

*Population and Reproductive Health
Oral History Project*

Sophia Smith Collection, Smith College
Northampton, MA

Allan Rosenfield

Interviewed by
Rebecca Sharpless

October 28–29, 2003; April 27, 2004
New York, New York

This interview was made possible with generous support
from the William and Flora Hewlett Foundation.

© Sophia Smith Collection 2006

Narrator

Allan Rosenfield, M.D., F.A.C.O.G. (b. 1933) is dean of the Mailman School of Public Health and was the founding director of the Center for Population and Family Health at Columbia University. He serves on the boards of a number of international, national, state and local health-related organizations. Dr. Rosenfield has worked throughout the world, notably in Nigeria and Thailand, and has written extensively on domestic and international issues in the fields of population, women's reproductive health, human rights and health policy.
<http://cpmcnet.columbia.edu/dept/sph/popfam/fac/rosenfield.html>

Interviewer

Rebecca Sharpless directed the Institute for Oral History at Baylor University in Waco, Texas, from 1993 to 2006. She is the author of *Fertile Ground, Narrow Choices: Women on Texas Cotton Farms, 1900–1940* (University of North Carolina Press, 1999). She is also co-editor, with Thomas L. Charlton and Lois E. Myers, of *Handbook of Oral History* (AltaMira Press, 2006). In 2006 she joined the department of history at Texas Christian University in Fort Worth, Texas.

Restrictions

None

Format

Four 60-minute audiocassettes.

Transcript

Transcribed, audited and edited at Baylor University; editing completed at Smith College. Transcript has been reviewed and approved by Allan Rosenfield.

Bibliography and Footnote Citation Forms

Audio Recording

Bibliography: Rosenfield, Allan. Interview by Rebecca Sharpless. Audio recording, October 28–29, 2003; April 27, 2004. Population and Reproductive Health Oral History Project, Sophia Smith Collection. **Footnote:** Allan Rosenfield, interview by Rebecca Sharpless, audio recording, October 28, 2003, Population and Reproductive Health Oral History Project, Sophia Smith Collection, tape 1.

Transcript

Bibliography: Rosenfield, Allan. Interview by Rebecca Sharpless. Transcript of audio recording, October 28–29, 2003; April 27, 2004. Population and Reproductive Health Oral History Project, Sophia Smith Collection. **Footnote:** Allan Rosenfield, interview by Rebecca Sharpless, transcript of audio recording, October 28–29, 2003, April 27, 2004, Population and Reproductive Health Oral History Project, Sophia Smith Collection, p. 23.

Population and Reproductive Health Oral History Project

Allan Rosenfield

Interviewed by Rebecca Sharpless
October 29–30, 2003; April 27, 2004
New York, New York

Sharpless

Okay. Today is October 29th, 2003. My name is Rebecca Sharpless, and this is the first oral history interview with Dr. Allan Rosenfield, dean of the Mailman School of Public Health at Columbia University. The interview is taking place in his office at the School of Public Health, his office looking out over the Hudson and the George Washington Bridge. And he's graciously agreed to spend some time with me today. Dr. Rosenfield, you've had a wonderful career in public health and caring for women and reproductive health. And I'm very grateful to you for spending this time with me today. What I want to do is to back you up a little bit and talk a little bit about—how did you decide to become a doctor?

Rosenfield

My father was a leading obstetrician/gynecologist in Boston, and so I always was interested in medicine. I used to make rounds with him. There were two of us, my brother and I. My brother was older. And at one point, he decided he wasn't going into medicine, so therefore it was my responsibility, he used to jokingly say. I went in without any thoughts of the kind of career I ended up in—without thoughts about population, family planning, or public health.

So after college at Harvard I went straight to medical school, I guess,

in part because of my father's work and in part because of a personal interest. I can't say I loved medical school, particularly the first two years, which are very heavy basic science. I enjoyed the clinical years a lot more—the last two years—and made the decision that I thought I'd like to go into obstetrics and gynecology, and that I'd like to train in a particular program in Boston at Harvard—what was then called the Boston Lying-In Hospital. They required two years of general surgery prior to going on into the OB residency. I went to medical school at Columbia Medical school—the College of Physicians and Surgeons [P&S], it's now called.

Sharpless

Um-hm, right across the street here?

Rosenfield

Well, it's part of this whole campus. We're all on the Columbia Health Sciences campus. And the medical school and the School of Public Health are all on campus, as well as the nursing and dental schools. So I applied to P&S, and went to P&S. And then for my training, I went back to Boston, where for two years, I did general surgery in Boston. And then I was in the era of the doctor's draft.

Sharpless

The doctor's draft?

Rosenfield

Yeah. In those days you could gamble whether or not you were going to be drafted right in the middle of something or you could—there was a doctor's draft plan—you could tell them when you wanted to go and then not be pulled out of something in the middle. So I planned to go between the two years of general surgery and the start of my OB residency. So I was assigned to Seoul, Korea, which is not where I expected. They told me I was going to Germany or France. But, that didn't happen.

Sharpless

Now, were you an OB/GYN at this point?

Rosenfield

No, I had just finished my two years of surgery. So I was what you call sort of a partially trained surgeon, which is a category in the military. And I went to Korea for a year. Actually, I was assigned to go to Thule, Greenland. And I was very unhappy with that assignment. They said, well, there were no alternatives except if you wanted to go to Korea. They assumed I wouldn't. But, I said, "Yes, I'll take it. I'd be a lot more interested in Korea than Thule, Greenland." And it was a good decision.

It was after the war, but before Korea embarked on its extraordinary economic growth. It was a very poor country back then. It was a very interesting introduction for me to the problems of the developing world (telephone rings) and I didn't have a lot to offer because of the amount of training I had at that point. That was interesting. I was still not considering a public health career or thinking about population issues, but—something became inculcated there.

And I guess one other point about how I ended up—none of this was planned. During medical school here—in those days the Montefiore Hospital was still a teaching hospital at Columbia. Einstein Medical School [Albert Einstein College of Medicine] was just being founded. And the head of that hospital was an individual who was very charismatic and who had amazing concern about the community, not just about clinical care but about the community. And that at that time did not exist at P&S. We were sort of an elite institution on the hill and the community was lucky to have us.

Sharpless It was strictly academic at that point.

Rosenfield And I think that head of hospital also had an impact on me.

Sharpless What was his name?

Rosenfield Martin Cherkasky. He's someone very well known who passed away a couple of years ago and who was a pioneer in the concept that an academic institution and a hospital had a responsibility to the community in addition to simply being a site where medical care is provided. And that maybe stirred something in me, even a public health type agenda.

So, I came back from Korea and went into my OB residency. And some—

Sharpless In Boston—?

Rosenfield In Boston.

Sharpless At the Lying-In—?

Rosenfield It was then the Boston Lying-In and Free Hospital for Women, which in time became the Brigham and Women's Hospital. They joined with us—what was, in my time, the Peter Bent Brigham Hospital. My dad had been head of OB/GYN at the Beth Israel Hospital in Boston. So the BLI, as it was called, was the sister institution of Harvard, where I did my OB training—not at his institution. Somewhere near the end of it, there was a Peace Corps-like influence—some combination of my time in Korea and my interest in community activities and the Peace Corps era of the early sixties that made me think—I was in my residency in OB from '63 to '66—that I would be interested in something before I went into practice in Boston.

I had made plans to possibly play some role in my dad's practice. I had made plans with someone who was about a year behind me in the residency to go into practice together, and to have a practice primarily at the Brigham, not at the BI. But some relationship, I'm sure, would have developed with my dad, as well.

Sharpless

Um-hm.

Rosenfield

(telephone rings) But I wanted to do something else for a little bit of time. Board-trained people didn't go to the Peace Corps. So my chairman identified an opportunity for someone at my level to work and teach in Nigeria—at a brand new university teaching hospital in Lagos, Nigeria. And so I went for one year with a plan to come back. And everybody expected me back, I expected to come back and go into practice with this colleague of mine. But I really got interested there, began to think about issues of family planning and population, thanks to a wonderful mentor, Dr. Robert Wright, a senior public health physician from Hopkins who was running the department of community medicine at this hospital. This was a new medical school that was turning over leadership to Nigerian physicians. And they already had a number of extraordinary Nigerians, but in OB the head of the department, Dr. Wright, was someone from Ireland and in community medicine.

Sharpless

This was not too long after independence, right?

Rosenfield

Right—1966 was early on when there was great hope and promise for Nigeria. And it was—my wife and I arrived there just about a year before the civil war, and left—by coincidence, my time was up maybe a week

before the civil war in Nigeria.

Sharpless

Wow.

Rosenfield

So I went there and opened my eyes to the issues of health care in poor countries and some of the issues. And Dr. Wright had a major influence on me. He was very interested in family planning, albeit as a public health person, not as an OB person. And this wasn't an area of great interest in Nigeria at the time. But he was trying to promote it—and it was a little bit difficult for a white American professor to be promoting family planning, but in a subtle, careful way, he was having an impact on the department and the Nigerian faculty that were there.

Sharpless

Now, explain to me what the difference is between a public health view and an OB/GYN view.

Rosenfield

Well, public health and medicine have a lot of overlapping areas, but there's a significant cultural and organizational difference. In public health, we think about prevention first for populations and medicine—how to heal the individual—later. In public health, I'm interested in a broad array of problems, whether it's population issues, you know, how to put into place a national family planning program, how to deal with maternal mortality on a grand scale. So we're population based, prevention oriented, and medicine is individual, cure oriented. And while there's lots of overlap and differences, the culture—at one point here at Columbia, I was both head of the Department of OB/GYN and head of the public health-oriented Center for Population and Family Health. And that was really very interesting because it was two very different cultures.

It was during the Reagan administration, and my OB colleagues were sort of supporters of Reagan and his kind of economic policies which supported their own personal income and practices. Over at the school of public health, Reagan was the enemy—we're not focused so much on personal gain. Everybody wants to make a living, but the central piece is the programs in which we're engaged. So there's a different culture. And that's not to be negative on physicians, who ideally have consciences as well. But there's a different focus in medicine versus public health.

Sharpless And how did you see that playing out in Nigeria?

Rosenfield In Nigeria, I was still very much a clinician. I was there to teach physicians and medical students—

Sharpless Okay, so this was a teaching post?

Rosenfield This was a teaching post. As far as seeing patients, I was operating, I was delivering babies, working with what we would call residents and interns. And my introduction to some of the public health agenda was through Dr. Wright, chair of the Department of Community Medicine, who was interested in the family planning, population-related issues in Nigeria, and that was sort of my beginning. Actually, another part of my introduction to being interested in population came through the Pathfinder Fund. This was a small organization at that time run by the Gamble family. Richard Gamble, who later ended up running the Pathfinder Fund for a number of years, was the son of the founder of the Pathfinder Fund. He was living in Nigeria as a businessman when I was there. And my wife and I were socially fairly friendly with him and his then wife—he divorced and

remarried later. And through him, I met his mother. I think his father may have died by then. But Mrs. Gamble was still carrying on, as were some others who worked with Pathfinder's almost missionary approach at that time. In fact, I remember receiving a supply of IUDs [intrauterine devices] after their person visited, and I hadn't asked for them, but they just arrived as part of their you-ought-to-be-doing-family-planning-at-your-OB-clinic.

So, I was there for one year, and planned to go back to Boston and practice. But I had gotten somewhat of a bug about health issues in developing countries. I had been working in an infertility clinic where the people there wanted me to stay on, to work on both infertility and family planning in a new clinic they intended to build. It never got built because of the civil war that broke out. So I was looking at what I might do. I considered accepting, even though it was a very low-paying job—I was receiving a Nigerian salary. I was newly married, and that year in Nigeria was our honeymoon, in effect. And that was fine for both of us for a year. Although they gave us housing at a very low cost and funded my work, I wasn't sure I wanted to do that for a second year at that level. But I debated it.

Meanwhile, Dr. Wright, who wanted me to join the Hopkins program—but he had little or no funding—suggested I interview with the Population Council. I followed his advice, went back to the States, and was interviewed by people at the Council. And they were interested in me because I'd had a year of overseas experience. They didn't have many OBs with any experience in population. At that time, they didn't even know

what the word demography meant. And so after my meetings in New York, I flew back to Nigeria, and in two weeks they offered me a job. I decided to accept, telling my friends in Boston, “One more year and I’ll be back.”

So I went to New York awaiting my country assignment, and it turned out they assigned me probably the only assignment that would have kept me with the organization. I probably would’ve gone back to practice if they had sent me anywhere but Thailand. And so my wife and I went to Thailand for one year and stayed six. Our children were born there and Thailand was an extraordinary opportunity, an extraordinary experience. And that’s where my life direction turned one hundred and eighty degrees. Thailand changed my career.

Sharpless

Okay. When you arrived in Thailand, what did you find? What was the situation like?

Rosenfield

Well, interestingly, I was basically totally unprepared for the role I was undertaking. Everybody was very kind to me in New York when I was getting ready to go, except for one person who was a very smart and experienced international health person at the Rockefeller Foundation. I went to meet with him and get advice. And he rather bluntly said, “What qualifications have you got to be doing this job?” “I’m an obstetrician, but,” I said, “I don’t know—maybe none.” And, basically, I hadn’t been trained in public health, I didn’t understand the issues that were current in Thailand. I didn’t know that much about family planning at that time, other than what I learned as a resident in OB/GYN. So, I was humbled by

that.

But I went there and there was someone else who at that point was representative—a social science-oriented person. My job was based in the ministry of health. He was based elsewhere. And I sort of learned on the job. And I arrived at a time when Thailand didn't have a population policy, didn't have major plans in family planning. But I arrived at exactly the same time as the new undersecretary—now they call the permanent secretary—at the ministry of health. He decided that Thailand was going to get active in family planning, and he wanted help in getting ready for that. They'd had a couple of Pop Council-sponsored national meetings on population. And they had had one research project in a rural district which had demonstrated tremendous interest on the part of a lot of women in family planning services, particularly the IUD in that study. So that was what was there on the ground. Contraceptive prevalence when I arrived there was about 3 or 4 percent. There were no family planning programs other than a small hospital-based demonstration program, an earlier research project and one or two national meetings that had taken place.

Sharpless

So was the Pop Council the only presence there?

Rosenfield

Pretty much. Ford Foundation was there, but with a broader agenda. And we had someone at one of the universities, Chulalongkorn University, helping develop a demographic studies program. Someone from the Pop Council came around the time I came, I guess, so maybe there was already something called the National Economic Development Board, helping with the economic implications of population growth. And I replaced

another physician who'd been working at the ministry of health who had left because she didn't think anything was going to happen. And the Council wanted her to go to Pakistan, to what is now Bangladesh, based in East Pakistan. And with the advent of this new undersecretary who was more interested than some of his predecessors—who had been interested but hadn't really moved forward very much—he decided to move forward.

Luckily, I arrived just at the time he had made that decision. And I was working with a couple of Thai colleagues in the right part of the ministry. We began to develop the plans for a national family planning program. So I happened in at exactly the right time. And it was right there at the end of the year that I was into something really exciting. But I did go through a difficult time. In the summer after the first year, the University of North Carolina, which had an active program in Thailand, basically wanted to recruit me to come back to UNC after my second year. And it was to be a very exciting position. I was going to have a position in OB/GYN part time, in the School of Public Health and the field of maternal and child health. And also, they had an active population studies center. And I would be responsible for UNC's activities in Thailand. It was really a very nice academic opening for a young academic—I was early in my career and could have gone there. And I accepted to come a year later.

And then as that year got closer, I got more and more uncomfortable with the fact that this was the wrong time to go. I had not begun to write. I did a lot of writing in Thailand eventually. And there was too much happening. I was in a unique position. And I won't go into the details of

my negotiations with UNC. But I actually flew back to try to convince them to at least give me one or two more years. And they didn't want to do that. I left Chapel Hill saying, "Yes, I'll come." I came back and was very depressed.

Finally, through discussions at the Pop Council and such, I withdrew from accepting the position. The person in OB sort of understood, because he thought it was kind of strange anyway. OBs don't do what I was doing. The person in the population center understood because he'd worked overseas. The person who was really upset and angry with me was the person at the School of Public Health, the chairman of MCH, because he was a very organized man with plans of what I was going to do. And he was going to have to substitute at the last minute. So he was very angry.

The good news in that is about a year or so later, he did come to Thailand for UNC for three months—sort of a short sabbatical. And we became the closest of friends. And he understood why I stayed, forgave me. And when he was ill, and they were having a sort of testimonial dinner at UNC, the family and he chose me as the person to come give the major address. So I knew I had been forgiven. A few years later, I went back when he tragically died and spoke at his funeral.

But the six years there were—it was just an extraordinary opportunity. Thailand has ended up with probably one of the most successful national family planning programs in the world. I'm the one who—Mechai [Viravaidya] may or may not have told you—brought Mechai into the population field, and we've been friends since 1968 or so. That's a great

story. But it's in his book.

Sharpless [From] *Condoms and Cabbages*.

Rosenfield Along with Malcolm Potts. We wrote the introduction to that book. And he does describe fairly accurately—not he, but the person who wrote it—Mechai and I got together—basically we agreed to do some work with the private family planning association there.

Sharpless How does one build a national family planning program from scratch? What did you do in Thailand?

Rosenfield Sort of the right person at the right time, where almost anything I suggested worked. Things work in Thailand because they're very pragmatic people. I sat in the division of family health, which encompassed maternal and child health, where the head of it who sort of was interested—not the easiest man to deal with. But for the first year or two that I was there, I collaborated with a woman doctor who had worked in the original rural family planning research project. And she'd come in to help develop the program. We would sit and talk and think of what we had to do, and we began to develop training programs and training modules and things like that.

Probably the single most important thing I did there, maybe the most important single study I've ever done—it was clear that family planning services were not getting out because there weren't very many doctors in rural areas at that time. A lot more now, but at that time, there weren't. And I became more and more convinced as an obstetrician that you didn't really need a doctor to prescribe oral contraceptives. And so, today it

would've taken much longer to plan the study—with all the necessary reviews. We actually did the study in just one year-long period of time. But I came up with an idea of developing a checklist for auxiliary midwives to use.

Auxiliary midwives—there were probably three thousand of them in Thailand. They were scattered around the country in rural areas, ostensibly to do maternity care. But they didn't really have much more to offer than the granny midwives, the TBAs [traditional birth attendants], had to offer. And the TBAs would come and stay with the family for two or three days. These auxiliary midwives were not being well utilized. People weren't using them to deliver babies.

So it seemed to me that they were a great force to be able to train to provide oral contraceptives following a simple checklist. Complicated to do, and again today it would've been much more difficult, because it wasn't the standard of care at the time in the U.S. I felt, on a risk-benefit analysis, that it was more than justified to set up this new type of program. And we developed a—I was not a researcher at the time—but we developed a simple design. In four provinces, the midwives would be trained to use a checklist, and allowed to prescribe oral contraceptives. And ten out of twelve of the provinces would be as usual—only doctors. And there was a huge uptake in the pill acceptance in the four study provinces over the next year.

And we finished the study basically in one year. Like I say, it would've taken us that year just to plan it in current day ways you develop that kind

of a study. It wasn't too well designed, because I didn't know anything about design, but we did it. I had a little bit of money from the Pop Council that was sort of my discretionary fund for the ministry. And we did it with small money without going through any kind of review process in the States.

And it actually changed family planning in Thailand. The ministry reviewed it. There were no deaths, there were no unexpected events, and proved that auxiliary midwives could prescribe pills in the national program. We had already embarked on a training program in case that was the finding. So there were a lot of midwives already ready to do it. And family planning just took off. IUDs were still popular. They didn't go down. Those were the only methods, along with sterilization at that point in time. But it was just added. The IUDs continued to increase somewhat. But pills just took off—you could get them in the local community for the trained auxiliary midwives. Subsequent studies addressed how you could train non-physicians to insert IUDs. And that was another study. And injectibles came in.

We had studies, and those were actually—some of those were after I left Thailand, but [involved] the same concept of use of non-medical personnel, non-physician personnel to prescribe that. So that had a major impact on family planning in Thailand. And part of it was because the Thais were so pragmatic. In some other places, that might not have worked as well. But it did, they accepted it, and we moved forward very quickly. And the concept spread to many other countries throughout the

world.

Somewhere along that time was when I did meet Mechai. Mechai was writing a very articulate English-language column in one of the English-language papers. He wrote a terrific article on population, and I got to meet him in about 1968—and he was a young Thai of Scottish and Thai parents. His father was a Thai physician, his mother a Scottish physician. And he had gone to Australia for education and was somewhat of a playboy in Australia, but very smart, majored in economics and came back to—no graduate education—to a fairly responsible position on the economic planning board. And I think in conjunction with the then head of the planning board, he wrote this article in the English-language [paper], a series of articles under a pseudonym which was called GNP, on a variety of ideas, many of which were probably sounding boards for the director general of the organization—the two of them were quite close—ideas that they wanted to surface and get the public thinking about that he couldn't do officially, so he wrote under this pseudonym this article on population. And someone then introduced me to him.

He resigned not too long after that from the planning board to run for office in Bangkok. He didn't win, but he was then doing some consulting work for a couple of banks and I said, "Why don't you—there's this new private association that's not doing well. Why don't you spend a day or two up there and help them?" And he did, and eventually he took it over—interesting coup. And while he didn't totally succeed in that, he had another opportunity to set up a new organization with IPPF [International

Planned Parenthood Federation] help, the only time the IPPF ever set up an organization that wasn't part of their family planning network—or affiliates, and that was initially called Community Based Family Planning. It actually became Population Development Association.

And he had a significant impact on family planning because he popularized condoms and he talked about family planning—in many ways, a very charismatic man. The Thai family planning program probably would have been a dramatic success even without Mechai, but he really did help move it forward, and certainly, the press helped locally and globally, because the charisma he brought to the thing, made the thing better and better.

Sharpless Um-hm.

Rosenfield Where Mechai had—save it for another time—had an important impact on family planning, but he also had a dramatic impact on Thailand, on AIDS, in terms of their response to AIDS. Need to go change your tape?

Sharpless Yeah, I need to turn it over.

Tape 1, side 1, ends; side 2 begins.

Okay.

Rosenfield And AIDS is where Mechai deserves a prize. If you're interested another time we can talk about that.

Sharpless Um-hm.

Rosenfield So, the Thailand experience for me was—as I tell people, that was my public health training, was in the field there, rather than formal training. And because Thailand was beginning to move in family planning, and also

had a wonderful population studies program in Chulalongkorn University, and an interesting economic planning board-type program—I, by the second year, had become the representative of the Council so I was involved in these two other initiatives, although my own office was in the ministry of health. It was a different era for the Pop Council. Nowadays they have regional offices, and they're involved in a lot of regional work. I did some things in the region, but I was primarily based in Thailand, and I didn't have a Pop Council office, I was in the ministry. We had someone at Chulalongkorn and someone at the NESDB—National Economic and Social Development Board. So we were really working with the government.

When I was at the ministry of health, there was only one other organization that had an office in the ministry, and one that was very close to the ministry. In the ministry was WHO with offices, and UNICEF was nearby. I was the only other non-Thai. It was a wonderful opportunity to do a lot of interesting work with the Thais. And it was interesting. It was an era where I only had maybe a budget of fifty thousand dollars a year that the council gave to me and the ministry to work with. USAID was not a major player yet—they did come in, in about 1968 or '9, but they were not funding me or my programs, so I didn't have to do what people have to do today, in terms of working with USAID.

Sharpless

USAID—(both speaking) USAID is kind of the five-hundred pound canary.

Rosenfield

Can be. But at that time, I was the key person there, and they would

interact with me, as did a couple of the other foundations, because I was in the ministry and they weren't. And they were just starting the program. I was very friendly actually with the first population officer who was assigned there—a very good person. But, as compared to today, there was no e-mail, there was no fax, there were telephones. If I wanted to call New York, or they wanted to call me, I had to book a call at the central post office. And mail took two, three, four weeks. So I was pretty much on my own.

And while I was inexperienced, I had some common sense and some good Thai people to work with. And much of what I did was sort of on my own, without people in New York telling me what I should or shouldn't be doing. And because things were working well, I continued to have a long leash and do what I wanted. So it was a unique opportunity. It was the only kind of job that would have kept me from going back to Boston to practice.

During my first year in Thailand, I did do some clinical work. But the place I was working, Chulalongkorn Hospital, was across town with heavy traffic, and it became more and more difficult. And I was doing a lot of upcountry travel and it became unreliable. So I basically withdrew from it—and that's when I basically became a public health doctor.

Sharpless

Um-hm. And you were based in Bangkok?

Rosenfield

I was based in Bangkok but traveled all over the country. So it was a unique experience, and as I say, it led—one of the other good things about Thailand is that Bangkok is an attractive city to visit. So almost everybody

in the population field, from demographers to sociologists to public health people to bio-medical researchers, if they were going to Asia, they almost always made Bangkok one of the places they would visit. And because I was sort of one of the most well-connected persons among the foreign community, most of them would come to see me at one point or another. So I really had the opportunity to meet all kinds of people from other fields I would normally not have met. So I became a pseudo-demographer and a pseudo-sociologist, just because of the opportunities to meet some wonderful people who came through Bangkok for meetings, or business, or whatever. And also because the council had some extraordinarily good people that they recruited. I stayed there for six years, but during that time there were a series of people that came into Chulalongkorn and NESDB, and I had the opportunity to learn from them and they all became friends, so it was a good situation.

Sharpless What changes did you see family planning making in Thailand? What difference did it make?

Rosenfield Well, when I came there, the number of people practicing modern contraception with prevalence was about 3 percent, and most of that was in Bangkok, most of that was sterilization. For the most part, it was sterilization programs.

Sharpless They had significant maternal mortality problems?

Rosenfield They had significant maternal mortality problems, and they had family size of six or seven kids by the time someone completed family childbearing. It was clear from a couple of the early surveys that women and men were

interested in smaller family size. And the successes were well beyond anything I would have predicted during my six years there. But by today, Thailand is like a western nation. About 65 to 70 percent of the people are using one form of contraception or another. On the average people have two kids, maybe three, but somewhere between two or three kids per couple by the end of childbearing. They moved into totally western-style demographic position—appearance.

And that was not through coercion, not through paying people to do things, it was because that's what they wanted to do. They wanted better education for kids, they wanted better job opportunities, whatever. So it really allowed the Thais, ahead of many other countries, to do what they basically wanted to do, and facilitated that happening more easily than it would otherwise have happened. And the Thais are very good about reviewing all of the modern methods, and if they were acceptable by WHO or USFDA standards, then that was okay to introduce. And so they kept introducing the newer methods: the injectibles, the implants and such, newer IUDs and what have you.

Sharpless You did quite a bit of research on technology and delivery while you were there.

Rosenfield Mainly on, one, the use of paramedics; two, looking at some of the different contraceptive methods, some related to how you deliver services. Accidentally, I prevented Thailand from having a difficult time with the Dalkon Shield that occurred in this country.

Sharpless What happened?

Rosenfield

Well, the people selling it tried to convince the Thais they ought to use it. I had no idea it was going to cause the problem it caused. But the IUD, the Lippes Loop, which was the one being used, when it straightened out was a very thin IUD insertion. The Dalkon Shield was a shield and (telephone rings) it didn't really become a small thing. It was painful to put it in, as compared to the Lippes (telephone rings), and it was painful to get out. And I just advised, you know, you've got a good IUD. This one doesn't make sense, I don't like the way it looks. And the Thais bought that, and we never introduced it. But it wasn't (telephone rings)—I can't say it was because I knew of the problems it caused. But nonetheless, I saved Thailand from—pretty much single-handedly on that one—from having to deal with deaths from Dalkon Shields.

Sharpless

Yeah.

Rosenfield

But it was not because I had predicted that. As someone who was doing IUD insertions at that time, I had done a few Dalkon Shields and I just thought, women really have pain with this one going in, and I had taken a few out, and it was very painful to remove them. I didn't have that problem with the IUD, and then the copper T was coming in soon afterwards, which was even easier to insert. So that was the IUD— good luck on IUDs.

Sharpless

What about sterilization?

Rosenfield

Sterilization was a major method of contraception in Thailand in the beginning. It was the first method. And when I went there for the Council, one of the big programs the Council had was something called the post-

partum program, because—helping educate women, at the time of delivery and before, if you saw them, about the opportunity for sterilization if they had as many kids as they wanted to have. So Thailand had an active female sterilization program, and Mechai made efforts to popularize male vasectomy with a moderate degree of success, but far more women were sterilized than men, as is true in many countries, not all—it depends.

And the major thing that family planning provided was opportunity for women to use reversible contraception until they were really certain that they did not want any more children ever. So sterilization, I think, was actually number one. The pill was number two if you combine both male and female sterilization—which is also true worldwide. Sterilization is one. And Thailand is one of the places where research on laparoscopic-type sterilization procedures [was conducted], and open laparoscopy was developed in Thailand. And so again I was in the forefront of some of the contraception and sterilization research, some while I was there, some after I left. The whole concept of that kind of research grew out of the auxiliary midwife study.

Sharpless

Um-hm. To what extent could or did what happened in Thailand be replicated in other countries?

Rosenfield

Well, take the pill study. I did spend a moderate amount of time in the other countries. I went to both Philippines and Indonesia, but mainly Indonesia. And, working with some colleagues in Indonesia, we introduced the checklist there as well. And so pill off prescription took hold there, and through some of the writings and such, that became a model in other

countries that you could do this.

It was interesting—I had gotten to know the Indonesians—well, I almost went to Indonesia when I finished in Thailand, instead of coming back. I was offered a job at the World Bank to lead a bank team on family planning. But at that time, I had some reservations about the style and the way that the Bank worked in countries, and decided I probably wouldn't be happy. But the Indonesians were quite supportive and encouraged me to come. And they liked the checklist, and they used it in the program, and one of the subsequent consultants from the WHO wanted to—there was a cute story—he wanted to simplify the checklist. And the Indonesians would not let that happen unless I came down and said that was okay, because it was my checklist, and they couldn't change it for their country. I was flattered. And I was more than open to seeing it simplified if it could be done and still protect the health of women.

But I was very pleased, and I've been very interested in maternal mortality and other areas since, especially in the role of personnel other than doctors—particularly when you're working in poor countries and in rural areas where there just aren't a lot of doctors available. Whether it's considering how to train non-doctors to provide a caesarean section and other emergency obstetrical care, anesthesia and a variety of things—for that matter, emergency care more generally, including trauma from car accidents, et cetera—you need trained people in district hospitals where there may not be sufficient numbers of doctors. So the pill was sort of an introduction to me into the potential of other personnel who could be

trained to provide various levels of care.

Sharpless

How different was the Philippines as a Catholic country?

Rosenfield

The politics of family planning were a little more complicated, but the government had a formal population (telephone rings) commission and a very active private population organization. I forgot the name of it, but it was sponsored by Mrs. Marcos. The Marcoses were clearly very bad people, but they did allow and support the development of family planning activities. The Catholic Church—it's sort of like in Latin America—the Catholic Church is against family planning and contraception, but they sort of closed their eyes—except when the Pope comes by. Family planning services became fairly successful in the Philippines, and certainly equally so or more in many parts of Latin America, which is similarly predominantly Catholic. Philippines didn't go anywhere near as far as the Thais did, and the success of the program certainly has progressed a lot over the years from where they were, say in 1970, to where they are today.

Indonesia had very dynamic leadership within their family planning program. One reason I regretted not going there was that I would have gotten to work with the person who did run the program, with whom I had become good friends. They probably did better than the Philippines in terms of where they took their national program.

Sharpless

Um-hm. So, you were in Thailand for six years. You turned down the position in Boston, turned down the position in Chapel Hill. How did you decide when it was time to leave Thailand?

Rosenfield

Oh, the Council began saying, You've been there six years, don't you think

it's time—they wanted me to come back and run something in New York, a major program in New York. And my family was saying, You've been overseas for seven years: we never see our grandchildren. I was not very sympathetic. I am more so now that I have grandchildren, (Sharpless laughs) but I was not—yeah—I'm on my own, I'm doing my thing, leave me alone. And in fact, both of us were saying that, because my wife was very happy in Thailand. But finally—you know, they almost had to pull me out. I kept vacillating on whether I really wanted to come back, or do I want to go to Indonesia. But maybe six years was enough time.

I finally decided it was time to go back. And debated a couple of jobs, one of which was to come back to the council in and run a broad-based program, which in retrospect, was not that dissimilar from our maternal mortality initiative now. That program did not succeed, unfortunately. And after being in the Council for about a year, I decided I really didn't want to be in that kind of position, and I started looking. I really wanted to go back to Boston, but we'd bought a house and so I thought, Well, I'll stay in New York a little longer.

And I considered two jobs. Mount Sinai Hospital was looking for someone to run the OB/GYN service in their city hospital in Elmhurst. (telephone rings) And Columbia was interested in—they had had funds to set up from Ford Foundation something called the International Institute for the Study of Human Reproduction. And it was having some difficulties for a variety of complex reasons. And first they approached me to run that. (pause in recording)

Sharpless Okay, when you stopped to take the phone call, you were talking a little bit about what you were going to do—after leaving Pop Council, and I did want to ask you one or two other questions about that, your time back here in the New York office at the Pop Council. How much were you around Mr. Rockefeller?

Rosenfield Very little.

Sharpless Very little?

Rosenfield The person I admired most on the Pop Council in those days was Barney Berelson, who was the president and I thought was a great man. And there were some very good people at the Council in that era. When I first flew to New York—I happened to joke with him later when I learned more about the world—I paid my own way to come to New York to see whether this is what I wanted to do, and I realized later that they would have paid for me if I'd only asked. But there was a man named Cliff Pease, who has passed away—most of the people have passed away—and a man named Richmond Anderson, who ran what was then called the Technical Assistance Division. Today it's the International Programs Department. Those are the people I met when I came from Nigeria, and those were the same people—I guess by the time I came back to New York, Dr. Anderson had retired—Cliff Pease was in charge of the Technical Assistance Division. Berelson was very important as the president, and a man named Parker Mauldin, who I'm sure is on the list of people because he's a man now in his mid to late eighties. So he was very active until his wife died, and he sort of—in the last years I guess she had Alzheimer's—in

the last bit of time he sort of was withdrew and took care of her. But he was vibrant and active—at least up to close to eighty, I think. And so there were some wonderful people at the Pop Council in those days.

When I debated about coming back, aside from going to the Council—Rockefeller was recruiting me for a position at Rockefeller, but they were going through a transition that wasn't quite clear as to who you'd be reporting to and what it was. And they couldn't really give me some answers, and so I decided not to go there. Had I gone to Rockefeller Foundation, it is not inconceivable I would have become the president of the Council, because they were having a very difficult search process at that time. And they weren't finding people they liked, and really just struggling. And one or two people had suggested my name, even though I would have been very young for the position at that time. But I would have jumped over a number of people at the Council to become a candidate. But had I been at Rockefeller, and had I done well at Rockefeller for a year or so—some people thought that might have happened.

But I came back to run an interesting program on maternity care and family planning, a global program called the Taylor/Berelson Program. Howard Taylor was a former chairman of OB/GYN here at Columbia and a very distinguished obstetrician in the country, and he'd linked up with Berelson and come up with this program idea. And I came back to run it. There were going to be sites in six countries around the world. And I did run it for a year and a half until I finally made my decision to leave.

Sharpless What were the problems with it?

Rosenfield In retrospect, I should have stuck with it, and put it in very much like the maternal mortality program I had (telephone rings) but—

Sharpless What were they trying to do?

Rosenfield They were trying to make maternity care services (telephone rings) available to women who don't have access in poor countries, and link an effective family planning program to them.

Sharpless Okay.

Rosenfield It was a little heavily U.S. modeled at that time. I didn't totally buy into some of the ways we were introducing the program. And the funding sources were iffy for the longer term. Again, that's a program I probably should have stayed with longer, and done more to try make it as successful as I think it might have been able to have been. But my job, while sort of running it, was also a heavy desk job, and I began thinking—I also by then had been away for seven years, and I was thinking, Is there some kind of job where I can do some of what I'm going to continue to do internationally, but also deal with some of the issues and problems that exist locally? And the job that Columbia was offering me gave me that opportunity to develop a new program that was both domestic and international in orientation. And that ended up calling me.

This international institute I already mentioned to you was having major difficulties, and they originally approached me to possibly run that, but that ran into difficulty, and they decided that essentially—although they kept the name—to divide it into two independent centers. One center

for biomedical research, and one a more applied center and I was recruited to basically establish the center of population and family health, which was a small program when I took it over, and grew into a very large program.

Sharpless Well, let me ask you one more question about the Pop Council, and then I know you need to get downtown.

Rosenfield Right.

Sharpless Mr. Rockefeller's speech in 1974 at Bucharest has been noted by a number of people as maybe shifting some ground in the field of population. How much did you notice it at that time? And how would you evaluate its impact?

Rosenfield Its major impact at that time, that I saw—I'll tell you [about its impact] locally and I'll say more later, probably—it was seen by Berelson as a personal attack on him. And he was very, very hurt, and angered by that speech which sort of was unexpected. Joan Dunlop, as you know, played a significant role in that. And it wasn't too long after that that Berelson made his decision to step down. He'd had a very good relationship with JDR before that, and I think the relationship soured because of the tone of the speech and what Barney, who was a very sensitive person, took as a personal affront.

Actually, there were two things that happened with Barney that were sort of unfortunate, because I really did like him. Around the time—just prior to my coming back, and before the international Bucharest meeting on population—the Council organized their first-ever field retreat, a retreat for New York and field staff. And I had written a—something I have

searched for and searched for, and no one can find it either at the Pop Council or here—but I wrote a long, like four- or five-page, single-spaced thing towards the end of my time in Thailand on thoughts from the field. And it wasn't really critical, but it was just raising issues that sometimes you forget about when you're in the New York office compared to being in a field office. And it generated quite a response. I got a long letter from Berelson, a long letter from the vice president, a long letter from Cliff Pease. And it generated some of the discussion at the retreat. There was a very frank discussion at the retreat. A lot of things came out that—problems that New York didn't think about. I thought it was one of the healthiest retreats of this type that I had been at.

Barney took it personally, took it as a critique and criticism of him. And so he was hurt by that, and I don't think anybody wanted that because everybody respected and loved him. So people, when they heard how upset he was, we were all upset that he had that kind of reaction. And then on top of that came the Bucharest slap by JDR, and those two things led to his decision to step down as head of the Council. I've forgotten how I got into that.

Sharpless

Well, the larger—you said there was a local impact, and then there was a broader impact of JDR's statement in Bucharest.

Rosenfield

Oh, you know, it began to get people thinking beyond sort of the demographic aspects of family planning and population, and begin to think of some of the broader issues—join in creating the International Women's Health Coalition, and some of what eventually happened at Cairo. Some

would say that JDR got that sort of started, and maybe he did. I don't know.

Sharpless Um-hm. Well, why don't I release you for your—

Rosenfield This is a good breaking time, I would think.

Sharpless —downtown commitment, and we'll pick it up with your joining Columbia—

Rosenfield Okay.

Sharpless —tomorrow.

Rosenfield All right.

Sharpless Thank you so much.

Rosenfield Thanks.

end Interview 1

Interview 2

Sharpless Okay. Today is October 30th, 2003, and this is the second oral history interview with Dr. Allan Rosenfield. The interview is taking place in his office at the Mailman School of Public Health at Columbia University, and my name is Rebecca Sharpless. Okay. Dr. Rosenfield, when we left off yesterday, you were just at the point of joining the faculty here at Columbia, after your time with the Population Council and others, and you indicated that the work that you were being brought here to do was very appealing. So, tell me what the scenario was. It was—

Rosenfield One of the leading obstetricians in the country, and actually a cancer specialist in gynecology, Howard Taylor, had been chairman of obstetrics and gynecology at Columbia for many years and had created something called the Institute for the Study of Human Reproduction. And his concept, when he got some funding from the Ford Foundation to establish it, was to create in the field of human reproduction and population something comparable to the Sloan-Kettering Institute on cancer research [Memorial Sloan-Kettering Cancer Center]. And he received a fairly large grant, and he wanted the Institute to cover basic science all the way through to the social sciences and applied family planning.

For a variety of reasons, mostly related to the unrest at Columbia in the late sixties and the riots downtown and all the pressures on the administration of the university, some of his plans with the Ford Foundation didn't materialize. They were going to have a building, quite an enterprise was planned, but it just never materialized. And although there

was some funding and some things still going on by the time I was being recruited first to actually run the Institute—but for a variety of reasons, the senior authorities within the health sciences and the university weren't sure that they wanted to maintain the Institute with the same framework. The decision was made to create two centers, one to continue the work in the basic sciences and the laboratory, and one to be structured on some of the broader family planning and population issues of the type I had been engaged in abroad.

And since they had approached me about the Institute with this plan for restructuring, they wanted me to come and sort of establish what became the Center for Population and Family Health. This was attractive to me because it allowed me to take some of the experiences and things that I'd been doing overseas and develop a program here at Columbia that was going to bridge both international activities and domestic activities with a great deal, I felt, and it turned out to be true, of—what's the right word? Just an ability to develop this without a great deal of excess guidance from on high at Columbia that gave me the ability to develop what I could and raise the monies that I needed to make that happen.

And so we did develop what we called then, at first, the Center for Population and Family Health. And we had some U.S. government money and some foundation money, and that was winding down from the earlier institute. And I was able, due to the contacts I had made during my time in Thailand and with the Pop Council, to get some of the donors to give me an extra year or two of funding to give me a chance to develop the

program. And Rockefeller Foundation came on with a grant again to give me some money to see if I could do what I said I wanted to do. And this was developed, both an international and domestic program focused on issues around reproductive health and family planning.

Sharpless Okay. What sorts of—as you started to develop an agenda, what sorts of issues were you most interested in?

Rosenfield Actually, it's very interesting. A few years ago, my successor as head of the Pop Center—we've now left and stayed here about eleven years—we found my original letter to the Rockefeller Foundation and what I wanted to do with a Pop Center here. And while it wasn't exactly everything I said in that letter, it was amazing that the letter I had written in 1975 was still relevant in 1995, or whenever it was we actually reviewed it, somewhere in the last five years.

So, what I hoped to do was domestically build a team that included people providing services, family planning and related reproductive health services, to the Washington Heights community; develop research activities around the delivery of care in Manhattan and Lower Manhattan; be able to build component or demographic studies that were broad, national and international; and then develop an applied program of applied research in developing countries—training and research—on issues around women's reproductive health and including family planning and eventually, later, maternal mortality. And the donor community was prepared to support that concept, and we were able to build a program over a period that's been quite successful, and it became quite large.

In fact, at one point, the programs at the Pop Center were larger than the rest of the School of Public Health put together—about nineteen divisions or so. The school is still the smallest school. So it was a great opportunity. Very early on, as I was building the program, the Center was a center and as such—at Columbia you can't make academic appointments through the Center; you have to have an academic department in a division of your program. So I was borrowing titles, in effect, from several of the other departments in the School of Public Health. I made a proposal to the person who was dean at that time that let me create a department or division—we called them divisions then—of population and family health, because there was no comparable program at that time.

Sharpless Uh-huh. I need to stop this while you sign the letter.

Rosenfield Yeah. (pause in recording)

Sharpless Okay, so you went to the dean to ask about creating a division.

Rosenfield Which would allow me then to recruit faculty with appointments in professorial ranks. And because I had a moderate amount of general-purpose funds to make it more attractive, because the school is a small school with a small budget at that time, I said for the first several years I wouldn't require budgetary support, that I would cover the budget and hope eventually that there would be school contribution, but that would be my offer in order to get this status. And that worked, and we continued to call it the Center for Population and Family Health, but it was in actual fact a division, now a department, in the School of Public Health. That allowed us to grow as we had funding to grow, and be able to make our own

appointments, and not have to go to other departments in the School of Public Health to request—

Sharpless Um-hm.

Rosenfield They allow us to jointly recruit someone even though their role will be almost totally in the Center.

Sharpless Let me ask you a couple of follow-up questions, if I might. In shifting to Columbia, what capacities does being at a university, at a medical school, allow you to have that you didn't have? I mean, that's kind of a naïve question, but what does being at a medical school allow you to do that you wouldn't be able to do otherwise?

Rosenfield Certainly the teaching—mainly the teaching component, and having students around. In an academic institution you're more inclined to do research than outside, although the Pop Council is certainly where—people who have done very credible research are based at the Council, so it isn't that you couldn't do the research. And I guess for me personally this was coming to a place where I could kind of build my own program. And that was attractive. And academically, for some people it's a very attractive place to be, rather than at a nonprofit. So there were—this was not to play down what I thought was a very important role at the Pop Council. But an academic institution is just attractive as a place to try to develop this kind of program. (laughs)

Sharpless What about the clinical aspects?

Rosenfield Yeah, I couldn't have been involved in running a family planning program. I was real involved in the school-based clinics and other community-

related activities. From an organization like the Population Council, I would have been primarily involved with international activities only. This allowed me the ability to do both domestic and international.

Sharpless Um-hm. This is a new copy of—

Rosenfield Here we go again. (pause in recording)

Sharpless Okay. And how much outreach had there been to the Washington Heights area prior to this time?

Rosenfield Very—the university, when I was a medical student here, and historically, the medical school by and large did not reach out very extensively to its community. It saw itself as a benefit to the community, but—come to us for what you need. And so I think our program was one of the first major initiatives to reach out and work in the community.

Sharpless What did you all do?

Rosenfield Initially we developed an evening—we were running the family planning services for the medical center. And with the identification of teenage issues as a major issue, we developed sort of the first ever scheduled evening clinics for teens. And that became called the Young Adult Clinic for young women [Young Adult Clinic for Female Adolescents].

And a few years later we decided that we really wanted to find a way to bring young men in, and created a Young Men's Clinic. One of our social workers who was very creative—everybody was saying, Well, how do you get men in, since they do play a role in all of this? They began—they had a new video camera—they began going out and videoing young kids on the street break dancing, playing basketball, whatever, and then saying, Come

to this clinic site on Monday evenings—you'll be able to see yourself on television. And that brought them in. And we had to do that maybe for six—I don't know how long, for a while. And then eventually they just kept milling around just to [have] a place to go, because you could get a physical exam, you could get a check-up. If you were worried about a sexually transmitted disease or something, you could do that as well and get instruction.

So, it became a major—it's successful to this day, a model of how you get young men—due to a couple of very creative, adolescent-oriented social workers and doctors that made it into a national model. So, we started with clinical services here in the afternoon—all day for adults, but specialists at the programs in the evening. We were very proud of the—we had major problems with the staff that we overcame connected with our kids—some of them, in violation, started coming at three and they got in the way of everybody and people were not happy with us. Eventually we raised money and we were able to set up our own facility just for family planning and reproductive health, in a different area, which was a major step forward for the program. That actually came about at least in part due to Warren Buffett and his wife and a family named Heilbrunn, for whom the department is now named, who were early, early Buffet investors and owe their very large fortune to their having invested in Mr. Buffett back before he was a very big (unclear)—and then creative leadership of some people, particularly a woman named Judy Jones, who helped set up these clinics.

We established programs for junior high schools, initially two and then four. Health clinics weren't making contraceptive services available because junior high school seemed early, but we were talking to kids about sex and referring those who were sexually active to our evening clinic—had one of the social workers working in the school, be there to help get them, to assist them when they came. And then eventually senior high school—we were offering service within the high school. And it was a very—it was one of the first programs (pause in recording)

Sharpless

Okay, you were talking about services to the junior high age—

Rosenfield

Right. This was a very creative initiative, originally was funded by some foundations that Judy Jones was able to convince this was an exciting new way to go. And the community basically liked these programs very much, signed on to it. And the local politicians liked it, and so the local politicians, without our urging, which is very unusual, went out and raised money in Albany to both expand two more, so we had a total of four. And as the foundation money was decreasing, they advocated for the state and city to cover these programs, that they were too good to let go because the foundation [money had come] down.

So those have been very creative programs. We've had a wonderful program in the community to educate parents. There's a twelve-week course—they get a little certificate. They treat it like a graduation from college almost, where they get a lot of skills on how to deal with mainly mothers, but a few fathers—it's bilingual, it's a predominantly Hispanic community—on how to deal with your kids on sexual issues, drug issues,

and all of the other issues that need— if you're a parent and a teenager in an inner-city community. So these kinds of things have been a rather remarkable success. And it was nice that we got, at the same time—that we're still doing many of the types of things I did with the Pop Council overseas.

Sharpless Uh-huh. Thinking about the school thing—"the school thing," that's not very articulate—the school aspect of it, the academic aspect, tell me about the types of people you recruited as faculty members.

Rosenfield One of the nice things at a school of public health is you can recruit people from very different backgrounds. We had, at the Pop Center—and this is true for the school more generally—people from a diverse—we had some sociologists, demographers. We had a couple of lawyers. We had people whose basic background was public health. We had some clinician types—just a broad array of backgrounds. What we were looking for in the international side were people who actually worked and had been involved in developing community programming, that had some academic interest and or good teaching abilities. Domestically, similar—people who were a little bit of an activist model. So we wanted people who had academic interest and research interest but also were interested in applying it in programs in the field.

We were well funded. Some general-purpose monies from the foundation were augmented. The family planning program was funded by the feds under their domestic family planning money, and the international program had a significant amount of money in the early days from the U.S.

Agency for International Development. We had money from them for about twelve years. We had major training activities, operations research, some legal and policy support. We lost in competitive bidding a couple of these. One program was just canceled by AID. It had nothing to do with us, it was just an area they cut. But two of them were competitive bidding, and we lost in both cases, we thought, inappropriately. And we lost the biggest AID program we had just after the time I had stepped down and just about the time the new director of the program was coming. Thought I was giving him a present with a great AID-funded program in transnational operations research. And instead, to our great surprise, we lost a competitive bid to, actually, my old organization, the Population Council, who had submitted a lower bid. And they had some private money, so they could pilot the program.

Sharpless

What was it to do?

Rosenfield

Generally, operations research on family planning programs, primarily in Africa. It was a good program, we had been there for quite a while, we had a lot of field staff overseas. It was a blow to the people, and it was a blow, not so much to me, but to me only in that I thought I was passing on to my successor a successful AID-funded program. As a result, we didn't go back to AID, and the Center built a very interesting, foundation-supported series of initiatives. And so, for the very first time, for our eighth program, which is not at the Pop Center, we had gone back to AID funding.

But the Pop Center basically ran its programs with some interesting, innovative activities funded by the foundation world. The general mortality

and refugee health and AIDS were—we just didn't—because the AID can be somewhat bureaucratic, and many times tended to micromanage programs, we were freer with our foundation monies to do what we thought was the right way to do things and with less detail involvement from the funders. So the Center's gone through several stages. It was interesting that I was the first director as a clinician, the second director was a demographer, and the third is a pediatrician. I had the most international experience, but my immediate successor had more experience domestically, with some international, and the current person is more of a maternal/child health expert than a reproductive health expert, but very supportive of the reproductive health agendas that the Center continues to carry, or the department now carries.

Sharpless

And what—trying to think of how to word this. Why traditionally has there not been more interaction between reproductive health and MCH?

Rosenfield

Well, it sort of led to the paper Deborah Maine and I did—a colleague of mine—called “Where's the M in MCH?” Historically, both in this country and abroad, maternal/child health was very heavily focused on kids, zero to five in particular, but young children in general. And without—for several reasons. One, the majority of physicians involved in the field of maternal/child health are pediatricians. Obstetrics is a more lucrative specialty, and more people are doing OB and less involved in some of the public health agendas than pediatricians. Also, the numbers of kids who die in the first five years of life are in the millions, whereas the number of women who die are in the half-million figure. But for a variety of reasons

the bulk of attention in maternal/child health has been on the child.

And we wrote this paper in the mid-eighties on “Where’s the M in MCH?” And the major issue we were focused on was maternal mortality. Five to six hundred thousand women a year die of complications of pregnancy, and probably two or three more million people have serious complications, many of them complications that last for life. So we wanted to build a program that focused on the issues that—women in public health programming in the field of maternal/child health. Family planning was sort of a little bit separate over here, if you will, developed almost in a vertical type of track. And I think we played a major role in sort of getting the M back into MCH. So that’s where that—

Sharpless In terms of your programs here in Washington Heights—the national policies over reproductive health were getting more and more heated, I would say, in the late seventies and eighties. How did that affect your work?

Rosenfield Not in any real way, other than—we never signed what you call the Mexico City clause, which did have an impact on international programming. We were able to find a mechanism while we still had AID funding to get around that, so we didn’t have to sign anything.

Sharpless How did you do that?

Rosenfield By describing the kind of programs we were doing, and the way we were funding them was sufficiently different from the standard that they just didn’t push us on it, which was surprising because actually there’s no good reason not to fund us—not to require us to have that. But we never did

sign it, and they didn't take our money away. But I think for the field in general, the Mexico City clauses, which Clinton did away with but Bush II put back in, do have a chilling impact on some organizations, who worry about are they going to get caught, are they going to have to pay a fine. So there's been a just not helpful, or a destructive policy for family planning services and programs.

Sharpless Um-hm. But not a huge impact on your work?

Rosenfield Not a huge impact on our work, but of course we—it was in place before we left AID operations research, but we had been allowed not to sign, and by the time they were getting stricter, we were out of AID, and then along comes the Clinton administration and they did away with it, the Garrett rules and such. Now George W. has put them back in.

Sharpless Uh-hm. Did the clinics here offer abortion services?

Rosenfield We, until about two or three years ago, we had an abortion service—not in the clinic: it was in the hospital. It was not as good an abortion service as I thought Columbia should have. It wasn't a real user-friendly clinic. We had doctors who sort of reluctantly rotated through and did abortions one day a week in their practices. And partly this was because prior chairmen of OB here were, not anti-choice, but they were also not strongly pro-choice. And they were not that happy or comfortable in having a major, strong abortion service identified as such.

More recently, in the last four or five years, one obstetrician who's been the medical director of our various programs in the clinic, who met with our young adults, among others, got very interested in research on

some of the medical patients and in running a good abortion service. And we now do it, not at this hospital, but at the Allen Pavilion, which is at the tip of the island but part of the Columbia Presbyterian—well, the New York Presbyterian hospital system. So, I think today we offer a good abortion service. We have some dedicated physicians and staff working on it, and better than we had when I was—back, say, five or ten years ago, when we did have an abortion service, but it was not the kind of abortion service I wanted to see us have in place.

Sharpless Has that created any difficulty or any controversy for the hospital?

Rosenfield You mean the fact that we have one?

Sharpless Um-hm.

Rosenfield So far, none. No one has called and said, You guys have got to stop. So far.

Sharpless On a completely different tack, when you were developing the Center, and then the division, what sorts of changes—or how did you develop a curriculum?

Rosenfield Not well. (laughter) Fortunately I had some very good people on staff who were very interested in teaching and curriculum development. And basically, the core faculty that made up sort of a committee on this, I really gave the job to developing what an introductory course would look like and what were some of the required courses you had to take to be in this major. And that evolved. There'd been some teaching done before I came. So some of it was continuing what had already been on the books, and then over a period of time the committees at the Pop Center gelled and

more people were there that could understand it and types of offerings, and they now offer several different tracks. So it evolved over time by interest of the faculty.

Sharpless Um-hm. And what does your student body look like? What kinds of people enroll in your program?

Rosenfield A number of five- to ten-year students, and most of our—our student body is just like the faculty; it's a huge mix of people. Generally speaking we like you to have a little bit of experience between college and entering the school. Not 100 percent, but as a school, and I think Pop is one of the more—(telephone rings)—and I haven't been running it for over ten years. I think that they are a little stricter on having prior experience. Some are probably, of course, taken right out of college.

But the backgrounds—some of the people have worked in the Peace Corps, some of the people have worked for a family planning clinic, for a Planned Parenthood. Some of the people have done research. Some come from another area of health and just want the major here, and there are nurses or doctors who work. So, there's a wide array of backgrounds of the people—and that's true for the whole school, not just for the Center of Population and Family Health. (both talking) The Department of Population and Family Health.

Sharpless I need to turn the tape.

Tape 1, side 1, ends; side 2 begins.

Okay. Well, we've talked a little bit about the domestic work. Tell me about how you developed the international work.

Rosenfield

Well, we started with a very active program in the field area of family planning in Asia, Africa, and Latin America. We had programs both in training, particularly in Africa, operations research, which I mentioned, and in some health policy/legal policy issues globally. When my colleague and I published the paper on “Where’s the M in MCH?” there was a new group at the Carnegie Corporation, which is a foundation that had an interest in international health, and we submitted a concept table of what we’d like to try to do. And working with them, they accepted that, and we got funding from Carnegie for, I guess, almost ten years—most of the nineties—to run a program in three West African countries—it was Nigeria, Ghana, and Sierra Leone, I think, but whatever, three countries, and we began to hone our interest in that area, and it was totally foundation funding. And that led to a very large proposal and funding from the Gates foundation in late 1999, I guess.

Fifty million dollar grant, which—at the time it was the largest foundation grant that Columbia had ever received, not the largest grant that we had, but the largest foundation grant. And that allowed us to build a much larger program. We just had a four-and-a-half-year “where are we” type meeting and we had over three hundred people from fifty countries, a large representation from several partner agencies like UNICEF, United Nations Population Fund, CARE, and Save the Children, all working on this initiative. And the initiative has been, I think, changing the paradigm of what’s needed to have an impact on maternal mortality. For example, historically—historically meaning post–World War II—there had been a

major focus on training people to deliver women at home with traditional birth attendants or granny midwives. And in potential that was a good idea, but in practice it didn't have any impact, or very little impact, on maternal mortality. The traditional midwives were taught to cut the cord, clean, treat it so it didn't get infected—all good things, all preventive of tetanus, but not having been much of an impact on the health of the women or maternal mortality rates.

Sharpless Why not?

Rosenfield Training a traditional birth attendant how to cut a cord cleanly doesn't help to teach her what to do if the woman has postpartum hemorrhage, if a woman has obstructed labor, if a woman is having a convulsion from eclampsia, so that it doesn't teach the things that kill women. It's not a poorly cut cord.

Sharpless Right, the infection—

Rosenfield What kills women—well, infection yes, but mainly you're worried about the child when you're cutting the cord. You're worried about the woman a little bit, but you're predominantly worried about infection of the newborn. And so, no attention was given in those early programs to the things that actually killed women. And that's what we think our program brought attention to. And we're—there's still people who want the programs to start at village level and do a lot of work in the village, but our basic mantra on this is, until you have emergency care facilities, at least district hospital level, everything else you do will have a minor impact, other than family planning, until you have a place when a woman does

have a complication that you'll have a place to send her. And that's been the focus of our program, and while some of our partner agencies had some reservations at the beginning, they now totally now are all on board. We're having a definite impact upon how people think about and implement programs to change maternal mortality.

Other programs in Pop: on the international side, with the help of one foundation, we recruited some people to work on reproductive health issues, and health issues more generally, but in refugee health, within refugee settings, forced migrations, where conditions were really awful for people, and what are some of the issues. So we developed a program to look at that. One of the people that had been very active in operations research programs—when that grant ended, she had skills that we didn't realize in terms of research, because she hadn't been a major research-type person, [but did] more applied field-based research. But when we lost that grant she turned around and presented a terrific proposal to NIH involving AIDS-related research. And one of them was in Uganda and one of the areas in Uganda with the highest prevalence in the world at that particular time. And very unusual of NIH to have someone funded—for someone they never heard of and doesn't have a real impressive CV. She was funded on her first program and has been funded ever since. In significant ways she worked in AIDS, and has been supplied everything. Her husband was at Hopkins, and they do a lot of this together.

So it's a Columbia/Hopkins/local university in Uganda called Makerere. And it's a wonderful program and continues to this day, and

they're considered major researchers in the field of HIV/AIDS in Africa. We since developed other AIDS-related activities, our largest being what we call the MTCT [Mother to Child Transmission]-Plus Initiative. Did I mention that?

Sharpless No, you didn't.

Rosenfield Well, it's interesting. Over the last three or four years people have developed low-cost means to try to prevent transmission of HIV from an HIV-infected mother to her baby during pregnancy. And that's called the MTCT program, or PMCT, Prevention of Maternal Child Transmission. Someone who knew of my work on maternal mortality was running a meeting in Durban, South Africa, two years ago, and asked me to do a plenary address, and they said they had my title already worked out for me, and I said, "Oh really, what is it?" And the title was, Where's the M in MTCT Programs?

So when I began to think about it—I hadn't thought about it before that. You're an HIV-positive mother and pregnant, we give you a dose of drug prevention and give a dose to the baby to prevent him getting it, or decrease the chances, but then I'm done with you. You go off and basically you're going to die in the next two to five years. Partly that was because there were no funds: that was the year when people thought you couldn't get the money to treat. That's changed how we deal with all this.

And so one of the foundations was looking to do something creative in relationship to the call from the UN secretary general to—a call to action to begin to put in place student programs. And they didn't want to

go to work through the UN, but they wanted to be responsive to its call. This was Rockefeller Foundation. They came to me saying, Would you be interested in—the idea of the MTCT, of course, came from my talk—would you like to help coordinate this and give us some idea of how to do this? One thing led to another, and we did it, and we recommended that the program be run out of here, not out of the foundation. They wanted to bring a consortium of foundations, so, a total of about eight foundations, and they are working on this issue. And it's become a major program, and now [it's] added U.S. government for the first time since I lost our grant fifteen or sixteen years ago. We're back with USAID. They're funding part of our program, and this is now a program over a hundred million dollars over five years, so it's quite a large program, with eight foundations and the U.S. government.

Sharpless

Back when you were working with the Center, with the whole world to work in, how did you choose what countries to target your work in?

Rosenfield

In the family planning program we worked in a large part of Africa. But we were part of the other organizations that were funded. Initially we were funded globally, but soon AID decided that was too much for one university-based organization, so they broke it up into regional programs, Latin America and Asia and Africa. We run the program for Africa, and so we worked in a large number of [countries]—not all of them, but a large number. And it was where the AID mission wanted some programming of the type we were talking about. The local people wanted it, and we thought it was appropriate, so it was an investigative process. With our maternal

mortality initiative we decided to work with these partner agencies. And together with the partner agencies we chose the countries around the world in which we would work. We were very heavily interested in working in the Indian subcontinent, or South Asia, because that's where maternal mortality—the most deaths occur in Asia. So different programs have different ways of decision-making about which countries in which to work.

Sharpless You mentioning the subcontinent reminds me of something Nafis Sadik said to me when she was a physician working at home. And she said that a man said to her, “So my wife dies, I'll just get another.” How much has your work been in dealing with attitudes?

Rosenfield Well, certainly some of it. The concept that it's natural for women to die in pregnancy—which was sort of another way of saying what you said, I can always get another wife—is just foreign to our way of thinking. And part of what we're doing is educating them that, one, women don't need to die and two, women are valued—and sort of coming out of the Cairo meeting and other meetings, the concept of the empowerment of women, which I'm sure Nafis talked about when you talked with her. And so I think that's a major issue that has changed—not where we want it to be yet, but it's changing.

Sharpless But that has been part of your work over the years?

Rosenfield Absolutely. Our maternal mortality initiative is, and some of our work before, but it's based on a human rights framework, equity and access to services. If women have a human right to get services that are available

elsewhere—I mean, it's not like AIDS, where I don't have a vaccine to offer, I don't have a drug that cures. I have a drug that temporizes it, but not cures. In maternal mortality we know what to do; it's a matter [of] that we haven't done it. And we make services accessible to people who don't have the money and may never.

So the ethical issue is if there are ways to prevent women from dying, contraceptives which are not hugely expensive, countries have a moral and ethical obligation to make those services available, and so we've been arguing quite strenuously that the high rates of maternal mortality are actually an abdication of the human rights agreement.

Sharpless How has that message been received?

Rosenfield Actually with UNICEF, which is our largest partner, particularly in South Asia, they've been talking about human rights as a sort of core value within UNICEF, but they haven't really had a good understanding of how to use that to actually be involved programmatically. And they loved it. In that sense, the maternal mortality initiative gave them a program in which they could apply a construct or a concept that they've been talking about, but haven't figured out quite how to do it. And now they're doing it with us in maternal mortality.

Sharpless Looking at your list of publications, since you've joined Columbia—

Rosenfield Right.

Sharpless —things like family planning and primary health care. Could you talk a little bit about that?

Rosenfield Did I write a paper on that?

Sharpless Um-hm. (laughter)

Rosenfield Well, both maternity care and family planning services are not tertiary care, they're not quarternary care, they're very simply services that ought to be readily accessible to all women and men. And they ought to be part of any kind of a primary health care movement. And even beyond—some of the programs I supported and advocated for were outside the health care system. There were several that were social marketing and other things. Basically, primary health care certainly should include the concept of family planning and maternity care.

Sharpless And how—

Rosenfield I think the paper was sort of a long exposition on that philosophical concept.

Sharpless And how well received was that idea?

Rosenfield I think—you know, family planning and reproductive health is a complicated issue for a lot of people. If you were working overseas on malaria and called yourself a malariologist, to everybody that's great, you're working to cure a bad disease—or a tuberculosis specialist, or whatever. I found, in my early years particularly, that a lot of the people who worked in family planning would not say, I work in family planning, but would have some broader definition that didn't sort of tie them to—family planning wasn't as bad a word as abortion, but it wasn't much better.

And so, the idea that I'm a family planner was not something that most professionals, docs and others, talked about. And I thought that was wrong. I thought that was as—what's the right word?—as reputable and

reasonable a place to work as someone who works on malaria, or diarrheal diseases, or any other area. But this certainly was a connotation of work in that area, was that those people do something I wouldn't do. And I think we helped change that. We had really good people, both here and at lots of other organizations, who are very much concerned with family planning and family services and the whole range of broader reproductive health services that sort of grow out of it.

Sharpless

How did you change it?

Rosenfield

I was fortunate in that—I don't think I changed it, certainly I didn't, but a lot of people taught—but I've been fortunate at Columbia, and before that at the Pop Council, that I do write some, and do public speak some, and no one has tried to tell me what I can and can't say—including Columbia. I sometimes have been out front on abortion issues. And I've never been called on the carpet: No, you can't cover controversial subjects. So Columbia has been very good in that regard. And I've been pleased with the university as they've sort of left me alone on most of those issues.

Sharpless

So, you're getting the message out that this is an honorable calling.

Rosenfield

To a certain extent. You know, in the world of abortion, people fight abortion, as always. There are a number of people around the country that think abortion is awful. And many of the medical profession who are neither strongly anti-choice, or strong—well, if they were strongly pro-choice it would follow, but are not strongly anti-choice, but are certainly ambiguous and a little bit confused about where they come down, don't really think someone who does abortion is really a real doctor who

deserves the same kind of respect as doctors who treat heart disease or—
so we're not totally there, but it's a lot better than it was.

Sharpless Um-hm. What about work on reproductive technology over the years?

Rosenfield We haven't done a lot of that here. I've certainly been on committees and panels and discussions about new contraceptive agents. I've been involved in some of the applied research on injectibles and implants and the newer medical abortion methods such, [but I have personally not been involved in basic research. However, Carolyn Westhoff is a joint appointment in public health and OB-GYN at Columbia and is a leader in contraception and abortion research.]

Sharpless Um-hm. You mentioned Cairo earlier. What impact did Cairo have on your work?

Rosenfield On my work?

Sharpless Um-hm. On your work at the school.

Rosenfield I don't think Cairo had a dramatic impact on our work. But Cairo had an important impact on population activities. Up until that time much of the attention of people who funded and were involved in family planning programming was on population, population growth, and its adverse effect on social development, which remains a valid concept today. But some people were quite concerned that by focusing on demographical family planning numbers, you were in effect developing something that had the potential of coercion of women. You must practice family planning. You must be sterilized. China was accused of some of this over the years. And that became sort of an unfortunate part of it.

Most of the people I know who work in family planning were not at all interested in coercive aspects of such programming. And I'm forgetting what got me started on that.

Sharpless

Cairo.

Rosenfield

Oh, Cairo. So, Cairo—through the actions of a number of women's groups—they wanted—the previous two meetings in '74 and '84 focused very heavily on population and demographic issues. And a lot of the women's groups said, That's not the issue: it isn't to have golden targets about demographic change, or about family planning, it's more about meeting the needs of women. And if you look at the data in almost every country where studies have been done, a majority of women do want family planning services, and certainly enough to meet whatever targets anybody would want. It says you don't have to set forced targets; in almost every setting it will work. Just make the services readily available. So, Cairo changed the dynamic from focus on demographic issues to more empowerment of women and human rights. But the rights to family planning, maternity care, abortion services—so it was more focused on women and women's issues. And family planning was a component rather than population growth was a driver.

I coauthored with two other people, but one person was current head of IPP[F]—I've actually met him, Steve Sinding—initially wrote a first draft of the paper on a rationale that if you met the needs of women, stated in surveys, that demographic and health services were taking place, where sizable percentages didn't want more children than they had once

they had either two or three. That if you met that unmet need, you would reach most of the demographic targets that have been set around the world, so that the change and the focus from demographic issues to more women's issues—some of the family planning people were very upset with that change in focus. I wasn't particularly, because I thought we could reach the same goals with a somewhat more sympathetic message than we originally—very heavily demographic message. You're a population growth institute, you must do something about it. So—

Sharpless

At what point did you become aware of HIV/AIDS? How early did that have an impact?

Rosenfield

Well, certainly it began to come on the scene in this country in the eighties. I got involved in some of the domestic issues. I chair a committee for the New York state AIDS advisory council on AIDS. At one point about eight years ago I became chairman of the actual AIDS advisory council for the state. So I got involved in domestic issues. I wasn't a basic researcher on AIDS, but I was moved, as everybody in the field was, to how this was impacting a number of gay friends who were dying, like the person who ran the AIDS advisory council. He was a great person, used to be a Columbia faculty member, who unbeknownst to us was gay and became infected, and he died really an awful death. A very smart young man. You know, he was probably thirty-five or forty at the time he died.

I wasn't really in the art world that much, but anybody who lived in lower Manhattan, Greenwich Village, and some of these areas where there were a lot of gay people, gay men, people just lost all kinds of wonderful

people who died. I think it changed the whole perception of gay people. One, we didn't know anything about the sexual practices, and two, there was sort of a stereotype of what a gay person was like. And as you got to know people through the AIDS epidemic, you saw people who looked like everybody else. They didn't fit the stereotypes. They were lawyers, doctors, researchers, teachers who had a different sexual preference.

And so that's how I got initially introduced to the field, to all that was going on in this country. As AIDS began to grow and become such an extraordinary pandemic in Africa, particularly, because we'd worked in Africa, just—I don't know at what point, but it increasingly became clear we had an [epidemic]. A major—my own personal major involvement beyond the work of Maria Wawer, who worked in Uganda, is more recent (airplane noise; unclear). We're done with my second tape?

Sharpless Almost.

Rosenfield You don't get a third tape.

Sharpless (laughs) Yeah, let me go ahead and change it.

Tape 1 ends; tape 2, side 1, begins.

Sharpless This is the second tape of the second interview with Dr. Allan Rosenfield on October 30th. Okay, you were going to say—

Rosenfield One thing that's been nice in my career is that I sort of see three components in the reproductive health side, not my life as a dean or any other areas in which I've been involved, but within the field. I started primarily with family planning in Thailand and think I made some impact on the use of auxiliary midwives to prescribe pills, and some other issues

that became, as I learned a lot—some of what I learned I was able to write about and have an impact, together with my colleague Deborah Maine, coming up with issues in maternal mortality and “Where’s the M in MCH?” and developing a program we thought made a difference. And that was sort of a stage two in my reproductive health career.

And then stage three would be then moving on and looking at the issues of AIDS. Coupled with that, in addition to work at Columbia, I became involved with a lot of organizations as a board member, a committee member, a sort of—I guess I don’t really see myself as that age. I guess I became more of a senior statesman in the field. But I wanted to help, then, on the boards of or involved with most of the major population and public health organizations. I just rotated off the board of Engender Health, which used to be AVSC International. Been on the board of AGI forever, the New York board of Population Action International, which used to be Population Crisis Committee.

Sharpless Did you know General Draper?

Rosenfield Yes. Not well. I was in Thailand when he was at the height of his—I met him in a meeting in Thailand. I knew almost everybody else after him that was involved in that organization. I—

Sharpless The list of organizations.

Rosenfield Yeah, I’ve been on those three. I was asked—it seems like after I came back from Thailand—late seventies, I guess—to go on Planned Parenthood’s medical advisory committee, PPFA, and the guy who was chairing that committee had a little debate with the leadership of Planned

Parenthood and he resigned, and so even though I had only been there a year was asked to take over that. When you chair a medical—they don't call it medical committee—that automatically puts you on the board of Planned Parenthood. So I went on the board of Planned Parenthood. When my term was up as head of the medical committee, I was asked to stand for election as a regular board member, not as—because of membership on the committee. So I did, and I was on for the full duration of Faye Wattleton's time.

And about the time I was due to rotate off, I was elected vice-chair. And that means the term was temporarily put aside, and at the end of the two years I then became—two or three years—I then became chair of the board, and that takes you off the rotation list. When you're done being chair—in those days, at least—you then stayed on the board as sort of an honorary board member for another two or three years, and finally, after about ten or eleven years, which is a very long time on that board to be on continuously—and some people do come back—I actually did step off for a period of two months. But I then became the chair of the Alan Guttmacher Institute board, and they very much wanted me back on the board, because I had all these relationships. I guess I initially became vice-chair, and then chair.

Sharpless

At AGI?

Rosenfield

At AGI. And so in my role at AGI, I went back on the board of —AGI recommended it. So I had about fourteen or fifteen continuous years. I was there for the entire time of Faye Wattleton and the entire time of her

immediate successor, who left under unpleasant circumstances. So I had a long time.

I think I may be—I'm not sure—when I became chair, I was either the first or possibly the second chair of Planned Parenthood, PPFA, that actually was a professional in the field rather than a volunteer. I mean, I was a volunteer, but I was also a professional in the field. And I think I still am the only person who has chaired both PPFA and AGI, so that's kind of a nice thing. AGI doesn't rotate quite as frequently, and also brings people back on. Most of the people who have ever been chair of AGI are still one way or another on the board. Planned Parenthood—when you rotate off you generally don't come back on. I've been asked on a few occasions would I stand for election again for Planned Parenthood. They get fifteen years' worth of contribution.

So I've been on those and one way or another worked with almost every major reproductive health, population—not all, but most organizations, whether on a board or on a committee, or just because of my friendship with a person who's running the organization I've been actively involved. And also internationally with WHO and with—I was on the International Planned Parenthood medical advisory panel for a while. So I've been able to not only work here at Columbia, but have a role—sometimes I accept too many things, so I'm not as good a board member as one would like. Even when I try to get off they often say, Well, stay, we'd like to have your involvement. But I ended up and still am on a lot of other organizations' governing structure or committee structure, and now

with a couple of foundations in addition to funding (unclear).

Sharpless Coming to this as an outsider to the field, it's been one of the interesting and surprising things to me, is how many different organizations there are, each one with a slightly different—

Rosenfield Right.

Sharpless —niche in the scene. What's your overview of the reproductive health scene now, based on, I mean—

Rosenfield Well, it's a difficult—it's a difficult time right now. One, because of the administration, which is very unfriendly to what the field stands for. But it's also a difficult time because the major foundation funders that were the pioneers—the Fords and the Rockefellers and some of those, Mellon, are really going back on population and reproductive health. And there are only a smaller number of foundations outside of the U.S. government still committed to this field. It's not so much that these other organizations aren't committed, it's just they're often doing other things. And that's been unfortunate for the field, that there are fewer and fewer groups, foundations, which are funding core activities within family planning and reproductive health.

Sharpless Are they expecting Gates to pick up the slack, do you think?

Rosenfield No. Gates does have a reproductive health component, but Gates is really into infectious diseases, more and more technology innovation. They still have a reproductive health component, and given the size of Gates, that's not trivial. So there's Gates, and there's Packard Foundation, there's Hewlett Foundation, who's still in, [and] Ford is in, but in a very peripheral

way. Rockefeller is barely in. Mellon is funding its last round of programs in this area, and then they have other things. And then some of the smaller foundations are still involved. But it is a changing time. And that coupled with a very unfriendly administration in Washington, it's not the easiest time for the various people that develop the population programs.

Sharpless So what's going to happen?

Rosenfield We've got to change the administration.

Sharpless Well, I know that we need to bring this to a stop, but is there anything that we—I mean, we could do this for many hours, but is there anything in specific that we need to talk about that we haven't covered?

Rosenfield Well, unfortunately, you didn't ask me to talk about the people of the field. I knew most of the major figures in the field over the last thirty-five years. And there's some wonderful people in the field and some controversial people. That's been one of the nice things being in it for so long, is that I know so many. I don't know as many of the younger people in the field today.

Sharpless Who are some of your favorites?

Rosenfield No, I'm not going to go there.

Sharpless (laughs; both talking)

Rosenfield There are some wonderful people working in population who do this, starting with [Bernard R.] Berelson; the people I've worked with at the senior level of the Council: Berelson, [W. Parker] Mauldin, Clifford Pease, Shelly [Sheldon J.] Segal, who's remained a very close friend all these years. I'm sure he's someone you may be talking to. We still are very close.

(pause in recording) And then there are just huge numbers of people. At AGI, Faye Wattleton is obviously a giant. Jeannie Rosoff, who ran a—and her successor, Sara Seims. A whole bunch of people in AID: Duff Gillespie, Liz Maguire, others that worked there.

Sharpless And of course they've gone into other things, like FHI [Family Health International]—

Rosenfield And a whole range of newer people on the Pop Council. I mean there's just—the list really is a long list of very, very good people whom I've been fortunate enough to work with over the years. Someday I ought to make a list of all of those people and comment on them. Maybe if we ever do another interview on this one, I would be willing to sit down and think about the contributions of various people.

Sharpless That would be a nice thing to do. And I bet we can work that out. So, I'm making a note because you also said you were going to tell me about Mechai and AIDS. And I don't know that we have time to do that or not.

Rosenfield Well, I can give it briefly. I'm through at the end of the day. Briefly, when the AIDS—you know, Mechai did this wonderful work in popularizing condoms and developing PDA [Population and Community Development Association] in a major community-based organization. As AIDS—we all knew, given the sexual activities that went on both among Thais and among foreigners who came to Thailand, that it was highly unlikely when AIDS broke in both the U.S. and Africa—there wasn't any information, and Thailand specifically. But it didn't come as fast as some of us thought it would. Asia really had become the sex tourist site for many people.

Sharpless In Bangkok?

Rosenfield Bangkok and outside Bangkok. But when it did hit, Mechai was critical of the way the Thai government was responding. One, there were people who were concerned that you shouldn't even talk about it because of an impact on tourism. The responsibility was given totally to the ministry of health. It wasn't necessarily as strong as some. And he was quite critical of the programs as it was developing. There was a coup in Thailand in late '89, late eighties, early nineties, I can't remember exactly. But it was at a time when AIDS was really becoming the major issue. And a technocrat government was set up with a prime minister who was probably the best prime minister they ever had. I ended up, just by dint of—coming with—three of my really close friends were ministers in that technocrat government.

One of them was Mechai. Mechai was a minister in the prime minister's office, so the portfolio had been decided by the minister. You didn't have a ministry you ran, but it was—[he] had minister in [his] title. And among other things, he was given responsibility to set up an AIDS program. The prime minister was concerned. And he took it out of the authority of the ministry of health, and he put the government's structure in the prime minister's office with him as chair, but with the prime minister as the chair, but he as sort of the executive director under them, and developed what I think is a concept that is a model for all countries: high-level involvement of the prime minister or president; responsibilities for almost every ministry as to what they should do, whether ministry of

defense, ministry of material, ministry of finance—each of them had a response. And he laid this out in a brilliant way, particularly very heavy on preventive messages. This is before treatment was available at that time, but heavy focus on safe sexual practices, and where drugs were used, on safe drug use—but particularly safe sexual practices.

And Thailand is a country where, while prostitution wasn't legal, it was practically accepted, and actually [there] were these women who worked as sex workers. There were—in those days they called them VD clinics—now they call them sexually transmitted disease clinics, where women every two weeks who worked in the brothels [and] the other forms of entertainment that weren't called brothels, but where sex took place— were checked every two or three weeks for gonorrhea, syphilis, and other such diseases. They put in effect what they were calling 100 percent condom policy, where people using brothels and having sex with a sex worker were required to use condoms.

Well, how do you measure that? The initial, short-term way to measure that was, since the women were being checked every two or three weeks for sexually transmitted diseases, see what happens. And as this policy went in and it was being enforced, we saw a dramatic decrease in the number of cases of syphilis and gonorrhea. And if a woman was positive for syphilis or gonorrhea, she was fined and so was the brothel. And if more workers from that brothel continued to turn up positive for sexually transmitted disease, then the brothel would be fined seriously, and even closed for six to twelve months. And word got out that if you want to go

to a brothel you're going to have to use a condom, period. And that's not as well enforced today as then, but the concept was there.

And I give Mechai credit for developing the construct of what a national policy should look like, and having the opportunity to enforce it during his relatively brief, two-year period as a minister running this program. So, while family planning certainly contributed to Thai's success in family planning, in AIDS, he is, in my opinion, the creator of a very effective program. And the program's probably quite different today. It's now six or seven years since that government ended, and it's different—the ministry of health plays a broader role. But the basic framework of major education on safe sex, condom use being essential, has really continued. So, he's a very important figure in my mind in AIDS both in Thailand and beyond. He's become a—one of the spokesmen for UN AIDS, speaks out around the world because he's a very good public speaker and a very charismatic figure, and he's very comfortable in English. You said you interviewed him?

Sharpless No, Deborah McFarlane, my colleague, did.

Rosenfield Oh, Deborah did, yeah.

Sharpless Okay. Well, let's stop, but with the view to getting back together again sometime.

Rosenfield Okay. All right.

Sharpless Thanks.

end Interview 2

Interview 3

Sharpless Today is April 27th, 2004. This is the third oral history interview with Dr. Allan Rosenfield, dean of the Mailman School of Public Health at Columbia University. My name is Rebecca Sharpless and we are in his office in New York City.

Rosenfield This is really the third?

Sharpless Yeah, now we did two last October—we did, we did. And so, when we were together last October—gosh, almost six months ago now—you said that you wanted to spend some time talking about various people that you know in the field of reproductive health and public health. So I'm just going to let you talk and I'll ask questions occasionally.

Rosenfield Okay. I guess the first person I met in the area of reproductive health was while I was in Nigeria, where I was teaching obstetrics. And the head of the department of community medicine at the University of Lagos where I was, was a public health professor from Johns Hopkins who was there a couple of years while they were building the department, before a local Nigerian took over the department. And this is now back in 1966. And he was already very interested in family planning and its importance, he felt, to health and development issues in Nigeria.

Sharpless And who was that?

Rosenfield His name was Dr. Robert Wright, W-r-i-g-h-t. He's deceased. And he was way ahead of his time, because there weren't very many people talking, certainly in Africa, about family planning. And he got me thinking about it and by the time I left and went to the Pop Council, which we've already

been through, Bob is one of the key people as a sort of a senior guru at that time. I was a relatively young person. It got me interested in thinking more about it and reading more about it—beginning to understand more. When I did join the Population Council, it made much more sense because of what Bob had instilled in me. It is also interesting, by pure coincidence, one of our social friends in Nigeria was a man named Richard Gamble, whose father was—I forget what his father's first name was, but—Clarence.

Sharpless

Rosenfield

Clarence Gamble, who was one of the original missionary pioneers in family planning. Richard, then, was living in Nigeria as a businessman, not working on family planning activities, although later he became the president of the Pathfinder Fund, which Clarence had founded. I remember meeting—I'm not sure when Clarence actually died, but his wife came through a couple of times—I remember meeting her, talking about all the work her husband did and some of the original missionary-like people that worked for Pathfinder.

When I went to Thailand for the Pop Council, there's several very important people that I looked up to in those early days. Perhaps the person that was the greatest model for me was a man named Bernard Berelson, who was president of the Pop Council. I think all of us who worked at the council in those days just admired Barney greatly.

Sharpless

What was it about him?

Rosenfield

Just his integrity, his intellect, his way of thinking. Some of his writings today would not be seen as sensitive to some of the current issues, but if

he'd lived today he would've been a leader in reproductive health and all of that just because of was the type of individual he was. But he was just very thoughtful and just a very decent good person. I think all of us looked up to him as a leader that we all admired.

There were other people at the Council in that era that would remain close friends as long as I knew them. Parker Mauldin, who was a wonderful applied demographer who became the president of the Council [for a short period of time], but mainly ran some of the demographic research work and up into his eighties remained an active figure in the field. Always looking young and involved and hard working, put out very important applied publications on various aspects of problems of the use of family planning and how programs were going and such things.

Also at the council at that time, someone who's remained a close personal friend to the present, was Shelly [Sheldon] Segal, who was head of the biomedical division at the Council then, eventually [went] to be head of Population Sciences at Rockefeller [Foundation] and [came] back as a senior scholar at the Pop Council after he finally stepped down at Rockefeller. Shelly, in those days, was a still a scientist [spending a percentage of his time] in the laboratory, but [also a] major supporter of a lot of young people from around the world through the awarding of many Pop Council biomedical fellowship programs, so a lot of the current leaders in countries throughout the world originally came through Pop Council. Shelly still travels the world getting honors and awards from many of his former fellows, who are now in senior positions in Asia and Latin

America, [and to a] lesser extent in Africa.

Sharpless But he took seriously the training of young researchers—

Rosenfield Took it very seriously. Actually, the Council, both in biomedical areas and demographic areas, was a major [leader in helping develop future] world leaders in the applied area—now it's called international health programs, then the technical assistance division—[but did not have a similar fellows program]. We didn't do as good a job—that was the area in which I worked—in the kind of training programs that both the demography and biomedical groups did.

Within the Council, the other two people that were important in running international programs: one was a man named Richmond Anderson, who was only there a couple of years after I joined. And Cliff Pease, who I worked with and admired—an old-time, public health, USAID type who moved to the Pop Council—was there for a number of years. Very smart, knowledgeable guy.

Sharpless Why do you say he's an "old-time, public health type"?

Rosenfield He'd been in public health from his early career. Well, before he was involved with family planning, he worked in a variety of health-related jobs. And Anderson was, I guess, too, a little different type of person. Anderson's career had been mainly in the Rockefeller Foundation, whereas Cliff was more a USAID—type of things they did. And whatever the preceding unit [was called]—in the earlier days, I don't even know what USAID was called. It was before I was involved. It was USAID by the time I got involved.

Among some of the young people that I met at the Council then, a couple have died, a couple have continued, have been people I've admired and worked with. John Ross is one, continues to be very productive. He's sort of almost an heir to Parker Maudlin in terms of the type of work he does. John was in Korea for the Council at the same time I was in Thailand, or part of the time, and then John was back in New York and we worked together in New York [where he joined me for several years at Columbia]. And we just remained friends. We lived near each other and we remained friends over the years.

Another person from those early days who has passed away is Bob Lapham. He's another applied demographer, very close to Parker Maudlin, did a lot of coauthored work with Parker. I was very close to him and his wife [and he was my deputy in a major Council program called the Taylor-Berelson Program]. So I was involved and tried to be helpful during his [illness]—he had a brain tumor, eventually killing him at a relatively young age, probably in his fifties.

Sharpless How much esprit de corps was there among you young fellows?

Rosenfield Good, it was good. The people from the Council in that era—it was a very different Pop Council in those days from the Council today. We were all quite close. Communications were much more difficult. We didn't have e-mail, we didn't have—back when all of us went, in the sixties, we had almost none of the [modern technologies]—we were still using mimeograph machines, [carbon paper for letters, no fax machines], and telephones you didn't do overseas except in rare occasions, because it was

very [difficult]. They had scheduled telephone calls. In Thailand, I had to go to a central post office to make a call to the United States. And there was just none of the current conveniences. You met at meetings. You didn't communicate—most of us didn't write a lot of letters, so we didn't communicate very much, except when we were together. But those of us who worked in the Council in that era were quite close and we'd get together at the meetings [on a regular basis].

And there was a whole slew of people around my age, plus or minus. A man named Hugo Hoogenboom, who was a lawyer, came to the Council [initially to backstop staff working in Asia. Previously] he had administered programs in Asia for USAID and then moved. [Later, under the presidency of] George Zeidenstein, [he became a] vice president for [administration]. And then he eventually moved to run AVSC [International, formerly the Association for Voluntary Surgical Contraception], which is now called EngenderHealth but at the time it was AVSC. He ran that for a decade and was quite popular there. He briefly moved from there to be president of Population Action International, formerly known as the Population Crisis Committee. It didn't work well, so he didn't stay at that job very long. And he left the [population reproductive] field, and he's done some other things in the last year. (telephone rings)

There were some [other leading] academics. Moyer Freymann at UNC was one of the first people to work overseas as a public health doc in family planning in India, and then set up the Carolina Population Center

[CPC] and was its first director. He was a major figure in the field for many years. But the last years were not happy: he had some disagreements and [eventually] left the CPC.

[At the same time, Leslie Cors, a professor at the University of Michigan started a population center around the same time. Les was actually one of the two or three founders of the Population and Family Planning section of the APHA [American Public Health Association]. I've forgotten where Les worked overseas.

Ron Freedman was another great, great person who was head of the demographic population center [at Michigan]. One of the nice things about my time in Thailand is I got to know people that I would not otherwise have known in the demographic world and in the biomedical world, as well as in the more applied international health world where I was mainly involved. So, Ron Freedman and his wife, Deborah, used to come through, [and my wife and I] got to know them very well and a [large number of the] leading demographers spent time in Thailand.

Probably the most outstanding was a young man there named John Knodel, who continues to work in Thailand to this day, primarily at Chulalongkorn University. When he's not in Thailand, he's at Michigan. A man named Gavin Jones and then Warren Robinson, both economists who worked at the National Economic and Social Development Board [NESDB]—great people, particularly Gavin, who [returned to] Australia but would go back and forth between Australia National University [and several Asian countries].

Sharpless You mentioned working with demographers and other people that you wouldn't ordinarily have. How important is interdisciplinarity in public health?

Rosenfield Oh, I think, if I look at my school of public health today, over 40 percent of the faculty are social scientists, as compared to, say, medical school where maybe 1 or 2 percent would be. And you name a discipline and we have someone from that discipline. So we have lawyers here; we have people from business backgrounds; we have all the various social sciences, from anthropologists to sociologists, historians, political scientists, economists. We have even different parts of the medical and nursing fields. So public health really brings together a wide array of people.

My first introduction to social science was through Pop Council and the world of the demographer, particularly the sociology-oriented demographers, so I got to know a lot of them. And I became what I used to call a pseudo-demographer by just on-the-job training, by being in Thailand and dealing with these people. There was another great academic who was hugely admired by a lot of people named Sidney Goldstein, who was the chairman of the department of sociology and the population center at Brown University. [He spent two years in Thailand as an advisor at Chulalongkorn University when I was at the ministry of public health.]

Sharpless At Brown?

Rosenfield Brown. And he was involved in (unclear). It was endless. It was a great opportunity to meet all of the people. [An applied demographer, until recently] running international programs at Pop Council, and before that

ran Population Reference Bureau, Peter Donaldson [was a close friend whom I recruited to the Council]. (pause in recording)

Peter was a University of North Carolina fellow from Thailand and I sort of recruited him to the Pop Council and then to an evaluation position at the ministry with me, and then I left and he then stayed on, worked with other people in Korea. Worked with the Council off and on, did other things. Now he's back at the Council for the third time. [Peter was appointed president of the Population Council in January 2005.]

There were a whole slew of people in USAID, dating back to my early work with [Reimert] Ravenholt, who I'm sure you've interviewed. A very controversial figure, but a figure that, while sometimes outrageous, actually, in terms of his baseline concepts of making services available to people, was correct and played a major role in moving family planning programs forward [in the early 1970s], even though there were a lot of [bruised egos along the way]. Dealing with Rei—he wasn't an easy person. And within his office, Joe Speidel, who [eventually left to be president of] Pop Crisis Committee for a while and now Pop Action International and then, until this past year, he was the population officer at Hewlett. Now he's [working at] UCSF [University of California, San Francisco].

Another [major figure], Duff Gillespie, whom I've known from the beginning of his career there—[he spent many years heading USAID's Population Office and after leaving USAID he spent a year] as a fellow at the Packard Foundation. Now he's at Hopkins in a senior [consultant position].

There were a lot of good people at USAID [in those days]. Liz Maguire was a wonderful—she was one of our first program officers for what was called operations research at the time, and she eventually moved on to become head of the pop office, and now she is happily out of government, running a pro-choice organization called Ipas. And there were just a whole series of people at AID that I knew over the years. I almost went to AID.

Sharpless What was it at AID that attracted good folks?

Rosenfield For a long time, that was the largest funder of programs in population—or in health, for that matter. Steve Sinding [spent many years in leading positions at USAID], came out of AID, spent time at the World Bank, [ran a great population program at the Rockefeller Foundation], spent two years here [at the Mailman School]. Now, of course, he's running IPPF, which is a major, important organization in the history of all this. There are people at the World Bank who played a major role, dating all the way back to a man named Dr. K. Kanagaratnam, who was the first population advisor in the Bank.

Sharpless Nobody else has talked to me about the role of the World Bank. Could you say a little bit about that?

Rosenfield Starting in the early seventies, the World Bank began to get involved—during the era of McNamara, who was a real hawk on population. And he attempted to get the organization involved in a major way. The Bank's approach in those days, and to a certain extent still, was very cumbersome and difficult. But they hired a man in the head of health and family planning in Singapore named Dr. K. Kanagaratnam—his nickname was

K.K. And he came to the Bank and tried to run the population department, but at the time, the Bank was organized differently than now. At the time the Bank, the population program and the health programs had their own staff and they actually sent teams into countries and developed programs. But they were cumbersome and difficult large programs. I think he did good work when he was in Singapore, [but had a poor record at the World Bank].

Then he was followed by a [major medical and health academic] named John Evans, who was committed particularly to international health. John was a major figure from Canada. His son, Tim Evans, is the person who [until recently ran the] health sciences program at Rockefeller, now with WHO [World Health Organization]. Tom Merrick was at the Bank for a long time. All these people—the Bank position evolved more into a policy position than a direct program-related position. Steve wrote some very good papers while he was there on, sort of a focus on where it might go. And Tom's been there—he just stepped down and retired this past year, I think. He must've reached the Bank retirement age, which is relatively young.

And then, there's a whole bunch of people in various organizations. Gordon Perkin, who was one of my first contacts when I got to Thailand. He [worked for] the Ford Foundation, and we became very close friends there—[a friendship which has continued to the present. After several more years with Ford in Ghana and then Columbia, he] created an organization originally called PIACT, Program for the Introduction and

Adaptation of Contraceptive Technology, which eventually became PATH, Program for Appropriate Technology in Health. He did a great job in developing that program. He also was the key person in the early days at the Gates Foundation, along with Bill Gates, Sr., Suzanne Cluett, and eventually Bill Foege as well. And Gordon's just been around here for a long, long time, [but now is moving into a senior-consultant-like position at] Gates. He's made major contributions over the years in population and family planning. People who run JSI [John Snow, Inc.], MSH [Management Sciences for Health], which are with non-profit organizations, don't focus solely on population but it's a major part of their agendas. Joel Lamstein, who runs JSI, and Ron O'Connor, who runs MSH, and Dan Pellegrom, who now runs Pathfinder, [are all outstanding leaders. Dan came to Pathfinder] from the domestic scene where he was the Planned Parenthood executive director in Baltimore and somewhere before that.

Sharpless Memphis.

Rosenfield And then he went from there to Pathfinder. He's been at Pathfinder a long time. There are several people who moved from the domestic Planned Parenthood arena to international jobs.

Tony Measham, who spent a long time with the Bank on health, but did some wonderful work in Latin America with the Ford Foundation. He worked for a couple of years as deputy director of our Center for Population and Family Health, then back to Ford in Bangladesh and then to the World Bank. He was at the Bank for many years and retired

recently, but is still very active as a consultant.

There's a whole group of outstanding women. Sarah Clark, who was at AID, now running population program at Packard. Sara Seims, who was also at AID, then MSH, then the Rockefeller Foundation, then Alan Guttmacher Institute, and now at Hewlett. Jeannie Rosoff, who ran AGI for a long time. Faye Wattleton, of course, is a superstar, someone I had the pleasure of working with during—I was on the board of Planned Parenthood for the entire time she was president, including two or three years as chairman of the board.

Sharpless Why do you classify her as a superstar?

Rosenfield I think when the history is written on domestic family planning as well as some international work, Faye will go down in the history of family planning in this country and reproductive health and rights in the same league with Margaret Sanger, I predict.

Sharpless Wow.

Rosenfield She's a very powerful public speaker, very powerful presence. Controversial, as was Margaret Sanger. Totally devoted to reproductive rights.

Sharpless Moved Planned Parenthood into providing abortions?

Rosenfield During her tenure, PFA's commitment that all women should have access to safe abortion services was greatly strengthened. She was a very strong spokesman that you can't separate reproductive rights from contraceptive rights from women's rights and that was one continuum. Faye is very smart. When she has a strong opinion, you know, she doesn't bend. She

will discuss, but it's hard to get Faye—once Faye becomes convinced of something, it's hard to get Faye to moderate those views when she thinks she is right on a particular issue. So she's quite strong. Her first successor would only stay for about two years, Pam Maraldo. And now, with Gloria Feldt, who is a good friend—Gloria does good work. And there's Kate Michelman, who runs NARAL [Pro-Choice America, formerly known as the National Abortion Rights and Reproductive Action League], is stepping down. There's Ellie Smeal, who is president of the Feminist Majority, on the domestic side of our work.

At the Population Council, John Bongaarts, who is one of the absolute stars of the demographic field. There's all the people at UNFPA, from Nafis Sadik—actually from Rafael Salas to Nafis to Thoraya Obaid. All interesting and committed. Nafis came from a Pakistani family where women weren't supposed to be quite so public, but had a father who believed in women getting an education and doing things. And then, even more shocking in a way was Thoraya Obaid, who is a Saudi woman whose father also believed that a woman should have a right to education and to do things, and that's very uncommon for Saudi women from wealthy families. So those are two rather remarkable women. Nafis was head of UNFPA for a long time. And even when Rafael Salas was the head, he was pretty much Mr. Outside raising money and Nafis was running it from inside. And then when she became the head, she continued, she did both. She was Ms. Inside and Outside. There was no—she had no Nafis Sadik working for her. She had some very good people in the next levels down,

but there was no one in the kind of role she had taken on with Salas. She took the work and she was very talented in it.

People at WHO—and there's the range of people that worked at IPPF, Julia Henderson, to [Halfdan] Mahler, who was wonderful. Carl Wahren from Sweden that got into all kinds of battles with some of the people in the Latin American bureau in some of his attempts to change the federation. Very interesting man from Malaysia, Bradman Weerakoon, who preceded Mahler. And the fact that he was going to IPPF was a nice message to send, that the former head of WHO thought that the field of population and family planning's important. And he was quite outspoken on abortion issues for someone who wasn't able to be outspoken when he was at WHO.

Sharpless Interesting.

Rosenfield There's a lot more names. It's sort of fun going over them, but why don't you ask me questions because I'm just rambling about individuals.

Sharpless No, but it's interesting. Let me turn the tape right quick.

Tape 1, side 1, ends; side 2 begins.

Sharpless This is not so much about individuals, but say a little bit about what role the foundations have played in family planning in the last forty or fifty years.

Rosenfield Well, in the early days, the primary foundations were Ford and Rockefeller. The Population Council was founded because John D. Rockefeller III wanted the Rockefeller Foundation to do work in the population field, but the Foundation board was reluctant. As a result Mr. Rockefeller then

decided to establish the Pop Council in the mid 1950s. The Rockefeller Foundation and later the Ford Foundation contributed the core money to help them get started and build, and they've continued. Although they've both changed their population agenda, in the early days they were very important.

[Other large foundations that developed agendas in the field of population, family planning, and reproductive health included the Hewlett, Mellon, MacArthur and Packard Foundations, although until the 1990s, Packard focused on the Bay area. The program at Columbia was funded by all of these foundations at one time or another, with Mellon and Hewlett providing general purpose use funds since the 1970s. Since the 1990s Packard and Hewlett have been increasingly important, as both foundations grew.]

Sharpless Well, one of the things that continues to fascinate—

Rosenfield Buffett Foundation as well.

Sharpless And then Gates.

Rosenfield Gates of course. Gates is the largest foundation [in the world and provides incredible leadership in the broad area of global health, including reproductive health].

Sharpless One of the things that continues to fascinate me is the extent—the role of the foundations in—and the question, do they shape policy, you know, do they lead or do they follow?

Rosenfield I think both. There are some places where the foundations have taken the lead and got things going and foundation support. There have been other

places where they've been willing to support ideas that other people put in. So I think it is a variable thing.

Sharpless What impact has Gates' entering the field had?

Rosenfield Well, Gates, when they came on, had a [most important] impact, although it's more in global health than [reproductive health] per se. But they've supported a number of [reproductive health] initiatives in the early days, less so today. They support our maternal mortality initiative. They're now more into technology in areas of vaccine development and other technological innovations, but they still are a strong supporter of reproductive health issues, globally as well as domestically. Some domestically. But they [have truly] galvanized the international field.

Sharpless What has been the niche of the UNFPA?

Rosenfield You can say, oh that's another UN agency so it's not all that one would like. But they've been a pretty effective organization. They have country offices and they try to fund and encourage good programs and my guess is—and I haven't done an evaluation of the UN in a long time—my guess is the impact on individual companies and programs would be very varied—probably, depending on who the staff are and how effective they are. But I think, overall, the UNFPA [has made very important contributions] to the field.

Sharpless How important do you think that the population conferences have been—Bucharest, Mexico City, Cairo?

Rosenfield It seems like the Cairo one changed the paradigm, [which was most important. And it generated major international attention. But the costs are

very high, with] the pre-planning sessions, then the planning sessions, then the final thing. So people are spending a lot of money. Is that money well spent? I'm not sure and I think, in fact this year, they've decided not to do another ten-year conference. They'd rather put out some reports. May make sense in the amount of money that they have to raise from donors who would do something else if they weren't doing that. You know, the whole—I think the foundation world has played a very important role.

Then, obviously, AID and UNFPA and the UN system—it sort of makes the private role less, because you now have multilateral as well as bilateral support. The World Bank has been nowhere near as useful as they should be because they have trouble, in my opinion, dealing with the soft, social sector programs as compared to the capital programs, building a dam or a highway or a factory. And they don't do the others that well. But their budget support is very large and therefore it's very important and has strong influence with the finance ministries.

Sharpless

Thinking about the individuals in the field, you know everybody and everybody knows you. And you've mentioned several names, but who would you say has had the greatest impact on you personally and your career?

Rosenfield

Me personally? Well, a couple of people, I think. [Dr. Martin Cherkasky] used to be the president of Montefiore Hospital back when I was a medical student [at Columbia P&S]. The school at that time didn't care very much about the community or community activities; rather the people should be grateful we're here. [Under Dr. Cherkasky's leadership,]

Montefiore cared about its community and provided [community-oriented] services. In those days, it was just the beginning of the Einstein Medical School, so we still rotated up to Montefiore as part of our rotation. He was a very impressive figure who I think colored my thinking later as I moved from clinical into public health field.

Bernard Berelson, [president of the Population Council in the late 1960s and early 1970s], also was a major model [and a remarkable leader]. Shelly Segal also was an important influence. The Council people really, sort of, got me started in this new career that I have. And I left out one of my—a couple of people I really admire the most: two international people. Fred Sai is a Ghanaian doctor who was a superstar in the field for many years. I met him first when he was at IPPF. And probably my closest friend of that whole group is Mahmoud Fathalla, who is another superb human being, very quiet and very dedicated. Works in the same kind of areas I work in.

One of the nice things about this, I haven't done this—I should probably do some more thinking, but there's just so many people whose paths have crossed mine during this period of time. You know, Thailand was a great place to be for the six years I was there, because family planning and population programs were growing. Almost everybody who traveled to Asia would stop in Thailand, partly because good things were happening, partly because it was good place to stop en route to wherever else you were going. So I got to know, in that six years that I was there—almost everybody who was major in population field came through

Bangkok at one time or another. The way things worked, we'd have dinner together, we had lunch together, we had social time in addition to formal meetings. It was a great place to meet the major figures of the field and many of the minor figures.

So the list of names of people with whom I've come in contact with in this field could go on and on. Jim McCarthy who came here, he was another major person who did a lot of work in adolescent sexuality. He was someone that, when he graduated with his Ph.D. from Princeton, he applied for a job here at the same time an African American woman applied. And for a whole range of reasons, I selected the African American woman—even though people who knew them both well said in terms of scholarship and things, Jim will add more to your school. But I didn't want to hear that. I wanted to hire a woman who had gotten herself through the Ph.D. program at Princeton and seemed really smart and I liked her. In the end, it didn't work out, though. She only stayed here about three years or four years. She moved on. She wanted something other than the soft-money, raise-your-own-money type place, which is not easy for a lot of people. I think she went on, did fine elsewhere, but Jim went on to Hopkins at that time, but we ended up recruiting him back to replace me as the head of the Pop Center and he did a very good job for about twelve years until he finally left.

Judy Jones, who was the first person I recruited here—Judy came here with just a bachelor degree. And she had run Preterm in Washington [one of the first abortion providers in the pre-*Roe* days]. She'd been a mother

first and then she went to—her husband had become a Peace Corps director in North Africa, and she went there and became a great Peace Corps person. Came back and helped a man named Harry Levin, who was a pioneering man, a businessman who worked with the Population Council on communications and new strategies. He was very much someone who believed in abortion and abortion rights and abortion services and eventually left the Council and set up Preterm in Washington. And Judy [came to work for him and soon became the Preterm director]. Then her husband took a new job in New York, she came to New York and people told me, This is a great woman, you ought to meet her. At that time, she was a young and very smart African American woman. She was the first person I hired when I moved to Columbia from Pop Council. And she has stayed [to the present and has been a major force at Columbia].

She helped me basically set up the family planning program that we run [with a focus on teens. She helped to establish the first evening clinic at Presbyterian Hospital for teens]—programs, teen activities, the young men's clinic. We established the first junior high school, school-based clinics and then the Ford Foundation and Carnegie Corporation approached her. They wanted to set up sort of a think tank on children's issues. After a lot of debate, she decided to leave her family work and became the first director of our National Center for Children in Poverty, also here. Did that for five or six years and then recruited a more academically oriented person to take it over and she went on to develop with the Robert Wood Johnson Foundation a program [Free to Grow]

that works through Head Start to get at parents who have substance abuse problems. Sort of incubates educational support for the parents of Head Start children. Very, very creative woman. Raised a huge amount of money during her time. In every program she was involved in, she raised money for it. [And she's a great teacher].

Sharpless

Other folks here at Columbia?

Rosenfield

Well, Judy's here. John Ross was here for a number of years. Measham was here for a while. Jim McCarthy. There's a [great number of wonderful people who were there at one time or another at the Center]. There's a woman named Susan Philliber, who is a wonderfully talented person. She left to bring up young children and then founded with her husband her own consulting firm, Philliber Associates. It's one of the biggest consulting firms, not just in family planning and population [issues], but reproductive health and general health, with offices across the country. [She runs it] from upstate New York, so she can bring up her kids. Susan Scrimshaw—who is an anthropologist, dean at the University of Illinois [at Chicago] and before that she was associate dean at UCLA—left here shortly after I came, but was someone important for all these years as a leading anthropologist. A woman named Harriet Presser, who was here when I came. She went to the University of Maryland. Did wonderful early work on sterilization. (telephone rings) I mean, it's endless. I could just keep going on and on.

[I'll mention a few more names of people I worked with at the Pop Center: Martin Gorosh, who was there when I arrived and was very active

in our international training efforts; Stephen Isaacs, who developed and ran our law and policy program; Don Lauro, who was the director of our large USAID-supported operations research program; Andy Davidson, who conducted important research efforts; Bill Van Wie, who ran much of the Center's teaching program; Ron Waldman, who developed our refugee health program; Deborah Maine, who ran our AMDD program (I have mentioned her elsewhere); and Lynn Freedman, who took the law and policy program and, more recently, the AMDD program.]

Sharon Camp, who now runs AGI, has been just a huge person in the field from her days of Population Crisis when she was there.

Sharpless How did your paths cross with hers?

Rosenfield Just similar field. In those days, I was very much—we had a lot of funding from AID, so there was a sort of a group of organizations funded by AID, plus a couple who weren't like PCC, Pop Crisis Committee. I was one of the sort of people who helped lead some of the activities of meeting, planning and plotting with and against AID on various issues, considering how to effectively educate and lobby issues. So Sharon and Joe Speidel were there at the same time. Robin Duke is a close friend, major figure for many years in the field. I guess if we stayed here for a couple hours, I could go through another thirty names, but maybe that's enough. I'm sure when I think about it, I'm sure I'll think of all the names I didn't think of.

Sharpless Certainly you can add those to your transcript if you want to. But just, by way of summary then, let me—

Rosenfield I think one of the good things—let me say, for summary, from my

perspective, having been in the reproductive health field since the late sixties, it's been—and even though I've gone on doing others things, being dean, I've got a very broad agenda and now I'm much more involved in AIDS work and maternal mortality work. But sort of my original core was reproductive health and reproductive rights and I've always stuck with it and I've felt fortunate at the numbers of really great people that I've come in contact with and consider friends, even though I don't see them very much, except at meetings and such and we always have a good time reminiscing about the past. We'd have these meetings.

Sharpless Is there anything that these people that you've named have in common?

Rosenfield Oh, I think the majority of them have a commitment to women's health, women's rights, the whole pro-choice concept: a woman should have access to contraception; they should be able to plan their kids when they want them; if they're pregnant unnecessarily, that they can, if they so desire, have the right to terminate the pregnancy. I think there's a general commitment to [the empowerment of women and gender equity]. I think despite the attack of opponents, these are fine, very good people, very dedicated people. It's interesting to me when—I think I mentioned my early ones—when I went from being a medical school-type person to a person in public health, it's just a different culture and these type of people are more—and that isn't to say in medical school there aren't great people, but the whole agenda's different, somewhat different.

Sharpless Well, I will let you go, but I hope you will take, you know, when we get the transcript if there are folks that you want put in, by all means—

Rosenfield If you can send it to me as an electronic attachment, it's a lot easier to edit.

Sharpless Okay. All right. Well, let's do that.

end Interview 3

© Sophia Smith Collection 2006