Expanded Number **CF/RAI/USAA/DB01/HS/1996-0122**

External ID **CF/NYH/SEB/HST/1996-0122 ; CF/HST/INT/HOL-003/M**

Title

Interview Dr. Johannes Holm by John Charnow: Immunization; Child Survival & Development Revolution; WHO; disease; primary health care; malaria;

Date Created	*Date Registered*	*Date Closed*
12-Sep-1985	**29-Mar-1996**	

Primary Contact
Owner Location **Strategic Information Management Section DPP = 6090**
Home Location **Strategic Information Management Section DPP = 6090**
Current Location/Assignee **History Related Records =60909132 since 20-Mar-2001 at 11:14 AM**

Fl2: Status Certain? **No**
Fl3: Record Copy? **No**
d01: In, Out, Internal Rec or Rec Copy

Contained Records Container

Date Published	*Fd3: Doc Type - Format*	*Da1:Date First Published*	*Priority*

Record Type **A02 HIST CORR ITEM**
Document Details **Record has no document attached.**

Notes

= c + 018 pp + 0 b
Archive Code Valid Date: 10/30/1989
Alma Ata; tuberculosis; Rockefeller Foundation
WU_Staff:
Correspondent:
Main or Elec Storage: Wang Item RSN: 2887 Box Year: Folder File Code: CF/HST/INT/HOL-003/M
Owner Archive Code: CF-NYH-06.H Arch Code V.Date: 30/Oct/1989 Ref Code: CF/NYH/OSEB/HST
F_Folder_Code: CF/HST/INT/HOL-003/M
Cross Ref or Related Record: CF/HST/INT/HOL-003/M
CF/NYH/SEB/HST/1996-0122 ; CF/HST/INT/HOL-003/M

Print Name of Person Submit Image	*Signature of Person Submit*	*Number of images without cover*
JOHN MANFREDI	John Manfredi	18

Blank Page

Back of

Cover Sheet

2231Q

12 November 1985

Interview with Dr. Johannes Holm

by John Charnow in his home in Copenhagen

12 September, 1985.

Charnow: Dr. Holm, as you know, UNICEF, as part of the Child Survival and Development Revolution, is putting a great deal of emphasis on working with WHO on the Expanded Programme of Immunization, and I think it would be very useful to us to have your views on that in the light of your involvement in the mass campaigns for BCG in the early years of UNICEF.

Holm: Yes, I have given some thought to the Expanded Programme of Immunization during the last several years and have tried to follow in through the WHO publications and talks with some of the important people who how this Programme has developed. Recently, I had a talk with the Director of the Indian Council on Medical Research here in Copenhagen; he came and gave a speech for the media about the Expanded Programme of Immunization and he stated that he had tried to calculate for India, what importance it would have if this Programme of Immunization was really carried out in an effective manner, and his conclusion was that just by the Immunization Programme he could lower the child mortality and child morbidity by at least one-third. And then I discussed with him how the Programme worked, actually, and I think we agreed

that at present the EPI as directed by WHO doesn't work very effectively, because it carries through on a basis of Primary Health Care. The situation is actually, that we have three highly effective vaccines, namely, vaccine against measles, polio and diphtheria, and these three can contribute to nearly almost eradicate, or possibly completely eradicate these three diseases, just in the same way as was done with smallpox. The other vaccines are effective but they don't contribute to eradicating the diseases. For instance, vaccination provides a high protection for tetanus but you can't eradicate tetanus. The same is true for BCG. BCG vaccination does not contribute very much, only marginally, to control of tuberculosis in the sense of diminishing the spread of the tuberculer bacilli. But it gives a high degree of protection against that killing disease in children who have tubucular meningitis and miliary tuberculosis and that's enough to use the BCG vaccination; they may contribute also to lower child mortality and child morbidity. Now, the question is, how such an immunization programme should really be carried out, and therefore it is necessary to study how it's done; and what are the weak places. The idea is vaccination must really be carried out by the personnel in most peripheral health centres and health posts. They should vaccinate not only the people coming to the Centre but they should go out to the villages and make propaganda and vaccinate. The experience, is that the personnel in these Health Centres don't like to do this, and try to find all excuses for not going out of the Health Centre, and therefore the total coverage they obtain through the vaccinations they make is very low.

In order to have an effect upon these three diseases I mentioned, to really control the diseases, you have to obtain a coverage of about 80 per cent. Second, the weak point is that the vaccine is not treated well enough. The two vaccines, namely, the vaccines against polio and measles are live vaccines, therefore they must be protected completely against too high temperature and light from the moment they are produced in a laboratory till they are applied to the people out in the villages. My impression is that the Health Centre do keep the vaccines not well enough protected so very often the vaccine has lost its potency when it is actually applied. And the third weak point is that the methods of application used by these personnel who do all types of health work is not up to the standard it should be.

Therefore, there is a need to obtain effective vaccination that really could control or eventually eradicate the three diseases. I think we will have to go back to the old method of mass vaccination made by personnel specially trained and employed for making vaccinations, having a team for, I don't know how many - maybe 100,000 population, and having direction for a province and district, a whole set-up, - but to have this personnel move around and go about in the villages and make it there. In order to obtain a good coverage you have to apply the vaccination in such a way that it fits the population, that is to say, it must be made where the people live. That was exactly our experience in the ITC, that only when you move around to where the people live, then you obtain it. It would have to be organized so that there is an organization in advance as we had in the ITC that

people go out in the villages and explain the whole thing and organize and get the cooperation of the people through whatever voluntary groups exist because it is the people who not only must make sure that the children who should be vaccinated come to the team that's there, but they all should be able to fill out of files and whatever is done and assist in many ways, that is to say, they would help to be a community participation in a full way, because a whole community participation is, in my opinion, lacking in the Primary Health Programme, which I believe could be obtained.

Charnow: Well, Dr. Holm, as I understand it, the theory of PHC is to have community participation. What is your answer to people who say that we that especially since Alma Ata, we have been trying to convince all the Ministries of Health to put in their resources for into PHC. All this is a process now in progress. How do you answer the question that what you suggest may deflect the resources and attention from Primary Health Care?

Holm: Yah, in that respect, I make a clear distinction between disease care and health care. PHC is primarily concentrated on disease care. Disease care, in my opinion, is emergency help to an individual. The situation is that what you try to do is to bring the situation for an individual person to the status it was before he got the disease, but this has no influence on the health situation in a country, not one bit. Health care is something quite different - they have not as an objective an individual person, but a group of people in a health situation.

It is quite different methods you have to use for this. It is for this last part you need community participation.

The fault, in my opinion, in PHC, is that everything is based on this idea that the same people who take care of the sick person also should take care of health care, directed by the medical doctors. But the medical doctors are not interested in health care. They are interested in disease care. That is the only thing they have learned about, that is the only thing. That's money. It is absolutely defeating the purpose of Primary Health Care to think that all this activity must be done by the personnel that take care of disease care in the primary health sector. Therefore certain aspects have to be done out in the communities and build much more participation. In Primary Health Care there is very little community participation. In order to mobilize people out in the community to do something they must have specific tasks to do, not just saying you should go to the Centre, you should do so and so; they should have specific tasks to do; and that is what you can do in the Expanded Programme of Immunization. Also on tuberculosis control. I have written a paper to WHO recently about it and I think that is also a task for UNICEF to give support to the voluntary groups in the community that really must do something to control tuberculosis.

Charnow: Earlier in talking to me, you had referred to the importance before large sums of money are invested in some pilot studies or the effectiveness of certain approaches and methods. I wonder if you would elaborate on that.

Holm: Sure. If you are going into a big programme you have to have scientific evidence for its effect. Therefore, I would not right away start such a programme. I would make a study, based on research methods, and that should consist in selecting in a country, or even in several countries, some population group of sufficient size and carry through. The method I suggest is to mobile teams vaccinate in these areas and compare the result of the vaccination where they continue doing it in the present way based on primary health care, and I would measure the result in a simple way on the child mortality and child morbidity. It is difficult to get the exact diagnosis for disease and death, that a child died of measles or of diphtheria, but it is easy to count the number that died, and if the programme is really effective I think you would get a lowering of the child mortality and child morbidity about one-third and that would show the effect of it. In the same way a number of organizational measures would be reviewed: how the team should be trained, what equipment they should have and how they should be directed and all this, exactly as we tried to do in ITC before we started the mass campaigns.

Charnow: How long a period, Dr. Holm, do you think those studies should encompass to know what the effects are?

Holm: That is difficult to say, but I think it would take one or two years. After one or two years I think you could show a high effect. I don't think that's a kind of study which would be very expensive but they would need support, for instance, from UNICEF. I understood the Director of the Indian Council Medical

Research might be prepared to make such a study in India and I discussed with him. He said, yes, he would be ready to do it, but doesn't have any money. He can't mobilize from the Indian Government any money for this project.

Charnow: Now, UNICEF has encouraged large-scale vaccination campaigns trying to get the 80 per cent coverage in a number of countries. Now, are you suggesting that we not do move forward on this while the studies are going on?

Holm: The places where you are making these studies - may very well be used for campaigns. The point is not only to obtain the 80 per cent coverage but to obtain it with sufficient good vaccine at the time that they use it, that the vaccine should be protected and applied with the right technique, and this might be introduced in these studies.

Charnow: But are you suggesting that UNICEF not encourage large-scale campaigns pending the outcome of these studies in a year or two; that we hold off for a year or two?

Holm: No, that may be too difficult for UNICEF to do.

Charnow: I think it would be.

Holm: Much too difficult, and therefore, one has to be pragmatic and see the actual situation as it is. I think that the money spent for these research studies, I suggest, should be given extra by

UNICEF, not out of the money that you have allocated to the ongoing programmes.

Charnow: Well, you suggest that the Indian Medical Council might undertake these studies. Can you mention other bodies who would be competent for such evaluation or would you suggest this be done by WHO or a combination of agencies?

Holm: I would suggest that WHO come very much in on this. WHO is now, in contrast to when I was in WHO, interested in research, especially in research in diseases in under-developed countries. Therefore, I think it would be quite natural to have WHO Geneva, the central Body in Geneva, plan, direct and evaluate the research. It would have to be done in collaboration with different groups in different countries and it should be done, not only in India, it should be done in different countries in the world, because local conditions are different.

Charnow: Now, you said that for ITC that is what you did. I assume this was done in the period preceding the campaigns which were started jointly with UNICEF so it had been pretty well worked out, or was that done during the ITC campaign?

Holm: We had done some research in advance but I visualized right away and discussed with Rajchman that we could encounter many problems during the campaigns especially when we went to countries outside Europe. Therefore I insisted that we had to have research to find out these problems and that was the reason that the

Tuberculosis Research Office was established in Copenhagen and I insisted also that time that it should be under WHO and against much opposition in the Secretariat of WHO we succeeded in having it established in WHO through the Joint Health Policy Committee especially through the big help of Dr. Rajchman.

Charnow: Was this due in part, would you say, Dr. Holm, because in WHO and within the medical profession at that period there were a large number of doctors who were more interested in the clinical rather than the preventive aspects of health, or is that over-simplifying the story?

Holm: It is a long story. I think it is interesting to look into already in the International Health Conference in New York where WHO was created, there was a terrific fight between the two groups - those interested in what I call disease care and those interested in health care. Fortunately, there were few strong men on the side of health care, namely Dr. Evang from Norway and Dr. Stampar from Yugoslavia, and they insisted that WHO should concentrate on health care and they managed to get that through with an instruction to WHO on the first priorities, the first five priorities. When I joined WHO in 1952, our instruction was you cannot take care of disease care; it is health care. But there was more and more opposition against people from the medical profession.

The typical thing was malaria. We had in WHO a very clever and strong leader of the Malaria Section and he said if to control

malaria we will have to study the epidemiology, so he sent out to the different countries people to study mosquitoes and see the habits and all this. He was heavily criticized. Also the World Health Assembly stated that in countries where people are dying from malaria, WHO sent out people that go around and collect mosquitoes and do nothing for the people dying and suffering from malaria. And there came a strong opposition, I must say, supported strongly by Dr. Candav, that WHO should take care also of disease care and finally it became practically only disease care. That is what Dr. Mahler has fought against because it is the medical profession that states that they should take care of disease care, and therefore, Dr. Mahler speaks about a medical Mafia.

Charnow: Would you, just to make sure, confirm that when you say disease care, that may be roughly synonymous to treatment and health care is synonymous with prevention.

Holm: Yah, practically. There are two quite different units in it. One is the old clinical medicine, the doctor, medical man to take care of the one person, and that was the old story, that's from old time. Health care is something quite new and was started only in this century, and people found out that ordinary things, there is a risk in everything we are doing, and we should study the risk of it. They should study what we eat, what we drink, how we defecate and how we work, and all this. And this should be studied. That is a new business--interest in improving in the health situation for a total population. This is part of

development, whereas disease care is only, I would say it is the same as emergency. UNICEF is speaking about emergencies, there has to be a catastrophe, earthquake or something. You give health with the aim of making the situation as it was just before, and nothing more. That has nothing to do with development. Therefore, my conclusion is that disease care has nothing to do with development. That is health care.

Charnow: If I understand you correctly, you seem to say that Primary Health Care is predominantly disease care. Now, everything that I have read about Primary Health Care, at least in theory, is that it is supposed to be Health Care; it is in the title that way. So, I wonder if you would comment on that.

Holm: Sure. In the programme for big conference at Alma Ata, they made a big splash on prevention, on health care, and it is still done in a programme in each country. But when you see what happens in practice, they state that health care was done by the same personnel that gives disease care, and this personnel is not one bit interested in or educated in prevention. And that is the reason it does not work. They are not interested in community participation. The doctor doesn't wish to have a group in the community saying what his personnel should be doing. He is the director of it, and he is doing what he wishes, and therefore, in my opinion there is practically no community participation. In a project I have been able to follow--a big project in India supported by DANIDA where I am in on the group here in Copenhagen that gets all the reports. It is typical that everything is

health care. Buildings, Primary Health Centres, and also living quarters for the personnel and means for transport and all this, but the personnel is sitting in the centre and have all good excuses to do so.

Charnow: You seem to have a not very happy opinion of your colleague in the medical profession, at least some of them.

Holm: Now, I can give you my personal opinion from way back, which may be a shock for you. I graduated as a Doctor in 1928. I went out for two months replacing a private practitioner and then two years in a hospital in a province. I had an opportunity to see what the private doctors were doing. Automatically at that time one became Member of the Medical Society when one graduates, so I was made Member, and as I was the leader of my class, they put me in a Director capacity. After one year, in 1929, I resigned from the Medical Society in Denmark and I have never been a Member of it later, and don't wish to be a Member. That is my point of view, for doctors were interested in money, and I have been fighting against this. I decided I didn't wish to use my medical education for taking money from patients and decided at that time I would never take any fee from any patient and I have kept that.

Charnow: What did you do then?

Holm: I had to get employment in the Government and therefore I went to the State Serum Institute and made my Doctor's Degree and I finally got position as Director of the Tuberculosis Unit as a

Government employee after 12 years experience in hospitals, because that was part of it.

Charnow: Dr. Holm, in the Expanded Programme of Immunization I find that among the vaccines, BCG is sometimes mentioned and sometimes not. What is your opinion about the value of including BCG?

Holm: I think that BCG vaccination should be included in all the countries where tuberculosis is a major health problem, that is to say, where a high proportion of the children are affected every year by tuberculosis. The effect of the BCG vaccination in my opinion is to protect against the two killing diseases in children, tubercular meningitis and miliary tuberculosis but it does not contribute very much, or perhaps not at all, to control of tuberculosis, to diminish the spread of the tuberale baccilli vacillae in the community.

Charnow: Which has to be done through environmental and nutritional factors?

Holm: No. It has to be done by making early diagnosis of the cases of tuberculosis and then give them today's highly effective anti-tuberculosis drugs, and that can be done. We have no other option that can ensure close to 100 percent that if the patient gets the drugs in time it can take then for two months intensive treatment then for four months less intensive treatment then they are cured, they are not discharging tuber bacillae any more, this is what I have written in ...

Charnow: This round table article, a copy of which you have given me. Is this practical in developing countries for developing countries to have this early diagnosis?

Holm: If you do the right thing, but again, you have to have community participation. The thing about diagnosing tuberculosis is simple. You have to collect the sputum, and that sputum has to be examined by direct microscoscopy. If you find tuberale bacilli by direct micrscoscopy the diagnosis is made and you should forget about clinical examination and x-rays, and for treatment, you should start as soon as possible with antibiotics. In order to do this you have to mobilize the community because collection of a sputum can be done by ordinary people in each village. Those who have had productive cough for more than two weeks should deliver a sputum specimen which should be sent to a laboratory and then the answer comes back. For the treatment the important thing is for the patient to have complete supervised treatment for two months. In my opinion, you don't have to be hospitalized. I think that a voluntary association could very well make simple hospitals close to the Primary Health Centre where people could just sleep and get their food, and that I have described in detail.

Charnow: Thank you very much. Dr. Holm, I wonder if you would elaborate a little bit more on your attitude toward Primary Health Care as a philosophy, and as your see it is carried out in practice.

Holm: Yah. I was in on the formulation of the document for the Alma Ata Conference and the basic idea about it was obviously correct and I was all for it. The idea was Health by the People and not Health For the People. The important thing was to involve the community and make sure that Health which means development of health, promotion of health, prevention of diseases, is something that the people out in each locality, each village, must take an active part in. That was the idea of it and then, of course, the original idea was also that there should be health care, disease care, because disease care is almost a human right and sure it should be there. But it was not the idea at that time that the people responsible for disease care also should be completely responsible for health care. That came in only as compromises in Alma Ata. The theoretical emphasis on community participation, on working through voluntary organizations and all this, but in reality they did not in practice apply it. I tried in the early times when I was a Consultant with WHO to get the voluntary associations involved, and at the time of the World Health Assembly when they discussed and came to conclusion that there should be conference at Alma Ata, I organized to have a meeting with leading voluntary associations in Committee in the Health Centre attended by ??? and also by Mahler...

Charnow: Where was this Conference held?

Holm: In WHO Palais and there was participation, all type of voluntary associations, Catholic, and other church organizations, professional. They agreed and made a recommendation that they

would be ready to take part in the Primary Health Care if it, as presented at the time, became a reality. But as far as I can see, very few have participated to date.

Charnow: Dr. Holm, I understand that you knew Dr. John Grant.

Holm: Yes, it was at the time of ITC. I got a visit from Dr. John Grant in Copenhagen. He was at that time working for Rockefeller where he had spent his life and he was extremely interested in how to organize this mass vaccination campaigns and not only in a practical organization but also in a financing and what difficulties we had with personnel and all this, and he stayed with us in our Doctors' College where I lived, for about one week and then he went and visited some of the teams in different countries in Europe and as far as I know, also in India, and on several occasions I met him. I met him again during the second World Health Conference in Rome; that must have been in 1949, and then I met him again at the World Health Assembly in 1951 at the time when it had been decided that ITC activities should be taken over by WHO and UNICEF jointly. I had been asked at that time by the Director-General of WHO, Dr. Chisholm,to take over the position as Chief of the Tuberculosis Unit in Geneva on 1 July 1951, the time that WHO should take over. But I asked to get one year's vacation, so to say, because I had been travelling around in the world for four years and had no time to study or read and felt there was much I should look into before I took over the position; and that was accepted by Dr. Chisholm. At that time I had lunch in Palais des Nations with Dr. John Grant and the

Danish Director of Health Services, Dr. Franson, and I told Dr. Grant that I had now one year off to catch up on what I had not been able to study during the last four years. He suggested that I should use this year for taking a Public Health course in the United States. I said I didn't think I had the money to do that because that was expensive and John Grant said right away, I think the Rockefeller Foundation should give you a scholarship that will pay your travel and stay and living conditions and all this, and I will try to do it. He said right away there was some difficulty in it because one who gets a Fellowship should not be over 35, and I was at that time 48. Furthermore, there was the difficulty that I had already in '38 had six months' travel grant from Rockefeller in the United States and it would be difficult to give a Fellowship. He said we will overcome this; I will call my office in New York. He came back in the afternoon and told me that I was accepted; Rockefeller will give me the Fellowship, and he asked me which school I wished to attend. I said either Johns Hopkins in Baltimore or Harvard in Boston. He said, of these two I will take Boston. I would arrange it and he came back the next day and said, I have arranged everything, you can start in September.

Charnow: Was that a useful year for you?

Holm: It was very useful. It was nice at that time, after having had all the responsibility again to be a student without any administrative responsibility, and to be able to spend you time exactly as you wished, and I used it for all possible things, and it was extremely useful. At the same time it was useful to study how a Public Health course was made in the United States.

Charnow: Well, thank you very much.

****