of the kinds of history that would serve reflection best. May this book encourage others to do more and different, and so contribute also to debate over the history of embryos.

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Christian W. McMillen. *Discovering Tuberculosis. A Global History, 1900 to the Present*. New Haven and London, Yale University Press, 2015. xii, 338 pp., \$40.00.

KEYWORDS: World Health Organization, BCG vaccine, HIV/AIDS, antibiotic resistance

Tuberculosis (TB), as Christian McMillen points out at the start of this volume, kills one-and-a-half to two million people every year, and yet, since the 1940s, the means to cure it have been available: antibiotics work. Why then are there still millions of people suffering and dying from this curable disease in the twenty-first century? This is the question that McMillen sets out to answer, and he does so with commanding knowledge and compassionate insight. This study is, despite the many breakthroughs in TB control, an account of failure: not one failure but many. However, as he is at pains to emphasize, this is not an exercise in blame but an attempt to analyze the structures that constrain and direct the decisions and actions of individuals and organizations. Amongst the significant structures, he includes the discourse of race, the lure of cost-effectiveness, the “trap of compliance” that led to a focus on patient behavior, the “well meaning, though lumbering, behaviour of a global bureaucracy” and a “willful blindness to readily apparent failures” (228).

McMillen’s history of TB is rightly termed “global” because it provides the history of the disease across the globe, including the Americas, Africa, and India, and because it traces the global responses to the disease. The book tells its story in three parts. In the first part, McMillen explores the arguments around race and biology most strikingly formulated in relation to American Indians and Africans as the subject. With little or no epidemiological knowledge of TB amongst these peoples, racial susceptibility and virgin soil explanations proved, he shows, very compelling. Even though the discursive predominance of such explanations had waned by mid-century, race never entirely disappeared, and McMillan shows how it remerged in new guise in recent discussions on genetics and TB.

In the second part of this book, McMillen focuses on the 1950s and 1960s. He claims that this period, when “will,” “money,” and “expertise” came together, was the most productive period in the history of TB control (61). With the advent of the BCG vaccine and antibiotics, TB could, it was thought, be rendered impotent. McMillen argues that this optimistic prediction rested on both “hope” and “hubris”

(61). It was a time when scientists, medical professionals, and policy planners believed that the world's health problems could be solved entirely by a technological fix without improving social and economic conditions. It was not to be; McMillen graphically exposes how this misplaced optimism influenced the path taken by professionals in devising control programs. The problems that soon emerged with both these "magic bullets" were brushed aside or ignored. BCG was never definitively proven to be an effective vaccination, and yet it was rolled out over the entire world in mass vaccination campaigns. In the absence of an alternative, it was embraced as better than nothing. McMillen interprets this as a consequence of faith rather than science. He shows that even when it was found to be totally ineffective as in the Chingleput Trials of 1968–79, it was not abandoned altogether. Instead, it was included in the WHO's "Expanded Programme on Immunization" because it was effective against a severe but rare form of the disease in infancy.

McMillen also documents how resistance to TB drugs emerged quickly in the effort to treat TB, almost at the point that they began to be used. By 1961, for example, the WHO reported that approximately 20 percent of TB cases in Kenya were drug resistant. The problem here was not with the antibiotics but with the difficulty of getting them into people's bodies in the real world. Domiciliary and short course treatments were technological breakthroughs; they could cure TB, but if drug regimes were not followed strictly then infectious and drug-resistant cases were let loose on the community to compound the situation. McMillen argues that public health officials who focused on patients' behavior to explain failures to complete treatments missed the real problem—the lack of effective health and communication structures to ensure an adequate regular supply and the proper use of the drugs. McMillen shows that the social factors around TB were never investigated as thoroughly as the biological ones.

By the 1980s, TB, although not under control, had fallen off the radar until the major challenge of HIV/AIDS appeared in Africa from whence it spread across the world to deadly effect. The "new disease breathed life" into the "old and intractable one" (174). In this third part of the story, McMillen charts the progress of the lethal partnership of AIDS/HIV and TB and the sometimes half-hearted and belated efforts to deal with it. McMillen's trenchant analysis of the WHO DOTs therapy of the 1990s illustrates again how what appeared to be a sensible and workable policy went badly wrong. It could and did work in places but its lack of flexibility in responding to different environments and a lack of resources hindered its overall effectiveness. Moreover, DOTs ignored HIV/TB and multi-drug-resistant TB.

McMillen's global study of tuberculosis illuminates the occasional breakthroughs and many setbacks in TB control over the long twentieth century. His conclusions are based on a wide range of sources and some first hand research. (He visited TB clinics in Africa, for example, to see for himself the difficulties inherent in preventing and treating tuberculosis in resource-poor environments.) It should be read by anyone who has an interest in the history of medical interventions, public health, and global health. Hopefully, policy makers especially will read it and gain an understanding of

some of the parameters that surround and underpin their choices in order that they can make better ones.

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Tanya Hart. *Health in the City: Race, Poverty, and the Negotiation of Women's Health in New York City, 1915–1930*. New York, New York University Press, 2015. 327 pp., illus., \$55.00.

KEYWORDS: infant mortality, maternal mortality, charity, maternalist reform, public health

New York City provides an ideal setting for historians to examine the interactions between elite reformers and the poor communities whose conditions they have sought to improve. In the early twentieth century, the city's Department of Health was arguably the most innovative in the country, and its philanthropic and human services sector—charitable organizations that linked improvements in health with moral uplift—was among the largest and most active. The immigrants who were drawn to the city from all over the country and the world navigated an urban environment that produced some of the unhealthiest conditions imaginable. And the gulf between poor communities' perceptions of their situations and the views of health professionals was often vast.

Tanya Hart's thoroughly researched monograph examines the maternal and child health programs that New York City created for poor mothers and families in the decade and a half following its first mortality survey in 1915, and the ways these efforts were received by their intended beneficiaries. She narrates the stories of three groups of women: African American, British West Indian, and Southern Italian. She situates the experience of these women—who were very different from each other culturally yet shared many commonalities by virtue of their poverty and vulnerability—within the broader social milieus of the Manhattan neighborhoods where they made their homes: Columbus Hill, Mulberry Hill, and East Harlem. The 1915 survey identified these areas as “sore spots” with particularly high infant and maternal death rates. In response, the New York City Department of Health contracted with a private charity, the Association for Improving the Condition of the Poor, to undertake health demonstration projects aimed at lowering mortality rates and improving the lives of neighborhood residents. These programs embodied the “maternalist” reforms that were so characteristic of the Progressive Era, when the confluence of social meliorism, eugenic beliefs, and the growing sophistication of laboratory methods resulted in disease prevention efforts that, although they had the patina of science, reflected deeply rooted cultural prejudices about the poor and immigrants of different backgrounds.