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From Plagues to Peoples: Health on the Modern Global/International Agenda

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From Plagues to Peoples: Health on the Modern Global/International Agenda

Anne-Emanuelle Birn

The term ‘globalization of health’ implies a historical process whereby health understandings, institutions, actors, status, etiologies, determinants and priorities have moved from a primarily community domain to a linking of the local to worldwide trends, concerns, and political and social forces. While the globalization of health suggests shared phenomena across space, the notion of global or globalization is totalizing and so fraught with scholarly anxieties (Appadurai 2001) that its utility is questionable. Clearly the underpinnings of the ‘globalization of health’ vary across time and place and must be qualified, making historical contingencies and contextualization vital to illuminating the notion. This chapter takes up the historicization of the ‘globalization of health’ (on the importance of historicizing, see the preceding chapter) by first exploring how health became an international issue in(to) the modern period and then describing how health concerns were institutionalized at an international level before and between the two World Wars. This effort – conceptualized at the time in terms of ‘international health’ – involved the creation of intergovernmental and multi-lateral (though not supra-national) agencies, as well as philanthropic and voluntary organizations with an (often self-declared) international purview. Notwithstanding these new institutional arrangements and the idealism of the many new actors who appeared on the scene, the power politics and policies of international health remained, to a great extent, aligned with and subsidiary to the existing Europe-centred imperial order. As such, institutionalizing health at an international level in this period created intractable dilemmas regarding reach, approaches, and inclusion/exclusion, many of which resonate to the present day.

1 This chapter is partially adapted from chapter 2 of Birn, Pillay and Holtz (2009).
Globalization’s Antecedents: The Historical Context of International Health

The modern system of international health – involving disease surveillance, sanitary regulation, international organizations, information exchange and ‘cooperative’ activities – emerged in nineteenth century Europe and the Americas, but preoccupation with public health was present in ancient Chinese, Egyptian, Persian, Hindu, Greek, Roman, Ethiopian, Maya and other civilizations. Until the Middle Ages, however, health concerns and disease outbreaks rarely extended beyond limited regions, except in the case of military incursions.

Great plagues

The sixth century Plague of Justinian, and, especially, the Great Plague of the fourteenth–seventeenth centuries sorely tested this localism. Originating from rodents (likely in China or Central Asia) whose habitats were disrupted by a mix of human invasion, expansion of farming lands and new trading patterns, what became known as the Black Death travelled by land and sea across trade routes such as the Silk Road. The most destructive epidemic in the history of humankind, it resulted in an estimated 100 million deaths (almost one quarter of the world’s population, and up to half of all Asians, Europeans and Middle Easterners). The plague revealed the sanitary backwardness of Europe’s growing towns and prompted authorities into action. The appearance of disease was understood by some in cosmological or environmental terms; others considered it God’s punishment for collective or personal sin. These interpretations motivated, variously, days of prayer and the disposal and burning of corpses and belongings. Still others held that plague was transmitted from person to person, a notion that helped stimulate harsh measures, and appeared to justify the fleeing of the well-off into the countryside. In 1348 the city-state of Venice adopted a 40-day detention period – quarantine, from the Italian word for 40 – for entering vessels after which time the disease was believed to subside. This measure was soon copied by other major ports. Quarantine’s stricter counterpart, the cordon sanitaire – a protective belt barring entry of people or goods to cities or entire regions – was also used frequently in succeeding centuries.

Because the Black Death’s initial appearance preceded the formation of nation-states, sanitary efforts were adopted and implemented by local authorities. While disease spread through rumour and travellers, there was no official system of notification or cooperation between city-states. Many cities established temporary plague boards, with some creating more permanent public health bodies charged with imposing the necessary measures at times of outbreak.

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2 Venice established the first lazaretto in 1403, a quarantine station to hold humans and fumigate cargo. Its island location was emulated by many other cities.
The Birth of imperialism (and its health accompaniments)

In part fuelled by the social and demographic devastation of the plague, mid millennial Europe underwent a colossal set of transformations in the realm of political economy, including: consolidation and enrichment of powerful kingdoms; adaptation, application and extension of scientific and technical knowledge from the Islamic and Chinese worlds; and a gradual transition from feudalism to capitalism.

After curbing Muslim influence in the fifteenth century, Europe’s monarchs instigated Crusades-inspired military-proselytizing campaigns, coupling newfound power with greed for expensive commodities and new territories. Portugal and then Spain (whose united Catholic monarchs unleashed the repressive Inquisition in 1478), both maritime societies, were in the vanguard of these sea conquests. Portugal’s plundering raids into North Africa and later India became permanent garrisons for the lucrative spice trade from the East. After the Spanish-sponsored Columbus expedition ‘discovered’ the ‘New World’ in 1492, Spanish and Portuguese monarchs – abetted by a series of Papal bulls – arrogantly divided control of the world and embarked upon a brutal land grab.

The English and Dutch challenged Iberian dominance in the seventeenth century, extending European commercial, political and military power even further. The Westphalian system of nation-states emerged around this time, setting national boundaries and asserting sovereignty within Europe, even as European powers were violently staking territorial claims across the world. Subsequently, France, Belgium, Italy, Germany and others became colonial overlords, with Russia, Japan and the United States among the last to enter the imperial fray in the late nineteenth century.

The era of imperialism, roughly spanning the late fifteenth to the mid twentieth centuries, spawned multiple ‘health concerns across place’, leading colonial offices, military authorities and missionary organizations to fashion an uneven precursor to the modern system of international health. Conquest itself bequeathed dire health consequences, which accompanied every phase and locale of imperial expansion, centuries before industrialization’s urban misery put public health on domestic political agendas. Most infamously, smallpox is believed to have been spread intentionally throughout meso-America via distribution of infected blankets by Spanish conquistador Hernán Cortés’s soldiers. Yet mortality from forced labour was likely far higher. All told, between one-third and one-half of indigenous inhabitants were killed in the late fifteenth and early sixteenth centuries by the military, economic and social aspects of the conquest (Berlinguer 1992; Crosby 1993; McCaa 1995; Cook 1998).

Throughout the colonial period and beyond, disease and death were rife among subjugated populations, owing to a variety of factors: conflict; bondage and indentured servitude; dangerous work in mines, construction and plantations; dispossession from land, cultural heritage, community and livelihood; corporal punishment; crowded living conditions with attendant respiratory and gastrointestinal diseases; famines and food shortages; trade and travel; and ecological
alterations, including swamp-filling, canal and later railroad construction and forest exploitation, which created breeding sites for malarial mosquitoes. Colonists also suffered widely from infectious diseases, but occupational mortality and early death among Mestizo labourers, African slaves and indigenous groups, combined with staggeringly high infant mortality rates, meant that these groups on average lived far shorter and sicklier lives than Iberian elites (Crosby 1972; Kiple 1989; Gaspar and Hine 1996; Florentino and de Góes 1999).

While pre-Columbian societies in meso-America also experienced high death rates from violence, occasional famine and infectious diseases (Alchon 2003), the conquest stood out because of the magnitude of death as well as the enormous mortality differential between invaders and invaded. Spanish conquistadores used this differential to military and cultural advantage, trumpeting the presumed constitutional superiority of the invaders (now understood to have been immune due to previous exposure to microorganisms). In subsequent centuries, corresponding devastation was wrought by other European invasions and occupations across North America, Africa, Asia and the Pacific.

Medical practitioners, initially hired to protect military forces, joined the colonial ventures. As region after region came under European control, physicians began to be integrated into colonial authority structures, treating colonists, setting rules for medical practice and, sometimes in competition with the viceroy and Church, implementing emergency measures during epidemics (Lanning 1985; Hernández Sáenz 1997). By the eighteenth century, medicine and public health were established as major ingredients in the colonization of peoples around the world, far more nefarious activities than their sometime portrayal as the humanitarian component of military and political ventures. Indeed, the ‘assumption that imperialism, whatever its other faults, at least led to an improvement in the health of the indigenous populations’ (Farley 1988, 189) belies the intent of colonial public health measures: to protect the well-being of the imperial military; to make ‘the tropics’ habitable by European settlers; to improve the productivity of local workers; to subjugate conquered populations; and to reinforce the political and social stratification between colonizer and colonized (MacLeod and Lewis 1988; Bashford 2004).

**Slavery and the (ill) health of the tropics**

Labour was central to the imperial project. With indigenous populations wiped out by conquest or deemed ‘unfit’ for labour, colonial production in the Americas and beyond came to rely on voluntary migrants and European indentured servants and convicts. But these groups were hard to check in vast territories and too limited in numbers to meet production demands. Britain eventually became adept at transferring forced labourers from one part of its empire to another, explaining the large populations of Indian ancestry in places as distinct as Trinidad, Fiji and South Africa. Before this, as of the sixteenth century, the expanding colonial system relied on the capture, transport, trade, sale and condemnation to slavery of millions
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of human beings. Slavery was not a new phenomenon – Italian city-states, for example, relied on slaves to fill labour shortages following plague epidemics – but it had never before been practiced on a worldwide scale or in such a racist manner. Europeans targeted Africans as the source of slave labour due to a combination of factors: dark skin colour that facilitated control and vigilance over escapees; European perceptions of Africans’ physical suitability to tropical climates, where most agricultural labour was needed (on plantations growing coffee, cotton, rice, sugar, tobacco and so on); and the relative ease of capturing slaves in Africa.

The Atlantic slave trade between Africa and the Americas accounted for the bulk of traffic, following a triangular route whereby slaves were traded for sugar, indigo, tobacco and other cash crops in the Caribbean, brought to Dutch, Portuguese, French and British ports in exchange for textiles, arms, alcohol and metals, which were in turn sold or bartered for slaves in West African ports. Enormous profits were made at each stop. Between 1502 and 1870, an estimated 11.4 million Africans were captured, shipped and forced into bondage. Between 8 and 10 million were sent to Brazil and the Caribbean with another 1 million to the United States and Spanish South America. Some 12 to 15 per cent of those captured died in the ‘middle passage’ before reaching American shores (Curtin 1968). For the survivors, slave life expectancy in the United States before the Civil War was 21 years, approximately half that of whites. This was largely due to astronomical rates of infant mortality: half of all babies born into slavery died before turning one year old, compared to one-fourth of non-slave infants. For those slaves who survived into adulthood, few lived past 50. Slaves in Brazil, the Caribbean and elsewhere faced similar conditions (Postell 1951; Campbell 1984; Amantino 2007).

As long as profits were being made, imperial authorities paid limited attention to the health of slaves and other labourers. By the 1800s, as colonialism expanded into Asia and Africa and profiteering and production accelerated, health concerns demanded more than intermittent attention. Diseases spread via ship (such as yellow fever) and parasitic diseases associated with the tropical climates of many colonies (for example, malaria, trypanosomiasis and leishmaniasis) all raised alarm as threats to trade, European invaders and settlers, and labour productivity. Calling a part of the globe ‘the tropics’ also became a way for imperial powers to define something culturally alien to, environmentally distinct from, and even threatening to Europe and the other temperate regions (Arnold 1997; Harrison 1999). The arena of tropical medicine emerged to address health in the colonies. Most famous, perhaps, were discoveries regarding the etiology, parasitic life-cycle, vector and transmission patterns of malaria (Packard 2007) in which French, Italian, British and South American scientists, medical officers, and local assistants (most of whose contributions went unrecognized) in colonial Algeria, Formosa and India, as well as Italy, Brazil and Argentina, participated.

The ‘invention’ of the tropics and of tropical medicine also shaped a series of racialized explanations regarding underdevelopment, susceptibility to disease and suitability for work (Gorgas 1909; Arnold 1996; Harrison 1996; Peard 1999; Deacon 2000; De Barros, Palmer and Wright 2009). Acclimatization arguments inevitably favoured the colonizer – whether providing an explanation of why so many
Europeans perished in their initial encounters with hot climes despite supposed racial superiority; rationalizing the use of ‘brown labour’ that could better tolerate hot, humid weather; or justifying the exploitation of regions and peoples deemed unable to escape their medico-geographic state of underdevelopment. Colonizers’ belief in the ‘civilizing’ effects of medicine upon native peoples, their adherence to the notion that infectious diseases originated in the ‘primitive and dangerous world’ of the tropics, their fascination with questions of acclimatization and racial difference (Lorcin 1999), and the hiding of diseased settlers in order to perpetuate the myth that Europeans possessed superior immunity all attest to the centrality of health matters to imperial power.

**Industrialization and the Emergence of Modern Public Health**

At the height of the imperial grab for colonies in the eighteenth and nineteenth centuries, European countries began to undergo a massive transformation from largely agrarian societies into urbanized capitalist industrial economies. This transformation was largely financed by the riches amassed – and fuelled by the raw materials extracted – through colonial exploits.

The transition from feudalism to capitalism entailed vast social and demographic shifts, fundamentally altering the way people lived and died. Between 1750 and 1900 the human population doubled from about 800 million to 1.7 billion, following centuries of stagnating and sometimes falling populations in times of food shortages. The feudal era’s social divisions among monarchs and noblemen, a small artisan class and the vast peasantry were displaced by new classes of merchants and industrialists (the bourgeoisie) and urban industrial workers (the proletariat) under a capitalist economic system.

The term ‘industrial revolution’ denotes the period from about 1750 to 1850 during which factories and power-driven machinery were first employed for the mass production of commercial goods (based on developments in engineering and chemistry), and unprecedented volumes of raw materials and consumer goods crisscrossed the world. Advances in science and technology both contributed to capitalist industrialization and, particularly, were stimulated by it. The textile industry played an early role in industrializing northern Europe. Textile machinery initially relied on water power, restricting the placement of mills, but after James Watt’s invention of the steam engine in 1781, factories could be located at almost any site, limited only by supplies of labour, coal and materials. The need for factory workers produced a whole new category of wage labourers drawn from landless farmers, impoverished apprentices and destitute women and children. With a seemingly unlimited supply of workers, most factory owners displayed utter indifference to their welfare, comparable to attitudes of slave traders. Safety measures were minimal and small children, sometimes literally chained to the
machines, toiled from dawn to dusk in dusty, noisy, unheated and unventilated workrooms.

The new factories generated enormous wealth for their owners, who bought raw materials at rock bottom prices from the countryside and colonies and paid the lowest wages they could get away with, even as they invested heavily in changing technology. It would take over a century of struggle before workers would be protected by welfare states through economic security, workplace safety and social services.

Sanitary reform

In the first half of the nineteenth century, industrial cities were bursting at their seams, with populations doubling, tripling or more within a generation. Labourers flocked to factory towns from the countryside, unable to survive as pastoralists after new laws banned collective farming. Urban housing was built as quickly and cheaply as possible, packing dozens of people into windowless rooms. City planning was non-existent and sanitation neglected. The smoke from innumerable factories and coal fires filled the air and blackened buildings and lungs alike. Despite some improvements in agricultural output, nutrition was poor. Rickets became common in children rarely exposed to sunshine, and contagious diseases such as tuberculosis, diphtheria, typhus and diarrhoea took a great toll. Occupational injuries and deaths were common, as were diseases arising from unrestricted industrial use of lead, mercury, phosphorus and other toxic substances.

Workers began to organize collective efforts to better their conditions, joined by certain middle-class social reformers who were outraged at the shocking conditions in city slums, factories and mines. These efforts faced formidable foes in industrial owners and their political partners, but by the mid-nineteenth century, the resistance of moneyed interests to sanitary reform was no longer tenable.

The movement for sanitary reform in Britain engendered heated debates, featuring most prominently Edwin Chadwick and Friedrich Engels. Chadwick, a lawyer and lifetime civil servant who had authored the Poor Law of 1834, which drove the growth of the industrial workforce by compelling the destitute to enter urban ‘hellhole’ workhouses instead of receiving welfare assistance in their home parishes, then turned to preventing illness (as a means of reducing welfare expenditures) in his report on the health of the working class (Chadwick 1842; Hamlin 1998). Chadwick’s belief in the miasmatic origins of disease – putrid air arising from festering filth – shaped his zeal for clean water, sewage and public sanitation, measures which he believed would prevent most diseases and poverty. However, he rejected improved working conditions, wages and food as remedies for pauperism. The notion that poverty itself was the cause of illness was, for Chadwick, unthinkable.

Friedrich Engels, the son of a wealthy German manufacturer sent to manage a factory in Manchester, likewise examined the living and occupational conditions of industrial workers (Engels 1845). With a fundamentally distinct explanatory
framework, Engels attributed the cause of misery and ill health to the exploitation of the industrial working class under the capitalist economic system. Moreover, he believed political action was necessary to redress these conditions (Waitzkin 2005). In 1848, Engels joined with Karl Marx to issue *The Communist Manifesto*, calling for the revolutionary overthrow of the exploitative capitalist system. Across Europe and throughout the world, an unfurling of social movements, culminating in a series of 1848 uprisings across the world, showed widespread resistance to the industrial revolution, to imperialism and to the concentration of wealth and power and the oppression that they generated (Krieger and Birn 1998; Rapport 2008).

While Britain did not undergo a communist revolution, a combination of sanitary (later public health) reforms and militant class struggles from the mid-nineteenth to early twentieth century resulted in marked improvements in social conditions, moderate income redistribution and increases in life expectancy, although intractable social inequalities in health remained (Wohl 1983; Szreter 1988; Harris 2004).

The appalling conditions in England were shared across industrializing societies, but distinct political contexts, traditions, institutional cultures, historical trajectories, configurations of class power and geo-epidemiological conditions affected the development of public health in different countries (Porter 1994; Baldwin 1999). Germany’s commitment to aggressive public health policies, such as compulsory vaccination and quarantines, was rooted in the need to fend off epidemics from the East, as well as to fashion a domestic politics of power – in large part to stabilize worker unrest – in a state that was late to form (Evans 1987; Weindling 1994). In the Soviet Union public health was centralized from above, with local level medical societies and health initiatives abolished after the 1917 Revolution (Solomon and Hutchinson 1990). Britain’s more laissez-faire approach drew from a long history of local and voluntary governance and a belief that its island geography protected it against epidemics (Hardy 1993; Porter 1999). In China, the political fragmentation following the 1911 Revolution meant public health problems received only isolated and disorganized attention (Yip 1995).

In most Latin American countries, now independent, the sanitary authorities that had periodically mobilized to combat epidemic outbreaks during almost four centuries of Spanish and Portuguese colonialism were transformed into permanent health and hygiene boards and departments beginning in the late nineteenth century. Hampered by limited state capacity, they catered mainly to urban elites (Alvarez 1999; Armus 2002; Armus 2003; Palmer 2003; Hochman and Armus 2004; Quevedo 2004). In the United States, public health responsibility, other than for immigration and border control, remained largely decentralized until the Great Depression (Fee 1994), encouraging the involvement of the private sector, including insurance companies and foundations.

These varied developments were undergirded by the increasing scientific and technical potential of public health and medicine. Spawned by the germ theory of disease transmission, and the bacteriological and parasitological findings by the likes of Louis Pasteur, Robert Koch, Carlos Finlay and Patrick Manson, public health’s new capacity included laboratory-based verification of disease and a small
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but growing armamentarium of disease-control measures, such as diphtheria antitoxin deriving from work by Emile Roux, Emil von Behring and others. The bacteriological revolution’s influential explanatory framework and accompanying interventions began to displace public health’s environmentally oriented activities. The ‘new’ public health thus found itself at the vortex of clashing constituencies – scientific experts striving to assert their status, reformers seeking to improve the social order, liberal industrialists eager for steady economic growth and bureaucrats looking to increase their purview, as well as socialists, feminists and labourites fighting for better working and living conditions.

In colonial settings, these measures were not systematically applied outside colonists’ enclaves and sites of commercial importance; only in ‘model’ colonies, such as Ceylon (Jones 2004), did the new public health lead to significant reforms. Even so, developments in metropolitan public health generated ideas, legislation and practices influenced debates and schemes that would emerge in a new domain, ‘international health,’ which would have great bearing on public health policies across the world.

The Making of International Health

By the early nineteenth century, intense commercial competition between empires (and mounting intra-imperial health concerns) heightened the threat of epidemic disease throughout the world, as the political and epidemiological implications of colonial health problems began to be understood in new ways: for their impact on trade, profits and denizens of ‘mother’ countries.

Even as individual imperial powers undertook incipient efforts to carry out surveillance and control disease outbreaks, the scale of interchange between, among and beyond empires demanded cooperation and communication. A confluence of factors brought epidemic fears to the fore circa 1850: (a) large-scale immigration from Europe and Asia to the Americas, itself spurred by social unrest, particularly around the 1848 social uprisings deriving from industrialization, political disenfranchisement and their health and social effects; and (b) the explosion of materials extraction, manufacturing, circulation and marketing of goods in turn enabled by a revolution in transportation (steamships and railroads) and transport routes, such as the completion of the Suez Canal in 1868. Together these heightened the threat of disease throughout the world, not just between colony and ‘mother country’. The now globalized commercial system meant that a real or threatened epidemic in one part of the world could impede production, trade and consumption elsewhere, and on a fast timetable (Saralegui 1958; Goodman 1971; Howard-Jones 1975; Chandavarkar 1992; Bynum 1993; Fidler 2001; Ronzón 2004; Stern and Markel 2004). A new global economic interdependence magnified the potential dangers of disease and made its control a far more politically complicated matter.
The Americas first

In the Americas, absent the age-old rivalries of European societies, international sanitary cooperation was less contested than elsewhere and the United States, commercially ambitious and politically and economically powerful in Latin America, was strongly motivated to provide regional leadership. Under the Monroe Doctrine of 1823, the United States had occupied ports and countries across the region whenever it sensed its interests were threatened. Moreover, as the world’s foremost immigration destination between 1890 and 1920, the United States also became a potential importer of transmissible disease. In the late 1870s, the US Marine Hospital Service started publishing epidemic outbreak news from a worldwide network of informants in weekly bulletins. An 1893 US Presidential Act obliged all immigrants and cargo ships to present certificates of health signed by the US consul and a medical officer in the departing port, and the Marine Hospital Service (later the US Public Health Service) stationed personnel in key ports in the United States (most famously Ellis Island in New York) and around the world to inspect ships and passengers for disease and to enforce quarantine (Birn 1997).

These concerns intensified when the United States acquired colonies in the Caribbean and the Pacific after its 1898 war with Spain (Anderson 2006). US forces invading Cuba had suffered disastrous troop losses from yellow fever and other infectious diseases. Like other colonial powers, the United States began to take on public health activities both to protect its troops and colonists from ‘tropical’ diseases and to prevent yellow fever from reaching US ports aboard merchant ships (Cirillo 2004; Espinosa 2009). But it was the construction of the Panama Canal that decisively alerted the United States to the importance of international health. Though the building of the Canal hinged upon malaria and yellow fever control, its very completion ironically raised the peril of new epidemics due to shorter shipping routes to and from Asia.

Commercial concerns had long affected political relations among South American countries. The meat and hide economies of Argentina and Uruguay were intent on keeping out yellow fever from Brazil, which might interrupt their profitable exports. An 1887 Sanitary Convention signed by Brazil, Argentina and Uruguay detailed quarantine periods for ships harbouring cholera, yellow fever and plague and was in effect for five years before breaking apart. The following year the Andean countries of Bolivia, Chile, Ecuador and Peru signed the Lima Convention of 1888 (Moll 1940), but these efforts were circumscribed and short-lived due to mutual mistrust and poor enforcement.

In December 1902, representatives of seven American governments met at an International Sanitary Convention in Washington, DC, at the behest of the Conference of American States. Together, they founded the International Sanitary Bureau, which became the Pan American Sanitary Bureau (PASB) in 1923 and the Pan American Health Organization in 1958 (Bustamante 1952). The United States was the prime mover behind the founding of this first international health organization, which was initially run out of the US Public Health Service and headed until 1947 by a succession of United States Surgeon-Generals.
Most Latin American republics soon joined the Bureau and were represented at its quadrennial conferences. The United States was especially interested in having Latin American countries participate in the drafting of, and thus comply with, enforceable sanitary treaties. The PASB’s early years were devoted to the establishment of region-wide protocols on the reporting and control of epidemic diseases, including yellow fever, plague and cholera, culminating in a 1924 Sanitary Code, the first Pan American treaty of any kind to be signed by all 21 member countries.

In its leadership and activities, the Bureau reflected US economic interests in Latin American oil, fruticulture, mining and metallurgy, real estate, railroads, banking and other industries. Yet even as its agenda remained focused on sanitary and commercial matters into the 1930s, the Bureau began to engage in other activities, sponsoring a widely disseminated public health journal; addressing – after being pushed by Latin American members – maternal and child health concerns; and organizing an incipient system of technical cooperation to support healthcare systems organization, vital statistics collection and a variety of public health measures (Birn 2002; Cueto 2004). After World War II, the PASB would officially become the Americas Office of the World Health Organization.

**Health Cooperation in and beyond Europe: The Long Journey from Meetings to Measures**

Notwithstanding fierce imperial rivalries and ongoing wars, Europeans realized, at least in principle, the importance of meeting to resolve mutual problems. The 1814–15 Congress of Vienna sought to chart a post-Napoleonic peace and was the first effort to negotiate treaties face to face, rather than through emissaries and missives. But mutual agreement would be a tortuous process in health and (other) political arenas.

Well before the yellow fever problem had served as the impetus for the organization of the PASB, another ailment had emerged as a worldwide menace, shaping an even larger effort. Cholera had been endemic for centuries in the Ganges River basin, but in 1818 it spread to Southeast Asia, China, Japan, East Africa, the eastern Mediterranean (Syria and Palestine) and southern Russia. Less than a decade later, another wave swept through Russia, where hundreds of thousands died, and into the major cities of Europe by 1831.

Cholera’s emergence in Europe was intimately tied to industrialization – the acceleration of trade, together with the urban squalor accompanying urban life, facilitated its spread and increased its severity (Evans 1987). Within a year, transatlantic ships brought this terrifying disease to New York, New Orleans, Montreal and other ports. It spread to the North American interior, reaching the Pacific Coast and Mexico in 1833. The Middle East was not spared, and Muslim pilgrims returning from the Hajj in Mecca were blamed for carrying cholera to
Egypt and the countries of northern Africa. In 1882 the Ottoman Empire set up a quarantine station in the Red Sea (which lasted until 1956) specifically to prevent spread of infectious diseases through the Hajj. In 1854, English physician John Snow had deduced that cholera was transmitted through contaminated water (though without contemplating the class and social dimensions of transmission patterns); the same year Italian researcher Filippo Pacini identified *cholera vibrio* in the stools and intestines of cholera patients and cited it as the cause of the illness. Thirty years later, German bacteriologist Robert Koch, in imperial service, showed that cholera in Calcutta was caused by the same organism.

Indeed, as alluded to above, a flood of discoveries emanated from the world’s laboratories in the latter half of the nineteenth century, identifying the causal agent and basic means of transmission of almost every major bacterial and parasitic disease of humans and domestic animals. From roughly 1850 to 1910, theories of miasma and vague conceptions of communicability of disease gave way to experimentally based laboratory data regarding the genesis of infectious disease and its effects upon the body. New knowledge and techniques fostered and were fostered by extensive institutional developments that served both imperial and industrial needs. The Pasteur Institute was founded in the late 1880s with an outpouring of funds donated by a citizenry anxious to help in the development of Louis Pasteur’s anti-rabies vaccine. The Institute quickly flourished in the research and teaching realms. Starting in Saigon (now Ho Chi Minh City) in 1891, Pasteur Institutes were also established in several dozen countries in France’s colonial empire in Africa, Asia and the Caribbean, as well as in Europe and the Middle East (Moulin 1996; Pelis 2006). In these outlying laboratories, pioneering work was done on plague by Alexandre Yersin, on malaria by Charles Laveran and on the Bacille Calmette-Guérin (BCG) by Albert Calmette.

Simultaneously, international conferences in virtually every scholarly and professional domain marked the rise of an international exchange of ideas, standards, challenges and breakthroughs. For example, in 1851 alone, the ‘Great Exhibition’ of London (the first World’s Fair) celebrated trade and manufacturing, and the First International Congress on Statistics was held in Brussels, followed by a demography and hygiene congress in 1852, and congresses on ophthalmology in 1857, veterinary medicine in 1863 and so on. During the same era, the first international non-governmental agency, the International Red Cross, was founded by Jean-Henri Dunant, a Swiss national moved by his witnessing of the terrible suffering of war victims in the Battle of Solferino. The founding document of the Red Cross, which promoted neutral humanitarian assistance to wounded combatants and entered into force in 1865, became known as the original Geneva Convention. Notwithstanding its charitable mission, the original Red Cross became allied with—and even justified—militarism and state power, ‘render[ing] war more easy’ in Florence Nightingale’s words (Hutchinson 1996).

The rise of internationalism among professionals did not inevitably lead to international cooperation in health matters. Moreover, as attested to by the rise of international journals and the exchange of correspondence in this period, professional interactions sometimes tested the dual loyalties of scientists (to their
disciplines and their countries). Still, by the mid-1800s, the repeated pandemics of cholera compelled governments to develop some sort of international agreement to prevent spread of the disease. The *cordon sanitaire*, enforced by quarantine regulations and even military force, had existed since the fourteenth century, but as international commerce grew, such blockades were increasingly seen by maritime nations as obstacles to trade.

Accordingly, an International Sanitary Conference was organized in Paris in 1851 involving 12 states: Austria, France, Great Britain, Greece, the Papal States, Portugal, Russia, Sardinia, Spain, Tuscany and the Two Sicilies. At this six-month long meeting, learned representatives could not agree on whether cholera was contagious or not. The meeting eventually produced a lengthy convention dealing mainly with the quarantine of ships against plague, cholera and yellow fever. Only France, Portugal and Sardinia ratified the document, whereupon the latter two revoked their acceptance. A similar convention, generated by the second (1859) conference, went unratified.

The early conferences ended in frustration partly because participating countries were represented by diplomats defending commercial interests rather than by scientists. But even among scientists there was no consensus concerning the causes and transmission of the diseases in question. A third conference, held in Constantinople in 1866, reviewed voluminous evidence regarding the cause of cholera, including the works of Snow and German hygienist Max von Pettenkofer, and concluded that the disease was transmitted through what we would today call the ‘fecal-oral’ route. At the fourth International Sanitary Conference in Vienna (1874) a proposal was made to establish a permanent International Commission on Epidemics, but was rejected (Howard-Jones 1975; Bynum 1993). Altogether 11 conferences were held over more than 50 years before agreement was reached to establish an international health organization.

Britain remained opposed to any form of regulation of its extensive trade, ready to condemn the Hajj for the 1865 cholera pandemic (Afkhami 1999), but refusing to implicate British trade routes. The British government went so far as to reverse its quarantine and isolation policies in India before the opening of the Suez Canal, 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). Britain’s refusal to endorse cholera conventions stemmed from more than commercial self-interest: it had its own system of ‘intercolonial’ (de facto international) health structures of information-gathering, research and conferences, essentially precluding the need for participation in a supranational effort with potential rivals (Maglen 2002). The United States’s first involvement in the International Sanitary Conferences was its hosting, on its own initiative, of the fifth conference in 1881. With the participation of seven Latin American countries plus China, Japan, Liberia and the usual Europeans, the conference aimed to obtain international approval for the US’s 1879 law to inspect and regulate vessels en route to the United States to prevent ‘the introduction of contagious or infectious diseases from foreign countries’. While some delegates expressed interest in a system of disease
notification, the US proposal was struck down. Like Britain and Mexico, the United States proceeded to develop a system of epidemic informants on its own.

The sanitary conferences took on greater urgency in the 1890s: punctuated by new cholera pandemics, they 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).

At long last, the 1903 agreement led to a 1907 conference in Rome that set up l’Office International d’Hygiène Publique (OIHP). Opening its doors in Paris in 1909, the OIHP was charged with collecting and disseminating public health information (especially relating to cholera, plague and yellow fever) among participating countries, overseeing sanitary treaties and sharing ‘measures to combat these diseases’ (Rome Agreement Establishing the Office International d’Hygiène Publique, 9 December, 1907). Its original 23 European members subsequently expanded to almost 60, including participants from the Americas and Asia.

A formal internationalism in health had finally been established. The OIHP, with a staff of barely half a dozen people, worked diligently but could hardly keep up with its stated mission. Nevertheless, progress was made – for example, in research on the most effective methods of ship crew and passenger inspection, the de-ratting of ships, an international agreement to control sexually transmitted diseases in seamen, standardization of some biological products and a study of hospital organization.

But just as health professionals had begun to collaborate across borders, Europe’s uneasy peace was unravelling amidst growing militarism, nationalism and imperialist territorial and commercial rivalries. The OIHP’s permanent committee representing each of the member states did not meet at all during the World War I years of 1914–18, and the OIHP was impotent in the face of outbreaks of diseases such as typhus, which infected millions of people amidst the deprivation of war-torn Europe. Even more dramatically, the great influenza epidemic of 1918–19 killed an estimated 50–100 million people worldwide, almost half of whom were already suffering from famine in Assam and elsewhere in colonial India. War conditions starkly revealed the limits to international cooperation. Only Spain, which was not a party to the war, notified international authorities about the influenza outbreak, leading to the misnomer ‘Spanish influenza’. The OIHP could not intervene to decry or address the pandemic, and war secrecy impeded early and effective communication regarding the outbreak and spread of influenza among troops, including the half million US soldiers who were mobilized precisely as the epidemic was unfolding, undoubtedly exacerbating it.

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3 The International Classification of Diseases devised by Parisian statistician-bureaucrat Jacques Bertillon and adopted by dozens of countries in 1901 (first revision) was an exception to the pattern of international health cooperation failure.
The Rockefeller Foundation and the Making of International Health

Even as Europe’s diplomatic crisis was threatening incipient internationalism, another development was afoot in the United States. With bureaucratization, standardization, epidemic disease control and the safeguarding of trade beginning to be addressed through nascent multi-lateral institutions, international health entered a new phase, one that combined tropical medicine concerns with on-the-ground cooperation among metropolitan powers, in particular linking industrialized and underdeveloped settings. In addition to controlling disease outbreaks, cooperation offered: the potential to stimulate development and economic growth; stabilize colonies and emerging nation-states by helping them meet the social demands of their populations; improve diplomatic relations; expand consumer markets; and encourage the transfer and internationalizing of scientific, bureaucratic and cultural values. At the same time, local elites – through participation in international health activities – could be linked to the world’s great powers. International health thus proffered the promise of generating goodwill and economic development in place of gunboat diplomacy and colonial repression, all the while supporting the expansion of global capitalism.

At this time a novel kind of player, the Rockefeller Foundation (RF), emerged on the international health scene as part of a new American movement – ‘scientific philanthropy’. The RF virtually single-handedly popularized the concept of international health, and was the major influence upon the field’s twentieth century agenda, approaches and actions. Heeding rags-to-riches steel magnate Andrew Carnegie’s call for the wealthy to channel their riches to the good of society by supporting systematic social improvements rather than charity, the RF was founded in 1913 by oil mogul John D. Rockefeller ‘to promote the well-being of mankind throughout the world’. Rockefeller, his business and philanthropic consigliere Frederick Gates (a Baptist minister), and John D. Rockefeller Junior built upon Carnegie’s ideas, expanding from hospital, church and university donations to fund medical research and large-scale campaigns aimed at social melioration.

Public health became the ideal vehicle through which Rockefeller philanthropy could apply scientific findings to the public good. After uncovering the important part played by hookworm disease in the economic ‘backwardness’ of the US South – and the possibilities of public health campaigns to eliminate the disease through an anti-helminthic drug and public health ‘propaganda’ – the RF soon created an International Health Board, reorganized as the International Health Division (IHD) in 1927. The IHD befriended dozens of governments around the world by helping

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4 Philanthropists partially succeeded in staving off the US welfare state: compared to European and many Latin American countries, the private and philanthropic sectors have had since the early twentieth century a far greater role in the provision of social welfare – both limiting the size of the welfare state and giving private interests undemocratic purview over social welfare.
modernize their health institutions, promoting the importance of public health among countless populations and preparing vast regions for investment and increased productivity. By the time of its dismantling in 1951, the IHD had spent the equivalent of billions of dollars carrying out scores of hookworm, yellow fever and malaria campaigns, as well as: efforts to control tuberculosis, yaws, rabies, influenza, schistosomiasis, malnutrition and other health problems in more than 90 countries and colonies around the globe; the sponsorship of some 2,500 fellows to pursue graduate study in public health, mostly in the United States; and the founding of 25 schools of public health in North America and across the world (Fee 1987; Cueto 1994; Farley 2004).

With field officers in virtually every setting where it operated, the RF could rely on a well-honed bureaucracy to infuse – often in the face of resistance and refashioning – its particular ideas and approaches into local efforts to institutionalize public health (Birn 2006) even as each campaign became a new experiment in international health (Palmer 2010). Perhaps the greatest success attributed to the IHD was yellow fever control, involving: (a) extensive campaigns across Latin America to reduce the presence of the *Aedes aegypti* mosquito vector through use of insecticides, drainage and larvicidal fish; and (b) the development of the Nobel-prize winning 17D yellow fever vaccine in 1936, which showcased American scientific expertise to European rivals. While yellow fever campaigns ended costly commercial interruptions, the disease was, ironically, of minor epidemiological concern in Latin America, where even during epidemics, it felled a relatively small number of people, mostly newcomers.

The RF also claimed credit for eradicating malaria: in the 1930s, the introduced African mosquito *Anopheles gambiae* was responsible for an immense outbreak of malignant tertian malaria in Brazil, with more than 100,000 cases and 14,000 deaths in 1938 alone. RF efforts, supported by Brazilian nation-building strongman President Getulio Vargas, eventually eradicated *A. gambiae* from Brazil after years of larval control, demonstrating the possibility of vector eradication in the case of introduced species, or on islands, as in Sardinia (Packard and Gadelha 1994; Löwy 2001; Stapleton 2004).

While the RF was involved in country-by-country activities it was also mapping, directly and indirectly, international health’s institutional framework. Its activities and organization provided the groundwork for a new international health system featuring its own bureaucracy, legitimacy, and mode of conduct. Indeed, the IHD identified its most successful contribution to be ‘aid to official public health organizations in the development of administrative measures suited to local customs, needs, traditions, and conditions’ (League of Nations Health Organization 1927, 743). Thus, while highly influential in shaping the enduring *modus operandi* of international health through technically based disease campaigns and transnational public health training, the RF’s self-defined mark of success was its role in generating political and popular support for public health, in the creation of national public health departments across the world, and in its support for the institutionalization of international health.
The new international health, as pioneered by the RF, was neither narrowly self-interested nor passively diffusionist. Instead, the RF actively sought national partnerships to spread its public health gospel via interaction with political and professional authorities and local populations. The RF’s philanthropic status, its purported independence from both government and business interests, and its limited accountability enabled its success. Its work patterns included rapid demonstrations of specific disease-control methods based on proven techniques, a missionary zeal in its own officers, marshalling national commitment to public health through considerable co-financing obligations and using fellowships to mould a cadre of public health leaders. It also carefully avoided disease campaigns that might be costly, overly complex, time consuming or distracting to its technically oriented public health model (Birn 2006). Other US philanthropies, such as the Milbank and Commonwealth Funds, Kellogg and Ford Foundations and, more recently, the Bill & Melinda Gates Foundation entered the international health arena, but none have come close to the RF’s purview over the field’s ideologies, institutions and practices.

International Health Institution-Building: The Inter-War Years

The Great War (WWI) and the Russian Civil War devastated much of Europe, even as new hopes for a more just world emerged from the ashes. Institution-building took two key forms: first, the establishment of international institutions that played a strategic role in planning and marshalling expertise to address world health problems, and second, the cultivation of a cooperative spirit that began to make health an international priority.

A 1920 London conference recommended that the OIHP be absorbed by the health section of the newly created League of Nations (based in Geneva), but this plan was aborted by the United States (which was an OIHP member but declined to join the League of Nations) and France (which preferred to retain the Paris-based OIHP). Nevertheless a health section of the League of Nations was permanently established in 1923, building upon a successful post-war Epidemic Commission formed to control outbreaks of typhus, cholera, smallpox and other diseases in eastern and southern Europe. With minimal official US participation, the League of Nations Health Organization (LNHO) convened health experts and institutionalized international health, providing a collective response initially to Europe’s public health needs, eventually expanding its mission and reaching southwards, eastwards and westwards (Balinska 1995; Weindling 1995a).

The LNHO played a vital coordinating function for an array of activities far beyond disease control, its wide charter allowing opportunistic social activism under Polish hygienist Ludwik Rajchman’s widely recognized leadership (Borowy 2009). Where there had been none just 20 years before, now three official international health organizations operated more or less separately: the PASB in Washington, DC, the OIHP in Paris and the LNHO in Geneva.
War and its aftermath led to further proliferation and fracturing of international health institutions. In 1919 Henry Davison, head of the wartime council of the American Red Cross, orchestrated the establishment of the League of Red Cross Societies (LRCS) as a federation of the national societies that had attracted thousands of committed volunteers during wartime. He envisioned the League as a truly international agency that would spearhead peacetime international humanitarian cooperation to combat epidemic disease and war-induced destitution, transcending the International Red Cross’s war focus and the lack of cooperation among national societies, and modelling itself after the new League of Nations. While the LRCS soon became involved in nursing education, first aid, disaster relief, community health and youth training, Davison’s dreams for a US-led coordinating international health and humanitarian agency were triply dashed by the US’s failure to join the League of Nations, an overshadowing by the LNHO, and ongoing feuds with the International Red Cross (Hutchinson 1996).

The issue of responsibility for the health aspects of worker welfare also produced certain tensions. The International Labour Office (ILO) was founded in 1919 to protect workers and promote peace through social justice efforts. Charged by the Treaty of Versailles with guiding occupational health standards and the prevention of worker sickness, it expediently pulled back from involvement in medical matters after the LNHO’s founding. Later, the ILO and LNHO heightened joint work, after Rajchman became more politically vocal and the onset of the Depression demanded greater coordination between the two agencies (Weindling 1995b).

A set of international initiatives and agencies focused on children’s health and well-being also emerged in this period. In 1919 English social activist, socialite and teacher Eglantyne Jebb established the war relief agency ‘Save the Children’ to feed and rescue children in war-torn Germany and Austria. By 1921 she established the Save the Children International Union in Geneva to extend rescue efforts to children suffering from famine in Russia and elsewhere. Meantime a rival organization, the International Association for the Protection of Child Welfare, was founded in 1921 in Brussels. In 1924, Jebb was able to get the League of Nations Assembly to adopt her ‘Declaration of the Rights of the Child’ and to establish a child welfare committee to oversee a range of social questions relating to child protection (Marshall 1999). In 1927 the International American Institute for the Protection of Childhood in Montevideo was established with the LNHO’s support as a policy and practice clearinghouse and beacon for the Pan American Child (movement and) Congresses, which had been meeting in Latin America since 1916. The Institute would give Uruguay a worldwide platform for its child rights approach to children’s health in the 1930s (Birn 2005).

Even with the competing efforts and overlapping missions of these and other agencies, the LNHO became a fulcrum for international health policy in the interwar years. Rajchman’s particular interest in child health, for example, led the LNHO to carry out a series of international comparisons of the social causes of infant mortality, and motivated him to help establish UNICEF after WWII. By the late 1920s Rajchman and the LNHO were drawing on social medicine precepts that called for the political and structural underpinnings of health to be addressed
Health on the Modern Global/International Agenda

(Weindling 1995b; Zylberman 2004; Borowy 2007; Borowy and Hardy 2008) – from living and working conditions to political representation – part of the scientific basis for public health action.

The LNHO’s multi-national staff and advisors pursued an ambitious agenda of epidemiologic surveillance, expert scientific research, standardization and interchange of health personnel. Its activities were far broader and more ambitious than the quarantine mandates of previous decades. In matters of outbreaks and gathering epidemiological information, the office collaborated with the OIHP. It pioneered the collection, standardization and dissemination of vital and health statistics from around the world. In 1926 the LNHO started publication of the Weekly Epidemiological Record, which has been continued to the present day by the World Health Organization. It also organized a branch in Singapore in 1925 to gather information on health conditions in Asia, and it held conferences around the world. Communication was carried out by (sea) mail, telegrams and, where possible, by telephone or two-way radio. Obtaining timely information about disease outbreaks in remote areas was a continuing challenge (Howard-Jones 1978).

The LNHO also established numerous scientific and technical commissions to set standards for drugs and vaccines; to study general subjects such as medical education, public health reorganization, housing, the operations of medical facilities and the health impact of the worldwide economic depression; and to report not only on major infectious diseases (for example, syphilis, tuberculosis and malaria), but also on malnutrition, opiates, traffic in women, rural hygiene, health insurance, cancer and heart disease (Mazumdar 2003; Borowy 2009). Health personnel were sent to other countries for training and consultation and to establish international networks of professionals, enabling the circulation of knowledge and multi-directional learning.

Despite Rajchman’s capable protagonism, the LNHO became mired in League of Nations politics, and budgetary constraints meant that it could realize only part of its ambitious agenda. By the mid-1930s, operations of the OIHP and the LNHO were marred by international bickering, the chaos of the worldwide economic depression and tensions in Europe, with resultant wavering support and a worsening shortage of funds (Solomon, Murard and Zylberman 2008; Borowy 2009). And the LNHO, like most of the public health world at the time, grappled with eugenic policies seeking to sidestep population and birth control questions (Bashford 2007; Connelly 2008).

The OIHP retained its official jurisdiction over international health agreements serving, in principle, as an advisory council to the LNHO. This arrangement permitted the United States, as a non-member of the League of Nations, to keep a window open to the LNHO. Various US experts served as staff members or consultants (Dubin 1995), sustaining a rising role for the US in international health that would solidify after World War II. Another important American connection was through the RF. The LNHO was partially modelled on the RF’s International Health Board and shared many of its values, experts and know-how in disease control, institution-building and educational and research work. Rather than being supplanted by the LNHO, the RF became its major patron and lifeline, funding
study tours, projects and eventually its operating budget, and it took over some of its key activities during World War II.

Both the LNHO and OIHP diminished their activities with the advent of the war, although other international health efforts continued with a military focus. For example, US authorities tested, with the RF’s cooperation in Mexico, and then administered widely the use of the insecticide DDT against louse-borne typhus and to destroy malaria mosquito vectors in the Pacific military theatre, around military bases and in areas of strategic military importance (Stapleton 2004). Also receiving sanitary attention were rubber- and quinine-growing regions of Brazil and the Andes, which were needed to replace Malaysian and Dutch East Indies sources of these items following the Japanese occupation (Cueto 2008). As well, the accelerated production of newly developed sulfonamides and the antibacterial wonder drug penicillin enabled distribution to Allied soldiers in the latter years of the war. During this time, the US government also launched a large-scale cooperative sanitary effort throughout Latin America to improve diplomatic relations and forge alliances to fend off Axis influence in the region, as well as to assert its leadership in the projected post-war development and rebuilding (Vieira De Campos 2008). But other international health concerns dwindled; the research and standardization efforts of the LNHO and the public health projects of the RF (outside the Americas) had to be suspended because of the war, only to be resurrected under a new guise in the post-war period.

Conclusions: Poised for the Future?

Notwithstanding the humanitarian impulse of many of organized international health’s advocates, its origins were deeply intertwined with the colonial, commercial and expansionist exigencies of the age of imperialism and the inauguration of global capitalism, engendering certain lasting metaphors, themes and influences. International health’s primary efforts, then, were focused on disease control to facilitate conquest and occupation, increase worker productivity in factories, mines and plantations in metropolitan and colonial settings, fend off epidemic unrest, and ensure a smooth and uninterrupted trade system.

With the long effort to institutionalize international health on a cooperative basis cemented in the aftermath of the horrific first world war, a new optimistic focus, drawing from principles of social justice and social medicine, sought to reorient international health to address the political, structural and scientific factors underlying the health of the public, blurring boundaries between local and international goals.

But just as international health’s focus was shifting from plagues towards peoples, the LNHO’s aspirations were disrupted by worldwide economic and political crises in the 1930s and the onset of war. After World War II, a new geopolitical configuration took shape, one that initially unified international health efforts in the World Health Organization’s technical cooperation mission...
– drawing from the LNHO’s ideals and organizational structures – but that almost immediately was undermined in its potential to democratize international health in an age of decolonization. The Cold War rivalry between Western (US-led) and Eastern (Soviet-led) blocs, together with the rise of the ‘international development’ paradigm, elevated anti-communism and narrow disease-control efforts to international health’s dominant ideology. As in the past, however, this meta-narrative framing would be countered and contested in various places and moments, making the struggle over global, reductionist, charitable, top-down efforts versus integrated, sociopolitical-scientific and community- and rights-based approaches one of international/global health’s enduring challenges.