Healthy spaces for kids

Tobacco documents' deadly secrets (p.14)

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Together, shaping the future of life

Environmentalists often cite our obligation to future generations as the most compelling reason for protecting our planet: We owe it to our children to care for the environment they will inherit from us. But as the theme of this year’s World Health Day—“Shaping the Future of Life”—reminds us, we also owe it to our children to provide them the best possible environment now, while they are children. A child’s environment can have a major impact on his or her health and happiness, both now and in the future.

Every year throughout the world more than 5 million children under 14 die from diseases related to their environments. Countless others suffer nonfatal illness, injury or long-term disability as a result of environmental hazards in their homes, schools and neighborhoods. These hazards range from long-standing problems such as contaminated water, inadequate sanitation and household chemicals to newer and emerging risks including outdoor air and noise pollution, ozone depletion and persistent organic pollutants. In Latin America and the Caribbean, an estimated 80,000 children die each year from diseases or injuries related to environmental hazards.

Children are uniquely vulnerable to such risks. Young children breathe faster and eat and drink more in proportion to their weight than adults, thus absorbing more toxicants from air, water and food. As they grow, there are “windows of susceptibility” when their organs and systems are especially sensitive. Children who become chronically ill or who have developmental problems as a result of environmental threats will not grow up to be healthy and fully productive adults.

The point of dedicating this year’s World Health Day to this topic is that most of the environmental threats that harm children are avoidable. In developing regions, many of these threats are related to poverty: inadequate sanitation, contaminated drinking water, poor food hygiene, indoor air pollution and unsafe housing. Eliminating poverty through sustained and equitable economic development would go a long way toward solving these problems, but in the meantime people can be empowered in other ways to reduce environmental dangers to children.

At the individual and family levels, people need to know more about household and outdoor hazards and ways to eliminate or minimize them. Educational campaigns that emphasize such essentials as proper storage of household chemicals, good hygiene and the use of seat belts and bike helmets can give parents and caregivers the information they need to do their job well.

At the community level, the challenge is greater but so is the potential reward. As our cover story suggests, one of the best ways to build healthier environments for children is through community mobilization. The success of São Paulo’s Jardim Paraná in improving environmental conditions has been mirrored in other communities throughout the region: the efforts of Huaquillas, Ecuador, and Aguas Verdes, Peru, to clean up the Zaramulla Canal between them, and the work of sister cities along the U.S.–Mexico border to clean the air they share come to mind.

This issue of Perspectives in Health looks at community empowerment in other contexts in a new special section on community public health. Two of the articles hold special meaning for me, as I have personally visited the projects highlighted. The first focuses on El Salvador’s Villa Centenario, a project that might be considered “experimental” in that it starts with the provision of housing to 100 homeless families and tries to build a community from that base. The many challenges this presents are outlined in the article, and the final outcome remains to be seen. But Villa Centenario is clearly a community empowerment project characterized by hope.

Las manzaneras of El Alto, Bolivia, also hold special significance for me. I was in Bolivia around the time the group celebrated their second anniversary, and I was privileged to meet a number of the volunteers. Their unique access to community members has allowed them to carry out effective health education campaigns and bridge the gap between public health services and the clients they are intended to serve.

Community participation has always been a key element of public health campaigns, in sanitation, vaccination, health education and others. I have personally seen how much people can accomplish by working together, defining common needs and joining forces to make just demands of elected authorities. This is essential not only to public health but to our region’s democratic development. Helping people to strengthen their sense of community, and through community, their collective health, has always been and remains one of PAHO’s strongest commitments.
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In El Limón, Guatemala, support groups organized by La Leche League International teach new mothers the benefits of breastfeeding and help them build confidence in their maternal skills.
Six-year-old Jonathan Bispo dos Santos is a restless little boy. He makes a game of grabbing things out of people’s hands. And like many children, he finds it hard to sit still.

“I like playing football and running around,” he tells a visitor while proudly showing off several round red scabs under his shorts.

“Jonathan is terrible,” his 22-year-old mother Rute chimes in. “He gets these rashes and doesn’t stop scratching them, so they get all red.”

Jonathan lives in a three-room brick shack with his mother and three siblings, Jessica, 8, Luiz, 4, and Milena, 3. The children share a tiny windowless bedroom with a bare-mattress bed, a wardrobe and a handful of toys. According to Rute, they are normally healthy except for occasional fevers she attributes to the wild temperature fluctuations in São Paulo’s subtropical climate. It’s not uncommon for a daytime high of 30 degrees Celsius (86°F) to be followed by a rainy 15 degrees (59°F) at night.

“When he was younger, he had water in his lungs,” says Rute of Jonathan. “But he is all right now with this weather.”

Jonathan is luckier than his sister Jessica. In her short life she has suffered a collapsed lung, the beginnings of pneumonia, bronchitis and appendicitis, her mother says. On this hot summer afternoon, Jessica is at school,
a good 2-kilometer uphill walk through heavy traffic from her house. She seems healthy enough for now, says her mother.

“It’s destiny,” says Rute. “I don’t think living conditions have anything to do with it. You can live in a good neighborhood and have health problems too.”

The dos Santoses live in São Paulo’s downtown neighborhood of Vale do Anhangabaú, in a compound of six houses. Residents share a central yard strewn with rubble and crisscrossed by clotheslines that droop under the weight of wet laundry. The families get their running water and electricity through illegal tapping. Dirty water from washing and showers runs through the middle of the yard, while the toilets empty into a covered ditch. There are 13 children living in the compound (and three more to be born this year). They share their living and play spaces with rats (fewer now that poison was put out) and abundant cockroaches and mosquitoes. All this is within sight of São Paulo’s City Hall.

Jonathan’s compound is an example of the environmental risks that millions of children in Brazil and throughout the Americas are exposed to every day. The lack of access to treated water and sewage disposal and the presence of vermin are primarily the result of chronic poverty and haphazard urban development. Though Jonathan’s mother sees no connection, experts say environmental conditions like these contribute to an estimated 5 million childhood deaths worldwide every year.

**Dangers all around**

In Latin America and the Caribbean, some 117 million children live in poverty, according to the U.N. Economic Commission for Latin America and the Caribbean (ECLAC). Most live in crowded, substandard housing in neighborhoods that lack basic infrastructure. This exposes them to respiratory tract infections and diarrhea—illnesses that along with perinatal conditions are among the top causes of death among children under 5 in the region.

The lack of play space, formal leisure activities and often even access to schooling exposes poor children to another set of environmental risks. Accidents such as falls, traffic accidents, electrocution and suffocation kill an estimated 100,000 children annually in Brazil alone, according to the Brazilian church group Pastoral da Criança. Poverty also increases children’s exposure to violence, including stray bullets, domestic abuse and homicide.

Those problems can be particularly acute in cities. “Children mostly play in the streets, because they have nowhere else to go,” says Katia Edmundo of the Center for Health Promotion (CEDAPS), a nongovernmental organization based in Rio de Janeiro, Brazil’s second largest city.

“There are also cases of children being locked in their houses all day because the parents are afraid of the violence on the streets but have to go to work and can’t afford day care.”

There are signs that the situation has improved in some ways in the last decade. Sanitation coverage in the region rose from 66 percent of the population in 1990 to 79 percent in 2000, while potable water coverage rose from 80 percent to 85 percent during the same period, according to the Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS), a technical center of the Pan American Health Organization (PAHO). These improvements have contributed to declines in both infant (under age 1) mortality and child (under age 5) mortality throughout the region in the last decade.

Brazil is one of the countries that have seen the biggest reductions. Its child mortality rate dropped from 64 per 1,000 live births in 1994 to 45.2 per 1,000 in 1999. (By comparison, Colombia reached a relatively low rate of 34 deaths per 1,000 in 1999 but started with 42 per 1,000 in 1994.) One of the main reasons for the improvements in Brazil has been increased access to clean drinking water, along with health promotion initiatives first introduced in 1991 and significantly stepped up in the last seven years. An increase in school enrollment also has helped.
But there is still a long way to go. “About 20 percent of the urban population has 21st-century living standards, but the rest are heavily impacted by the environment they live in,” says Ivan Estribi, a PAHO consultant in Brazil and expert on environmental health.

“In cities, people have easier access to drinking water, which goes a long way in reducing deaths from preventable diseases. But they live in unhealthy houses, exposed to dangers such as factories and pollution, and at risk from landslides because of the areas they live in.”

Tito Nery, a pneumologist in the São Paulo Mayor’s Office, offers the following analysis: According to the city government, about 2 million people live in shacks or substandard housing in the city’s favelas, or shantytowns. At last count, there were more than 2,000 favelas. If the local government were to begin diagnosing problems and implementing solutions at the rate of one community per month it would take more than 150 years to reach the whole city. For Nery, further improvements can be reached only through community mobilization.

In rural Brazil, an estimated 20 million people, or about 12 percent of the population, are considered out of reach of government programs.

“There is no official information about how these people live, where they get their water from,” says Estribi.

In the past, large-scale government programs were viewed widely as the only way to address such problems. But these have gone only so far in getting children out of danger zones. Chronic financial woes have made it difficult for federal, state and local governments to detect communities’ problems, let alone solve them.

Jardim Paraná is an eight-year-old community of just over 1,400 families in the far west of São Paulo city. On a sunny afternoon, two girls’ soccer teams are competing in a tournament on the community’s bare-earth sports field.

“Canu,” a 23-year-old soccer enthusiast, bounds off the field where he has been helping out with the tournament. The 6-foot-tall right-midfielder’s real name is Jose Nilton Adelino Pereira. He confides to a visitor that he is waiting for the most important news of his life: whether he will get a professional contract with a soccer team in the state of Santa Catarina or with the club his manager is negotiating with in the town of Guaratinguetá in São Paulo state.

The improvised soccer field also serves as the main venue for community meetings, Pereira explains. More important, it is where the municipal government will soon build a $3.8 million educational project that includes a kindergarten, an elementary school (it will be the neighborhood’s third school), cultural and sports centers, and a community space known as CEU, an acronym for Unified Educational Center that in Portuguese also means “heaven.”

“The shantytown of Glicério, beneath a highway overpass in central São Paulo, presents a host of environmental hazards. They increase the risks of accidental injuries, poisoning, respiratory problems and vector-borne diseases in children.”

“It will be good because it will take a lot of the kids off the streets, and that is just what they need,” says Pereira. Pereira speaks of children’s needs with the authority of recently acquired adulthood and its responsibilities. He lives with his sister, and together they pay about $25 a month for their 60-square-meter lot. They also pay for running water and electricity. When a new sewage drainage system is completed, as expected in the near future, they will also pay for and benefit from that.

But Jardim Paraná has not always been the community it is now.
“I arrived here when I was 16, and violence was rife,” Pereira recalls. “Besides the drug trafficking gangs there were petty crooks and lots of fighting over land, since community leaders tried to stop new settlements. At the time, one of my friends got killed in a bar robbery because the girl carrying out the robbery fired by accident. I kept out of trouble because I always make friends with everybody.”

He also remembers long trips to health centers and hospitals and long waits to get treatment. His main ailments were the flu and stomach aches. Bad conditions did not help, he says. “At the time we had to filter the muddy water and boil it to drink, but I know a lot of people didn’t do it,” he says.

Jardim Paraná’s transformation was difficult but did not take long. The community came into being in the early 1990s, when rising rents and lack of housing options prompted some 180 settlers to invade what was at the time privately owned land. In 1995, a court eviction order forced the

Diagnosing health and the environment

The relationship between health and the environment is no mystery for children, says Paulo Capucci, a former technical aide at São Paulo’s city health secretariat.

“Kids identify the problems in their neighborhoods. A kid in a middle-class neighborhood will point out air pollution and the lack of leisure spaces, while a kid in a poor district will point out lack of running water,” he says. “If you target the problems that children face, you have a better chance of solving a lot of the environmental concerns in a city like São Paulo.”

One of São Paulo’s most important initiatives in the past three years has been a significant expansion of a federal health promotion program known as “Health in the Family.” The program deploys district-based health promotion teams that visit families to identify health and environmental problems. The number of teams has increased to 701 from just 90 in 2001. The target is to get 1,749 teams in São Paulo’s 41 health districts by the end of 2004.

Each team is made up of a doctor, a trained nurse, two assistant nurses and six community health agents. Its goal is to visit 200 families—ideally the same ones—every month.

“This close contact with families allows the agents to educate people about the environmental risks that children face,” said Anna Chiesa, coordinator of the program in São Paulo. “From the first contact you can start to change things because the agents can show better ways of solving problems.”

The results of the teams’ efforts can be almost immediate, according to the program’s staff. In São Paulo, officials credit slight declines in infant mortality, particularly from respiratory infections, to the program’s work. In Belo Horizonte, Brazil’s third-largest city, an 80 percent reduction in children’s hospitalizations for asthma and respiratory infections was attributed to such efforts.

“The agents trained the mothers to avoid risks and treat the symptoms,” explains Maria do Socorro Alves, a health promotion consultant at Brazil’s federal Ministry of Health.

Nationwide 16,192 family health teams are in contact with an estimated 50 million people, the ministry says. The environment is a major focus of their work.

“The idea is to get people to have a different attitude toward public health services and their environment,” says Alves.

In a city like Recife, the teams might discuss the preservation of saltwater swamplands, where many poor people live and catch crabs for a living. In a place like São Paulo, they are more likely to focus on issues such as environmental conditions in urban schools.

For Thelma Nery of the non-governmental National Health Organization, programs like these focusing on direct contact with communities, diagnosis of problems and community empowerment are the most effective ways of reducing the risks to which children are exposed. Providing public health may be a primary responsibility of government, she says, but “it’s up to society to show what is needed.”
occupiers to organize, and in the end they and hundreds of other followers purchased the land for just over $570,000 to be paid over 10 years. With legalization came the possibility of improving living conditions.

“The eviction notice was the last straw; ever since then we have organized ourselves,” says Antonio Calisto, a bus driver and community leader.

A second turning point in the neighborhood’s history came in 2000, when a child and an adult died of hepatitis after drinking sewage-contaminated water. The deaths prompted demands to the state government for potable water and sewage collection. In October 2001, after several months of protests and negotiations, the whole neighborhood received treated water and a rudimentary sewage collection system from the state sanitation company. Now the community is negotiating a storm drainage system and the installation of a medical post, and is raising funds to build a kindergarten run by the community center, Calisto says.

Today the 2,379 children living in Jardim Paraná are considerably better off than those in Vale do Anhangabaú, some 30 kilometers away. Most Jardim Paraná homes have potable running water, and the area receives regular visits from 12 health promotion agents.

“There are some families that still don’t have access to treated water so we’re trying to get the water company to extend the network,” says Calisto, who serves as president of the residents’ association.

“The conditions there [in Jardim Paraná] are far from perfect, but at the beginning the situation was so dire that I was surprised not to find typhus in the region,” says Thelma Nery, a pediatrician and founder of the nongovernmental National Health Organization, which has helped the Jardim Paraná community organize itself and fight for environmental improvements using a strategy known as Primary Environmental Care, promoted by PAHO.

The successful community organizing has led to “green” environmental initiatives as well. Jardim Paraná borders an Atlantic forest preservation area known as Serra da Cantareira, and some 45,000 square meters of the land purchased by the community lies within the forest’s boundaries. The community is seeking partnerships with private organizations to protect and manage the forest and preserve it for their children’s future.

Jardim Paraná’s organizing has had other benefits, too. It has attracted the attention of the Rotary Club, which plans to build a community center focusing on small business development as a way to create jobs.

Health and environmental initiatives must be developed alongside programs that create income and redistribute wealth in poor regions, says Marcia Westphal, head researcher at CEPEDOC, a University of São Paulo research center on “healthy cities.”

“You have to think of biomaps and include in the planning not only health and environment but also housing and the economy,” she says. “If the houses are substandard and people in the region don’t have a job, then you don’t produce social health, you produce social illness. You have to coordinate activities in different sectors.”

Using the healthy cities concept as a basis, Westphal develops strategies to empower local communities. The process starts with rallying community members around a cause and teaching them to diagnose their problems and define priorities. Once the local communities are aware of the problems they can start working with local governments and private entities to improve basic services.

Katia Edmundo, of CEDAPS, has seen this process in the Rio de Janeiro district of Vila Paciencia, where her organization has a health promotion and community empowerment program. There, community members determined that the main source of a common skin disease in children was their direct contact with pigs that wandered freely in the neighborhood feeding on rubbish. Eventually the pigs were confined, and the skin problems began to diminish.
Ecoclubs for the environment

Since 1992 more than 6,000 children and adolescents in more than a dozen Latin American and Caribbean countries and Spain have joined Ecoclubs (www.ecoclubes.org), youth-run nongovernmental organizations dedicated to improving the quality of life in communities through environmental action. The clubs help build leadership skills and give youths firsthand experience in using collective action as a tool for building healthier environments.

In Argentina, where the first clubs were formed, Ecoclubs in the province of Santa Fé mobilized their communities in support of a solid waste management project. Club members raised awareness about the need to separate organic from inorganic waste and then arranged for municipal waste plants to process organic refuse into fertilizer. Most of the fertilizer is used in community vegetable gardens, while a portion is sold and the proceeds used to support other club activities.

In Brazil, Ecoclubs in the city of Toledo have set up a “Useful Refuse” project to promote recycling in homes and offices. In Paraguay, club members have joined public health efforts to fight dengue, distributing pamphlets and talking with community residents about the need to clean up potential mosquito habitats in their homes, yards and neighborhoods. Other Ecoclubs in the region are working in environmental education, organic gardening, wildlife protection and alternative energy use.

The clubs work closely with city and local governments to identify priority concerns and join forces with businesses, universities, church groups, volunteer fire departments and other nongovernmental organizations to carry out projects. In addition to door-to-door organizing, members also write articles about environmental issues for local newspapers and magazines and appear on television and radio.

“It’s a very good way to meet people, to make friends. It’s also a way to protect the environment, which I only learned about when I joined our Ecoclub,” says Diego Ruiz, a high school student from Argentina.

One of the main lessons Ecoclub members learn, according to the clubs’ adult supporters, is that many environmental problems can be solved outside of government and without major expense, through organization and dedicated volunteerism.

“When communities are organized, they can solve or significantly help to solve environmental problems,” says Ricardo Bertolino, who first helped launch the clubs and now serves as coordinator of the International Network of Ecoclubs’ advisory board. “Not everything depends on money; not everything depends on the budget. I believe we must develop a little creativity. We must try to muster the collective will to bring about important changes.”

Alexandre Spatuzza is a Brazilian freelance journalist living in São Paulo.

“The health of children is by far the main motivator for community organization,” says Edmundo. “Once the diagnosis is made, people can start to take action.”

That assumes one important additional detail: that communities are somehow “legalized.” In many poor neighborhoods, residents lack property titles because they “invaded” the land or it was sold to them illegally, or in some cases because they cannot pay for the necessary paperwork. In the absence of official documents, government agencies find it difficult to arrange to provide basic services.

Jardim Paraná is a case of a community that mobilized, legalized and began to construct a better future for its children.

Meanwhile, in Vale do Anhangabau, Jonathan dos Santos continues to build mud castles 200 meters from City Hall while his 50-year-old grandmother looks on.

When a visitor asks her who owns the land, she answers: “I’ve been here for 15 years and am still trying to get the property rights in court.”

Smog from cars, buses and industrial emissions casts a grey pall over São Paulo and obscures the distant outlines of the city’s skyline. When pollution levels peak, city officials close the downtown area to automobile traffic.
Anthony Fauci sits in his spacious office at the National Institute of Allergy and Infectious Diseases in Bethesda, Maryland, USA. He glances out the window but doesn’t seem to focus on the scene outside.

Fauci has been director of the prestigious institute for the past 18 years, and his office wall is a tapestry of academic titles and honors. As one of the leaders in the global fight against AIDS, he has a vision that encompasses countries, regions and entire continents.

With his hands on top of his head and a somewhat distant look, he describes in clear terms what he calls the “new wave of AIDS.” Like a volcano in permanent eruption, the epidemic is spreading throughout the world, but most notably in five countries—China, India, Russia, Nigeria and Ethiopia—that are home to more than 2.5 billion people.

“If you have a country that has a billion people, like India or China, all you need is to increase the incidence by 1 percent and you’ve added 20 million people,” says Fauci. “I’ve been in India, China … my feeling was ex-
available by now. Today, however, they are much more cautious. The AIDS virus constantly mutates, making it exasperatingly evasive and complicating the search for a vaccine. Many now believe that the most effective tools for dealing with the epidemic are other forms of prevention and treatment with the potent antiretroviral drug “cocktails” that restrain viral replication.

To these measures, Fauci adds a third key tool for containing the epidemic: medical research.

**A non-discriminatory virus**

HIV has proved itself largely nondiscriminatory, affecting both rich and poor (particularly in the first years of the epidemic), strong and weak, children and adults. Passing through entire continents unseen in the microscopic spaces of cells, it has followed a relentless logic in producing epidemics: Wherever, whenever cracks appear in a system, the virus will seize the opportunity to invade.

“It happens whenever a country’s socioeconomic order is affected, as in the case of many African countries and in the former Soviet Union,” says Fernando Zacarías, chief of the HIV/AIDS unit of the Pan American Health Organization (PAHO). “Wars, crises, induced migrations, major breaches in the health system, these generate ideal conditions for HIV to expand.”

Will the same laws hold in this hemisphere? In North America, nearly 1 million people are believed to be living with HIV. In Latin America and the Caribbean, an estimated 1.9 million adults and children are HIV positive. This includes 210,000 people who contracted the virus in 2002; it does not include the estimated 100,000 people in the region who died of AIDS the same year.

Zacarías recalls that 20 years ago, when some people referred pejoratively to AIDS as the “pink plague” and the virus itself was a recently solved mystery, the future looked apocalyptic. “There was an international survey of experts, and our vision was terrifying. We imagined a year 2000 completely devastated by the disease.”

Time and medical research have demonstrated that the infection can be transformed into a chronic disease, that many can remain HIV-positive without developing AIDS and that the planet will not be decimated. But the battle against AIDS requires clear health policy decision making and political commitments.


In Latin America and the Caribbean, the AIDS epidemic has until now followed a slow but expanding path. Prevalence rates in some Caribbean countries are among the highest in the world after sub-Saharan Africa. In the two decades since the start of the epidemic, Latin America has undergone wars, sociopolitical crises and system breakdowns. Yet the epidemic has not exploded as in other regions.

Zacarías explains the difference citing genetic as well as social and cultural factors: “There are currently two major groups of HIV circulating in the world, HIV1 and HIV2. We already know of 10 subtypes of HIV1 and five subtypes of HIV2. It so happens that in the Americas, the strain that is circulating is the same one that is circulating in Western Europe—HIV1, subtype B—and it is apparently less virulent than the HIV2 strains that are circulating in Africa.”

Not only are the African strains of HIV more pathogenic, they are also more easily spread heterosexually, which partially explains the accelerated pace of Africa’s epidemic, says Zacarías. However, the virus mutates so readily that the relatively favorable scenario in the Americas could easily change in the coming years.

Zacarías notes with approval that many countries of the region took the threat of this “new disease” very seriously as early as the beginning of the
The AIDS lifeline: access to drugs

The first drug found to treat HIV successfully was zidovudine, or AZT. It was for many years essentially the only medication available. Then in 1996, during the 11th International AIDS Conference in Vancouver, Canada, drug makers announced that the combination of three antiretroviral drugs—the so-called AIDS cocktail—could effectively halt the virus’ replication in the human body. In 2003, two decades after the first officially recorded AIDS case, the U.S. Food and Drug Administration has a list of 14 drugs approved for treating the disease.

The progress has been encouraging, not only in the availability of drugs but also in their effectiveness and administration. Until 1998, HIV/AIDS patients had to take up to 15 tablets a day for a complete treatment. Today, a single pill taken twice daily can provide that. People who have access to these drugs can live long, nearly normal lives.

But access is the key. Of the world’s 42 million people living with HIV, fewer than 5 percent have full access to antiretroviral medication. According to the United Nations Program on HIV/AIDS (UNAIDS), some 170,000 people in Latin America and the Caribbean (most of them in Brazil) received antiretroviral treatment during 2002. Although some countries formally “guarantee” free and universal access to these drugs, real access to treatment continues to be uneven, largely because of the wide variability in drug prices.

As recently as three years ago individual AIDS treatment cost an average of $10,000 per year. Today the same treatment can cost as little as $1,000. During the past three years countries have begun joining forces to negotiate lower prices with drug manufacturers. The point is not simply to lower costs but to make sure that reductions bring costs in line with countries’ per capita income. In Uganda, for example, where the average annual income is $200 per person, the relatively low price tag of $1,000 is still prohibitive.

As part of this process, international agencies and organizations representing people living with HIV/AIDS have opened an important ethical debate: If there is a drug available to prevent mother-to-child transmission, shouldn’t all pregnant women who are HIV-positive have access to that drug? The same question applies for the treatment of HIV-positive adults.

And HIV treatment includes more than drugs; it requires periodic examinations and tests to monitor both the amount of virus circulating in the body and the number of immune system cells that have been lost or gained. Thus the costs of care include not just drug prices but also the costs of all the other weapons in the therapeutic arsenal. Moreover, patients often become resistant to a drug, and their treatment has to be reformulated.

In the Americas, Brazil was among the first countries to negotiate drug prices, install its own national laboratories for generic drugs and offer comprehensive and universal treatment to people living with HIV. More recently, 15 countries of the Caribbean negotiated agreements with drug makers within the framework of the UNAIDS Accelerated Access Initiative. The agreement reduced the cost of 1980s. “In Brazil, for example, there were from the outset clear decisions at every level—ministerial, public health, in the communities,” he says.

“Through effective campaigns and interventions they were able to slow the progress of the epidemic. Also, in Cuba, they took drastic measures, which were strongly criticized, but they managed to keep the virus out of the island during the first years of the epidemic.” In today’s world of travel, tourism and globalization, however, he and others insist that such “epidemiological fences” will no longer work.

The UNAIDS report for 2002 notes that one factor favoring the spread of HIV in Latin America and the Caribbean is the combination of inequality and a highly mobile population. For Zacarias, it is behavior that has most influenced the evolution of HIV in the region. “Heterosexual transmission is emerging as a major mode of infection. And the most recent target of the epidemic is women, particularly monogamous women who are infected by their own partners, who in many cases are having sex with other men. What happens is that the chain of contagion stops there, in the wife or girlfriend.” In other words, what is slowing the epidemic is basically a cultural phenomenon.

Two years ago, the slogan for UNAIDS’s world campaign called on men to “make a difference.” Far from endorsing male control over sexual relations, the campaign was instead appealing to men to be conscientious about using condoms to protect themselves as well as their partners. Using a condom was in a sense assuming personal responsibility in the battle against AIDS.

This is no arbitrary approach; condom use continues to be critical in preventing infection. But it is also something over which many women have little control. “In some countries women are not given the status to be able to make their own decisions about safe sex,” says Fauci. “We have to continue to educate everyone from the leaders of the countries down to the people who are the community leaders in order to make the changes that we need.”
In South Africa, where one out of four people is infected, a tribal king can have dozens of children and several wives. Will a king use a condom? Will a Latin American truck driver who delivers goods in several countries? Or the small farmer from China’s Jilin province who donates blood once a month for his only steady income?

Zacarías shares Fauci’s belief in the importance of education but adds that, to educate, one must do it in the language and culture of the target group. “In Haiti, we’ve done campaigns where a voodoo priest explains, in his own language and rituals, how to properly use a condom. Interventions should be aimed at new cohorts, the newly vulnerable groups, mobile populations—there are many in our continent—sex workers, assembly plant workers and indigenous groups, where the virus has expanded dramatically. The Garifuna population of Honduras has from 15 to 20 percent prevalence of HIV.”

So where on the AIDS road map do we now stand? The experts agree: We are at a crossroads. It is the perfect time to do things right, to take the correct path to make sure that the epidemic does not explode.

Fauci believes that a clear political and economic commitment is most decisive. “If you look at the U.S., we are putting an extraordinary amount of resources in HIV/AIDS. In my institute, 50 percent of the budget is for HIV/AIDS. We would not have that commitment if it were not for the President, who put that into his budget.”

Zacarías’ main concern is, what will happen when HIV stops being a problem in the rich countries?

“Proprietary (nongeneric) combination treatment to $1,100 per patient per year—equal to the cost of treatment in sub-Saharan Africa. The negotiations—led by the Caribbean Community (CARICOM), PAHO/WHO and UNAIDS—began in February 2002 and culminated in the signing of the agreement between drug makers and the Pan-Caribbean Partnership Against HIV/AIDS at the 14th International AIDS Conference in Barcelona, Spain, last July.

George Alleyne, director emeritus of PAHO and special U.N. envoy for HIV/AIDS in the Caribbean, notes that “even with drugs available there is still need for the infrastructure, human resources and system organization to make them widely available.”

According to Alleyne, regional cooperation has been essential to address these issues, but “some countries are still aggressively pursuing other avenues for the further lowering of prices.”

Following in CARICOM’s footsteps, Central America and the Andean countries are also devising strategies to increase access to treatment and improve the quality of life of people living with HIV/AIDS. Last February the Central American governments signed an agreement with pharmaceutical companies to reduce AIDS drugs prices by 50 percent.

For Fernando Zacarías, chief of PAHO’s HIV/AIDS unit, the debate over drug prices lays the ethical issues squarely on the table, positing access to treatment as an essential human right: “Luckily, many countries—South Africa, Brazil—have acted. The greater challenge now is to ensure access to treatment without discrimination on the basis of social or economic condition.”
Behavior change

Many nations of the Americas have accepted the challenge of AIDS head on. One example already mentioned is Brazil. “What Brazil did serves as a model,” says Fauci. “They have excellent vision at the top. The country’s political leaders and leaders in health realized very early on that it is important to link prevention with treatment, to provide access to treatment throughout the country, to try and overcome in a creative way the obstacles to the availability of very expensive drugs, making those drugs generic and that way available for people with low incomes. They have shown leadership, creativity and concern. They didn’t deny the problem; they faced it.”

Another key element in slowing the region’s epidemic has been organized advocacy by self-described “seropositives.” The Latin American Network of People Living with HIV/AIDS coordi-
Zacarías notes that “with the new antiretroviral therapies, fewer patients go on to develop AIDS, and the number of hospitalizations in the countries has declined significantly.”

Then why not step back and rest a bit? In San Francisco, the epicenter of the epidemic in the 1980s, prevention efforts succeeded in dramatically lowering the incidence of infection among men who have sex with men. In those early years, fear was the driving force. Friends and lovers were dying; people had to be very careful. Yet a recent study by the city’s Department of Public Health shows an increase in infections over the last six years.

“The new generations of men who have sex with men do not have the same perception of the danger to them,” says Zacarías. “They know there is good medication, that the infection can be treated. But we must keep telling them, it is always, always best not to become infected.”

Zacarías and Fauci are veterans in this war, and both are competent to forecast the epidemic’s future. Zacarías proffers the following: “This process of stabilization of the epidemic, I might not be around to see it myself, but it can be achieved. In the general population the culture of sexuality is changing. Young people who became sexually active in the AIDS era know it is essential to protect themselves. The key words are care, prevention and treatment.”

Fauci says: “We are at a critical point right now. If we are not aggressive in prevention and education and behavior modification, if we don’t put the resources there to treat people who are already infected and link treatment with prevention, then it could get much, much worse. But if we do it right, we have the opportunity to have a major impact on the epidemic right now.”

There are two lines of research: one toward a preventive vaccine, which would immunize people against infection; and one toward a therapeutic vaccine, which would block the virus from replicating once inside the human body.

Robert Gallo, co-discoverer of the AIDS virus with Luc Montagnier, has said no AIDS vaccine could be 100 percent effective. But experts agree that developing a less-than-perfect vaccine would also be a tremendous advance, in that:

- A vaccine that decreased the rate of infection would slow the epidemic’s progress, a major achievement in health policy terms.
- It would succeed in lowering the rate of infection in high-risk populations.
- Those who did become infected, if vaccinated, would develop a lower grade infection than if they were not vaccinated.
- A lower viral count would offer a person living with HIV two major advantages: He or she could receive less potent treatment drugs, and it would take longer to develop AIDS. This would also decrease the person’s likelihood of transmitting the virus.

Such a vaccine could well tip the balance in the AIDS epidemic, which is currently in the virus’ favor.

The search for a vaccine creates a number of dilemmas, however. Most of the leading candidates currently in the race target HIV strains that are circulating in the United States, Europe and Asia rather than those circulating in Africa, where a vaccine is most urgently needed. Moreover, the virus’ ability to mutate makes it unlikely that a single vaccine model will be sufficient.

Yet researchers are continually pursuing new alternatives. One of the more intriguing of these is the work of the Canadian infectious disease specialist Francis Plummer. He followed the health of 2,000 female sex workers in Kenya and found that 200 of these remained HIV-negative even after repeated exposure to the virus over a number of years. British researchers found a similar result among sex workers in Gambia. The findings point to a natural form of defense against the virus, a gene responsible for HIV resistance. Identifying that gene and understanding its role in biological immunity could speed development of a vaccine. Similar research is under way involving the 5 percent of HIV-positive people known as “non-progressors,” who have been able to live many years with the virus without developing AIDS.

The International AIDS Vaccine Initiative (IAVI), a global effort launched in 1996 to jump start the search for a vaccine, estimates that some $470 million is being invested worldwide in AIDS vaccine research. While this represents a significant increase from a decade ago, it is still only 1 percent of total global spending on health research and development.

For Benetucci the importance of finding a vaccine cannot be overestimated: “While treatment has succeeded in halting the progression of the disease [in individuals], for many of the world’s regions, the vaccine is the only option, the only health tool that can halt the epidemic’s dramatic advance.”

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The Tobacco Files

What insider documents show about tobacco industry tactics to protect profits at the expense of public health efforts in Latin America and the Caribbean

by Donna Eberwine
Editor's note: The release of internal tobacco industry documents as part of anti-tobacco litigation in the United States in the 1990s provided a treasure trove of evidence of the industry’s attempts to confuse and deceive consumers and undermine public health efforts in the United States and abroad. To find out what these documents show about tobacco industry activities in Latin America and the Caribbean, the Pan American Health Organization (PAHO) in 2001 commissioned a research project focusing on the two market leaders in the region, British American Tobacco (BAT) and Philip Morris International (PMI). The result, drawn from more than 10,000 pages of documents, is Profits Over People: Tobacco Industry Activities to Market Cigarettes and Undermine Public Health in Latin America and the Caribbean (PAHO, 2002), by Stella Aguinaga Bialous and Stan Shatenstein. The full text of the report is accessible online at www.paho.org. Printed copies can be requested by e-mail from Heather Selin at selinhea@paho.org.

It was 1990, and the two leading multinational tobacco companies in Latin America and the Caribbean were concerned that anti-tobacco sentiment was spreading from North America and Europe to their fast-growing markets south of the U.S. border. Sharon Boyse, then a public affairs specialist with British American Tobacco (BAT), described the situation in a memo to officials of her company’s affiliates in Argentina, Brazil, Chile and Venezuela: “The main issue facing the industry in South America, now and in the future, is ETS [environmental tobacco smoke]/public smoking restrictions/social unacceptability of smoking…. The influence of anti-smoking stories in international media (particularly those emanating from the U.S./England) and of WHO [World Health Organization]/PAHO [Pan American Health Organization] must not be underestimated in this context.”

Boyse’s concerns were echoed in a presentation that same year by Marc Goldberg, Latin America manager for Philip Morris International.

“Legislation efforts have been intensified by governments to restrict smoking in public places and further limit advertising,” he said, according to the transcript. “We have been able to challenge successfully anti-smoking proposals in Costa Rica, Guatemala, and Paraguay, but it is clear that the tendency to restrict smoking in public places will continue to prompt legislation throughout the region.”

Goldberg’s notes make it clear that the industry would not just watch these growing threats to some of its most lucrative developing markets. Instead, it would enlist the help of one of the region’s most prestigious medical organizations to counter them.

“Under the guidance of Shook, Hardy and Bacon [a U.S. law firm] and under the sponsorship of the Interamerican College of Physicians and Surgeons, a survey is being conducted to determine the health priorities of the region according to the deans of medical schools,” Goldberg reported.

“We expect the results of the survey will demonstrate that the concern with smoking in Latin America as a public health hazard is the result of outside pressure and not a primary item of concern among the medical community. If the study confirms our suspicion, we expect the Interamerican College of Physicians and Surgeons to amply publicize these findings.”

He added: “We are continually developing lobbying strategies and coalitions with those who share an economic interest with us, and plan to stay one step ahead of our adversaries.”

According to insider documents released by the tobacco industry since 1998 and reviewed at the request of PAHO, this wasn’t the first or the last time that the industry would enlist the help of respected medical and scientific professionals to undermine tobacco control efforts in Latin America and the Caribbean. In one such effort, tobacco companies recruited the dean of the Graduate Program in Health Sciences of the Catholic University of Argentina, a friend of then Argentine President...
Carlos Menem, to lobby against legislation that would ban advertising and restrict smoking in public or enclosed areas (see sidebar p. 21).

In addition, according to insider documents, tobacco companies:

- Secretly hired medical and scientific researchers throughout the region to misrepresent the science linking secondhand smoke to disease in nonsmokers;
- Courted the media with expenses-paid junkets and cosponsored pro-industry conferences with journalists’ associations;
- Designed “youth smoking prevention” campaigns primarily as public relations tools while simultaneously targeting young smokers in their marketing strategies;
- Actively participated in smuggling networks to increase market shares and sales volumes, while publicly opposing illegal cigarette sales.

**Science for hire**

In the early 1990s, the issue of secondhand tobacco smoke came to the fore in the United States as scientific evidence mounted concerning its harmful effects on health. The U.S. Environmental Protection Agency (EPA) and the National Institute of Occupational Safety and Health (NIOSH) both issued reports confirming that so-called passive smokers were at significantly increased risk of disease.

These reports, issued by U.S. government agencies, put new pressure on the tobacco industry to counter the science linking environmental tobacco smoke (ETS), or secondhand smoke, to disease and in particular to preempt growing tobacco control efforts in this area in Latin America and the Caribbean.

A 1992 proposal by the tobacco industry law firm Covington and Burling outlines the industry’s response:

The ETS Consultants Project in Central and South America (“Latin Project”) was initiated in early 1991. The Latin Project currently includes 13 consultants from seven countries: Argentina, Brazil, Chile, Costa Rica, Ecuador, Guatemala and Venezuela. The consultants represent a wide variety of scientific disciplines, including chemistry and biochemistry, epidemiology, oncology and pulmonary and cardiovascular medicine. The Latin Project currently receives 40 percent of its funding from Philip Morris International [and 60 percent from BAT]. The Latin Project is managed by Covington and Burling.

Unlike many other regional ETS consultant programs sponsored by the industry, the Latin Project was initiated in anticipation, rather than in reaction to, the full-force arrival of the ETS issue to Central and South America. Critical to the success of the Latin Project is the generation and promotion of solid scientific data not only with respect to ETS specifically but also with respect to the full range of potential indoor and outdoor air contaminants. This approach encourages government agencies and media in Central and South America both to resist pressure from anti-smoking groups and to assign ETS its proper place among the many potential indoor and outdoor air contaminants found in these regions.

In addition to funding research by the consultants, the industry deployed them as presenters at scientific seminars and symposia and used their influence to obtain co-sponsorship of such events by some of the region’s most prestigious academic bodies. Among
these were the Argentine National Academy of Sciences and National Academy of Medicine, the University of São Paulo in Brazil, the Chilean Academy of Sciences, the Catholic University of Chile and the Faculty of Medicine of the University of Chile.

Although the purported goal of the Latin Project was to produce and disseminate “solid scientific data” to counter “extremist” tobacco control efforts, the links between the consultants and the industry were to be strictly concealed. A 1991 letter by BAT’s Boyse to Edgar Cordero of Republic Tobacco in Costa Rica makes this point clear:

I cannot stress strongly enough the absolute necessity for the industry to have no direct contact with these scientists that are part of the program.... If one scientist in the group is perceived by anyone to be associated with the industry, then we run the risk, by association, of this happening for the rest of the group and the whole exercise will become pointless. All contact, as previously explained, must be carried out through Covington and Burling.

A key strategy of the Latin Project was to shift the focus of public debate from the health effects of passive smoking to broader issues of air quality in the region, suggesting that secondhand smoke was a minor contributor to indoor air pollution. Toward this end the project proposed original research on these issues, including a study in Central America that would “acquire data on levels of various gas and particulate phase airborne substances in offices and restaurants in Costa Rica, Guatemala, Panama, El Salvador, Nicaragua and Honduras. Levels of outdoor air pollution will be determined simultaneous to the indoor air measurements.” The results of the study, published in the journal Ciencias Ambientales (Environmental Sciences) of the National University of Costa Rica, showed predictably that smoking was not a significant contributor to poor-quality indoor air.

Similar findings were presented at a 1993 industry-sponsored seminar at the International Center for Higher Studies in Communications (CIESPAL) in Quito, Ecuador. Latin Project consultant Carlos Alvarez told dozens of assembled journalists that there was no statistically significant relationship between passive smoking and cardiovascular disease and that, “even assuming a worst-case scenario, the problems presented in Latin America by ETS exposure pale in comparison by those caused by outdoor air pollution, malnutrition, cholera, diarrhea, illiteracy, poor housing and marginalization.” This is despite an overwhelming body of established scientific research indicating a causal link between secondhand smoke and heart disease.

Tobacco industry documents show that events such as the CIESPAL seminar were a favorite public relations tactic in Latin America and the Caribbean.

Similar symposia sponsored jointly by BAT and Philip Morris throughout the region targeted journalists with pro-industry messages on the issues of smoking and health, secondhand smoke, freedom of speech and WHO activities and priorities. For speakers, the companies drew heavily on Latin Project and other ETS consultants but also relied on allies in advertising and related industries. Only when addressing the core issue of smoking’s direct effects on health—which the industry has subsequently conceded to its critics—was it forced to rely on its own
paid staff. “We do not have any external consultant willing to do this, let alone a Spanish speaker,” as Boyse put it in a 1994 memo.

The purpose of these symposia was, as another Boyse memo put it, to “inform local media representatives of the company’s position on smoking issues; to persuade them that we have a credible and interesting response to the claims that are made about our products, and that our position is based on independent research and thus supported by independent experts. More specifically, to persuade media to become allies in lobbying against smoking restrictions.” [emphasis added]

Other documents show that both BAT and Philip Morris frequently invited journalists from the region to visit their corporate headquarters, often at industry expense. These visits were designed, according to a 1994 proposal, to give journalists a “better understanding … of the other sides of tobacco issues” as well as to establish “better personal relationships” between industry representatives and “the editors and senior journalists of the South American media.”

We have discussed the possibility of having articles written in a suitable style and on suitable issues that could then be circulated to operating companies and hopefully, through their contacts, printed in the local press.

It was agreed that for the purposes of this region it would probably be most suitable to have a freelance journalist based in the USA to write these articles. Philip Morris have therefore been looking for a suitable Spanish-speaking journalist for some time now and believe that they have found one that may be suitable for us.

Copies of the first articles that were drafted by this journalist are enclosed: two short pieces: one newspaper story and one editorial, and one longer feature piece, ‘Historia de la evaluación sobre el riesgo en el fumador pasivo’ [A history of the evaluation of the risks of passive smoking]. I would be grateful if all companies could let me have comments on these articles … Are these the kinds of articles that companies feel they could pass on to local media contacts for possible printing?

A Lima shopkeeper displays a carton of Philip Morris’s Marlboro Lights. Marlboro’s “full flavor” version is the region’s leading brand among “starters and young adult smokers.”
along to the press conferences and harangue people like [former U.S. President] Jimmy Carter about health priorities. That would have influenced coverage and we were going to arrange for training in how to disrupt a press conference—but they declared (as usual) that this wouldn’t work in Argentina.

For adults only?

Facing growing public sympathy in Latin America and the Caribbean for stronger tobacco control, the industry made special efforts beginning in the 1990s to appear amenable to, even cooperative with, “reasonable” regulation. A 1993 memo by Cathy Leiber, Philip Morris’s director of corporate affairs for Latin America, describes the industry’s approach to the particularly sensitive issue of youth smoking:

Taking into consideration the emerging adverse legislative climate in the region, we have an opportunity to create good will for the tobacco industry by going public with a campaign to discourage juvenile smoking. Our objective is to communicate that the tobacco industry is not interested in having young people smoke and to position the industry as a “concerned corporate citizen” in an effort to ward off further attacks by the anti-tobacco movement.

By 1997, Leiber was describing the development and promotion of model legislation on minimum age for cigarette purchase, for use throughout the region. The idea was that “to continue to protect our ability to market and advertise to adults, we must be preemptive, proactive, communicative and cooperative with government officials.”

Yet during the same period, industry marketing plans for the region refer openly and repeatedly to the “Young Adult Smoker” or “Young Adult Urban” market segments. The vast majority of the industry documents define these groups as 18- to 24- or 25-year-old smokers, but several point to the deliberate targeting of so-called “starters.” One such document is a 1992 brand strategies report by the Argentine BAT affiliate Nobleza Piccardo:

Camel is the U.S. International full flavour cigarette for men who see themselves as independent, self-assured and individualistic in their lifestyle. The target smoker is male, urban, aged 19 to 24.... Starters are an important part of the target.

Similarly, a 1994 analysis of Marlboro in the region describes the brand as “#1 in terms of starters and young adult smokers.”

If there is one truly “smoking gun” in the tobacco documents, it is the revelation that the industry has detailed knowledge of, and actively participates in, cigarette smuggling. The industry’s support of such illegal activities deprives governments of much-needed revenues, but also puts downward pressure on prices, making cigarettes more affordable for lower-income and younger consumers.

As a result of other documentary investigations, officials in the United Kingdom have launched an investigation of BAT involvement in smuggling in Asia and Latin America. In addition, authorities from Canada, Colombia, Ecuador, the European Union and the United States have filed lawsuits to recoup tax revenues they believe have been lost to the illegal cigarette trade.
Analysis of industry documents in Latin America and the Caribbean shows that strategies for competing in and expanding so-called “duty not paid” (DNP) markets could be traced to the highest corporate levels. In a 1993 memo, BAT’s regional manager for Latin America, Keith Dunt, wrote:

Due to the sensitivity, management and co-ordination of the DNP business, all brand should be concentrated on one operator per channel,… There should be complete clarification in the co-ordination and management of the DNP… Due to the importance of this business in the region, we propose that a “Border Trading Group” be formed to monitor and take decisions, when appropriate, to protect BAT Industries’ interests. It is recommended that there be one member from Souza Cruz, one from Nobleza Piccardo, and one from BATCo.

Other documents discuss the contraband market in great detail with respect to product pricing, competition for market share and contributions to total sales.

Yet the ethical dilemma presented by the industry’s active participation in smuggling was not ignored. In a 1992 memo, Dunt wrote to Nobleza Piccardo, BAT’s affiliate in Argentina: “We will be consulting here on the ethical side of whether we should encourage or ignore the DNP segment. You know my view is that it is part of your market and to have it exploited by others is just not acceptable.”

A 1992 memo from BAT’s Mark Waterfield to Delcio O. Laux, then president of C.A. Bigott in Venezuela, discussed the companies’ strategy for straddling the ethical fence on the issue, preserving the image of a good corporate citizen while maintaining its presence in the illegal trade:

It is recommended that a BATCO Company is given responsibility to develop the group share of the others DNP segment of the Venezuelan market. It would be unappropriate [sic] for Bigott’s marketing staff to develop the strategy to increase share of this segment. The role of Bigott is to persuade the authorities to close the borders and confiscate DNP product which is transmitted into Venezuela.

Similarly, a 1992 BAT marketing document confirms the involvement of both Philip Morris and BAT in supplying Argentina’s illegal market through their affiliates in Brazil and Paraguay. The document glibly rationalizes this involvement, noting that “contraband is 9 percent of the Argentine cigarette market and 46 percent of the market in NEA [northeast Argentina]. DNP cigarettes are a fact of life and almost institutionalized. DNP has at no recent stage been significantly restrained by the authorities. DNP volumes are more likely to grow than to reduce in the foreseeable future.”

The writer notes that the potential market for DNP is even greater and that “assuming there is an unsatisfied market, our priority is to cover this with brands which have a future in the Argentine market.”

Aside from these clearly illegal activities, it is perhaps not surprising that the tobacco industry has employed aggressive strategies in Latin America and the Caribbean—as it has elsewhere—to defend its products and its ability to promote them as
it sees fit. Any industry might be expected to do the same; the difference is that tobacco is the only product that, when used legally and as directed, will kill up to half of those who consume it.

Yet the revelations about its past deceptions should make it increasingly difficult for the tobacco industry to develop new arguments and to conceal the true dangers of its products and its marketing practices. For public health advocates, the hope is that growing awareness—among policymakers, government officials and consumers throughout the region—will translate into growing support for tougher tobacco controls.

Friends in high places

In 1992, Argentina’s parliament passed groundbreaking tobacco-control legislation known as the “Neri Bill.” If enacted, it would have banned all cigarette advertising and promotion, restricted smoking in enclosed public areas and required extensive disclosure of ingredients on all cigarette packaging.

Fearing a domino effect throughout the region, the tobacco industry quickly swung into action, mobilizing its allies in the advertising industry and elsewhere to prevent the bill’s final passage. According to insider documents, the industry “organized a closed door working session with media owners, sports figures, advertising executives, and other interested parties to initiate a campaign in favor of a presidential veto.”

The campaign consisted of letters to then President Carlos Menem and other government officials from groups including the World Federation of Advertisers, the Inter American Press Association and the Interamerican Society for Freedom of Commercial Speech. All these echoed the industry’s ready-made arguments, outlined in a 1993 Philip Morris “case analysis”:

1. The Neri law was an unconstitutional limitation of freedom of commercial speech.
2. There is no evidence which shows a connection between cigarette advertising and consumption.
3. Cigarette advertising is designed to preserve brand loyalty and promote brand switching.

At least as effective as the letters, however, was the industry’s strategic deployment of the prominent Argentine cardiologist Carlos Alvarez. The dean of the Graduate Program in Health Sciences at the Catholic University, Alvarez was a friend of then Argentine president Carlos Menem and served as his brother Eduardo’s private physician. He was also a paid consultant in the industry’s so-called “Latin Project,” which recruited scientists to support the industry’s views on secondhand smoke.

A November 1992 memo by industry lawyer John Rupp describes Alvarez’s intervention:

Dr. Carlos Alvarez played a very useful role in the larger industry efforts to defeat, and then to convince President Menem to veto, the anti-tobacco legislation approved by the Argentine Parliament at the end of 1992. Dr. Alvarez’s activities included conversation with Senators from both parties and a series of conversations with President Menem as well as President Menem’s brother, who serves as President of the Argentine Senate. Dr. Alvarez also provided President Menem with a briefing package and a covering letter that pointed out that the smoking restrictions that had been proposed lacked a solid scientific basis.

This and other documents show that Alvarez was expected to remain active on the industry’s behalf should Argentina introduce new tobacco control legislation in the future.
Out of the Ashes

by Jorge Jenkins Molieri

The residents of El Salvador's Villa Centenario have built a whole new “healthy community” to replace the homes they lost to the earthquakes of 2001.
The first two months of 2001 were a living nightmare for the Osorio family, as for thousands of Salvadoran citizens. On the morning of Jan. 13, a 7.6-magnitude earthquake struck, centered 100 kilometers off the country’s Pacific coast. Its force was felt as far away as Mexico and Panama, but it hit El Salvador the hardest, collapsing homes and buildings, destroying roads and bridges, and setting off mudslides and landslides throughout the country. Thousands of aftershocks followed, one of which—on Feb. 13—was strong enough to be considered a quake on its own. In the end, more than 1,200 Salvadorans were dead, nearly 9,000 were injured and some 1.6 million were left homeless.

Before the earthquakes, Carlos Osorio, his wife María Ester Echeverría and seven of their 10 children had been living in poverty as caretakers on a large farm in Acajutla, in Sonsonate department in western El Salvador. Their house—a rickety structure of stick-and-mud walls and a makeshift plastic roof—was destroyed by the earthquakes. Used to hardship, the family now began a truly desperate search for new work and someplace else to live.

“I thought I was going to die and that my children would be left fatherless, just as my father left me when I was a child,” Osorio recalls with tears in his eyes.

But six months to the day after the first earthquake, the Osorios found new hope back in Acajutla, this time in the small village of Suncita. They were among the first of 100 families who would join an effort to build, from the ground up, a whole new community to replace their lost homes. Their town, named Villa Centenario in honor of the 100th anniversary of the Pan American Health Organization (PAHO), would become a model “healthy housing” project built with support from PAHO, El Salvador’s ministries of housing (which donated the land) and health, foreign donor countries, local missionaries and the Municipality of Acajutla.

Most important, however, was the active participation of the 100 families who are the project’s enthusiastic beneficiaries.

“It’s a miracle that God and all the organizations that helped us would give us our own house,” says Osorio.

From shortage to crisis

The Osorios’ plight in early 2001 was typical of thousands of Salvadoran families who lost their homes in the earthquakes. According to the National Emergency Committee, the quakes affected nearly a quarter of the country’s housing, with more than 180,000 units damaged and 150,000 units destroyed. The brunt of the impact fell on the rural poor, whose poorly constructed houses in precarious locations stood little chance against the quakes’ force. What had already been a serious shortage of adequate housing was rendered a full-fledged crisis by the earthquakes.

This presented a major challenge to the government and citizens alike: to rebuild not just houses, but entire communities that would be stronger and healthier than those destroyed.

“It was an opportunity to rethink rural housing and rural communities and to introduce a new concept of healthy living even in the context of poverty,” says Horacio Toro, PAHO representative in El Salvador. “It was a chance to come up with solutions to enduring problems like the lack of
basic sanitary services and the unhealthy human behaviors that accompany poverty and poor living conditions.”

The task of developing a prototype of healthy housing was taken up by a group of sanitary engineers in PAHO’s country office in San Salvador. PAHO helped secure funding from donors including the Bahamas, Canada, Italy, Norway, Sweden and the Pan American Health and Education Foundation to finance the first 60 houses, while the Marist Brothers religious order raised funds to finance the remaining 40. The goal was to make Villa Centenario a model that shows it is possible to have healthy housing and healthy communities even in the poorest rural zones.

The core of Villa Centenario is its 100 houses, built to withstand earthquakes and also to ensure healthy living in a low-income setting. Designed by PAHO sanitary engineers as a prototype of antiseismic, low-cost and easy-to-construct housing, each home was built by future residents themselves using simple tools and durable materials such as concrete blocks and metal roofing. Each house has three small bedrooms, a kitchen and a social area, all in a space of 440 square feet. Conveniences include a water storage tank and purification filters, a shower, a kitchen-laundry sink, a wood-burning or gas stove, a latrine and a system for eliminating wastewater. Fine mesh screening covers the doors and windows to keep out disease-carrying insects. The total cost of materials: just over $4,000.

Today, less than two years after construction began, Villa Centenario has, besides its 100 homes, a community center, a central plaza, a park with a playground, a sports field, a medical dispensary, a bakery and a nixtamal, or corn tortilla, mill. Children attend school just a kilometer from town, and the Municipality of Acajutla provides the community with garbage collection. Recently the community finally got its own electricity and water services.

▲ Residents of Villa Centenario built their own houses and now meet regularly to discuss ways of improving living conditions in their community.
The focus on healthy housing (vivienda saludable, or VIVISAL, in Spanish) is critical, but the emphasis on social participation is equally important. The country’s president, Francisco Flores, highlighted this fact in a speech delivered at the community’s inauguration: “It’s worth noting that the community’s design also takes account of the kind of social spaces needed to stimulate harmonious co-existence among the residents, with special emphasis on the spatial needs of children and adolescents.”

For Francisco López Beltrán, El Salvador’s minister of health, Villa Centenario represents “the new approach that ministries of health are taking, bringing programs to the communities and making Salvadorans the true protagonists of health.”

Toward that end, Villa Centenario has an elected city council, volunteer health and sanitation brigades, community training programs, several income-producing projects and community nutrition initiatives supported by PAHO’s Nutrition Institute of Central America and Panama, or INCAP. A number of government and international agencies and nongovernmental organizations have helped organize community campaigns for mosquito control, childhood immunization, animal worming, vitamin supplementation and adult literacy.

Model community

Villa Centenario has already served its purpose as a model for healthy living. El Salvador’s Vice Ministry of Housing has adopted the VIVISAL concept as the basis for construction of some 50,000 new homes in rural areas, incorporating both its sanitary features and its focus on community participation in health.

As for the town’s own residents, their “transformation”—from earthquake victims to protagonists of social change—can be seen in the Osorio family. One of the first to contribute to the construction of Villa Centenario, Carlos Osorio is today a well-known and respected figure who has taken on considerable responsibility in the community. He has served as president of the city council on five occasions, he holds primary responsibility for the functioning of the community center and the central park and he supervises the bakery and the tortilla mill. He also attends courses on family and community hygiene and participates in a hydroponic orchard program sponsored by INCAP.

His wife has a paid job in the bakery and in a local women-run microenterprise, and volunteers in one of the community health brigades. Their two youngest children are once again in school.

Yet the transformation is by no means complete. “To build a successful, sustainable community, there must emerge a strong sense of belonging among the families—who didn’t know each other before—so they can identify the problems they share and come up with common solutions,” says Maritza Romero, expert in health promotion in PAHO’s country office in San Salvador.

“This helps them transcend individualism and begin to build representative and participatory structures as well as a commitment to work for the common good. That process may take years, even decades.” She adds that while adequate housing is a necessary prerequisite for healthy living, success also depends heavily on advances in other basic areas of human development, including literacy, education and vocational training, gender equity and perhaps above all, employment and income.

“Villa Centenario is a successful model community in terms of environmental health, but it still faces the intractable problems of people living in extreme poverty,” notes Gerardo Merino, a nutrition expert and INCAP consultant in El Salvador. “Some of the residents are apparently so undernourished, for example, that they lack the strength or motivation to participate in community activities or training.”

Osorio is living proof that the lack of employment sources is perhaps the most difficult and necessary obstacle still to surmount.

“My main problem is economic, because I don’t have work,” he says. “I depend on what my older children give me to support the rest of my kids. Sometimes we only have corn to eat, and often we go to bed with empty stomachs. I give thanks to God and to all those who have supported us, but I hope to find work soon because I don’t like to beg.”
It’s been five months now that Esther Ballivián has had a new son. She met him by chance one day, and since then she has visited him every day of the week after lunch. She only sees 16-year-old Ramiro long enough to watch him take his tuberculosis medication, making sure that the disease that claimed his father’s life doesn’t kill the son. Despite their limited time together, Ballivián sees her relationship with Ramiro as anything but short term.

For the last year, Ballivián has been a soldier in an army of neighborhood health promoters known as las manzaneras in the city of El Alto, in the department of La Paz, Bolivia. Each of the 800 mostly female volunteers is responsible for monitoring the health of the inhabitants of a given manzana (about 1.5 acres) of the city’s residential area. In door-to-door visits, the manzaneras encourage residents to use community health services and, when appropriate, refer potential patients—particularly pregnant women and children under 5—to nearby hospitals and health centers. Their task is not only to offer practical health information but also to boost awareness of and demand for health services, somewhat like “health vendors,” says Fernando Amado, a Pan American Health Organization (PAHO) consultant in La Paz.

Patient shortage

In its less than two decades of existence, El Alto—situated 13,000 feet above sea level—has become one of the fastest growing cities not only in Bolivia, but in South America. If the current rate of growth continues, the city’s population will double in just 14 years. The continuing growth represents a kind of time bomb, as basic services have failed to keep pace with the population expansion. Twenty percent of the city’s 629,000 inhabitants lack access to drinking water, electricity and sewerage services. Health officials say the shortfall contributes significantly to high mortality rates for mothers, 390 per 100,000, and among children, 89 per 1,000 under age 5.

Las manzaneras are like “health vendors.” And yes, they make house calls.

by Abdel Padilla
But another part of the problem is that many people do not take advantage of available health services, according to city officials. Some local public health providers could handle twice as many patients as they do now.

“People feel mistreated and misunderstood by health workers, so they don’t seek their services,” explains El Alto Mayor José Luis Paredes.

It was at the start of Paredes’ term as mayor, in January 2000, that the manzzeras initiative began to take shape, with the primary goal of ending the “patient shortage.” It has become one of the most successful neighborhood health promotion projects in all of Bolivia’s 313 municipal districts.

The project started officially in early 2001 as part of El Alto’s Social Network Program, a health promotion effort sponsored by the Ministry of Health. From the outset being a manzzeran has been strictly a voluntary undertaking. More recently, a new and important element has been added: Each manzzeran (or manzanero—about 10 percent of the volunteers are male) is now elected by a neighborhood council, making the experience not only voluntary but also democratic and representative.

“Before, many avoided signing up because they felt the work was too solitary,” says Johnny Tórrez, who heads the program.

“Today, every manzzeran has the support of her own neighbors, and she feels accountable to them because she was democratically elected.”

Like having a doctor

While the program is considered a success, it has a high turnover rate. In 2001 the number of volunteers peaked at 1,600, but by January of this year there were fewer than 800 to cover the five to 40 manzanas in each of El Alto’s six health districts.

“Volunteers go through a cycle,” says Sarah Arnez, one of the program’s founders and a member of El Alto’s city council. “People burn out and leave, but they leave with the advantage of having been trained and sensitized.”

PAHO’s Amado agrees, although he believes that the program should offer more incentives for the manzaneras—for example, providing them with more educational materials. Each volunteer now receives only the special green jacket that allows neighborhood residents to identify her.

“You cannot pay the volunteers,” Amado says. “This is voluntary work and must continue to be so. Otherwise it loses its reason for being.”

Once a volunteer has been elected and trained, her first task is to take a census of the manzana where she will “market” health services door to door. She then begins her work of providing health education to residents, including telling them about the warning signs of health problems in pregnant women and children under 5. She tells mothers-to-be what to do in case of bleeding during pregnancy, prolonged labor and childbirth, or a high fever after giving birth. She tells parents what to do if a child has diarrhea or if there is a foul odor around a newborn’s navel. She also provides detailed explanations of childhood vaccination schedules.

Each manzanera decides when she will visit her manzana, although most make their visits at mid-morning or in the early afternoon, after feeding their own families.

“First we cook for our spouses and our children, then we can leave to do our rounds,” explains Susana Quispe, a manzanera from Health District III, also known as the Centennial District in honor of the 100th anniversary PAHO celebrated in 2002.

Quispe’s manzana has 20 houses, all two- or three-room adobe-and-brick structures packed closely together along dirt and cobblestone alleyways. One of these is home to 21-year-old Lizet Silva, who has relied on Quispe throughout her first pregnancy and with whom she made her first visit to a health center. “It’s like having a doctor at home,” says Silva.

For El Alto’s health authorities, the manzaneras have achieved what traditional strategies have failed to produce: a lower risk of death from complications of pregnancy and childbirth, and a higher number of institutional or attended deliveries. How have they done it? By restoring “power to the people,” says Tórrez and other supporters of the program, and by drawing on the natural social inclination for neighbors to want to help one another—both strongly rooted cultural features dating back to Bolivia’s precolonial Quechua and Aymara cultures, and still passed on from generation to generation.

Abdel Padilla is a reporter for the Bolivian daily newspaper La Prensa.
Rescuing the Art of Breastfeeding

by Maria del Mar Mazza

Rosaura Veliz Rixton sat in a circle with six other women on the patio of a neighbor’s home on the outskirts of El Limón, a low-income district of Guatemala City. The women spoke in low voices, almost whispering so as not to wake up the tiny sleeping babies some of them held in their arms. Veliz listened intently, holding her 25-day-old baby girl Dara close. Leading the meeting was “Doña Amalia,” a more experienced mother and the designated monitorea, or peer counselor.

Doña Amalia explained that breastfeeding was the best option for both mother and baby, no matter what relatives and friends might tell the young mothers. Other women chimed in their agreement. They assured Veliz that when her baby cried, it was not because she was doing something wrong. And despite what Veliz’s mother-in-law said, it was not necessary to give little Dara infant formula—or water, or juice or anything else for her first six months.

“I was glad to hear that I didn’t need to give her a bottle,” recalls Veliz. “They explained to me how to breastfeed the baby correctly. I liked the group so much that I continued to go.”

Breastfeeding is the healthiest and best way to nourish babies, particularly during the first half-year of life. Breast milk contains all the nutrients babies need, along with mothers’ antibodies that boost the babies’ still-developing immune systems. Research has even shown that breastfeeding makes babies smarter. Moreover, breast milk requires no preparation and therefore cannot be overdiluted or contaminated by dirty water. And it is always just the right temperature.

Starting in the middle of the last century, however, breastfeeding began to decline in both developed and developing countries, the result of a number of factors: the marketing practices of infant formula makers, the social perception that it was somehow more “modern” to give babies formula, and a lack of knowledge about the tremendous benefits of breastfeeding for both mother and baby.

La Leche League was founded in 1956 by seven U.S. women to counter these trends and “rescue” the art of breastfeeding. In the years since, this international nongovernmental organization has worked in a growing number of countries both to encourage breastfeeding and to give support to new mothers.

Today La Leche League International’s programs focus on training peer counselors like Doña Amalia and establishing support groups in which mothers are encouraged to share their experiences and exchange knowledge. The goal is to increase mothers’ self-confidence, not only to breastfeed but also to practice other maternal skills. New mothers ask questions, and more experienced mothers give advice. Throughout, the group facilitator listens, gently guides the discussion and respectfully corrects any misconceptions she might hear.
“I went to listen to the other mothers’ experiences, but the monitora explains things best,” says Karla Duarte, six months pregnant and the mother of a 3-year-old boy and a 2-year-old girl. She recalls how she gave up breastfeeding her first baby, who was delivered by caesarean section. Because of her surgery, she had to go to the doctor for a series of follow-up visits but felt too weak to carry the baby with her. The babysitter gave him formula, and when Duarte tried to nurse again, the baby refused her breast. Duarte believes this had a great deal to do with the nearly chronic stomach infections her son suffered as a small child. Her second child, who breastfed exclusively, was never ill. Duarte swears that now she will feed her baby-to-be exclusively with breast milk.

La Leche League support groups meet in private houses or in health centers and welcome new or soon-to-be grandparents and aunts and uncles along with new parents and parents-to-be. The organization actively encourages fathers to participate, since they can provide breastfeeding mothers with invaluable support.

The role of trained peer counselors in these groups is essential. Their activities range from personal counseling, including home visits, to forming new support groups. “They are women who belong to the community,” explains Veliz. “They are leaders by nature, and they know the mothers’ needs.”

Veliz was a support group participant for three years before receiving training to become a peer counselor. Last year, she was elected La Leche League coordinator for all of El Limón. Being a peer counselor allows her to do what she finds most fulfilling: helping other mothers in need.

“When I began, as I talked with the mothers, I recalled when I had my first baby and I was just starting. Mothers need help because the influence of others can sometimes be negative,” she says.

The peer counselors face their own challenges. One of these is getting young mothers to communicate openly, to discuss their problems and to learn from each other. “Sometimes it’s hard for women to feel comfortable talking about their experiences and their beliefs with people they’ve only just met,” says Mimi de Maza, a member of La Leche League International’s board of directors and a promoter of the support group program.

To help, La Leche League Guatemala has developed special cloth posters, called mantas, that provide illustrations of breastfeeding concepts and techniques. The point, however, is less to provide “how-to” instructions than to encourage more open exchange. Says Maza: “The images help women talk about the choices they have made and give them an easier way to connect with other mothers.”

Maria del Mar Mazza is a nutritionist and a program administrator in La Leche League International’s Peer Counselor Program.
Eight years after the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) came into force, and more than a year since the Doha Declaration insisted on the priority of public health over patents, hundreds of millions of people in the developing world are still unable to access essential drugs.

There are many reasons why. Patients are unable to get to a doctor because they cannot afford transportation to the clinic or hospital. Or they arrive at the hospital, and the doctor is not in that day because he has private patients elsewhere. Or the doctor is in, but there are too many patients to be seen in one day. Or the doctor sees the patient and writes a prescription, but the patient has no money to buy the drug. Or the drug is in theory free, but the government budget for essential drugs has run out. Or the health ministry bought the drug, but it has “gone missing” from the hospital pharmacy, only to reappear, at a price, in a private pharmacy next to the hospital.

In other words, corruption, inefficiency and poverty may all restrict an individual’s access to the drugs he or she needs. These are issues that must be resolved at a national level.

There is, however, one major obstacle to essential drugs that can only be resolved internationally. That is the extent to which patented drugs can be replaced by generic equivalents. Under TRIPS, patent holders can extend their monopoly to 20 years in countries that are members of the World Trade Organization (all members of the Pan American Health Organization are also members of WTO).

Because patents create monopolies, manufacturers can charge high prices. When those monopolies are broken, prices fall. When manufacturers in developing countries began producing generic versions of patented antiretroviral drugs, the annual price of individual AIDS treatment fell from $10,000 to just over $200 in countries where generic versions were available.

Governments can override patents by issuing compulsory licenses, which grant the right of manufacture to another company on payment of a royalty to the patent holder. But licenses must be predominantly for domestic use. A poor country without the capacity to manufacture drugs cannot issue a compulsory license to a manufacturer in another country and therefore must pay the monopoly price on the patented drug.

This issue—compulsory licensing for export from a country with manufacturing capacity to a country with none—has remained unresolved on the WTO negotiating table for more than a year. From time to time, delegates spend several days discussing how to resolve it, but they have not been able to come to an agreement. Essentially, the organization is split in two. The developing world seeks an arrangement whereby compulsory licenses for export are granted no differently from domestic licenses, while the industrialized world wants to restrict licenses to HIV/AIDS, tuberculosis and malaria drugs (but not drugs for pneumonia, diarrhea, cancer or heart disease) and to subject licensing to an extensive bureaucratic procedure.

It is not surprising that the countries that oppose extending compulsory licensing are the host countries of the pharmaceutical industry, which holds the vast majority of medicinal patents. The industry argues that the monopoly protection offered by patents is essential to fund research. If patents are not respected, they cannot recoup costs nor sufficiently fund new research on important new drugs, such as antiretrovirals for treating HIV/AIDS.

There is some truth in this argument, but it is not the whole picture. First, the bulk of pharmaceutical companies’ profits are made in the industrialized world. In 2002, sales in North America, Western Europe, Japan and Australasia accounted for an estimated 79 percent of the industry’s income. Latin America and the Caribbean represented 7.5 percent. In other words, a shift from patented to generic drugs in the developing world would represent a minor loss to the pharmaceutical industry.

Second, for-profit pharmaceutical research is increasingly focused on drugs for so-called “lifestyle” conditions rather than those for serious diseases. Many of these conditions, such as erectile dysfunction or aging skin, are not life-threatening, while others, such as obesity and tobacco addiction, are only life-threatening over time, and alterna-
There are a number of problems with such “solutions.” First, they depend entirely on the donors’ goodwill, which is necessarily secondary to their need to sell drugs. They may also create a burden for the public health system by requiring staff to manage separate disbursement systems. The number of patients and geographic regions that benefit is likely to be limited, and need may not be the deciding factor. Donations, because they are free, may discourage the rational use of drugs.

These less-than-ideal solutions may make the pharmaceutical industry appear generous in public, but the reality is that millions of people who need antiretroviral and other patented drugs still do not have access to them. It is only in those very few countries (such as Brazil) where governments have used the threat of compulsory licenses that the industry has been forced to compete on a level playing field with generic manufacturers, and where the general public has genuinely benefited.

The industry argues that significantly reduced prices in the developing world may lead to demands for reduced prices in the developed countries. Indeed, in the United States the cost of drugs has become a major political issue. But maintaining relatively high prices in the industrialized world is unlikely to be a major issue. Commuters in New York do not demand that subway fares be brought down to the level of those in Santiago, and beer drinkers in London do not insist on paying Bangkok prices. Patients in the developed countries, whose medicines are usually subsidized or paid for by government or insurance companies, are unlikely to demand that those prices be reduced to developing-world levels.

With most of its profits being made in the developed world, the pharmaceutical industry loses little by allowing others to enter their developing country markets. This means that compulsory licenses—for export as well as domestic production—for all essential drugs—are the best compromise: They provide the pharmaceutical industry with guaranteed income while also allowing increasing numbers of people to access essential drugs.

Drug companies lose little by allowing others to enter their markets in developing countries. This makes compulsory licenses—for both export and domestic production—the best compromise on essential drugs.
Mailbox

Obesity in the Caribbean

⇒ As your article on “globesity” (Vol. 7, No. 3) notes, this problem is by no means limited to the United States. In the Caribbean, more than 50 percent of adult women are overweight (rates among men are about half that). Not surprisingly, diabetes and other chronic nutrition-related diseases have replaced malnutrition and infectious diseases as the main contributors to mortality in our region.

As is true elsewhere, obesity in the Caribbean is closely related to the region’s development. “Modernization” has brought changes in dietary patterns and levels of physical activity that are conducive to weight gain. Particularly in urban areas, the dietary emphasis has shifted from minimally processed traditional foods requiring significant preparation time to imported foods that are easily prepared, nutritionally dense and—thanks to mass production and foreign export subsidies—less expensive than many locally produced, minimally processed foods.

The problem of obesity has many faces, and several sectors must collaborate to effect control and ultimate reduction of obesity. Two key sectors are agriculture and health. An interesting proposal for tackling obesity was presented at an interdisciplinary obesity symposium organized by PAHO’s Caribbean Food and Nutrition Institute in 2001. Authors Chelston W.D. Braithwaite and Byron Noble, of the Inter-American Institute for Cooperation on Agriculture, tied the Caribbean’s nutrition transition to underdevelopment of the region’s agricultural sector. They argued for the creation of a Ministry of Food that would coordinate import, production and market policies, as well as provide education and training to better integrate the rural sector into the national economy. This would encourage consumption of both local and imported foods, thereby restoring some of the traditional, healthier components of the average Caribbean’s diet.

Fitzroy J. Henry, Director
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Fat makes fat

⇒ Congratulations on your article “Globesity: The Crisis of Growing Proportions” (Vol. 7, No. 3). We think it is important for readers to understand that while genetics may place some people at higher risk of obesity, all of us are at increased risk when eating a diet high in processed and fast foods. The transition from a diet of traditional native foods to fast foods has removed the protections most people enjoyed against obesity, heart disease, diabetes and some cancers.

While the obesity epidemic and its sequelae are public health problems, and while the public health systems of countries have important roles to play in education and awareness, the ultimate responsibility for making dietary changes rests with the individual. In order to be effective in losing weight and maintaining a healthy weight, individuals must have the proper knowledge to make good food choices. The real culprits behind the obesity epidemic are the high fat content of commonly available foods and a sedentary lifestyle. To be successful, one needs to exercise regularly and eat low-fat, high-fiber foods, including lots of fruits, vegetables and whole grains. The high fiber content helps fill you up before you overeat, a property not found in high-fat, low-fiber foods. And healthier foods contain many vitamins, minerals and other chemicals that protect against diseases in unknown ways and that are not available from any other source.

Ron and Nancy Goor
Authors, Choose to Lose: A Food Lover’s Guide to Permanent Weight Loss
Bethesda, Maryland
USA

Cheers for Don Francisco

⇒ I was pleased to read the last issue of Perspectives in Health, which, as always, offered a textured and nuanced look at health in the Americas.

I was especially moved by the story about Don Francisco. It is lazy thinking to forget that health interventions and health change come from many sources. As good health, broadly defined, requires more than hospitals, clinics and providers, so it is equally true that health care cannot, and should not, become solely the province of the credentialed few working within traditional healthcare systems and structures.

Facing seemingly intractable health problems, underfunding, grinding poverty, staggering health unfairness and other discouragements, we all need to believe in the power of a single voice. Don Francisco’s contribution to health care is one example; there are hundreds more. Health care needs a thousand Don Franciscos.

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We encourage readers’ comments on articles in Perspectives in Health and on the issues they raise. We will run a sampling of letters received in each issue. Some may be edited for space. Please include your name and address. Send to the Editor, Perspectives in Health, Office of Public Information, Pan American Health Organization, 525 Twenty-third Street, N.W., Washington, D.C. 20037, or via fax at 202-974-3143 or by e-mail to eberwind@paho.org. Perspectives in Health cannot be responsible for unsolicited manuscripts and/or photographs. Please query first. Guidelines are available upon request.
Gabriela Ibáñez, 21, of Asunción, Paraguay, is a member of a local Ecoclub, one of hundreds of youth clubs throughout Latin America and the Caribbean dedicated to improving the environment through community action. Ibáñez’s Ecoclub spearheaded efforts to eradicate mosquito breeding sites to reduce transmission of dengue fever in Paraguay’s capital. Members received basic training in entomology and health education and in turn trained other students how to identify mosquito larvae and how to deliver messages about dengue prevention. Participating students worked a city block each, identifying breeding sites house by house and certifying eligible households as “Aedes aegypti free.” The campaign has increased community awareness about and participation in the prevention of dengue. (See sidebar page 7.)