

5 Health, Development, and Community Participation

Between the 1960s and the early 1980s, the Pan American Health Organization continued to grow and face new challenges. This chapter describes and analyzes the Organization's activities and approaches for addressing the short-, medium-, and long-term problems of inter-American public health, especially under the leadership of the Pan American Sanitary Bureau's fifth and sixth Directors: Drs. Abraham Horwitz and Héctor Acuña. Also noteworthy during those years was the inclusion of a group of Caribbean nations as new Member States in the Organization.

Two major perspectives that are still evident today could be distinguished during this period in the Organization's life. The first is the incorporation of health programs into socioeconomic development; the second is community participation in health activities. Some Organization officials emphasized the institutional development of health services, management of technical programs by professionals, and the extension of health care services to marginal urban and rural zones. Others focused instead on the importance of sparking positive change from the bottom up, giving priority to what the community needed, felt, and could itself contribute. Tension between these two points of view existed throughout the 1970s, and even intensified with the emergence of the primary health care strategy at the end of that decade.

Dilemmas of this type emerged as a response to essential questions that are still valid today. Is health the result of an external intervention aimed at improving the living conditions of the beneficiary population, or is it a tool to give the community power in its struggle for development? How might the two ideas be combined? How might high-quality technical work and solidarity be partnered? How could whomever needed to be convinced be successfully persuaded that investing in and promoting health are vital? The answers to these questions opened up a rich process, marked by diversity of thought and action in the field of Pan American health, and pointed to new paths for public health.

At that time, PAHO was operating in a political context marked by the Cold War and the rise and fall of an ambitious approach to development put forth by the United States known as the Alliance for Progress. The need for social reform did not come just from the north, but was also posited by

Latin America. In the early 1960s, President José Figueres of Costa Rica, President Rómulo Betancourt of Venezuela, and President Eduardo Frei of Chile pointed to the need for agrarian reform, a move away from *latifundismo*, and increased opportunities for employment, housing, and education for society's poorest sectors. These reforms, like the Alliance for Progress, were born, in large part, as a response to the Cuban Revolution of the early 1960s, a challenge to U.S. hegemony and to the conservative regimes of the Americas. The idea was to provide an alternative model for many radical intellectual youths, politicians, and physicians in Latin America. As the Pan American Health Organization moved into the final decades of the twentieth century, the Cold War crisis and a questioning of the United States' world hegemony came to the forefront.

ABRAHAM HORWITZ, THE FIRST LATIN AMERICAN DIRECTOR

In the midst of this scenario, the Pan American Health Organization was directed with prudence and wisdom by a distinguished Chilean physician and public health servant highly devoted to his work: Abraham Horwitz. He became the Bureau's new Director in 1959 and held the post for 16 years, until 1975.⁴³⁷ This was the first time the responsibility had fallen to a Latin American—surely an honor for him and for his country. In order to understand his contribution to the Organization, it is important to know a bit of information about his background and career. He was born in a small town in Belarus (Belorussia) to a Jewish family that emigrated to Santiago, Chile, fleeing czarist persecution. The Horwitzes' had initially thought of going to New York, but his mother had conjunctivitis at the time, thus preventing them from meeting entry requirements into the country. Paradoxically, the sanitary controls for immigrants set up at almost the same time as the International Sanitary Bureau—PAHO's precursor—came into existence made the family look to Chile, perhaps with the thought that they would still be in the Americas, the dream of many immigrants, albeit at the other end. Abraham would be born in Santiago in 1910. No member

of the family had been a physician or scientist, nor of an academic background, but he graduated with a medical degree from the University of Chile in 1936. This achievement is perhaps one of the hallmarks of the immigrant mindset: to work hard and see one's children have the possibility, through higher education, of a better life. At the same time, it is illustrative of the magnificent opportunities offered at the time by Chile's public education system for the social betterment of its citizens.

His talent, spirit, sense of responsibility, and love of the arts were among the qualities that made him a unique individual. Another of his traits is also worth noting: he never took vacations. To him, his work was not just an occupation, it was a devotion. That must have been part of the reason why he never had children and married only when he left the Director's position.⁴³⁸

Horwitz chose to specialize in infectious diseases, working in a laboratory, where he learned the value of patience and precision. He published noteworthy papers on tuberculous meningitis and the epidemiology of infectious hepatitis. His interest in public health was born around 1943 when he was studying on a Rockefeller Foundation scholarship in Detroit, Michigan. There he served his medical residency at the Herman Kiefer Hospital. The same scholarship helped him earn a master's in public health at Johns Hopkins University. When he returned to Chile, he was appointed to a professorship in the University of Chile's School of Public Health, one of South America's most prestigious academic institutions, where he eventually became its director.⁴³⁹

Then Horwitz shaped and was shaped in the ranks of one of the first unified services in the Americas: the National Public Health Service of Chile, an official institution established in 1952.⁴⁴⁰ He eventually became its policy director, the second-ranking position, and editor of the Service's *Boletín*, to which he added a somewhat cryptic but logical tagline: "Any action in individual and collective medicine takes shape in the application of a technical standard through an administrative procedure."⁴⁴¹ The rationality of

this statement is best understood within the context of the rivalries and disputes that were prevalent among the various organizations comprising the National Service. It was also a tacit recognition of the ups and downs that characterize partisan politics and generally interfere with the experts' decisions. The entities that came to fall under the Service's umbrella—and whose functions Horwitz had to harmonize—were the Directorate of Charity and Welfare, the Medical Service of the Disease and Disability Mandatory Insurance Fund, the National Health Service, the Technical Section of Hygiene and Industrial Safety of the General Directorate of Labor, and the Bacteriological Institute of Chile. Unifying them—to prevent duplication, save resources, and improve the effectiveness of the interventions and coverages—was also a valuable social experience in collective work. The National Health Service was administered by a national board that included workers, businesspeople, and physicians.⁴⁴²

In the late 1950s, the Government of Chile nominated him for PAHO's top position. When Horwitz assumed the directorship of the Pan American Sanitary Bureau in 1959, some 247 projects were being carried out in diverse areas: infant mortality prevention, environmental sanitation, control of communicable diseases, nutrition, and health education.⁴⁴³ The beginnings of his tenure were dedicated to ensuring the continuity—and the adaptability—of a large international organization during a period of transition. For example, the malaria eradication program continued to move forward. But an idea that was gaining credence was that neither the malaria program nor any other vertical program could be effective or lasting without some form of integration and a strengthening of health services in general.

It wasn't just the vertical programs that were maintained; so were other activities that had been initiated during Soper's tenure, such as those involving the advancement of nursing and scholarships. Horwitz most likely felt a personal commitment to scholarships, since he himself owed his career to the opportunities opened up by a scholarship. During the period of 1958–1961, the Organization awarded 2,098 schol-

arships, an increase of 70% over the previous four-year period. Of these scholarships, 804 were earmarked for advanced studies in specific public health disciplines. Also, in 1961, 21 nursing education programs were carried out with PAHO's cooperation.⁴⁴⁴ At the same time, Horwitz began to introduce new objectives and methodologies to inter-American public health work and to allocate more resources to activities that had been initiated previously, such as basic sanitation, nutrition, and the risks to health caused by tobacco use.

Another of Horwitz's noteworthy contributions was the promotion, in international forums, of the importance of vitamin A. Vitamin A deficiency was common in the poorest countries and entailed a set of health risks, especially for mothers and children. His interest in the issue continued and, after leaving PAHO's directorship, Horwitz chaired the vitamin A consultation group of the U.S. National Academy of Sciences and the U.N. Subcommittee on Nutrition. Another important foundation was created around the same time under Horwitz's leadership: the Latin American Center for Perinatology and Human Development, with headquarters in Montevideo, devoted to perinatal health. This institution was an offshoot of the obstetrical physiology service directed by two prominent Uruguayan physicians: Roberto Caldeyro Barcia (who was the Center's first director, starting in 1970) and Hermógenes Álvarez.

PAHO studies and programs on the harmful effects of tobacco use were also strengthened under Horwitz's leadership: in 1964, the Director endorsed the conclusions of the U.S. Surgeon General's Report, which addressed the harm caused by the smoking habit. A short time later, in 1969, the Directing Council advised the Member Governments of the taxation and legal measures that should be taken to control cigarette advertising and, in 1971, the "Tobacco or Health" Unit was established within the Organization. One study conducted in eight Latin American countries during that time period showed that at least one-third of men smoked. In subsequent years, the requirement to include stern warnings on cigarette packages became widespread, subregional

workshops were organized, and a series of fundamental studies and publications on the subject was produced.⁴⁴⁵

Horwitz used to write short yet substantive articles for the editorial section of the Bureau's *Boletín*. One of them shows that he placed a high value on culture and cultural diversity:

Health is not an end in itself; we do not live only to be healthy. One of the greatest endeavors of our time is the preservation of cultures with due respect for traditions and the way of life of all peoples, and with full confidence in the supreme values of humanistic ethics.⁴⁴⁶

A valuable innovation Horwitz introduced to the Organization's agenda was the promotion and dissemination of information about the close relationship between health and economics. To him, this meant, first of all, that health conditions depended on the level of economic development achieved, and that an example of this was the drop in the infant mortality rate: it could only be decreased to a certain degree by health care interventions, but beyond that limit further reductions required the presence of such factors as good nutrition, adequate housing and sanitation, and a reasonable per capita income. Measures such as these did not depend on health care, he noted, but rather on socioeconomic development.⁴⁴⁷ Second, to Horwitz this relationship meant that the health of the population, especially the economically active population, was a necessary ingredient for improving productivity and consumption in society in general.

The latter concept is reflected in a phrase that contains terms more suited to economics and that Horwitz would repeat in various publications: "without high-quality human energy, there can be neither efficient production nor sufficient consumption."⁴⁴⁸ Health was also indispensable to the economy as a result of the growing importance of occupational illnesses, such as miners' problems with silicosis and agricultural laborers with pesticide poisoning, as well as the exposure of other large groups of workers to air pollution and

ionizing radiation. Horwitz wisely asserted that while social security systems were addressing the consequences of these problems, they were not doing much to prevent them. According to the Bureau's Director, the incidence of job-related accidents and occupational illnesses was higher among workers in Latin America and the Caribbean than among those in the United States and Europe. Moreover, he stressed, investment in the creation of safer workplace environments would be easier in places where an adequate public health infrastructure was already present.

These concepts and assertions therefore posited a concrete linkage between health and economics. Or, said another way, they recognized that, unfortunately, there generally existed a vicious cycle of lack of health and of economic underdevelopment. In this cycle,

... the lack of resources causes high rates of disease, while the high rates of disease make it impossible to produce the resources needed to improve health conditions for the population and the economy in general.

A *New York Times* journalist who interviewed Horwitz summed up the argument, saying that the basic problem in Latin America was that:

... low productivity leads to inadequate income, resulting in deficient diet [and] inadequate housing, which, in turn, lead to poor health and low productivity. This is the cycle which must be broken.⁴⁴⁹

It is important to stress that Horwitz's ideas reflected and inspired the work and the research of other health workers of the Region. For example, Jordan J. Bloomfield, a PAHO consultant, drew up a document on health and industrial development in Latin America. Gustavo Molina and Freda Noam proposed a methodology and indicators for measuring the relationship between health and economic development in Latin America that were presented at various national forums and were published in the *American Journal of Public Health*.⁴⁵⁰

Moreover, it is worth mentioning that Horwitz was in no way naïve about the intrinsic benefits of economic growth, and he criticized the assumptions of some economists who considered health an epiphenomenon of development. In a 1963 publication he clearly indicated that some of them maintained that health was merely an indirect consequence of economic growth.

. . . without considering that neither one nor the other is possible without human development, which is synonymous with health and education . . . only with a healthy, active population can progress be nurtured.⁴⁵¹

Likewise, his notion of linking health to economics was not limited to a passive attitude with respect to policies and economic models. For example, Horwitz never tired of criticizing the harmful dependence that resulted whenever economies of the Region chose to concentrate on only one or a few export products, generally raw materials subject to the vicissitudes of the international markets. And he thought it was not only necessary to convince private enterprises and international organizations to invest in public health and social infrastructure, but also to make a special effort to avoid the pattern of discontinuity in these investments.⁴⁵²

Horwitz also showed a concern for needs-based planning, particularly as this related to the projected population explosion and the development of effective responses to the new challenges that would inevitably result from this population growth.⁴⁵³ In the mid-1970s the estimated population of Latin America was 324 million, and there was a fear that it would double by the end of the twentieth century. That translated into a growth rate much higher than that experienced by the United States. During the first five years of the 1970s, the annual population growth rate in Latin America was 2.7%, in comparison to 0.9% in the United States.⁴⁵⁴

Among the diverse social investments needed to address the needs of this new population, Horwitz assigned great importance to the issue of clean drinking water. He believed that water was key

to economic progress and essential in almost all spheres of human life, such as health, agriculture, and industry. He also felt it was necessary to explain that supplying water was a costly service, that appropriate rates for water provision had to be established, and that this service had to be administered efficiently.⁴⁵⁵ To illustrate the magnitude of the task, it should be pointed out that in the early 1960s there were an estimated 100 million people in Latin America without access to clean drinking water services. Supplying such a large population segment required undertaking a 10-year program and planning for an annual investment of US\$ 300 million.⁴⁵⁶ This task was begun with support from the W. K. Kellogg Foundation. Joint Foundation-PAHO programs made it possible to fluoridate the water (effective in preventing tooth decay), equip local laboratories to measure water purity, and train sanitary engineers and technicians to carry out these tasks. In this way, between 1966 and 1971, the Pan American Health Organization and the W. K. Kellogg Foundation supported the training of about 500 sanitary engineers from 24 countries in the Region of the Americas.⁴⁵⁷

In addition to the W. K. Kellogg Foundation, Horwitz's ideas found a sounding board in the Inter-American Development Bank (IDB), an institution established in 1959 and directed, at that time, by another Chilean and a friend of Horwitz's, economist Felipe Herrera. Herrera was convinced that the Bank was a powerful tool for development and that supporting health was a fundamental means of investing in human resources that would, in turn, lead to economic growth. The fact that the Director of the Pan American Sanitary Bureau and the President of the Inter-American Development Bank believed that health would increase the workers' and a country's productivity resulted in important social programs.⁴⁵⁸ By early 1966 the IDB had granted 60 loans (46 for urban projects and 14 for rural projects) in the amount of US\$ 243,562,296 for initiatives to benefit some 30.5 million people. The Bank also contributed funds for other environmental sanitation projects, for hospital construction, and to improve schools of medicine and public health.⁴⁵⁹

The ideas of Horwitz, Herrera, PAHO, and the IDB are better understood within the ideological context in which they developed. They reflected an aspiration—and a certain urgency—for “development,” an idea that was gaining important hold in Latin America at that time. It was formulated on the basis of two great models: the model of modernization and the theory of dependency. The seminal text on the model of modernization was the book by W.W. Rostow, an economist and advisor to the U.S. Government, entitled *The Stages of Economic Growth*. Its subtitle clearly stated the author’s intention: *A Non-Communist Manifesto*. Rostow believed that the process of development was basically the same for all countries and that their history would run from a traditional, agricultural stage to a modern, capitalist stage. The key was creating the conditions sufficient for a rapid, irreversible economic take-off.

According to Rostow, all societies went through similar stages until reaching—thanks, above all, to impetus from external forces—a moment when they were launched on the road to industrialization. Some ideas derived from the model were that the Latin American societies possessed a modern focal point, generally associated with that which is urban, that which is industrial, and Western culture, and a traditional focal point, almost always related to that which is rural, the indigenous cultures, and the absence of a sustainable, ongoing relationship with the commercial marketplace. The modern focal point would need to spread its cultural values and its systems of work through political projects that would stimulate, regulate, direct, and control change. In other words, in both the industrialized countries and the modern focal points of traditional societies, development could be promoted and overseen.

The theory of dependency has a different perspective. The theory’s leading exponent was Argentine economist Raúl Prebisch, and its mecca was the Economic Commission for Latin America and the Caribbean (ECLAC), a United Nations body operating out of Santiago, Chile.⁴⁶⁰ One of the principal postulates of that theory was that the international market persistently reproduced a relationship of inequality between the center and

the periphery. The center was comprised of the industrialized countries, which processed the raw materials from the peripheral countries. The peripheral countries consumed products manufactured abroad and were subject to the vicissitudes of worldwide demand for their products. Their export economies were often mining or farming enclaves that were connected mainly with the outside world; that is, with sending the profits abroad. So they did not have major local impact on the labor market or on increased consumption. According to those who subscribed to the dependency theory, development of the Latin American countries entailed breaking a pattern that robbed them of autonomy and imposing equity in the terms of exchange on the international market. They also championed the idea that import substitution industrialization and the creation of a domestic market for consumption of locally made products were highly desirable goals, noting that some Latin American countries were already on the road toward achieving them.

While at the time the modernization model and the theory of dependency seemed very different from one other, they actually had some points in common—the notion that development should be directed by the State, for example. They did not assign an important role to private institutions, civil organizations, or community efforts. The most important determinant of development appeared to be the wisdom of economic policies. Both constructs also suggested that true ruling classes in Latin America had not been in evidence, at the same time that they embodied a certain disdain for everything that was agrarian, considering it to be in conflict with that which was industrial and synonymous with underdevelopment. Also, both schools showed a fear of social movements, such as the one that occurred with the 1959 Cuban Revolution, and of the more radical and anti-imperialist tendencies which emerged in its wake.

Official PAHO documents of the early 1960s make little mention of the Cuban Revolution. But it is clear that the OAS, the U.S. Government, other governments of the Region, and PAHO itself were concerned and sought a road to consistent development that would offer an alternative to the

radical measures adopted in Cuba. It is also clear that there was tension at the Pan American Health Organization during the early days of the Revolution, especially with respect to the U.S. delegation. Significant changes in Cuban public health, such as the establishment of a single national health system, formalized by law in 1961, began during those years. It was a State system in which there was no place for private ownership in any health-related activity (such as clinics, pharmacies, learning centers, equipment, or the manufacturing of drugs). In addition, priority was assigned to prevention, and efforts focused on comprehensive, universal coverage. Noteworthy among the processes related to the emergence of this system were the extension of health services to the most remote areas in the countryside, thanks to the Rural Social Medical Service; the establishment of hospitals far from the cities; the formation of sanitary brigades by the Federation of Cuban Women and of a volunteer corps for the malaria eradication campaigns; and the reorientation of medical education following the large-scale exodus of Cuban physicians after the Revolution.⁴⁶¹ It is important to note that the Cuban revolutionary regime, which in its early days had not participated in PAHO's malaria eradication program, signed an agreement with Horwitz to initiate the campaign. Under this agreement, Cuba promised to contribute US\$ 5 million toward carrying out the malaria elimination program over the next four years.⁴⁶²

One indication of the tension generated at the Pan American Health Organization by the Cuban Revolution is the report of a delegate from the United States to the XII Meeting of the Directing Council, held in August 1960 at the La Habana Libre Hotel (prior to 1959, the Havana Hilton). The PAHO meeting took place at the same time as the Seventh Meeting of Consultation of Ministers of Foreign Affairs held in San José, Costa Rica. This latter group would take initial steps—in the name of regional unity—that would culminate in the expulsion of Cuba from the OAS two years later. PAHO—partly because it had a more direct connection with the United Nations system and partly because it was considered a technical and

apolitical organization—did not proceed in the same way. At the time of the holding of the PAHO meeting in Cuba's capital, Fidel Castro was already in power, holding the official title of prime minister while Oswaldo Dorticós occupied that of President. The government had already issued a series of nationalization measures and had implemented radical agrarian reform, but had not yet announced its alliance with the former Soviet bloc and had not severed diplomatic relations with the United States.

The opening ceremony of the XII Meeting of PAHO's Directing Council was held in Havana's famous Capitolio where, at a rally the night before, a large banner reading "*Cuba sí, yanquis no*" had been unfurled. The meeting was attended by delegates from almost all the member countries. According to the U.S. delegate's report, there was a highly charged political atmosphere, even though the agenda included an innocuous array of routine administrative, financial, and technical matters. Included among the Council's resolutions was a recommendation for a future "technical" discussion of the methods for evaluating the contribution of national public health programs to economic development.⁴⁶³ As interesting (or perhaps more interesting) than the matters discussed were the delegates' impressions. According to the U.S. delegate, the day before the meeting opened, the hotel had been full of Cuban youths from the rural areas "dressed in uniforms and quasi-uniforms, carrying battered knapsacks or gunnysacks with attached cups, tin plates, and canteens." The author said that most of the young men "wore beards or, in many cases, fuzz that was heroically attempting to shape itself into a beard," and that many made it clear: "we like Americans; it is only your government we don't like."⁴⁶⁴

An essential link among the delegates was proffered by Pedro Nogueira of Cuba, who had been participating in PAHO meetings ever since the Pan American Sanitary Conference held in Caracas in 1947. He knew PAHO and Cuba well. He worked tirelessly to ensure that things went as smoothly as possible, welcoming delegates as they

arrived at the airport and explaining to the new Cuban officials that if the meeting went badly for political reasons, that this would be harmful to Cuba. The aforementioned report describes Nogueira's unflagging efforts to make the meeting a success:

. . . as a link between the new regime and the old-timers. . . . He may well have been the key political factor in preventing the introduction of controversial political matters into the sessions.⁴⁶⁵

The report also says that while they were in Cuba, the delegates were overwhelmed with propaganda about the work of the hospitals and health centers established by the Revolution. In a final comment, the author of the report made a prediction, acknowledged a new political reality, and suggested the importance of U.S. foreign aid to international health and, above all, to countering the influence of the Soviet model:

There is no reason to believe that the government is faking. If they hold out, they will get health services to the people as all communist countries are doing. . . . Observing Cuba today raises the question of whether the U.S. is making maximum use of health in combating communist infiltration there and elsewhere. In every country in the hemisphere, except Argentina and Cuba, there are health facilities . . . that are joint projects of the country and the U.S. They stand as symbols of our interest in the people of those countries. Are there enough of them? Are we now standing by to let the Soviet Union move in to fill the vacuum we will not fill? . . . It would appear that the Soviet Union has learned much from our foreign aid program and is using effectively methods that we have tended to abandon. Chief among these is the creation of material things to serve as a lasting symbol of our interest.⁴⁶⁶

The above quote is best understood within the framework of the United States' foreign policy response to the social revolution that had arisen in the Caribbean and appeared to be spreading to the rest of the Americas, and which crystallized in an ambitious proposal for socioeconomic development. In March 1961, President John F. Kennedy announced an Americas-wide program called Alliance for Progress. Kennedy was convinced that social reform was essential for pre-

venting violent revolution. Hundreds of U.S. volunteers answered his call and joined the Peace Corps, assembling their backpacks and traveling to Latin America and other regions of the Third World to promote community health and education projects.⁴⁶⁷

One individual who maintained continuity in U.S. foreign policy was Dean Rusk. After serving as president of the Rockefeller Foundation for nearly a decade (1952–1961), he was named Secretary of State, a position in which he remained when Kennedy was tragically assassinated and Lyndon B. Johnson assumed the presidency. Rusk actively championed the provision of economic aid to developing countries, the maintenance of low tariffs to strengthen world trade, and the use of military force to stop the “expansion of Communism.”

A special OAS meeting of the Inter-American Economic and Social Council, held in August 1961 in Punta del Este, Uruguay, was decisive for the Alliance for Progress. It was then that the urgent need to promote sweeping social and economic reforms, to encourage a more equitable distribution of national income, and to raise the standard of living—including providing better employment opportunities and access to arable land and social services for the rural population—were stressed. These changes were framed in terms of gradualism and evolution, because it was felt that violent social upheavals, hurried nationalizations, and preemptive expropriations of foreign holdings did not serve progress and development over the long run. In the Alliance's Charter and the discussions related to it, the close relationship between the attainment of public health objectives and the improvement of social and economic conditions was recognized, and it was announced that the governments would develop national health plans for the decade and install planning units in their ministries of health.⁴⁶⁸

The proposal won support and enthusiasm at the Pan American Health Organization. For example, water supply goals were established for the coming 10 years: to supply 70% of the urban population and 50% of the population in rural areas, where the difficulties were greater. By 1966, nine

Latin American countries had exceeded this objective first put forth in the Punta del Este Charter, benefiting 44 million inhabitants. But the goal was far from accomplished in the rural areas: only two countries had succeeded by the decade's midpoint.⁴⁶⁹ The appropriate combination of health and socioeconomic development programs would be—and continues to be—a matter of reflection and action for PAHO.

A BUILDING AND NEW PROGRAMS

One of the most momentous events for PAHO during the 1960s was the opening of its new Headquarters building, the first permanent home for the staff of the Pan American Sanitary Bureau, who, until this time had either occupied rented space or shared offices with other institutions, such as the Pan American Union. The land where the building was to be constructed was at the intersection of 23rd Street and Virginia Avenue, in a picturesque part of the city known as Foggy Bottom. A few blocks away was the future site of the John F. Kennedy Center for the Performing Arts (inaugurated in 1971), and just a block away was the U.S. Department of State. It was close to the White House and across the Potomac River from the historic Arlington Cemetery. The plot consisted of an entire block, with an irregular triangular shape, truncated at two vertexes, donated by the U.S. Government thanks to arrangements made by Soper. The gift came with a caveat: the height of the building needed to comply with Washington, D.C.'s, requirement that no construction rise above the city's national monuments.⁴⁷⁰

The best architects of the Americas competed, and nearly 60 proposals were submitted.⁴⁷¹ It was a time when Latin American architecture was blazing new frontiers. Perhaps the most quintessential expression of its bold and pioneering spirit was the design and construction of Brasília, the new capital of Brazil, in the country's geographical center, by Oscar Niemeyer and Lúcio Costa. Román Fresnedo Siri, a Uruguayan architect who devoted six months to the development of his winning formula for the PAHO project, acknowledged that he had been strongly influenced by such ar-

chitectural luminaries as Le Corbusier of Switzerland, who had placed extraordinary importance on the use of concrete columns to express verticality, and by the clean esthetic of Frank Lloyd Wright of the United States. He was, moreover, an astronomy buff, and that may be the reason his constructions always imparted a sensation of open space.

Fresnedo Siri's design combined simplicity and moderation, in which he proposed two buildings, esthetically and functionally complementary, to occupy part of the allocated land, with the rest to be accented by a small plaza. The first building was a rectangle, slightly arched, like a half moon, with a series of solid, medium-high columns connecting the rotunda with the second floor to create the impression that the second floor was floating on air. The other building, partially surrounded by the half-moon structure, was circular and looked like a giant drum. The first building housed the lobby and reception area, two meeting halls, and staff offices, including the Director's suite on the top floor. In the second building was the large, circular council chamber to be used for the Organization's regional meetings with public health authorities and other dignitaries. The buildings were connected at the second floor, easily accessible from the reception area.

The building luminously melded seemingly disparate elements: steel, wood, marble, granite, and glass. According to an article in the OAS's *Américas* magazine, the complex was a sculpture of light and concrete. The paneling in the offices was Honduran mahogany, Brazilian jacaranda, and American oak. But even more important than esthetics was the building's embodiment of the Organization's essential requirements: highly functional office space, accommodations for all sizes of meetings, and the projection of an image of professionalism, solidity, and moderation.

The Region's public health ministers caught their first glimpse of PAHO's new Headquarters on 27 September 1965, the opening day of the XVI Meeting of PAHO's Directing Council.⁴⁷² Since that day, the flags of the member nations and the PAHO flag have flown in the plaza adjacent to the

entrance. The inauguration ceremony was attended by representatives of the international organizations headquartered in Washington as well as officials of the W. K. Kellogg Foundation, which had generously provided an interest-free US\$ 5 million loan for the building's construction.⁴⁷³ Several countries of the Americas also made valued contributions. At the opening ceremony, Horwitz quoted Churchill: "We shape our buildings, and afterwards they shape us."

As part of the celebration of the new building, Professor René J. Dubos, a famous microbiologist and pathologist at Rockefeller University, gave a lecture entitled "Man and His Environment," and four days later, a piano recital was held.⁴⁷⁴ Dubos proposed a comprehensive vision of the relationship between human beings and the environment, marked by the coexistence of health and disease.⁴⁷⁵ Since its opening, the Headquarters simultaneously has become an emblem, a reference point, and a place of business for the health workers of the Americas.

In 1966, the *Bulletin of the Pan American Health Organization* was launched. It was published annually with selections from the *Boletín de la Oficina Sanitaria Panamericana*. From 1973 to 1996 the journal appeared quarterly. At that time the Organization had a budget of US\$ 16,277,238.⁴⁷⁶ By 1966, the largest share of its revenue was coming from the member countries' contributions (US\$ 6,460,000, or 40% of the total budget). An additional US\$ 100,000 came mainly from quota payments from France, the Netherlands, and the United Kingdom. To this was added the voluntary funds for special projects, such as malaria eradication. For example, in 1964, quota assessments under this heading came to US\$ 5 million. In addition, as the Regional Office for the Americas, PAHO received approximately US\$ 2.8 million from the regular WHO budget and US\$ 1.5 million from United Nations funds for various specific technical cooperation initiatives. To PAHO's total budget of more than US\$ 16 million, between 1961 and 1964, UNICEF added its valuable contribution of an estimated US\$ 5,000,000 per annum

for the malaria eradication campaigns and another US\$ 1,000,000 for other health campaigns.

Environmental health, environmental preservation, and the dissemination of medical and scientific information were important areas of concern and action starting in the late 1960s. By that time, large metropolises such as the Mexico City, Santiago in Chile, and São Paulo in Brazil were already beginning to face significant air pollution problems, and other Latin American cities had dangerous levels of water contamination. Given that situation, the Inter-American Association of Sanitary and Environmental Engineering (AIDIS) and PAHO's environmental health division agreed on the need to establish a multinational sanitary engineering center dedicated to cooperating with the countries to resolve environmental health problems. A PAHO consultant determined that the major cities in the best position to accommodate that center were Lima and Caracas. After Lima was selected, a PAHO mission visited the city in 1967 and began negotiations with the Government of Peru. The Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS) was formally established in Lima in September 1968. Its members quickly moved to consider general programs of technical cooperation and specific environmental health projects. In general, they were concerned with the establishment of conditions favorable to the development of a healthy environment at the community level. Over time, CEPIS included in its work the study of the epidemiological, biological, and toxicological impact of the principal environmental contaminants on human health.⁴⁷⁷

Another regional center important to the Organization during that period was the Latin American and Caribbean Center for Health Sciences Information (BIREME), established in March 1967 in São Paulo thanks to an agreement signed by PAHO, the Government of Brazil, and the Universidade Federal de São Paulo's School of Medicine, and with support from the W. K. Kellogg Foundation. The decision to establish a center of this kind was based on the spectacular growth in the number of students, professors, and journals

of medicine and the health sciences throughout the Region,⁴⁷⁸ resulting in the need for centralization of the production and indexing of bibliographical references, often scattered among distant libraries. Another fundamental task assumed by BIREME was the training of librarians specialized in health sciences. Under the leadership of Amador Neghme of Chile, BIREME's capacity expanded rapidly. One indicator of this growth is the fact that, between 1969 and 1973, the library processed almost 250,000 requests for photocopies of journal articles.⁴⁷⁹ In 1968, the Expanded Textbook and Instructional Materials Program (PALTEX), which made it possible to produce a series of high-quality scientific teaching materials at affordable prices for university students and health workers, was established at PAHO's Headquarters.

Two other issues that were on the Organization's agenda during those years deserve to be highlighted because of the quantity and quality of talent they attracted: health planning and studies on medical education; or, better said, increased efforts to correct the misalignment between medical education curricula and current public health needs. In the eyes and minds of many health professionals at that time, the dilemma was "planning or revolution," a consequence of the fact that human resources and materials for health training were both scarce and often misused. Moreover, these human and material resources were technically deficient and poorly distributed; being concentrated in the cities and in critically short supply in the rural areas. So planning was seen as an unavoidable need, both for promoting development and for avoiding the social upheaval of a revolution.⁴⁸⁰

Mindful of these problems, PAHO sponsored, in conjunction with the Government of Canada, the First Pan American Conference on Human Resources Planning in Health, which was held in Ottawa in September 1973. One of the most interesting proposals for national health systems planning, which emerged a short time later as the result of a collaborative effort between the Organization and the Center for Development Studies, or CENDES, created at Venezuela's Universidad

Central, was the so-called "PAHO-CENDES method." It was inspired, in part, by the Punta del Este agreements made in 1961. According to PAHO staff member Juan Manuel Sotelo, the collaboration between PAHO and CENDES originated with a conversation between Horwitz and fellow Chilean Jorge Ahumada, who was then the head of CENDES.⁴⁸¹ Ahumada was interested in health planning and called a meeting of various Latin American public health planning experts, including Mario Testa of Argentina.⁴⁸² They promoted the training of health professionals in planning and the use of statistics in the development of health programs. The PAHO-CENDES method borrowed heavily from economics in evaluating health systems, needs, and resources; determining opportunities for coverage, growth, and intervention; maximizing the availability of services (bearing in mind that resources were limited); and developing specific regional plans.

These activities received more impetus when the United Nations declared the 1960s the decade of development and, through ECLAC, set up, in 1962, the Latin American and Caribbean Institute for Economic and Social Planning (ILPES) in Santiago, Chile. Upon the foundation of ILPES, the Center for Health Planning was established, also in Santiago. It was directed by David A. Tejada de Rivero, who would later play a leading role at WHO in the promotion of primary health care. One of his colleagues at that institution was Carlyle Guerra de Macedo of Brazil, who would later become Director of the Pan American Sanitary Bureau in 1983. Several countries of the Region adopted all or part of the PAHO-CENDES method and began making intensive use of the Center's planning methods. But an evaluation conducted early on indicated that the results had not been satisfactory because they had been limited to only a part of the work performed by health ministries and because there was no direct connection to the national health budgets.⁴⁸³

One indication of the influence that public planning had during Horwitz's tenure was the development of a decade-long health plan for the Americas.⁴⁸⁴ The plan was intended to anticipate the population's health needs and the public's

perceptions of these. It tried to strengthen capacity for control, oversight, and administration and to expand the coverage of health services. The continuity of these objectives became apparent when, at the Third Special Meeting of Ministers of Health of the Americas, held in Santiago in 1972, a new 10-year plan, more sensitive to the individual circumstances of each public health program and to the diversity of subregions within each country, was approved.

One of the most fundamental of all planning issues was the need for an evaluation of the training level and distribution of human resources devoted to health. In February 1962, experts from Brazil, Chile, Colombia, Mexico, and the United States met at PAHO Headquarters to study the most effective methods of reorienting medical education in accordance with the premises of the Punta del Este Charter.⁴⁸⁵ The problems were many and complex. One very important problem was that there weren't enough medical school and public health school graduates. At that time, just 63% of the population was receiving any type of health service at all. In other words, almost 40% relied on self-care or traditional medicine.⁴⁸⁶ One reason was the critical shortage of professionals. In the early 1960s, it was felt that the approximately 100,000 doctors in the Region represented just half of the number that was actually needed. The scarcity of well-trained health professionals was felt in other areas as well, such as nurses (there were 37,000, and at least 23,000 more were needed), dentists (there were 38,000, and 62,000 more were needed), and sanitary engineers (there were 2,000 and, ideally, there should have been 4,000 more). Added to these shortages was the fact that professionals were concentrated in the urban areas and the major capitals and training did not emphasize prevention.

All of the concerns just described precipitated a series of studies and proposals for the reform of medical education, placing more importance on prevention and on service to society. Many of these criticized an educational system that was incongruent with current realities, the lack of local opportunities for professional work and research,

and the large-scale emigration of skilled health workers from Latin America to the developed countries, especially the United States. One PAHO study estimated that approximately 565 Latin American doctors, or 8% of those who graduated each year from Latin American medical schools, emigrated to the United States every year between 1960 and 1965.⁴⁸⁷ What started out as a flaw of the higher education systems became a pattern: the health systems of the developed countries began to operate on the assumption of an ongoing influx of professionals trained abroad. Meanwhile, some Latin American medical schools resigned themselves to accepting a permanent exodus of some of their most promising graduates.⁴⁸⁸

PAHO collected some of those studies in a new journal: *Educación Médica y Salud*, developed by PAHO's Division of Human Resources and Research. Among the works showcased were those of Juan César García, a distinguished Argentine physician and sociologist, highly esteemed by his colleagues, who had joined the newly established Division in 1966. He was the author of several academic pieces, not just on medical education, but also on the history of health in Latin America and the various schools of thought prevalent in the health field; all were quality works that demonstrated the relevance of social studies to health.⁴⁸⁹ García died in Washington, D.C., in June 1984, while serving as PAHO's Acting Research Coordinator. His presence at PAHO suggests the malleability of an institution that did not have, as a rule, a permanent team of researchers, but whose members were considered "advisors," "consultants," or "specialists" whose priority was not to publish academic works. It is, moreover, an indication of a time of reorientation for the Organization, when a new international public health strategy was being forged, extending from Geneva to its regional entities: primary health care. This will be studied in the section that follows.

The adoption and adaptation of the primary health care strategy to the Pan American context occurred during a time of flux at PAHO. In January 1975, Horwitz stepped down after four terms as the Sanitary Bureau's Director. At the

end of his tenure he bequeathed a very important institution: the Pan American Health and Education Foundation, with headquarters in Washington, D.C., the purpose of which was to promote the acquisition of additional funding for the Organization's work through philanthropic and private foundations. The previous year, at the XIX Pan American Sanitary Conference, the Mexican Government had nominated as Horwitz's successor Dr. Héctor R. Acuña, who received a surgeon's degree at the National Autonomous University of Mexico (1947) and a master's in public health at Yale University (1951). Acuña brought with him valuable experience in field work and a distinguished national and international career that included serving as WHO Country Representative in Pakistan in the early 1960s. In 1964 he returned to his native country, where he carried out a series of planning activities and held the position of Director of International Affairs for the Department of Health and Welfare.⁴⁹⁰ Dr. Acuña served as Director of the Sanitary Bureau from 1 February 1975 to 1983. One of PAHO's new perspectives under his direction was that of primary health care.

PRIMARY HEALTH CARE

The criticism of traditional medical training, the push for community medicine, and an ongoing concern with linking health to development that had been evident in the Organization since the 1960s all laid the groundwork for the adoption and adaptation of the primary health care approach. The origin of the concept dates back to a series of critical studies on the limitations of Western medicine in the developing countries. According to those studies, the principal flaw was the assumption that the training of more health professionals, the establishment of hospitals, the extension of services, and the organization of vertical programs would solve the Region's health problems. Several authors, such as John H. Bryant, thought that this model failed to consider the common preventable health problems in the population, many of which were caused by lack of safe drinking water; inadequate housing, nutrition, and hygiene; and generalized circumstances of pov-

erty.⁴⁹¹ Singularly influential was the Lalonde Report, published in 1974, bearing the name of Canada's Minister of National Health and Welfare, Marc Lalonde. (Canada joined the Pan American Health Organization as a Member Government in September 1971.) This report views health as the result of four factors: human biology, the physical and social environment, appropriate financing of health care organization, and lifestyles.⁴⁹²

The Christian Medical Commission, which Bryant chaired, was a semiautonomous body formed in 1968 to assist the World Council of Churches in evaluating and assisting church-related medical programs in the developing world and provided valuable input to WHO in its development of the concept of primary health care. Also, in the early 1970s, the People's Republic of China joined the United Nations system, (and thus WHO), and it became clear that one of the country's main achievements during this period was a vast rural medical service known as the "barefoot doctors." These health care providers were locally trained, lived and worked in remote villages, and gave priority to prevention.⁴⁹³ It was during this time that WHO and its charismatic leader, Halfdan T. Mahler, adopted the cause of primary health care and proposed that WHO Member Governments strive for the attainment, by the year 2000, by all peoples of the world of a level of health that would permit them to lead socially and economically productive lives.

With the invaluable assistance of David A. Tejada de Rivero, one of the WHO's Assistant Directors, Mahler organized, jointly with UNICEF, the International Conference on Primary Health Care, held in September 1978 in Alma-Ata, Kazakhstan, in the former Soviet Union. Some 134 countries, 67 United Nations organizations, and dozens of specialized national institutions participated. In some cases, the representation was at the highest level. For example, the Costa Rican delegation included Rodrigo Altman, first Vice President of the Republic. Costa Rica had been firmly committed to primary health care since the decade's beginning and had taken appropriate steps, such as promulgating a national health plan, reaching almost

universal social security coverage for its citizens, and launching a rural health and child vaccination program.⁴⁹⁴ The Alma-Ata Conference concluded with a Declaration stating that:

Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.⁴⁹⁵

Three ideas pervaded the thinking behind the Declaration of Alma-Ata: “appropriate technologies,” opposition to medical elitism, and the concept of health as part of and an impetus for socioeconomic development. With respect to appropriate technologies, there was criticism of disease-oriented medical technology which was too sophisticated and/or costly for underdeveloped countries with more urgent and basic health problems, such as the diarrheal diseases, which could be resolved in the presence of adequate water and sanitation systems, and respiratory diseases, which would abate with improved conditions of housing, food, and shelter. Moreover, there was criticism of the assumption that the establishment of more hospitals in urban areas would resolve the problems of medical care. Health facilities and technologies adapted to the majority of the population, exemplified by adequately equipped health centers established in rural and peri-urban areas, were offered as viable alternatives.

A second idea contained in the Declaration was criticism of medical elitism and the over-specialization of health workers in developing countries. Rather, the training of community health workers and the incorporation of informal practitioners—such as traditional healers and midwives—into the continuum of health services, as well as the promotion of community participation, were proposed.

Finally, the Declaration posited a relationship between health and development. Public health work was no longer considered an isolated short-term intervention, but part of an ongoing process focused on improving the population's health and living conditions. Moreover, it was thought that primary health care was the new crux of health work, requiring both public and private intersectoral coordination to ensure effective results.

In embracing the new directions of international and Pan American health, Acuña adapted the primary health care approach and applied it to a series of activities and programs.⁴⁹⁶ At that time, certain groups of professionals in the Region, such as nurses, were already applying essential elements of primary health care. During this same period, maternal and child health was becoming one of the central pivots of the Organization's new agenda. PAHO incorporated an important program bearing this name into its structure.⁴⁹⁷ In the ensuing years, the Region made original contributions to the Alma-Ata initiative, such as promoting a local infrastructure of services throughout each country that supported the objectives of primary health care. This effort resulted in the creation of local health systems (or SILOS, for its Spanish acronym).

To discuss how best to achieve the objectives of the International Conference on Primary Health Care, the Fourth Special Meeting of Ministers of Health of the Americas was organized by PAHO in Washington, D.C., in September 1977 and was considered to be a preparatory meeting for the Alma-Ata Conference the following year.⁴⁹⁸ It was understood that the goal of “health for all” implied not merely the achievement of a significant improvement in the traditional indicators of health—such as an increase in life expectancy and decrease in child mortality—but also, in the interpretation of public health leaders in the Region, the extension of health services coverage to underserved populations in rural and marginal urban areas. Many of these unifying ideas had, in fact, already been advanced five years earlier at the previous (Third) Special Meeting of Ministers of Health of the Americas, held in Santiago, Chile.

Some of the interventions that emerged as a result of the primary health care approach proposed at Alma-Ata focused on one problem, such as malnutrition, or on a vulnerable group, such as mothers, and, especially, on children. Some thought that the goal of health for all was too idealistic, did not have a clear source of funding, or involved an unrealistic timeframe. Consequently, an alternative, more restricted interpretation of primary health care attracted the attention of some organizations (UNICEF was one), which began promoting a set of specific, low-cost interventions.⁴⁹⁹ This new approach, known as selective primary health care, was associated with the acronym GOBI, representing four major interventions: growth monitoring, oral rehydration techniques, breast-feeding, and immunization. Also, training of midwives and health assistants, education of mothers, and close collaboration with practitioners of traditional medicine were encouraged.⁵⁰⁰ But some experts felt that this interpretation of primary health care undermined the original concept, resulting in a loss of the holistic potential that had existed at the outset and a return to reductionist interventions very similar to vertical, isolated campaigns. To some Latin American thinkers, this version reduced primary health care to a first level of basic care and exacerbated the danger of turning it into poor medicine for poor people.⁵⁰¹

In 1983 Acuña published a book in which he used the history of the Organization as a backdrop for delineating the path PAHO should follow to reach the goal of health for all by the year 2000. He pointedly noted that the potential obstacles to achievement of the Alma-Ata objectives included recession and inflation, political instability, and poorly integrated health systems. Acuña also explained that: “the goal of health for all should be considered not just a desired objective, but also an essential dynamic factor for the process of change.”⁵⁰²

The positive reception for primary health care in the Region coincided with the attention the Caribbean was starting to receive at PAHO. Examples of effective community health work were emerging in several different countries. One worthy example was the Community Health Aides pro-

gram carried out in rural Jamaica. In 1972, the Department of Social and Preventive Medicine of the University of the West Indies in Kingston published (and twice republished) a manual for these workers. In that year there were 300 community health aides in Jamaica; by 1979 the number had grown to 1,200.⁵⁰³ Michael Manley, leader of the People’s National Party and Prime Minister of Jamaica from 1972 to 1980 and again from 1989 until 1992, made a strong commitment to the program as part of his political platform for what he called “democratic socialism.”⁵⁰⁴ In 1977, Manley unveiled a national policy known as Health for the Nation, defining health as a basic human right and not as a privilege reserved for a minority.

One of PAHO’s achievements during the Acuña years was undoubtedly the inclusion of several Caribbean nations, many of which had been part of European empires as late as the 1960s, in the Organization.⁵⁰⁵ Haiti and Cuba were the only two Caribbean charter members of the Organization, having joined in 1924 and participated in PAHO sanitary meetings since the early years of the century. The fact that the rest of the Caribbean countries, once sovereign, eventually joined PAHO was a highly significant step forward in the life of the Organization. According to Peter Carr, one of the first Jamaican officials to have a distinguished career with the Organization, starting in the 1970s, the stimulus for requesting admission into the Organization came about when the prevalent stereotype of the day held by many Latin and North American officials—that the Caribbean “was a single country”—began to change.⁵⁰⁶ Additionally—contrary to the way others viewed them—the Caribbean public health leaders themselves were keenly aware that their countries’ social and public health challenges were not simply a miniature version of the problems of the larger or more populous Latin American nations. They were, instead, diverse and complex problems with their own set of characteristics and dynamics.

The motivation to participate in PAHO and other inter-American organizations ultimately came from the individual Caribbean countries, one by one. An interesting case is that of the three largest

members of the British-sponsored West Indies Federation. Formed in 1958 and comprised of 10 British West Indian territories, the Federation was dissolved four years later in 1962 due to nationalist pressures that soon led to the independence of Barbados, Jamaica, and Trinidad and Tobago. Each of the three new nations sought membership in the inter-American system, increased trade with the United States and Latin America, and access to financial entities such as the Inter-American Development Bank. All in all, the Caribbean subregion included a total of 17 political units; the largest, geographically speaking, being Barbados, Dominica, Grenada, Guyana, Jamaica, and Trinidad and Tobago.⁵⁰⁷ The first of them to join the OAS was Trinidad and Tobago (1967). Two years later Jamaica joined (although it had officially joined PAHO much earlier, in 1962). One milestone in this Caribbean self-government and identity movement was the establishment of the Caribbean Community and Common Market (CARICOM) in 1973.

The ties between the Caribbean countries and the rest of their geographical neighbors had been limited until then, partly due to the legacy of British colonialism. Some authors believe that entry into the inter-American system was part of the former colonies' strategy for protecting themselves from the influence of U.S. foreign policy. According to this line of thought, the inter-American system of that era was also used by the Latin American countries as a way of maintaining their autonomy. Both subregions—Latin America and the Caribbean—felt antipathy toward any form of colonialism and sought sovereignty and self-determination.

During the 1960s and 1970s, several Caribbean countries joined PAHO, including Trinidad and Tobago (1963) and Barbados and Guyana (1967). During Dr. Acuña's tenure, the Bahamas joined in 1974, Suriname in 1976, Grenada in 1977, Saint Lucia in 1980, Dominica and Saint Vincent and the Grenadines in 1981, Antigua and Barbuda and Belize in 1982, and Saint Kitts and Nevis in 1984 (shortly after Acuña left).⁵⁰⁸ In 1977, Sumedha Khanna was named PAHO/WHO Representative in Jamaica, becoming the first woman to head a country office. Spain and Portugal,

which had traditional ties to various countries of the Americas, joined the Organization as observers in 1981 and 1986, respectively. Finally, in 1992, Puerto Rico was recognized as an Associate Member Government of the Organization.

The Caribbean's public health and political leadership was partly due to the training of several generations of doctors, scientists, and health officials at the University of the West Indies. The University, located in Mona, Kingston, Jamaica, had been established in 1948 as a college of the University of London, but in 1962 it became an autonomous institute of higher education. *The West Indies Medical Journal* which it publishes has gained wide currency and respect among physicians, nurses, researchers, and health officials not just in Jamaica but throughout the English-speaking Caribbean. The University established a presence on various Caribbean islands and appointed prominent researchers, such as Dr. George A. O. Alleyne of Barbados (who was elected to be Director of the Sanitary Bureau in 1994), as professors.

One example of the Caribbean's leading role in Pan American public health was the establishment of new specialized centers as part of the Organization. In association with the University of the West Indies, and with support from the U.N. Food and Agriculture Organization, the Caribbean Food and Nutrition Institute (CFNI) and its journal, *Cajanus*, named after the local pigeon pea found throughout this subregion, were established. Following its creation in 1967, the Institute began conducting essential studies to address the challenges of a population suffering the double burden of nutritionally deficient diets and insufficient local production of meat and vegetables.⁵⁰⁹ CFNI's activities were directed at a diverse clientele of government officials, physicians, researchers, and community workers in the fields of health, agriculture, and nutrition. Another Caribbean institution associated with the Organization was established in the mid-1970s: the Caribbean Epidemiology Center (CAREC). The Center was established with support from the Caribbean Health Ministers' Conference held in Dominica in 1973, and it was set up two years later,

using a regional laboratory operating in Port-of-Spain, the capital of Trinidad and Tobago, as its base.

Other noteworthy achievements by the Organization under Dr. Acuña's leadership were the strengthening of epidemiological services, an administrative reorganization, and the establishment in 1977 of a regional disaster preparedness program. With respect to the first of these, the *Epidemiological Bulletin*, which, starting in 1980, disseminated not just information but also quality-related norms, methods, and standards for compiling and analyzing quantitative health indicators, is worthy of special mention.⁵¹⁰

The principal modification of PAHO's structure consisted of doing away with organization by zones and setting up country-level offices, with representatives who had significant authority and substantial resources. They were generally not natives of the host country and were supported by a small group of resident consultants. Concern for dealing with the public health emergencies caused by natural disasters such as earthquakes, hurricanes, floods, and volcanic eruptions led to a consideration of how best to address this issue through the development of appropriate, ongoing technical cooperation activities. In 1976, at the XXIV Meeting of the PAHO Directing Council, the Region's ministers of health called on the Organization to establish a program that could formulate plans of action to respond to the various types of disasters, and concepts that were novel at the time, such as the idea of "preparing" for disasters and the possibility of "mitigating" their effects, informed the program's basis. When an earthquake devastated Mexico City in 1985, teams of PAHO and Ministry of Health experts provided valuable logistical support and assistance to the thousands of injured left in the tragedy's wake.⁵¹¹

THE VICTORIES OVER SMALLPOX AND POLIOMYELITIS

The development of primary health care made it necessary to change the structure and approach of the disease eradication programs, which traditionally had been vertical. The most important

change was that eradication and immunization programs, especially those aimed at smallpox and poliomyelitis, stopped working in accordance with a rigid "top-down" design. At the same time, attempts were made to avoid a repetition of errors committed in the past, such as excessive confidence in technology and weak community participation. Rather, the new thrust was to adapt program design to local conditions and obtain cooperation from a variety of private organizations and community leaders, thereby enlisting the support of interests outside the public health sector and stressing the principle of inclusion. This new strategy made it possible to strike an appropriate, sustainable balance between new, powerful, low-cost medical technologies and the commitment of individuals and society.

The decision to eradicate smallpox from the Americas dates back to a resolution of the XIII Pan American Sanitary Conference, held in 1950, which recommended that countries cooperate in the eradication effort through an intensive program of vaccination and revaccination. By this time, the disease already had been eliminated from Canada and the United States, whereas endemic smallpox was gone from the Caribbean and virtually nonexistent in Central America. In 1967, WHO launched a comprehensive plan for global eradication, at which time a special budget was allocated and the WHO Intensified Smallpox Eradication Program began. By this time, several types of vaccines were available, but the most cost-effective and efficacious was a freeze-dried thermostable vaccine administered with a jet-injector gun, which began to be used in the mid-1960s following a PAHO-assisted pilot project in Brazil. Using this newer and quicker method, a health worker could vaccinate 259 people in a single day, as opposed to 68 using the more traditional multiple pressure technique. Decisive in the Americas campaign were the enthusiasm and dedication of young health workers and the wide dissemination of two principles: each local situation would be different, and adapting to it was the key to success. Also, the campaign against smallpox introduced a new concept in the history of eradication: acceptance of the fact that while it would be impossible to vaccinate entire populations, a

disease could nonetheless be eliminated by concentrating on the endemic areas.

By 1960, the number of officially reported cases of smallpox in South America was 9,075, and the majority of these were in Brazil (72%). By 1967 the number of cases had decreased significantly: 4,544. Almost all of these were in Brazil, where the disease was clearly endemic. Since Brazil shares borders with all but two South American countries, the danger of cases and/or outbreaks being imported into neighboring countries was real.⁵¹² The process of eradicating the disease was progressive, with advances and setbacks. For example, in Peru, where no cases of smallpox had been reported since the mid-1950s, a major epidemic broke out in 1963–1964, with 1,319 cases; it took two years of painstaking work before transmission was interrupted and the disease was gone once again from that country.

Since the best way to eliminate smallpox was to conduct a simultaneous vaccination campaign, PAHO signed agreements with most of the South American countries in 1966 and 1967 to coordinate this task and deploy massive vaccination efforts. The following figures for 1970 are indicative of the scope of this effort: more than 37 million vaccinations in Brazil, a country whose total population was nearly 96 million; 11 million vaccinations in Argentina, which was home to almost 24 million people; almost 3.6 million in Colombia, a country with nearly 21 million inhabitants; and 2.6 million in Peru, with a population of 13 million.⁵¹³ The last case of smallpox in the Americas was recorded in April 1971 in Brazil.

Of all the PAHO programs that derived from the primary health care strategy, immunization was probably the one that achieved the greatest success. In 1980, many developing countries had low immunization coverage, sometimes just 5% of children for one or more of the six most important vaccines: measles, tetanus, diphtheria, tuberculosis, poliomyelitis, and whooping cough. Yet by the end of the decade the majority of the countries had immunized more than 50% of all children, thanks to greatly intensified campaigns at the community level. For example, in 1984, im-

munization in Colombia became a national crusade whose promoters included teachers, priests, police officers, nurses, union leaders, and journalists.⁵¹⁴

Immunization, moreover, served as a powerful catalyst for reconciliation in Central America following a decade of political violence and civil war there during the 1980s.⁵¹⁵ In 1985, the Organization launched an initiative utilizing health—because of its unique value and universal acceptance—as a “bridge for peace” to promote solidarity, greater understanding among the warring parties (the government and guerilla forces), and preservation of the health infrastructure. For example, in El Salvador, during the height of civil conflict, one-day truces were negotiated for immunization against poliomyelitis, diphtheria, whooping cough, tetanus, and measles. During these “days of tranquility,” held every year between 1985 and 1991, around 20,000 people—health workers, community volunteers, and guerilla soldiers—administered the actual vaccinations. Radio and television announcements and newspaper articles urged parents to bring their children to health posts and special vaccination sites, and the collaboration of all those working in health helped to raise the population’s level of trust and hope. By the late 1980s, the regional levels of vaccination were high: 86% for diphtheria, whooping cough, and tetanus; 89% for poliomyelitis; and 85% for measles.⁵¹⁶ The strategy used by PAHO in Central America (and shortly after in Peru, in the midst of the Shining Path guerilla movement) was later adapted by WHO and its partners in the global polio eradication campaign.⁵¹⁷

PAHO’s work against poliomyelitis, a highly contagious disease that paralyzes the muscles of the arms, legs, and respiratory system, was precipitated by a meeting held in Washington, D.C., in the late 1950s to discuss vaccines against thiscrippler and killer, particularly of children. The first vaccine (injectable) was developed by Jonas Salk of the United States in 1955 and consisted of killed virus, which produced immunity in the human body. In 1961, virologist Albert Sabin introduced an oral form of the vaccine, consisting of the weakened virus, which was more effective, cheap, and easy to administer. Because no needles were

needed, the oral vaccine could be administered on a wide scale by nonmedical personnel and volunteers. Sabin and his team had first demonstrated the power of this new vaccine earlier that year during field trials in Chiapas, Mexico, which had suffered a polio epidemic. In order to ensure the vaccine's affordability, Sabin refused to patent his discovery. PAHO worked actively with the countries to establish and preserve the "cold chain" required for the vaccine's potency, using both modern refrigeration and portable ice chests for its storage, and delivering it to every corner of the Region, whether by truck, motorcycle, horse, or on foot.⁵¹⁸

Various countries of the Region, such as Cuba and Mexico, implemented effective and widely publicized vaccination programs during the 1960s. One indicator of the campaign's value was brought to light by an evaluation conducted in Cuba, which estimated that 1,200 cases of paralysis and 200 deaths were prevented between 1962 and 1970 as a direct result of mass immunization campaigns carried out by the Ministry of Public Health.⁵¹⁹ In May 1974, the WHO World Health Assembly created the Expanded Program on Immunization (EPI), signaling the beginning of a global thrust to immunize all children under age 5 against the six earlier-mentioned vaccine-preventable diseases over the next decade and a half. In the case of polio, EPI experts felt that if the human reservoir of the wild poliovirus were eliminated, the disease would be extinguished. The campaigns were designed to overcome the obstacles faced in the past, such as intermittent political will and support, rigid administrative systems, lack of ongoing epidemiological surveillance, and the need for a stable corps of volunteers.

Under the leadership of an internationally renowned Brazilian physician, Dr. Carlyle Guerra de Macedo, who directed the Pan American Sanitary Bureau from 1983 to 1995, PAHO proposed the eradication of indigenous transmission of wild-type poliovirus from the Americas by the end of 1990. When the announcement was made in 1985, US\$ 500 million was budgeted for achieving this objective. Essential support for conquer-

ing the disease also came from the International Rotary Club, a private nonprofit organization, which adopted the cause as its own. In 1987, Rotary Clubs all over the world began collecting funds in order to meet the goal of US\$ 120 million which would guarantee universal child vaccination. By the following year they had vastly exceeded the goal: US\$ 247 million, largely due to the mobilization of local Rotary chapters throughout the Region and the commitment of its volunteers.

Building on the success of the "days of tranquility" in Central America, a series of national vaccination days was organized that encouraged the widest participation possible of health and other government authorities, the media, and the community at large, a strategy that became a true health promotion movement.⁵²⁰ One example of the campaign's success occurred in Mexico, where 10 million children were vaccinated in a single day in January 1986.⁵²¹

The goal of eliminating poliomyelitis from the Americas was finally achieved. The last case of poliomyelitis in the Region was that of a two-year-old Peruvian child, Luis Fermín Tenorio Cortez, who lived in Pichanaqui, a rural Andean town in the department of Junín, an eight-hour car trip from Lima. Health workers found the child in August 1991; that is, eight months after the original date targeted for eradication that had been established in 1985. Once the case became known, and despite the danger of working in an area where the Shining Path terrorist group was known to be active, workers from Peru's Ministry of Health, with PAHO's assistance, launched what became the most comprehensive "mop-up" exercise in the history of the campaign, conducting some two million house-to-house vaccinations of nearly the same number of children under the age of 5, all in a single week. In September 1994, the International Commission for the Certification of Poliomyelitis Eradication confirmed that the disease had disappeared from the Americas.⁵²²

A testimonial to hope in the face of adversity was obtained in 1996 by a journalist for *Perspectives*

in *Health*, PAHO's general audience magazine, who visited Luis Fermín:

Luis . . . 7 years old, has left his small town in central Peru . . . and has moved to Lima Since the time doctors first examined Fermín, his young life has gone through several stages. After the initial notoriety subsided, his life regained much of its normalcy. He began to grow. And soon he realized that he couldn't run as well as his brothers and friends and that he had trouble speaking (he could only say two or three words well). . . . He's in the first grade now, and when visitors arrived at his school one day recently, the first thing he did was hold out his hand and ask "Do you want to see my notebook?" His handwriting is very good, even though he only learned to write last April and came to this school with a series of problems. Psychologists working with him felt, nonetheless, that it would be best to place him in a regular school for his formal education. . . . It is time for the visitors to leave. Fermín waves and tells them cheerfully, "Come and see me again." "We will, Fermín. We will," the visitors reply. "To learn from you."⁵²³

In 1989 the WHO World Health Assembly issued a call for the global elimination of neonatal tetanus by 1995. At that time it was estimated that 10,000 newborns would die of this disease in the Americas every year. By 1990, PAHO had put into place its regional strategy: reduce the case numbers down to less than one per 1,000 live births, emphasizing the vaccination of women of

childbearing age living in high-risk areas, the training of midwives in vaccination administration, and the importance of hygienic deliveries and neonatal care, among other measures. PAHO also focused its attention on measles: in September 1994 the countries of the Americas set the goal of interrupting the autochthonous transmission of measles by 2000. The following year, the ministers of health approved an action plan to eliminate the transmission of that disease.

Despite these achievements, primary health care remains controversial even today. In the opinion of some, the original principles of Alma-Ata were never fully implemented. Moreover, it is clear that the initial proposal failed to specify some factors, such as the importance of including a gender perspective, the source of funds to support it, and how to achieve alliance-building for health in civil society. What is certain is that while vertical and primary health care programs coexisted, the comprehensiveness, flexibility, and consistency of the health systems remained in question. In the decades that followed the Declaration of Alma-Ata—the 1980s, the 1990s, and into the new millennium—increasing evidence was offered that political commitment and community participation were indeed essential to the sustainability of any health work. These were some of the major lessons learned in the struggle against the cholera and AIDS epidemics, as we will see in the next chapter.