Let me begin by thanking the organizers for inviting me to talk about primary health care.

This title is rather presumptuous - A more appropriate title would have been On Some Primary Health Care Roots and I probably should have made it clear that the PHC I’m referring to is the one that WHO presented to the Executive Board in 1975 where seven principles were listed:
The central focus of these principles is the community level.

Other levels of the health system are there to support communities and to be as close to them as possible.

You will note that in this version of primary health care, there are no individual elements listed. These were added later in the course of preparing for the Alma-Ata conference in 1978.
I decided that going backwards from 1970s to earlier decades would be much too confusing so from here on I will follow a chronological order beginning with people and events before World War II as outlined in this slide.

In the process of preparing this presentation I’ve learned how hard it is to locate pictures and even to get birth dates and years of death.

I will be interested in learning from any of you if there are other personalities or events that I should have included.

NEXT SLIDE
Selskar ‘Mike’ Gunn (1883-1944)

- Born in Ireland, early schooling in England
- Father sent him to MIT to study electrical engineering
- There he heard William Sedgwick speak and shifted to biology and public health.
- Between his graduation in 1905 and 1917 when he joined the Rockefeller Foundation he had a multitude of jobs including being a professor at the MIT-Harvard school of public health.

Gunn is the oldest member of this distinguished group and my personal hero. Not only did he go to MIT, my Alma-Ata, he is the only person in this history who does not hold a degree in medicine.

Gunn’s father ran musical theaters in Dublin and in England. It was rumored while he was at MIT that he might return to America as head of a traveling theatrical group.

Instead, under the inspiration of William Sedgwick, who was considered the greatest teacher of public health in America at the time, and with his active help in finding employment, he opted to pursue a career in public health.
Gunn on housing

- Every effort to abolish crowding and unsanitary conditions must be made to save people from premature death and suffering. Standards of modern civilization demand decency, and decency is not at all compatible with dirt and filth of any nature whether productive of disease or not.
- Poverty is intimately associated with bad habits, with dirt, waste, idleness and vice. All these factors, economic and others, operate both as cause and effect. They cannot be separated in real life and are continually reacting upon each other in such a manner that it is impossible to arrive at their respective shares in producing existing evils.

Gunn was a workaholic. He may have been driven to work hard because of the inadequacy of his salary as a professor at the MIT-Harvard school to support his wife and child.

He carried out studies for numerous cities in America; he participated in many meetings organized by various organizations; he was the senior editor for the American Journal of Public Health for a number of years.

This quote is from a 50 page report on Salem, Massachusetts’ housing conditions. Gunn’s argument that decency is not compatible with dirt and filth is illustrative of his humanistic approach to public health.
As senior editor for the American Journal of Public Health Gunn contributed numerous articles mostly on model city health departments. He also used this position to propagandize essential points of his public health philosophy as illustrated in this slide.

These aphorisms were not unique to Gunn.

The first one, for example, is generally associated with Herman Biggs, a major American public health figure of that time. Charles Winslow, another graduate of the MIT school was certainly author of some of the others.

Probably the ones concerned with health education represent the central thrust of Gunn’s early work.
While Gunn was beginning his career in America, Andrija Stampar was beginning his career in Yugoslavia. Not only is he considered one of the public health giants of the 20th century, he was physically a giant – he was 6’5” tall and of massive built. Later he became known as the Bear of the Balkans.
Unlike Gunn who grew up in relative richness, Stampar grew up in a humble environment where he witnessed what he wrote about in a paper on social medicine while still a medical student.

Stampar was clearly motivated from the beginning of his life to improving the social welfare of those in greatest need.

The expression **social medicine** is not to be found in the American Journal of Public Health until the early 1920s. Needless to say it smacked too much of socialism and was opposed by America’s anti-red politics. This is an important part of 20th century history but outside of today’s talk.
Like Gunn, Stampar was a keen believer in the value of health education.

This example is illustrative of Stampar's efforts to link health work with the educational sector and agricultural work.
Gunn stared his Rockefeller career in France as part of an anti-TB campaign. After several years in Czechoslovakia he moved back to Paris where he was in charge of the Foundation’s health work in Europe.

After his first visit to Yugoslavia in 1923, he concluded that: 'without any assistance from outside and with limited and inadequately trained personnel Yugoslavia had been able to accomplish much within a short period of time'. In fact, he doubted if there was any country in the world in which such strides had been made in 'so short a period of time'. Without help Yugoslavia would continue on its path but with help 'we can accelerate it very materially'. Of perhaps even greater importance was the fact that 'by showing our interest in a material way we can undoubtedly assist in stabilization of the whole public health program'.

His contact with Stampar also led him to push the Foundation to take more interest in Social medicine. In particular he attempted to get the Medical Education division of the foundation interested in incorporating preventive medicine in the undergraduate curriculum and to organize courses for practicing physicians that
would help better understand how they could contribute to community medicine. These efforts failed.
Foundation funding was largely for the expansion and construction of facilities. Without it this number of institutions could never have been established.
This next slide describes what Gunn hoped to develop in Europe after having been promoted to the position of Vice-President for Europe and director of the Foundation’s Social Sciences program in Europe.

He described these hopes during an important meeting held with the Foundation’s Board of Trustees in October 1930.

Gunn referred to certain European countries, but as far as I can judge Yugoslavia was the only one where there was a serious possibility of developing a multi-sectoral approach to health.
Political pressures forced Stampar to leave his country.

With no other prospects availability and in his new position as Vice-President, Gunn was free to seek other opportunities elsewhere in the world.

Both found themselves in China where John Grant, a Foundation officer was present.

John Grant joined Gunn’s program in 1933 and later said: I felt that if Gunn was going to survey or review opportunities throughout the world for a multi-disciplinary RF program, that China would probably offer him as good an opportunity as any other country he could visit. Knowing that was in the offing, I felt that if such a potential developed, I could play a more useful role with him than continuing within the narrow confines of the PUMC itself.
So who was John Grant?

To begin with he is another 20th century public health giant.

He studied at Johns Hopkins where Arthur Newsholme indoctrinated him in the virtues of state medicine.
Up until 1928, or so, Grant concentrated his attention on improving the opportunities for introducing medical students to preventive medicine.

At first, he did this using an urban health center that he helped establish.

With the arrival of Jimmy Yen’s Mass Educational Movement in nearby Tinghsien he was able to extend training opportunities into rural communities.
Chen is certainly one of the most important figures in the history of primary health care. It is largely due to his efforts that some have labelled Grant as the Father of PHC.

Unfortunately, his book *MEDICINE IN RURAL CHINA* was not published until 1989 so accounts of his accomplishments were not easily available for others to read.
Chen's work demonstrated the possibility of developing a health services system from the bottom up.

Chen on Tinghsien (1934)

- The Tinghsien experiment represents the introduction of uplift from the bottom, instead of, as has generally been the case, from the top down. Being based on demonstrated village needs, it stands out as a distinct contrast to the usual institution of central governmental machinery which, even when it succeeds in filtering through the unit of administration, may be not entirely suited to local requirements. It is hoped that this experiment may some day be of historical significance.
What Chen did not say here is that he had to develop special training programs for the graduates of provincial medical schools, programs designed to provide them with the skills, knowledge and attitudes that would make them suitable workers for rural health.

Chen managed to develop this basic district structure in a period of 5 years.
While Grant and Chen were working on rural health in China, the League of Nations Health Organization turned its attention to rural hygiene, largely due to the success of what Stampar had accomplished in Yugoslavia.

The key elements of any rural health program were those showed in this slide.

NEXT SLIDE
The Chinese government invited the League of Nations Health Organization to advise and assist in the development of their health system. One key element was the establishment of a Central Field Health Station (CFHS) in Nanking in 1930 which helped train medical and health officers and auxiliary staff, including popular education and health propaganda.

Stampar visited China several times to help specific rural health departments develop basic elements of their health services.

This slide outlines the basic model that was developed in several hsiens.
While the LNHO was developing a health station and Chen was continuing with his work in Tinghsien, Grant was pursuing his campaign to involve the PUMC in a significant manner. It has to be understood that the Rockefeller Foundation was a private organization and thus the PUMC was not a state run institution.

As illustrated in this quote, Grant was keen on the importance of organization. Later he became a champion of regionalization. He fought hard to involve the PUMC in actively supporting China’s efforts to train physicians on a large scale.

**NEXT SLIDE**
While Grant worked on involving the PUMC in preparing the medical staff needed for such a program, Gunn worked on identifying the universities to be involved and subsidizing their program with funds from the Foundation.

Gunn established the North China Council for Rural Reconstruction for this purpose:

Nankai University for the field of economics.

Yenching University for the field of public affairs.

National Agricultural Research Bureau

And of course

Yen’s Mass Education Movement and the Peking Union Medical College.
The League followed up its 1931 rural hygiene conference for Europe with one in Bandoeng in 1937. This conference is a milestone in the history of public health – up there with Alma-Ata.

In addition to the China experience and other countries such as Japan and India, two other Foundation staff members joined Gunn at Bandoeng, John Hydrick and Sylvester Lambert.

NEXT SLIDE
Lambert was hired by the Foundation in 1918 to work in the South Pacific, where he was the Foundation's sole representative from 1918 to 1939, the year of his retirement.

During a visit to Fiji he discovered the presence of Native Medical Practitioners – natives given a three-year course in simple medicine and surgery. They had “no classroom, no charts, only one small book of simple medicine and hygiene, and that was written in Fijian.” He studied this system, which had been in place for over thirty years. In time he persuaded the Foundation to assist in the construction of a new school, whose aim was “to encourage the training of students from territories other than Fiji.”

With the financial support of the Foundation the Suva school was established on a firm footing, and in 1928 was designated the Central Medical School for Native Medical Students.

**Sylvester Lambert (1883-1959)**

- Lambert’s formula for improving the health of indigenous populations in the Pacific: Native doctors and nurses to care for current illnesses and educate their people in the prevention of disease . . .; attention to infant and child welfare; reliable census-taking to check results — all under the supervision of competent European physicians and nurses. Add to this a careful study of native customs on the part of the civil administrations, so that they may learn respect for the more wholesome of the folk ways that have given life’s zest to the people.
Hydrick began his work in the Netherlands India in 1924. The sanitary habits that were promoted in the anti-hookworm campaign were to serve as “the foundation upon which general hygienic work” could be built. Such work included “the use of mosquito nets ... (and) the use of boiled water.” The cooperation of the people was necessary in all of this work and active cooperation “is to be secured only through education until the public has understood the ‘why’ of the measures proposed.”

The detailed activities of each of the field stations that he helped establish were carried out by hygiene mantris, midwives, and other members of the subordinate personnel. Mantris were health workers who initially were concerned with educating the public about hookworm before moving on to other problems. They were all males (at first), were literate, spoke well and inspired confidence. Midwives entered the program at a later date. Hydrick arranged for their training to be conducted by experienced midwives.
These images are from his book

Appropriate Technologies - Hydrick

NEXT SLIDES
These next two slides are some of the recommendations made at this conference. There was no effort to consolidate them or to rank them as they emerged from the different working groups that met during the conference.

Bandoeng Recommendations – 1

- Preventive medicine is the cheapest means of improving the health conditions of the population in the rural areas, and it is along preventive lines that the effort should be principally directed.
- It is absolutely necessary to bring medical and health services as near to the population as possible, but the decentralization of activities should be guided and supervise by a central body in order to maintain efficiency and ensure a uniform policy.
- The spirit of preventive and social medicine should permeate more and more the whole programme of medical education.
- A large body of adequately trained auxiliary personnel is important to ensure that the connecting link between the rural inhabitant and the medical men may be as efficient as possible.
Bandoeng Recommendations - II

- As any success in rural reconstruction is dependent on the presence of properly trained personnel it is necessary that adequate facilities should be provided for the formation of technical personnel needed in all branches of work. The selection and training of suitable personnel, both men and women, is all-important. The training must be of practical nature, including actual participation in rural work.

- Realizing the increasing importance of the role which must be played by women in rural reconstruction... everything [should] be done to ensure that women shall be given all opportunity to develop their activities in this important field.

- Without land reform... rural reconstruction will not rest on a permanent basis; serious consideration of this problem and the study of methods best adapted to local conditions is urgently recommended to Governments.
One final point before turning to the post War period,

When Gunn was forced to leave China in 1937 he returned to Paris where he explored some of these items with Stampar who also had left China and returned to Yugoslavia. They were particularly interested in the education of peasants.
I am not convinced that this portrayal of the post-World War II period is anywhere near complete.

The World Health Box 1950-1953 sits there as if it had no impact on the years that followed.

I would appreciate any suggestions of names, events and experiences to add to this remembering that it is a picture of the roots of WHO’s PHC program in the early 1970s. There are many other arrows that could be added if one were looking further into the future, e.g. Kark’s influence on Jack Geiger in America to mention just one.
What is clear is that World War II dramatically altered international health work.

It should also be noted that Gunn never managed to convince the Foundation’s Medical Education Division to incorporate preventive medicine in its educational programs and that Grant never convinced his superiors to accept the PUMC playing a central role in the building up of the Chinese health services.
Chronologically speaking the first new person to add to this history is Sydney Kark who Grant visited in 1947.

There is strong evidence that suggests that key South African health leaders, who were in China in the early 1930s, learned of programs such as Chen’s, and brought those ideas back to South Africa on their return.

After graduating from medical school in 1936, Kark undertook a year-long survey of health and nutritional state of South African children before being appointed head of the health unit at Pholela in rural Natal Province, where he and his wife Emily established a model health center.

From there he moved to Durban to direct a newly created Institute of Family and Community Health whose mission was to train personnel for the large network of health centers based on the Pholela model.
Getting doctors involved in community care was one of the essential features of the social medicine movement that had developed in the European context earlier.

Changes in the national government put a stop to these centers. He and his wife left for Israel, where he headed the Department of Social Medicine at the Hebrew University, a position he held until his retirement in 1980. During this period he developed ideas that he placed under the heading of community oriented primary care.

Kark on role of medical schools

The fact is that doctors and nurses and their substitutes in many countries are not trained to practice community medicine. Their medical schools, built around teaching hospitals, have directed their orientation and skills towards individual care only and they have little competence in other fields which are no less important.

The investments by a university in exploring ways of developing new institutions for health care in the community is essential for the growth of community medicine as an added dimension of medicine.
The next new name is that of Milton Roemer

Roemer was hired in 1950 as a consultant by WHO to visit El Salvador and then Ceylon in the hope of developing demonstration areas in each country. At the time, he was with the US Public Health Service. He had co-authored a book on rural health and he was an ardent student of rural health programs in different nations, something that he managed to do throughout his life. In an address that he had given three years earlier, he referred to the LNHO 1931 rural hygiene conference and indicated that there was no question ‘that the present World Health Organization ... will likewise devote much of its efforts to the advancement of rural public health services throughout the world.’ He clearly was the ideal person for this assignment.
As I am concentrating on what influenced WHO to adopt PHC in the 1970s, I did not make any effort to identify other projects that demonstrated the potential of PHC-like ideas. Instead, I looked for publications that profited from such projects – such as Maurice King’s book on medical care in developing countries published in 1966.

This publication grew out of the fact that when he took over responsibility for a remote mission hospital he discovered that there was no literature to prepare him for this job. So he organized a conference in 1963, took all of the papers from it and spent 18 months preparing this publication.
Of particular note in his list of axioms is the call for organizing medical services from the bottom up and not from the top down.

Both Kark and Fendall contributed chapters in King’s book.
Kark contribution was a chapter entitled *An Approach to public health* from which this slide was taken.

Kark went on to write Epidemiology and Community Medicine which was published in 1974 and is considered a classic.

This is another publication that one wished had been available much earlier.
Fendall contributed to King's book with a chapter on the health center in which he had this to say about the value of auxiliary staff.

**Rex Fendall on the value of auxiliary staff**

- In most developing countries professional staff, especially doctors, are so scarce that health centers have to be staffed by auxiliaries, and preferably by auxiliaries indigenous to the region. But this is no disadvantage, for they are at the same time more economical and are generally more closely in touch with the local inhabitants than are doctors, and, very important indeed, they are also much more content to remain in the rural areas.
It is around this time that Fendall joined Jack Bryant and two other investigators to carry out a study of health and the developing world, the result of which was written up by John Bryant.
Effective approaches to providing health care cannot be developed without a strong commitment from the university. But that commitment requires more than adding a course in preventive medicine or providing time at a rural health center. It involves new roles of leadership for physicians and nurses, and the university must understand these roles and develop settings in which they can be learned. It involves welding the potential of students from different educational levels into effective health teams, and that will require reaching outside the usual university boundaries...It involves new sets of professional attitudes, and these cannot be developed without changing the academic atmosphere with new values.

Bryant added his name to that of Grant in calling for a strong commitment to community health on the part of universities. I’ve lost count of the number of publications that have made the same call.
Two final publications perhaps better known to most of you:

The *alternative approaches study* grew out of a call on the part of UNICEF to search for better models for delivering health care. Many of the same experiences that were written up there found their way in *Health by the People* which was edited by Ken Newell, Director of WHO’s Strengthening of Health Services Division and responsible officer for the PHC document that went to the Executive Board in January 1975.

NEXT SLIDE
A firm national policy of providing health care for the underprivileged will involve a virtual revolution in most health service systems. It will bring about changes in the distribution of power, in the pattern of political decision-making, in the attitude and commitment of professionals and administrators in ministries of health and universities, and in people's awareness of what they are entitled to. To achieve such far-reaching changes, political leaders will have to shoulder the responsibility of overcoming the inertia or opposition of the health professionals and other well-entrenched vested interests.

Some of you may have noticed the arrow linking Roemer to this study. This is due to the fact that he wrote the concluding chapter, something I learned from the secretary who typed it only a few years ago.
I like this last quote as it suggests a role that historians might play in the promotion of PHC, namely describing and analysing in greater detail significant changes that have taken place in the manner in which countries have approached health systems development – both those that have failed and those that have succeeded.
This last slide is a more complete picture of the multitude of factors that helped in the development of WHO’s PHC strategy.

It illustrates if nothing else the almost impossibility of really describing which roots and branches were most important in this history.

Thank you for your attention.