

Global health in the making: health demonstration areas in Europe, 1950s and 1960s

Construcción de la salud global: zonas de demostración sanitaria en Europa, décadas de 1950 y 1960

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Abstract

Global health is a multifaceted concept that entails the standardization of procedures in healthcare domains in accordance with a doctrine agreed upon by experts. This essay focus on the creation of health demonstration areas by the World Health Organisation (WHO) to establish core nodes for integrated state-of-the-art health services. It explores the origins, theoretical basis and aims of this technique and reviews several European experiences during the first 20 years of the WHO. Particular attention is paid to the historical importance of technical cooperative activities carried out by the WHO in regard to the implementation of health services, a long-term strategic move that contributed to the thematic upsurge of primary health care in the late 1970s.

Keywords: health demonstrations; health services; Soissons (France); Uusimaa (Finland); Larissa (Greece).

Resumen

Salud global es un concepto complejo que implica la normalización de los procedimientos de actuación sanitaria siguiendo una doctrina acordada por expertos. Este trabajo se ocupa del establecimiento de zonas de demostración sanitaria por la Organización Mundial de la Salud (OMS) a modo de núcleos de modernos servicios sanitarios integrados. Revisa el origen, las bases teóricas y los objetivos de esta técnica y examina diversas experiencias europeas durante los primeros veinte años de la OMS. Pone de manifiesto la importancia histórica de las actividades de cooperación técnica de la OMS en la puesta en marcha de servicios sanitarios, una estrategia de largo plazo que ayuda a entender la aparición de la atención primaria de salud a finales de la década de 1970.

Palabras clave: demostración de salud; servicios sanitarios; Soissons (Francia); Uusimaa (Finlandia); Larissa (Grecia).



The concept of global health encapsulates various meanings, ranging from the description of a new awareness of social and political conditions linked to health-threatening phenomena to a rationale for managing health and health inequities on a world scale. It is also the name of an academic discipline: a new twenty-first century field producing knowledge and action on the health of populations, which entails common knowledge and common procedures within the domain of healthcare, facilitated through the reproduction of organisational patterns (Spiegel, Labonte, Ostry, 2004; Brown, Cueto, Fee, 2006; Koplan et al., 2009; Beaglehole, Bonita, 2010; Zylberman, Flahault, 2017). Standardization in health and medicine began in conjunction with the achievements of laboratory science towards the end of the nineteenth century. During the next century this historical process was successfully continued by interstate and private international agencies. Most prominent was the World Health Organisation (WHO), established in 1948 to take on the duties of the International Bureau of Public Hygiene (Office International d'Hygiène Publique), the League of Nations Health Organisation (LNHO) and the United Nations Relief and Rehabilitation Administration. The WHO's technical cooperation functions have been a major factor in establishing universal standards of medical practice across the world (Lee, Fang, 2013; Jamison, Frenk, Knau, 1998). Although, as has been claimed, the WHO's scientific authority originates from its ability to mobilize knowledge, the production of this knowledge depends on practical agreements on professional practices (Sturdy, Freeman, Smith-Merry, 2013, p.551).

In this study I focus on one particular professional practice, the health demonstration and training area, which the WHO used to address problems in the availability and accessibility of healthcare in complex geographical, ethnic and professional contexts. This technique, created and disseminated during the interwar years, was maintained by the WHO through the 1950s and 1960s. While its main targets were less developed countries, the European region also hosted a number of these initiatives. As I will demonstrate, the European health demonstration and training areas established in the 1950s were intended to be international training grounds for modern health practices in rural settings, and, in line with the origins of the WHO and its initial supply of Western-based officers, were dependant on American philanthropic legacies linked to pre-Second World War interventions (Löwy, Zylberman, 2000; Farley, 2004; Birn, 2014). The European health zones initiated during the 1960s and 1970s were framed within national contexts of planning for development, thereby maintaining an intellectual connection with interwar social medicine. All of these zones shared a common pattern of integrated health services for rural populations, in which non-medical professionals held relevant functions in close contact with local people, and doctors performed both curative and preventative activities.

The current historiography on the WHO highlights the mixed blessings of the grand eradication campaigns, the short-lived primary health care strategy, and the eroding of the WHO's leadership capacity following the neo-liberal thrust (Packard, 2016; Cueto, 2004; Brown, Cueto, Fee, 2006; Fee, Cueto, Brown, 2008; Birn, 2018). The recent book by Cueto, Brown and Fee (2019) widens this scope to include disputes over the human right to health and the most recent developments of the twenty-first century. Still, I believe insufficient research has been dedicated to the history of health service planning and administration, an

inner thread in the Organisation's fabric which significantly contributed to its development as an international actor, in the sense applied by Chorev (2012). Cueto (2004, p.1866) has pointed out that, from the late 1960s, increasing numbers of WHO projects were related to basic health services, which he views as the "institutional predecessors" of the primary health care programmes, while Gorsky and Sirrs (2019) have recently focused on the lineage of advisory work carried out by the WHO concerning health services and explored the intellectual history of health service organisations.

My article contributes to establishing a longer genealogical chain for the proposal for primary health care and the health for all strategy in the late 1970s, which has previously been explained as a conjunction between LNHO's rural health interventions up to the late 1930s (Borowy, 2009a, 2009b) and criticism of the campaign's paradigm that had appeared by the mid 1960s, together with certain local inspiring experiences (Litsios, 2002; Cueto, 2004; Cueto, Brown, Fee, 2019, p.170-171). Most of these local ventures developed along the basic health services approach disseminated by WHO (Djukanovic, Mach, 1975) infused with a political and educational community approach, labelled "health by/with the people" instead of "health to the people" (Gish, 1979). Among others modern authors, Litsios (2002, 2015) claims that LNHO's rural health interventions up to the late 1930s (Borowy, 2009a, 2009b) were precursors of these strategies. Yet the concrete ways in which concepts and techniques migrated from the 1930s to the 1970s remain to be disclosed. The study of local case projects by the WHO in health services during the 1950s and 1960s in the health services domain enables us to uncover some of these paths and locate valid explanatory clues. By following the patterns of the organisation and implementation of the health demonstration and teaching areas as a model of basic rural health services, my approach complements the theoretical stance taken by Gorsky and Sirrs (2019).

The main sources for this essay are official WHO documents, most of which can be freely accessed through the internet. These include the annual reports of the director-general, reports by expert committees issued in the Technical Report Series and the official chronicles like *The first ten years of WHO*, *The second ten years of WHO*, *Forty years of WHO in Europe* and *Sixty years of WHO in Europe*. I also consulted an unpublished report of a European workshop of 1963 on health demonstration zones kindly furnished by the current director of the regional public health centre at Talavera de la Reina. I have scrutinised exhaustive literature in French, English and Spanish on each specific area, along with sources relating to the two older ventures from the Rockefeller Archives. Ignorance of the Greek and Finnish languages prevented me from access to a presumably useful bibliographic body.

In what follows I will briefly examine/review the origins of the health demonstration technique and its survival after the Second World War, then discuss the extent of public health demonstrations in post-war Europe, summarise different experiences – some with EURO-WHO support, others without – and end with some conclusions.

Health demonstrations: the origins

The concept of "health demonstration" was born within the dynamics of the new public health movement in the interwar years, in a cluster of ideas that also included

“health centre” and “health survey.” It was forged in the US public health practices of the interwar period, particularly in the industrial North-East, where short-term showcases of “community health machinery” (The Framingham..., 1920) were intended to educate both the general public and local authorities about health, and persuade the latter to consider health promotion an abiding aspiration (Weindling, 2008; Murard, 2008). Demonstrations put into practice the new principles of public health, which had moved from a sole emphasis on the natural environment (i.e. public health as sanitation, hygiene as a complete cleansing operation) to bringing individuals into focus through a consideration of germs, the social environment (adding housing, nutrition, education and occupation) and heredity, and even further, to pointing towards a concept of positive health. The technique was a direct avenue through which to conduct the shift “from moral exhortation to the new public health,” as Paul Weindling (2002) has phrased it. This transformation of public health had begun in industrialized Europe against specific so-called social diseases like tuberculosis, and complex conditions such as high infant mortality, and was generally known as social medicine or social hygiene (Porter, 1997; Rodríguez-Ocaña, 1983, 1992; Rodríguez-Ocaña, Molero Mesa, 1993). The value of a demonstration area lay in its flexibility: its ability to be carried out in a complex institutional context and serve as a means of establishing cooperation toward a common goal between different charity organisations, state or municipal authorities, insurance companies and anyone else with a vested interest (D’Antonio, 2017).

Historians of health agree on the existence of various initiatives during the interwar years that traversed oceans and modified local scenarios through blending with the “translocal community experiments” developed by a generation of internationally-minded public health experts (Murard, 2005, p.219). This was certainly the case in the newly independent Yugoslavia, where American philanthropists discovered a richer concept of health centre – including recreational aspects – shortly after the First World War (Weindling, 2008, p.73). American experts were fully aware of this multi-centred development, recognised at the Symposium on the Health Center held by the American Public Health Association at its 49th meeting in San Francisco in 1920 (Symposium..., 1921). Demonstrations, in the working concept employed by American foundations, were viewed as laboratories, as Weindling (2008, p.70-71) has shown, in which principles of national – and international – value could be formulated. Demonstrations were a way of educating the public through their own experience, thwarting unhealthy conditions and producing new knowledge relevant for health authorities and professionals. They stood, as Lion Murard (2008, p.144) has phrased it, on “a well-worn positivistic faith in an unforced universalization of best practices.”

Coexisting with these developments was the birth of a new structure: the health centre, a “department store of health” (Rosen, 1971; Wilinsky, 1927). Often the installation of a health centre and the launch of a health demonstration would be coordinated, as in Cincinnati between 1917 and 1920, the Bellevue-Yorkville (New York city) health demonstration in the mid-1920s, those by the US Public Health Service and the Rockefeller Foundation’s funding for rural health services, including those in Europe. Here, as shown in the European conferences on health centres (Budapest, 1930) and rural hygiene (Geneva, 1931), the launching of “a comprehensive rural health system,” according to Borowy (2009a, p.337), required the establishment of a technical space, the health centre (Packard, 2016, p.66-88).

Whereas a health demonstration programme was temporary, a health centre or unit was a permanent facility, materially one building, which supported many or all of the activities showcased in a health demonstration, including the health survey.

Another technical device to attain its modern form in the same matrix as the health demonstration and the health centre (Ichok, 1929; Weindling, 2005), the health survey was defined as “an investigation conducted by a trained corps of workers to determine the exact status of those conditions which may affect the health of the community” (Horwood, Schevitz, 1921, p.113). By 1920, in the USA, a large number of public health surveys had been conducted “during the past five years alone” through philanthropic foundations and health demonstrations (p.114).

If we had to identify the single most significant, professional characteristic in the development of health demonstrations and health centres, it would undoubtedly be the consolidation of home-visiting and public-health nursing, in many cases intertwined with an increasing interdisciplinary context, such as transpired in the East Harlem case studied by D’Antonio (2017). The name of Richard Cabot (1865-1939) and his *Social service and the art of healing* (New York, 1909) must also be included in this discussion: the figure of the social worker made a significant appearance within this complex matrix.

As rural health became a burning issue immediately before the Second World War, we know that health centres and health demonstrations were a familiar sight in many European countries and spread to other parts of the world, thanks to the actions of the League of Red Cross Societies, American health philanthropists and the League of Nations Health Organisation, in association with local European initiatives. Numerous experts and organisations active in rural public health who survived the war committed themselves to WHO initiatives, which, in turn, were decisively marked by this legacy. Prominent among these were certain Rockefeller men actively involved with social medical tasks, such as John Grant (Birn, 2014, p.133).

The survival of health demonstrations after the Second World War

The notion of the health demonstration was kept alive by the newly established WHO, as it corresponded with the prevailing idea of top-down international health action: that is, the transfer of science, technologies, experts and experiences from developed to underdeveloped countries. Demonstrations relating to health, as well as agriculture, education and other fields of expertise, were the primary way of transferring knowledge (WHO, 1953a, p.30). According to Chisholm, demonstrations could portray health work as “an integral part of the social and economic development of the community,” closely linked to “the improvement of health aspects of economic and working conditions” (WHO, 1951, p.1, 25).

Once the most urgent post-war demands had been met, the WHO sought to implement the expanded Programme of Technical Assistance for Economic Development of Under-Developed Countries, as approved by the Third World Health Assembly (1950), around three priority fields: communicable diseases, professional and technical education, and public health administration (WHO, 1950). As mentioned earlier, the commitment of the WHO to

the first item has so far received the strongest attention, obscuring the historical importance of the other two concerns. The concept of health demonstration was of immediate use in all three fields, as can be followed through the annual reports of the director-general. Use of the technique in campaigns against communicable diseases produced a number of care and teaching centres that concentrated resources, provided experiences of new techniques and regularly trained health personnel of various professional levels to be employed in the same tasks elsewhere in the country. In its chronicle of the *Second ten years of WHO*, the Organisation acknowledged the partial failure of this venture, as “training and demonstration projects alone were not sufficient” against communicable diseases (WHO, 1968, p.127).

Concerning health services, the director-general of the WHO had received multiple requests of help from Ceylon, Chile, Colombia, Egypt, El Salvador, Haiti, Korea, Peru and Venezuela by 1950, and therefore highlighted the preparedness of his organisation to establish health demonstration areas (WHO, 1951, p.25). The health demonstration areas, or districts, served as model organisations for integrated health services, both preventive and curative, in mostly rural areas. This notion of “integrated health services,” first advanced in the 1920s (Gorsky, 2006), expanded by the elite of internationally-minded health experts by the end of 1930s, was put into action in several pre-war situations in Europe and Asia, and thrived in the post-war era (see for instance Terris, Kramer, 1949; Roemer, Wilson, 1950). At the height of Cold War in the absence of the USSR and fellow socialist countries, it became the subject of discussions during the fifth to seventh World Health Assemblies (1952 to 1954) (WHO, 1952). With the understanding that “the human factor is fundamental to social and economic development and that the protection and improvement in health must underlie any programme to raise the standard of living” (WHO, 1953b, p.29), the goal of integrating health services was accepted as a criterion for implementing the UN Technical Assistance Programme. Similar discussions took place at the second session of the expert committee on Public Health Administration (Geneva, September 1953), which defined integrated health services as necessary for the health protection of a given area. In this context, health protection represented a label covering health promotion, prevention of sickness, and curative and restorative medicine (WHO, 1954, p.4). This idea would live on through the notorious resolution of 1970 on Basic Principles for the Development of National Health Services, made by the plenary of the 23rd World Health Assembly at the instigation of the USSR (Litsios, 2002). Thus, it can be considered as removed from the capitalist vs. socialist ideological conflict within UN organisations. As a British consultant recorded in 1967, this issue lay at the core of professional public health theories at that time (Brockington, 1967). Meetings of the Expert Committee on Public Health Administration held in 1951, 1953 and 1959 put forward recommendations and plans for devising basic schemes, as noted by Gorsky and Sirrs (2019), to provide “reasonably adequate health coverage of the total population” (WHO, 1968, p.22).

In 1950, the WHO had approximately 30 advisory and demonstration projects operating in around 20 countries. The actual success of these ventures cannot be judged from its official chronicles, which categorised local health demonstration merely as “a well-known technique, used in most country projects” (WHO, 1958, p.152), while during the second

decade concerns over long-term national planning came to the fore (WHO, 1968, p.22); in fact, we would need a host of local studies, so far non-existent, to achieve such a judgment. Yet its overall failure can be deduced from later critical testimonies endorsing plans for primary health care, as evidenced in the joint WHO-UNICEF report by Djukanovic and Mach (1975).

Two of the aforementioned ongoing WHO projects in 1950 were developed in Europe: a port demonstration project against venereal diseases in Rotterdam, and a multifaceted operation to create a rural public health demonstration area in Soissons, the latter being part of the “steady increase in the cooperation” with the European Office of the Rockefeller Foundation (WHO, 1951, p.111). The contributions of personnel, infrastructure and agenda from the Foundation to a nascent WHO were significant, at least during the initial two decades (Birn, 2014, 2018). The Soissons area was identified as akin to one in El Salvador (WHO, 1953b, p.25), which in turn was “similar to the rural reconstruction programs run by the League of Nations and the Rockefeller Foundation in China in the 1930s,” according to Packard (2016, p.101-102), who underlines the leadership of Milton Roemer.

By 1959, the WHO project list included demonstrations in up to 38 projects affecting 27 countries. Half of these were public health administration projects, including Soissons in France, Uusimaa in Finland and the recently launched Larissa in Greece. Confidence was high that “the standards and procedures” used in the selected areas would become routinized throughout the country in question or even be useful in other territories (WHO, 1966, p.99-100). In 1969 there were 29 demonstration projects in 24 countries, 14 of them including demonstration zones, of which 64% were based in Africa. Only Larissa and a new Spanish area, later located at Talavera de la Reina, were recorded as WHO-assisted projects within the European zone. At the same time, health demonstration areas established without EURO-WHO advice or financial backing could be found in several other European countries.

The rationale underlying these European developments was not uniform, and differences in scope, functional and material structure were evident, as discussed in the following section.

European health demonstration areas, 1950-1970

Soissons (France), 1950-1968

According to official WHO sources, a rural demonstration and training area was being planned for Soissons during 1950 and 1951 by several “interested agencies,” with the WHO providing assistance in the form of a statistician in 1952. During 1954 and 1955, the project EURO 61 was branded the Rural Public-Health Training Centre, Soissons, and funded by EURO-WHO, the International Children’s Centre (Centre International de l’Enfance, Paris) and the Rockefeller Foundation. From 1956 on, under project EURO 61.1, references are made to a series of five Rural Public-Health Training courses, plus a Public Health Nursing course (1959) and a course on Public Health Practice (1967) at the site, attended by international participants funded by the WHO and students from the French School of Public Health.

Soissons was historically the centre of activities carried out by an American philanthropic association developed around Anne Morgan (1873-1952), daughter of the financier J.P. Morgan, as of the start of the First World War, and its French version known as the Association d'Hygiène Sociale de l'Aisne (AHSA), which managed to establish a unique social nursing service carried out by women in rural France (Diebolt, Fouche, 1994; McGuire, 2014; Galoin, 2018). In 1945, along with Rose Dolan and Eva Dahlgreen as senior administrators, Morgan was back in Soissons to continue the work and help revitalise the AHSA (Saint-Gilles, 2003). They established a social home service in an original way, convincing all the relevant institutions to pay for service provision, which remained under AHSA control. This novel local tradition was highlighted as one of the main reasons to select Soissons as a demonstration area (Note..., 1954).

In Paris on 29 June 1948, Rose Dolan met Mary Elizabeth Tennant, assistant director specializing in nursing and public health for the Rockefeller Foundation, to request support for the AHSA.¹ After three years of negotiations between the organisations and French local and national authorities and, by 1950, the WHO and UNICEF, a general plan was drawn up to consolidate the work of the AHSA in the area, while adding a training dimension. Morgan's philanthropy provided a fellowship for the retraining of a future director, and Louis Lataillade (1910-1988), a medical doctor in microbiology, hygiene and colonial medicine at the University of Algiers, *inspecteur de santé* and head of the departmental health office of Hautes Alpes since 1946, was selected. He spent a year (1949-1950) at Harvard University Public Health School, securing a Master's in Public Health.² The Rockefeller Foundation offered to support the creation of a "laboratory for public health and social medicine" and the Centre de Santé Publique de la Région de Soissons, instituted in 1951, went on to develop a combined programme of complete public health and social work service training for national and international students (Tennant, 1952).

The Soissons centre, legally owned by the AHSA, provided services for around 150,000 inhabitants and covered a third of the Aisne *département* around Soissons. Between 1953 and 1958, a Rockefeller grant enabled the development of core services. The centre was introduced as a coordinating hub for the health concerns of the existing province and municipal administration, social insurance agencies and Mutualité Agricole, thereby skilfully securing the cooperation of all health service providers; "Dr. Lataillade's keenness and diplomacy" were particularly noted (Note..., 1954, p.4). By 1963, the director had recognised that initiating collaboration between pre-existing services had been easier than the integration of preventive and care activities (Broyelle, 1964). Involvement of the local civil hospital was of paramount importance, both for providing space – housing the centre's central office, for instance – and supplies. Incidentally, both the mayor and vice-mayor of Soissons were medical doctors based in the local hospital when the centre was founded. The provincial health officer delegated his authority over the area to the director of the centre, his deputy officer. As with previously implemented social work and home care, the idea was to avoid functional and personal duplications and overlaps.

According to its founding director, the work of the Soissons centre related to four subject areas, namely health and demographic statistics, public health (*hygiène publique*), social hygiene, and training and education (Lataillade, 1957). Interestingly however, a diagram

in the same paper illustrating the initiative provides a different, twofold view: a general public health section including social hygiene, and a health education area with statistics, surveys, sanitation and training. Social services lay at the heart of assignments and served as a link to integrated care, accurately reflecting the core technique of the demonstration area: to add training, experimental and quantitative dimensions to already established health activities.

Initially the centre was intended to address issues relating to mother and child health, the fights against tuberculosis and cancer, and the experimental study of sanitation devices. The proximity of Paris made it easy to secure specialists; only social workers were recruited locally, although two of the initial recruits had undergone complementary training in psychiatric social work. The centre introduced regular X-ray examinations in the countryside through a mobile unit, encouraged the establishment of mother and child consultations in all rural communities and created a premature baby unit at the hospital, furnished by UNICEF. It also supported the establishment of three child guidance clinics within a decade. External advisors indicated that, rather than seeing a doctor at a well-baby clinic, mothers preferred to be visited at home by multifunctional women social workers (*assistantes sociales*), of whom there were two at each rural station, equipped with a small car (Note..., 1954, p.2). However, over a decade or so, hospital-centred activities came to dominate the mother and child health field and the centre attempted to replace the women social workers with specialist nurses. By the mid-1960s, pressing issues revolved around changes in ambulatory care and new forms of hospitalization, such as day hospitals and aftercare centres, mental rehabilitation care and health problems of the elderly.

The training and education branch was in constant development, providing instruction to local, national and international personnel. This included refresher sessions for local medical practitioners, monthly social worker and nurse assemblies and specialist talks and presentations. The centre hosted groups of students in varied disciplines and professions from across the country, and from 1955 to 1967 it provided up to six courses on rural health or public health practice, organised by EURO-WHO. The Soissons facilities had been used as a practical training field for students at the French School of Public Health and the International Children's Centre since at least 1957. Visiting public health officers came from across Europe and the Near East for lectures, expert discussions and practical teaching. In 1955 the Soissons centre received 137 interns and 42 visitors, from 49 nations. In 1959 it provided a two-month public health nursing training course with the assistance of nine foreign European trainees plus three from Morocco. Almost a decade later, in 1967 and 1968, the Soissons centre received at least two groups of almost a dozen public health doctors from Spain each time, together with a consultant guide from the WHO (1973, p.257).

Uusimaa (Finland), 1959-1966

Uusimaa appeared for the first time in the annual report of the director-general of the WHO under project EURO 61.2 in 1959. Later annual reports refer to a "Rural Public-Health Training Course" (1959, 1961, 1962) and a "Course on Public Health Practice"

(1966). Previously, between 1952 and 1954, the WHO had sponsored project Finland 4 as a catch-all public health programme, encompassing tuberculosis control, the control of venereal and other communicable diseases, public health administration, environmental sanitation, nursing, social and occupational health, maternal and child health, mental health, and education and training.

Like Soissons, this area had prior connections with American philanthropy. The Rockefeller Foundation's International Health Division began to support professional nursing instruction in Finland in 1930 and continued until 1957 (Tallberg, 2006). By 1939, the Finnish National Health Administration had authorized a nursing and midwifery training area linked to the provincial health administration of Uusimaa. This area, extended after the war to the totality of the province, excepting the capital Helsinki, obtained a US\$ 36,000 grant from the Rockefeller Foundation in 1950-1953 to cover organisational tasks and the training of teaching personnel (Certification..., 1953) with strong support from John B. Grant (1949), and a further US\$ 32,500 during the period 1954-1957 (Official..., 1954). This money paid the salaries of consultants, sanitary inspectors and clerks, as well as additional income for health workers engaged in teaching.

The Uusimaa area extended across nearly 10,000km² with a population of slightly over 300,000. It contained three mental hospitals, four tuberculosis sanatoria with three associated mobile units, 16 minor local hospitals and 22 communal homes for the elderly (Uusimaa..., 1953). The area was presided over by the assistant provincial health officer, by then Leo A. Kaprio (1918-1999), who, with a Rockefeller bursary, had studied at Johns Hopkins University in 1947-1948 and earned a PhD from Harvard University in 1955. From 1948 to 1952 he directed the Uusimaa Health Teaching and Demonstration Centre, and between 1952 and 1956, as chief of the Public Health Section of the National Board of Health, he supervised the health services of the ten provinces of Finland (Kaprio, 1991, p.31; WHO, 2010, p.24). The first chief midwife/nurse supervisor was Kather Brotherus, who spent 1949 in the USA on an International Health Division fellowship.

In Uusimaa, the health demonstration area did not override pre-existing health services as it was conceived as educational support for professional training (Finland, 1949). Fields of work were roughly similar to those at Soissons and included rural obstetrics, mother and infant health, mental health, homecare for tuberculosis patients and environmental sanitation. The Finnish health system at the time was based on the municipal provision of health services (Lataillade, 1954). Each community was furnished with at least one physician, a part-time health officer and a part-time provider of private and charity care, as well as public health nurses and midwives according to population size. In the words of Lataillade (1954, p.661): "in the rural areas, by far the most populated, medical care is integrated with preventive medicine and sanitation and health education as long as they are dispensed by the same persons, who are in charge of a multipurpose service focused on families."

With a bare minimum of staff – a part-time director, secretary and assistant – activities within the area were carried out by the regular personnel on a teamwork basis. Certain programmes were directed by external consultants: an obstetrician, a paediatrician and a mental health specialist would periodically travel from Helsinki. The post of

consultant in maternity care was held by Dr. Anja Huhtinen from October 1951 until October 1952, when she was promoted to deputy provincial medical officer and director of the Uusimaa area. After her untimely death in 1955, the position was filled by Dr. Kirsti Valanne (Maier, 1955). A full-time nutritionist was employed in the early days, reputedly the only one in Finland (Lataillade, 1954).³ The emphasis was placed on all-purpose complementary training, which would add ideas about nutrition, mental health, the social aspects of maternal well-being etc., to the professional training of nurses and midwives.

Four teaching centres – the state school of public health nursing, the Swedish school of nursing, the Helsinki school of nursing and the state school of midwifery – sent up to 324 students a year to the Uusimaa area for four to six weeks (Valanne, 1964). This created a working prototype, and the opening of further schools of nursing in Finland (which numbered 22 by 1963) was accompanied by the extension of practical teaching, although the teaching of midwives remained limited to Uusimaa (Lataillade, 1954). Medical students on the Public Health and Social Medicine course at the University of Helsinki received lectures by professionals working at Uusimaa, but no practical arrangements for further undertakings were ever reached; this remained an unfulfilled goal in the early 1960s. Two international courses on rural health conducted in English took place in 1959 and 1961 and a further one on public health practice in 1966, with the area hosting 25 to 30 overseas students a year; UN programmes had previously sent officers from India and South-East Asia engaged in rural development (Maier, 1953). From 1960 onward, it also offered national courses for local students and professionals.

Surveys conducted in Uusimaa established that unifying the roles of midwife and public health nurse in one individual was preferable for health interventions in small communities.

Larissa (Greece), 1958-1972

With funding from the WHO and UNICEF within the UN's Technical Assistance programme, project Greece 25 was started in 1958 with the intention of establishing a health demonstration area in the district of Chrysoupoli (eastern Macedonia), in close cooperation with a community development project of the kind promoted by the European Productivity Agency, a quasi-independent body within the Organisation for European Economic Cooperation (ended in 1960), largely financed by the USA (WHO, 1961, p.150). After local authorities and a WHO consultant had spent a year surveying the needs and resources of the area, this location was discarded – for undisclosed reasons – in favour of Larissa, in the Thessaly region, where the project was carried out between 1959 and 1965. After 1965 the project's title changed to Development of Public Health Services and Training of Personnel, though its elements remained unchanged. The health area built upon an earlier Greece 4 project, a mother and child health demonstration, started in 1952 across the same zone and supported by the International Labour Organisation, UNICEF and the UN Technical Assistant Programme. This had relied on the rural mobile services of the National Welfare Foundation's Mother and Infant Protection Service (founded in 1915 as the Patriotic Institution of Social Protection and Custody) and was

linked to sustained post-war British-American support (Close, 2004; Gillespie, 2008; Giannaki, 2014).

The self-explanatory description of the area was “to organize comprehensive and co-ordinated health services in a rural area where new methods of public health administration can be tested, all categories of public health personnel given practical training, and demonstration and research carried out” (WHO, 1960, p.196). The Thessaly demonstration area extended over almost 14,000km², encompassing four districts (Larissa, Kardhitsa, Magnesia and Trikala) and nearly 700,000 inhabitants. Implementation of the project started in the Larissa district and by 1963 was to be expanded throughout (Strakalis, 1964). Along with periodic visits to the villages, the area hub in Larissa provided the following health services: a mental health unit, a tuberculosis centre, a dental service, venereal disease consultation, a mother and child unit and a public health laboratory – responsible for the analysis of water, milk and food, and the diagnosis of infectious diseases across the whole region – as well as a School of Rural Health in the city of Pharsala, which hosted health professionals and students from diverse fields. Other existing facilities consisted of four public hospitals, the four district public health centres that acted as delegates of the Ministry of Health, a network of public dispensaries (established by laws 2592/1953 and 3487/1955), the mobile units, comprising one or two vehicles per sector (the district of Larissa was divided into nine sectors), in charge of mother and child health and sanitation advice, and ten health stations (four within Larissa), which provided general health care, emergency and obstetric care, and organised mother and child health consultations. Services were dependent on a number of organisations, including the National Social Insurances, the Red Cross, the School Medical Service and the National Welfare Foundation, all coordinated through the demonstration area by a central office staffed with a public health doctor and director, plus several specialists and external consultants. The tasks and goals of the Greek venture were very similar to those of the previous European demonstration areas: coordinating – and improving – existing health services through the application of health surveys and statistics, education of the community and personnel training, with the strategic intention of developing a suitable model for rural integrated health services.

As usual, the WHO provided consultants and fellowships, while others – notably UNICEF – provided supplies and equipment. According to the annual reports, consultants carried out studies in their respective fields – laboratory services, health statistics, hospital and public health administration, maternal and child health, tuberculosis – while assisting with training activities and evaluating results. Fellowships were awarded for national public health workers to study abroad (WHO, 1954, p.34-35). In 1959, a five-week fellowship enabled the future director of the area to travel to Finland, Denmark and France, visiting the Uusimaa and Soissons pilot zones.

Other European training and demonstration areas

In 1961, the EURO-WHO Regional Committee paid “special attention” to active health demonstration areas in Europe and called for a workshop of experts intended to assist countries in the technical assistance programme (WHO, 1964, p.80). The meeting took

place in Le Vésinet, a small, charming garden city near Paris, from 20 to 23 March 1963. Thirteen countries were represented: Albania, Algeria, the German Federal Republic, Bulgaria, Finland, France, Greece, Malta, Poland, Spain, Sweden, Turkey and Yugoslavia. Four EURO-WHO officials formed the Secretariat, with three consultants and two observers completing the number of participants. The consultants were Professor Bruno Kesić, director of the Zagreb School of Public Health, Doctor Jeanne Bruyelle, director of the Soissons Health Centre, and Doctor Kirsti Valanne, director of the Uusimaa zone. Lataillade and Kaprio were among the attending WHO officials. The organisers prepared five case-studies, adding Lublin (Poland) and Rude (Croatian Yugoslavia) to the three WHO-backed areas already described. In addition, five further areas in Senegal (via France), Turkey, West Berlin, Serbia and Malta were described. Experiences in the Croatian county of Rude, the Senegalese town of Khombole, the Turkish health station at Kazan, as well as the extremely short description of several Serbian demonstration zones, were in line with templates for a fully integrated rural health service.

Since the end of the Second World War, Rude had come under the protection of the Health District Centre at Samobor following guidelines by the Zagreb School of Public Health, and a subsidiary health centre had been installed in the area, which covered six villages and a population of little more than 2,600 (Centre..., 1964). The centre was permanently staffed by a public health midwife and an assistant, and a general practitioner visited three times a week. Programmes covered the usual areas – mother and child protection, nutrition, sanitation, tuberculosis – and included preventive and therapeutic activities. Graduate and undergraduate students from the Zagreb School, including physicians, nurses, sanitation engineers and technicians, regularly visited the demonstration centre. After their sixth semester, small groups of five to six medical students received a month of practical education. The intention was for Rude to be the core of a network of similar centres covering the entire Samobor territory, encompassing 36,000 inhabitants.

Although the Polish speaker at the workshop, Doctor J. Rychard, placed the Witold Chod ko Institute of Occupational Medicine and Rural Health at Lublin under the banner of “health demonstration area,” it displayed a far stronger institutional basis (Rychard, 1964). As an official foundation endowed with authority over the whole of rural Poland, the Institute’s main goal was the protection of the health of the rural population, from occupational health to sanitation, through research, reports and healthcare, including orthopaedic surgery and medicine, the study and treatment of anthroponozoonotic disease, dermatology and child health (Parnas, 1954). Established in 1951, the institute was inspired by a Bulgarian venture – as yet, unknown to this author – and by the work of psychiatrist and social activist Witold Chod ko (1875-1954) (Parnas, 1961). Until 1964 the institute was directed by a parasitologist, Józef Parnas (1909-1998), formerly a researcher at the Veterinary Medicine University in Lviv and a WHO expert. Medical students and teachers regularly attended summer camps at Lublin and the institute offered courses for rural physicians, while meeting the needs of all health personnel categories.

Whereas differences between the projects in terms of organisation, financing and working methods were self-evident and related to the socio-political situation of each country, a consensus was reached on the overall utility of the health demonstration

technique for less developed zones in the categories of laboratory experimentation, testing grounds and training facilities. During the workshop it was also emphasized that demonstration areas should strengthen existing organisations, and that their activities should not endanger the regular medical and public health services, over which they should have authority. Rather than a single demonstration model being proposed, there was explicit recognition of a plurality of models, respecting diverse aims, geographies and organisational structures, in order to produce “the style that suits them [each place] best” (Zones..., 1964, p.1). However, integration with the general plans for the social and economic development of each country appeared a convenient strategy to all participants.

Two strategies stood out as the most difficult to implement: positively engaging the local population and establishing permanent collaboration with universities and institutions of research. Both were carefully dissected during the workshop and a number of reasonable guidelines were devised in the proceedings. However, despite this consensus, in the years to come only one new demonstration area would be established in Europe: Talavera de la Reina, Toledo, Spain, under country project Spain 30, extending from 1965 to 1976.

Final considerations

Health demonstration areas funded by the WHO in Europe during the 1950s were linked to rural health services, customarily less attended than those in urban areas. They were situated in places with a tradition of international, American or British-American intervention. Soissons and Uusimaa health areas were intended as breeding grounds for sound rural health practices with a global projection, extended through the training of health officers from other regions of the world. They were not a response to a shortage of economic or professional resources; rather, they were intended to consolidate an American legacy into the newly founded WHO – as recognised by a former director of the European Office (Kaprio, 1991, p.8) – and to serve as a global resource to be used in the forming of appropriate networks. They reinforced an already organised health sector by adding a national and international educational dimension to the work being carried out by regular district health services, which were in turn provided, normally on a part-time basis, with extra support from out-of-the-region specialists. Training for nurses, social workers and midwives was locally relevant, while the majority of international visitors were medical practitioners and public health officers. This international activity fuelled by fellowships and short stays originated from a core aim of the WHO: to establish a “constituency of experts” and “secure invaluable partners” (Kaprio, 1991, p.8-9). In fact, both its directors, Louis Lataillade and Leo Kaprio, joined the WHO shortly after standing down from national positions; the former was the object of a disagreement between the Rockefeller Foundation and the WHO, while the latter was accused of stealing the Rockefeller’s ablest officers (Birn, 2014).⁴

On the other hand, the Larissa and Talavera initiatives were largely national in scope and focused on promoting internal changes in the health organisation of, respectively, Greece and Spain. Their most relevant operational aspect was the establishment of comprehensive, co-ordinated health services, hand in hand with training programmes for rural public health personnel and community development.

The measure of each health demonstration's national impact requires individual assessments. In France, to my knowledge, it appears the Soissons centre was a rarity, at least until the development of Health for All programmes, according to the general trend that shifted public health investigations towards biomedicine, as represented by the change from Institut National d'Hygiène to Institut National de la Santé et de la Recherche Médicale in 1964 (Berlivet, 2008). The Finnish case merits further study in connection with the critical period of *Sairas Suomi* ("sick Finland") during the 1960s – epitomised as "how and why do the healthiest babies in the world grow up into the sickest adults in Europe?" – and the shifting emphasis of their national health organisation toward primary health care from 1972 on (Harjula, 2004, 2016). We lack adequate sources to fully explore the activities and outcomes of the Greek venture, while the Spanish one, which only began functioning in the late 1970s, instituted a model organisation, today's Centro Regional de Salud Pública de Castilla-La Mancha, which produced no impact beyond the demonstration area. This can be attributed in great measure to the profound divide between the two existing national health administrations, the Instituto Nacional de Previsión, which managed the money and healthcare facilities of the workers' obligatory insurance system, and the Dirección General de Sanidad, which held jurisdiction over preventive health services and the network of public charities (Rodríguez-Ocaña, Atenza Fernández, 2019).

The stalwart figures among the health professionals involved in demonstration areas were the public health nurses/midwives and polyvalent social workers, cherished as those closest to the public in rural regions, the areas' local faces, entering people's homes and demonstrating their accessibility and reliability. This high appreciation tallies with general contemporary WHO trends in public health nursing, which highlighted university education plus training in public health services rather than traditional hospital training, as stated in the fourth report of the Expert Committee on Nursing (1959) (Galiana-Sánchez, 2017).

The health demonstration strategy fused with the goal of establishing the integrated health protection of populations, joining together the preventive and therapeutic aspects of healthcare; an interwar-born ideal for many public health experts, but not to the same extent for health professionals. For instance, the definition of a health demonstration district to the WHO Regional Office for South East Asia (SEARO) presupposed "a pattern for comprehensive health services which could recommend itself in all respects to eventual adoption in other districts" (WHO/SEARO, 13 Sept. 1957), with functions including the evaluation of major health problems, the creation of an integrated health organisation, coordination of all health services in the area and the improvement and development of additional services when necessary (WHO/SEARO, 8 March 1961). This parallelism between European and Asian WHO offices not only shows the internal technical consensus of the Organisation but also the strength with which the "integration" concept stood among certain professional circles. Yet integration remained an unaccomplished goal. In Soissons, overriding difficulties hampered the integration of preventive and therapeutic activities, while Uusimaa never contributed to local medical training. Those health domains where a good degree of unity had been reached, such as tuberculosis and mother and child health, appear to have been ceded to hospital and specialist care by the mid-1960s, according to

information given at the EURO-WHO 1963 workshop. Thanks to the post-Second World War development of technomedicine, the main trends of thought and action were not in favour of this integrative idea; on the contrary, they led to the model of prioritising hospital-centred medicine focused on the individual.

Despite its short-term failure, the idea of an integrated health system, along with a high appreciation of health and social workers other than doctors, maintaining a low-profile presence in the realm of public health, contributed to paving the road to contemporary health promotion. It is worth remembering that the European region, under the direction of Leo Kaprio, was the first in the WHO to produce a long-term strategy for the region as a whole (1969-1970) that included the promotion of healthy lifestyles, the reduction of preventable conditions and the provision of accessible health care for all, a meaningful step towards the primary health care policies and the Health for All global target (WHO, 2010, p.27-28). If we understand primary health care as the development of a particular health infrastructure coupled with a political and educational sense of community, the practice of health demonstration and training areas applied by the WHO during the 1950s and 1960s decisively contributed to this infrastructural design.

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NOTES

¹ Following Anne Morgan's death in 1952, the AHSA turned into Association Médico Social Anne Morgan and exists to the present day.

² A short biography can be found at: <<https://hsl.lib.unc.edu/specialcollections/bios/lataillade>>. His date of death is to be found at: <<https://data.bnf.fr/>>.

³ A full list of the health workers involved can be found in the memo "Uusimaa province health demonstration and teaching area, its activity and objectives for the next few years," undated (but March 16, 1953) included in RF records, projects, RG1.2 (FA387), series 787 Finland, Box 1, Folder 4 (Rockefeller Archive Center, Sleepy Hollow, NY).

⁴ A.E Birn, personal communication (23 January 2019), as the name of the person involved was not published in her article of 2014 where the dispute is documented.

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