Health Trends in the Americas

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FROM THIS analysis we have concluded that the Ten-Year Public Health Program of the Alliance for Progress¹ can be carried out, provided its objectives are integrated in a rational way with the other goals that our countries propose to reach and that the potential resources of each and every one of our countries, and our wills, are mobilized to the full in the service of a higher ideal: the attainment of well-being for the benefit of all the people of America.

"This noble task must be accomplished for the sake of the dignity of the people of America, in whom resides the destiny of the Hemisphere at this singular hour in history." ²

Thus ends the Final Declaration of the Report of the Meeting of the Task Force on Health at the Ministerial Level, which was held in Washington, D.C., from 15 to 20 April of 1963. It was undoubtedly the most significant event in the work of the Organization during that year. Seen in historical perspective, its importance is still greater. Since the establishment of the International Sanitary Bureau—today the Pan American Sanitary Bureau—in December 1902, it was the first time in this century that outstanding authorities from the Americas had met to examine the intrinsic purposes of health activities and their consequences within the general development process, to the fostering of which the Ameri-

² Official Document PAHO 51, 42.
cas have pledged to devote themselves with increased vigor. Health problems mirror the biological, economic, historical, and cultural factors that condition diseases and their distribution in each society. The available data show that the major ills of Latin America are the communicable diseases, both acute and chronic, malnutrition, deficient sanitation, insanitary housing and working conditions, ignorance, and a low income per person. Taken as a whole, they produce a general morbidity and mortality higher than in the technologically more advanced countries; high mortality in infants and in children under five years of age (more than 40 per cent of all deaths); and a precarious course of pregnancy, delivery, and postpartum, which is reflected in reduced life expectancy at birth. They are also responsible for the meager schooling of children, the limited output of the "labor force" in relation to the investment, and a hostile attitude and pessimistic outlook on life. The distribution of these health problems varies from country to country, within each country, and between urban and rural areas.

The meeting analyzed in depth all the health problems mentioned in the Charter of Punta del Este and made a series of recommendations to the Governments and to international organizations. Because they are part of the process which leads to health promotion—a true infrastructure—the "instruments" which are essential for solving those problems were also discussed; in particular, planning, the organization and administration of health services, education and training of professional and auxiliary workers, and scientific research.

The discussions were of both a theoretical and a practical nature; reference was made to the scientific basis of each function and to modern techniques; basic health doctrines, such as the integration of preventive and curative activities, were reiterated—they should go beyond policies and regulations and live in the minds and conduct of officials. Emphasis was given to the importance—and the present weakness, despite advances—of vital and health statistics as the starting point of all
programming and evaluation; attention was drawn to the small proportion of the national income devoted to health, although it was acknowledged that there was waste, especially in administrative practices which need reform and modernization. In the statement that “preventive and curative services are but parts of an integrated whole,” the meaning was that it is essential that the official health services have effective coordination at the policy-making and executive level, both among themselves and with semiofficial, self-supporting, and autonomous organizations which provide any type of health care. In keeping with the spirit and the letter of the Charter of Punta del Este, health planning was examined in the light of present experience and measures were enunciated for progressing toward the formulation of sound plans which will enlighten the political authorities and help them in making their decisions.

The interdependence of health and development permeated all the discussions. The Final Declaration states that “perhaps there has been no other occasion when the importance of man, on whom all the efforts of society are focused, has been more clearly brought out. Those who have the moral authority to do so, have pointed out the humanitarian core of every economic system and never before, either in the Hemisphere or in this century, has a sense of national purpose been made manifest through the recognition of health as a fundamental factor in social progress and economic development.”

To sum up, the Meeting of the Task Force highlighted the ideals and techniques of health activities for the common good, placed them in the historical context of the Americas, and projected their future in accordance with economic, social, legal, and cultural development.

The Report of the Meeting is a valuable document for those interested in these problems, and the ideas and recommendations it contains, when translated into prac-

*Ibid., p. 37.
*Ibid., p. 42.
tice, will satisfy the long-held and deeply felt aspirations of the peoples and Governments of the Hemisphere. They now form part of the policy of the Pan American Sanitary Bureau, by virtue of Resolution XXXII 6 of the XIV Meeting of the Directing Council, XV Meeting of the Regional Committee of the World Health Organization for the Americas. They were also approved by the Special Committee on Health, Housing, and Community Development of the Inter-American Economic and Social Council; 6 the Council is responsible for examining the extent to which the objectives of the Charter of Punta del Este have been achieved and for recommending measures to speed progress. At its Second Annual Meetings, held in São Paulo, Brazil, in November 1963, the Council adopted the conclusions of the Meeting of the Task Force 7 as its own. By so doing, it reaffirmed the profound political and social significance of the prevention and cure of diseases, and their value for individual well-being and the growth of the economy.

The Inter-American Economic and Social Council devoted its attention to other health problems, among them the financing of malaria eradication. It also suggested that the Pan American Foot-and-Mouth Disease Center be expanded so as to provide Governments with advice on the formulation of national plans for the control of the disease, in the light of its significant economic importance.

The continent-wide program of rural environmental health and well-being 8 was also actively discussed.

These meetings of the Inter-American Economic and Social Council in 1963 were of great importance to the work of our Organization. Statements such as that set forth below justify this assertion: "The goals of the Alliance—and therefore the evaluation of its prospects—ex-

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7 OAS Official Records, OEA/Ser.H/X.4 (Eng.), CIES/305, p. 34.
tend far beyond the production of goods and services... But the essential aim is not merely to increase wealth; what is desired is to create wealth for distribution; to distribute it more equally so that it may be used to free the dispossessed masses of the Hemisphere from the servitude imposed upon them by ignorance, hunger, and disease. It is fundamental that Governments recognize clearly the interdependence of economic progress, social progress, and institutional reforms.”

It is gratifying to report that 13 of the 19 delegations included a health expert and that both the careful examination of the various problems and the resolutions approved were due to their presence. There was an excellent opportunity to enlighten the other members of the delegations and to learn their points of view about various economic and welfare projects. In the course of debates in both plenary and committee sessions, they were also able to learn about basic concepts, problems, and programs for accelerating progress in the Americas. National aims have continental implications. Without surrendering their political identity, the countries are seeking a better correlation, and a true interdependence which, in the economic field, should be an integration. Because of the nature of their mission, specialists in the health sciences and arts cannot remain isolated and aloof to this process. On the contrary, they must take an active part in it because their contribution is aimed at human development, without which there will be neither political stability nor economic progress. Their participation in the most important events in the inter-American system should be routine, as is that of the Pan American Sanitary Bureau.

It is a pleasure to state that in 1963 the Pan American Health Organization gained a new Member. The reference is to Trinidad and Tobago which, as a Member

Government, will add luster to the group of nations that form the Organization.

In 1963 the rural problem was given special attention by the health agencies of the Hemisphere, both national and international. Because all definitions are conventional, it was agreed to consider as a rural community one with up to 2,000 inhabitants, except for very large countries, where this maximum may be as high as 5,000.

The interest in this problem will continue in the years to come. Even the most valuable ideas, those which serve essentially humanitarian purposes, need certain circumstances in order to come to fruition and to blossom into achievements at the right time. It appears that that time has come for the improvement of rural welfare. This matter has gained relevance from several points of view; there is a clearer understanding of geography as a negative factor. “The impact of the mountain, the deserts, and the forest in history, in politics and in social organization has been profound. Almost in no part of Latin America does one meet human beings that fill the rural areas and fill the spaces between the cities; on the contrary, Latin America consists of cities, towns, and villages, without dwellings in between.”

This geography fosters isolation and regionalism within each country and between nations; shows the difficulties involved in tackling and solving social problems; brings out the importance of communications in drawing an increasing number of persons into the development process. For unless the people have a sense of national purpose, unless they take an active part in community and government affairs, progress will not be promoted nor will a nation be formed. As long as ethnic differences persist, it will be difficult to incorporate

large groups of the marginal population into civilized life and to enable them to produce, consume, invest, and create.

Although the motivation may appear to be economic, the intent is essentially humanitarian. To some extent, it is a reaction against skepticism based on impressions rather than on facts. Doubts have been expressed about the capacity of the inhabitants of small rural communities to contribute with their intelligence, inventiveness, and efforts to projects for the common good. A paternalistic spirit has cast a shadow on the scene because it has left those inhabitants outside the main stream of modern life awaiting the arrival of progress. The tendency has been to impose rather than to motivate well-being and self-help. The reaction, which is understandable, has been a long time in coming, if we bear in mind that the cultures which preceded ours gave examples of ingenuity and spirit of enterprise which have not disappeared but which are latent, that is, in a condition to respond to appropriate stimuli.

Even a superficial examination of the evolution of health problems in the Americas in this century shows the progress made; it is expressed in terms of life expectancy at birth, mortality and morbidity rates, both general and specific, teaching institutions for professional and auxiliary workers, resources for medical care and preventive services, to mention only some indicators. At the same time there has been an accelerated population growth, at a rate of 2.5 to 3.0 per cent per year, depending on the country concerned, but that does not gainsay the progress made. A better knowledge has been obtained of the causes and consequences of prevalent problems, and of what has to be done to solve them. It is clear that the "know-how" of applying modern techniques of preventing and curing diseases must be perfected. Here is an ample field for research with immediate effects, which
is indispensable for the formulation of sound plans. Nevertheless, despite the fact that greater yield can be obtained from existing means, there are extensive areas in the Hemisphere which lack permanent health services or to which access is very difficult. The problem is one of "coverage," both qualitative and quantitative, and it mainly affects rural communities. Unfortunately we do not know its actual scope, although the time is now favorable for Governments to ascertain it, given the present interest in improving the living conditions of those communities. It is recognized that much depends on development in general and on a solid economic infrastructure, whose components must include means of communication, transportation, improvement of land use and tenure. In the health field the rural problem also depends on a great deal on the "regionalization" of services, that is, a definite assignment of the responsibilities of professional and auxiliary workers and the most rational use of resources to attain pre-established objectives. A series of experiments that are being made in Latin America today, based on the experience of the past, show, on one hand, the desire of the Governments to benefit a larger number of communities and, on the other hand, the importance of the work of auxiliary workers as assistants to professional health personnel who are in short supply. This is an aspect of the rural question which deserves a more detailed examination and accelerated efforts should be made to achieve the purposes in view. For it is clear that it will not be possible to solve health problems in Latin America with schemes which are based on the experience of technologically advanced countries. While continuing the application of what modern medicine recommends—out of respect to human beings—it is possible to do so by means of structures and techniques which are better geared to the true situation in the communities, to their possibilities, and to government activities.

Possibly, the most thorough analysis was made in 1963, as a result of the decision of the Pan American Sanitary Bureau to tackle the problem gradually by means
of a Special Rural Welfare Fund; that initiative was endorsed by the Ministers Meeting. The origin of this proposal is to be found in the objective of the Charter of Punta del Este, to provide water to 50 per cent of the rural population in the decade. The scheme proposed is based fundamentally on motivating the communities to organize themselves and take an active part in the installation of the services, and to contribute with their labor—which must be valorized—and with local materials and a certain amount of funds. The Governments will bring the amount up to 50 per cent of the total cost of the services. A catalytic fund to finance the balance is required. For this purpose it is proposed to establish a Special Fund fed by the contributions of all the countries of the Hemisphere. The Governments are to receive long-term, low-interest loans on conditions to be determined by the Inter-American Development Bank, which will be responsible for the administration of the Fund. The Governments, in turn, will make loans to the communities for a period of 10 years, at a rate of interest to be fixed in each country. With the money repaid by the organized communities, national revolving funds will be established and at the end of a certain number of years these will be able to extend the benefits to new communities, to amortize the foreign capital, and to make the whole scheme self-supporting.

The essential thing is to motivate the people, to stimulate their initiative, and to channel their efforts toward works for the common good. The first of these works would be water supplies; but, subsequently, any other activities that the communities might decide upon could be carried out. It is worth mentioning that although progress has been made in rural sanitation as a result of government action, supplemented by international loans, each project has only benefited a specific group because arrangements have not been made to extend similar benefits to other groups. To this end

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11 Official Document PAHO 51, 34.
more foreign capital and national contributions are needed. Hence the advisability of some financing machinery, such as the national revolving funds, to develop a continuing enterprise for rural welfare, strongly supported by the population.

In compliance with the above-mentioned recommendations of the Ministers Meeting, the Organization prepared a document\textsuperscript{13} containing an analysis of the rural welfare problem, the possibilities of reaching the objective of the Charter, and details of the scheme to which we have already referred. This document was submitted to the Directing Council at its XIV Meeting, which after a thorough debate adopted Resolution XX\textsuperscript{14} approving the principles and methods proposed and recognizing the need for foreign capital as well as the priority of the problem.

In view of its importance for the political, economic, and social development of Latin America, the project was discussed by the Special Committee on Health, Housing, and Community Development of the Inter-American Economic and Social Council and, with its approval, was transmitted to the Second Annual Meetings of that body. During the debate, which was extensive, more emphasis was placed on the importance of the aims than on financing. It was decided to speak of a program of sanitation and rural well-being and not of a Special Fund. It was stated that, in theory, development is an integral entity and that the funds for it should not be parcelled up as would be the case if a Special Fund were established. In our opinion, although this idea has merit, it disregards the fact that the financial mechanism proposed envisages the development of a self-supporting system, so that foreign capital is required only for a few years. The Inter-American Economic and Social Council recognized the urgency of the problem, endorsed the method proposed, and recommended that the Inter-American Development Bank assume the responsibility for the administration

\textsuperscript{13} Official Document PAHO 54, 106-115.
\textsuperscript{14} Ibid., pp. 15-16.
of external funds and that the Pan American Sanitary Bureau be entrusted with technical assistance and supervision of projects.\textsuperscript{14}

In view of the continuing interest of the Governments, it is to be expected that in the course of the coming year it will be possible to put the program into practice in its entirety in some countries.

\textbf{In 1963 the Pan American Sanitary Bureau prepared its first program budget.} The classification system—approved by the Governing Bodies of the Organization—provides an over-all picture and permits a detailed analysis of the activities and of the investment of funds. The “program budget” technique shows the objectives to be accomplished, particularly when they lend themselves to periodic measurements. It is a basic component of health planning and, at the same time, an essential method for the technical and administrative audit of each program. In the usual health budgets emphasis is on human and material resources, without any clear relationship to the purposes being pursued in each activity. Frequently such budgets are a list of items which give no indication of what is intended to be done.

It is evident that in an international advisory organization, whose objectives are those of the Governments, it is not a simple matter to express all the activities in the form of a program budget. Nevertheless we venture to say that the attempt made by the Bureau has been valuable and has facilitated an analysis of the various programs and projects at the meetings of the Governing Bodies. As the evaluation of activities in the countries improves and their results can be expressed in terms of activities carried out and effects achieved, it will be possible to formulate with more accuracy a true health plan of the Pan American Sanitary Bureau. This plan will necessarily have to be diversified, as is the present program, because it must meet the require-

\textsuperscript{14} \textit{OAS Official Records, OEA/Ser.H/XII.6(Eng.), p. 32.}
ments of Governments, which will go on improving the selection of the areas in which they believe international assistance is needed to supplement their own efforts.

In accordance with the wishes of the Member Governments, we intend to continue to improve the program budget of the Bureau. In any event, it already makes possible a more rational analysis of the activities accomplished in 1963, and we wish to deal with those in the pages that follow.

There were 394 projects, which in accordance with the accepted classification may be distributed as follows: health protection, 147; health promotion, 130; education and training, 117.

It has been repeatedly stated that the Americas are a continent in transition with respect to the prevalence of quarantinable diseases and the characteristics of the phenomena that condition health and disease and those of the corresponding services. The great pestilential diseases are fading away. In 1963 no cases of cholera were reported, and there have not been any such cases in the century; this is a situation for which there is still no clear epidemiological explanation. Nor were any cases of urban yellow fever reported; the last of these was diagnosed in 1954. On the other hand, there were 143 known cases of jungle yellow fever in four countries in South America. As development penetrates the jungle, this incidence may increase markedly, unless immunization programs with 17D virus vaccine are organized.

There were 423 cases of plague in 1963, one of which came from the United States of America and the others from four countries in South America. Since 1960 there has been a recrudescence of this disease, especially in Ecuador and Peru. Preliminary investigations sponsored by the Organization have shown that an ecological study of the disease is essential and should be initiated at the western end of the common border of these countries.
Whereas in 1954 the Governments notified more than 3,000 cases of louse-borne typhus, in 1963 there were only 465 cases.

That insecticides and antibiotics, especially chloramphenicol and the tetracyclines, have had an impact is obvious when we recall the major outbreaks in the Americas in the not too distant past. A vaccine which confers long-term immunity is still needed.

The progress made in the eradication of smallpox is clearly evident, despite the fact that there has been no reduction in the number of cases reported in the past few years. In 1963 smallpox cases were reported in only four countries, whereas 10 countries notified cases in 1954. More than 99 per cent of the cases notified in 1963 occurred in two countries. Systematic vaccination programs in the last 14 years have contributed to the improvement of the situation. It is clear that epidemiological observation will make it possible, in coming years, to determine whether the reduction in incidence is due to a higher level of immunity. With the assistance of the Organization, most of the Governments are producing a sufficient amount of high potency vaccine. Regardless of the progress made, great efforts still need to be made to eliminate the disease and, especially, to maintain an adequate level of immunity in the population. Although the information available about vaccination programs in countries that have succeeded in eradicating smallpox is not complete, it would appear that the level of immunity of the population is below that required, and that the number of inhabitants at risk is not insignificant, especially since contact with human beings from distant parts of the world is daily increasing. It has therefore rightly been pointed out that the epidemiology of a disease which is disappearing must be the object of special investigations because, theoretically at least, the relations of the microorganism and the host and those of both with the environment are changing. From a practical point of view, however, it must become the normal practice for health services to keep vaccinations at the necessary level to prevent epidemics or the reintroduction of the disease.
The eradication of malaria on a world scale is the most daring enterprise that health workers have attempted in this century. The results obtained to date show how difficult it is to conquer nature and how important it is for men to exercise consistent and intelligent authority over this phase of the problem. Nevertheless, the accomplishments are impressive. If we establish 1956, the year when a systematic program was started in the Americas, as the base of our estimates, the population at risk was 87,951,000. It has increased in the same original malarious area to 106,137,000, as a result of natural growth. Whereas in 1956, 7.7 per cent of the population lived in areas where the disease had been eradicated, in 1963 the number had increased to 10.1 per cent, or more than 10 million persons. It must be pointed out that the criteria for declaring that an area is free of malaria, approved by the Governing Bodies of the World Health Organization and the Pan American Health Organization, are very strict. The percentage of the population in the consolidation phase has increased from 1.4 per cent in 1956 to 31.9 per cent in 1963; in the same period the figures for the attack phase were 33.9 and 30.1 per cent, respectively. At the end of 1963, 27.9 per cent of the population was living in countries and areas in the preparatory phase and a very small proportion where there was no organized program; the comparable figure in 1956 was 57 per cent.

A more detailed analysis of the achievements in 1963 confirms the growing trend toward malaria eradication.

In a complex ecological problem involving three living organisms, unusual reactions are to be expected. Investigations in the "problem areas"—where the transmission of malaria has not been halted despite an organized program—have made it possible to identify the characteristics of the epidemic which justify the application of additional measures. Considerable progress was made in this respect. Because of its significance, mention should be made of the method developed for a scientific analysis
of "problem areas." Also of importance are the trials of the mass drug treatment, the use of larvicides, the testings of four new residual insecticides, and the methods to overcome the excito-repellency caused by DDT.

While the activities are continued in accordance with their stage of development, we believe that, in any case, it is essential to intensify epidemiological studies. As the rate of transmission diminishes and malaria becomes more and more a rural disease, analyses in depth of its epidemiological characteristics are acquiring more importance. Only in this way can scientific use be made of that knowledge which has been tried and tested and that which has still to be put to the test. Of the various experimental lines in progress in various centers in the world, the most attractive is the immunological. If it were possible to know the nature of the relation between the parasite and human beings, that is to say, the essence of the immunity which malaria generates, there would be prospects of a biological method of protection which would clearly respond better to the characteristics of the disease. There is no doubt that the most important successes in the struggle against communicable diseases have been obtained by procedures which create conditions similar to those of the natural disease and are harmless. The therapy applied for the control or eradication of a mass disease—unless it is bactericidal—and the techniques which act on vectors have indirect effects in that they do not attack the root cause of the biological phenomenon. They do not induce specific reactions in human beings every time a causative agent is present.

To the problems of a biological character must be added in some countries those of an administrative and financial nature. The first usually point to a state of affairs which affects all the public administration and which it is urgently necessary to remedy. The program involves very complicated logistics which cannot be submitted to factors or interferences which have nothing to do with the technical aspects.

More than 30 million persons are living in areas in
the consolidation phase, so that epidemiological observation is necessary in order to trace malaria patients as soon as possible to give them radical treatment and to discover the probable source of the infection. With this end in view, it is essential for the communities to be duly informed so as to motivate them to cooperate actively. It is also indispensable for private initiative to be equally conscious of the problem and to contribute toward its solution, and all the resources of the State should be assigned a responsibility in the program. The local organizations should coordinate their activities with those of the malaria eradication services. It must be borne in mind that once eradication is achieved it is the permanent institutions that will have to maintain their territories free from the reintroduction of the disease. The most important thing is to create in all health workers an identity of views and actions which is translated, in practice, into a single functional entity.

There is still a long way to go before this point is reached in the Americas. The moment has come to give a sustained impulse to the thesis of joint action, by the public and the private sector, to eradicate malaria. This procedure should be applied in all phases of the program and not only in the consolidation phase. This was the view of the Sixteenth World Health Assembly, after reviewing the Ninth Report of the Expert Committee on Malaria. This was also the objective of the seminars held in the Region of the Americas in 1964. In showing the true facts of the case, an attempt will be made to reveal their inconsistency, as well as the need to create an attitude, that is to say a habit, in all the persons responsible for a problem which affects a great number of human beings, the national economy, and social welfare.

Systematic studies have not been made of what the reduction in malaria incidence means for the Governments of the Hemisphere in terms of production, produc-

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tivity, and natural wealth. They should be made, because they would show that the investment is highly productive, one which justifies not only the funds spent but also those which Governments and international organizations must continue to allot until the accomplishment of the task proposed for the Americas at the XIV Pan American Sanitary Conference held in Santiago, Chile, in 1954.

Another indicator of the fact that the Americas are a continent in transition with respect to the frequency of communicable diseases, is the status of *Aedes aegypti* eradication. In 1947 the Governments resolved to get rid of urban yellow fever by eliminating its vector. They have succeeded in doing so to a large extent. At that time success had already been achieved in Bolivia and in a large part of Brazil. However, all the other countries and territories of the Hemisphere, with the sole exception of Canada, were infested. In December 1963, the problem of *A. aegypti* was limited to the extreme north of South America, the Caribbean region, and the United States of America. In all the countries and territories there are programs in various stages of development. There are also, as was to be expected, biological as well as administrative and financial difficulties. In some countries the vector has become resistant to DDT and dieldrin. Its ecology is being studied in those areas, and new insecticides are being evaluated, in particular those derived from an intensive program of anopheles research. It is hoped that an active preparation which is non-toxic for living organisms will be found.

It is to be regretted that *A. aegypti* has reappeared in some areas from which it had been eradicated; such a situation is fundamentally due to lack of vigilance. As in the case of malaria, the same considerations hold true with regard to the need for coordinating the activities of all health agencies working for a national purpose.
The problem was complicated by the occurrence of an epidemic of dengue which attained serious proportions in Jamaica, Puerto Rico, and Antigua. Some cases were imported into the United States from those places. The epidemic spurred on the efforts to eradicate *A. aegypti*.

It must not be forgotten that it is a matter of eliminating a species from one third of the surface of the world. It is an enterprise in which nature cannot remain static.

**Tuberculosis** continues to be a serious health problem in Latin America despite the progress achieved as a result of antibiotics and modern chemotherapy, large-scale BCG vaccination, and a better understanding by the public of its significance. The mortality rates are both a sign of progress and an indication of what remains to be done. In the Continent they vary from 4 to about 80 per 100,000 inhabitants. In more than half of the countries they are below 20 per 100,000 and only in three are they over 50 per 100,000. Where registration has been carefully done, it can be shown that between 1948 and 1960 the fall in mortality was in some cases 70 to 90 per cent. Nevertheless, as a general rule, the decline since 1954 has been slower.

The estimates of morbidity also show the seriousness of the problem. In 1961-1962, 125,000 cases of tuberculosis and 36,000 deaths were reported in the Americas. This information is incomplete because no figures are available for several parts of the Continent. However, if it is assumed that the rates for both the reporting and the nonreporting areas are similar, the number of cases would be approximately 240,000 and that of deaths 60,000, or 4 cases to each death. In 1958 there were 3 cases per death, which reflects better registration. In the United States of America there were 11 known cases per death. If this figure were applied to Latin America, there would be about 670,000 cases. If it is assumed that there are 2 unknown cases for each known case, the total
number of persons with the disease in Latin America would be 2 million. Let us admit that all the foregoing argument is based on estimates which, for the most part, come from technologically advanced societies and are applied to developing countries. In our opinion, however, this fact makes the figures more reliable because the probability of infection and disease is clearly greater in the Latin American countries than in the United States of America and Canada. In emphasizing the seriousness of the situation, we wish to overcome a certain complacency which has been growing as a result of the undeniable success obtained.

The fact is that there is still a great gap between what is known and what is applied to reduce the incidence of tuberculosis. Not less important is the persistence of traditional schemes into which it is difficult to incorporate modern ideas and methods to benefit large sectors of the population at risk. Because it is a health problem, all State resources must participate in solving it progressively. Of equal importance is private initiative and, above all, the motivation of communities toward their own well-being. Tuberculosis must be given its place among the priorities of the problems covered by national health plans. Tuberculosis control activities must be incorporated into the routine activities of local health agencies. To sum up, the largest possible number of persons must be helped with the available resources through the existing public and private institutions. This thesis has been put into practice in demonstration areas in 11 countries which the Pan American Sanitary Bureau assisted in 1963.

**The Seminar on Leprosy**\(^{17}\) held in Cuernavaca, Mexico, in August 1963 has had a vast impact. Its purpose was to examine the leprosy problem in the light of

\(^{17}\) *Scientific Publication PAHO 85.*
the principles and methods governing the epidemiology of chronic diseases and the administration of control programs. It is yet another expression of the clear tendency in the Americas to replace the "vertical" approach, which emphasized a particular health problem, by the "horizontal" approach, in which the essential is the societies and the persons who make them up and create their culture. The Seminar made a thorough analysis of planning, organization of control activities, and professional education and training. It devoted particular attention to methods of case-registration, including diagnosis of the clinical form, and to continued observation of patients and of contacts. The Seminar was held at a very favorable time in the evolution of ideas about this disease. As we have said, the obscurantism which surrounded it has disappeared and the walls of leprosaria in which patients were segregated have been broken down. Most patients have returned to their families and their social environment. There is a tendency to speak of leprosy patients and not of lepers, of human beings affected with a disease which can be cured or whose contagiousness can be reduced to a marked extent. The Seminar has made specialists aware of the social perspectives of the problem and of how to deal with it as a mass disease. It has stimulated the active search for new cases—hence the continual rise in its incidence—and their rational treatment. The magnitude of the undertaking is clearly shown by the figures available for 22 countries on 31 December 1963. The active register had risen to 167,038 patients, of which only 61.1 per cent were under supervision. The seriousness of this fact is accentuated if it is borne in mind that 45.4 per cent of the patients are suffering from the lepromatous form, which is especially infectious. What is more, only 45 per cent of the contacts registered are under periodic surveillance, and the total number is thought to be far greater. Much remains to be done to help patients and known contacts and to trace others that undoubtedly exist.
Yaws is still present to some extent in certain territories in the Caribbean region and in Jamaica, because systematic activities to reduce the reservoir of the disease are not being carried out. No autochthonous cases have occurred in Trinidad since 1961 nor in Tobago since 1959.

In Haiti, only 15 confirmed cases of yaws were registered during the year, so that the incidence was 0.34 per 100,000 population. The program is at present being carried on in combination with the smallpox eradication program. In the Dominican Republic, 38 cases were diagnosed in 1963, the incidence being 1.6 per 100,000 population. Generally speaking, endemic yaws spreads slowly in the Hemisphere, so that its incidence can be further reduced by organized and continuing programs. Experience shows that if a region does not possess a minimum health structure, as is the case in many rural areas in the Americas, the early diagnosis and treatment of patients and their contacts is much more complex and costly. This holds true for every eradication program; hence the importance of having all health services take part in the campaign and of motivating the community to solve a high-priority problem.

The prevalence of common childhood diseases such as measles, whooping cough, diphtheria, and tetanus neonatorum is still very high if we bear in mind that there are procedures for effectively immunizing persons against these diseases. An exception should be made in the case of measles since attenuated live-virus vaccine, injected with or without gamma globulin, is still not being produced on a commercial scale and therefore the cost is too high. Nevertheless, the results achieved in certain countries, in particular Chile and Brazil, are very promising. The high incidence of the other diseases mentioned above, and the occurrence of epidemics, can only be explained by the fact that no systematic control activities are carried on in health centers, because on occasions good-quality immunizing agents are lacking, or because the communities are not told how these diseases can be
prevented in children. This shows how necessary it is to improve the quality of local health services and to enlarge the coverage they provide by means of a system of regionalization.

**Closely related** to this issue is the recommendation of the Task Force on Health at the Ministerial Level concerning the Latin American common market for biological products. It declares that all countries should have biological products for the diagnosis, prevention, and treatment of certain human diseases. In order to ensure that this will be so, the annual production of the Continent should be increased, and arrangements should be made for ensuring the quality of the product, facilitating free interchange of biological products, and training the necessary technicians. In 1963 the Organization, in conjunction with the Inter-American Development Bank, had two of its experts make a detailed study of the main government laboratories producing biological products. Their report will be used as a background document for an expert committee that is to examine the production, control, financing, and distribution aspects of the matter. The report of the committee will enable the Governments to decide how best to implement the recommendation of the Ministers Meeting and what role should be played by the Pan American Sanitary Bureau.

**The health** of human beings is inextricably related to the health of animals, not only because of the inter-communicability of certain diseases—the zoonoses—but because of the depressant effect that some animal diseases have on the socioeconomic status of a country. Improvement in research methods and investigations has increased our knowledge of the number of diseases which either man or animal can transmit to the other.

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18 Official Document PAHO 51, 40.
It must be recognized that in Latin America there is no sustained program for the control of those prevalent zoonoses which affect both the population and the economy. Among them are rabies, tuberculosis, brucellosis, hydatidosis, and anthrax. Organized programs for the control of these diseases are the exception. Generally speaking, control programs are sporadic or, as in the case of rabies, are launched only when epidemics occur. This is not the place to analyze the reasons for this situation; nevertheless it is essential to emphasize the importance of the problems and the need for conducting pertinent activities, at the local level as part of a general health program and at the national level in coordination with the ministries of agriculture. If this were done, it would be easier to define the areas in which international cooperation, when needed, could be effective.

To provide such cooperation is, in effect, the long-term aim of the Pan American Zoonoses Center. In the short run, the emphasis is on the education and training of professional staff, advisory services for the diagnosis and control of common zoonoses, and research in connection with identification, vaccines, and therapeutics-testing regarding rabies, hydatidosis, brucellosis, leptospirosis, and other diseases.

In our opinion, with the experience it has acquired, the Center should enlarge its present functions and take on others, including food hygiene, which is of importance in Latin America. We believe that the time has come to explore the possibility of further financial resources for the institution, so that it can carry out all the purposes that were enunciated when it was established. The assistance given by the Government of Argentina, which has enabled the Center to make the progress it has attained up to the present, is worthy of great praise.

Special mention must be made of the foot-and-mouth disease problem. As is known, the Pan American Foot-and-Mouth Disease Center is administered by the Pan American Sanitary Bureau and financed by funds from the Program of Technical Cooperation of the Organiza-
tion of American States. The importance of foot-and-mouth disease for the general economy, especially the agricultural areas of South America where the disease is prevalent, the ever present threat of its reintroduction into Central America and Mexico, and its bearing on the nutrition of Latin Americans, in particular those under five years of age, are some of the factors that justify the important place which control programs occupy in the work of the Center. In 1963 work was continued in the fields of diagnosis, training of technicians, research, preparation of vaccines, especially with modified live-virus of the three types common in South America. Trials have been made in groups of animals with mono- and bivalent vaccines. Of particular importance was the epizootiological survey and the studies on the survival of foot-and-mouth disease virus in cured meat.

Sufficient knowledge is now available to allow foot-and-mouth disease to be brought under further control. Any organized programs that are undertaken must, however, have sufficient financial backing to ensure their continuity, for such activities are inherently complex. Should Governments decide to request it, international financial assistance is justified for this type of activity because of the significance of the disease for the economies of the countries and the well-being of their people.

The Technical Discussions at the XIV Meeting of the Directing Council were devoted to what is considered the most characteristic pathological entity of Latin America, namely, diarrheal diseases of infants and of children under five years of age. It has been estimated that diarrheal diseases account for a quarter of the million children under one year of age that die each year in Central and South America. If the diarrheal diseases mortality rate in the whole Hemisphere were the same

19 Scientific Publication PAHO 100.
as it is in North America, then the above-mentioned figure would be reduced by some 98 per cent.

In most of the children under five years of age who die in Latin America each year, death is the outcome of a complex chain of synergic factors, noteworthy among which are malnutrition and repeated attacks by infectious environmental agents. It would appear that diarrhea contributes directly or indirectly to most of the deaths which occur after the neonatal period. Nevertheless, this health problem, like many others, is deeply rooted in the economic situation, in the distribution of income, in ignorance, and in the broadening of opportunities as a result of education and social mobility, in the cultural characteristics which are reflected in the customs and beliefs of people; in short, in development in the broadest historical and cultural sense.

In order to reduce the magnitude of the problem and to prevent deaths whose numbers are excessive in relation to the ingenuity man has shown in this century, direct specific activities by health services are essential. The fact that the deaths of children under five years of age in Latin America are due to causes which are in large measure preventable is an affront to the spiritual and intellectual capacity of the Hemisphere and to the caliber of its people. The necessary techniques are simple and their effectiveness has been proven; all that is required is to apply them on a national scale, after having won the collaboration of the community and, within it, especially that of the mothers, whose instinct is powerful enough to offset their illiteracy. It is our wish not to discount the significance of social and economic factors in the etiology of the mortality of children under five years of age, but to emphasize what can be done to reduce mortality of children, particularly in the one-month to two-years age group, by direct activities of health services. This was the aim of the Technical Discussions held at the XIV Meeting of the Directing Council, and also of the dis-
Discussion of the problem during the Ministers Meeting. The working papers prepared by distinguished experts and members of the Organization contain all the necessary background information and recommend practical measures for dealing with the problem on a national scale. The ideas contained therein were supplemented by the suggestions of the participants in both the above-mentioned meetings.

Some of the most difficult obstacles to overcome in reducing the mortality of children under five years of age are the economic, geographic, and cultural conditions in the rural areas. That it is an illusion to imagine that this problem can be solved exclusively by university trained professional health workers is clear if we bear in mind the rate at which such workers are trained and the rate which mortality maintains. What is more, even with the best of vocations it is not easy to adapt oneself to difficult conditions of life which offer little or no incentive. In addition, even in the best of circumstances there are barely enough applicants to fill the posts vacant in the capital cities and in the large cities of the Continent, and in some countries professional health workers are not being trained quickly enough to do more than replace those who die or become incapacitated. It is therefore essential to use well-trained auxiliary workers and to give nurses, midwives, and other professionals increased responsibilities in the field of supervision. Minimum yet sustained health care by a competent auxiliary worker is preferable to sporadic care—where geographic conditions allow it—by a trained professional. A time will come in the Americas when development will make it possible for all the basic health activities to be carried out by professional health workers. Likewise, it is necessary to work with measurable objectives so that the social impact of health activities can be ascertained and the influence of non-specific although fundamental factors can be distinguished.

20 Ibid.
That progress has been made in reducing infant mortality is shown by the fact that in 1930 the mortality rate in seven countries of the Americas ranged from 65 to 234 per 1,000 live-births, whereas in 1960, in the same countries, the rates ranged from 26 to 132. These statistics are of course, incomplete, but even making allowance for population growth the differences are noteworthy. In view of the experience available today in the Hemisphere, all the necessary measures should be taken to reduce this mortality rate by half, the objective laid down in the Charter of Punta del Este.

Because of their close connection with mortality and morbidity in children under five years of age, nutrition, environmental sanitation, and the organization and administration of health services call for comment, and this we shall do in the light of the advisory services provided by the Organization in 1963.

It is to be hoped that, as a result of the recommendations contained in the Charter of Punta del Este, agricultural production policies in Latin America will harmonize the basic biological needs of the population of each country with the imperative economic need to export. As pointed out in the report of the Economic Commission for Latin America (ECLA): "In the twenty years just ended agricultural production expanded by 80 per cent (2.6 per cent annually), that is, at a higher rate than in other regions of the world ... Nevertheless, if population growth is taken into account, the per-capita production increment barely amounted to 0.2 per cent annually, a negligible proportion exceeded in the other regions of the world where demographic growth is much slower than in Latin America. Moreover, this annual rate of growth of 2.6 per cent for aggregate production was well below that of consumption, which increased at a rate of 3.7 per cent.”

Deficiencies in production are being aggravated by the emphasis in agricultural policy on products which have little or no nutritive value although they may be important for the economy of many countries. We refer in particular to tobacco, coffee, sugar, cotton, cocoa, bananas, among others. As a result, it has been necessary to increase imports of indispensable proteins; this, in some cases, has seriously affected the balance of payment. According to the above-mentioned ECLA report: “these imports constitute a relatively small percentage of total consumption; nevertheless, they add up to a very considerable sum, i.e., about 450 million dollars’ worth of items, which, given a rational production policy and reciprocal trade, could be largely obtained in Latin America itself.” 

All the ramifications and all the implications of the nutrition problem are much better understood in Latin America today. In the health field research has been actively pursued to discover vegetable proteins whose nutritive value is equivalent to that of animal proteins. The most conspicuous success in this field is the preparation of INCAPARINA, which is now being used in several countries of Latin America. In addition, the food distribution programs have been expanded in an attempt to palliate the present food shortage. Nevertheless, it is to be hoped that agricultural policy will enable the countries to become self-sufficient in animal proteins and in other basic foods.

Education in all aspects of food and nutrition sciences is the most effective and lasting method of overcoming malnutrition. In our opinion, the results of a better oriented agricultural policy based on increased agricultural production and increased consumption of food by the population would be more in evidence if it were but-

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Loc. cit.
tressed by a concentrated effort of specialists in nutrition, agriculture, and community organization. The training of these technicians must be intensified so as to ensure that the present pressing needs will be satisfied.

In 1963, outstanding work was carried out by the Institute of Nutrition of Central America and Panama (INCAP). Taking advantage of the favorable movement toward long-range planning, INCAP intensified activities aimed at achieving more effective integration of nutrition into the national health programs of the countries.

With respect to urban water supply and the amount of international funds contributed for the program, these funds will furnish adequate water services to about 17,650,000 persons in 17 countries, or 38.5 per cent of the total population to be served if the 10-year target for urban water supply fixed in the Charter of Punta del Este is to be reached. The figures show that the rate of progress of the programs in the urban areas in Latin America has been highly satisfactory in the first three years of that 10-year period and give promise that the target fixed in the Charter will be met and improved on.

Once again, the efforts of the Inter-American Development Bank in this field, as in other aspects of the economic and social development of Latin America, are worthy of comment. In a relatively short period of time it has become the true development financing agency. It is to be hoped that, in the future, it will have the necessary resources to be able to grant the credits the Governments need for attaining the objectives of the Charter. The close correlation which the Bureau has maintained with the Governments and the Bank in the formulation of a series of water projects has been particularly gratifying. It is likewise to be hoped that other public and private lending agencies will increase their capital loans to the countries. What has been done in the last three years—a very admirable manifestation per se of the social function of
health in the Americas—must be completed for the sake of those who still await similar benefits. If this is not done, the accelerated population growth will bring to naught the achievements which have cost the Governments so much effort, and, even more important, will result in an unnecessary loss of life.

Reference has already been made to the problem of rural areas and the efforts undertaken by the Pan American Sanitary Bureau in 1963 to lay the foundations for gradual solution, which will begin with sanitation.

Of special significance were the direct advisory services provided by the Organization in urban and rural water supply, sewage disposal, occupational health, industrial hygiene, and the training of professional and auxiliary personnel. These activities were allocated funds amounting to a little over 10.5 per cent of the total budget of the Organization.

With respect to the organization and administration of health services, the Pan American Sanitary Bureau advised the Governments following three fundamental guidelines: integration of prevention and cure of diseases and health promotion activities; regionalization involving the coordination of all the resources of an area, at different levels, so to enable the basic health needs of the population to be attended to; continuing education for students and graduates and for auxiliary workers so that they can gain experience in training and thus knowledge of activities aimed at the total health of the community, taking into account its stage of development.

These, then, are the guidelines on which the activities of our consultants were based. It must be recognized, however, that their simultaneous application in the Americas is the exception rather than the rule. The usual pattern is for preventive to be separated from curative services and for coordination with teaching institutions to be
lacking. In the field of medical care there is no correlation between the activities of ministries of health and those of the social security services. In many instances, the institutions and services are unnecessarily duplicated. If such duplication could be overcome, more persons could be cared for with the same resources. And this is a pressing need. In Latin America the health services, regardless of their organization and their function, do not cover the entire geographic area of the countries or the entire population. In the latter's "scattered rural areas"—where dwellings are not close enough together to form communities and there are no social relationships between the people—there is a complete absence of health services or they can be said to hardly exist. Where the rural population is concentrated in communities with 500 or more inhabitants, medical care is usually sporadic or intermittent, and is not supported by preventive measures and health promotion activities. The population does not take part in health work nor is it motivated to do so; it is purely passive. In the urban areas there is a greater concentration of resources. Nevertheless, there are instances where the demand for medical care outstrips the available means, a fact which is aggravated by lack of coordination between the agencies responsible for preventive and health promotion activities.

We are well aware of the danger of oversimplifying a phenomenon which is so complex, extended over so vast a territory, and has such variegated cultural features. We realize how important it is for a study of the quality and quantity of resources to be made in each country with a view to preventing and curing diseases. Such an analysis would delineate for each region or each area the health care being provided by public and private bodies. For the Hemisphere as a whole, and for each country, it will describe the situation in the urban and rural environment and outline remedial measures. The fact of the matter is that more persons should be cared for with the technical staff now available and the supplies and equipment in use. This should be done without delay, and
within each country coverage should be broadened to the extent that geographic conditions and resources permit. There is therefore no justification whatsoever for giving priority to institutions or for making investments which do not basically aim at the common good, which, in the very special case of health, is that of all the population without distinction.

The Ministers Meeting recommended that the countries "secure the legal and institutional instruments required for the effective coordination of the planning and executive elements responsible for preventive and curative services of the State, as well as coordination between these and private, semiautonomous, and autonomous organizations providing health services of any type." 23

The existing systems are both a cause and a consequence of the training of physicians and of other related professions. Although what it is hoped to obtain from education has been clearly expressed in theory, in practice it is rare for technicians in this field of knowledge to perform their task with an over-all view of the problems, a grasp of their social and ecological roots, and a tendency to coordinate their activities so as to attain the essential aim: to prevent diseases, halt their spread, and promote health.

In the last 10 years, sustained progress has been made both in ideas and in methods in the field of university training. However, much remains to be done, in the many teaching institutions in the Americas, in order to put into effect the recommendations of the seminars on the teaching of preventive medicine sponsored by the Organization in 1955 and 1956.24 The subject of the Technical Discussions held on the occasion of the Sixteenth World Health Assembly was "Education and training of the physician for the preventive and social aspects of clinical practice." 25 An analysis was made of the present situation and the measures for accelerating the training of

24 Scientific Publication PAHO 28.
25 WHA16/Technical Discussions/6, Rev. 1.
professionals suited to the social conditions in the countries.

The Bureau's consultants carried out a series of activities in specific projects all aimed at improving the organization and administration of health services in the Americas. Naturally, the functions and work areas are those determined by the Governments. Although, by and large, the results are good, they show that many activities being conducted are not national in scope and have benefited only certain sectors of the communities. They are, however, aimed at fundamental problems which will undoubtedly have priority when a general health plan for the whole country is drawn up. In our opinion, both initiatives should be accelerated simultaneously until they merge into a single effort under the guidance of the ministry of health; in other words, the communities must be provided with services for solving immediate problems and at the same time arrangements must be made for a rational programming which is broader in scope.

In this connection the collection and elaboration of vital and health statistics are of special importance. The Pan American Sanitary Bureau reports have shown how much progress has been made in this field, especially in the training of technicians at various levels. They have also drawn attention to the serious gaps which need to be filled. Latin American statistics are believed to be too incomplete to provide a basis for planning or evaluation. In fact, there is no systematic registration of the work done or of the results achieved, that is to say, of their social impact. With the exception of those programs whose purpose is to eradicate a disease—an absolute objective—measurable objectives are seldom defined and are seldom of a practical nature; in other words, they are not a quantitative expression of preventive and curative activities, qualitatively efficient, that are aimed at the
gradual solution of each problem. If no point of reference is established, it is difficult to ascertain the import that the work done will have for the community. Neither will it be possible to calculate the cost nor to justify further expenditures. Furthermore, the determination of what the service intends to do and how it is to be done gives officials a permanent incentive to correlate the progress made with pre-established targets, and likewise makes it possible to motivate communities and to obtain their participation.

The situation is complicated by the fact that vital statistics are also incomplete and the normal indicators used to measure health, namely morbidity, mortality, and the like, cannot be expressed accurately because of the unreliability of statistical data.

The Governments that signed the Charter of Punta del Este undertook to achieve the health objectives spelled out in the Ten-Year Public Health Program of the Alliance for Progress. That program enumerates the problems which experience has shown to be prevalent in the Hemisphere and whose solution has been attempted, in some measure, in all countries of the Americas. It is essential to record activities being carried out and to measure their effects against the targets laid down in the Ten-Year Public Health Program. It will clearly be necessary to gradually improve the systems for the compilation and elaboration of data at the national and local levels, along the lines to which we have referred. In some countries, it will be advisable to establish registration areas of the largest possible geographic extent in which the necessary statistics will be collected. While similar services are being organized in other regions, the information gathered there can be used to make projections applicable to the whole country.

In 1963 the work of the Pan American Sanitary Bureau in the field of statistics included the compilation and elaboration of data, direct advisory services to countries, the training of technicians and other specific activities, all
of which were guided by the principles to which reference has already been made.

**IN THE FIELD OF MENTAL HEALTH**, the Organization has succeeded in the last three years in compiling objective and reliable data concerning the prevalent problems and the professional and material resources available. This background information was examined at two seminars, one held in Cuernavaca in 1962, and the other in Buenos Aires in 1963; there, resolutions were adopted recommending that activities for prevention and cure of mental diseases should be incorporated into general health programs and criteria were formulated for so doing. Also, the Mental Health Information Center on Latin America, which was established in January 1963, thanks to a grant awarded by the National Institutes of Health of the United States Public Health Service, laid the groundwork for the systematic collection, analysis, and distribution of information concerning mental health problems and activities in Latin American countries. The Center is organizing a permanent system which will facilitate communication between professionals in this field and promote research.

At the next stage in the development of mental health activities of the Pan American Sanitary Bureau, emphasis will be placed on studies of the epidemiology of mental diseases so as to ascertain what the most common types of disorders are, and to organize programs for the prevention and treatment of such disorders in health centers. For this purpose, it will be essential to have definitions, at least operational definitions, that will permit comparative country studies to be made. The influence of such studies will make itself felt in the teaching of psychiatry and mental health, and in the work of the medical care and preventive services.

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26 *Scientific Publication PAHO* 81.
27 *Scientific Publication PAHO* 99.

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The work undertaken in the fields of **dental health** and of **radiation and isotopes** shows progress in both training of personnel and services provided.

**The Governments** of Latin America are generally agreed about the importance of efficient **administration** in achieving the aims of any activity, whether in the public or the private sector. The subject was examined in some detail at the Meetings of the Inter-American Economic and Social Council. As a result of Resolution XXXV\(^{29}\) of the X Meeting of the Directing Council, the Pan American Sanitary Bureau, since 1957, has been giving advisory services to Governments to help them introduce sound administration into their health services. In recent years three seminars—the last of which, held in 1963, was for the English-speaking and Dutch-speaking countries and territories in the Caribbean area—have provided opportunities for an examination of various aspects of public administration in ministries of health, and have led to the formulation of pertinent regulations. In some countries direct advisory services were given in the field of administration to malaria eradication programs. Since 1962 the Organization's consultants have been helping the Governments introduce improvements in the services responsible for personnel, finance and budget, supplies and procurement, and other administrative functions.

In this fundamental field of the activities of ministries of health and their agencies, much remains to be done and it needs to be done urgently. "It is indispensable to create an administrative conscience and a sense of responsibility in all officials, in keeping with the high purposes of the health services."\(^{29}\) It is necessary to train officials either by means of in-service training or university courses, depending on their rank. At the same


\(^{29}\) *Official Document PAHO 51*, 26-27.
time, systems and methods must be simplified; in short, the administration must be rationalized in order to make it more economical and more efficient and capable of better serving the purposes of each program in terms of health and well-being.

THE ACTIVITIES undertaken by the Bureau in the field of education and training include advisory services given to teaching institutions and the award of fellowships.

In the medical education field, assistance was given in the training of teachers of medicine and in ascertaining present and future needs for medical manpower and their implications for education, in addition to direct advisory services to medical schools.

It is only in recent years that the basic concepts and methods of pedagogy have been introduced into the teaching of medicine. The reason for this is that there is a substantial difference between teaching and learning, and that the greater the motivation and participation of students, the more they learn. Learning, in other words, is an expression of the human relations between the professor and his students. A professional health worker who knows his subject very well and has great experience in it is not always capable of transmitting it in such a way that students grasp it and acquire that fundamental cast of mind that enables them to form their own judgments and apply the knowledge gained. In 1962 and 1963, thanks to the initiative of the Pan American Sanitary Bureau, the faculty of various schools of medicine began to receive advice on teaching methodology. This development has aroused much interest in Latin America and that warrants the expansion of this type of activity to the extent budgetary limitations will allow, since its results are so clearly beneficial. It is worth recalling, mutatis mutandis, that Leon Bernard maintained that medicine should be practiced as a form of friendship, and we would make bold to add, as an expres-
sion of kindness. It is to be hoped that if medicine is taught and is learned in a climate of mutual understanding between professors and students, then when students practice it in the future their attitude toward the persons they care for will be the same, regardless of whether they are healthy or ill.

Of major importance was the Round-Table Conference on Health Manpower and Medical Education in Latin America, sponsored by the Milbank Memorial Fund and the Organization. Its purpose was to study ways of determining both the number and type of professional and auxiliary health workers that would be needed by the countries of the Region, bearing in mind economic development and population growth. The aim, then, was in key with that of the Charter of Punta del Este, which stresses the need to plan education. The Conference recommended a series of studies in three fundamental areas: measurement of health needs and demands and establishment of targets; the resources health services must have in order to reach those targets; the changes that should be introduced into the policy for medical education.

The methods proposed will, it is hoped, be tried out in one country in 1964, and, if it is possible, use will be made of the information collected to enable the Government to prepare a national health plan. It is hoped to devise methods for calculating the human resources needed in health work that can be applied both in Latin America and in other countries of the world.

Direct advisory services were given to 26 schools of medicine in 13 countries, and a series of other activities were undertaken in the field of medical education.

Nursing education programs were carried out at three levels: for auxiliary nurses; for nurses, to improve their basic training; and for graduate nurses, to give them advanced training. At the Ninth Seminar on Nursing Services, where the training of auxiliary nurses was examined, it was pointed out that at least 100,000 nursing auxiliaries were employed by the public health services in Latin
America, and had very little training. A great many of them, of course, work in hospitals. This situation justifies the need for accelerating the training of these workers, who should have at least the minimum knowledge necessary to enable them to exercise their profession, which has an essentially humanitarian aim. Since they are members of the health services, the only funds needed are those for organizing training courses that should be held simultaneously in various parts of the country and should be conducted by nurses. Furthermore, it has become equally essential to increase the number of health aides who, under supervision of professional health workers, can serve in rural areas where even the minimum health services are lacking.

The advisory services given to schools of public health, in particular the analysis of the teaching of administration that was made at the Third Conference of Deans of Schools of Public Health, are worth mentioning. The teaching of the fundamentals and methods of prevention and health promotion is as important in the teaching of veterinary medicine as it is in medical education. Because of this, the Organization sponsored a seminar that discussed the problem thoroughly and made recommendations which, it is hoped, will be applied in all the schools in the Hemisphere.

Considerable work was done in 1963 in training technicians in various aspects of environmental sanitation. These activities are in keeping with the wishes of the Governments, as mirrored in the important investments they have made in water supplies and, to a lesser extent, in sewage disposal. Noteworthy advisory services were also furnished in the field of industrial hygiene and air pollution by the Institute of Occupational Health sponsored by the Government of Chile, the United Nations Special Fund, and the Organization, which acts as the executive agency for the project.

Special mention should be made of the financial assistance given by the Organization of American States to some of the courses conducted in 1963.
In 1963, 570 fellowships were awarded, or 7.5 per cent more than in 1962. The number of applications received—791—was 12.8 per cent greater than in the preceding year. If the fellowships that were not dealt with in previous years are added to this figure, it is clearly seen that the demand for fellowships is far in excess of the financial capacity of the Bureau to supply them. This illustrates the interest shown by Governments and universities and is an incentive to obtain more funds for fellowships, on which progress in the field of prevention and cure of diseases and the promotion of health, as part of the process of national development, largely depends.

It is clear that insofar as the possibilities of each Government for training professional and auxiliary workers in basic health services are increasing—and the progress made in recent years is impressive—the fellowships the Organization will award in the future will be for specialization in various branches, and for a deepening of ideas and methods or the acquisition of new knowledge. The time will come when the Governing Bodies will wish to revise and redefine the Organization's fellowship policy, in the light of this valuable experience.

By resolution XXXI of the XIV Meeting of the Directing Council, the Pan American Health Organization endorsed the research program, and approved the necessary allotments to enable the Office of Research Coordination to continue its activities in 1964, when the grants made by the National Institutes of Health of the United States Public Health Service for planning and initiating activities will come to an end.

By the end of 1963 the research program of the Pan American Health Organization encompassed 38 projects, for which 12 agencies had provided funds amounting to $1,857,000. The Institute of Nutrition of Central America and Panama and the Pan American Foot-and-Mouth

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80 Official Document PAHO 54, 22-23.
Disease Center account for most of the money spent and most of the research carried out.

Viewed as a whole, the projects are in keeping with the policy outlined by the Advisory Committee on Medical Research and approved by the Governing Bodies. The policy is aimed at solving problems related to health in ways that will promote human well-being. The research projects are of great importance for Latin America and involve international cooperation. The information obtained will also be valuable for other regions of the world, provided that the cultural traits of different societies are taken into account.

Today there is a better understanding of the role of the Pan American Sanitary Bureau in the field of research and, as was to be expected, it resides primarily in two fields: (a) promotional, by means of an analysis of public health problems in the Americas, which results in an exchange of information and experience between distinguished investigators from the Hemisphere and, on occasions, from other regions of the world, and by means of visits to institutions dealing with specific problems, fellowships for potential scientists, and the distribution of scientific information; (b) operational, in which the Bureau carries out programs that are international both because of the nature of the problem involved and because several countries take part in the program. Good examples of the latter are the inter-American investigation of mortality and the use of modified live virus against foot-and-mouth disease. It is hoped that for the promotional activities it will be possible to obtain funds from the regular budget of the Organization in the years to come. The importance of this undertaking is illustrated by the fact that up to December 1963 the Bureau had had the priceless collaboration of 141 distinguished experts from the Americas. Nevertheless, we would like to see a continuous expansion of the program which the Pan American Sanitary Bureau is carrying out with funds provided by various public and private agencies.

A characteristic need of Latin America today is a
study of how to apply proven knowledge in order to solve certain problems within the framework of the cultural patterns of each society. What are called "operational studies" have acquired particular relevance in the Hemisphere because they make it possible to define targets for the solution of specific problems. These studies bear on the application of biological and administrative methods to enable the results of research to be placed at the service of mankind.

Possibly the most important method for obtaining the objectives of the Charter of Punta del Este, both in practice and in potential, is development planning and the planning of each of the sectors involved in national development, among which is the health sector. In little more than two years the idea of planning has come to be more and more accepted by ministries of health. It is to be seen in the interest shown in drawing up plans, in enacting or amending pertinent legislation, in setting up planning units in the ministries, and in establishing administrative links between these units and the national development planning boards. At the same time it has been necessary to train planners and to develop a method for framing local and national health plans. The Pan American Sanitary Bureau has been active in this field since the Charter was first signed. This is exemplified by the two courses held jointly with the Latin American Institute for Economic and Social Planning in Santiago, Chile, and by our participation in the course on planning held in Venezuela and in the course at the Johns Hopkins University School of Public Health. Furthermore, outstanding technicians on the staff of the Center for Development Studies (CENDES) attached to the Central University of Venezuela in Caracas, of the Ministry of Public Health and Social Welfare of Venezuela, and of the School of Public Health of that country, together with Organization consultants, have prepared a document dealing with conceptual and methodological problems of
health planning which is being revised with a view to publication. The method it proposes has been tried out in various areas in the Hemisphere and was used in drawing up the first national health plan in El Salvador.

Advisory services have been given to several countries on various aspects of the formulation of health plans. These activities have brought to light both the complexity of this task and its potential value both for the country and for international organizations. They gave a clear indication of where planning techniques need to be improved and where research needs to be carried out, and disclosed the difficulties in the way of putting any plan into action and of attaining pre-established targets, difficulties which arise essentially from deficiencies, common in both local and national health services, in applying technical standards and administrative procedures. Of no less importance in this matter is the fact that vital and health statistics are incomplete, which makes it very difficult to use them to assess the real facts of the situation, to determine the prevalence of problems and the priority to be given them, to set up targets, to evaluate results, and to revise programs in the light of the progress made. It is clear that there is an urgent need to measure the capacity of existing resources, both in personnel and in supplies and equipment, which knowledge is useful in drawing up a sound plan and checking its implementation.

It has also become clear that it is necessary to intensify the dialogue between experts in the various disciplines that are components of social well-being, who up to the present have been working independently. In short, 1963 has shown the importance and complexity of health planning, but it has also brought further advances based on solid foundations. This effort should continue until each country can channel its resources into activities aimed at the solution of the most prevalent problems at the lowest cost, in an integrated system of preventive and curative measures. Meanwhile, projects to deal with problems that are fundamental both in the Hemisphere and in each
country in particular must be expanded, as must be the instruments needed to solve them, among the most important of which are education and training. It has been said on more than one occasion, and it still holds true today, that planning is not an end but a means of facilitating the investment of efforts and funds for the common good.

The program of administrative rationalization, which has been under way in the Pan American Sanitary Bureau since 1959, was continued in 1963. The term “to rationalize” has many meanings, one of which is to apply scientific principles of administration to an undertaking. It is efficient organization for the purpose of obtaining certain objectives, of increasing output, but of reducing costs. Among the methods used is mechanization. Since the program was put into practice, the number of personnel has been reduced by 57, which up to 31 December 1963 had resulted in savings amounting to $434,000. This amount has been invested in direct services to Governments. In our opinion this policy should continue insofar as it is useful for accomplishing the purposes of the Organization. It must be pointed out, however, that in every institution administrative practices, which are a means and not an end, are meant to allow the fullest possible benefit to be derived from knowledge and experience; in our case it is the health of the peoples of the Hemisphere.

The construction of the new headquarters building of the Pan American Health Organization was begun on 18 September 1963, and it is expected that the building will be completed in mid-1965. The W. K. Kellogg Foundation has given the Organization the necessary funds in the form of a generous non-interest-bearing loan to the Governments of 5 million dollars, which is to be paid off in the form of health programs over a period of 20 years.
In keeping with the repeatedly stated wishes of the Governments, the Pan American Sanitary Bureau continued to maintain close relations with other international organizations, governmental or private, whose common purpose is to serve man both as an individual and as a member of society. The Organization of American States, including the Executive Secretariat of the Inter-American Economic and Social Council and the recently established Inter-American Committee of the Alliance for Progress; the W. K. Kellogg and Rockefeller Foundations; the Milbank Memorial Fund; the Agency for International Development of the United States of America; the United Nations Children's Fund; the United Nations Food and Agriculture Organization; and others, stand out among the organizations with which close working relationships have been maintained.

Concerning measures for fulfilling the health objectives of the Charter of Punta del Este, the Ministers declared in their meeting in April: “Their execution will mean greater well-being; failure to carry them out may lead to discouragement or frustration.

“In the field of health this veritable challenge takes on the most tragic proportions. The motivation exists or is latent; it can only be intensified or stimulated by concrete activities of such scope that they will bring home to the people both the magnitude of the effort and the basic fact that health is a good the conquest of which will enable them to attain their aspirations. In that conquest, man is the protagonist and the only beneficiary of development.” 31

This is the task to which we are dedicated and these the aims we seek to attain.

31 Ibid., p. 42.

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