Introduction

When Raphael Cilento drafted his unpublished autobiography, he called it ‘The World, My Oyster’. Some of the other titles he considered—such as ‘Confessions of an International Character’, ‘20th Century Spotlight’, ‘Mankind in the Raw’ and ‘Tapestry of Humanity’—similarly evoked his international career. Other alternatives—such as ‘Topical Confessions of a Tropical Doctor’, ‘Where the Fever Lurks, There Lurk I’ and ‘The Southern Cross is Hard to Bear’—instead suggest how Cilento, an Australian doctor, colonial official and administrator, remained preoccupied with health and sickness across the tropical spaces of northern Australia, the Pacific Islands and South-East Asia.1 Like many public health experts in the twentieth century, Cilento enjoyed significant mobility across the imperial and international professional networks of the time. Between 1918 and 1950, he studied and worked in northern Australia, British Malaya, New Guinea and other Pacific Island colonies, as well as Europe, the United States, Latin America, Palestine and other states in Asia and the Middle East. He stayed for several years in some places, as in the Mandated Territory of New Guinea in the mid-1920s, while elsewhere he simply passed through as a student, a conference participant or a member of an international health survey.

Cilento’s memoir titles and the breadth of his colonial and international experience are, at first glance, striking for a man who dedicated his career to national health and racial fitness. In the 1920s, even as knowledge of the causes and preventability of disease spread among the medical profession and the public, the belief that European residence in tropical climates led to sickness in the short term and to racial deterioration over a few generations still cast doubt on the realisation of the White Australia

Policy. As a senior Commonwealth Medical Officer between 1922 and 1934, and then as Director-General of Health and Medical Services in Queensland until 1946, Cilento was part of a cohort of reformers who challenged this lingering orthodoxy and pursued a white Australia through state-provided medicine and hygiene. He wrote extensively for public audiences about race and health in the tropics, intervened in the medical policing and segregation of Aboriginal people, and vocally urged the state to enlarge its role in organising health and medical services. Gendered anxieties about racial decline and impurity were central to his thought and action, as time and again he returned to the importance of cultivating both the whiteness and the virility of Australia. Cilento thus emerged as the foremost champion of the view that individual hygiene knowledge and discipline, racial segregation and the organisation of health and medical services by the state would ensure Australia remained a ‘white man’s country’.

Cilento’s memoir titles are nevertheless a reminder that his experience and vision stretched across the Pacific Islands, Asia and, ultimately, the world. In fact, his nationalist public health agenda in Australia was rooted in larger fields of colonial and international discourse and practice. In his 1926 book, *The White Man in the Tropics*, Cilento sourced much of his advice on personal and domestic hygiene from British, French and American texts on colonial life in Asia and Africa. Cilento spent his early working life in New Guinea and Malaya and, for much of the 1920s, it was Australia’s imperial role in the Pacific that held his attention.

---


He explicitly linked public health in Australia to wider networks of colonial knowledge and practice, often claiming that his training in London and experience in the Pacific and South-East Asia uniquely positioned him to tackle tropical hygiene in Australia. ‘Probably no man,’ acknowledged The Mail in Brisbane, ‘medical or otherwise, knows more about the habits and customs of the aborigines of Queensland and the nearer islands of the Pacific than does Dr. R. W. Cilento.’ He recommended on several occasions that specific strategies for surveillance and management of indigenous people in New Guinea be adopted across Aboriginal reserves and missions in Queensland. National security and the preservation of indigenous populations against Asian migration and microbial invasions were, moreover, the central premises of Australian engagement with international health in the Pacific.

In Cilento’s thought and practice, the threads of race, gender, food, land and population both bound together and distinguished national and colonial spaces of government. In working among colonised peoples in foreign and testing environments, experts in tropical medicine such as Cilento could believe they exemplified white masculinity, leading the kind of productive, physical, vigorous and commanding life that Theodore Roosevelt and others had promoted. Such beliefs had grown in part from anxiety about racial deterioration in Europe and settler-colonial societies. For some politicians, scientists and reformers, evidence of declining physical and mental quality among the urbanised masses in the late nineteenth century made the deepest impression. Others dwelt on stagnant fertility rates and depopulation, especially in settler-colonial societies and the Pacific Islands, where the fear of invasion or other foreign demands on unoccupied land loomed large. Cilento wrote in 1944 that ‘we cannot preserve our frontiers unless we can effectively occupy the lands we claim’—a geopolitical situation that demanded an increased birth rate. He always insisted, however, on steering a middle

---

4 The Mail, 22 October 1933, National Archives of Australia [hereinafter NAA]: A1928, 4/5 SECTION 1.
8 Raphael Cilento, Blueprint for the Health of a Nation (Sydney: Scotow Press, 1944), p. 94.
road between unbridled pronatalism and eugenic control. Where some doctors and scientists emphasised eugenic intervention in reproduction, Cilento’s proposals for public health reform in the 1930s were in keeping with mainstream international thought on the social and environmental roots of sickness. He argued that beyond the preservation of racial purity, the state must safeguard and maximise the health of white Australians, and therefore national efficiency, against the effects of modern food production, industrial working conditions, urban housing and cultural decadence. In this sense, Cilento echoed longstanding apprehensions about the effects of industrial urban modernity on national and racial health.

If Cilento moved comfortably through imperial and international networks, much of his work was also grounded in place. A new biographical study can thus deepen understandings of how public health took shape across connected imperial spaces in Australia and the Pacific. In embracing biography, historians have insisted on taking it beyond a traditional focus on the agency and achievements of high-profile individuals. The job of the historian as biographer, it is said, is not to simply narrate the life of an individual, but to also describe and analyse in detail their relationships to local communities, larger societies, culture and material exchanges. The individual subject, in other words, serves as a hook to gather historical threads that might otherwise remain separate or overlooked. The scale of biographical studies of such relationships can thus range from the family or neighbourhood to the movement of people and ideas across regions, empires or even the globe.

---

9 ibid., p. 98.
Tracing Cilento’s career relates tropical medicine and public health in Australia to a larger web of connections in the Pacific. Fedora Gould Fisher based her conventional biography of Cilento on thorough research of published works and a range of personal, government and institutional archives. She endeavoured to situate Cilento’s work within wider historical contexts of medicine and public health. Yet her work remains a traditionally heroic narrative of his achievements as an individual, centring Cilento as an autonomous subject intervening in the world. She left aside, for the most part, a detailed and critical examination of his work. In New Guinea, for example, Fisher focused on Cilento’s role in building a public health system in difficult political and environmental circumstances. In doing so, she largely reproduced Cilento’s own image of himself as a pioneer: ‘Cilento’s work in New Guinea was of a magnitude much greater than can be described here.’ The emphasis here is on the scale and extent of Cilento’s individual mission. Even though Fisher acknowledged conflict within the New Guinea administration, she represents this as an obstacle that Cilento had to overcome rather than the main subject of analysis. Fisher lists policies and practices that Cilento introduced in New Guinea without scrutinising their governmental objectives and discursive frames. This book instead examines those discourses and practices of tropical medicine, as well as the connections between colonial government in the Pacific and Australia. There is thus great value in writing about Cilento in an extensive fashion again by adopting critical approaches in biographical history that focus on relationships between subjects and their contexts.

Cilento framed and enacted public health in ways that make postcolonial accounts of the entanglement of nations and empires obvious. Historians have been trying to escape the confines of the nation-state for some time, hoping to understand a wide array of past connections, subjectivities

14 ibid., p. 52.
15 ibid., pp. 52–6.
and spatial imaginaries. ‘Transnational’ has emerged as a particularly popular catch-all term for such studies of international or global history. Yet the meanings of all these terms have veered from reframing specific national histories to attending to mobilities and diasporic communities that transcended or defied the nation-state. Critics have also suggested that transnational and global histories tend to reproduce neoliberal claims about the smooth flow of ideas, people, capital and goods, while ignoring the channels, frictions, adaptations and blockages arising from the material power of nation-states and modern empires. These critical readings of ‘transnational’, as well as reminders of the insights of postcolonial thought, resonate with Cilento’s career, which itself illustrates the expanding scientific and intergovernmental networks that allowed health officials to move between imperial territories and places. The surveillance, management and cultivation of individual subjects and populations were shared aspects of public health everywhere in the


twentieth century, not just colonial territories. Cilento’s experience of public health administration in New Guinea and his engagement with larger networks of colonial research and legislation shaped his general understanding of health and disease. The ways in which he represented diet, health and race in Australia rested on an understanding of how a modern, imperial world order had transformed relationships between populations and their environments on a global scale. In turn, Cilento’s nationalist ideal of racial homogeneity informed his understanding of colonial government and international health. In many ways, therefore, he embodied the postcolonial claim that empire was a ‘spatialized terrain of power’.

Rather than tell a comprehensive story of a life, the chapters of this book focus on examples of how Cilento’s work connected tropical hygiene, international health and social medicine across the colonial spaces of Australia and the Pacific. The first explores how Cilento joined a growing number of students passing through imperial institutions in London, Liverpool and elsewhere in the twentieth century, absorbing knowledge and ideas while bearing a particular political and cultural subjectivity. Cilento was born in Jamestown, South Australia, in 1893, but his grandfather Salvatore had arrived in Adelaide from Italy in 1855. Instead of sweeping his heritage under the rug, Cilento would reconcile his Italian background with a white Australian subjectivity throughout his life. His path to the


London School of Tropical Medicine emerged out of chance and initiative. After serving briefly as an army medical officer in occupied German New Guinea, Cilento grew bored of private practice in Adelaide and applied for an advertised position in the Federated Malay States. While he was there, the nascent Commonwealth Department of Health (CDH) offered him the job of Director of the Australian Institute of Tropical Medicine (AITM) in Townsville, Queensland, on the condition that he study for a diploma in London. These years shaped Cilento’s professional identity as a mobile expert in tropical hygiene who could adapt a body of portable colonial knowledge to particular places. Yet these years also sharpened his sense of Australia’s particular situation in the world as he began to engage in a more conscious way with contemporary discourses about health, race, population and conflict.25

Cilento returned to New Guinea in the mid-1920s as Director of Public Health in the Mandated Territory, while he was also nominally head of the AITM. His appointment was part of a plan to expand the Commonwealth’s activities from quarantine to responsibility for a unified medical service for the Australian tropics and territories. As Chapters 2 and 3 show, public health in New Guinea under Australian administration was enmeshed in exchanges between empires of knowledge, ideas and practices. As elsewhere, in New Guinea, public health aimed to govern populations through forms of surveillance—by justifying and enforcing racial segregation and devising systems for managing labour.26 Yet, while in New Guinea, Cilento also began to conceive of health and difference in terms of social and environmental histories beyond strictly hereditary conceptions of race, especially in his growing interest in nutrition.27


In formulating policies and practices for workers’ rations and racial segregation, Cilento looked to Asian, African and Pacific colonies for guidance. At the same time, Australia administered New Guinea under a League of Nations mandate that gave Cilento a language with which to critique existing colonial policies and promote his expert knowledge. While the practical efficacy of the mandate system was itself minimal, the discourse surrounding the status of the mandated territories shaped public health politics in New Guinea through the initiative of officials such as Cilento.

Cilento’s emphasis on surveillance, hygienic discipline and racial segregation in New Guinea extended to Queensland, where a variety of colonial intersections shaped the discourses and practices of Australian tropical hygiene, examined in Chapter 4. *The White Man in the Tropics*, Cilento’s major work in the mid-1920s, drew from Asian and African colonial texts to advise on clothing, diet, bathing, exercise, housing and patterns of work and leisure that would keep white settlers healthy both in northern Australia and in Australian territories in the Pacific. The Australian Hookworm Campaign of the 1920s, which sought to instruct working-class communities in better personal and domestic habits, was funded by the International Health Board (IHB) of the Rockefeller Foundation and relied on methods it used in campaigns across the southern United States, Latin America and Asia.28 In the ongoing colonisation of northern Australia, white working-class communities in Queensland thus became subjects of hygienic scrutiny and discipline in ways that drew on ideas and practices from colonial Asia and the Pacific Islands.

As Cilento sought to cultivate white settler health in the tropics, he simultaneously sought to reform and reinforce racial segregation on the basis of hygiene. In promoting changes to the institutionalisation of Aboriginal people, Cilento appealed to his own experience of tropical hygiene in the Pacific and South-East Asia. As in New Guinea, he reimagined and reorganised the segregation of Aboriginal people in Queensland as the hygienic management of labour, yet on a much more extensive and profound scale. In keeping with conventions of tropical medicine, Cilento described Aboriginal communities as ‘reservoirs’ of disease, either because they harboured pathogens or because they created environments

in which they might flourish. 29 His construction in the late 1930s of a new leprosarium on Fantome Island to separate Aboriginal inmates from Europeans patients at the Peel Island institution is indicative of his segregating impulses. 30 Yet this regime of racial hygiene developed relative to wider imperial concerns and practices. Health officials had long blamed Chinese immigrants and indentured Melanesian labourers for introducing leprosy and hookworm to Aboriginal communities in Queensland. 31 Cilento argued further that the growth of mixed communities of Aboriginal, Melanesian and Asian peoples—‘indistinguishable’ from ‘native communities in the Pacific Islands’—meant that public health problems in the urban spaces of Queensland were little different from those of Rabaul or Suva. 32 Indeed, the health problems of such colonial spaces seemed to arise from historical relationships between them. The focus of Queensland’s existing *Aboriginals Protection and Restriction of the Sale of Opium Act* (1897) on a narrow definition of ‘Aboriginal’ meant that the state was unable to effectively control these heterogeneous communities. Cilento thus defined problems of race and health in Queensland as typically colonial, collapsing racial categories into an idea of the ‘native’ as a broad social and administrative category familiar in the Pacific. 33 Amendments to the Act in 1934, which gave the state more control over a broader range of ‘half-caste’ groups, followed soon after Cilento’s reports, although the Queensland Government had many more reasons to change the law. 34

To Australian health officials, the Pacific Islands seemed like stepping-stones for diseases brought from Asia on steam ships. Cholera or smallpox could invade Australia directly from the islands, but they might

also catastrophically depopulate the islands of Melanesia. As prospects of further Australian territorial expansion dimmed, the Department of Health organised the first International Pacific Health Conference, in Melbourne in 1926, where delegates from New Zealand, several Pacific Island colonies and various Asian states met with Australian officials to discuss the potential of a regional epidemiological intelligence service, standardisation of quarantine regulations, training programs for medical officers and coordinated research in the Pacific Islands. By the mid-1920s, such practices had become the standard repertoire of international health under the Office International d’Hygiène Publique (OIHP) in Paris and the League of Nations Health Organization (LNHO) in Geneva.35 For Cilento, the explicit aim of such practices was to define a space in the Pacific in which an Australian institution, not an international organisation, would determine the development and administration of public health. In shaping medical knowledge and health practice in the region, Australia would enhance its epistemic authority, prestige and security. Chapter 3 thus explores how Australia—much like the United States in Latin America—sought to turn northern Australia and the Pacific Islands into a distinct space of hygiene governance and a sphere of influence for Australian imperial dreams.36

While the direct connections between hygiene in the Pacific Islands and in northern Australia reflected an ongoing colonial project, an imperial mentality remained central to Cilento’s contributions to national public health in the 1930s. As Director-General of Health and Medical Services in Queensland from 1934, he often framed his proposals for national reform in terms of ‘social medicine’. Although it had a long genealogy, it was not until the 1920s that health officials and medical schools across

Europe, the United States and much of Asia widely embraced the idea that sickness had social and environmental roots. Cilento drew extensively on cross-Atlantic exchanges of articles, surveys and official reports, and shared widespread anxieties about declining fitness and fertility in imperial and settler-colonial societies. British inquiries and texts, for example, conflated national and imperial decline against a backdrop of population growth and anticolonial agitation in Asia. As Chapter 5 shows, however, Cilento’s articulation of social medicine also spoke to specific nationalist and Pacific colonial contexts. His commitment to state supervision of collective and individual health in New Guinea, through surveillance and preventive practices, differed little in principle from social medicine elsewhere. Nutrition was a central element of social medicine in the 1930s and became a major topic of international discussion, especially through the LNHO. Cilento’s own belief in the importance of nutrition, however, came directly from his practical experience in New Guinea, while colonial research in South and South-East Asia had produced much of the basic nutritional knowledge on which he and others relied.

Race was fundamental for Cilento throughout all these spaces, where it worked as a global organising concept and a prism through which to view anxieties about transformation and decline. As he moved through Queensland and the Pacific Islands, Cilento constructed white, Aboriginal, Asian and Pacific Islander peoples in relation to each other. If the superiority of white men and the importance of racial homogeneity were articles of faith for him, whiteness also seemed to be always changing or under threat. Cilento had made it his mission to show that tropical climates did not themselves cause disease or degeneration. Yet in The White Man in the Tropics, he also had to admit that:

---

39 Dwork, War is Good for Babies, pp. 6–10; Connelly, Fatal Misconception, pp. 34–5.
The race is in a transition stage, and it is very apparent that there is being evolved precisely what one would hope for, namely a distinctive tropical type, adapted to life in the tropical environment in which it is set.42

This new type was ‘tall and rangy’, with ‘long arms and legs’, but also ‘moves slowly’, which in women ‘becomes a gracefulness of movement that reminds one of those nations of the East that live in similar environments’.43 Although not explicitly Lamarckian, Cilento clearly represented race, fitness and health as historically and environmentally contingent. Remarking on indigenous population decline in New Guinea, Cilento suggested that nutrition shaped both the health of individuals and ‘the place to which a tribe or race has won in manliness, energy, and soldierly instincts’.44 In later arguing against climatic determinism, Cilento reminded readers that ‘belief in national superiority has been a universal delusion’. Civilisation was instead ‘ephemeral’, the product of ‘maintained accord between man and his environment’.45 ‘This of course meant that races and societies could also deteriorate if such a balance was lost.

In public lectures and journal articles in the 1930s, Cilento dwelled on cycles of progress and decline that linked sickness in New Guinea and urban Australia within a causal network of empire. The importance of a stable relationship between populations, local agriculture and diet remained a central theme in Cilento’s writing about national health. In fact, he argued, Australians and Pacific Islanders shared a dietary deficiency that underpinned their poor physical development, ‘instability of the nervous system’, fatigue and lack of resistance to infectious disease. This, he suggested, ‘may explain the decay of primitive and sophisticated alike, for there is no less evidence that the same conditions occur in people resident in cities’.46 In addition to situating Australian health reform in international networks of knowledge and practice, Chapter 5 thus also examines how empire lay at the heart of Cilento’s construction of the white Australian subjects of public health.

43 ibid., p. 74.
These themes of equilibrium, mobility and disruption are keys to how Cilento thought about race, national health and world order. After volunteering for the United Nations Relief and Rehabilitation Administration (UNRRA) in 1945, he joined the United Nations itself, where population growth and migration animated much international discussion and research on demography, public health, agriculture, education, family planning and other fields. The final chapter explores Cilento’s time as director of the social welfare program of the UN Department of Social Affairs, which worked with various government departments and universities to provide fellowships and expert consultants in welfare legislation, social work training and other related fields when governments requested them. These practices—which also underpinned the UN Technical Assistance program of the 1950s—recognised and promoted the nation-state as the fundamental unit of world order.

For his part, Cilento continued to express settler-colonial anxieties about the threat of Asian population growth to Australian nationhood and peace in the Pacific. The larger aim of the UN social welfare program was, in his view, to ameliorate regional and global effects of population growth across a decolonising Asia, which would in the future make these people ‘a threat to every specialized frontier of culture and civilization’. Since it was impossible to arrest such growth, it was vital for international organisations, through social and economic programs:

‘To direct the activities, the intentions and the ideas of the peoples of these huge undeveloped areas in such a way that … their actions will be along lines that experience has proved to be the most progressive socially.’

Cilento’s understanding of the aims of UN social welfare and development programs thus stemmed from his old preoccupations with race, population and empire. His ideal world order was static—one of arrested cycles of decline and progress and of settled peoples, ‘rooted in the soil’.

---

50 ibid., p. 298.
While many scholars have recently shown how imperialism and racial thought influenced the United Nations and its specialised agencies, Cilento eventually concluded that the United Nations represented a rupture with the imperial world order he had worked within.\(^{52}\) Rapid economic development and modernisation, human rights and Cold War politics seemed to him a decisive break with gradual colonial development of the kind represented by the League of Nations mandates.\(^{53}\) He felt increasingly out of step with these trends in liberal internationalism and decolonisation, and said so in a letter to Robert Menzies shortly before resigning from the United Nations.\(^{54}\) Decolonisation was, in reality, a protracted process, while policies of racial segregation and immigration restriction remained in place in Australia and South Africa well after World War II.\(^{55}\) By the 1970s, however, the Australian Labor Party had dropped the White Australia Policy from its platform, while the admission of students and refugees from Asia ushered in the policy’s final collapse. In one of his last public statements, Cilento prepared a recorded lecture for the far-right League of Rights in 1972 on the subject of ‘Australia’s Racial Heritage’, warning about the ‘incompatible racial clots that might end in disaster’ if biological and social racial mixing continued.\(^{56}\) Cilento clearly felt the world was changing beyond recognition. He had worked with Labor governments in Queensland in ways that contributed to comparatively expansive public health services in Australia, which made medical services more widely available, and yet he was enmeshed in empire. If many of the institutions and practices of contemporary public health took shape in Cilento’s time, few now would frame their purpose in his terms.


\(^{54}\) Raphael Cilento to Robert Menzies, 11 September 1950, p. 1, Cilento Papers, UQFL44, Box 4, Item 11.


This text is taken from *A Doctor Across Borders: Raphael Cilento and public health from empire to the United Nations*, by Alexander Cameron-Smith, published 2019 by ANU Press, The Australian National University, Canberra, Australia.