In 1970 Brian Maegraith, distinguished in tropical medicine, delivered the University of London Heath Clark Lectures on the theme of ‘One World’, inspired by a recent photograph of Earth taken from space.

‘The planet appears as a lovely blue, white and brown globe…quiet and peaceful…you cannot see the sprawling populations riddled with disease, badly fed, living below subsistence level, plagued by poverty, aggression and the inequalities of terrestrial life. It seems a pity that you have to go so far to see it in perspective for what it is – One World, on which mankind must learn to live peacefully and well.’[1]

While a global concept was implicit in the setting up of the World Health Organization and other UN agencies after the Second World War Maegraith was ahead in time of the concept of global changes and their implications for human health developed during the last three decades. Even at the end of the 1980s neither ‘globalisation’ nor ‘global change’ appeared in the Fontana Dictionary of Modern Thought.

Maegraith ranged over matters relating to health in the tropics. One of these concerned ‘Human ecology and imported disease’, directing attention to ‘dynamic processes at work….speeded up by the technical revolution’, and drew widely for examples, particularly of associations between population movements and the transmission and diffusion of disease and attempts at disease control.

During the last three decades many of the dire conditions which Maegraith specified have changed little and some have worsened. Peace and wellbeing for many people have not advanced and while poverty and inequality may have been reduced they remain widespread. Dynamic processes have intensified and new ones have developed. Global warming has been identified at the present and for the future with implications for the spread of vector-borne diseases among other impacts[2]. Smallpox, an old disease, has been eradicated but new diseases, pre-eminently HIV/AIDS, have emerged and they now warrant a journal, Emerging Infectious Diseases. For an old disease like malaria the strategy of eradication established in the 1950s was not successful and was replaced in the 1970s by one of malaria control, with renewed efforts of the WHO since 1998 to ‘Roll Back Malaria.’ over the next decade by reducing levels of morbidity and mortality from the disease particularly in Africa.
Measles, a highly contagious viral disease transmitted directly from person to person, was introduced into the Pacific region in the early nineteenth century. In the next hundred years it spread through dispersed small island communities separated by vast areas of ocean who had previously not been exposed to this infection and with no immunity. It was among other introduced diseases for which there is no record. The measles experience illustrates how spread can take place through the movements by sea of small numbers of infected people, causing epidemic outbreaks and in one instance an epidemic with high mortality.

At the beginning of the nineteenth century there were scattered areas of endemic measles on the eastern Pacific seaboard but none on the western. In the next fifty years it spread to south-eastern Australia, to the western seaboard of North America and from California made its first incursion into the Pacific to Hawaii. In the following decade it spread to the other parts of Australia and to New Zealand, Tahiti and the Cook Islands, and then in the last forty years of the century widely to islands in the south-west Pacific. It was introduced, for example, to the southern Papuan coast of New Guinea by a vessel of the London Missionary Society. There was high morbidity and variable mortality, with the deaths of about a twentieth of the population of Tonga, but the greatest mortality was in the Fijian islands. In January 1875 the return a Fijian chief and some of his followers brought the infection from Australia, and subsequent ceremonial contacts spread it to widely scattered islands. By the time the epidemic came to an end in the middle of the year between 30,000 and 40,000 people had died, a fifth to a quarter of the Fijian population, with varying rates of attack between islands and between villages. It was a major demographic tragedy with social and economic implications. Sporadic small outbreaks followed in the latter part of the century, with what was described as a ‘serious epidemic’ in 1903 when some 2000 people died. With acquired immunity and vaccination outbreaks were of lesser importance during the twentieth century.\[6\]

Figure 1  The diffusion of measles in the Pacific in the nineteenth century

Box 1   The diffusion of measles in the Pacific in the nineteenth century

Measles, a highly contagious viral disease transmitted directly from person to person, was introduced into the Pacific region in the early nineteenth century. In the next hundred years it spread through dispersed small island communities separated by vast areas of ocean who had previously not been exposed to this infection and with no immunity. It was among other introduced diseases for which there is no record. The measles experience illustrates how spread can take place through the movements by sea of small numbers of infected people, causing epidemic outbreaks and in one instance an epidemic with high mortality.

At the beginning of the nineteenth century there were scattered areas of endemic measles on the eastern Pacific seaboard but none on the western. In the next fifty years it spread to south-eastern Australia, to the western seaboard of North America and from California made its first incursion into the Pacific to Hawaii. In the following decade it spread to the other parts of Australia and to New Zealand, Tahiti and the Cook Islands, and then in the last forty years of the century widely to islands in the south-west Pacific. It was introduced, for example, to the southern Papuan coast of New Guinea by a vessel of the London Missionary Society. There was high morbidity and variable mortality, with the deaths of about a twentieth of the population of Tonga, but the greatest mortality was in the Fijian islands. In January 1875 the return a Fijian chief and some of his followers brought the infection from Australia, and subsequent ceremonial contacts spread it to widely scattered islands. By the time the epidemic came to an end in the middle of the year between 30,000 and 40,000 people had died, a fifth to a quarter of the Fijian population, with varying rates of attack between islands and between villages. It was a major demographic tragedy with social and economic implications. Sporadic small outbreaks followed in the latter part of the century, with what was described as a ‘serious epidemic’ in 1903 when some 2000 people died. With acquired immunity and vaccination outbreaks were of lesser importance during the twentieth century.\[6\]