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Abstract

This chapter argues that during the Long 1970s, health and medicine played an important role in the politics of the PRC and its relationship with both the First and Third Worlds. It examines the widely acclaimed Barefoot Doctor Campaign in Mao's China. The Barefoot Doctor Campaign was applied domestically in the PRC in the aftermath of the Great Leap Famine, and then during and immediately after the Cultural Revolution period (1968–1978), partly to redress rural health disparity and health crisis but more importantly as a political tool for the CCP to re-establish its power in the Chinese countryside In the Long 1970s, the Barefoot Doctor Campaign, referred to in the West as the "Chinese approach to health," came to hold out the promise of a true alternative to the crumbling single-disease-centered "vertical" health program advocated by the United States and the centralized healthcare structure of the Soviet Union. The World Health Organization (WHO) embraced it as a model of Primary Healthcare, adopted to achieve a goal of "health for all" by the World Health Assembly in 1977, and formally included in the Declaration of Alma Ata the following year. Concurrently, the PRC's purported success in healthcare delivery also became useful to those in the West who were prepared to see some good in the Maoist China.

CHAPTER 6

From China's "Barefoot Doctor" to Alma Ata: The Primary Health Care Movement in the Long 1970s

Zhou Xun

A Long Journey Always Begins with a Single Step: The Background of the First US Medical Delegation to the People's Republic of China, 1971

In the Chinese calendar 1971 was the Year of Pig, a symbol of the Chinese Zodiac that denotes steady prosperity. The United Nations (UN) 26th General Assembly designated 1971 as the Year of China. According to Richard Hottelet, the UN correspondent for CBS News, "Peking's approach to the UN suggests that it now prefers to enter the game of international politics."[1] At that time more than a dozen countries had recently established diplomatic relations with the People's Republic of China (PRC). Even the United States, formerly the PRC's greatest enemy, supported it taking a seat at the UN. In 1971, too, at the invitation of the China Medical Association (CMA), the first medical delegation from the United States visited the PRC. For 24 years there had been a complete absence of contact between Chinese and American health

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professionals, meaning this trip was often termed the "historical visit." It was indeed historical, not least because it was far from being simply a medical enterprise. 'Medicine' and 'humanitarianism' had both played pivotal roles in the political and diplomatic negotiations within the White House that eventually led to the opening to China.

The visit had been initiated by Edgar Snow, the American journalist and author of *Red Star over China*, who was, according to John Stewart Service, at that time the "chief contact" between the United States and mainland China.[2] At the invitation of the Chinese Communist Party Central Committee, acting on behalf of Chairman Mao Zedong, in June 1970 Snow visited China. The invitation came in response to an earlier request by Snow to be allowed to observe the Chinese Cultural Revolution, since confusing reports of this event had disturbed him. He became the first Western journalist to visit China since 1966 and report on the Cultural Revolution. On his return to the West, Snow published numerous articles on his trip and his interviews with Chinese leaders in both *Life Magazine* and its popular Italian counterpart *Epoca*, in which he stated that China was willing to welcome US President Richard M. Nixon. One of his articles for *Epoca* also featured the PRC's achievements in medicine and public health, citing examples that included Chinese successes in limb reimplantation and acupuncture anesthesia, together with various public health initiatives, especially its birth control efforts and the Barefoot Doctor program.[3]

Snow's accounts of the PRC's achievements in public health and medicine aroused much interest in the West, but also provoked criticism from some quarters. Snow's attackers claimed he was not a qualified observer, since he lacked any medical training. In response, Snow asked his friend E. Grey Dimond, a cardiologist, medical educator, and innovator who had founded the University of Missouri-Kansas City School of Medicine, to visit China and report back on his professional observations.[4] Dimond agreed to do so but he urged Snow to extend a further invitation to his mentor, Paul Dudley White, a distinguished cardiologist who had been President Eisenhower's personal physician. Professionally, Dimond argued, White's inclusion would enhance their medical credibility. Other historical evidence, however, reveals that White's contribution went beyond being an authoritative medical voice, and that he played a crucial role in US foreign policy.

A few years before this episode, in July 1962, Huang Jiasi, a renowned cardiologist who was president of the Chinese Academy of Medical

Science, had invited White to visit China the following spring, after the two men had met at an international cancer congress in Moscow. At the last moment, however, the Chinese host withdrew the invitation, on the grounds that the United States had "persistently adopted a reactionary policy against New China, and blockaded every possible channel of communication between the peoples of our two countries."[5] At this juncture, White approached the lawyer Grenville Clark, his patient and personal friend, for legal advice on the subject. Although Clark—whose daughter was married to Dimond—had no professional interest in building medical connections between the two countries, he perceived this as an opportunity to break down the estrangement and alienation separating both the peoples and governments of China and the United States. More importantly, Clark also saw this as the first step on his long personal journey toward achieving international peace, and believed that the PRC could play an integral role in implementing proposals for global disarmament that he supported. Initially, Clark had hoped that the Soviet Union would persuade the PRC to agree to this, but as the growing Sino-Soviet split became more apparent after 1962, he had lost faith in this outcome. Meanwhile, Clark had become increasingly disenchanted with official American hostility toward China. According to William Worthy, the civil rights activist and journalist, Clark was also eager to visit the PRC himself.[6]

When White sought his help, Clark immediately took on the case and sought Edgar Snow's advice. The two men embarked on a long, friendly correspondence on the subject. Snow wrote many letters to Chinese leaders, while Clark and White negotiated with Averell Harriman, at that time under-secretary of state for political affairs and subsequently ambassador-at-large during the administration of President Lyndon B. Johnson. In one letter to Johnson, dated August 10, 1965, and probably drafted by Clark, White offered to help "to break our deadlock with China."[7] In a further letter on August 16, White went so far as to pledge: "If at any time, you think that you may be able to use me in any mission, no matter how difficult or hazardous, please don't fail to call on me." After reading this, Johnson expressed deep interest and decided to involve McGeorge Bundy, his special assistant for National Security Affairs.[8]

Although Bundy felt that any official backing for White's visit to China would be disadvantageous to the United States, since "the Red Chinese would turn it down," he nonetheless kept an open mind. At a time when he believed US policy in Vietnam was reaching "a new level of clarity and firmness," he thought White's appeal might have come at an apposite

moment. Bundy summoned James Thomson, the White House's China expert, to his office and handed him White's letter, telling him: "Take it and run with it. Here is your chance." Thomson thereupon drafted a memorandum for the president. Following Thomson's recommendation, Bundy proposed to "ease our present travel restrictions and make a general rule that doctors and public health specialists—or perhaps all workers in the fields of health, education, and welfare—would be authorized to receive visas." White's ostensibly "professional" trip to China was put on the agenda for discussion at a meeting of Secretary of State Dean Rusk and Secretary of Defense Robert S. McNamara.[9] That meeting agreed to a clear, but unofficial presidential authorization for the issue of unrestricted passports to doctors, scientists, and individuals in public health and related fields. Their activities, the White House explained, could be viewed as neither political nor threatening. In terms of positive public relations, endorsing such professional exchanges between China and the United States as White's trip to China as a physician was desirable, since these visits could be perceived as designed to "increase the understanding essential for the promotion of human welfare."[10] Officials also believed that the health and welfare dimension, and especially the participation of White, who was known to be on the center-right of American politics, could help to deflect right-wing criticism.

For the next few months "health" became a useful term that featured regularly in White House discussions of China and its foreign policy. At the first White House Conference on Health in November 1965, for example, Secretary of State Dean Rusk openly declared that "health is a matter which cuts across national frontiers, cuts across ideologies, cuts across political controversies. [. . .] For example, if an American doctor receives an invitation to visit a place to which we do not ordinarily encourage Americans to travel, I can assure you I would do my very best to see that he gets a passport to accept such an invitation. Because these are not problems which ought to be governed by political process but ought to be governed by the elementary interest of man in his health." At the end of his address, Rusk described the export of American health capability as one of the strongest aspects of US foreign policy.[11] For health professionals, Rusk's speech marked a new era for health and medicine in America. There was a strong sense that the government and health professionals could work collaboratively to meet growing global demands and address domestic and international social change.

A few days later, at Thomson's request, White wrote formally to Rusk, asking if he would put his Health Conference speech into practice by issuing unrestricted passports for all travelers in the field of medicine and public health. A month later, on December 29, 1965, after several maneuvers back and forth, the White House formally announced the revised regulations, highlighting White's pivotal role in these.[12] In this sense, one might argue that the negotiations over White's China trip represented the first step in the long journey of the 1970s toward US–PRC rapprochement. Thanks to the Chinese Cultural Revolution and escalating US involvement in the Vietnam War, White nonetheless had to wait until 1971 before his China trip finally became reality. While the request to include him undoubtedly came through Dimond, it was politically vital that this first US medical delegation to Communist China should include White.

On September 18, 1971, four months after the US ping-pong team set foot in the Chinese capital, the first US medical delegation arrived in Beijing. In addition to White and Dimond, the delegation included White's wife, Ina, and Dimond's wife, Mary; Samuel Rosen, an internationally acclaimed ear surgeon from New York, and his wife; and Victor and Ruth Sidel. Although none of the group had previously visited China, Rosen and the Sidels had, like White, long wished to do so. According to the State Department, in August 1961 Communist China had sent Rosen an invitation through the PRC Consulate General in Geneva, asking him to visit China to demonstrate his unique surgical technique to relieve a common form of deafness. Rusk initially refused to permit this trip, but after years of negotiations between Wang Bingnan and Jacob Beam, the Chinese and US ambassadors to Poland, the State Department eventually agreed that Rosen and his wife could go to China "for humanitarian purposes." When announcing this, the State Department nonetheless denied that the United States had any interest in normalizing its relationship with Communist China, thereby angering the Chinese. On December 21, a week before Rosen's scheduled China trip, the CMA—Rosen's Chinese host—claimed that the US government's "policy of hostility towards China" was "besmirching science and friendship" and therefore asked him "for the time being" to cancel his visit.[13]

Victor Sidel, who grew up in an Eastern European Jewish immigrant family in New York City, was well known for his work in social justice, public health, and international health. A strong opponent of the US government's use of chemical weapons in Vietnam, Sidel worked closely

with Arthur Galston, a biologist at Yale University, who was in Vietnam when the American ping-pong team visited China, an event that inspired Galston to go to the Chinese Consulate in Hanoi to ask for a Chinese visa. His request was granted. After Galston returned to the United States from China, Sidel, by then filling a new chair of Social Medicine at Montefiore Medical Center and a professor of Social Medicine at the Albert Einstein College of Medicine, approached Galston to secure Chinese visas for himself and his wife, Ruth. Galston promptly wrote to Guo Moruo, the director of the Chinese Academy of Sciences (CAS), whom he had met while in Beijing. The invitation came quickly, with the Sidels successfully granted Chinese visas from the Chinese Embassy in Ottawa.[14]

The "Chinese Approach" to Healthcare Delivery in the Long 1970s

During their 12-day tour, the delegation was taken to 12 medical and health facilities and also had 30 hours of scheduled discussions with Chinese physicians. According to Dimond, while none of the delegates had been to China before or knew any Chinese words, such *lingua medica* as stethoscope, ophthalmoscope, electrocardiogram, and laboratory data, nonetheless "bridged whatever other language gap existed." Deeply impressed by the PRC's mass public health measures, and China's ability to provide inexpensive and convenient (if inexperienced) healthcare to its rural population of 700 million, Dimond argued that Communism was only "a part, but not whole of the exuberant drive of a people [in China]," contending that "China's achievement in public health shows that Communist China had more to offer the world."[15]

Dimond's fellow delegate Victor Sidel felt strongly that China's Revolutionary experience in health and medicine could offer valuable lessons for public health and community health work in the United States, and indeed the rest of the world. Sidel's own commitment to community primary care had grown in reaction to the chilling effects of McCarthyism and the Cold War. Like many of his generation on the American Left, he believed strongly in the need for greater social and economic justice in the United States and elsewhere in the world. As a physician, Sidel channelled much of his political energy into public health work, particularly community health undertakings, and he founded the

oranization Physicians for Social Responsibility. In preparation for their first China visit, Sidel and his wife Ruth, a social worker at a paediatric health center at the Albert Einstein College of Medicine, read a number of works: Edgar Snow's *Red Star over China*, William Hinton's *Fanshen*, and British surgeon Joshua Horn's *Away with All Pests*. The latter depicted healthcare in the PRC in a highly favorable light, and all three volumes were decidedly propagandistic, eulogizing Communist China politically. The Sidels apparently found these books, "detailing the extraordinary changes in China during and after the revolution, were particularly useful."[16]

Sidel used his reading material to develop questions scrutinizing healthcare delivery and community primary care in rural China. On returning to the United States, the Sidels lectured and wrote extensively on public health achievements in China, winning enthusiastic audiences. Meanwhile, in New York's Bronx district, a Community Health Participation Program that recruited, trained, and supervised neighborhood health workers, modelled on the Chinese Barefoot Doctor program, was introduced. One year later, the CMA invited the Sidels to return to China for a lengthier visit, to observe China's public health innovations in more detail and greater depth.

Another well-publicized admirer of China's public health achievements was Joshua Horn, a British surgeon whose lectures attracted large audiences in New York in 1971. When he first visited China in 1936 as a ship's doctor, what he had witnessed appalled Horn. "China was truly the sick man of Asia, rampant with poverty, disease and corruption," the result, he believed, of feudalism, imperialist oppression, and social evils such as concubinage. "China needed a revolution" was the thought that filled the young Horn's mind. When the PRC was founded in 1949, Horn was won over by its claims to social justice. In 1954, Horn, by then an established surgeon in Great Britain, took the first opportunity available to him to watch the new China of which he had dreamed, moving there with his family and staying for 15 years. What he found, or intended to find, in China's new incarnation was markedly different from the past. In his 1971 New York lecture, which was subsequently broadcast in May 1972, Horn argued forcefully that "the sick man of Asia" had been transformed into "the most healthy man in the world," with politics the driving force behind China's remarkable public health achievements. When delivering another

lecture at the University of Hong Kong a year earlier, Horn had marvelled at China's Barefoot Doctor program:

> There are more than one million health workers [in China], and most of them live in the countryside. This means one health worker for every six hundred Chinese. For the first time in the five thousand years of Chinese history, China has successfully achieved to deliver health services to its people no matter where they live. China is the first one in the world to achieve this. Yet in wealthy countries such as the United States millions of people have no access to healthcare.[17]

This last sentence resonated with many US health professionals and public health advocates, growing numbers of whom received opportunities to visit mainland China. Like the first delegation, they were generally impressed by new China's public health achievements, in particular, how China managed to resolve the problem of providing healthcare to its 700 million rural population, whereas the United States had failed to meet its own population's needs. Resident foreign medical specialists, such as Shafick George Hatem, a Lebanese-born American physician living in China, enthusiastically advertised Communist China's accomplishments to visiting Western health delegations. Hatem, originally from New York City, had first ventured into eastern China in 1933, as a medical student. He stayed on to practice medicine in China while seeing the sights, and soon became attracted to the teachings of Communism. In 1936 Madame Sun Yatsen introduced Hatem to Edgar Snow. Hatem accompanied the latter on his visit to the Chinese Communists' red base in Yan'an, where he joined the Chinese Communist Party and became involved in CCP health planning. After the Communists won control of China in 1949, Hatem became the first foreigner to acquire Chinese nationality from the PRC. Thereafter he assumed an active role in China's public health work, in particular the prevention and treatment of venereal diseases and leprosy.[18] In addition to his public health and medical work, Hatem was known as "a brilliant apologist for the Chinese Communists."[19] Echoing Horn, Hatem argued that a country so vast as China, with its feudal past and uneducated masses, needed a centralized power to ensure its people were provided with medical care, food, and other essentials for survival.

In the West, on the other hand, by the late 1960s the scientific and technological revolution in medicine which had begun at the end of World War II had apparently peaked. Major changes in medical care and access

materialized more slowly, however. A growing consensus existed that in the Western world medicine was in a state of crisis. Despite the huge efforts and funds that had been invested in healthcare and medicine, in reality the general health of the population was deteriorating. "New ideas are needed, new systems of healthcare have to be explored."[20] Accounts by Horn, Hatem, and other Western health observers, especially the popular works of the Sidels, echoed in the 1972 documentary film *The Barefoot Doctors of Rural China* by a group of scholars from Stanford University, all claimed that China's healthcare delivery system offered a radical new model.

This "Chinese approach" to healthcare delivery, understood as a draconian government program intended to provide prompt, convenient, and inexpensive healthcare to the 700 million people living in the rural countryside, became increasingly attractive to Western health professionals and policymakers seeking a solution to the perceived Western health crisis. After spending several months in China as a CMA guest in 1973, one year later Phillip Lee, a professor of social medicine at the University of California's School of Medicine at San Francisco, who had attended the 1965 White House Conference, described China's healthcare delivery system in glowing terms: "Major epidemic diseases have been controlled, and in some cases apparently eradicated. Nutritional status has been improved. Massive campaigns of health education and environmental sanitation have been carried out. Large numbers of health workers have been trained, and a system has been developed that provides some health service for the great majority of the people."[21]

Both the postwar scientific and technological revolutions and the collapse of the remaining British, French, and Dutch colonial empires simultaneously brought major changes around the world that presaged what is now termed globalization. This brought greater awareness of growing global disparities, especially in healthcare and access. Beyond the field of public health, medical missionaries working in developing countries were equally strong voices alerting the world to the absence of basic healthcare in these nations. The very term "Primary Health Care" first appeared in *Contact*, the journal of the Christian Medical Commission, an organization that advocated Primary Health Care, created in the late 1960s by medical missionaries under the broad umbrella of the World Council of Churches and the Lutheran World Federation.[22]

In 1967, John Bryant, one of the foremost international public health leaders of the previous three decades, and at that time a Rockefeller Foundation staff member in Bangkok, published *Health and the Developing World*, the outcome of a Rockefeller Foundation-sponsored collaborative project. In this publication Bryant, a member of the

Christian Medical Commission, argued that "large numbers of the world's people, perhaps more than half, have no access to health care at all, and for many of the rest, the care they receive does not answer the problems they have . . . the most serious health needs cannot be met by teams with spray guns and vaccinating syringes."[23] Bryant's views reflected new developments in international public health during the early 1970s. By this time the Rockefeller Foundation's International Division had more or less retired from the global scene, and public health had embarked on a new post-imperial stage, now labelled the "Fourth Phase" of public health.

China's reputed ability to redress healthcare disparity, especially the manner in which the Chinese had successfully reduced the health burden on the state by incorporating existing medical practices into the national health service, impressed governments in postcolonial Africa, Southeast Asia, and Latin America, where healing and indigenous medicines played an integral part in the political struggle for a new postcolonial identity.[24] In 1967, for example, a medical delegation visiting China from Tanzania was "impressed by the stage of development of health services, which have been revolutionized and transformed by the new China."[25] These Tanzanian officials viewed both the training of barefoot doctors and the integration of indigenous methods and modern medicine as useful blueprints on which to develop a new national healthcare delivery system that would cater to Tanzania's rural population.[26] Driven in part, too, by their commitment to non-aligned socialism, assorted African states as well as socialist countries in Southeast Asia and Latin America approached China for health collaboration, including training and medical aid.

China's Health Aid to Africa

China quickly realized that health projects were "inexpensive but profitable" undertakings that could boost its effort to promote a new international order: a "people's revolutionary movement" against "colonialism, imperialism and hegemonism."[27] On June 5, 1971, in a conversation with the government delegation from Somalia, Premier Zhou Enlai carefully emphasized that health collaborations between the two countries were intended to serve local interests and thereby promote friendship. Chinese medical teams must renounce "superpower chauvinism."[28]

Between 1963 and 1989, China sent medical teams to more than 40 countries in Africa. Different provinces in China were each twinned with an African nation. Sichuan, for instance, was responsible for developing

health projects in Mozambique, whereas medical teams from Shandong went to Tanzania, those from Jilin to Somalia, and so on.[29] In addition, China gave medical and health training to a large number of students from Africa, Southeast Asia and Latin America, competing with the extensive parallel programs training physicians in the Soviet Union, such as that at Lumumba Friendship University in Moscow. China also sent regular "friendship delegations" to these countries, groups that always included at least one health worker, such as a model barefoot doctor. With this expansion, China's influence on healthcare delivery in Asia, Latin America, and Africa grew exponentially. As Stacey Langwick has demonstrated, in postcolonial settings such as Tanzania, China's "friendship," centered around health collaborations, also paved the way for the re-emergence of traditional medicine and a fast growing herbal market.[30] In the mid-1970s, Alan Hutchison observed that China's Barefoot Doctor program was particularly well suited to local rural conditions in many African countries.[31] The Soviet model was, by contrast, less effective.

Yet Chinese archival sources from this period reveal that politics were always integral to Chinese medical activities and China's crafting of Sino-African friendship. Chinese medical teams were well aware that, in addition to their medical work, their mission was to spread Mao Zedong Thought (毛泽东思想 or Maoism). While researching the African variety of schistosomiasis in Somalia, for example, the Chinese team organized an exhibition demonstrating how, with Mao's leadership, China had successfully eradicated this deadly disease. Invitees to the exhibition included workers, rural residents, officials, middle school students, and policemen. Not only was medical and public health propaganda displayed, but the villagers even learnt to sing *The East is Red*. This bore fruit. After seeing the exhibition, one local official went over to the Chinese team and said: "Thank you. Compared to the American, the British and the Italian doctors, the Chinese are our most loyal friends." Another government technician was convinced that only Mao Zedong Thought was guaranteed to bring happiness to the people of the world. During the 1971 Somalian New Year celebrations, a group of workers and rural villagers sang *The East is Red* while holding Mao's portrait aloft. After singing and dancing, they also shouted: "We thank Chinese doctors for helping us"; "Chinese bring us food and cure us from diseases"; and "China brings us life. Don't invade China."[32]

At the United Nations, China's medical activities and the bonds of friendship they forged contributed to China's success in its battle against

Taiwan.[33] As early as 1971, China was seen as a crucial player on so-called "African issues." "China could out do the Soviet Union rhetorically and also sponsor action that is too rich for Moscow's blood," argued Hottelet.[34] One reason why other states thought it necessary for the PRC to hold the "China" seat in the UN General Assembly and the Security Council was to prevent China furnishing military assistance and leadership to national liberation movements in volatile regions of Africa. Taiwan, by comparison, was considered too marginal to be a player in such matters.[35]

"Health for All"

After entering the United Nations, in 1973 China was invited to rejoin the World Health Assembly.[36] China's rural health delivery system—the Barefoot Doctors program—which involved a massive training program and the major mobilization and organization of health services, linked to mass political campaigns, soon became the foremost inspiration for the burgeoning worldwide Primary Health Care movement. The emergence of decolonized African nations and the spread of nationalist and anti-imperialist socialist movements in less developed countries with more limited economic resources demanded a new healthcare delivery model. Coupled too with the perceived failure of single disease eradication programs, also known as the vertical health approach, as promoted by the World Health Organization (WHO) and some US agencies in the 1950s and 1960s, all provided further incentives to move from elite-based healthcare and expert based medicine to primary healthcare and preventive medicine.

1973 was also the year when Halfdan Mahler, who had previously served as a WHO senior officer attached to the National Tuberculosis Program in India, was elected Director-General of the WHO. His experiences in India had made Mahler deeply concerned with issues of social justice. As soon as Mahler took office, he appointed Kenneth Newell the director of the new Division of Strengthening of Health Services. "Both men were visionaries who shared common values that included dedication to the pursuit of human development and justice," recalled Socrates Litsios, a former senior scientist in the WHO Control of Tropical Diseases Division.[37] Newell was a strong voice for broadening efforts in primary healthcare. He had become interested in China's Barefoot Doctor

program and comparable developments in Cuba, Tanzania, and India, and was keen to introduce similar programs in other developing countries.

Like Newell, Mahler responded enthusiastically to the widely cited example of China's successful experience in tackling health problems with limited financial, technological, and human resources, and believed it should be promoted around the world. In 1974, the WHO invited Wang Guizhen, a model barefoot doctor from a village near Shanghai, to address the Twenty-Seventh World Health Assembly on China's Barefoot Doctor program. In 1976, two barefoot doctors were again invited to speak in Manila at the WHO Regional Office for the Western Pacific's First Regional Working Group meeting on Basic Health Services.

Under Newell's leadership, in 1975 WHO and UNICEF mounted a joint project on "Alternative Approaches to Meeting Basic Health Needs in Developing Countries." Newell invited the Sidels to WHO headquarters in Geneva, to serve as consultants on this project.[38] This led to the landmark publication *Health by the People*, which included a chapter on China's healthcare delivery system contributed by the Sidels. In his Introduction to this volume, Newell criticized a strict health sectoral approach as ineffective. According to him, some 80 percent of the world's rural population had no access to the health technology that many perceived as "the shining example of present-day man's technological ingenuity and progress." Citing the examples of China's Barefoot Doctor program and the use of indigenous (subaltern) medicines, and also various Christian Medical Commission programs, he argued for a new system of Primary Health Care that was "either linked with the indigenous system or attempted to play a role having some of the same social qualities that the existing systems had."[39]

This outlook pervaded the joint WHO/UNICEF project report, *Alternative Approaches to Meeting Basic Health Needs in Developing Countries*. The report examined successful Primary Health Care experiences in Bangladesh, China, Cuba, India, Niger, Nigeria, Tanzania, Venezuela, and Yugoslavia, seeking to identify the crucial factors in their success. China and Cuba emerged at the top of the list of successful programs. Toward the end, under "Recommendations," the report proposed to adopt seven "principles in the orientation of and development of health services" to achieve extensive Primary Health Care, guidelines that closely resembled the Chinese Barefoot Doctor program, as outlined by the Sidels.[40]

Building on this report, in 1975 Mahler proposed "Health for All," which the Twenty-Ninth World Health Assembly formally adopted in 1976 as a goal to be achieved by the year 2000. Speaking to the Assembly, Mahler affirmed the need for radical change: "Many social evolutions and revolutions have taken place because the social structures were crumbling. There are signs that the scientific and technical structures of public health are also crumbling."[41] "Health for All by 2000" became the rallying cry for the worldwide Primary Health Care movement. According to the then technical assistant director general of WHO, David A. Tejada de Rivero, a Peruvian physician, by "Health for All," Mahler "made it clear that he was referring to the need to provide a level of health that would enable all people without exception to live socially and economically productive lives." Moreover, "the reference to the year 2000 meant that, as of that date, all the world's countries would have developed the appropriate political strategies and be carrying out concrete measures toward achieving this social goal, albeit within different time frames."[42]

Leading Up to Alma Ata

While major Western powers accepted the Mahlerian notion of Primary Health Care, the Soviet Union, still greatly preferring the Soviet centralized healthcare system, opposed and condemned it as a backward step from the great scientific and technological advances achieved since the beginning of the Cold War. Furthermore, the notion of Primary Health Care was seen as a victory for the developing or Third World that would in turn undermine the Soviet Union's status as the world leader in healthcare delivery and health provision. Even more important was the degree of open Chinese–Soviet antagonism. Since the goal of "Health for All" was largely inspired by China's Barefoot Doctor program, Moscow felt very strongly that it could not permit Beijing to win "a victory within the Third World."[43] The PRC, however, used the World Health Assembly meeting to wage diplomatic battle against the Soviet Union. At the Twenty-Seventh World Health Assembly meeting, Wang Guizhen, China's model barefoot doctor and spokesperson, was briefed to use the meeting to propagate not just Mao's health policy but also Mao's international political line, so as to defeat China's enemies. On returning, Wang proudly reported that the meeting had been a great triumph for China and Chairman Mao, since many Third World countries and WHO officials

had praised China's cooperative health system and the Barefoot Doctor program, while condemning Soviet medical training and aid to the Third World as inappropriate for those countries.[44]

After the Chinese WHO delegation first proposed the idea of an international conference on Primary Health Care, the Soviet Union began intensive lobbying to host the conference in the Soviet Union.[45] In January 1976, one day before the WHO Executive Board meeting, the Soviet Minister of Health Dimitri Venediktov appeared at Tejada de Rivero's home in Geneva and proposed: "I will give you US$2 million for an international conference on Primary Health Care." Despite Tejada de Rivero's reluctance to accept this offer, Venediktov repeated this proposal at the Executive Board meeting. Only after Venediktov agreed that the conference would not be held in Moscow but instead in a developing country would the Executive Board accept his offer, with the conference scheduled for 1978.[46]

The search for a suitable Third World location was difficult. Since the Soviet Union was sponsoring the conference, this excluded China, the world's leader in, and a major inspiration for, the Primary Health Care movement. Other countries the WHO favored included Costa Rica, Egypt, and Iran, but none could successfully secure the additional US$1 million the conference required. After traveling extensively around the Soviet Union, Venediktov and Tejada de Rivero agreed on Alma Ata (present-day Almaty), the capital of the Kazakh Soviet Socialist Republic (present-day Kazakhstan) as a suitable location for the conference. According to Tejada de Rivero, two factors drove the choice of Alma Ata: it possessed a most impressive conference hall and also an extremely dynamic Minister of Health, Professor Turgeldy S. Sharmanov.[47] For the Soviets, however, Alma Ata was also significant because it was geographically proximate to China. Furthermore, it was a showcase of Soviet socialist achievements in providing healthcare for the backward Kazakhs through a centralized state-run health delivery system bringing modern biomedicine to rural villagers.

Lying south of Siberia and east of the Caspian Sea, Kazakhstan bore no geographic or cultural resemblance to the rest of the Soviet Union. Most of its population were Turkic-speaking Muslims. From the late nineteenth century, Russians and Ukrainians from European Russia began to settle in the northern part of Kazakhstan and introduced agriculture to the previously nomadic Kazakhs. In 1925, the region was made an Autonomous

Soviet Socialist Republic. From 1928 onward the Soviet government, seeking to build a strong and self-sufficient nation, embarked on a modernization program—also known as the Stalinist Revolution—encompassing rapid industrialization and agricultural collectivization across the region. This led to a devastating famine that killed half the population between 1932 and 1933.[48]

To improve the local human stock of manpower and thereby facilitate its program of bringing modernity and socialist rationality into the hinterland, in 1928, numerous Soviet health professionals were sent to Kazakhstan to provide the indigenous population with advanced biomedical services. Aiming to transform them into the new Soviet man and woman, who "would have faith in the Soviet State's and the Communist Party's ability to lead the citizenry towards a higher stage of economic and cultural development," medical cadres taught Kazakh villagers that diseases were caused by germs, not evil spirits, and that they should have faith in the power of science, not superstitions.[49] The new Soviet order had no place for superstitions, irrationality, and a backward and therefore unscientific past. In 1931 the V. M. Molotov Kazakh Medical Institute or Kazakh National Medical University was founded in Alma Ata. Turgeldy S. Sharmanov was one of its proud graduates. Between 1927 and 1937 the number of modern doctors in the region tripled. In 1942, to celebrate the 25th anniversary of the October Revolution, the Kazakh Commissar of Public Health proudly declared that Kazakhstan's backward culture had disappeared forever. Between 1950 and 1970, following Soviet healthcare norms that emphasized large numbers of hospital beds and doctors, many hospitals and polyclinics were built in Kazakhstan.[50] By the time the Alma Ata conference took place, the Sovietification of Kazakhstan had been completed. Soviet authorities claimed that life expectancy had increased, diseases and epidemics had subsided, and the general health of Kazakhstan's people had greatly improved. In 1981, Kazakh National Medical University received the Order of the Red Banner of Labor for "great services and people's public health development."

Back at WHO headquarters in Geneva, Newell was made responsible for drawing up documents for the Alma Ata conference. Extensive conflicts occurred over the wording of the text of the Declaration. "Not only the Soviet Union but many Member States supported a centralized health-systems approach. Primary Health Care will not succeed unless we can generate participation from individuals, families and communities, but this community participation will not work unless there is support from the

health system," Mahler recalled in a 2008 interview.[51] According to Tejada de Rivero: "Many delegations and individual delegates fought to include details that had more to do with medical specialties than with health.... The Declaration and Recommendations went through 18 drafts revised in meetings in the six WHO regions, in the Special Meeting of Ministers of Health of the Americas in 1977 and in meetings of special country groupings and certain individual countries as well."[52] "It wasn't easy," Mahler remembered. "But there was an overwhelming feeling that 'we must arrive at a consensus.'... That did not mean trying to convince our adversaries they were wrong, but trying to unite ourselves with them at a higher level of insight. This was exactly what happened in Alma-Ata. It was almost a spiritual atmosphere, not in the religious sense, but in the sense that people wanted to accomplish something great."[53]

In September 1978, 3,000 delegates from 134 member states, 67 international organizations, and a dozen NGOs from around the globe attended the world's first Primary Health Care conference at Alma Ata. China, the inspiration for the conference, was absent. "At the end of the conference, a young African woman physician in beautiful African garb read out the Declaration of Alma-Ata. Lots of people had tears in their eyes. We never thought we would come that far. That was a sacred moment," Mahler fondly recalled. "The 1970s was a warm decade for social justice. That's why after Alma-Ata in 1978, everything seemed possible."[54]

The End of Barefoot Doctors in Post-Mao China

Although contemporary international politics meant that China was excluded from the Alma Ata conference, around the same time China by choice gradually began to abandon the Barefoot Doctor program. The program was officially ended after 1983, as China opted for neoliberal market capitalism, or the so-called system of "Socialism with Chinese characteristics." Born out of the specific political and economic context of the Maoist period, the Barefoot Doctor program could only exist within the collective socialist economic system, which was fundamentally flawed. Once the farming collectives (the People's Communes) were dissolved after the death of Mao, and the household quota system (包产到户) was introduced, the cooperative medical service (合作医疗), which provided the framework for the Barefoot Doctors program, was no longer viable and collapsed.

Without the cooperative medical system and farming collectives, rural health services had to be contracted out (承包). According to a 1980 Ministry of Health report, rural China had over 5,000 commune hospitals with 777,000 hospital beds and more than 1 million health workers. They had previously been paid by the communes from collective funds, and subsidized by the government. Once the collective economic system ceased, the communes had no money to cover their expenditure and salaries, a huge number of beds were cut, and health workers lost their livelihood.[55] To support themselves, these health workers and barefoot doctors opened private practices and charged high prices. It seemed highly ironic that by the mid-1980s millions of rural villagers in China, once the world leader in Primary Health Care, were left without healthcare.

Yet China was not alone in abandoning the Primary Health Care approach. One year after the Alma Ata Declaration, Kenneth Warren, who had been appointed Director of Health Science at the Rockefeller Foundation in 1977, and his colleague Julia Walsh, proposed Selective Primary Health Care as an "interim" strategy for disease control in developing countries.[56] Several UN agencies quickly adopted this selective approach, since it was less costly than the more integrated approaches preferred by Mahler and Newell. Warren, sometimes described by those who knew him well as "contemptuous," was obsessed with health quality and information.[57] Under his leadership, the Great Neglected Disease Network (GND) was established.[58] This move greatly disappointed advocates of Primary Health Care such as Mahler: "That brought us right back to square one." He lamented:

> We had started with selective health-care programs, single diseases such as malaria and tuberculosis in the 1950s and 1960s. Then we had this spiritual and intellectual awakening that came out of Alma-Ata, and suddenly some proponents of primary health care went back to the old selective approach again. Perhaps, paradoxically, Alma-Ata had in such instances the opposite effect to the one intended, as it made people think too much about selection, rather than following the Alma-Ata gospel of health for all.[59]

Interestingly, although in China a large section of today's population enjoys little or no access to adequate healthcare, in recent years the Chinese government has continued to make the Barefoot Doctor program a central component of its international health diplomacy, most notably across Sub-Saharan Africa. A 2010 Chinese Xinhua News Agency report

claimed that China's Barefoot Doctor program could help African countries reduce their infant mortality rates. As President Xi Jinping's "China Dream" extends to Africa, the Chinese government is increasingly prioritizing health aid to this region. As in the Long 1970s, when health cooperation with African nations was seen as a useful tool facilitating Chinese efforts to promote a new international order, in the twenty-first century China's health aid to Africa helps the PRC enhance its profile in the developing world as a major reformer and provider in the field of healthcare, not merely as the market for raw materials from Africa.[60] This led to the regular Ministerial Forum of China–Africa Health Development, first inaugurated by Chinese President Xi Jinping in September 2013. Noting the long and positive history of Chinese–African cooperation on health, Li Bin, Minister of China's Health and Family Planning Commission, proclaimed at the Forum that "China will continue to strengthen cooperation with international organizations on global health and population development, and make use of international platforms to explore new approaches to South-South cooperation in the area of health with developing countries in Africa and elsewhere."[61]

Conclusion

As the Cold War explicitly demonstrated, Medicine and Health invariably possess political dimensions. Mainland China deftly deployed healthcare in propaganda efforts in both the First and Third Worlds, initiatives that complemented the sports diplomacy and aid programs described by Xu Guoqi and Shu Guang Zhang elsewhere in this volume. By the mid-1960s, the US government viewed politically well-connected American medical professionals as potential intermediaries, whose purportedly neutral visits might signal US interest in developing more connections with mainland China. China skilfully utilized Western fascination with both its mass healthcare achievements and traditional Chinese medical practices. Western critics of existing health disparities in industrialized nations and advocates of Social Medicine came to view the PRC as a model for primary healthcare delivery. This complemented increasingly positive images of the PRC and its totalitarian government purveyed from the second half of the 1960s by its cohort of Western sympathizers who associated Communist China with opposition to American aggression in Vietnam aimed at suppressing a Leftist revolution. In developing countries and the United Nations, the rise of the "Third Way," championed by Yugoslavia and India, offered China global space to effect its political goals

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through healthcare. During the Long 1970s, mainland China—standing in opposition to the American system (with its perceived healthcare shortfalls) and the Soviet centralized healthcare structure—seemed to hold out the promise of a true alternative model, one that seemed on the verge of triumph throughout this pivotal decade, and climaxed at the Alma Ata Conference. Ultimately, as Chinese healthcare became an ever less exportable cultural propaganda asset, this model collapsed, proving as ephemeral as the predominance of the Barefoot Doctors program, which disappeared with the ending of China's agricultural communes, all alike swallowed up in the ravening late twentieth-century morass of global neoliberal capitalism.

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Chapter 6

Number	Query
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AQ2	Is the use of initial capitals OK here? Not just 'primary healthcare'?
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