The Origin of PHC

Some leading names and major events 1928-1974
Health services development needed to be guided by 7 principles which stressed the need:

(a) to shape PHC “around the life patterns of the population”;
(b) for involvement of the local population;
(c) for “maximum reliance on available community resources” while remaining within cost limitations;
(d) for an “integrated approach of preventive, curative and promotive services for both the community and the individual”;
(e) for all interventions to be undertaken “at the most peripheral practicable level of the health services by the worker most simply trained for this activity”;
(f) for other echelons of services to be designed in support of the needs of the peripheral level; and
(g) for PHC services to be “fully integrated with the services of the other sectors involved in community development.”
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 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 in his capacity as AJPH editor

- Public health is purchasable. Within natural limitations a community can determine its own death-rate.
- Sanitary instruction is even more important than sanitary legislation.
- No sanitary improvement worth the name will be effective, whatever acts you pass or whatever powers you confer on public officers unless you create an intelligent interest in the public mind.
- Nothing great was ever achieved without enthusiasm.
- Public health is the foundation upon which rests the happiness of the people and welfare of the state.
- Reform directed towards the advancement of public health must ever take precedence over all others.
- Money spent for the public health is an investment, not an expenditure. It costs less to keep the people well than to get them well.
Andrija Štampar (1888-1958)

- Born in a small village in Croatia; he went to Vienna in 1906 to study medicine, where he received his degree in 1911.
- In 1913 he became district health officer at Nova Gradiška. In 1918 appointed Health Advisor to the Commission for Social Welfare in Croatia but within a few months, he was made Head of the Department of Hygiene and Social Medicine, a position that he held until a year before King Alexander exiled him in 1931.
The poor have to prepare meals, eat, sleep, and give birth to children in one and the same room; some, still poorer, have to share one single room with another family, their children growing up together.

Workers have to work in factories with no basic hygienic facilities, inhaling stuffy, polluted air, moving round machines placed too close to each other, always afraid of being injured by them. And exhausted with all that, they very often have nothing but a dry crust of bread to eat at home, or sometimes not even that.

Peasants, too, live crowded in small cottages on their small holdings, differing from industrial workers only in that they enjoy fresh air during their work, all other conditions are the same.
An example of Štampar’s approach

- The Yugoslavian Central Institute of Hygiene trained district school teachers in rural hygiene and equipped them with lecturing materials, portable projection equipment and slides especially created to appeal to local peasant interests. During the winter slack season in the agricultural areas, these teachers toured villages giving lectures, which were further reinforced by the agricultural and veterinary inspectors of the agricultural cooperatives, as well as by traveling ‘health visitor’ classes on hygienic housekeeping, nutrition, maternal and child care, and traveling dispensaries for the treatment and control of infectious diseases.
As responsible RF officer in Paris – Gunn visited all European countries – first met Štampar in 1923 – he was so impressed that he managed to obtain $300,000 between 1924 and 1929 to help fund Štampar’s efforts.

On the receiving end, Gunn learned about social medicine in particular about rural health and the linkages between rural health and other sectors especially that of agriculture.
Yugoslovia 1920s

- Under Štampar's leadership, 250 socio-medical institutions were founded in the first five years, including: 1 Central Institute of Hygiene in Belgrade, 6 Institutes of Epidemiological Research, 19 Bacteriological Stations, 23 General Health Stations, 1 Institute of Tropical Diseases, 1 Institute of Malaria, 3 Malaria Control Stations, 50 Anti-venereal Dispensaries, 34 Anti-tuberculosis Dispensaries, and 2 Institutes of Social Medicine.
Gunn referred to the work of the IHD in “certain European countries,” out of which there was a “growing feeling that the time has come when governments should consider the possibility of elaborating more unified programs.” In particular, “health officers feel that the development of a health program is an isolated effort (and as) important as such a program is, it is far from solving the complicated problems of the community.” A wider effort was needed, as suggested by the initiative of some countries to create ministries of Public Welfare.

Gunn illustrated the beneficial results that could be expected from this new initiative by an example drawn from Yugoslavia. There, it was found that epidemics of diseases in cattle were so severe as to cause great financial loss, so much so that there were not adequate funds for public health work. In such a situation “steps must be taken to introduce the known methods of preventive and veterinary medicine.”
Unexpected Developments (1932)

• Štampar forced to leave Yugoslavia.
• Gunn leaves Europe to explore possibilities elsewhere.
• LNHO hires Štampar as a consultant for China.
• Gunn decides China is where he wishes to move to.
• John Grant who joined Gunn’s program said later: 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.
John Black Grant (1890–1962)

- Grant spoke Chinese fluently having grown up in China where his parents were Canadian missionaries.
- Joined Rockefeller Foundation in 1917; assigned to Peking Union Medical College (PUMC) in 1921 to teach preventive medicine and to help the Chinese government initiate public health activities.
- Grant’s major contributions were through his students and his influence on Governmental policies and programs.
The use of a local community for teaching purposes

- Grant constantly made the argument that a good sample community of from 40,000-60,000 population was to a department of public health what a 250-bed hospital was to the departments of medicine, surgery, and obstetrics.
- At first he used a health center in an urban neighborhood in Peking that he helped establish to work towards this goal.
- In 1929 he associated the PUMC with Jimmy Yen’s Mass Education Movement which had established its rural base in Tinghsien a rural district and town of the same name, less than 100 miles from Peking.
CC Chen (1903-19??)

- According to Chen, it was Grant, whose lectures in public health he first heard in 1926, who “steered” him into public health and who led him and others “to recognize the hazards involved in adopting foreign models in toto, rather than adapting medical practice to local needs and conditions.” Chen dedicated his book *Medicine in Rural China: A personal account*, to “Betty and Jim, in memory of their father, John B. Grant, M.D.”

- Chen took over responsibility of health program in Tinghsien in 1932.
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.
China – Tinghsien Experiment

- In time the rural health services developed at Tinghsien covered more than 150 villages and consisted of three levels of health care. Village health workers, selected by villagers, carried out simple health measures. Over them were sub-district health stations where a health officer, one or more public health nurses and an attendant, were present. The health officer was a graduate of a provincial medical school and was considered a general practitioner of public health. He and his nurses supervised the village health workers, in addition to conducting daily clinics and vaccination campaigns. Maintaining technical competency of these stations was the responsibility of the health center, which was located in the town of the county, and which comprised a hospital of 45 beds, a diagnostic laboratory, a central supply room and a health education section.
LNHO – Rural Hygiene Conference (1931)

- Rural populations have as good a right to health as children of urban population.

- Needed were:
  1. Control of epidemic and infectious diseases;
  2. Maternal and infant welfare;
  3. Pre-school and school hygiene;
  4. Campaigns against the ‘social diseases of TB, VD and trachoma;
  5. Sanitation;
  6. Mass health education;
  7. Medical Treatment.
LNHO – Rural Health Model for China

• A hsien health center including a small hospital of 30-50 beds in the hsien capital;
• A health station for each sub-district (about 50,000 population) with a physician, two nurses, one midwife and one or more helpers.
• A health sub-station with each commune, connected wherever possible with the school. The maternity, child, school health, vaccination, and general first aid work to be performed by a nurse.
Role of PUMC in China’s Health System

- The use made of medical knowledge and the efficiency of health protection depend chiefly upon social organization. The lower economic levels are, the more does the use of medical knowledge depend upon organization.
- The individual village with an average of one thousand inhabitants cannot support a physician, but ... it can support a village health worker ... who can undertake such primary things as statistics, smallpox vaccination, and first aid, provided he is supervised by a physician.
- Training physicians for such a role depends upon the provision of provincial training centers staffed by competent teachers and well-trained administrators.
- These are to be provided by the PUMC operating at the apex of a medical system and integrated with other vertical social activities in a joint horizontal attack upon the problem of social reconstruction.
The China Program, as conceived by Gunn, had “no precedent in Foundation history from which guidance” could be drawn. Being “a venture in an untried experiment”, it must “necessarily be free from rigidity, so that the lessons gained from experience can be used to advantage…” The program “involves bringing together Doctors, Public Health men, Agriculturalists, Engineers, workers applied Biology and Chemistry, Economists, Sociologists, Educators and others, in a most intimate manner, so that all realize that the success of the different technical fields is interwoven with the success of other technical groups.”
The LNHO 1937 Bandoeng Conference

LNHO
Rural Hygiene

China (1928-1937)
Tinghsien Experiment (Chen)
LNHO Rural Health (Stampar)
Rural Reconstruction Project (Gunn)

Selskar Gunn

John Hydrick

Sylvester Lambert

LNHO 1937 Bandoeng Conference on Rural Health and Rural Reconstruction
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
John Hydrick (1888-1958)

- Hydrick's 60-page book, *Intensive Rural Hygiene Work in Netherlands India*, was published in 1937. Essentially a ‘do-it-yourself’ manual, it is largely dedicated to environmental sanitation: latrine building, boiling of water, making houses safe, bringing clean water into the schools, protecting food from flies, et al. To bring about these advances it is necessary “to awaken in the people a permanent interest in hygiene and to stimulate them to adopt habits and to carry our measures which will help them secure health and remain healthy.”
Appropriate Technologies – Hydrick

An easily made toothbrush

The cost of the latrine should be proportional to the value of the house.
Bandoeng Recommendations – I

- 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.
LNHO – Agenda European Rural Life Conference (planned for 1939)

- the rural ambiance – peasant culture, art and folklore, farm loans, agrarian reform, the cooperative movement, rural development, community planning, transportation, electrification, local administration;
- food and produce;
- the rural house and its outbuildings;
- peasant education – general, technical, hygiene, homemaking;
- peasants at work – new farming methods, rural industries;
- peasants at rest – libraries, radio, cinema, *dopolavoro*; and,
- medical and social policies: maternal and child care, birth control, nurseries and kindergartens, malaria, hookworm, health personnel, midwives, *feldschers*
ORIGIN OF PHC – POST WORLD WAR II

Sidney Kark
Pholela Health Center (South Africa)

John Grant
RF Staff Member
Paris and New York

Andrija Štampar
‘Father’ of WHO

Rex Fendall
Kenya Rural Health

Maurice King
Medical Care in Developing Countries

John Bryant
Health & the Developing World

WHO Alternative Approaches

WORLD HEALTH ORGANIZATION 1973-1974
PHC

WORLD HEALTH
1950-1953
Rural Health Demonstration Projects

Milton Roemer

Ken Newell (editor)
Health by the People

John Bryant

WHO

Milton Roemer

WORLD HEALTH ORGANIZATION 1973-1974
PHC
Institutional Loss of Pre-War Momentum

- LNHO allowed to die
- Key Bandoeng participants no longer involved in international health
- Chen stayed on in China
- Rockefeller Foundation ended its international health program
- WHO had other priorities than rural health
- Continuity mostly through Grant and Štampar
Sydney Kark (1911-1998)

• In 1947 Grant visited 12 countries – one of which was South Africa where he ‘discovered’ Kark’s Pholela health center.

• Grant spoke about Kark’s program in America indicating that it could serve as model of how to use nursing personnel attached to health centers in areas undersupplied with physicians.

• Grant arranged grants to Kark and his wife to travel to US and fellowships for US students to visit Karks program in Pholela in South Africa.
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.
WHO Health Demonstrations 1950-51

Milton I Roemer

- Objectives:
  1. To demonstrate a unit of well balanced health services.
  2. To demonstrate the modern methods and techniques in medical science as applied to a community for its prevention of diseases and promotion of health of the people.
  3. To demonstrate that health is a determining factor in an organized effort in social and economic development of an area. By organizing the simultaneous multiple approaches, the social and economic development of a community can be achieved more efficiently and effectively.
Maurice King (1927- )
Maurice King – some axioms on medical care (1966)

1. The medical care of the common man is immensely worthwhile.

2. A medical service must be organized to provide for steady growth in both quantity and quality.

3. Patients should be treated as close to their homes as possible in the smallest, cheapest, most humbly staffed and most simply equipped unit that is capable of looking after them adequately.

4. Some form of medical care should be supplied to all the people all the time.

5. Medical services should be organized from the bottom up and not from the top down.
Sydney Kark example of an aid for community diagnosis

kwashiorkor in the community.

- Occupation
- Education
- Beliefs
- Attitudes
- Framework of knowledge
- Food habits
- Season
- Food production
- Rainfall
- Urban versus rural living
- Family composition
- Infections
- Age & sex
- Child movement between homes, maternal deprivation
- Child rearing practices, weaning
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.
John Bryant (1922- )
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.
Key WHO Publications

- Alternative approaches to meeting basic health needs in developing countries
- Health by the People
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.
If rural and community development is to be a series of progressive changes rather than a convulsive jump, the persons involved with health will also have to be able to change, improve, and adapt themselves in step with the community organization. It is possible to visualize a series of steps whereby a community could start by improving the service already there …

One would need to evolve a way of feeding in ideas and techniques progressively as the need arose and the priorities changed. With this type of education it would be inconceivable that the present irrelevance of education to service could continue
ORIGIN OF PHC – EARLY 1970s

OTHER AGENCIES
- UNICEF – BASIC SERVICES
- ILO – BASIC NEEDS
- UNRISD – CIVIL SOCIETY

WORLD HEALTH ORGANIZATION
1973-1974
- PHC

Christian Medical Commission (CMC)
- James McGilvray
- Nita Barrow
- John Bryant
- Carl Taylor

HEALTH for All

Alternative Approaches

Maurice King
Medical Care in Developing Countries

John Bryant
Health & the Developing World

Milton Roemer

Other Publications
- Paulo Freire – Pedagogy of the Oppressed (1970)
- Ivan Illich – Tools for Conviviality (1973)
- EF Schumacher – Small is Beautiful (1973)