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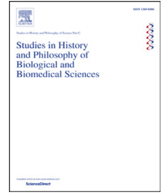

Essay Review

Transitions, traditions: From colonial to global health

Christoph Gradmann

University of Oslo, Institute of Health and Society, P.O. Box 1130 Blindern, 0318 Oslo, Norway

A history of global health: Interventions into the lives of other peoples, Randall Packard. Johns Hopkins University Press, Baltimore (2016). 432 pp., Price $35.00 paperback, ISBN: 9781421420332

Epidemics, empire, and environments: Cholera in Madras and Quebec city, 1818–1910, Michael Zeheter. University of Pittsburgh Press, Pittsburgh, PA. (2015). 336 pp., Price $45.00, hardcover, ISBN: 9780822944461

Languished hopes: Tuberculosis, the state and international assistance in twentieth century, India, Niels Brimnes. Orient Black Swan (2016). 336 pp., Price 1095 (Indian rupees) hardback, ISBN: 978-81-250-6282-0

Call them what you like, there were some big changes under way in health all over the planet around 1980: The replacement of a political economy of health by a business economy; the associated increase in the popularity of metrical tools of evaluation geared to determine an interventions efficiency; and the proliferation of non-state actors in a field in which privileged positions used to be held by international agencies. For context think of the growth of a pharmaceutical industry in the global south and of the n ensuing innovation crisis in such industries in the north. In addition, all these events seems to have coincided with approaching end of the cold war. Clearly, major changes were under way. Whether one approves of the designation for what followed as global health, is another matter. Some have argued that the term is more a smokescreen for a strange blend of benevolence, heroism and neoliberal politics for which 'postcolonial' is the right designation.[1]

Much of what could be put forward as criticism of the term global health, however, does not seem to be all that new. Partisan undertones are nothing new in the study of the history of public health on this planet. The historiography of the older international health shows us that naïve and vague concepts of progress have been abundant ever since the field came to named as such in the late nineteenth century.[2] Still, there is an argument on the table that historians should start from the notion of a great transition that got off the mark, not coincidentally, with the end of the cold war and the rise of neoliberalism.[3] Historiographically speaking, the consequences are interesting: international health could then be understood as a historical period. It would span the period from the transformation of tropical medicine in the age of imperialism to the 1980s, when tropical medicine gave way to global health. Thinking of international health as a historical period could guide attention to possible continuities from the later colonial to the early postcolonial period. Recent examples from the history of medical microbiology and epidemiology—a personal hobby horse—tells us that this perspective has in fact, been employed in some important work already.[4]

Michael Zeheter's *Epidemics, Empire, and Environments*, a comparative history of cholera in Quebec City and Madras through the nineteenth century, is clearly situated in a period when a distinction between colonial and international health was mostly meaningless. This lack of a distinction was certainly the case for the two provincial capitals of the British Empire that the book covers. In his exposition, the author attempts to put some distance between his endeavour and traditional histories of colonial medicine and of cholera.

> This book is not another study of cholera in an urban setting based on social history and urban geography but an examination of the reactions of the local authorities and medical experts in Madras and Quebec city to cholera epidemics, …(p. 14).

In order to achieve this desired distance, Zeheter has lightly borrowed Bruno Latour's actor network theory, to give urban environments and diseases the rank of actors – actants in Latourian terminology—in his analysis. Since, however, he abstains from using the language of actor-network theory and does not get back to his methodological opening statement in the rest of the book it is not easy to say what his approach amounts to beyond providing an interesting accent on changes in urban environments. Attributing agency to cholera as such is a definitely a good idea in the analysis of a dynamic epidemic infectious disease, but it is hardly a piece of

E-mail address: Christoph.gradmann@medisin.uio.no.

[1] Anderson (2014); Hodges (2012).

[2] Birn (2009).

[3] Brown, Cueto, and Fee (2006); Chorev (2012).

[4] Chakrabarti (2012); Tilley (2011). Both books, while focusing on colonial days, reach out into postcolonial histories.

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insight for which the application of the actor-network theory is a requirement.

That said, other historiographic considerations are probably more important and it is interesting to see how Zeheter relates to the condition's historiography from Asa Briggs to Richard Evans.[5] Mostly he seems to be in agreement with these authors: Like them, he sees cholera as a disease that gained importance through the societal response it triggered rather than though its epidemiology as such. The result is that in his comparison, Zeheter follows the classical three stages-scenario of an epidemic, which for instance Evans' book Death in Hamburg that we have just mentioned follows: an initial response, followed by a societal and urban health focused response that the persistent threat resulted in, and finally, a re-affirmation of state power that coincided with the arrival of bacteriological hygiene.

The peculiar conditions of colonial government, however, resulted in rather different trajectories and that is what makes *Epidemics, Empire, and Environments* an enjoyable and interesting read. Of course, the locations differ and here Zeheter compares a town in a settlement colony—Quebec City—to one in a colony of exploitation—Madras (or modern day Chennai). Through the course of the book, he mostly follows government politics in those two provincial capitals. At the outset there was a parallel occurrence in both cities, in that the emergence of Asiatic cholera, which seemed to signify the great failure of contagionist hygiene—quarantines, for example, failed consistently—resulted in a crisis of government. But where European history is rife with examples of government more permanently weakened, the colonial state in Quebec managed to expand its reaches: "The sanitary infrastructure had another, less obvious political consequence. It added another layer of governmental control over the environment and population of Quebec" (p. 129). In contrast, in Madras the crisis unveiled a split between the colonial government and local elites upon which it had to rely. Where British engineers were keen to remodel the urban environment in accordance with sanitarian ideas, the government was held back by a perceived political need to safeguard a sensitive balance of different populations in the region. It was only 20 years later, after the Indian rebellion of 1857, and through the associated strengthening of the military in the colonial government, that the sanitarian movement gained any momentum, again due to a constellation of forces that would have been unusual in a non-colonial context. Zeheter is very readable when he describes the effects of sanitarian approaches in both towns. We follow the emergence of an environment where natural and technical waters were becoming increasingly separate: Fresh water came from far away or far below and it was disposed of as sewage after use. The arrival of bacteriological hygiene, seen from the vantage of environmental history, did not indicate a change of direction but a completion of a technological transformation of urban spaces (pp. 201–40).

The comparison between Madras and Quebec City is somewhat less meaningful for this last period since cholera had all but disappeared from the North American town by that time. The example of Madras, however, suffices to convey another interesting insight. Even as towns in industrialized societies witnessed the gradual slipping of infectious disease from the agenda of urban health into the twentieth century, the situation in Madras and presumably in many other colonial centres was influenced more by the emergent international health of the imperial age. Cholera's place as the major threat to imperial possessions and commerce, was taken over by the plague in the agenda of urban health.

The strength of Zeheter's analysis lies in his exploration of colonial states and their politics through a set of two perfectly graphic examples. One might have wished to learn more about the involved societies but the book is still a very valuable analysis of the technological transformation of urban spaces in the nineteenth century and the specific turns it took in a colonial setting. *Epidemics, Empire, and Environments* also reminds us that the nineteenth century and more specifically, medical microbiology in that period, was unique in the sense that it inspired a vision of a future without infectious disease. This vision was based on specific remedies such as therapeutic vaccines and antibiotics that seemed to be implied by the discoveries in medical microbiology. It was a modernist dream with peculiar features; most importantly, it tended to be in excess of reality. For instance, the arrival of specific remedies always seemed to lie in the near future, despite not truly getting off the mark before the mid-1930s with the advent of sulpha drugs.[6] The efficacy of such medicines, once they were developed, seemed to reach far beyond the control of infections in individual patients into utopian dreams of total disease eradication. Finally, rising problems tended to be answered by affirmation rather than critique. In this modernist dream problems such as drug resistant microbes would find their answer in more medicines or in better ones, preferably both.[7] The long-term outcome of such an utopian vision of a future without infectious disease has been the dystopian counter-image of a post-antibiotic age that we are left with today, where technology is still central; alas, this technology is now absent.[8]

It is from this vantage point of the failed promises of the technological control of infectious disease that we can grasp the scope of the story of tuberculosis control in India, which Niels Brimes tells in *Languished Hopes*. The story is one of a modernist dreamland turned bleak. In its heyday in the first decades after the Second World War and Indian independence, the dream brought local elites in state and society with experts in international health and development together in the pursuit of a grand control scheme. Covering a longer period from right before the Great War to the arrival of global health at the DOTS standard in tuberculosis therapy in the early 1990s, the book is centred in the three decades following Indian independence. It was a period when the field of tuberculosis control at large underwent major changes, sliding slowly from the health-policy agenda in developed countries while rising to importance in international health. In the era of decolonisation it became the responsibility of newly emergent states and of such international agencies as UNICEF or WHO. Eventually the field became thoroughly phamacologised though large scale vaccination campaigns and the arrival of effective antibiotics and chemotherapies.

The story of Indian tuberculosis control, we learn from Brimnes' analysis, can be read as an example of what other decolonized countries had lying in wait: Namely the prospect of facing a large epidemic of a condition that had been mostly neglected during colonial rule. Analyses of such matters have been written by Sunil Amrith, Christian Macmillan and Randall Packard.[9] Brimnes, however, goes a step further than his predecessors and delivers an in-depth analysis of the history of tuberculosis control in a single

[5] Briggs (1961) is a paper that paved the way in the history of cholera as a social history of disease. Evans (1987) is arguably the most impressive book from that direction, developing the history of the 1892 cholera epidemic in Hamburg into a panorama of state, society, medical science and disease.

[6] Gradmann (2017): 383–386.

[7] Podolsky (2015).

[8] Gradmann (2017): 388–92.

[9] Amrith (2002); McMillen (2015); Packard (1990).

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country outside of the affluent world that the historiography on the condition has been focused on so far.[10] The choice of the populous and vibrant nation of India implies that there is every chance that our understanding of the history of tuberculosis control in international health is given a new footing.

What we meet in the book is a history that differs massively from what has been described for Europe. In Europe, tuberculosis was essentially tackled on the basis of its framing as a social disease, the control of which had been on a road to completion by mid-twentieth century, before the arrival of antibiotics and chemotherapies. In contrast, tuberculosis control in India, and presumably in other less-developed areas as well, became a modernist utopia fuelled by pharmaceutical technology. In addition, it had to deal with dynamic rather than receding epidemics.

Brimnes' first example in relation to this point is the history of BCG vaccination through which he graphically shows the outcome of an endeavour that was driven by too much faith in a technological solution (pp. 106–147). Not only was the efficacy of the vaccine exaggerated, but the vaccine also became a tool for a campaign that was itself soaked in high modernist confidence in technology and planning. As a result, international health experts and local technical elites turned their backs on two rather basic problems: the insufficient resources available for expanding from a testing phase to a large-scale rollout of the vaccines, and the lack of societal acceptance for that technology. The outcome was what Brimnes identifies as a "failed pasteurization" of India, lacking in both technological and intellectual ways, where the optimism for the vaccination was not shared by many and the funds for a nation-wide campaign were lacking anyway (p. 126).

Brimnes' second example supporting his argument for the history of tuberculosis as a technology-driven utopian vision is that of chemotherapy. In this case the British Medical Research Council's research centre in Madras arrived at an insight in 1959 that was met with huge enthusiasm; namely that home treatment for tuberculosis could be as effective as its counterpart in a hospital (pp. 185–9). The social conditions of suffering and treatment which had played an important role for so long were rendered irrelevant in that experiment; after all, pills seemed to work irrespective of the patient's situation. This practice opened the door to a blame-game that we all know only too well. While trust in the efficacy of treatment as such was unshakable, non-compliant patients could threaten the successful application. In the clinical trials undertaken to establish the applicability of home treatment, the social conditions of the tuberculosis patients had all but disappeared. To be sure, there was some disagreement within the group of researchers. Although some argued for a continued emphasis on social conditions, what emerged by and large was an attitude that shifted all the blame to the patient and could almost be regarded as a phamaceuticalisation of global health *avant le lettre*.[11] As Brimnes explains:

> The debate on patient compliance revealed a profound ambiguity toward the patient. On the one hand, the tubercular subject was clearly viewed with a degree of distrust and suspicion at the Madras Centre [...]. On the other hand, the prevailing notion of self administration invested a considerable amount of faith in the patient (p. 195).

In reality, social conditions became very significant when it came to building a national treatment program. In contrast to the technotopia of the BCG campaign, the National Tuberculosis Program (NTP) could hardly avoid engaging with local politics and people. In fact, as Brimnes shows, things went the other way. The technological modernity of tuberculosis chemotherapy had initially been an import of mostly European medical trial science, visibly embodied in the Madras Tuberculosis Chemotherapy Centre that had remained in "gentle but firm control" of BMRC scientists well into the post-colonial age (p. 202). Beginning in the 1960s, the NTP developed into a piece of national pride that was actually shared by the Indians and international health experts. Gradually from the late 1960s the Madras centre became Indianized. As Halfdan Mahler, then responsible for the tuberculosis work of WHO in India, put it in 1964, what Indians had developed in the past years "had since become the holy book for tuberculosis control in the whole world" (as quoted in p. 241). Over time, however, this Indian way turned into a bumpy road. Expansion from promising trials to a large-scale program failed, mostly due to lack of resources. By the 1980s, all the initial momentum had been lost, resulting in a situation very much resembling the situation that Christian McMillen recently described for Kenya.[12] Unacceptably low treatment completion rates combined with rising drug resistance due to the excessive reliance on oversimplified treatment regimes. On top came institutional chaos in a decentralised system.

Brimnes concludes his book with the eclipse of the NTP and of international health in the 1980s, dedicating only a few pages to the reforms around 1990 when it became a part of the Directly Observed Treatment, Short-Course (DOTS) system in practice – despite the fact that it sports a very national outlook to this day. Since *Languished Hopes* is a story about the rise and fall of an Indian brand of modernism, concluding the narrative at this point in time is reasonable. In fact, it is the way in which medical history is embedded into the larger history of India that makes the book a very good read. In a related vein, another strength of Brimnes' book lies in exemplary story it tells: of tuberculosis control in India as an example of international health in high modernity. Throughout the book Brimnes has given wide space to the involvement of international health experts in the Indian experiment.

It is tempting to discuss *Languished Hopes* as a confirmation of the idea that there was indeed a distinct transition from international to global health in the 1980s. If we think of the criteria listed by Nitsan Chorev, who has delivered an analysis of WHO in that period, has listed, it would strike us that what characterizes global health is all but missing in the story that Brimnes tells.[13] The system that he describes is based on a political rather than business economy of health. There is no trace of the focus on efficiency or the extreme reliance on metrical tools of evaluation which had come to characterise global health interventions. Instead of the plethora of NGOs that one would find today, there was a meeting of intricate local politics with international agencies. In addition, the benevolent takeover of local healthcare that seems to characterise health care and higher education in low-income countries today, was absent.[14] In fact, things went the other way and, as discussed earlier, the research centre in Madras originally under BMRC control became Indianised as time went by. One feature, however, that has been associated with global health—namely the use of statistically evaluated clinical trials and the RCT in particular, was clearly present already.[15] The evidence in favour of domiciliary chemotherapy was collected in such trials. Still, *Languished Hopes* is a book

[10] For a critique of the narrowness of the existing historiography of tuberculosis see Condrau and Worboys (2010).

[11] Petryna, Lakoff, and Kleinman (2006).

[12] McMillen (2015): 119–137.

[13] Chorev (2012): 230.

[14] Crane (2013).

[15] Adams (2016): 30–37 has forcefully argued for considering this aspect as a defining feature of recent global health.

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about international health and takes us beyond the history of tuberculosis control in these years, deep into the history of a class of bureaucrats and experts, their high-modernist, technology-fuelled dreams of development and the eclipse of such dreams. Anybody who might wish to venture into the biography of Halfdan Mahler and his vision of primary health care that was deeply inspired by his time as head of WHO's Indian tuberculosis operations, would surely profit from reading this book.[16]

The period in time covered in Brimnes book was soaked in the belief that humanity's crusade against diseases would invariably succeed. Arguably, much of that spirit has survived the innovation crisis in big pharma and the transition from international to global health. Think for instance, of the Gates Foundation's obsession with technological solutions to problems that have huge social dimensions. This enterprise may well be regarded as revamping of a rather dated approach that promised magic-bullet solutions to complex problems, be they syphilis before World War One or Ebola today.[17] While one might argue that today, the optimistic visions of the 1960s have given way to an atmosphere of beleaguerment by bio-terrorism, resistant microbes or re-emerging infections, there is little reason to assume that the underlying fixation on technology has waned.[18]

Luckily there is now a chorus of critical voices accompanying the coming of age of global health. In that sense, it was about time for the appearance of Randall Packard's *History of Global Health*. Rather than focusing on specific places or times, this book provides a synthesis of the vast library that can be consulted for the histories of international and global health from colonial days until today. The author, well known for his monographs on the histories of malaria and South African tuberculosis is more than qualified for the undertaking.[19] The narrative is organised, around the traditions that feed into what we label as global health today. Thus, it opens and closes with analyses of the 2013 Ebola crisis, and the reader faced with questions that become pressing in such a situation. The biggest one is why, after several decades of a recurrent epidemic of a highly contagious haemorrhagic fever, are the basic health needs of the populations it threatens still not being met. Instead, crisis management dominates long-term goals. In a rather effective rhetoric move, Packard juxtaposes the proclaimed aims of global health with whatever can be elucidated about the trajectories of its history over the long twentieth century.

The result is a very impressive synthesis spanning more than a century. Packard brings together two large and rather different sets of studies: first, certain critical global health studies by social scientists and public health, and second, studies by historians who have explored the history of international health often with a focus on institutions. By doing so, he implicitly takes a different stance from those authors who have argued that there is a big divide between international and global health.[20] Instead, Packard argues, there are traditions—a few more venerable than others—some of which stretch all the way from colonial days to the present, which, when taken together, shaped what we know today as global health.

Looking at some of those traditions is nice way to sum up the book: The most important is the well-known combination of technological intervention and limited social reform that we often associate with the early decades of WHO history.[21] Packard finds it in pre-World War One yellow fever–campaigns in the Caribbean. He then follows this tradition through the work of the Rockefeller Foundation in the interwar years into the post World War Two period where the tradition re-emerged in the accent on technical assistance that was the hallmark of WHO or UNICEF policies in the 1950s. Any proud ship is bound to have crowd of shrieking seagulls circling its mast and a second notable tradition is a similar chorus of critical voices attacking the narrowness of technological approaches, calling instead for social reform, empowerment and community mobilisation to be at the heart of global health. Packard identifies the critical tradition in nascent form in rural health initiatives of the interwar years and sees a short resurgence at the end of World War Two, when social reformers indeed shaped the agenda of WHO in the making. The most distinctive flowering to date came still later in the days of Primary Health Care in the late 1970s. Subjects on the agenda even switch sides between the long-term traditions. Birth control, as Packard shows in a long chapter (part five), started out as modernist, technology-driven specialist enterprise of the control of populations' fertilities after the Second World War. Following a few interesting twists and turns towards the end of the twentieth century it became connected to maternal health initiatives that would emphasize the basic health-rights of individuals and communities in a broad fashion (pp. 215–25).

Packard, being a balanced and subtle historian, leaves no doubt that traditions are subjected to transitions, some of which deserve to be called disruptive—the last in particular holding true for the rise of the neo-liberal world order from about 1980. Structural adjustments did not just have a detrimental effect on what health systems existed in decolonized countries, they also cleared the way for the rise of economic logic in development politics. Packard does a splendid job at unravelling the multitude of non-government actors that came to characterise global health from those days on. It is one of the strength of the book that it moves far beyond the history of WHO that often dominates in histories of international health. In the earlier chapters, such players as the Rockefeller Foundation, UNICEF or UN agencies involved in population programs are given a lot of attention. More recent big players such as the Gates Foundation, GAVI or the World Bank are also treated comprehensively. Still, Packard's historiographic strategy to apply the term global health in an indiscriminate fashion to histories that cover more than a century serves to downplay the changes that happened in the 1980s. The evidence could have been employed to argue for a disruptive and seminal change from international to global health. Instead, Packard, for whom the history of global health spans a century and not a generation, argues for picture of recent global health that emphasises a revival of traditions of vertical, technology driven interventions. Admittedly, some very good points can be made in that way. For instance, why is the success of the smallpox eradication program constantly referred to in current global health, while failure of the eradication program for malaria is seldom mentioned? Asking such questions might have better prepared us for dealing with the 2013 Ebola crisis. Packard clearly has his doubts about the potential of an approach that may be summarised as throwing high-tech solutions at problems as they arise with the aim of improving the health of people in the end. We have had, he suggests, more than enough of a certain type of emergency intervention that is the trademark of some NGO. What is, really lacking, in Packard's view, is a focus on comprehensive services on the ground (pp. 338–41). Without resilient health systems for delivering them, the business of tackling crises which so many NGOs excel in, is unlikely to prevent to occurrence of such events in the future.

All in all, Packard has produced what can only be called a comprehensive analysis. Its great benefit lies in bringing together rather disparate bodies of knowledge from the social sciences,

[16] Cueto (2004).
[17] For a pointed critique: Birn (2005).
[18] Weir and Mykhalovskiy (2010).
[19] Packard (2007, 1990).
[20] Chorev (2012) has argued convincingly for such a divide and so have Brown et al. (2006) in their landmark paper.
[21] Good overviews are to be found in Lee (2009) and Bud (2007): 75–96.

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public health and history into a well-organised historical narrative. The approach that focusses on long lines that reach into our present from the days of colonial medicine could be criticised for not being adventurous enough in historiographic terms. Yet, it has the big virtue of convincingly historicising a massive body of global health expertise. Packard clearly harbours some sympathies for approaches to global health that prioritise long-term investments into the health of populations rather than a focus on crisis intervention. At the end of the day, he concludes, the narrow focus on technical assistance in crises is colonial tradition, even if it arrives cloaked as an all-good-intentions NGO "Ironically, the likelihood of primary health-care strengthening happening in Liberia, Guinea, or Sierra Leone is threatened by the news that a vaccine has been developed", he cautions his readers in his conclusion (p. 341).

Given the comprehensive approach, it is not easy to come up with some major topic that is not duly treated in the book. Still, a certain prerogative for conditions that have dominated in the work of the author and in fact, in older histories of global health is discernible. Infections such as malaria, tuberculosis or HIV are more present than non-communicable conditions and cancers. Arguably, these are beginning to be formidable challenges for health care in low-income countries. Their historiography is poorly developed, but with regards to cancers for instance there is inspiring work.[22]

Mark Harrison has recently encouraged medical historians to engage with global history.[23] From the vantage point of the books covered in this essay-review there is some indication that their authors are already engaged in this activity. The long lines from colonial days to the current situation are beginning to be properly described. That said, global health is, as Harrison has pointed out, still an elusive concept. It lingers somewhere between the actors' usage, where it would have strong partisan undertones and violent criticism that denounces it as smokescreen for systems of power, and attempts to use it as a category in pursuit of historical analysis. Whether one prefers the term to designate a history that spans from colonial days or goes for a narrow definition that reserves it to phenomena that originated after 1970, it would seem that the historical dimensions of the term are still insufficiently developed. Historians are hardly the prime experts when it comes to doing global health footwork. "Global health interventions are composed of disparate forces" Ruth Prince has reminded us recently.[24] Historians can hardly amend that, yet, they are in a position to make it more comprehensible.

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[22] Livingston (2012).

[23] Harrison (2015).

[24] Prince (2016): 163.

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