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The stages of international (global) health: Histories of success or successes of history?

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International health funders, leaders and researchers frequently cite ‘successes’ in this field as validation for past labours and justification for future endeavours. However, the question of what constitutes success – from both historical and contemporary perspectives – has been inadequately analysed. This paper reviews and periodises understandings of success in international/global health during the past century and a half, mapping out shifts and continuities over time. It then turns to the implications of these changing conceptualisations for current and future global health ideologies, strategies and activities. It concludes by arguing that historians of global health and policymakers need to interact further, so that historians are exposed to the contemporary problems of global health and policymakers better understand the historical complexity of extracting ‘lessons’ from the past.

Keywords: history of international health; global health success; international organisations

Introduction

How is success gauged in the field of international health? Many share the belief that international health success entails the control or eradication of diseases of global transcendence – as defined by a mix of public health experts, industrial, financial and media interests and political actors – through the international mobilisation of resources and technical expertise (Goodman et al. 1998). Of course, present or past, there is not always consensus on which ailments should be prioritised: the biggest killers (cardiovascular diseases, AIDS, cancer, respiratory infections); those with a ready measure (polio, onchocerciasis, tuberculosis (until the emergence of drug resistance)); those that are particularly threatening to international commerce and industrialised countries (SARS, avian influenza, diabetes); or those affecting particular populations (diarrhea in children, violence and injuries among young adults). Nor do international health actors agree on how these problems should be addressed.

In recent years, the eradication of smallpox (officially declared in 1980) has been the most consistently cited success by global health² decision-makers, serving as a rationale – if an increasingly contested one (Vastag 2003, Arita et al. 2004) – for the pursuit of technical tools to conquer diseases one by one. For example, at his address

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to the 58th World Health Assembly in May 2005, Bill Gates employed the case of successful smallpox eradication in discussing the global health approach employed by his eponymous foundation: ‘... the world didn’t have to eliminate poverty in order to eliminate smallpox – and we don’t have to eliminate poverty before we reduce malaria. We do need to produce and deliver a vaccine ...’ (Gates 2005).

The definition and identification of success in international health across time periods is not just a matter of rhetorical flourish or academic debate: many funders and policymakers use historical episodes or precedents – often selectively invoked – to push forward particular agendas based on (mis)perceived successes of the past.

What then is the role of the global health historian? Certainly, the present generation of historians has brought enormous insight into the origins of the technical and disease-based orientation of international health by exploring the political evolution and cultural context of the field’s ideas, institutions and practices (Arnold 1988, MacLeod and Lewis 1988, Lyons 1992, Packard 1997, Harrison 1999, King 2002, Jones 2004, Anderson 2006). We now have an understanding of how international health has been employed, variously, as a tool for productivity, trade and market expansion; colonial and neocolonial control; modernisation and development efforts; anti- or pro-communist cant; and neoliberal ideology.

At the same time, the question of how success in international health has been defined and evolved historically has received little scholarly attention. How is it that the singular perception of international health success as the fruition of technically based disease control measures dominates other understandings? In an attempt to challenge the prevailing historically simplified ‘international health versus disease’ model, this paper returns to a familiar history through a critical analytic lens: how have leading international health players – here depicted as the actors and agencies involved in the principal activities of health interchange among countries – judged success in their own eras? This article will evaluate a selection of these portrayals (which were at times constrained by political and institutional agendas) against a backdrop of major developments in international health in order to create characterisations of success across five stages over the last century and a half.

Any periodisation is potentially problematic: since there is no hiatus between each stage examined here, the reader will no doubt detect continuities over time, and the germs of developments from one era may only be fully expressed in another. Hence, the stages should be understood also in a theatrical sense, that is, as platforms for the international health field’s dominant self-definition of success, rather than as systematic accounts of each thread of activity in the field. Because the concept of success was more nebulous during the earlier periods than more recently, for the initial stages under scrutiny this article will sometimes rely on related terms, such as ‘accomplishments’. A further complexity derives from occasional difficulty in distinguishing ‘successes’ from ‘goals’. While the establishment of goals is a distinct process from their realisation and conceptualisation as successes, I argue that the very setting of goals is often defined by anticipated success.

In historicising the understanding of international health success – drawing from depictions of a variety of the field’s ‘inside players’ – this analysis aims to demonstrate that meanings of success are neither uniform over time nor steadily progressing but, rather, are framed within the political, economic, social and medical contexts of particular eras.

Stage of meeting and greeting: 1851–1902

Following Norman Howard-Jones's study on the scientific background of the international sanitary conferences (Howard-Jones 1975), most scholars have argued that the 11 conferences held between the 1851 inaugural meeting in Paris and the 1903 conference, when a full-time health office was proposed, marked a slow but sure advance in cooperation against infectious disease. This progress was prodded by the shared European fear of epidemics crossing from one country or colonial empire to another and by burgeoning medical consensus on the causes, mode of spread, and control of disease in triumph over trade protectionist positions put forth by merchant and producer dominated state interests (Bynum 1993, Fidler 2001, Stern and Markel 2004).

Most often convened by France and attended by Europe's leading imperial powers plus Russia and Turkey – the main foreposts (especially via new railroad lines) of disease – the conferences were punctuated by periodic pandemics of cholera and resulted in international conventions in 1892 and 1893 (on cholera control along the Suez Canal and in Europe), in 1894 (specifically on the sanitary control of the Mecca pilgrimage), in 1897 on plague, and in 1903 (replacing the previous conventions) (*Textes juxtaposés 1897, International Sanitary Convention of Paris, 1903*).

According to the standard narrative, the debates and discussions that took place at the conferences among diplomatic and medical emissaries over time convinced the represented governments of the need to act multilaterally to stave off commerce-threatening epidemics through mutual agreements on disease notification and quarantine. As such, the international sanitary conferences are typically interpreted as an era of hard-earned success for international cooperation based on growing scientific knowledge.

Yet the political and economic underpinnings of the international conferences – not to mention the slowness of signing accords, limited enforcement of the conventions, and the contentious 'Britain versus France and everybody else' conclusions of most of the meetings (Maglen 2002) – suggest a competing notion of success for this era: simply agreeing to meet – obviously facilitated by months of fine dinners and liquors – was international health's most important accomplishment.

Far from supporting a convergence of germ theory-based policy, official Britain remained opposed to any form of regulation of its extensive trade, ready to condemn the Hajj for the 1865 cholera pandemic (Afkhani 1999), but not the transmission of disease along its own commercial routes. The British government went so far as to reverse its quarantine and isolation policies in India before the opening of Suez Canal in 1868 so that the reduced transport time for trade to and from its most profitable colony would not be inconvenienced by disease-control measures (Watts 1997).

Yet even as Britain refused to endorse cholera conventions or negotiated side deals to arrange for its exemption from them, its very presence at the conferences was significant. After all, Britain had its own system of 'inter-colonial' (that is, *de facto* international) health structures of information-gathering, research, and conferences, essentially precluding the need for participation in a supranational effort with potential rivals. As late as 1914, Britain's international health delegate, Sir George Buchanan was 'expected to do his best to make our liberal ideas prevail when it came

to imposing restrictions on shipping on account of infectious disease, and be ready to give a national turn, from the point of view of British interests and British hygiene' (Buchanan 1934: 879).

Similarly, demonstrating the importance of 'meeting and greeting' over incipient cooperation was the first involvement of the USA in the International Sanitary Conferences: its hosting, on its own initiative, the 5th conference in 1881. With the presence of seven Latin American countries plus China, Japan, Liberia and the usual European participants (represented by diplomats posted in Washington and through special medical delegates from a handful of European countries), the conference aimed to obtain international approval for the USA's 1879 law to inspect and regulate sea vessels en route to the USA to prevent 'the introduction of contagious or infectious diseases from foreign countries'. While some delegates expressed interest in a system of disease notification, the USA's proposal was struck down. Nonetheless, US President Chester Arthur, in his first Annual Message to Congress on December 6, 1881, remarked that although the conference 'reached no specific conclusions affecting the future action of the participant powers, the interchange of views proved to be most valuable' (Arthur 1881).

With the results deemed positive despite the failed ratification, the US government – as part of a long tradition of disregarding the international community in pursuing its interests (at that time most apparent in Latin America, as outlined by the 1823 Monroe Doctrine; most recently evidenced in Iraq) – inaugurated its own costly and complex system of epidemic disease notification and ship inspection in ports around the world via paid informants, consuls and, subsequently, the posting of US Marine Hospital Service (later Public Health Service) officers abroad³ (Cliff et al. 1998).

In framing this era as did France's Foreign Affairs Minister, who declared the 1851 meeting as one of 'glorious accomplishments', key international health players defined success as the enormous international will required to convene international meetings at which discussion of sensitive issues and exchange of strategic information among highly competitive imperial powers took place.⁴ Although some observers find the Minister's statement ironic—after all, not a single agreement was reached over the course of six months (Basch 1991)—I would argue that the holding of meetings, far more than the elaboration of the germ theory, the identification of vectors and microorganisms, or the signing of conventions best characterise success in this initial stage. Over time, the convening of international meetings continued to serve as an important legitimising and organising feature of the field, even as the conventions became subsumed under a new set of international health agencies.

Stage of institution-building: 1902–1939

When, in 1907, the delegates from 12 European nations agreed to establish the Office International d'Hygiène Publique (OIHP) in Paris, international health gained a home base charged with the collection of disease statistics, the study of epidemic diseases, the implementation of measures passed by the international conferences, and the continued organisation of the conferences. The international goodwill garnered through the 'meeting and greeting' stage was now transformed into

international health's institutionalisation, gradually enabling the wide application of burgeoning scientific ideas and techniques.

Reaching agreement in Europe had taken so long that the Americas prefigured its efforts by founding an International Sanitary Bureau (later Pan American Sanitary Bureau (PASB)) in December 1902. US Surgeon-General William Wyman believed the 'young Republics of the Western Hemisphere' would be in a position to influence other continents (*Transactions of the First General International Sanitary Convention of the American Republics* 1903: 9). This puzzle of the institutionalisation of international health occurring first in the Americas despite longer-term European concern with sanitary cooperation (and the limited involvement of American countries in the International Sanitary Conferences) might best be explained by four factors that coincided circa 1900: high waves of European and Asian immigration (believed potential carriers of disease) concentrated in a dozen ports across the region; recurrent outbreaks of yellow fever, even deadlier to commerce (though not necessarily to humans) than cholera; the imminent opening of new trade routes through the Panama Canal; and the emergence of the USA as the unrivalled economic power in region. In its initial decades, the PASB provided a forum for the region's public health leaders to meet every few years to discuss mutual concerns, culminating in the 1924 Pan American Sanitary Code, signed by all 21 Pan-American republics (Cueto 2004a). While its journal and burgeoning role in cooperation later played an important part in the professionalisation of public health across the region, the PASB's initial mark of success was as the world's first international health agency.

Numerous other institutions aimed at international health cooperation were subsequently founded, including the League of Red Cross Societies (1919) and Save the Children (1920) in Geneva, and the International Institute for the Protection of Childhood in Montevideo (1927), even as imperial powers, including the US, maintained their own, at times competing inter-colonial health systems.

But one agency stood out in mapping a new institutional framework for international health – one that would go beyond narrow political and economic self-interest, war relief and information exchange. The Rockefeller Foundation (RF founded 1913) was the most far-reaching international agency of the first half of the 20th century, operating health projects, research and educational efforts in over 90 countries (Fosdick 1952, Cueto 1994). Not only did the RF shape the priorities, practices, and ideologies of international health, it influenced and helped finance the development of virtually every other international health organisation until the 1950s, serving (much as the Gates Foundation does today (Cohen 2002)) as the lead agenda-setter of its day. The RF's International Health Division (known as the International Health Board until 1927) is best remembered for its disease campaigns, most notably against yellow fever, hookworm and malaria, and for its pioneering role in establishing several dozen schools of public health across the world (mostly in North America and Europe), funding a fellowship programme for public health professionals to train in the USA, and for worker training stations associated with the disease campaigns (Fee 1987, Marinho 2001, Farley 2004, Birn 2006).

Yet, the International Health Division itself identified its most successful contribution to be 'aid to official public health organisations in the development of administrative measures suited to local customs, needs, traditions, and conditions' (League of Nations Health Organisation (LNHO) 1927: 743). While the RF placed its own staff as field officers in virtually every country where it operated, in

international health circles it cited ‘the immeasurably greater aid [given] in enabling governments to train their own personnel to carry out their own’ work’ (LNHO 1927: 743). Indeed, even the RF’s greatest proponent of disease eradication, famed health officer Fred Soper (later Director-General of the PASB) expressed doubts about disease-based efforts in the absence of strong administration (Soper 1970). As the RF’s first international health director, Wickliffe Rose, memorably put it, hookworm campaigns served as an ‘entering wedge’ (Rose and Green 1915): success was not defined in terms of disease eradication, but rather in terms of popular and political acceptance of the importance of public health. Thus, while highly influential in shaping the enduring *modus operandi* of international health through technically based disease campaigns and public health education, the RF’s self-defined mark of success was its role in the creation of national public health departments across the world and its support for the institutionalisation of international health.

Another key (if less renowned) entity of the early 20th century was the LNHO, founded in 1923 out of a predecessor Epidemic Commission that garnered kudos for fending off postwar outbreaks of typhus, cholera, smallpox and other diseases in Eastern Europe. With minimal official US participation, the LNHO convened health advocates and institutionalised international health, providing a collective response to Europe’s public health needs, eventually reaching as far as Asia and South America (Balinska 1995, Weindling 1995, Zylberman 2004). The LNHO, drawing on social medicine precepts, had a multi-nationality staff and set of advisors who pursued an ambitious agenda of epidemiologic surveillance, expert scientific research, health commissions, standardisation, and interchange of health personnel. Its special inquiries resulted in seminal reports on issues as varied as the social causes of infant mortality, housing conditions, malaria, traffic in women, nutrition, opiates, rural hygiene, and health insurance. While widely admired by public health professionals across the world, the LNHO’s work received stingy financial support from member governments and was sustained only through RF funding.

Notwithstanding the uncharacteristic misjudgement of Eric Hobsbawm (1994: 34) that the League of Nations ‘proved almost a total failure except as an institution for collecting statistics’, the LNHO played a vital coordinating function for an array of activities far beyond disease control (Borowy 2005), its wide charter allowing ‘active opportunism’ under Polish hygienist Ludwik Rajchman’s ‘universally recognised’ leadership. As noted by Britain’s Buchanan (1934: 882), ‘The official collaboration required is now not only the prevention of particular exotic diseases but something very much wider’.

Despite considerable historiographic focus on the disease-control efforts of the Rockefeller Foundation and the LNHO’s Epidemic Commission, the cataloguing and staging of success from 1902 to 1939 might best be understood, as alluded to by contemporaries, largely in institution-building terms. This took two key forms: first, the establishment of supranational institutions that played a strategic role in planning and marshaling expertise to address world health problems (Weindling 1997) and second, the purveying of cooperative support (directly and through popular health campaigns) to enable governments to organise permanent national health agencies.

Stage of bureaucratisation and professionalisation: 1946–1970

Even with the proliferation of international health institutions, their stability was not guaranteed. The LNHO was chronically underfunded and often under political attack; almost all of its commissions were necessarily temporary and it was never able to merge with the OIHP. The RF's International Health Division, though never in financial jeopardy, had an implicit (even prophetic) time-limited lifespan based on the achievement of public health institutionalisation across the world. As such, the success of the institution-building era was a fragile one until the creation of the World Health Organisation (WHO) in 1946 as a permanent international health agency. Officially launched in 1948 (once its constitution was ratified by a majority of then United Nations member states), the WHO was associated with the United Nations and its optimistic mission, while sheltered from its day-to-day politics.

With the establishment of the WHO, international health's broadest mandate – including standard-setting, data collection, epidemiologic surveillance, training and research, emergency relief, and cooperative activities resided—in a single agency for the first time. Thanks to its growing membership from the original 26 countries (especially as decolonised nations began to join in the 1950s) and what was planned to be an open decision-making structure through the annual World Health Assembly, the WHO enjoyed more legitimacy and permanence than its predecessors (Walt 2001).

The coincidence of 1946 marking the birth of both WHO and the Cold War demands examination of the embodiment at the WHO of Cold War ideologies of international health as a tool of development in the contested terrain of the Third World (Brown 1997, Litsios 1997, Packard and Brown 1997). Certainly, postwar anti-malaria efforts have been understood in terms of an eradication campaign against communism, as well as against the disease and its vector (Brown 1998).

In spite of the polarisation provoked by the Cold War, there was wide agreement on WHO's authority, international reach (through central headquarters with six regional offices and regiments of in-country field staff) and role in creating a new cadre of international health professionals. The Soviets generally backed the WHO and provided concerted support for particular public health campaigns: even during the years when the USSR was not an active member (1949–57), it provided fully 6% of the WHO's budget, with its share more than doubling to 13% by 1959 (US Congress, Senate Committee on Government Operations 1959: 143).

The renewal of interest in the Cold War context of the WHO's Global Malaria Campaign launched in 1955 (Cueto 2007), and the reasons for its 'failure' (Packard 1998, Packard 2007), has overshadowed this period's extraordinary success: the professionalisation and bureaucratisation of international health.

Instead of focusing solely on malaria, we might look at WHO's evolving organisational structure and demand for personnel, with staff expanding from 206 persons in 1948 to 1481 in 1957 to 3178 in 1967, accompanied by budget increases from \$3.8 million in 1948 to \$17.7 million in 1957, \$67.6 million in 1967 and \$187.2 million in 1978 (Beigbeder 1995, Siddiqi 1995). With approximately one-third of staff in Geneva in this period (the so-called capital of WHO) and another quarter at regional offices, bureaucratisation of international health – involving short and long range planning, programmes and research, setting regulations and standards, convening meetings and expert committees, and evaluation – was a clear mark of

success: the legitimisation of international health in a permanent supranational body aimed at impartial technical cooperation for health improvement and development.

The 1948 film, 'The Eternal Fight', produced by the UN film board, expressed this notion of global bureaucratic success in cinematic terms through maps of rapid response, instant communication between offices, and professional preparedness in the face of multiple international health problems against a musical anthem pronouncing the role of the WHO as *the organisation* to 'promote the welfare of all people' and combat disease (Ostherr 2005).

Hand in hand with bureaucratic growth was the formation of professional international health workers who could work in new settings and agencies: policymakers and administrators, researchers, and field health workers. While colonial authorities and, especially, the RF (which sponsored some 2500 public health fellowships between 1917 and 1950 (Rockefeller Foundation 1950) were instrumental in the initial efforts to train public health professionals, the WHO greatly expanded this effort to countless settings across the world. In its first two and a half decades, the WHO sponsored more than 50,000 fellowships, focusing on the areas of public health administration, sanitation, nursing, maternal and child health, health services, communicable diseases, and clinical medicine. As with the RF, the fellowships were awarded 'as a means of strengthening the health services of [each] country' (WHO 1976: 66).

Demonstrated by the WHO's global map of activities and increasingly complex organisational charts, worldwide reach, rapid growth, professionalisation of the field, and ability to mobilise resources, this period was portrayed in its day not as a stage of embarrassment due to the inability to eradicate malaria (after all Africa was paradoxically never incorporated into the 'global' campaign because of what were recognised to be insuperable challenges of controlling malaria there (Dobson et al. 1998)), but rather as one of successful professionalisation and bureaucratisation. Of course, this stage was also defined by development ideology, whereby Eastern and Western blocs employed health efforts as a means of influencing (and politically dominating) underdeveloped countries, including former colonies, as part of the larger Cold War struggle.

Stage of contested success: 1970–1985

With the institutionalisation, bureaucratisation and professionalisation of international health as hallmarks of its success in the post World War II period, the subsequent years might have witnessed continued consolidation internationally and further institutional growth in developing countries. Instead, these years saw mounting dissatisfaction from different quarters regarding how the ideals of international health were being fulfilled. The most prominent activities of this period – the smallpox eradication campaign and the 'Health for All' strategy were not sequential episodes – as is often portrayed, but unfolded simultaneously. In success-defining terms, both reached a climax in 1978, with not a single new case of smallpox that year and the convening by WHO and UNICEF of the International Conference on Primary Health Care in Kazakhstan (then USSR), and the signing of the Alma-Ata Declaration by 175 countries. These competing visions of achievement revealed deep divisions in the international health community's self-definition of success, particularly visible at the WHO.

The effort to eradicate smallpox, supported by both the Soviets (who had initially proposed a WHO campaign in the late 1950s) and the Americans, consumed enormous resources at both national and international levels while also exposing the inadequacies of basic health infrastructure and poor living conditions (Greenough 1995, Bhattacharya 2006). An estimated two-thirds of the smallpox campaign was funded by “recipient” countries, further squeezing national public health budgets. The command and control smallpox effort might ideally have been integrated with social and infrastructural approaches, but major funders, particularly the US government, had neither the time (in terms of Cold War conflict) nor the inclination (in terms of massive redistributive efforts) for such an approach and the two camps splintered.

While smallpox eradication was paraded as a success for science and for global health cooperation (Yekutiel 1981, Fenner et al. 1988, Henderson 1998), the Alma-Ata conference and the ‘Health for All’ strategy – which enjoyed lively debate and discussion in the international health field through the 1980s and beyond – were painted as a victory for international health at the community level (*Declaration of Alma-Ata* 1978, Luecke 1993, Venediktov 1998). Although these positions were in a sense coterminous, they uncovered contradictions (some of them longstanding) in the meaning and strategies of international health success: vertical versus horizontal, technical versus social, centrally driven versus locally defined, disease-based versus health-based, individually versus collectively-oriented, doctor-centred versus healer-centred versus community-centred, and so on. With these dichotomies deeply politicised and ultimately irreconcilable, the broadly defined primary health care success was selectively dismantled into a technical shadow of its former comprehensive approach (Newell 1988, Mull 1990, Werner and Sanders 1997, Litsios 2002, Cueto 2004b, Navarro 2004).

To a great extent the other international health agencies that emerged in the postwar era, including numerous bilateral and non-governmental agencies, were also faced with implementing ambiguity: were international health efforts liberating or coercive? For example, was the promotion and distribution of contraception (highly effective in lowering fertility rates) a family planning approach that empowered women or a eugenic form of population control (Nichter 1989, Lane 1994, Hartmann 1997)?

These ambiguities were reflected in the way the international health field portrayed itself through its symbolic and substantive headquarters – the WHO. A 1976 publication aimed at a broad public entitled *Introducing WHO* emphasised international health’s dual success as the prevention and control of specific diseases and the basic activities of strengthening health services, family and community health, environmental health, health statistics, and manpower. In budgetary terms, the latter camp appeared to have won out, with health services strengthening enjoying almost twice as much of the WHO’s budget as communicable diseases. However, because much of the smallpox campaign (like the previous malaria campaign) was funded through large, specially designated (extra-budgetary) funds by a few donors, the apparent budgetary advantage of the basic infrastructure camp was erased.

The WHO pamphlet ended with an ambitious section entitled ‘WHO: the changing emphasis’, in which the political economy of health was underscored as a logical successor to the WHO’s previous emphasis on agreements, disease control

and health services aid. In a sense capitalising on the pending eradication of smallpox, the author (presumably Director-General Halfdan Mahler) called for WHO to be ‘a catalyst, a world health conscience behind national change, and, when requested, a helper giving visible expression to progressive ideas and decisions within national social policies’. The pamphlet concluded: ‘this means the end of well-intentioned international technical paternalism in health and its replacement by an era of international collaboration and cooperation’ (WHO 1976: 80–81, Mahler 1976a, 1976b).

But this ideal of international health success would soon be marginalised. Although the smallpox campaign was viewed differently by different parties to international health, the stage of contested success was subsequently reinterpreted (through selective memory) as an era of uncontested success in the technically based eradication of disease.

Stage of evidence and evaluation: 1985 – present

The current period may be understood as a reaction to the previous stage, characterised by the entry of new actors and values in the international health field (Global Health Watch 2005, Ollila 2005a). This new stage began in the mid 1980s, as East-West relations warmed and the Soviet Union experienced increasing economic and political problems, a few years before the demise of the Cold War in 1989. This moment also marked the end of the divided paradigm of international health success, with the fragile balance at the WHO (and more generally in the international health field) no longer undergirded by Cold War tensions. If the previous period saw an ascendant role for the non-aligned movement in international health policy-making (as reflected in the development of the primary health care strategy), in the mid 1980s the prominence of Third World interests began to be displaced by financial and private sector involvement in international health. The business orientation of these emergent players emphasised success in terms of reaching concrete goals through management-style performance accountability measures in place of the preceding era’s broader assessments of health and social wellbeing.

The first sign of this transformation was external pressure on the WHO to reign in its international public health activism and embrace a narrow technical role, reflecting the political agenda of the Reagan-Thatcher era. For example, a 1985 study published by the conservative Heritage Foundation thinktank entitled: *The WHO: Resisting Third World Ideological Pressures*, advised US policymakers that the WHO’s (and the UN’s) mobilisation against private enterprise – whether through support for generic development of essential drugs, codes of conduct for transnational corporations, or the International Code of Marketing of Breast-Milk Substitutes (adopted in 1981)—had to be curbed. As argued by the study’s author, John Starrels, Western countries needed to ‘quietly and persistently insist that the Organisation adhere to its technical mandate’ of improving health in order to expand commercial markets in the Third World. Moreover, he advised ‘if the Health for All strategy were to bog down, WHO should reexamine carefully the long-term effectiveness of specific programs’ (Starrels 1985: 43–44).

A US-led effort to achieve the aims articulated in the Heritage Foundation study had a double effect. On one hand, the WHO was forced to scale down its ‘Health for All’ focus and abandon some of its long held principles, such as the free provision of

health care services in low-income countries. On the other hand, as both policy analysts and historians have pointed out, the WHO steadily lost its share of international health resources and influence to competing actors. Starting in the mid 1980s, the World Bank, regional development banks, and other financial institutions became increasingly involved in international health funding and policymaking (Finnemore 1997, Banerji 1999, Brown et al. 2006). These actors, together with various bilateral aid agencies, foundations and private-sector interests, infused free-market ideas into international health.

The new international health agenda was laid out in a series of studies, including the World Bank's 1987 review *Financing Health Services in Developing Countries* and its seminal 1993 report *Investing in Health* (World Bank 1987, 1993). The latter report cited poverty and lack of education as important determinants of health, but focused on misallocation and wastefulness as the key health sector problem in developing countries, a problem which it argued could be addressed through an increased private sector role in health services delivery (Laurell and Arellano 1996). In general, the new financial actors in international health advocated 'efficiency' reforms: cutting government spending on health (and other social sectors), decentralisation, privatisation, market competition, and the delivery of basic packages of technical interventions.

Within a few years, the WHO was no longer the hub of international health activity (today its budget comprises less than 10% of total international health spending) (Kates et al. 2006) compared to its 1970s peak of approximately two-thirds of spending) even as it began to compromise its own tenets. For example, in 1987 the WHO endorsed the Bamako Initiative, which called for African countries to implement user fees and community co-financing of public health services as a means to ensure their 'sustainability' (McPake et al. 1993).

Following sustained critiques of its inefficient bureaucracy and loss of funding in the 1980s and 1990s (Walt 1993, Godlee 1994a,b,c), the WHO has sought to fashion itself once again as a central actor in global health. It has done so by echoing the 'investing in health' for development argument of the World Bank (see the WHO's 2001 Commission on Macroeconomics and Health) (Waitzkin 2003, Katz 2005) – whereby ill health is conceptualised as a drain on the economy – and by participating in and advocating a model of public-private partnerships (PPPs) in international health, including Rollback Malaria, Stop TB and the GAVI Alliance (formerly Global Alliance for Vaccines and Immunisation). These partnerships have marshaled billions of dollars to international health (Cohen 2006, Garrett 2007), but have led to extensive commercialisation and enormous private sector influence in international health policymaking. The net result is that most PPPs channel public money into the private sector, not the other way around (Richter 2004, Ollila 2005b).

These new entities have also entrenched a business model to global health and reinforced circumscribed, technical approaches. The largest PPP, the Global Fund to Fight AIDS, Tuberculosis and Malaria, established as an independent financing entity in 2002, disburses approximately two-thirds of all donor monies to combat tuberculosis, half for malaria and one-fourth for HIV/AIDS. It raises money, reviews proposals, and disburses grants and contracts for programmes that focus largely on therapeutics. Designed to bypass the 'bureaucratic encumbrances' of UN agencies, the Global Fund's governing board is split 50/50 between representatives of donor countries, philanthropy and the private sector, on one hand, and developing

countries and NGOs, on the other. As of late 2007, the Global Fund had approved US\$10 billion to fund programmes in 136 countries, with \$5 billion distributed (<http://www.theglobalfund.org>). Its grant-making process requires applicant countries to propose technical, measurable-in-the-short-term approaches to each disease rather than addressing underlying determinants and health care needs of all three ailments.

The Bill and Melinda Gates Foundation, established in 2000 (in 2007 endowed with \$US37.6 billion, including annual top-ups of approximately \$1.7 billion from US investor Warren Buffett from 2006 until his \$31 billion donation is fully spent) has been the most influential new entrant, with huge challenge grants shaping the global health agenda, yet lacking public accountability (Birn 2005, Brown 2007). The Foundation heavily emphasises the ‘use of evidence for global health decision-making’ (Bill and Melinda Gates Foundation 2007), leading to narrow interventions rather than the integration of social and technical approaches. Evidence-based international health is to be institutionalised in a new ‘International Initiative for Impact Evaluation’ aimed at measuring the effectiveness of social development programmes as a guide to policymaking (Levine and Savedoff 2007).

In sum, the shift of players, power and paradigms in the international health field in the wake of the Cold War has had profound consequences for definitions of success: business-style evaluations of output over defined timelines and the use of cost analyses to justify specific interventions has resulted in this era’s predominance of narrowly targeted international health activities such as polio and measles eradication through vaccination (Gounder 1998, de Quadros 2006, Thompson and Tebbens 2007) and other individual disease-based efforts.

The international health field has also been influenced by the evidence-based medicine movement (Canadian Task Force 1979, Oxford Centre for Evidence-Based Medicine), which advocates the use of up-to-date evidence in clinical decision-making for individual patients, a standard that is only awkwardly applied to the public health field (Buekens et al. 2004, McMichael et al. 2005). The position that large scale success in international health is now predicated on ‘high quality evaluation’ as the only ‘credible basis for claiming the effectiveness of foreign assistance’ (Birdsall 2004: ix) is crystallised in the Center for Global Development’s study *Millions Saved: Proven Successes in Global Health*. While the book offers an optimistic assessment of past (and implicitly future) achievements and directions for the field, its focus on particular diseases and particular interventions precludes understanding of the hard-to-measure but critical effects on health of the interaction of employment levels, civil strife, income redistribution, education, commodity pricing, and many other features of the political and social context of health.

Critiquing the international health field is a perilous endeavour, given the enormous needs in this arena and the risk of angering donors. Still, the limits to the evidence-based approach to global health success are increasingly surfacing. An investigation led by Davidson Gwatkin commissioned by the World Bank highlighted the problem of reaching the world’s most marginalised populations in part because of the difficulty of measuring evidence of success as demanded by donors (Gwatkin et al. 2005). Reporter Helen Epstein, more pointedly condemned the international health system for losing millions of children to AIDS because of the narrow evaluative criteria employed by aid donors (Epstein 2005). For example, PEPFAR, the US government’s unprecedented \$15 billion global AIDS effort

(renewed in 2008 for \$37 billion move for 2009–13), emphasises counting interventions (primarily treatment and abstinence-only efforts) over broader means of preventing and controlling HIV/AIDS (IOM and Committee for the Evaluation of PEPFAR Implementation 2007).

The stage of evidence then is potentially at crossroads. Business may continue as usual, or alternately there may be a backlash to existing donor criteria of success: the international health field may begin to address the challenge of defining success in a more integrated fashion, for example, by gauging international health's achievements through the field's research, action, and advocacy roles in reducing social inequalities in health, life and death within and across societies (WHO 2008).

Conclusions

As we have seen, the history of international health – together with the field's own assessments of success – is not simply a consensual account of concerted efforts against (infectious) diseases of global transcendence, nor does it follow a 'rational' or 'punctuated equilibrium' model (Shiffman et al. 2002) of measurements of success. Instead, this is a complex domain whose internal evaluations of success have shifted and been renegotiated over time. Undoubtedly, the characteristics of success of one stage have often continued into the next, with meeting, professionalisation, and institution-building still central to the ideologies and practices of international health. In viewing these issues through the eyes of contemporaries, we see how the perceived successes (and potentially the failures) of each period were used to build momentum for the continuation and reshaping of the field.

Since past legacies are used to justify future plans of action, it behooves historians and policymakers to pay attention to the multiple ways international health success has been defined over time (not just the example of smallpox eradication) as a window on global health history. Of course, the present analysis does not consider other evaluations of success – whether on the part of the perceived 'targets' of international health policies and programmes or of the metropolitan, middle, or peripheral actors not directly involved in the international health field.

If policymakers tailor historical arguments to suit particular agendas (an obvious sign of political engagement) it strikes me that the historian's role is two-fold: first, to provide evaluation of the events or policies in question based on analysis of historical sources; and second, to demonstrate the selectivity and subjectivity of 'historical' references and to show how this selectivity is related to particular goals and ideologies. Through this effort, the historian may offer an illuminating, if at times troubling, perspective on contemporary debates about the shaping of international/global health paradigms, priorities and programmes. Policymakers in turn, may need to interact further with historians and examine the history of the field comprehensively if they wish to extract real 'lessons' from the past in defining what could and should constitute success in this field.

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Notes

1. This paper uses the terms *international health* and *global health* according to general usage in the historical period under discussion. The term international health was likely coined in the early 20th century, emerging as the international sanitary conventions of the previous five decades gave way to permanent bodies addressing health concerns internationally. It was employed most prominently by the Rockefeller Foundation's International Health Commission (later Board and Division) launched in 1913. By the end of World War II, *international health* was in widespread use, but the new World Health Organisation (as a semi-independent specialised United Nations agency) crafted its own name around the unifying notion of 'world health'. Still, the term international health retained its primacy. During the Cold War, the field of international health came to encompass the problems of health in underdeveloped countries and the efforts by industrialised countries and international agencies to address these problems. *Global health* – adopted broadly over the past decade – is meant to transcend past ideological uses of *international health* (as a 'handmaiden' of colonialism or a pawn of Cold War political rivalries) to imply a shared global susceptibility to, experience of, and responsibility for health. In its more collective guise, global health refers to health and disease patterns in terms of the interaction of global, national, and local forces, processes, and conditions in political, economic, social and epidemiologic domains. However, as Ilona Kickbusch (2002) has argued, this 'new' global health has also been used to assert US 'global unilateralism' that is, a tailoring of the world's health agenda to meet hegemonic US national interests and undercut bona fide internationalist efforts. Notwithstanding the invoked distinctions, there is considerable conflation between *international health* and *global health*, and the 'new' definition of global health bears many similarities to early 20th century understandings of international health.
2. The Marine Hospital Service's *Weekly Abstracts of Sanitary Reports*, later the *Public Health Reports*, published reports warning about yellow fever, plague, cholera and other disease outbreaks from US informants and local authorities in (port) cities around the world.
3. As leading Canadian hygienist Fitzgerald (1931: 267) later noted, 'That some measure of success attended this first effort seems to be implied in the fact that a second gathering of the same sort was convened'.
4. The Soviet bloc's withdrawal, undoubtedly motivated by Cold War tensions, stemmed from dissatisfaction with the WHO's insufficient attention to its numerous postwar health needs (despite the USSR's considerable financial contributions).

References

- Afkhami, A.A., 1999. Defending the guarded domain: epidemics and the emergence of international sanitary policy in Iran. *Comparative Studies of South Asia, Africa, and the Middle East*, 19, 122–136.
- Anderson, W., 2006. *Colonial pathologies: American tropical medicine, race, and hygiene in the Philippines*. Durham: Duke University Press.
- Arita, I., Wickett, J., and Nakane, M., 2004. Eradication of infectious diseases: its concept, then and now. *Japanese Journal of Infectious Diseases*, 57, 1–6.
- Arnold, D., ed., 1988. *Imperial medicine and indigenous societies*. Manchester, England: Manchester University Press.
- Arthur, C., 1881. "First Annual Message." Available from: <http://www.presidency.ucsb.edu/ws/index.php?pid=29522> [Accessed 21 March 2006].

- Balinska, M., 1995. *Une vie pour l'humanitaire: Ludwik Rajchman 1881–1965*. Paris: Editions la Découverte. Transl: For the Good of Humanity.
- Banerji, D., 1999. A fundamental shift in the approach to International Health by WHO, UNICEF, and the World Bank: instances of the practice of 'Intellectual Fascism' and totalitarianism in some Asian countries. *International Journal of Health Services*, 29 (2), 227–259.
- Basch, P.F., 1991. A historical perspective in international health. *Infectious Disease Clinics of North America*, 5, 183–196.
- Beigbeder, Y., 1995. *L'Organisation Mondiale de la Santé*. Paris: Presses Universitaires de France. Transl: The World Health Organisation.
- Bhattacharya, S., 2006. *Expunging Variola: the control and eradication of smallpox in India, 1947–1977*. Hyderabad, India: Orient Longman.
- Bill and Melinda Gates Foundation, 2007. Available from: http://www.gatesfoundation.org/GlobalHealth/OtherInitiatives/Advocacy/CES_Grantmaking.htm. [Accessed 12 December 2007].
- Birdsall, N., 2004. Preface. In: R. Levine and M. Kinder, eds., and What Works Working Group, *Millions saved: proven successes in global health*, New edition 2007. Washington, DC: Center for Global Development.
- Birn, A.-E., 2006. *Marriage of convenience: Rockefeller international health and revolutionary Mexico*. Rochester, MN: University of Rochester Press.
- Birn, A.-E., 2005. Gates's grandest challenge: transcending technology as public health ideology. *Lancet*, 366, 514–519.
- Borowy, I., 2005. World health in a book – the League of Nations International Health Yearbooks 1925–30. In: I. Borowy and W. Gruner, eds. *Facing illness in troubled times. Health in Europe in the Interwar Years, 1918–1939*. Frankfurt/Main: Peter Lang, 85–128.
- Brown, P., 1997. Malaria, miseria, and underpopulation in Sardinia: the 'Malaria Blocks Development' cultural model. *Medical Anthropology*, 17, 239–254.
- Brown, P., 1998. Failure-as-success: multiple meanings of eradication in the Rockefeller foundation Sardinia project, 1946–1951. *Parassitologia*, 40 (1–2), 117–130.
- Brown, H., 2007. Great expectations. *BMJ*, 334, 874–876.
- Brown, T.M., Cueto, M., and Fee, E., 2006. The World Health Organisation and the transition from 'International' to 'Global' public health. *American Journal of Public Health*, 96 (1), 62–72.
- Buchanan, G. 1934. International cooperation in public health: its achievements and prospects. *Lancet*, 879–885. April 28, 1934. Vol. 223 Issue 5774.
- Buekens, P., et al., 2004. Evidence-based global health. *JAMA*, 291 (21), 2639–2641.
- Bynum, W., 1993. Policing hearts of darkness: aspects of the international sanitary conferences. *History and Philosophy of the Life Sciences*, 15, 421–434.
- Canadian Task Force on the Periodic Health Examination: the periodic health examination, 1979. *Canadian Medical Association Journal*, 121, 1193–1254.
- Cliff, A.D., Haggatt, P., and Smallman-Raynor, M., 1998. *Deciphering global epidemics: analytical approaches to the disease records of world cities, 1888–1912*. Cambridge: Cambridge University Press.
- Cohen, J., 2002. Gates foundation rearranges public health universe. *Science*, 295, 2000.
- Cohen, J., 2006. The new world of global health. *Science*, 311, 162–167.
- Cueto, M., ed., 1994. *Missionaries of science: the Rockefeller foundation and Latin America*. Bloomington, IN: Indiana University Press.
- Cueto, M., 2004a. *El Valor de la Salud: Una Historia de la Organización Panamericana de la Salud*. Washington, DC: Organización Panamericana de la Salud.
- Cueto, M., 2004b. The origins of primary health care and selective primary health care. *American Journal of Public Health*, 94, 11, 1864–1874.
- Cueto, M., 2007. *Cold war, deadly fevers: malaria eradication in Mexico, 1955–1975*. Washington, DC: Woodrow Wilson Center Press.
- de Quadros, C.A., 2006. Is global measles eradication feasible? *Current Topics in Microbiology and Immunology*, 304, 153–163.

- Declaration of Alma-Ata* 1978. International conference on primary health care. Alma-Ata, USSR. Available from: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf [Accessed 12 October 2006].
- Dobson, M.J., Malowany, M., and Snow, R.W., 1998. Malaria control in East Africa: the Kampala conference and the Pare-Taveta scheme: a meeting of common and high ground. *Parasitologia*, 40 (1–2), 149–166.
- Epstein, H., 2005. The lost children of AIDS. *The New York Review of Books*, 52, 17. Available from: <http://www.nybooks.com/contents/20051103> [Accessed 20 October 2006].
- Farley, J., 2004. *To cast out disease: a history of the International Health Division of the Rockefeller Foundation, 1913–1951*. New York, NY: Oxford University Press.
- Fee, E., 1987. *Disease and discovery: a history of the Johns Hopkins School of Hygiene and Public Health, 1916–1939*. Baltimore, MD: Johns Hopkins University Press.
- Fenner, F., Henderson, D.A., Arita, I., Ježek, Z., and Ladnyi, I.D., 1988. *Smallpox and its eradication*. Geneva, Switzerland: The World Health Organization.
- Fidler, D., 2001. The globalization of public health: the first 100 years of international health diplomacy. *Bulletin of the World Health Organization*, 79, 842–849.
- Finnemore, M., 1997. Redefining development at the World Bank. In: F. Cooper and R. Packard, eds. *International development and the social sciences: essays on the history and politics of knowledge*. Berkeley, CA: University of California Press, 203–227.
- Fitzgerald, J.G., 1931. International public health. *Queen's Quarterly*, 38, 265–279.
- Fosdick, R.B., 1952. *The story of the Rockefeller foundation*. New Brunswick, NJ: Transaction.
- Garrett, L., 2007. The challenge of global health. *Foreign Affairs*, January/February. Available from: <http://www.foreignaffairs.org/20070101faessay86103/laurie-garrett/the-challenge-of-global-health.html> [Accessed 8 March 2007].
- Gates, B., 2005. Prepared remarks to the 2005 world health assembly. Available from: <http://www.gatesfoundation.org/MediaCenter/Speeches/Co-chairSpeeches/BillGSpeeches/BGSpeech/WHA-050516.htm> [Accessed 12 November 2006].
- Global Health Watch, 2005. *Global health watch 2005–2006: an alternative world health report*. London, UK: PHM, Medact, GEGA, Zed Books.
- Godlee, F., 1994a. WHO in retreat: is it losing its influence? *BMJ*, 309, 1491–1495.
- Godlee, F., 1994b. The World Health Organisation: WHO at country level: a little impact, no strategy. *BMJ*, 309, 1636–1639.
- Godlee, F., 1994c. The World Health Organisation: WHO in crisis. *BMJ*, 309, 1424–1428.
- Goodman, R.A., et al., eds., 1998. Global disease elimination and eradication as public health strategies. *Bulletin of the World Health Organization*, 76 (Suppl. 2), 162 pp.
- Gounder, C., 1998. The progress of the polio eradication initiative: what prospects for eradicating measles? *Health Policy and Planning*, 13 (3), 212–233.
- Greenough, P., 1995. Intimidation, coercion and resistance in the final stages of the South Asian smallpox eradication campaign, 1973–1975. *Social Science and Medicine*, 41 (5), 633–645.
- Gwatkin, D.R., Wagstaff, A., and Yazbeck, A.S., 2005. *Reaching the poor with health, nutrition, and population services: what works, what doesn't, and why*. Washington, DC: World Bank.
- Harrison, M., 1999. *Climates and constitutions: health, race, environment and British imperialism in India, 1600–1850*. Oxford: Oxford University Press.
- Hartmann, B., 1997. Population control I: birth of an ideology; and population control II: the population establishment today. *International Journal of Health Services*, 27 (3), 523–557.
- Henderson, D.A., 1998. Smallpox eradication: a Cold War victory. *World Health Forum*, 19, 113–119.
- Hobsbawm, E., 1994. *Age of extremes: a history of the world, 1914–1991*. New York, NY: Pantheon Books.
- Howard-Jones, N., 1975. *The scientific background of the international sanitary conferences, 1851–1938*. Geneva, Switzerland: World Health Organisation.
- International Sanitary Convention of Paris, 1903. *International Sanitary Conference*. Paris, France: 11th International Sanitary Conference.
- IOM and Committee for the evaluation of PEPFAR implementation, 2007. *PEPFAR implementation: progress and promise*. Washington, DC: Institute of Medicine.

- Jones, M., 2004. *Health policy in Britain's model colony: Ceylon, 1900–1948*. New Delhi: Orient Longman.
- Kates, J., Morrison, J.S., and Lief, E., 2006. Global health funding: a glass half full? *Lancet*, 368 (9531), 187–188.
- Katz, A., 2005. The Sachs report. Investing in health for economic development – or increasing the size of the crumbs from the rich man's table? *International Journal of Health Services*, 35, 1171–1188.
- Kickbusch, I., 2002. Influence and opportunity: reflections on the US role in global public health. *Health Affairs*, 21, 131–141.
- King, N.B., 2002. Security, disease, commerce: ideologies of postcolonial global health. *Social Studies of Science*, 32 (5–6), 763–789.
- Lane, S., 1994. From population control to reproductive health: an emerging policy agenda. *Social Science and Medicine*, 39 (9), 1303–1314.
- Laurell, A.C. and Arellano, O.L., 1996. Market commodities and poor relief: the World Bank proposal for health. *International Journal of Health Services*, 26 (1), 1–18.
- League of Nations Health Organisation, 1927. "International Health Board of the Rockefeller Foundation." In: *International Health Yearbook 1927 (Third Year) Reports on the Public Health Progress of 27 Countries in 1926*. C.H. 599 Geneva.
- Levine, R and Savedoff, B., 2007. International Initiative For Impact Evaluation (3IE): beyond good intentions. *Alliance*, 12, 4. Available from: <http://www.alliancemagazine.org/free/html/dec07k.html> [Accessed 20 December 2007].
- Litsios, S., 1997. Malaria control, the Cold War, and the postwar reorganisation of international assistance. *Medical Anthropology*, 17 (3), 255–278.
- Litsios, S., 2002. The long and difficult road to Alma-Ata: a personal reflection. *International Journal of Health Services*, 32 (4), 709–732.
- Luecke, R., ed., 1993. *A new dawn in Guatemala: toward a worldwide health vision*. Prospect Heights, IL: Waveland.
- Lyons, M., 1992. *The colonial disease: a social history of sleeping sickness in Northern Zaire, 1900–1940*. Cambridge: Cambridge University Press.
- MacLeod, R. and Lewis, M., eds., 1988. *Disease, medicine, and empire: perspectives on Western medicine and the experience of European expansion*. London: Routledge.
- Maglen, K., 2002. "The First Line of Defense": British quarantine and the port sanitary authorities in the nineteenth century. *Social History of Medicine*, 15 (3), 413–428.
- Mahler, H., 1976a. *Social perspective in health*. World Health Organisation, Off. Rec. 234.
- Mahler, H., 1976b. A social revolution in public health. *WHO Chronicle*, 30, 475–480.
- Marinho, M., 2001. *Norte-Americanos no Brasil: uma história da Fundação Rockefeller na Universidade de São Paulo, 1934–1952*. Campinas: Editora Autores Associados.
- McMichael, C., Waters, E., and Volmink, J., 2005. Evidence-based public health: what does it offer developing countries? *Journal of Public Health*, 27, 215–221.
- McPake, B., Hanson, K., and Mills, A., 1993. Community financing of health care in Africa: an evaluation of the Bamako initiative. *Social Science and Medicine*, 36 (11), 1383–1395.
- Mull, J., 1990. The primary health care dialectic: history, rhetoric, and reality. In: J. Coreil and J. Mull, eds. *Anthropology and primary health care*. Boulder, CO: Westview Press.
- Navarro, V., 2004. The world health situation. *International Journal of Health Services*, 34 (1), 1–10.
- Newell, K., 1988. Selective primary health care: the counter revolution. *Social Science and Medicine*, 26, 903–906.
- Nichter, M., 1989. Modern methods of fertility regulation: when and for whom are they appropriate? In: M. Nichter, ed. *Anthropology and international health: South Asian case studies*. Dordrecht, Holland: Kluwer, 57–82.
- Ollila, E., 2005a. Global health priorities—priorities of the wealthy? *Globalisation and Health*, 1, 6:1–5. Available from: <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1143784&blobtype=pdf> [Accessed 15 September 2006].
- Ollila E., 2005b. Restructuring global health policy making: the role of global public-private partnerships. In: M. Mackintosh and M. Koivusalo, eds. *Commercialization of health care: global and local dynamics and policy responses*. Social Policy in a Development Context. Basingstoke, UK: Palgrave Macmillan.

- Ostherr, K., 2005. *Cinematic prophylaxis: globalisation and contagion in the discourse of world health*. Durham, NC: Duke University Press.
- Oxford Centre for evidence-based medicine. Available at <http://www.cebm.net/index.asp> [Accessed 20 October 2006].
- Packard, R.M., 1997. Visions of postwar health and development and their impact on public health interventions in the developing world. In: F. Cooper and R. Packard, eds. *International development and the social sciences: essays on the history and politics of knowledge*. Berkeley, CA: University of California Press, 93–115.
- Packard, R.M., 1998. “No Other Logical Choice”: global malaria eradication and the politics of international health in the postwar era. *Parassitologia*, 40 (1–2), 217–230.
- Packard, R.M., 2007. *The making of a tropical disease: a short history of malaria*. Baltimore, MD: The Johns Hopkins University Press.
- Packard, R.M. and Brown, P.J., 1997. Rethinking health, development and malaria: historicizing a cultural model in international health. *Medical Anthropology*, 17, 181–194.
- Richter, J., 2004. *Public-private partnerships and international health policy-making: how can public interests be safeguarded?*. Helsinki: Ministry for Foreign Affairs of Finland.
- Rockefeller Foundation, 1950. *Public health fellowships and nursing fellowships for the years 1917–1950*. The Rockefeller Foundation Directory of Fellowship Awards, 1917–1950. RG 12. Series 100, Box 32, Folder 239, Rockefeller Foundation Archives. Rockefeller Archive Center, Sleepy Hollow, NY.
- Rose, W. and Green, J., 1915. RG 1.2, Series 300, Box 2, Folder 16. Rockefeller Foundation Archives.
- Shiffman, J., Beer, T., and Wu, Y., 2002. The emergence of global disease control priorities. *Health Policy and Planning*, 17 (3), 225–234.
- Siddiqi, J., 1995. *World health and world politics: the World Health Organisation and the UN system*. Columbia: University of South Carolina Press.
- Soper, F.L., 1970. The epidemiology of a disappearing disease: malaria. *American Journal of Tropical Medicine and Hygiene*, 9, 357–366.
- Starrels, J., 1985. *The World Health Organisation: resisting third world ideological pressures*. Washington, DC: The Heritage Foundation.
- Stern, A.M. and Markel, H., 2004. International efforts to control infectious diseases, 1851 to the present. *JAMA*, 292, 1474–1479.
- Textes juxtaposés des conventions sanitaires internationales de Venise (1892) – Dresde (1893) – Paris (1894) – Venise (1897)*, International Sanitary Conferences. Bruxelles: Hayez, 1897.
- Thompson, K.M. and Tebbens, R.J., 2007. Eradication versus control for poliomyelitis: an economic analysis. *Lancet*, 369, 1363–1371.
- Transactions of the First General International Sanitary Convention of the American Republics, 1903. *Held at the New Willard Hotel, Washington, DC, 2, 3 and 4 December 1902, under the auspices of the Governing Board of the International Union of the American Republics*. Washington, DC: Government Printing Office.
- U.S. Congress, Senate Committee on Government Operations, 1959. *The United States and the World Health Organization*. Washington, DC: GPO.
- Vastag, B., 2003. The siren song of disease eradication: is it out of tune with the times? *JAMA*, 289 (9), 1090–1091.
- Venediktov, D., 1998. Alma-Ata and after. *World Health Forum*, 19 (1), 79–86.
- Waitzkin, H., 2003. Report of the WHO Commission on Macroeconomics and Health: a summary and critique. *Lancet*, 361, 523–526.
- Walt, G., 1993. WHO under stress: implications for health policy. *Health Policy*, 24, 125–144.
- Walt, G., 2001. Global cooperation in international public health. In: M. Merson, R. Black and A. Mills, eds. *International public health: diseases, programs, systems, and policies*. Gaithersburg, MD: Aspen, 667–99.
- Watts, S., 1997. *Epidemics and history: disease, power and imperialism*. New Haven, CT: Yale University Press.
- Weindling, P., ed., 1995. *International health organisations and movements, 1918–1939*. Cambridge: Cambridge University Press.
- Weindling, P., 1997. Philanthropy and world health: the Rockefeller foundation and the League of Nations Health Organisation. *Minerva*, 35, 269–281.

- Werner, D. and Sanders, D., 1997. *Questioning the solution: the politics of primary health care and child survival*. Palo Alto, CA: Healthwrights.
- WHO, 1976. *Introducing WHO*. Geneva, Switzerland: World Health Organisation.
- WHO Commission on Social Determinants of Health, 2008. *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva: WHO.
- World Bank, 1987. *Financing health services in developing countries*. Washington, DC: The World Bank.
- World Bank, 1993. *World development report 1993: investing in health*. Washington, DC: The World Bank.
- Yekutieli, P., 1981. Lessons from the big eradication campaigns. *World Health Forum*, 2, 4, 465–490.
- Zylberman, P., 2004. Fewer parallels than antitheses: René Sand and Andrija Stampar on social medicine, 1919–1955. *Social History of Medicine*, 17, 77–92.