quickly became a widespread societal problem. The government sought technical and financial assistance from WHO to develop treatment and rehabilitation services. With support from the UN technical assistance fund, the Centre for Treatment and Rehabilitation of Opium Addicts was launched in 1959 in Rangsit, Patumthani province, about forty kilometers from the capital of Bangkok.¹⁵ The Rangsit Centre had a daunting task ahead, as it was estimated in the year of its launch that 300,000, if not more, were addicted to opium.¹⁶

Addiction science was new to the country and it was clear that officials wanted a quick and easily administered solution, as though drug addiction was an infectious disease that could be eradicated or prevented with a vaccine. Initially, Sarit Thanarat’s administration

¹¹ Richard A. Crooker, ‘Forces of change in the Thailand opium zone’, *Geographical Review* (1988) 78(3), pp. 241–56; M.L. Dispanadda Diskul, Ramrada Ninnad, Andrea Skinner and Vistorn Rajatanarvin, ‘Development not drug control: the evolution of counter narcotic efforts in Thailand’, *Journal of Illicit Economies and Development* (2019) 1 (1), pp. 80–8.

¹² Cui Feng, ‘KMT troops and the border consolidation process in northern Thailand’, *Southeast Asian Studies* (2022) 11(2), pp. 177–94.

¹³ Jeffrey Race, ‘The war in northern Thailand’, *Modern Asian Studies* (1974) 8(1), pp. 85–112.

¹⁴ Part and parcel of the legitimizing discourse of Thai military authoritarianism was the production of docile, economically productive and self-governing citizens. Within this, idle undesirable characteristics such as addiction were to be pruned out by a paternalistic and disciplinarian state. Thongchai Winichakul, *Siam Mapped: A History of the Geo-body of a Nation*, Honolulu: University of Hawaii Press, 1994, p. 150; Daena Aki Funahashi, ‘Rule by good people: health governance and the violence of moral authority in Thailand’, *Cultural Anthropology* (2016) 31(1), pp. 107–30; Craig J. Reynolds, *Seditious Histories: Contesting Thai and Southeast Asian Pasts*, Seattle: University of Washington Press, 2006; Diana Kim, *Empires of Vice: The Rise of Opium Prohibition across Southeast Asia*, Princeton, NJ: Princeton University Press, 2020; Laurence Monnais and Harold J. Cook (eds.), *Global Movements, Local Concerns: Medicine and Health in Southeast Asia*, Singapore: NUS Press, 2012.

¹⁵ Malai Huvanandana, ‘The centre for treatment and rehabilitation of opium addicts, Rangsit, Thailand’, *Bulletin on Narcotics*, 1 January 1962, at www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1962-01-01_2_page002.html (accessed 31 July 2021).

¹⁶ RD SEARO to HQ, ‘Drug addiction control–Thailand’, 18 July 1962, file: WHO022-SEARO-THA-086 Thailand Control of Narcotic Drugs (1961–1972), WHO Archives Geneva (henceforth all files will be from WHO archives Geneva, unless otherwise indicated).

sought to have Thai medical experts trained abroad. General Prasert Rujirawongse in charge of the police department wrote to the UN's Division of Narcotic Drugs (DND) in December 1961 requesting expert information on the curative aspects of addiction treatment.¹⁷ The DND referred Rujirawongse to Awni Arif of WHO's Addiction-Producing Drugs section, who agreed to provide two fellowships to Prayoon Norakarnphadung (medical officer and director of the Rangsit Centre for the Treatment of Opium Addicts) and Dr. Rawiwattanawongs (Department of Public Welfare) to study the medical and social aspects of addiction in different countries. The UN also facilitated support for Thai officials and physicians to attend events such as the Third World Congress of Psychiatry held in June 1961 in Montreal.¹⁸ In 1963, overseas visits for Thai experts increased as Bulsak Vadhanabhasuk (Ministry of Health), Sirivat Viseshsiri (Ministry of Public Health) and Suchint Bhanijakarn (Rangsit Centre superintendent) also visited rehabilitation programmes in Singapore, Hong Kong, Geneva, New York and Lexington (Texas).¹⁹

Following this, the Thanarat government decided to expand rehabilitation activities beyond Rangsit, announcing plans to build three new hospitals in the provinces and one in Bangkok in 1963. The WHO and the UN were alarmed by this announcement, since Rangsit in its first few years of operation was already struggling to process a purported patient population of 300,000. Treatment consisted of administering a syrup elixir using methadone, a long-acting medicine mitigating withdrawal effects, in decreasing concentrations for three weeks. Upon enquiry, it became evident that Rangsit staff did not conduct any follow-up confirming effectiveness and record-keeping was poor. The centre was doling out methadone and churning four thousand patients a year through its de-addiction programme but only 8 to 10 per cent had not relapsed.²⁰ With this level of progress, building four entirely new facilities for a treatment programme requiring strict and constant supervision like methadone substitution was thought by the WHO to be inadvisable. The UN agreed, and James Petrie, UN administrative representative for Thailand, wrote in a confidential letter to Chandra Mani, WHO South East Asia Regional Office (SEARO) director, that 'a more rational approach' would be to add annexes to existing medical institutions and focus on increasing the number of trained personnel.²¹

To improve Rangsit's results, WHO began recommending sending its own experts to advise on-site, rather than facilitating study-abroad activities for Thai bureaucrats. This advice was taken by the Thanarat government. Locating a suitable expert, however, proved challenging because of the multiple institutions involved in the decision-making process. The first individual recommended by the WHO was Dr Leung Hon Koon of Singapore's Opium Treatment Centre, since '[o]wing to the similarity of the various aspects of drug addiction in that area...the selection of an expert from a neighbouring country would offer certain advantages'.²² For reasons explained in private conversation between WHO headquarters in Geneva and its South East Asia Regional Office (SEARO), the Thai government did not find Koon acceptable.²³ A Dr Richmond from Canada was

¹⁷ Dr A.E. Arif to Police General Prasert Rujirawongse, 20 December 1961, file: WHO022-SEARO-THA-086.

¹⁸ James B. Petrie to Dr H. Halbach, 22 June 1962, file: SEARO-THA-086.

¹⁹ Daniel A. Chapman to A. Messing-Mierzejewski, 'Study tour for the three fellows from Thailand', 20 June 1963, file: SEARO-THA-086.

²⁰ 'Meeting at the department of public welfare', 15 March 1962, file: SEARO-THA-086.

²¹ James B. Petrie to Dr C. Mani, 'Subject: narcotics control, Thailand,' 4 April 1962, file: SEARO-THA-086.

²² Leong Hon Koon, 'The opium problem in Singapore', *Bulletin on Narcotics*, 1 January 1958, at www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1958-01-01_4_page003.html (accessed 31 July 2021); RD, SEARO, 'Thailand: treatment and rehabilitation of drug addicts', 23 January 1963, file: WHO022-SEARO-THA-086. Chief, APD, to SEARO RD, 'Thailand 68: narcotic drugs control', 12 July 1963, file: SEARO-THA-086.

²³ WHO SEARO writes to WHO HQ in Geneva, 'We should be grateful if you could locate a consultant other than Dr Leong Hon Koon. The reasons for this will be explained to you verbally as soon as the opportunity occurs'.

recommended next. As an expression of the UN's willingness to delegate the health aspects of drug control to WHO, Richmond's visit would have been funded by the WHO SEARO based in New Delhi. However, the selection of Richmond also caused debate, although this time it was between WHO and the Canadian government. Hugh G. Christie of the Canadian External Aid Office advised WHO that Richmond was not a leader-type figure and would not be effective in such a role.²⁴ Next considered was Dr Kjolsted, an expert on alcoholism and drug addiction in Norway, 'though experience in this field in Scandinavia is somewhat limited'. WHO later found that Kjolsted's qualifications were insufficient and withdrew its request.²⁵ Even as the UN and WHO tried to coax Thai officials away from rash decisions such as building new hospitals, the 'red tape' and bureaucracy of international organizations and their regional offices also prolonged the selection of a suitable expert.

Meanwhile, Thailand's political instability led to frequent radical overhauls in drug policy, which forced the WHO and the UN to adjust their offers of technical assistance. As WHO's selection process went on, abruptly in late 1963 Sarit Thanarat died and Thanom Kittikachorn came to power. Kittikachorn's administration intensified efforts to contain illicit traffic, enacting several laws punishing possession and seizure of narcotic drugs. Drug addiction rehabilitation was abruptly abandoned in an increasingly punitive approach. On 11 October 1963, the new government announced that it would no longer support the treatment and rehabilitation of those dependent on drugs and the Rangsit centre, which had only been operating for four years, would be closed.²⁶ The Ministry of the Interior declared that Rangsit had not been effective and the entire programme was too expensive. As the ministry saw it, prisons would instead be used as the main state institutions for containing those addicted to drugs.²⁷

Under pressure from this new announcement, WHO finally designated Joel Fort, an American national, as its chosen expert. Fort was both a practising psychiatrist and an advocate for marijuana decriminalization, running his Center for Solving Special Social and Health Problems, also known as Fort Help, in downtown San Francisco.²⁸ Given the time constraints and the fragility of the situation, WHO advised that he produce a compact appraisal that would, at the very least, strongly recommend improvements in clinical follow-up.²⁹ WHO SEARO regional director Chandra Mani reminded Fort that his constant endeavour should be to 'conduct yourself as an international civil servant, according to the oath taken with the Organization'.³⁰ Daniel Chapman, director of the Division of

RD/SEARO to HQ, 'Narcotic drugs control, Thailand', 12 February 1963, file: SEARO-THA-086, underlining in original.

²⁴ Hugh G. Christie, Canada External Aid Office, to Dr H. Halbach, 'Reference: Thailand 68', 4 July 1963, file: SEARO-THA-086.

²⁵ Mental Health, EURO, to Dr O.V. Baronyan, ADG/HQ, 'Subject: Dr TH.O. Kjolstad-Norway', 4 October 1963, file: SEARO-THA-086.

²⁶ Luna to Chapman, 11 October 1963, file: SEARO-THA-086.

²⁷ '[W]e are informed that the Ministry of the Interior (Dept. of Public Welfare) is ceasing activity in Rangsit on the grounds that effective rehabilitation of drug addicts is not being achieved, that almost all are recidivist who are frequently readmitted and that it costs too much ... In future, recidivists are to be imprisoned'. RD/SEARO to HQ, 'Subject: Dr Joel Fort-Narcotics Drug Control (Thai-68)', 21 November 1963, file: SEARO-THA-086.

²⁸ Steve Chawkins, 'Joel Fort dies at 86; iconoclastic psychiatrist testified in Patty Hearst case', *Los Angeles Times*, 27 August 2015, at www.latimes.com/local/obituaries/la-me-joel-fort-20150828-story.html (accessed 31 July 2021); H. Halbach to Dr J. Fort, 13 December 1963, file: WHO022-SEARO-THA-086.

²⁹ Halbach to Fort, 13 December 1963, file: WHO022-SEARO-THA-086 Thailand Control of Narcotic Drugs (1961-1972).

³⁰ C. Mani to Joel Fort, 20 February 1964, file: WHO022-SEARO-THA-086 Thailand Control of Narcotic Drugs (1961-1972).

Narcotic Drugs, added firmly that the UN would not be responsible for any statement made by an expert selected by WHO.³¹

Fort's resulting report, produced in 1964 just as the Rangsit Centre closed and titled 'Recommendations for the management of drug addiction in Thailand', largely fell in line with these requests. To WHO's alarm, however, the report also recommended changes that went beyond medical aspects.³² Part of Fort's report, enclosed in parentheses, mentioned that participation in the illicit narcotics trade by the Thai police and law enforcement was part of the reason for the country's growing problem of addiction. Fort recommended that the Thai government curb corruption in its own administration:

it is important to stress reducing the availability of narcotics in Thailand by... improved training, supervision and payment of policemen and *interruption of whatever illicit participation there may be on the part of the police or other Thai officials and citizens.*³³

WHO was concerned that this last claim had been informed by Fort's ad hoc observations and unofficial interviews. This catalyzed heated discussion between the UN and WHO as to the most diplomatic way such 'advice' could be communicated. In the end, the UN instructed its outpost Thailand officer to deliver Fort's report to the new government with the qualification that it originated from 'a WHO expert and not a UN expert'.³⁴ During the second half of the 1960s, Kittikachorn focused on controlling illicit smuggling rather than treatment, culminating in the 1973 arrest of the so-called 'opium king' Lo Hsing-han with military support from the US government.³⁵ Faced with a growing population of heroin-addicted Vietnam War veterans, US president Richard Nixon put significant pressure on the Thai government to curb illicit traffic through providing military equipment and surveillance technology in the early 1970s.³⁶

After a period of internal unrest in the late 1960s, Kittikachorn enacted a coup against his own government in November 1971, reinstating military rule. Drug policy changed yet again, moving away from discipline and towards rehabilitation. When UN support was again requested, the director general of the Department of Public Welfare, Thian Ashakul, gave three reasons for the government's shift: national security ('we are fighting for the minds of the Hill Tribe people in competition with the communists'), ecological protection ('the slash and burn agricultural practice of the Hill Tribe people is seriously damaging the watershed of the hills') and finally international cooperation - 'We have to live with the other nations of the world'.³⁷ While Rangsit would not be reopened, addiction treatment activities would be taken on by the nearby Thanyarak general hospital, and the responsibility for its administration was transferred to the Ministry of Public Health.³⁸

³¹ Daniel A. Chapman to Dr Joel Fort, 26 March 1964, file: WHO022-SEARO-THA-086 Thailand Control of Narcotic Drugs (1961-1972).

³² Joel Fort MD (consultant, World Health Organization), 'Recommendations for the management of drug addiction in Thailand', June 1964, file: WHO022-SEARO-THA-086 Thailand Control of Narcotic Drugs (1961-1972), p. 16.

³³ Fort, *op. cit.* (32), p. 15, added emphasis.

³⁴ D.A. Chapman to Mr. A. Messing-Mierzejewski, Mr. Messing, 14 August 1964, file: SEARO-THA-086.

³⁵ Malcolm W. Browne, 'Thanom criticizes US report linking Thai officials to drugs', *The New York Times*, 26 July 1973, at www.nytimes.com/1973/07/26/archives/thanom-criticizes-u-s-report-linking-thai-officials-to-drugs-lo.html (accessed 31 July 2021).

³⁶ Daniel Weimer, *Seeing Drugs: Modernization, Counterinsurgency, and U.S. Narcotics Control in the Third World, 1969-1976*, Kent, OH: Kent State University Press, 2011.

³⁷ Director, PTX, to regional director, SEARO, 'Consultation visit to Thailand-Dr Morris Seevers', 18 February 1972, file: WHO022-SEARO-THA-086 Thailand Control of Narcotic Drugs (1961-1972).

³⁸ V. Verachai, S. Dechongkit, A. Patarakorn and L. Lukanapichonchut, 'Drug addicts treatment for ten years in Thanyarak Hospital (1989-1998)', *Journal of the Medical Association of Thailand* (2001) 84(1), pp. 24-9; Viroj Verachai,

Whereas Rangsit had focused solely on addiction treatment, Thanyarak's trained staff would integrate addiction rehabilitation with other health services, including nutrition and wound care. The hospital also contained advanced laboratory facilities for chemical isolation and chromatographic analysis, necessary to identify narcotics and maintain a drug-free environment.

To this end, Kittikachorn's Minister of Public Health specifically requested the expertise of Maurice H. Seevers.³⁹ Seevers had attended the WHO Scientific Group on Opiates and Their Alternates for Pain and Cough Relief conference in Geneva in November 1971, where he met WHO's director of the Division of Pharmacology and Toxicology, V. Fattorusso, and the state undersecretary in the Thai Ministry of Public Health, Komol Pengsritong. According to Pengsritong, Seevers had visited Bangkok and Rangsit in 1959 and predicted that heroin dependence would sharply increase following the opium ban of the previous year. 'His prediction has become true' and the government desired Seevers's expertise in guiding Thanyarak hospital.⁴⁰ Unlike Fort, who was trained in psychiatry, Seevers was a former professor of pharmacology at the University of Michigan. He was also a significant presence in the American addiction science community, advocating a biomedical model of addiction.⁴¹ At the same time, he held another expert advisory role in his home country as a member of US National Commission on Marihuana and Drug Abuse, known as the Shafer Commission, which in 1972 recommended the decriminalization of marijuana use.⁴²

Seevers's visit was short, culminating in a 1972 'Assignment report on the control of narcotic drugs in Thailand'. In contrast to Fort's controversial recommendations in 1964, Seevers's report was more an evaluation of the efficiency of Thanyarak's operations as a health care service provider.⁴³ While the medical facilities, staff and equipment were competent, Seevers noted that there were critical gaps that needed to be addressed. For instance, he advised that Thanyarak should regularly conduct urine sampling in the narcotic detection laboratory to ensure a completely drug-free environment, necessary for patients not relapsing. Nevertheless, these were issues universal to all drug treatment centres, and Seevers encouraged Thai officials to manage expectations: 'In considering addict rehabilitation, it is essential to bear in mind that dependence upon heroin, opium, or for that matter, any major psychoactive drug, is a chronic relapsing disorder. *Success, therefore, is rarely measured in terms of absolute cure.*'⁴⁴

Due to his concurrent position on the Shafer Commission, Seevers could not refrain from commenting on Cold War politics and US foreign policy in Thailand. After assessing

Jarooporn Punjawatnun and Fernando Perfas, 'The results of drug dependence treatment by therapeutic community in Thanyarak Institute on Drug Abuse', *Journal of the Medical Association of Thailand* (2003) 86(5), pp. 407–17.

³⁹ Dr Komol Pengsritong to Dr Gordon J. Stott, WHO Rep Thailand, 9 December 1971, file: WHO022-SEARO-THA-086 Thailand Control of Narcotic Drugs (1961–1972).

⁴⁰ Dr Komol Pengsritong to Dr Gordon J. Stott, 9 December 1971, file: SEARO-THA-086.

⁴¹ His research involved administering opiates to animals and measuring withdrawal symptoms. N. Rasmussen, 'Maurice Seevers, the stimulants and the political economy of addiction in American biomedicine', *Biosocieties* (2010) 5, pp. 105–23; David T. Courtwright, 'The classic era of narcotic control', in D.T. Courtwright, H. Joseph and D. Des Jarlais (eds.), *Addicts Who Survived: An Oral History of Narcotics Use in America, 1923–1965*, Knoxville: University of Tennessee Press, 1989, pp. 1–44.

⁴² Fred P. Graham, 'National commission to propose legal private use of marijuana,' *New York Times*, 13 February 1972, at www.nytimes.com/1972/02/13/archives/national-commission-to-propose-legal-private-use-of-marijuana.html (accessed 31 July 2021).

⁴³ Dr M.H. Seevers, WHO short-term consultant, 'Assignment report on control of narcotic drugs in Thailand (rehabilitation of heroin and opium-dependent persons) (WHO project: Thailand 0068)', WHO Regional Office for South East Asia SEA/APD/2 (5 June 1972), file: SEARO-THA-086; Report of Maurice H. Seevers, 'Rehabilitation of heroin and opium dependent persons in Thailand', 1972, file: SEARO-THA-086.

⁴⁴ Seevers, 'Assignment report', op. cit. (43), p. 8, added emphasis.

the progress of the Hill Tribes Research Centre, he warned Thai officials, particularly the Ministry of Public Health, of the dangers of forceful prohibition at the expense of basic health care. Seevers argued that, despite the UN's claims to be a neutral multilateral agency, its Hill Tribes project had been co-opted by the US counterinsurgency agenda. In his view, the best way to reach the remote hill villagers cultivating opium was through WHO with its focus on health and well-being.⁴⁵ Unlike Fort, who recommended prohibition, Seevers advocated public health as the best way to achieve narcotics control.

Thailand is competing for the minds of the hill tribes with subtle, persistent and incredibly efficient activities of the Yunnanese communist insurgents. These activities challenge the very existence of Thailand as a nation. The hill people must be reached with equally subtle means, if Thailand is to survive. *Medical and public health may be the most subtle of all, and possibly the only one capable of crossing language, ethnic, and economic barriers.*⁴⁶

With the establishment of the Fund for Drug Abuse Control (UNFDAC) in 1971, the UN significantly scaled up its support from expert information exchange to launching actual interventions. Building upon their joint collaborations throughout the 1960s, in 1974, the UN and the Thai government jointly launched a Programme for Drug Abuse Control. The programme consisted of pilots rolled out in five core villages and twenty-five satellite villages. The pilots took a multi-pronged approach, balancing crop substitution, addiction treatment, social reintegration and preventive educational programmes for at-risk groups, declared 'the first of its kind in the world'.⁴⁷ The main crop substitution component consisted of training and incentivizing opium farmers to make their living from other crops, such as coffee, small grains and livestock. Serious cases of addiction would be referred to the Narcotics Treatment Centre for Hill Tribes, established in Chiang Mai in 1975 and supported by WHO and Chiang Mai University's Faculty of Medicine, which drew some of its staff (trained in both clinical medicine and social work) from Thanyarak hospital. The centre also served a surveillance function, gathering data on the nature and extent of narcotic use in northern Thailand.

Due to the sparse health care provision in the area, the UN–Thai project ended up creating a paradoxical situation wherein villagers were more likely to receive health care if they were dependent on drugs. In collaboration with the Ministry of Public Health, WHO worked with health professionals at the Chiang Mai Narcotics Treatment Centre to profile patients who came from different tribes. Through taking individual case histories, local doctors discovered that the opium problem was caused by poverty and lack of basic health care access, rather than sophisticated detoxification techniques or laboratory facilities.⁴⁸ Thus the 1974 UN–Thai project's final recommendation was to train village volunteers who spoke local languages in low-cost preventive care at the nearby Institute of Health Research, including basic hygiene, immunizations and nutrition. It was also important

⁴⁵ Seevers, 'Assignment report', op. cit. (43), p. 11.

⁴⁶ Seevers, 'Assignment report', op. cit. (43), p. 13, added emphasis.

⁴⁷ Following the 1971 Vienna Psychotropics Convention, the UN established a Fund for Drug Abuse Control (UNFDAC), which significantly expanded the technical assistance missions of the 1960s into pilot projects. 'Annex 3: WHO activities supported by the United Nations Fund for Drug Abuse Control' and 'Draft report of the work of the twenty-fifth session', 1 February 1973, file: A2-86-2 Sessions of the UN Commission on Narcotic Drugs (1957–1978); I.M.G. Williams, 'UN/Thai programme for drug abuse control in Thailand – a report on phase I: February 1972–June 1979', UNODC (1979), at www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1979-01-01_2_page002.html (accessed 31 July 2021).

⁴⁸ Charas Suwanwela, Somsong Kanchanahuta and Yupha Onthuam, 'Hill Tribe opium addicts: a retrospective study of 1,382 patients', *Bulletin on Narcotics* (1979) 31(1), pp. 23–40.

that these volunteers be properly incentivized so that they did not abandon their work in the middle of their projects.

The UN–WHO Narcotics Treatment Centre began its work in a new political climate after the 1973 democratic uprising and amidst the growing influence of the Communist Party of Thailand. By this time, WHO staff, local Thai doctors and researchers were tired of their efforts being interrupted by shifts in national and international politics. Closer to the grassroots realities of the drug problem, they pointed out that basic and sustained public services, including healthcare, were more efficient in reducing addiction in the long term. For WHO, integrating addiction treatment with community-owned primary health care resonated with its health-for-all mission during the 1970s.⁴⁹ Those involved with the project, with WHO's support, began to argue that health care should be extended to the highland communities as a right of citizenship.

In the political instability of Thailand during the Cold War, the military government saw treatment for drug addiction as secondary to national security. The establishment of addiction treatment centres, for which it needed UN and WHO assistance, was part and parcel of this primary geopolitical agenda. As individuals, Fort, a practising psychiatrist, and Seevers, a pharmacology professor, may have had different theories on whether addiction was caused by a psychosocial disorder or a chemical compound. Since Fort and Seevers were both American nationals, to a certain degree, their recommendations were coloured by their political views on US foreign policy in South East Asia. Ultimately, whether tactfully communicated or not, it was the universally pragmatic aspects of their expert recommendations that proved most pertinent: curbing corrupt participation in the drug trade, managing expectations in a new initiative, ensuring the availability of treatment if enacting strict prohibitions, and, ultimately, equitable healthcare access as the only long-term solution to preventing addiction.

India: developing pharmaceuticals

Opium was and continues to be one of the most important natural raw materials for developing essential painkilling medicines, from which a variety of useful chemicals such as morphine and codeine are sourced. Unlike Thailand, India was recognized by the UN and the international community as a trusted exporter for the global pharmaceutical sector. After achieving independence in August 1947, opium continued to be processed in alkaloid factories located in Ghazipur, Uttar Pradesh and Neemuch, Madhya Pradesh under strict supervision of the government of India. The Ministry of Finance granted licenses to farmers to produce a certain quota of opium raw materials, which the Ghazipur and Neemuch factories would process for extraction. In a carefully regulated system of international trade overseen by the UN's International Narcotics Control Board, these opium products would be sold to the US, the UK, Japan, Switzerland and other countries with pharmaceutical manufacturing interests.⁵⁰ At the same time, the Indian National Congress had an agenda for state-led planned development, which prioritized self-sufficiency and minimizing imports by encouraging domestic industry and establishing a manufacturing base. Given the country's existing natural resources of opium, this policy was also applied to a national pharmaceutical sector.

India's engagement with the UN's drug diplomacy was quite different from Thailand's. The country was comparatively not as welcoming, and even sensitive to advice from

⁴⁹ Alexander Medcalf, Sanjoy Bhattacharya, Hooman Momen, Monica Saavedra and Margaret Jones (eds.), *Health for All: The Journey of Universal Health Coverage*, Telangana: Orient Blackswan, 2015.

⁵⁰ The exporter, the Indian government, and the importer, the purchasing country, would submit data on volume of trade and other matters to the UN's International Narcotics Control Board (INCB).

foreign experts, particularly regarding social issues like health and welfare. This is evident in the reception of WHO consultant Erich Lindemann.⁵¹ A well-known social psychiatrist trained in Germany, Lindemann emigrated to the US in 1927 and was known for studying post-traumatic stress disorders and promoting community mental health.⁵² As part of the WHO Mental Health Programme's International Social Psychiatry project, Lindemann visited medical colleges across Agra, Madras, Bangalore, Hyderabad, Bombay, Poona and Nagpur from 1959 to 1960. He observed that psychology and psychiatry were considered secondary priorities in the Indian medical profession and 'most of the assistant physicians at the large mental hospitals are posted there because of failure in competing for other positions'.⁵³ Moreover, mainstream societal attitudes had little patience for those suffering from mental health problems: 'There are considerable strengths and competence in Indian psychiatry, but *very little of it benefits the mental patients*, improves public understanding of mental disease or safeguards the healthy population against the risk of falling mentally ill.'⁵⁴ Lindemann noted that the plan for India's health care after independence laid out by the 1946 Bhore committee report had included mental health, yet this either had not been fully realized or had been completely ignored. At the same time, he stressed advanced psychiatric research in the US, Britain, Canada and Scandinavian countries, involving new ultra-microscopic techniques to map neurotransmitters and brain receptors.⁵⁵ While this may have been his honest assessment, Lindemann's advice amounted to highlighting the contrast with advanced Western psychiatry without offering practical solutions. The consultancy was a one-off occasion and the government of India did not take Lindemann's advice. Significant investment in training and practice of addiction treatment under the psychiatric and psychological sciences would not begin until the mid-1970s.

Another reason for the sensitivity to foreign experts in India was the continuing influence of the revolutionary struggle. Outside its political dimensions, the Indian independence movement was also a scientific and intellectual movement. Leaders in various scientific disciplines – including medicine and pharmacology – resisted educational systems imposed by European colonization and tried to lay out a distinctly Indian path that would lead the country to modernization and development. In the pharmaceutical sciences, this meant blending indigenous medicine with Western science.

Unlike in Thailand, understandings of and treatment for drug addiction in India was linked to an anti-colonial discourse of self-sufficiency and prioritization of Indian systems of medicine. This was spearheaded by Ram Nath Chopra, professor of pharmacology at the

⁵¹ Harvard Countway Library, 'The Erich Lindemann papers', *Center for the History of Medicine (Francis A. Countway Library of Medicine) Harvard University Library*, <https://hollisarchives.lib.harvard.edu/repositories/14/resources/6671> (accessed 5 June 2022).

⁵² After moving to the US permanently, Lindemann practised at Massachusetts General Hospital and lectured at Harvard University School of Medicine until retiring in 1965. He promoted community mental health, following pioneering research on the survivors of the 1942 Cocoanut Grove nightclub fire incident in Boston. S. Fleck, 'Obituary: Erich Lindemann 1900–1974', *Social Psychiatry and Psychiatric Epidemiology* (1975) 10, p. 153; David George Satin, 'Erich Lindemann: the humanist and the era of community mental health', *Proceedings of the American Philosophical Society* (1982) 126(4), pp. 327–46.

⁵³ In contrast, community medicine and infectious-disease control had flourished, reflecting the priorities for public health of the Indian government at the time. Dr Erich Lindemann, 'Assignment report on teaching of psychiatry in medical colleges WHO project: India 158', 21 March 1960, file: WHO022-SEARO-IND-188: India Psychiatry Teaching (1960); Harry Wu, *Mad by the Millions: Mental Disorders and the Early Years of the World Health Organization*, Cambridge, MA and London: MIT Press, 2021, p. 52.

⁵⁴ Lindemann, *op. cit.* (53), p. 1, added emphasis.

⁵⁵ Lindemann's report also may have been controversial given the complex legacies of the colonial asylum, as Mills has pointed out. James Mills, 'The history of modern psychiatry in India, 1858–1947', *History of Psychiatry* (2001) 12(48), pp. 431–58.

Calcutta School of Tropical Medicine referred to as the ‘father of Indian pharmacology’, who promoted a hybrid approach utilizing indigenous and traditional substances. With support from the Indian Research Fund Association, Chopra studied cultures of substance use in various regions, such as opium consumption in Punjab and Rajasthan, and theorized whether marijuana or *bhang* addiction was a psychic or a physical disorder.⁵⁶ His research paid special attention to substance use and its connections to religious and cultural traditions, as well as the medical use of opium in the absence of public health services. For instance, in 1935, Chopra observed in the *Indian Medical Gazette*, that:

[t]here are no institutions established anywhere in India and the institutional treatment under expert guidance is unknown. It would certainly be advantageous if a few specialized institutions of the type of abstinence sanatoria were established in areas where the incidence of addiction is very high so that the treatment could be carried out on scientific lines.⁵⁷

He continued to research substance use treatment after independence, for instance, investigating insulin, lecithin and vesicatory therapies for mitigating withdrawal symptoms, though he noted in 1957, like Lindemann, that ‘the conditions under which the addicts were treated were far from ideal’.⁵⁸ Finally, Chopra served as a diplomat, representing India’s interests as an opium producer at the UN plenary sessions of the international narcotics treaties and as an expert member of WHO committees evaluating the addictive potential of new substances.

Linking his pharmacological research with the anti-colonial discourse of self-sufficiency, Chopra was also an advocate for domestic pharmaceutical development to reduce reliance on imported medicines. Through his position at the Calcutta School of Tropical Medicine, Chopra promoted experimental investigation of Ayurvedic plants, famously pioneering studies on *Rauvolfia serpentina* or Indian snakeroot as a sedative.⁵⁹ Chopra’s ad hoc and hybrid modern-indigenous style of pharmacology teaching spread from Calcutta throughout medical schools in the country.⁶⁰ As he personally recalled:

[w]hile many research projects which were undertaken appeared unconnected to a central pharmacological theme, I was not sorry to permit such a multipurpose and

⁵⁶ R.N. Chopra, K.S. Grewal, J.S. Chowhan and G.S. Chopra, ‘Addiction to “post” (unlanced capsules of *Papaver somniferum*)’, *Indian Journal of Medical Research* (1929) 17, pp. 985–1007; R.N. Chopra and I.C. Chopra, ‘Quasi-medical use of opium in India and its effects’, *Bulletin on Narcotics* (1955) 7(3–4), pp. 1–24; R.N. Chopra and I.C. Chopra, *Drug Addiction with Special Reference to India*, New Delhi: Council of Scientific and Industrial Research, 1965.

⁵⁷ R.N. Chopra, ‘Drug addiction in India and its treatment’, *Indian Medical Gazette* (1935) 70(3), pp. 121–31, 126.

⁵⁸ Sir R.N. Chopra and I.C. Chopra, ‘Treatment of drug addiction: experience in India’, *Bulletin on Narcotics* (1957) 33, at www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1957-01-01_4_page004.html (accessed 5 June 2022); Ministry of Health and Family Welfare, *Report of the Committee on Drug Abuse in India*, New Delhi: Government of India, 1977, p. 12.

⁵⁹ Chopra was influential in terms of national policy, advocating for India’s self-sufficiency in medicines through the Drugs and Cosmetics Act 1940 and the Indian Pharmacopoeial List in 1946. He also consulted in UN narcotics control sessions, occasionally serving in the WHO’s annual Expert Committees on Drug Dependence as a pharmacologist. David Arnold, *Science, Technology and Medicine in Colonial India*, Cambridge: Cambridge University Press, 2000, p. 145; Helen Power, ‘The Calcutta School of Tropical Medicine: institutionalizing medical research in the periphery’, *Medical History* (1996) 40, pp. 197–214.

⁶⁰ Malika Basu, *History of Indigenous Pharmaceutical Companies in Colonial Calcutta (1855–1947)*, London: Routledge, 2021; Nandini Bhattacharya, ‘From materia medica to the pharmacopoeia: challenges of writing the history of drugs in India’, *History Compass* (2016) 14(4), p. 131–9.

diversified approach. The climate of medical science in India at that time needed a dynamic experimental and rational appraisal of many theoretical concepts and dogmatic beliefs.⁶¹

In the years following independence, Chopra's improvisational approach did not lend well to a system of standardized teaching that would produce a competitive generation of young Indian pharmacologists. By the first decade of independence, the government became concerned that the prioritization of indigenous systems of medicine was hampering its developmental goals. Since pharmacology was noticeably lagging behind other departments, the Indian government requested WHO's expertise to improve pharmaceutical training and education in medical schools. From February 1953 to December 1955, WHO seconded Richard A. Lewis as a visiting professor of pharmacology to Seth Gordhandas Sunderdas Medical College (or Seth GS Medical College) in Bombay, Maharashtra. A member of the American School of Pharmacological Investigation and lecturer at Yale University, Lewis's main role was to help upgrade the pharmacology syllabi as well as advise on equipment and supplies for training purposes, for which a stipend of \$2,000 (later reduced to \$1,500) was provided.⁶²

Lewis's first impressions were that core medical teaching at Seth GS Medical College was of a high standard. At the same time, Lewis had trained in the United States. As Caroline Jean Acker has shown, in the early twentieth century, American medical teaching tried to set itself apart from European styles of pharmacy teaching. With significant government funding and strong links to industry, pharmacy and pharmacology education was structured 'for utilitarian ends' towards the discovery of innovative chemical compounds.⁶³ The main thrust of Lewis's recommendations was to introduce practical hypothesis-based experimental teaching methods, geared towards new drug discovery. In other words, Lewis's teaching was less concerned with the origins of substances (modern/synthetic or Indian, which was Chopra's preoccupation), and more on a systematic and replicable method that illuminated core chemical principles. Regarding Chopra's influence on pharmacology teaching in India, he observed the following.

The spirit of nationalism which has been so helpful in creating a superior medical college has also influenced the topics selected for study in the field of pharmacology. In this case, it may be that the influence was not all together beneficial. In recent years there has been a revival of the practice of, education in, and research about Ayurveda. This has led many pharmacologists to study the action of indigenous drugs, *despite the fact that they have not had adequate facilities or experience to isolate the pure principles contained therein.*⁶⁴

In recommending a teaching programme that, importantly, did not 'slight the field of indigenous drugs', Lewis proposed an teaching approach that included experiments

⁶¹ Ram Nath Chopra, 'Problems and prospects of a pharmacological career in India', *Annual Review of Pharmacology* (1965) 5, pp. 1–9, 5.

⁶² From WHO's perspective, improving India's pharmacological production capacities was also beneficial to its international disease control and immunization efforts. The following year, in 1956, the Indian government, WHO and UNICEF agreed that the country would maintain a domestic stockpile of emergency drugs for emergency relief measures and infectious-disease eradication drives. Roger A. Lewis, WHO visiting professor of pharmacology, 'Final report on Seth Gordhandas Sunderdas Medical College Bombay (India) WHO project: India 52', 10 January 1956, WHO Regional Office for South East Asia, SEA/Pharmacology/1, file: WHO022 SEARO IND 233.

⁶³ Caroline Jean Acker, 'Addiction and the laboratory: the work of the National Research Council's Committee on Drug Addiction, 1928–1939', *ISIS* (1995) 86(2), pp. 167–73.

⁶⁴ Lewis, *op. cit.* (62), pp. 2–3, added emphasis.

using chemically pure compounds, whether of synthetic or natural indigenous origin. Declaring that ‘clinical trials according to Ayurvedic precepts are not fruitful’, Lewis’s proposed training programme was also practical, focusing on treating endemic diseases prevalent in the area using locally prepared therapies.⁶⁵ As both an acknowledgement and a revision of Chopra’s style of pharmacological research, Lewis and his Seth GS Medical College colleagues reinvestigated Chopra’s studies on *Rauvolfia serpentina* conducted in the 1930s. In doing so, they concluded that Chopra’s discovery could be explained in the language of rational pharmacology as simply drawing attention ‘to the divergence between central sedative and peripheral sympatholytic action’.⁶⁶

Like Seevers on Thanyarak hospital in Thailand, Lewis noted some basic administrative issues at Seth GS College. Two postgraduates performing well in coursework were unable to take final examinations as there was no professor recognized by the University of Bombay (which administered the degrees) to mark them. The pharmacology department did not yet implement a culture of inventory checking to discard obsolete apparatus and machines ‘because of the elaborate routine involved in the disposal of municipal property’, though he noted the college’s particularly strong medical library. Lewis also stressed a culture of student engagement in learning and education and, in his words, cultivating ‘[c]apacity to reason and critical judgment’.⁶⁷ Seth GS College taught in a British format of long lectures and memorization tests but Lewis noted there were no demonstrations or tutorials. For postgraduates, he stressed statistical methods, controlled trials and clinical investigations that balanced theory with practice, as well as a journal club meeting weekly to discuss new literature. Finally, Lewis’s recommendations encompassed the college’s sustainable financial administration, with the aim that it eventually be supported without international aid.

Another reason that Lewis’s work with Seth GS Medical College was successful was because it garnered local support. Throughout his consultancy, the college received financing or equipment donations from a range of local partners, such as the Indian government, the Bombay Municipal Corporation and local businesses, as well as support from outside such as the Rockefeller Foundation (US philanthropy). In one case, the municipal corporation provided funds covering the high duties that the central government levied on imported equipment. Lewis also left the college with a series of incipient research projects to address endemic health issues in the country: from research on synthetic drugs such as Hetrazan (diethylcarbamazine) for tropical eosinophilia (a bacterial lung infection) to testing natural substances such as coconut milk against dairy milk in treating congestive cardiac failure.⁶⁸ Findings on tetanus therapy, cortisone therapy and antibiotics to counter nutritional deficiencies were published with Seth GS colleagues and students in the *Journal of the American Medical Association* and the *American Journal of Tropical Medicine and Hygiene*, and Lewis himself went on to release several textbooks on pharmacology in tropical settings in the late 1950s and early 1960s.⁶⁹ A tradition of publishing research conducted at the institution was established

⁶⁵ Lewis, op. cit. (62), p. 3.

⁶⁶ Lewis, op. cit. (62), p. 7.

⁶⁷ Lewis, op. cit. (62), p. 3.

⁶⁸ Lewis, op. cit. (62), p. 6.

⁶⁹ Roger A. Lewis, Rajaninath S. Satoskar, Gopalkrishna G. Joag et al., ‘Cortisone and hydrocortisone given parentally and orally in severe tetanus’, *Journal of the American Medical Association* (1954) 156(5), pp. 479–84; R.A. Lewis, M.P. Bhagat, M.M. Wagle, B.S. Kulkarni and R.S. Satoskar, ‘Antibiotic dietary supplements in the therapy of childhood protein malnutrition’, *American Journal of Tropical Medicine and Hygiene* (1956) 5(3), pp. 483–96; Roger A. Lewis (ed.), *Pharmacology for Medical Students in Tropical Areas*, Bombay: Popular Book Depot, 1957; Lewis, *Tropical Therapeutics: Its Pharmacologic Aspects*, Springfield: Charles C. Thomas, 1963.

with the launch of the *Journal of Post-graduate Medicine*, one of the oldest medical journals in India.⁷⁰

The project to modernize pharmaceutical education in Bombay instigated by Lewis's visit was soon incorporated into the broader national agenda for the pharmaceutical sector. By the Fourth Five-Year Plan (1966–71), the Planning Commission had begun describing pharmaceuticals as consumer goods and the central government planned larger projects to be rolled out across the country. From 1966 to 1973, the Indian government requested WHO support for upgrading laboratory equipment and facilities to improve quality control. The appointed consultant, L.F. Dodson, director of the Australian National Biological Standards Laboratory, noted that 'if India wishes to increase her export trade in these products, then *strong government controls over the quality of such goods produced in India* must be set up'.⁷¹ As WHO observed throughout the project, India was making significant progress as a pharmaceutical producer. By the early 1970s, the domestic drug industry aimed at a production level of 2,500 million rupees, which would 'take the country a long way towards self-sufficiency in drugs and pharmaceuticals and also provide substantial surpluses for export'.⁷²

Efforts launched during the mid-1950s to modernize pharmacology teaching in Bombay, now Mumbai, set the foundations for a burgeoning generic-pharmaceutical industry, as Roger Jeffery has shown.⁷³ In the 1960s, Cambridge-trained chemist Yusuf Hamied inherited his father's Chemical, Industrial and Pharmaceutical Laboratories established in Bombay in 1935. Hamied presented his concerns to Prime Minister Indira Gandhi regarding the high prices of imported medicines, such as beta blocker propranolol developed by British pharmaceutical Imperial Chemical Industries (ICI).⁷⁴ The 1970 Patents Act was introduced, prohibiting licenses on essential products such as medicines and food, and Indira later declared at the Thirty-Fourth 1981 World Health Assembly, 'My idea of a better ordered world is one in which medical discoveries would be free of patents and there would be no profiteering from life or death'.⁷⁵ The Act gave birth to the Indian generic sector and Hamied renamed his father's company Cipla, now a major generic producer. Many Indian generic companies, such as Sun, Lupin and Astral Pharmaceuticals, are still headquartered in Mumbai.

Politically stable India might on the surface appear to be a less demanding context than Thailand. Through commenting on the dignity of mental-health patients or the importance of independent critical thinking in student learning, neither Lindemann nor Lewis feared retaliation from the Indian government, nor were they instructed by WHO or the UN to present their findings in a certain light. Given India's relatively

⁷⁰ The journal is still published. *Journal of Postgraduate Medicine*, 'About us', *Seth GS Medical College and K.E.M. Hospital Mumbai*, at www.jpjgmonline.com/aboutus.asp (accessed 31 July 2021).

⁷¹ Dr L.F. Dodson, 'Assignment report on drug laboratory techniques and biological standardisation', October–December 1967, file: WHO-022-SEARO-IND157 India Drug Laboratory Techniques and Biological Standardisation, 1966–1973, p. 5, added emphasis.

⁷² 'Project for strengthening drug control in India', 1968, file: WHO022-SEARO-IND157; Government of India, 'Ch. 14 industry and minerals, Fourth Five-Year Plan (1966–1971)', *NITI Aayog*, at <https://niti.gov.in/planningcommission.gov.in/docs/plans/planrel/fiveyr/4th/4planch14.html> (accessed 31 July 2021).

⁷³ Roger Jeffrey, 'Commercialization in health services in India since 1980: A biographical approach', in Rama Baru and Anuj Kapilashrami (eds.), *Global Governance and Commercialisation of Public Health*, London: Routledge, 2018, pp. 77–96; Pierre Chapelet, 'India in the world of pharmaceuticals: dualities of a new challenger', in Alain Vaguet (ed.), *Indian Health Landscapes under Globalization*, New Delhi: Manohar Publishers, 2009, pp. 133–72.

⁷⁴ Andrew Jack, 'The man who battled big pharma', *Financial Times*, 29 March 2009, at www.ft.com/content/bd8dcee-f976-11dc-9b7c-000077b07658 (accessed 31 July 2021); Erica Check, 'The treasure of Mumbai', *Wired*, 12 January 2006, at www.wired.com/2006/12/indiadrug (accessed 31 July 2021).

⁷⁵ Thirty-Fourth World Health Assembly, *Verbatim Records of Plenary Meetings, Reports of Committees, 4–22 May 1981*, Geneva: WHO, 1981, p. 75.

peaceful bilateral relations with the US during this time, WHO experts, as American citizens or émigrés, did not feel a need to elaborate on their views on foreign policy. Moreover, since India was officially non-aligned, neither Lindemann nor Lewis delivered their expert assessments as a form of soft power, at least not overtly. Although the geopolitical stakes for controlling substances in India were less dangerous than in Thailand, the WHO consultants still had to walk a careful line to be heard by the Indian government. Ultimately, what differentiated the consultancies of Lindemann and Lewis was the depth with which they read the sociopolitical milieu of independent India. Lindemann merely highlighted the shortcomings of Indian psychiatry whereas Lewis acknowledged and incorporated Chopra's indigenous-modern medicine into his recommendations for experimental and discovery-driven pharmacology teaching.

Conclusion

This article has shown how WHO's consultants navigated overlapping and sometimes competing agendas of country governments and international agencies: Thai military authoritarianism, Indian developmentalism, American foreign policy and the UN's 'neutral' multilateral drug control. Whether in Thailand or in India, WHO experts performed their work amidst a particularly complex concatenation of interests. In the political instability of Thailand during the Cold War, the military government initially saw treatment for drug addiction as a way to secure the northern borders, reform troublesome subjects, thwart communist infiltration and control illicit cultivation and smuggling by the remote and potentially insurgent villagers. Despite asking for UN and WHO support, frequent changes in the military government's drug policy made it difficult for WHO consultants to deliver their advice. In contrast, non-aligned and democratic India inherited a colonial infrastructure for legal opium production, and exports of raw materials were an important source of national wealth. Still under influence from the anticolonial movement and the prioritization of indigenous Ayurvedic medicine, the Indian government sought to modernize pharmacology teaching with the aim of eventually manufacturing pharmaceutical products for export. WHO experts in India carefully navigated the subtleties of this atmosphere, some with more sensitivity than others.

In both contexts, the most insightful pieces of advice originated, not from the WHO experts' access to highly specialized technical knowledge and skills, nor their nationality or disciplinary training in psychiatry or pharmacology. Rather, it was that the experts evoked the language of health and well-being to remind national governments or international agencies of their responsibilities towards their beneficiaries – poor opium-producing farmers, mental-health patients and aspiring young medical students. Histories of science, technology and medicine point out that the transmission of expert knowledge, particularly in cross-national contexts, often becomes a vehicle for covert foreign-policy goals, beyond peaceful cooperation or the genuine pursuit and sharing of knowledge. As this article has shown, geopolitical and economic agendas deemed more important than health hampered the work of the WHO consultants. At the same time, medicine and its associations with well-being also provided a platform from which consultants made bold statements declaring their views of the true causes of 'ill health'. By using medical metaphors to tell broader universal, even idealistic and aspirational stories about health and well-being, WHO experts tacitly transmitted their beliefs about governance, administration and citizenship in a peaceful and economically developed country. Whether the stories were accepted by the primary stakeholders depended on the geopolitical constellation of the region, as well as individual expert's skills in tactful negotiation.

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