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SOCIAL MEDICINE IN THE INTERWAR YEARS. THE CASE OF JACQUES PARISOT (1882-1967)

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SUMMARY

Hygiene, asserted the "Pasteurians", is "the very base of politics". Professor of preventive medicine at Nancy medical school, the phtisiologist Jacques Parisot well epitomized the style of a discipline that had soon shown interest for the avenues of action. Just as many other practical minds in Europe and elsewhere, he lamented the discrepancies between medical innovation and organizational change. However, as a French Professor medicine he had more latitude than his foreign colleagues to try bringing together the laboratory, medical education and the clinics. Chair of the Health Committee of the League of Nations from 1937 to the war, Parisot is an interesting case of these "Statesmen in disguise": to him social medicine, a science for action, was nothing but a vehicle to improve the Welfare of the community.

With some notable exceptions – George Rosen, Dorothy and Roy Porter, Elisabeth Fee[1] – medical historians deal with social medicine only in a "local or national form"[2]: social medicine in France, in Belgium, Holland, Italy, Romania, to cite some of the chapter headings used by René Sand in his classic *The Advance to Social Medicine* (1952). One could even say of social medicine what has been said of malariology, torn between the League of Nations' socio-economic model (quinine plus roast beef) and the Rockefeller Foundation's ecological model (mosquito control), that it was "a house divided"[3].

Key words: Social medicine - Internationalism in health - Public health

Death, are we told, is a "social disease"[4]: indeed, the sharing of this belief does not hide the divisions in a discipline which doubts its guiding science, struggles to distinguish itself from socialist or socialized medicine and is unsure itself if it is a simple "hygiene of the underprivileged"[5], as Nicolai Semaschko, the first Soviet Commissar of public health in the 1920s, called it, or a more ambitious *Menschenökonomie,* a medicine of the social.
Like the social history of medicine itself[6], social medicine defies easy definition. It hesitates over the name of its patron saint — Rudolf Virchow and Albert Grotjahn for the Germanic world, John Ryle for England, Angelo Celli for Italy — and it stumbles over its date of birth. If one can believe the British literature concerning a discipline which was not widespread[7] — Charles Webster even said it was "almost unknown" in between the wars[8], — social medicine in England only took off because of the Second World War, which focused attention on bread-and-butter issues. This was a resolutely idiosyncratic development, without any equivalence on the European continent where the concept had been grounded in a political view of health since the revolutions of 1848 in the West and 1917 in the East. "The notion of social medicine is an answer to the notion of social illness" declares the Pasteurian school of the 1930s: "It could even be said that it consists in bringing about equality of the classes in relation to health" [9].
For our part, it is precisely a political reading which we favor, considering the recent call by Mark Mazower, author of *Dark Continent. Europe's Twentieth Century* (1998), to confirm the strength of ideologies. Liberal democracy, communism, fascism… apparently, only the Second World War taught democrats the lesson which had long been contemplated by the 'Fascist welfare states', "that granting individual liberties was not enough to secure people's loyalties"[10]. This argument is suggestive in that it takes seriously the many variations of 'welfare state' which were circulating between the two wars: the

eugenically conceived social-welfare state, the German racial welfare state, as preface to the British 'social citizenship state' which appeared after 1942[11].

Competition between models then, models which define themselves in relation to each other: social medicine fits this line of analysis so well that one could practically map the variations according to the main geo-cultural areas, recognizable by their major concerns – social class differentials in fertility, mortality and living conditions in the case of England, welfare eugenics for the Germany of Weimar or Scandinavia, etc. Thus, this succession of social, socialized, socialist medicines that can be readily analyzed in reference to the transitions from West to East which Alexander Gerschenkron called the European cultural gradient[12]. From our comparative perspective, the proper analytical framework appears to be less national than transnational, and even translocal.

It is such a translocal figure we would like to introduce here, namely the French phtisiologist Jacques Parisot (1882-1967), professor of bacteriology (1927), then of preventive medicine (1928), and finally of social medicine (1934) at the medical school in Nancy[13], member (1934) then president (1937) of the Health Committee of the League of Nations[14].

Some of his publications: *Alcoholism in the Lorraine Region, Tuberculosis among bakery workers, A necessary reform: paid holidays for workers, Tuberculosis infection: the role of slums and overpopulation, Malaria in Europe and the antimalaria campaign in Corsica, Social Welfare Insurance, The economic crisis and public health, The impact of unemployment on prostitution, The major tasks of public hygiene, The hygiene of milk, History of an unhealthy neighborhood, The return of rural artisans*.

These few titles chosen from among his publications are indicative of the spirit of curiosity of an aristocratic figure whom the 'Rockefeller medicine men' considered equal to the Croatian Andrija Stampar or

the Hungarian Bela Johan, as one of the best European statesmen for state medicine[15].

This is exactly what interests us with Parisot, exposing a current of thought in social medicine advocated by a conservative, but so similar in its content to that held by confirmed socialists. In line with Arthur Newsholme's analysis of Hungarian social insurance as "a bulwark against Bolshevism"[16], we will thus see him advocating its introduction into France, as follows: "Too often, among us, the word 'social' evokes the idea of a revolution. Quite to the contrary, social medicine and especially social insurance constitute an effective weapon for protecting not just health but also order, by creating an atmosphere unfavorable to communism"[17]. But in truth, what is the difference between the social-democrat agenda and his own? Salaries, family allocations, major public works, urbanism, housing: it's the entire political and social economy which is engulfed by the enlargement of the 'health-capital' of the nation. His language is not the same as that of a Charles-Edward Winslow (professor of public health at Yale University) entrusting to public health the task "to build upon earth the city of God"[18], nor is it that of Henri Sellier (the French Socialist minister of Health in 1936) and Robert-Henri Hazemann (former Director of Vitry-sur-Seine's health bureau) calling for it to "solve the most violent contradictions which oppose the individual to society"[19]. But all millenarianism aside, the Promethean tone did not dissipate in the slightest in this physician-sociologist who, throughout his life, continued to call for the abolition of the "general causes" of poverty and disease: "'*Bonificare*', to use the Italian expression, is to destroy the slums, build healthy housing, create workers' gardens, water works, build sewage systems, clean up cities, villages, land, create public baths, swimming pools, slaughterhouses, etc. "[20].

Some aspects of his biography allow for comparison, namely: 1. Creating a technical health consciousness, 2. The local becoming the cosmopolitan 3. The agrarian moment in social medicine. These are three dimensions which current historiography has left somewhat in the dark.

1. *Creating a health consciousness*

John B. Grant, the self-styled Rockefeller Foundation's 'medical Bolshevik', assures in his oral reminiscences: the chief thing he learned from his first assignment in Puerto Rico was that "you couldn't secure implementation unless you had a local agency and not only a local agency but also a technical health consciousness among the consumers"[21]. What is difficult here, everyone knows, is to not yield in the slightest to the luxury of a 'popular mobilization from above'. Believing that persuasion and education, patient explanation and demonstration would permanently bring the wants of the population into line with the plans of the experts, is to adopt the illusion which James C. Scott has rightly called the "populist technocrat's creed"[22].

Does Jacques Parisot totally avoid this? We would not swear to it. His enthusiasm for 'educational propaganda' is without limits[23]. But this is not the main point. Behind his commitment, there was the specter of a fading population, the brutal plight of the First World War, as he writes in *Curing is good, preventing is better* (1925), a war which, for France, dramatically posed the problem of 'to be or not to', a problem whose solution is "largely a matter of social medicine"[24]. These are marvelous observations because they encourage the historian to ask questions not only about the relationships between poverty, disease, ignorance, and misgovernment – that is between social medicine and social policy – but also about their no less intense relationships with nation-building, or re-building. Thus we have health demonstrations and other rural betterment experiments carried out in emerging Yugoslavia, nationalist China or fascist Italy and, as concerns our example, on that alarming border which Lorraine represents for France. The field demonstration taking place there has no other finality than that: create a new "mentality" in circumstances where "the nation's strength" is at stake[25].

And to do this, begin by making medicine social. With Jacques Parisot as with his mentor Léon Bernard (1872-1934, the grand Parisian phtisiologist, born in a Jewish family from Lorraine), the professor of hygiene "has to take to the streets"[26]. As Arthur Newsholme insisted, it is 'medicine from the social standpoint', medicine as the nucleus of community service. Here we find a common denominator on which the René Sands and the Winslows, Grants, Stampars or Sigerists can agree – all descendants of Virchow. Social medicine cannot be separated from a critique of clinical medicine and a reassessment of clinical training. A step beyond preventive medicine, it is presented here as a polemical concept directed against those practitioners suspected of only wanting to "grope the patient in his home" and to "extract his last penny". Etienne Malvoz (director of the Liège Institut bactériologique) wrote this in black and white at the dawn of the last century to his friend Albert Calmette[27]. It is easy to understand this tone: clinging to absolute secrecy, averse to the declaration of contagious diseases, devoured by contempt for dispensaries, paralyzed by fear when faced with social insurance (to the point of raising millions against the law of 1928-1930 on health and disability insurance), the private physician is all too often the worst enemy of public medicine in France. The brilliance of Jacques Parisot can especially be appreciated in that 80% to 90% of persons consulting in anti-tuberculosis dispensaries in Nancy and the surrounding area were reportedly sent there by their family doctor[28], as opposed to 24% for France as a whole in 1929, 50% in 1937[29]. These figures clearly illustrate the transforming power of a "University Faculty of Social Medicine"[30].

By Faculty of Social Medicine, we mean in this case the close voluntary association achieved in Lorraine between the teaching and practice of preventive medicine. In Nancy, the central anti-venereal dispensary of the regional Office of Social Hygiene, located next door to the School of Medicine's anti-syphilis chair, is presided over

by the professor who holding this chair. The same is true for the central anti-TB dispensary, where medical students are required to participate in the work. The main point being that each of the chairs devoted to tuberculosis, childhood diseases, or other illnesses directs the corresponding section (child care, cancer, propaganda and TB stamps, etc.) of the Office of Social Hygiene which, under the presidency of Jacques Parisot, does not hide the fact it is working for the interpenetration of preventive and curative medicine. He never tires of repeating that "The patient is a unit, but a unit in a group, which is the family, the workshop, the town"[31]. Like Henry Sigerist in Baltimore, whose students at Johns Hopkins were instructed to make a thorough survey of the state of health in each county of Maryland[32], Jacques Parisot required candidates for a degree in hygiene to conduct case studies of rural Lorraine villages, thus using the social survey as a tool to shape a profession.

A positive outcome of this 'saturation' of medical teaching by the spirit of preventive medicine was the three-party agreement, the first of its kind and the only one in France[33]. This agreement was signed in December 1930 by Parisot's Office of Social Hygiene, the local Medical Association, and the Union of Insurance Funds, which would provide the principal part of the Office's budget. This was a gold mine which enabled increases in visiting nurses and dispensaries, the latter under the name of health centers. With additional effort, Parisot would obtain from these same partners, joined by private charities, public housing offices, municipalities, and provincial authorities, the creation of a joint 'committee for the development of the means for protecting public health', conceived as a planning tool in the struggle against social afflictions on a regional scale. This is what gives this experience its demonstrative and translocal importance: the compromises made among differing interests, rational understanding organized to reach a certain goal. It is this problem-solution approach, local and tailored to the situation, which

the Popular Front would support when it called for generalizing the Lorraine precedent to the whole country. By preparing a 'health balance sheet' for each *département*, civically minded 'coordination committees' would guide politicians, and would encourage public opinion to be built on technical foundations.

2. *The local becoming cosmopolitan*

Collaboration, consistent methods and actions, the model here is a German one, namely that of the 'Committees for medico-social cooperation' – *Gesundheits-Arbeitsgemeinschaft* – which the members of the Health Organisation of the League of Nations (LNHO)-International Labor Office (ILO) joint subcommittee, beginning with Parisot, were able to admire across the Rhine in the spring of 1929. From this study trip, which he took in company of C.-E.A. Winslow through Germany, England, Austria, Hungary, Poland and Yugoslavia, Parisot brought back firsthand knowledge of these "techniques" for pooling disparate resources such as hygiene, insurance, assistance, private charities, and even medical practitioners, which seemed to be the Weimar Republic's secret[34].

But Weimar is only one of a thousand reinterpreted models circulating about, as though newly recreated. The Danish folk high schools, the Croatian 'Peasant University', the Italian *bonifiche* studied in the summer of 1928… the list is endless of these exchanges and reciprocal borrowings between closely connected 'translocal' professionals. Everything becomes a game of mirrors, with ideas reflected back and forth. For example, the case of these 'social consultations' begun during 1935 in the Lorraine health centers for the neediest patients:

> *Doctors and hygienists, argued Parisot, might think it completely abnormal, when visiting one of our centres to find courses in homemaking, cooking…*[35].

The example came from the famous ‘Peckham health center’ in London where mothers bring their babies to the nursery, spend the afternoon together sewing, cooking, and often come back in the evening with their husbands to see a show, attend a concert or dance in a room next to the preventive medicine department[36]. Mention should also be made of the “bibliobus” or “circulating libraries” inaugurated in the Lorraine countryside as a sort of substitute Italian Dopolavoro[37]. Social medicine in the 1930s is nothing less than this illicit mixing between entities apparently allergic to each other such as housing, nutrition, physical education, leisure activities and even civil service. There is a sort of generalized interconnectedness. John Grant said when he was in China, “The lower economic levels are, the more the use of medical knowledge depends upon organization”[38].

We spoke of translocal, reciprocal schemes of innovation. What is fascinating about the Lorraine example is the links established between the studies carried out by the Office of Social Hygiene and the new projects on the impact of the Depression that the LNHO was launching at a feverish pace. Synchronization was perfect: in the winter of 1932-33, his visiting nurses were carrying out studies on income, housing, health and especially nutrition among 8000 families. Similar topics, similar concepts… Another, earlier example was the inventories made in villages in Lorraine on typhoid fever or a safe milk supply (1934)[39], in line with the proposals of the European Conference on Rural Health (Geneva, 29 June-7 July 1931)… as though Lorraine were the LNHO’s testing grounds, as though the local were becoming global.

Parisot expands the frontiers and, making his Office into a staging area for the LNHO, gives it primary influence in Geneva. The same is true for Winslow in New Haven, Sand in Brussels, Stampar in Zagreb, Johan in Budapest, who are carrying out the same evaluations on typhoid fever or milk supplies, share the same interest in the cost of medical care and draft the same tools for measuring public health.

At times, one or another of these experiments was of a pioneering nature and at times it was seeking to transpose and adapt initiatives worked out elsewhere; miniglobalisation and interconnectivity…

3. *The agrarian moment*

It is commonly agreed, to cite Gertrud Kroeger, that social medicine was merely “the outcome of the industrial revolution”[40]. Inspired by Engel’s *Anti-Duhring*, Robert-Henri Hazemann thus proposed in the 1920s that the production, exchange and consumption of ills among the inhabitants of a working class city were conditioned by the way they produced, exchanged and consumed goods[41]. Armed with mathematical formulas, ‘indexes of poverty’, the father of the first French health center decided, in the same vein, to elucidate the economic underpinnings of health. The picture changes completely in the 1930s. Until now dedicated to *the working classes*, *the dangerous classes*, social medicine in the 1930s would become obsessed with helping the Central and Eastern European peasantry, which the Great Depression was pushing into the magnetic force field of fascism. In this sphere of lofty politics, it would be but another name for rural reconstruction.

C-E.A. Winslow had stated it following the First World War, “The rural problem was the great unsolved problem of public health”[42]. The village, and no longer the workplace; it is this reversal of priorities to which the epoch-making 1931 European Conference on rural health is devoted[43]. Carried forward by a new wave of holistic thinking on health care, Geneva had come to see the Depression as a crisis of under consumption rather than of overproduction. Home economics, electrification, land banks, and farm-cooperatives… rural hygiene from now on would be seen with an eye towards raising the standard of living rather than simply improving medical issues.

There was thus nothing remarkable about the case studies of rural communes in Lorraine that Parisot demanded of his students at the

regional Institute of Hygiene. Each snapshot of peasant life recorded in the thesis for the diploma in Hygiene was to be a complete epidemiological study of a given region or village — a locality's pathological history during the past thousand years, for instance, with miscellaneous items such as: peasant housing, lighting, ventilation, dunghills, flies, mosquitoes and rodents, food safety, control of fresh produce, diseases affecting both people and animals, work hours, the organization of leisure, sports, the population in the armed services, divorces, etc. In other words, a sort of return to the spirit of medical topographies[44]. And why be surprised of the affinities drawing social medicine toward 'open-air geography', at a time when half of Europe was rural? Field surveys, and more generally, familiarization with a community's mores, customs and economic status, were ways of learning "as indispensable to the health officer as clinical observation is to future doctors"[45]. Think simply of the 'health inventories' of rural communes bordering Paris drawn up around 1930 by Robert-Henri Hazemann. This former Rockefeller fellow, and former communist, now expert in Geneva's Health Section, filled more than fifty tables with numbers, ranging from the 'quantity of meat consumed per week and per person' to the 'distance of wells from unsanitary outhouses', while not forgetting the 'legal status of property' or 'ventilation at night'[46]. Doctor-sociologist, doctor-geographer, all are one.

At the same time, in Geneva, there was talk in the mid-1930s merely of a 'marriage' of health and agriculture[47]. Imbued with the potency of a 'Keynesian medicine' as the soothing balm of international strife, the League was now interested only in the family's purchasing power, and consumer economics. Vitamins turned into political facts. From Moscow in June 1936, Jacques Parisot, in the name of the LN Health Committee, thus called for a far-reaching European Conference on Rural Life – instead of on Rural Hygiene, as in 1931 – which would embrace nothing less than: *I*. The rural ambiance: peasant art and folklore, farm loans, agrarian reform, the cooperative

movement, repeopling the countryside, community planning, transportation, electrification, local administration; *II*. Food and produce; *III*. The rural house and its outbuildings; *IV*. Peasant education: general, technical, homemaking; *V*. Peasants at work: new farming methods, rural industries; *VI*. Peasants at rest: organization of leisure activities, physical education, libraries, radio, cinema; *VII*. Medico-social policy: maternal and child care, birth control, nurseries and kindergartens in rural areas, malaria, alcoholism, village health workers, midwives, *feldscher*, etc.[48]. Such an agenda clearly takes on an Austro-Hungarian hue. To 'start up, back up and speed up' the raising up of Central and Eastern Europe signaled a last-minute attempt to reinforce LN's declining legitimacy by shifting its center of gravity from the city to the hungry countryside.

Jacques Parisot was not outdone in Lorraine itself. What he now called a medico-social organization – a miniature ministry of welfare – set out to "penetrate the intimacy of the peasant life, improving the fate of country dwellers, fighting against their exodus and preparing [this] movement back to the earth"[49] for which Fascist Italy offered the example, and Rooseveltian America as well, visited in the autumn of 1935. Vocational schools for keeping youngsters interested in mechanics in villages, 'social centers for entertainment on Sunday'[50], etc: everything was justifiable for engaging that "people's war for health" which would transform rural dwellers from passive or reluctant on-lookers to the best craftsmen for their own improvement. The creation, through education, of a general will towards health: that was the yardstick used for comparing prevailing models of regional rural development (Tennessee Valley Authority, Croatia, Northern China, etc.).

At that point, the nature of social medicine changed. While retaining its original equity-derived, multisectoral and participative orientation, its agenda would include fully-fledged rural rehabilitation. No longer simply a by-product of a Depression-era program, it would be

but another name for comprehensive, durable development. Because the trend was tricontinental. As shown by the August 1937 Bandung conference, and the abortive Mexico City conference planned for November 1938, the staggering agenda defined in Moscow was to be broadened to cover the Far East and Latin America. Bandung, Mexico: we are on the road to the WHO 1978 Conference at Alma-Ata.

Conclusion

Our conclusion is confined to a single question: are social historians those best equipped to talk about social medicine? When it concerns Europe between the wars, they are usually satisfied in portraying food, housing and income as currencies of health, and to state that this social model of health ran right across the political spectrum. But social medicine cannot really be reduced to medical sociology. And shouldn't there be concern that, if he does so, the historian will sweep under the carpet those things with which he does not wish to dirty his hands, such as the part taken by social medicine in the birth of nationalisms, for example. To approach the problem only from the angle of social policy – the State as *pater familias* – is to paint only that corner of the picture that is not subject to controversy.

And yet, there is no lack of diversity. To read Charles Webster, Ann Oakley, John Stewart or Dorothy Porter, social medicine is nothing more than a short-lived discipline consistent with the ethos of postwar reconstruction and the move towards state-funded health services; a discipline, as Jane Lewis notes, which must narrow its concept in order "to stake a claim to academic respectability"[51], and furthermore, it was supplanted in the 1960s by 'community medicine'[52]. There is nothing here in common with that encyclopedic and governing science defined by Albert Calmette urging French public authorities at the centenary of Pasteur in 1922, to see social hygiene as "the very basis of politics"[53]. This is precisely the position of a Rudolf Virchow in the mid-1850s: 'medicine is a social science, and politics nothing but medicine

on a grand scale'. A world separates these antithetical visions. British medical historians dispute the frontiers between biology and the social sciences, continental activist-reformers debate an all-inclusive 'medicine applied to the nations', in other words, politics.
It is this cultural divide which we should study, using concepts such as that of 'path dependence', as Peter Baldwin proposes in his recent *Disease and Democracy*[54]. Basic decisions taken in the early nineteenth century to control cholera and syphilis continue to influence the response to AIDS. Tactics adopted 150 years earlier created a template, so that each nation tailored its AIDS strategy largely to its long domestic traditions of public health. Next to path dependence, broad geo-epidemiological factors that pushed nineteenth-century policymakers to adopt one set of tactics over another continue to influence us. This is to say that traditional political analysis of the response to the epidemic is inadequate. Left and right, conservative and liberal: these are not labels that help explain why nations differ in their approaches to the epidemic. Such decisions are taken in accord with deeper, pre-political policy structures already set in place during the previous century, in addition to being influenced by current national political cultures.
Social medicine constitutes a means to broaden the question of how political cultures and states differ across Europe. How do they treat the patient who is both citizen and disease carrier? How are individual rights and the public good pursued simultaneously? Public health allows a deeper plumbing of political instincts and attitudes than the surface of official ideology. What are more important, the rights of patients or of the uninfected? To understand why the models adopted here and there were so surprisingly and counter intuitively different, we should certainly not commit that error formerly denounced by Raymond Aron, of reducing the political to the sociological, that is to say to the infra-political[55].

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29. DEBRE R. and BERNARD E., *L'Etat actuel de la lutte antituberculeuse en France*. In: VIBOREL L. (ed.), *Savoir prévenir. Guide pratique de la santé et de la lutte contre les maladies sociales*. Paris, L.V., F. Bouchy, 1939, p. 167.
30. AUJALEU E., *Discours de M. le Professeur Aujaleu, Directeur général de la Santé publique*. In: *Hommage au Professeur Jacques Parisot*. Nancy, George Thomas, 1957, p. 20.
31. PARISOT J., *La Médecine sociale*. Revue Médicale de Nancy 1939; 6: 15.
32. FEE E., *The Pleasures and Perils of Prophetic Advocacy: Socialized Medicine and the Politics of American Medical Reform*. In: FEE E. and BROWN T.M. (eds.), *Making Medical History: The Life and Times of Henry E. Sigerist*. Baltimore and London,The Johns Hopkins University Press, 1997, p. 211.
33. AUBRY P., *described the agreement reached in the département* as a "fortunate exception". In: *Le fonctionnement des assurances sociales en Meurthe-et-Moselle*. Revue d'Hygiène et de Médecine Sociales 1931; 10: 266. Whereas, in many *départements,* the heads of insurance funds and representatives of medical associations "spent their time talking disagreeably to each other", tough negotiations between these very parties had ended in an agreement in Meurthe-et-Moselle on three points. First of all, dispensaries, those existing and any to be set up, were to be open for free to all persons covered by the insurance funds. Secondly, the OHS would follow up on the insured persons sent to curative or preventive establishments, and the Medical Association would exercise control over medical treatments. Thirdly, the insurance funds would pay two francs per semester per person insured to the OHS for its services.
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35. PARISOT J., *Le Comité français de Service social. A Lecture for the Journées du Service Social. 23-24 October 1937*. Revue d'Hygiène et de Médecine Sociales 1938; 3: 84.
36. SAND R., *L'Evolution des centres de santé*. Le Mouvement Sanitaire 1933; 12: 565.
37. On this point, AMIDIEU DU CLOS L., *L'amélioration des conditions sanitaires et sociales de la vie rurale. L'effort réalisé en Meurthe-et-Moselle*. Nancy, 1935; 368, a thesis for the hygiene diploma under J. Parisot's direction.
38. GRANT J.B., *Principles for Medicine and Public Health in the China Experiment [1934]*. In: SEIPP C. (ed.), *Health Care for the Community. Selected papers of Dr John B. Grant*. Baltimore, The Johns Hopkins University Press, 1963, p. 8.
39. PARISOT J. and FERNIER L., *Les procédés de traitement des fumiers les*

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41. HAZEMANN R.-H., *Le Service Social Municipal et ses relations avec les Œuvres privées*. Paris, Editions du Mouvement sanitaire, 1928, pp. 176-77.
42. WINSLOW C.-E. A. to VINCENT G.E. *(Rockefeller Foundation President), 15 June 1918, Sterling Memorial Library, Yale, Winslow Papers, Group 749, Series III, f. 1691*.
43. MURARD L., *Designs within Disorder: International Conferences on Rural Health Care and the Art of the Local, 1931-1939*. In: GROSS SOLOMON S., MURARD L., and ZYLBERMAN P., (eds.), *Shifting Boundaries of Public Health: Europe in the Twentieth Century*. Rochester, NY, Rochester University Press, 2008.
44. As Carl Prausnitz noted in 1930, each "snapshot" of peasant life recorded in the thesis for the Nancy diploma in Hygiene was to "be a complete sanitary and epidemiological study of a given region or village. […] The candidate must study the region's pathological history". PRAUSNITZ C.*, Rapport sur les Travaux des Conférences de Directeurs d'Ecoles d'hygiène tenues à Paris (20-23 mai 1930) et à Dresde (14-17 juillet 1930*). Geneva, November 1930, C.H.888, Appendix II: "Enseignement de l'hygiène en France", p. 58.
45. HAZEMANN R.-H., *Application de la méthode des indices en vue de l'établissement, de l'exécution et du financement des programmes sanitaires*. Bulletin de la Statistique Générale de la France 1939; 4: 668. On this: MURARD L., *Atlantic Crossings in the Measurement of Health: From American Appraisal Forms to the League of Nations' Health Indices*. In: BERRIDGE V. and LOUGHLIN K. (eds.)*, Medicine, the Market and the Mass Media: Producing Health in the 20th Century*. Londres, Routledge, 2005, pp. 19-54.
46. HAZEMANN R.-H. and TAYLOR R.M., *Les Inventaires sanitaires*. Revue d'Hygiène 1933; 2: 82.
47. *Following up a proposal by the Australian delegate (Stanley BRUCE on 11 September 1935, inspired by his economic adviser F. McDougall), the LN Assembly called for the League to 'marry health and agriculture'. SDN, Journal Officiel*, Actes de la Seizième Session Ordinaire, p. 53.

48. PARISOT J., *L'Œuvre poursuivie et à poursuivre dans le domaine de l'hygiène rurale par l'Organisation d'Hygiène de la Société des Nations. A report to the Health Committee's Bureau during the June 1936 session in Moscow*. Geneva, League of Nations Archives, CH 1218, pp. 14-15. PARISOT J. and RAJCHMAN L., *Note on further rural studies, Fifth Meeting of the Health Committee's Bureau, Paris, 29 October 1936*. CH/Bureau/6, Geneva, 8 October 1936, typescript, 4 p. On 30 October, Parisot declared to the Bureau meeting, attended by the French minister of Health, H. SELLIER: "It is almost useless to try to do public health work if we are not also concerned with improving the general conditions of rural life."
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