SPECIAL MEETING
OF MINISTERS OF HEALTH OF
THE AMERICAS

Buenos Aires, Argentina
14-18 October 1968

FINAL REPORT AND
SPEECHES

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

1969
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PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
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INTRODUCTION

The Special Meeting of Ministers of Health of the Americas, convoked by the Director of the Pan American Sanitary Bureau pursuant to Resolution XXXVII of the XVII Meeting of the Directing Council of the Pan American Health Organization, XIX Meeting of the Regional Committee of the World Health Organization for the Americas, was held in Buenos Aires, Argentina, in the Edificio de Congresos, Teatro San Martín, from 14 to 18 October 1968.

The Inaugural Session, held on 14 October, was attended by His Excellency, the President of the Republic of Argentina, Lieutenant General Juan Carlos Onganía, as well as by other high officials of the Government, and by the Ministers of Health of 26 countries or their representatives.

Dr. Ezequiel A. D. Holmberg, Minister of Public Health of Argentina was elected President of the Meeting, and Dr. Francisco Urcuyo Maliaño (Nicaragua), and Dr. Maxwell P. Awon (Trinidad and Tobago) were elected Vice-Presidents.

The Meeting held six plenary sessions, during which most of the Ministers presented summaries on the health programs being carried out in their respective countries. Detailed printed reports were also made available by the Ministers for distribution to all the participants.

Two Technical Committees were established, which were responsible for making an exhaustive study of all the items included in the agenda. Each Committee elected a Chairman and two Vice-Chairmen, who had the assistance of the Technical Secretaries appointed by the Director of the Pan American Sanitary Bureau. The Rapporteurs of each Committee, appointed by the respective Chairmen, were responsible for the compilation of the recommendations made during the debates, which in turn were delivered to the General Rapporteur for the purpose of incorporation into the Final Report of the Meeting.

The working documents that served as a basis for the discussions of the Committees have been published in *PAHO Official Document 90*.

The present volume contains the Final Report of the Special Meeting of Ministers of Health, the addresses delivered by the Ministers, the complete list of participants, as well as the list of officers and the agenda.
Final Report
SPECIAL MEETING OF MINISTERS OF HEALTH OF THE AMERICAS

Final Report

1. ANOTHER PHASE IN THE HISTORY OF HEALTH IN THE AMERICAS WHICH IS DRAWING TO A CLOSE—SOME BACKGROUND INFORMATION OF INTEREST

From 15 to 20 April 1963 the Task Force on Health, composed of the Ministers of Health of the signatory countries of the Charter of Punta del Este, or their representatives, met in Washington, D.C. The topics discussed at that meeting and the general and specific considerations which, together with a summary of each problem, served as a frame of reference for the recommendations approved, were presented in a special publication issued by the Pan American Health Organization.

The significant views it contained on the role of health activities in economic and social development in the Americas, on the principal health problems of the Hemisphere, and on the criteria for establishing priorities for their solution; its objective analysis of present and future prospects; and lastly, the Final Declaration of the Ministers—have not lost their topicality. On the contrary, later important events have endowed them with a permanence and validity implicit in their origin and development.

Since the holding of the First International Sanitary Convention in December 1902—the date of the establishment of the Pan American Sanitary Bureau—the meeting of the Task Force was the first occasion in this century on which the highest health authorities had come together to discuss purely technical matters of major importance. Perhaps at no other time has the significance of man, as the synthesis of all the efforts of society, been more remarkably demonstrated. Those who could speak with authority emphasized the humanitarian purpose of economics as a science at the service of man.

Nor had there been in the Americas or in this century, a more appropriate occasion for giving expression to a sense of common purpose by recognizing health activities as a fundamental component of progress and economic development.

In his preface to the Final Report of the Task Force, the Director of the Pan American Sanitary Bureau was right in describing it as historic. He was also right when, in quoting the following paragraphs from the Final Declaration, he referred to it as not merely an expression of faith but also the answer to the basic question which the Task Force had met to deal with, namely, could the Ten-Year Public Health Program of the Alliance for Progress be put into practice?

From this analysis, we have concluded that the Ten-Year Public Health Program of the Alliance for Progress 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.

From 12 to 14 April 1967 most of the Presidents of the American States and the Prime Minister of Trinidad and Tobago met in Punta del Este (Uruguay) for the express purpose of giving more dynamic and concrete expression to the ideals of Latin American unity and of solidarity among the peoples of the Americas which inspired the founders of their countries.

The auspicious outcome of their common and fraternal effort was the proclamation of their decision to achieve to the fullest measure


2 Ibid., p. vi.
the social order demanded by the peoples of the Hemisphere, through the creation of a Common Market; the economic integration of Latin America; the increase of foreign trade earnings; the modernization of the living conditions of their rural populations; the raising of agricultural productivity and increase in food production for the benefit of both Latin America and the rest of the world; the promotion of education for development; the harnessing of science and technology for the service of their peoples; and the expansion of programs for the improvement of health.

In their Declaration, the Presidents recognized that improvement of health conditions is fundamental to the economic and social development of Latin America; reaffirmed once more the principles of the Charter of Punta del Este; and gave implicit and full support to the recommendations of the Task Force on Health at the Ministerial Level.

Commenting on this Declaration at the Fifth Annual Meetings of the Inter-American Economic and Social Council at the Expert Level and the Ministerial Level (Viña del Mar, Chile, 15-24 June 1967), the Director of the Pan American Sanitary Bureau rightly said:

In their momentous Declaration the Chiefs of State recognized the fundamental role of health in the economic and social development of Latin America.

In reaffirming the goals of the Charter of Punta del Este (1961), the Chiefs of State enumerated a set of specific objectives and called upon the Pan American Health Organization to cooperate with the Governments in drawing up programs to achieve them.

In view of the foregoing, the XVII Meeting of the Directing Council of the Pan American Health Organization (October 1967) adopted Resolution XXXVII, which commended the Ministers of Health and the Director for the steps taken to comply with the mandate agreed upon at the XVII Pan American Sanitary Conference; expressed its satisfaction with the full recognition given the health sector in the Declaration of the Presidents of America; resolved to incorporate into the policy of the Organization the proposals in that document that were directly or indirectly related to health; and accepted with deep gratitude the task entrusted to the Organization of collaborating with the Governments in preparing specific programs relating to the health objectives set forth in the Action Program approved by the American Chiefs of State.

The Council also expressed its thanks to the Government of Argentina for its kind offer to be host to the Special Meeting of Ministers of Health of the Americas to be convened in Buenos Aires immediately prior to the XVIII Meeting of the Directing Council for the purpose of discussing and drawing up a plan of operations for implementing the decisions adopted by the American Chiefs of State; recommended to the Ministers that they invite representatives of other health institutions in their countries to attend that meeting; and authorized the Director of the Pan American Sanitary Bureau to take the pertinent steps to convene and organize the meeting.

II. AN OVERVIEW OF HEALTH ACTIVITIES IN THE LAST DECADES OF THE CENTURY

HEALTH PROBLEMS IN THE AMERICAS—GENERAL PICTURE

At the April 1963 Meeting of the Task Force, the Ministers of Health, after a full discussion of the principal health problems of the Americas, declared:

We have interpreted the purposes of the Charter of Punta del Este as a cooperative effort to stimulate the social progress of Latin America concurrently with, and as the outcome of, a sustained growth of the economy. As to health problems as such, we conceive of them as the aggregate of factors that condition diseases and their distribution in each society. These are factors of a biological, economic, historical, and

cultural nature. Available data show that Latin America is beset by infectious diseases, undernourishment, poor sanitation, unhealthful housing and working conditions, illiteracy, lack of proper clothing, and a low per-capita real income. These factors together produce a high general mortality, as well as a high mortality in children, especially those under 5 years of age (more than 40 per cent of all deaths), and accidents of pregnancy and motherhood which limit life expectancy at birth; they are also responsible for the poor scholastic performance of many schoolchildren, for low productivity, not to mention a pessimistic outlook on life. The distribution of these problems among the countries varies, as it does among parts of the same country, and between the cities and rural areas.

It is a well-known fact that qualified professional and auxiliary personnel are insufficient in quantity and quality. The funds available for the material resources required to promote and protect health are also insufficient. Priorities must be established to ensure that investments in health give the best possible returns and benefit as many people as possible. The data available, which have improved both in quality and in quantity in the last five years, show that the above-mentioned problems still persist, although there is a clear tendency for their frequency and seriousness to diminish. The variations within each country and between countries also persist.

No significant changes have occurred in the technologically advanced countries in the incidence of common communicable diseases other than that of measles, which is declining wherever systematic immunization programs have been instituted. On the other hand, there is an upward trend in the incidence of chronic respiratory and industrial diseases and new diseases due to the introduction of chemical processes in industrialization have appeared, as have iatrogenic diseases. Accelerated migration from the countryside to the cities—which in some countries involves 5 per cent of the total population—has led to the mushrooming of shanty towns around the large cities with serious concomitant health problems. These shanty towns are veritable foci of social unrest, and have come to be called foci of the "ruralization" of the urban environment. To a large extent they are the most visible negative expression of the serious imbalance between needs and resources that is the hallmark of large cities. The same phenomenon has also been occurring with comparable intensity in the technologically more advanced countries and areas of the Hemisphere. The most serious social conflicts are frequently occurring in the shanty towns as well as in the rural areas.

However, the five years since the Meeting of the Task Force on Health have witnessed the burgeoning in the Americas of a spirit that is breathing new life into old patterns and obsolete structures; an increasing willingness to meet social aspirations; a recognition—not only in words but also in the law and its application—of the right of every human being to a minimum degree of well-being, regardless of his social class, religion, or genetic origin. Life has quickened its pace and become more demanding, and demands far exceed the resources and the capacity of institutions to satisfy them.

POPULATION DYNAMICS

The study of the most varied problems has brought to the fore the question of population growth in relation to economic growth and to services for satisfying vital needs.

One of the distinctive features of the period under review is the debate on population dynamics and its consequences for well-being. Latin America and the Caribbean area have the highest annual rate of population growth in the world. It ranges from 3 to 3.5 per cent per annum in most countries.

In view of the importance of the question, the diversity of views on how to solve it is only to be expected. In any event the discussion has been very valuable in clarifying concepts and suggesting courses of action, that is to say, in developing a "policy."

There are individuals who, from religious or scientific conviction or because of a policy decision taken at the highest level, do not accept any deliberate interference with the size and normal structure of the population. They insist that the number of children in a family is the exclusive decision and responsibility of the parents. Nevertheless, they accept various types of legal measures designed to encourage genuine responsible parenthood; this step must help bring about a positive change in the structure of society whereby income and services are geared to the social nature of the population, whose basic unit is the family.

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At the opposite extreme are those who believe that it is urgently necessary to moderate the accelerated growth of the population in order to bring it into line with the growth of resources, to lighten the burden of the present generation, and to guarantee the future of generations yet unborn. For them family planning is an end in itself, and the more quickly it comes into general use the better the outlook for society; to spur on development, it is first necessary to limit the unrestricted growth of the population.

For the eclectics there is no antinomy between population growth and development. On the contrary, population growth and development complement each other. The essential thing is to stimulate development and well-being by all the means available to science, technology, and economics, and thus satisfy social aspirations. From the standpoint of health, family planning is one means, among others, of solving specific problems such as induced abortion or of aiding in the treatment of certain chronic diseases. Furthermore, if the population policy so provides, it may be included among the means for solving problems of social importance.

At sessions of the World Health Assembly and in the meetings of the Governing Bodies of the Pan American Health Organization, the Governments have established the principles and guidelines of that policy. Their basis is respect for the decision of parents arrived at without coercion or influence. It is the exclusive right of every couple to decide how many children they want. Therefore, if parenthood is to be responsible, the education of parents must be strengthened. In order to make such a decision, each couple is entitled to be fully informed of what it entails. It is up to the State to decide how it will provide that information and what measures it will take to enable each couple to make its decision.

Some Governments of the Americas have defined their policy and have applied it either in demonstration projects or throughout the country. Others have not yet taken a decision on the matter, although they recognize that among the questions that have characterized the period that has elapsed since the signature of the Charter of Punta del Este, this is a fundamental issue.

HEALTH AND DEVELOPMENT

The highest political authorities of the Hemisphere have recognized that health activities are essential to economic and social development in the Americas. By so doing they wished to emphasize the importance of health activities for production and productivity and for reducing environmental hazards and promoting the exploitation of natural resources. This interpretation in no way detracts from the moral significance of individual and collective health as a good for each person and society.

On the contrary, this spiritual conception draws strength from the recognition of the importance of health activities for development, in that they contribute to life in common and to the orderly functioning of communities. It therefore follows that national and regional health programs should be incorporated into general development plans, as early as the preinvestment phase. This is a reasonable proposition, and its implementation, although complex, is feasible, and, what is more, unavoidable. Since the political emancipation of the countries, progress has been made up and down rather than across the Hemisphere. Possibly, such factors as geography and geopolitics have contributed to the enormous disparity in development between the countries of North America and those of Latin America and the Caribbean area and to the latter's isolationism.

In recent years proposals have been made for concerted action which, while respecting national sovereignty and national interests, provides each country with a share in the benefits that can derive from regional and multinational programs. Examples are infrastructure projects that have facilitated an increasing exchange of ideas, persons, and goods throughout the length and breadth of the Americas; such are the highways traversing

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7 World Health Organization. Program of activities which can be developed by WHO on health aspects of world population (Resolutions WHA18.49, 1965; WHA19.43, 1966; WHA20.41, 1967; and WHA21.43, 1968).

several countries, the development of river basins, hydroelectric projects, and telecommunication systems. Some are being constructed, others are in an advanced stage of planning. A conspicuous example of the first is the Marginal Jungle Highway which will extend through Peru, Ecuador, Bolivia, Colombia, and Paraguay; and of the second, the program for the over-all development of the River Plate basin, in which the Governments of Argentina, Bolivia, Brazil, Paraguay, and Uruguay are taking part. Regardless of their nature, they all are multidisciplinary projects in the sense that they call for very varied experience which must be integrated from the time of the preliminary studies for formulating the project, during its execution, and, subsequently, in its maintenance. Each of these undertakings shows how necessary it is for a scientific and intellectual community to be established beforehand in the Americas and to serve as support to the economic community. We therefore need a development university that will produce not technocrats but cultivated men of vision.

As has been said, the prevention and early treatment of diseases must be part of any development project as early as the preinvestment phase. They should also be part of it throughout its course and should be adapted to its changing circumstances and conditions. The problems inherent in the magnitude and consequences of such projects must be recognized, and those that may arise as activities advance and progress is made must be foreseen. There are unexplored areas in the Americas whose present or potential ecology must be determined; for in due course they will be included in some facet of this great enterprise of cultural and economic rapprochement to which the Governments of the Americas have pledged themselves. It is up to public health workers, in close cooperation with all other persons having definite responsibilities in each program, to avert the risks of disease and death either by direct action, according to the nature of the problem, or by indirect action, by modifying unfavorable environmental conditions. Simultaneously, it is necessary to define the reciprocal influences within each project for the benefit of individual and collective health. We must recognize that our experience in multidisciplinary projects of this type is still very limited. Nevertheless, it is essential that we acquire it because of the importance of the ends in view.

**INTRAREGIONAL TRADE**

Measures for improving Latin American intraregional trade have been defined. They are of great importance for health protection, promotion, and restoration activities. They are important, of course, because they lead to an increase in national wealth for proportionate distribution among activities which are the responsibility of the State, including health activities. They are also important because they lead to an increase in the power to purchase goods and services. Of equal importance are their direct consequences for the relationship between economic and health activities. Health activities are so diversified that they enter into virtually all major development investments, as is shown by programs for the construction of health facilities; for the provision of increasingly complex and costly equipment; for the feeding of the sick and the population at large, in particular children; for the supply of drugs and medicaments; for the transportation of men and materials; for the training of professional, technical, and auxiliary personnel. Taken together, they represent in terms of public and private investment a significant proportion of the economy of a country.

In the matter of increasing intraregional trade, special reference must be made to the quality control of drugs and of reagents, of processed foods or foodstuffs for export, and of a whole series of products for use in hospitals and other establishments. It is urgently necessary to set up quality control procedures both in the exporting countries and in the importing countries. They must be based not only on an analysis of the composition of samples of each substance or preparation, but also on a detailed knowledge of the process of industrial production. With respect to drugs and medicaments, it is essential to speed up the implementation of the resolutions of the World Health Assembly and of the Directing Council of the World Health Organization. Drug quality control (Resolution WHA21.37, 1968).
Meeting of Ministers of Health

of the Pan American Health Organization, which recommend the establishment of international centers for the training of technicians and for research on methods of analysis. Both measures represent a rational approach to the problem.

COMMON MARKET IN LATIN AMERICA

It has been decided to establish a Latin American Common Market and to set up the necessary institutional framework for it. It is clear that, as progress is made toward the economic interdependence of countries, industrialization and intraregional trade will increase; modern technology will lead to more diversified production; progress will be made in the development of geopolitical regions; the need for more and better professional workers will be felt; and it will be possible to spell out the health activities for dealing with regional problems.

It will be for the Governing Bodies of the Pan American Health Organization to study, decide, and approve in due course the technical, legal, and other instruments that will make the above-mentioned activities possible.

EXTERNAL CAPITAL

Another distinctive feature of the period since the 1963 Meeting of the Task Force on Health has been the decision of the Governments to seek external loans with which to supplement domestic funds and thereby accelerate the solution of certain health problems. Those problems affect a large number of people or are prevalent in areas essential to national development. These loans, in addition to stimulating development, help to improve health and living conditions. The Inter-American Development Bank has established a health loan policy; it defines the programs for which loans can be made from the Fund for Special Operations. With the consent of the President of the Bank, the Pan American Health Organization sent a statement of that policy to the Ministers of Health. It reflects the experience of the Bank, which envisions the development of the Americas as a harmonious process of economic growth and social welfare. Its work has been outstanding and, insofar as it has established a health loan policy, completely original. Noteworthy among its social investments, among others, are those for water supply and sewage disposal programs; medical and health education; the construction of university hospitals; and the control of foot-and-mouth disease to prevent the loss of proteins essential to the population, especially children.

Funds for the construction and equipping of hospitals have been provided by certain European countries; for water supply services by Canada; and for malaria eradication, sanitation services, rural health units, to cite only the most important, by the United States of America.

We hope that this trend will continue and grow stronger, for the work accomplished has awakened in communities with similar problems an interest in contributing manpower, money, and materials. The Governments of the Americas are aware of the urgent need to satisfy the basic needs of the population, in tune with the cultural and natural resources of each country and of the Hemisphere as a whole. Development must be rationally planned, and it must be achieved without delaying the fulfillment of the aspirations of the people, for the end in view is true distributive justice.

By and large, present investments are not commensurate with the magnitude of health problems. Because of this, some countries are seeking new sources of financing from domestic sources. In any event, they are aware that there are considerable possibilities of treating a larger number of the sick and of providing more persons with health care if the resources available are rationally used. In each country there are suggestive differences in the cost of the same service depending on whether it is provided by public, private, or independent institutions. This fact points to the clear need for the installed capacity to be used more efficiently. Nevertheless, the growing social need and the justice of the demand of the


population for health services is spurring the authorities to increase investments.

**PRODUCTION OF FOODSTUFFS**

There are clear possibilities in the Americas for increasing the production of foodstuffs to satisfy the growing needs of its peoples and those of other regions of the world. At present, production is insufficient in both quantity and quality. There is no correlation between the needs of the inhabitants and the needs of the economy, nor between food exports and food imports. Furthermore, there is much food wastage, due to improper storage, destruction by rodents and insects, and a number of preventable animal diseases, some of them zoonoses. In addition, there are difficulties in the timely distribution of foodstuffs because of lack of roads and transport facilities. Finally, mention must be made of the low purchasing power of certain segments of the population and of harmful food habits that are part of their culture.

This statement of the most important factors involved in the food and nutrition problems in any society reveals the complexity of these problems; the inevitably multidisciplinary nature of their solution; and the importance of the functions to be undertaken by health services. It is urgently necessary for all the countries of the Americas to delineate an agricultural policy which provides for the systematic solution of the above-mentioned problems so as to guarantee their population an adequate level of nutrition and at the same time satisfy the needs of economic development. Unless that is done, it will be very difficult for health workers to fulfill their mission, that is, to prevent nutritional diseases, to provide the sick with early treatment, and to promote the physical and mental growth of children and the productivity of adults. As a result of scientific research, progress has clearly been made in the diagnosis and treatment of nutritional diseases. But no such progress has been made in preventive activities, because of lack of knowledge of the availability of protective and energizing foodstuffs with which to satisfy the vital needs of each population. This lack is related to the absence of an agricultural policy guiding national production in which proper consideration is given to the foodstuffs for consumption, for export, and for import.

Nothing reflects the urgency and the seriousness of the problem better than infant mortality and the mortality in children under 5 years of age, which continues to be high in the less developed areas of all the countries in the Americas. Available information shows that if the average mortality rate in Latin America and the Caribbean area were the same as that in the United States of America and Canada, 741,000 fewer children would die each year in those two regions. A high proportion of those children die as a result of protein-calorie malnutrition, on which are imposed infectious diseases, ignorance, insanitary conditions, and lack of medical services. Some of these shortcomings and environmental hazards can be better withstood by well-nourished children. The possibilities of social and economic progress depend not only on the number of children that are spared a premature death but also on those who are capable of becoming productive members of society.

It would appear that there is a correlation between living conditions and the mortality of preschool-age children, for when the former are improved, the latter diminishes. However, there is some evidence that, as social and economic conditions improve, the risk will be shifted to younger age groups, the result *inter alia*, of urbanization, working mothers, the decline in breast feeding, and earlier age of weaning. Recent research points to a possible direct link between malnutrition and mental retardation. If it is confirmed, the problem will assume unusual gravity and require absolute priority. Mention must be made of the studies on this problem being carried out by the Institute of Nutrition of Central America and Panama (INCAP). Furthermore, the influence of chronic malnutrition on physical and mental work output and on feelings of pessimism and hostility should not be overlooked. In the near future, perhaps the objective of malnutrition prevention programs will be the achievement of an optimum nutritional status for the largest possible number of children and thus the realization of all the genetic potentialities, both physical and mental, of the individual.

Because of their importance for health, for
the economy, and for development in general, mention must be made of certain animal diseases which may or may not affect man but which substantially reduce the availability of essential proteins. The problems they cause make close collaboration essential between ministries of health, of agriculture, and of finance. Those problems, which are biological in nature, influence agricultural policy and require for their solution the mobilization of a great deal of national resources and the aid of external capital.

Because of their high incidence in Latin America, we will cite foot-and-mouth disease, bovine tuberculosis, rabies, brucellosis, and parasitic diseases of animals. Procedures for the control of each of these diseases are available, and although they are not completely effective they do make it possible to reduce the incidence of the disease and to prevent the loss of protein. Programs for the control of animal diseases are based on the same principles as those for the control of human diseases. In the present situation in Latin America such programs could possibly become self-financing. It is the policy of both the Inter-American Development Bank and the World Bank to grant loans, under certain conditions, for animal disease control programs.

These circumstances have given a new dimension to the work of the Pan American Foot-and-Mouth Disease Center and the Pan American Zoonoses Center in rendering advisory services to Governments, training specialists, and undertaking research on diagnostic methods and prevention.

LIFE IN THE RURAL ENVIRONMENT

A further distinctive feature of this period has been the growth of awareness of the rural environment, in which more than 100 million persons live in the Americas. It has been recognized that for generations rural dwellers have remained outside the mainstream of progress. They have been nurtured on an alternating diet of promises and disillusionment. Their spiritual resources have been unappreciated, and they have been stigmatized as lacking in initiative, as irresponsible, and as dependent on state aid. Fortunately, that accusation has been disproved by the facts. Where rural dwellers have been motivated to carry out community works, their responsibility and disinterested collaboration have exceeded by far what was expected. They draw upon their ancient tradition of cooperative work and effectively contribute to the well-being of others. That has been clearly demonstrated in rural sanitation programs, which, with others, are the best reply to those who have voiced negative opinions. But the work already done is only a small part of what must be done for those who still expect and call for equal benefits.

For that reason the decision to modernize rural life is a wise one, and its gradual implementation is essential. It is enough to point out that mortality rates are three or more times higher in the countryside than in the cities.

On the basis of historical observation of the development of industrialized countries, it is considered by some that migration from the countryside to the city is an inevitable phenomenon. But the rural environment is changing and one might question what proportion of rural dwellers that migrate to the city in developing countries would have abandoned the countryside if their needs had been satisfied and their agricultural vocation respected. We recognize that industrialization is advancing in Latin America and in many other regions of the Hemisphere. We further recognize that, in the developed world, advances in agricultural technology have reduced the size of the labor force required. However, in every society part of the population must devote itself to agriculture and the Americas are no exception to this rule. We believe that agriculture will remain a major sector in the economy of the Americas until the end of this century. It is therefore essential to accelerate the modernization of rural life, including the health services that are essential to it.

PLANNING

In the Charter of Punta del Este, the signatory Governments agreed that planning was an instrument for establishing priorities in an objective manner, for increasing the output
of available resources, and for making investments to achieve measurable objectives. The World Health Assembly, the Pan American Sanitary Conference, and the Directing Council of PAHO have decided to make health planning part of the policy. For planning is a means, not an end; a process, not an endpoint; a path of action, not a terminus. The method used in preparing the plan is of no importance. The essential thing is the decision to draw up a plan and the achievement of its objectives. The method used will depend on the general and specific purposes pursued in formulating the plan. Once the policy decision has been made, the plan should ideally be as inclusive as possible, covering at least the health problems which affect most of the population and for whose protection the necessary knowledge and resources are available. Experience so far has shown that lack of continuity or changes in form and content have perhaps been the major obstacle to or the major constraint on planning.

During the period that has elapsed since the Meeting of the Task Force, progress has been made in health planning as a separate activity of ministries of health, and the need for planning has been further recognized. Considerable efforts have been made in the health sector, although all the health investments of a country have not been included in the national health plans. Nor has there been any realistic correlation with economic and social development plans where they exist, although a correlation between budgets and programs has been worked out. This situation is due in large measure to the absence of research that would make it possible to determine in each country and in each of its development areas the reciprocal influence of the various sectors composing the national development plan. While this positive relationship can be demonstrated in economic activities, it is not always easily demonstrated in social and particularly in educational and health activities.

The failure to incorporate health plans into national development plans is reflected in the paucity of the investments flowing from the policy decision. Although man has been recognized as "the protagonist as well as the beneficiary of all development," his actual contribution to the growth of the economy, to progress, and to well-being is ignored or underestimated by some. Those who think along these lines believe that funds devoted to education and health are not a true investment but an expenditure, that they are not "reproductive" in the economic sense. In education, professional productivity can be measured in terms of university or technical training plus experience. There is a true economic theory of education. Such a theory has not yet been established for health but we hope that it will be, for the bases and rationale are fully comparable to that of education. Attempts have been made to express the value of health in terms of the cost of sickness and the prevention of disease. So far no such attempt has been made to appraise the improvement of the physical environment by techniques that are part of health activities. A study of this nature would show that the funds devoted to that general purpose are a true investment.

Planning at present under way has already brought visible benefits, but it has uncovered weaknesses in the organization and administration of health services. We will refer to them later on. Nevertheless, there is an awareness of the value of planning as an essential tool for establishing realistic priorities in the use of health resources. The Governments have decided to continue to formulate, evaluate, and periodically adjust health plans and, insofar as possible, to correlate them with economic and social development plans. The experience gained so far shows that planning cannot be conducted in a vacuum, isolated from the realities of human existence. Therefore, both the "providers" and

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12 World Health Organization. Methods of project planning and execution (Resolution WHA18.37, 1965).


the “consumers” of health services should actively participate in it. The better informed the latter are, the greater their understanding and the deeper their perception of health problems, the factors conditioning them, and the circumstances under which they arise. The “consumers” should come from the most diverse segments of the community, from the rural areas, the shanty towns, and communities whose environmental conditions are to be deplored. It is difficult to identify leaders among such groups and to induce them to take an active part in planning and reviewing. The problem is one of communication in the health field and is by no means unique. We must solve it if we wish health plans to truly meet the most urgent needs and if the persons for whom they are intended are to obtain the maximum benefits from the opportunities offered by the programs. The more we take into consideration the value which our societies attach to their health needs and the way they view them, the more possible it will be for us to satisfy them.

At the same time the need has become clear for a multinational approach to certain activities, for coordination of the work of institutions of several countries in order to achieve common goals. These are true regional, multidisciplinary programs in which emphasis is put only on aspects deriving from geopolitical-social characteristics. The health sector is being incorporated into this type of regional programming.

ORGANIZATION AND ADMINISTRATION

There are still extensive areas in the countries of the Americas whose population is without basic health services. At the same time—a fact that will appear paradoxical—there is wastage and defective utilization of available resources. Although this situation has existed since the founding of each country, it has clearly been aggravated in recent years by a population growth out of all proportion to health investments; by the social demand stimulated by the transistor radio, by word of mouth, and by the sight of the goods which others enjoy; by currents of public opinion and by promises whose fulfillment the course of events at times frustrates. This explains the interest of Governments in establishing priorities and thereby obtaining better and greater social effects from the funds available. There is no antinomy between improving the quality and quantity of the services rendered in existing institutions and increasing the coverage, especially in rural areas. These are ways of achieving a goal that should be universal: health as the inalienable right of every individual.

The American nations have become aware of the importance of organization and administration as an essential tool for preventing and curing diseases and promoting health. Organization and administration are indivisible; without the one the other cannot exist. The purpose of organization and administration is to ensure that programs achieve their objectives. As has been repeatedly said, they are a means not an end, for the end is the health of the people, the prolongation of life and the prevention of disease or, if it occurs, the limitation of its spread.

In the last five years marked progress has been made in improving administrative principles, practices, and procedures in health services in the Americas. Within the framework of national legislation it has been possible to improve systems of public administration by training civil servants in universities or by providing in-service training; by adopting modern methods, including computerization in some countries; by organizing seminars and workshops to enable the technical personnel of several countries to exchange experiences; and, finally, through the provision of international advisory services.

The results are visible, and they are to be seen in departments and sections of the health ministries or other State institutions with similar purposes. Emphasis on administrative reform has been greater in central than in regional and local government agencies. The field is therefore still wide open for the modernization of administration to the end of improving the performance of technical personnel and their working equipment.

Experience has shown the need for what is called “operational research.” It had its origin in military operations in the last war and in large-scale industry. By analyzing the various factors involved in producing a given effect it is possible to ascertain the value of each and the most appropriate combination to achieve given
objectives. In health there is a wide field for operational research, the end in view being the rechannelling of resources according to their potential effects and their availability. Because of these characteristics operational research can be applied to very specific situations either in an institution or in a health department or program. Generalizations can only be made with respect to its principles and methods, but no assurance can be given as to its equal effectiveness in solving similar problems. In short, operational research is a valuable method of improving the organization and administration of health services. Its use is recommended, but its limitations must be borne in mind.

The modernization of rural life must lead to improved living conditions for communities, families, and individuals. The need for health services is clear from the general and specific mortality rates in rural areas, which are two or three times higher, for the same causes, than those of urban centers. With few exceptions, our knowledge of the dynamics of rural society is incomplete. We know that there is a tendency for rural dwellers to migrate, a matter we have already touched on. We know that work in rural areas is sporadic, with long periods of idleness. We are aware of the effects of inadequate land utilization and unfair systems of land tenure on the life of rural dwellers, their motivations, and their value judgments. People speak of rural population as being concentrated or as being dispersed, using conventional definitions rather than realistic ones. But such characteristics only provide a very general description of those societies. We do not have enough objective information about them to enable us to pinpoint their problems and apply specific solutions. For us modernization means applying modern technology without impairing the way of life of a community. Furthermore, it means seeing the process of modernization as a whole, with its own dynamics, in which the solution of problems is attempted in an integral way, with the active and conscious participation of the inhabitants. This is the cardinal factor of a rural welfare policy. What is certain is the worth of the beneficiaries of such a policy and their willingness to work for the common good, as we mentioned earlier.

In health work there are no standard formulas for solving the diversity of the problems to which the geopolitical-social conditions of each rural society give rise. It is a matter not merely of increasing health service coverage but of organizing it with the conscious support of the population, priority being given to their most manifest needs and to satisfying them with the aid of properly motivated and technically trained auxiliary workers. The task is an urgent one, but the possibilities of success are also great. However, through direct action by ministries of health or through coordinated efforts with ministries of agriculture, public works, etc., health must be incorporated as a social function into all projects for the modernization of rural life.

Planning, to which we have already referred, has pointed up the weakness of administrative structures and methods. The formulation of program budgets—the practical expression of the plan—has shown the disassociation between the specific objective and its attainment. If administrators do not work hand-in-hand with technical staff, there is no possibility of achieving the anticipated benefits. Frequently personnel are not appointed or supplies not provided on time or funds are not made available when they should be and the result is the failure of the best planned programs. It is the same—so experience shows—when the performance of professional and auxiliary staff is below what has served as a basis for formulating the program. In a word, unless organization and administration are efficient, no service can be effective.

HUMAN RESOURCES

In the Americas, in both the developed and the developing countries, there is still an absolute or relative shortage of professional and auxiliary staff for preventive and curative

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activities and for other activities that directly or indirectly promote health. The community demand is constantly increasing; services are far from covering the whole country, to the serious detriment of the rural population; medical technology is becoming increasingly complex and activities more costly; and health investments are not commensurate with what is necessary to provide even essential care. Nevertheless, available information\(^{19}\) shows that in the period under review there has been a substantial increase in health manpower and in the resources of university and technical institutions for providing health training. The problem of the uneven distribution of medical and other professional personnel, who still concentrate in large cities and are in short supply or totally absent in large tracts of the rural areas, is still with us. In some countries salaries are not high enough to induce them to take up full-time work in the State health services. Furthermore, in view of the average family income, the increasing cost of medicine already mentioned has considerably reduced private practice. At the same time, the social security system is providing only a part of the population with medical benefits even though the right of all to health is recognized. In these circumstances the State is required to provide health services for the indigent and the uninsured and even for those who cannot afford private medical care. Taken as a whole, this is a complicated social process whose immediate expression is a shortage of professional health workers and technicians. Hence the responsibility shared by the Governments and the universities.

The Charter of Punta del Este recommends the adoption of educational plans adjusted to the demands of economic and social development. Where necessary, new teaching institutions must be established and old ones strengthened with a view to increasing their capacity and improving the quality of their teaching. To that end it is advisable to ascertain the health manpower needed in the light of the priorities and objectives of the health plan and the gross national product of each country. This has been done in Colombia through a study sponsored by the Government, the Colombian Association of Medical Schools, the Milbank Memorial Fund, and the Pan American Health Organization.\(^{20}\) The method used is today known to all the Governments of the Americas, and in some countries it is already being applied. Its general use as a method of educational planning is recommended.

In the period under review, national associations of medical schools have been organized in all countries in which such schools exist. In 1963 they were united in the Pan American Federation of Associations of Medical Schools, which was recognized as an affiliated nongovernmental organization by the XVI Meeting of the Directing Council of the Pan American Health Organization. These associations have promoted closer ties between medical schools and the Governments and, at the international level, the Federation and the national associations, with the support of the Organization, are carrying out programs for the improvement of medical education.

During this period concern has been voiced about improving the quality of teaching and learning. Thanks to the initiative of the Pan American Health Organization, a number of universities have adopted active medical education methods based on a harmonious relationship and a continuing interchange of ideas between teachers and students. The results have been remarkable and justify the adoption of these principles by all medical schools and health institutions, the practical application being determined by the nature of the subject being studied. The essential thing is that the goals of students and teachers should be identical.

The importance of organizing teaching and properly administering the branches of each department has become clear, not only because of the enormous investments involved but because each university is a dynamic, constantly changing society \textit{sui generis}. These experiments should be expanded in the light of the findings of the survey on the teaching of

\(^{19}\) Facts on Health Progress. Scientific Publication PAHO 166, 1968.

preventive and social medicine, which are very pertinent.\textsuperscript{21}

Continuing education for professional and technical personnel is today a widely accepted idea in the Americas, although frequently not observed in practice. It is urgently necessary to satisfy the need felt by doctors in rural areas to refresh their knowledge to enable them to deal with the local population. This must not be done haphazardly but in an organized and sustained way, priority being given to the problems considered most essential for the professional health worker and the institution. For this purpose the health ministries and medical schools must work out joint schemes that take into account the situation in the country and area concerned, and are based on the regionalization of care and teaching facilities.

Another way of improving the quality of teaching is the provision of textbooks selected by instructors in the subjects concerned and produced in sufficient quantity and sufficiently cheaply to allow students to purchase them. At the same time, it is necessary to increase the library holdings of reference works or treatises on the same subject recommended by a number of instructors. In this way the student can compare and expand on the contents of his textbook. Such a program has been approved by the Governing Bodies of the Pan American Health Organization and recently initiated.\textsuperscript{22}

Where the ratio of physicians to nurses per unit of population has been studied, it has been found to be an inverse one. As a result, physicians are obliged to carry out preventive or treatment procedures which nurses could perform equally well. Nursing is another area of professional education in which the number of students must be increased and the quality of teaching improved. The shortage of nurses makes itself felt not only in preventive and treatment services but also in specialized services.

A further result of this situation is the increasing importance of nursing auxiliaries and other paramedical personnel. It has been recognized that they represent an element apart among the technical personnel responsible for the prevention and care of diseases. They are not a substitute for professional nurses and therefore require a special curriculum in which theoretical and practical instruction are well balanced. There is today a great diversity in the many training courses for auxiliary health workers. It is therefore essential to make a survey of their functions and responsibilities; the findings could serve as a basis for the formulation of a curriculum. Substantial progress has already been made in the education and training of auxiliary workers, with a view to making them even more efficient in the activities assigned to them.

Of special importance is the program for the improvement of sanitary engineers which is being carried out through a network of universities under the sponsorship of the Organization. It is a form of continuing education in modern techniques for dealing with the problems of the physical environment resulting from industrialization as well as other traditional problems which still affect a great many inhabitants of the Americas.

Today the Hemisphere is aware of the need to gear university and technical education to the needs of development. This approach is seen in the various subjects which make up the sciences and arts of health. It is necessary to integrate preventive and curative medicine in theory and in practice and to train the type of professional health worker that each country currently needs, emphasis being placed on those attitudes that favor continuing instruction and the ideal of service. What is normal in health problems must be stressed, not what is exceptional. That does not mean to say that the aim is to create mere technicians; on the contrary, it is to create educated men genuinely interested in the moral values governing their mission and in the progress of their country.

On the continental level the decision to move forward to an economic community has brought out the need to first create a well-organized intellectual and cultural community, eager to fathom the eternal truths concerning man and society. This is the mission of the university in our time.


Among the major developments in the five-year period under review is the recognition of research as essential to development in the Americas, and this is reflected in the decisions of the Chiefs of State and in the activities of public and private organizations. The urgent need to modernize institutions and systems in order to be able to apply the recommendations of science and technology has been acknowledged. We wished thereby to emphasize that, though the countries of the Region have a varying knowledge of the new technology—a knowledge that diminishes the farther one moves into the rural areas—they are nevertheless unable to put it at the service of their people. What is more, those decisions have reaffirmed what is a basic tenet: that unless there is due respect for the cultural traits of a society, its history, way of life, currents of public opinion and tradition, its beliefs and superstitions, the most outstanding scientific advances can make no headway and therefore cannot benefit the communities.

It has been shown that, as they are conceived today, the health sciences cover a range that runs from molecular biology to social biology, the latter including economics. With this conception there can be no conflict between pure or basic research and applied or practical research. To the extent that all new knowledge or experience helps directly or indirectly to humanize development and contributes to the well-being of human beings, it is genuine and authentic research. From a moral standpoint, what is important is not where research is done—in the laboratory, the hospital, or the community—but whom it benefits and how they benefit. The greater the suffering and the anxieties it mitigates and the more it contributes to the happiness to which each individual aspires, the more meaningful it is.

In short, government-supported research is today one of the basic tools for protecting, promoting, and restoring health. At the international level, research forms part of the policy and the activities of the World Health Organization and the Pan American Health Organization.

In their Declaration, the Chiefs of State emphasized the urgent need to apply modern technology and science to development and to undertake national research programs, that is, programs geared to the society concerned and, wherever possible, original. It is clear that this pronouncement covers the "life sciences," especially the sciences of human beings as biological units and as social beings.

There will have to be close coordination between the Regional Scientific and Technological Development Program of the Organization of American States and that of the Pan American Health Organization in all projects dealing with subjects of interest to PAHO.

What PAHO has done in the field of research is in line with the foregoing considerations, and represents a significant contribution to the sciences and arts of health. Its research studies deal with problems of basic importance for the Americas, and the results have opened up new prospects for deepening our knowledge of reality. We will refer to some of them later on. This experience is reflected in Science Policy in Latin America approved by the Governing Bodies of the Pan American Health Organization. That document pointed out that "the development of science and the use of science to aid man depends more on an understanding society than on an affluent society." In other words, the capacity to undertake research depends on the availability of understanding and a vocation and not only on the availability of funds. The number of talented scientists in the Americas is increasing, and they constitute the potential wealth of the Region. The future of research depends on the decisions of the political authorities and on the quality of the universities. The need to institutionalize the relationships between Governments and science, between decision-making and specific knowledge, has become evident. If the ultimate objective is well-being, everything society possesses must be directed toward and organized for that purpose.

A study of the Migration of Health Personnel, Scientists, and Engineers from Latin

25 Ibid., p. 5.
America shows the magnitude of the "brain drain," which is more serious for some countries than for others. It is the responsibility of the Governments and of the universities to reduce the size of the problem. It is recognized that it is an inherent trait of living beings to migrate, either temporarily or permanently, from one place to another. In a world which has enormously reduced distances, increased communications, and stimulated the imagination, it is not surprising that persons travel and emigrate. Nevertheless, if a society values its members, it must create incentives to keep them put and enable them to pursue their vocation in the society that trained them.

A recent updating of the reports shows that in some countries the situation remains unchanged; in others, it has improved except in the case of nurses.

We wish to underscore the work of the PAHO Advisory Committee on Medical Research, which is composed of outstanding scientific personalities from the countries of the Americas. Its annual examination of policy and current programs and studies has made a great contribution to the decisions taken by the Governing Bodies with respect to research.

So far we have commented on some of the various aspects of the Charter of Punta del Este and the Declaration of the Presidents of America directly or indirectly related to health as a social service. We have distinguished the principles and instruments those documents recommend for organizing resources and satisfying the health needs of each country and each community, such as planning, organization and administration, education and training, and research. We have also directed our attention to various declarations of the Chiefs of State concerning economic and social development. Hence our references to the Latin American Common Market; to increasing intraregional trade; to modernizing rural life; to the adoption of methods for improving the amount and quality of foodstuffs; to the extensive application of the contributions of science and technology; to education at all levels; to the development of geopolitical areas so as to benefit large sectors of the Hemisphere; to promotion of essential economic infrastructure projects covering several countries. Our purpose has been to show or enunciate the role of health activities and, as the Chiefs of State decided, the need for health services to participate in activities as early as the preinvestment phases.

We have paid particular attention to the relations between population and development, not only because they have been a subject of public debate during the period since the Meeting of the Task Force on Health in 1963, but also because they are at the basis of all economic and social planning.

We believe that all these considerations constitute a true frame of reference for health activities as we conceive of them today, and we believe that projections up to the end of the present century should be made. There is no activity for the protection, promotion, and restoration of health which does not find a place in the undertakings, programs, and instruments for development that we have examined. But at the same time, those programs cannot be carried out successfully if they do not provide for activities aimed at the prevention and treatment of the diseases of the persons who take part in or benefit from the programs.

We shall now deal with the goals of the Ten-Year Public Health Plan of the Charter of Punta del Este and the objectives of the Declaration of the Presidents, with a view to establishing specific measures for achieving them. As our starting point we shall take the results obtained so far by each Government and the Americas as a whole, the experience acquired in each program, the contributions of science and technology during the same period, economic and development trends, and the prevailing trends of public opinion as reflected in community demands.

26Scientific Publication PAHO 142, 1966.
III. CONTROL OF COMMUNICABLE DISEASES

1. GENERAL

Infection, in its widest sense, continues to be an important direct or indirect cause of sickness and death both in the technologically developed and in developing societies. The progress in diagnosis due to advances in microbiology and biochemistry is obvious, as is the progress in treatment due to the introduction of antibiotics and chemotherapeutic agents and in control as the result of new immunization systems and the use of insecticides; but in spite of it, infection is still important, as is shown by morbidity and mortality rates. The principal expression of infection is found in the communicable diseases, which continue to be a significant health problem in the Americas as in other parts of the world.

The relative importance of the communicable diseases in relation to health is nevertheless changing, because of the above-mentioned advances in science and technology, their application by means of systematic programs, education and the greater knowledge of the diseases that increasingly larger sectors of the population now have, and the improvement in the economy and the increase in the funds devoted to health—in a word, to development in general. On the other hand, the hazards arising from infections which have natural foci have increased because of the expansion of international trade and of the transport of live animals and food products, agricultural and industrial development, and the penetration into and exploitation of virgin land. Such infections include parasitic diseases in various parts of the world. Another point is that new diseases have been identified for which no methods of prevention and control previously existed.

If the prevalence of the commonest communicable diseases in the Americas in the last 20 years is examined in the light of what information is available, it will be seen that considerable progress has been made. The great pestilences are disappearing. In this century not a single case of cholera has been notified, except for two laboratory infections in 1965 in the United States of America. Urban yellow fever, for a long time one of the great scourges of tropical, subtropical and even temperate parts of the Americas, has been controlled, the last cases having been diagnosed in Trinidad in 1954. Nevertheless, jungle yellow fever is firmly established in the forests of the basins of the Amazon, Magdalena, and Orinoco Rivers, from which the virus spreads from time to time and gives rise to epizootic outbreaks with repercussions in man. A solid and long-lasting immunity is provided by a vaccine that is available in adequate amounts. In recent years plague has been on the increase in some regions, especially in Ecuador and Peru, but the total number of cases fell considerably in 1967. In the decade 1958-1967 the decrease in the number of cases of smallpox notified was 54 per cent as compared with the previous decade 1948-1957. The number of cases of louse-borne typhus has continued to decrease, the disease at present being limited to the mountainous parts of Mexico and the Andean area.

In spite of these favorable trends, the fact that the incidence of acute and chronic communicable diseases is high in Latin America and in the Caribbean area in comparison with what it is in developed countries shows that preventive measures of proven value are not applied sufficiently widely to control or interrupt their transmission. Outstanding examples of this are children's diseases (such as diphtheria, whooping cough, measles, poliomyelitis, and tetanus neonatorum); tuberculosis, leprosy, and venereal diseases; and rabies and other zoonoses. In the case of Chagas' disease more effective treatment methods and less costly control measures need to be discovered through research.

There is thus greater knowledge of preventive and curative methods for the common diseases than is actually being applied. This is the immediate task, and to carry it to a successful conclusion it is essential to consider the characteristics of the problem within the countries themselves, and in the different communities, in the light of the organization of the health services, the coverage of the national...
territory, the availability of human, material and financial resources, and the possibility of increasing such resources in proportion to the magnitude of each problem. To deal quickly with epidemic outbreaks efforts must be concentrated; but to prevent them and to keep the population free from them, health units, however small, are essential in all the areas where human beings live.

To make the best use of the available resources, it is important to establish a list of priorities on the basis of the following groupings:

a) The first depends on the availability of effective methods for the eradication of the vector or the disease, as in the case of malaria, smallpox, yaws, measles, or *Aedes aegypti*.

b) The second covers diseases for which proven methods of control make programs feasible. Examples of such diseases are tuberculosis, leprosy, diphtheria, whooping cough, tetanus, plague, poliomyelitis, rabies, and venereal diseases.

c) The third covers such infections as Chagas' disease, filariasis, onchocerciasis, hydatidosis, schistosomiasis, and other endemic parasitic diseases.

d) In the fourth group may be included other diseases such as louse-borne typhus, which is a potential hazard.

An urgent need is for ways and means of improving and speeding up the diagnosis of the common communicable diseases—a diagnosis that should be of the cause but also, if possible, of the ecological factors involved. The training of epidemiologists, microbiologists, and parasitologists needs to be improved and their numbers increased; laboratory services should be created or strengthened in a regionalized system; a larger number of technical staff should be trained in the various disciplines; departments for the epidemiological study and control of communicable diseases should be expanded in all branches of the health services and equipped with at least the minimum of resources for continuous work, particularly with effective vaccines and sera in sufficient quantity; and methods and techniques should be modernized when required. On such a basis a fresh drive is possible to reduce the common communicable diseases in the Americas in the next 20 years to the status of a minor public health problem.

**Recommendations**

1. That the Governments of the countries of the Americas organize or expand their epidemiological services responsible for planning, conducting, and supervising communicable disease control or eradication programs, according to national and regional priorities, and pay particular attention to the establishment of surveillance services.

2. That the Governments organize or expand public health laboratory services, which are a basic tool in the control of communicable diseases.

3. That in communicable disease control programs efforts be made to reach and maintain a useful level of coverage of the susceptible population through better use of personnel and equipment so as to reduce the cost of operations but without reducing the efficiency of the program.

4. That the Governments promote and support basic and applied research designed to lead to a better knowledge of activities for the prevention and control of communicable diseases.

5. That the Governments promote and stimulate the training of epidemiologists and personnel in methods for the diagnosis, prevention, and control of communicable diseases.

6. That the countries that are more advanced in their knowledge and control of communicable diseases provide the countries that need it with technical assistance.

**2. SMALLPOX**

Between 1958 and 1967 the countries of the Americas reported to the World Health Organization and the Pan American Health Organization a total of 61,088 cases of smallpox. During the last five years 97 per cent of the reported cases have come from Brazil; this country is therefore the key country in any
attempt to eradicate smallpox from the Hemisphere.

An effective vaccine against smallpox has been available for more than a century and a half, and if it is applied systematically and in an organized manner, it will provide complete protection of the population. There is no doubt that the eradication of smallpox from the Americas can and should be achieved. Today there is a sufficient amount of good quality vaccine available for the purpose. Furthermore, all the countries have sufficient technical resources in their health services to complete the smallpox eradication program and to maintain freedom from the disease.30

So said the Ministers of Health at their meeting in 1963. We agree with their views and reaffirm the goals they set. The possibilities are even better today as a result of Resolution WHA19.16 of the Nineteenth World Health Assembly (1966), in which the program and budget estimates for the world-wide eradication of smallpox were approved.

All the conditions required to achieve such an objective are present in the Americas. The only reservoir of the disease is man, and vaccination protects for some years. All that is required is systematic, well-organized immunization programs for the population.

Smallpox can be eradicated from the Americas. That it has not been done so far is due to a great variety of factors, the most important of which are incomplete coverage of the population because of insufficient health services, lack of adequate priority, and economic and administrative difficulties. The funds required are relatively small when compared with the costs and particularly the sufferings arising from the continuing presence of the disease. The resources needed to keep the disease from entering countries that are free of it are high; hence the interest of such countries in its eradication from the Americas. For these reasons it follows, as is the rule in eradication campaigns, that the efforts put forth by countries should be joint and, ideally, simultaneous when they embark on immunization programs and on the series of measures to reduce gradually and then eliminate the disease.

The plan of operations of each Government is prepared with and can rely on the collaboration of the World Health Organization and the Pan American Health Organization. It is agreed that priority should be given to countries where smallpox is indigenous, especially to Brazil and to countries that have already eradicated it but, sharing a common frontier with infected countries, need maintenance and epidemiological vigilance programs. All Governments are urged to keep a high proportion of their population immune to smallpox. The greater the movement of people between countries in the Hemisphere and other parts of the world, the greater the need for such programs.

Recommendations

1. That it should be reaffirmed that the eradication of smallpox, as part of the world program, is one of the most important priorities of countries of the Americas and of the Pan American Health Organization.

2. That, with a view to keeping the Americas free of smallpox, Governments should establish and maintain an immunization program with adequate funds that should cover each year not less than 20 per cent of the population, including 80 per cent of the children born during the year.

3. That countries that have eradicated smallpox should establish well-planned programs of epidemiological surveillance and maintenance, with special stress on the investigation of suspect cases capable of reintroducing the disease.

4. That thanks should be expressed to countries that have generously donated supplies of smallpox vaccine, and that the wish should also be expressed that other countries follow that laudable example.

5. That the Pan American Health Organization and the World Health Organization should continue to provide the countries with technical and material assistance to enable them to maintain effective eradication programs.

3. POLIOMYELITIS

The possibility of establishing solid immunity has led to important changes in the
characteristics of poliomyelitis mortality and morbidity. The information available shows that, in 1955, 30,000 cases and more than 1,000 deaths were reported in Northern America. In 1966 the number of reported cases had fallen to 116 and the number of deaths to nine. These results were due to immunization programs and the motivation and interest of families in Canada and the United States of America.

In Middle America the mortality rate fell from 5.2 per 100,000 population in 1955 to 1.9 in 1967. This reduction was due to the systematic immunization of millions of children in Cuba and Mexico.

In South America, with the exception of Brazil for which no information is available, the reduction in the rest of the area was smaller, from 4.1 cases per 100,000 population in 1955 to 2.2 in 1967. These results were due to the oral vaccination with live attenuated virus of a varying number of children in the different countries.

The epidemic of 1967 which affected various countries in the Pacific region of the Continent and required the adoption of emergency measures, is to be regretted. It brought out the need for a continent-wide program to prevent new outbreaks; to ensure and maintain a satisfactory immunity level; to organize epidemiological vigilance in order to ascertain variations in the immunity level for each type of poliomyelitis virus; to have on hand sufficient quantities of modified live virus vaccine either to interrupt transmission during epidemics or for regular vaccination programs; to establish a network of laboratories in the Americas for diagnosis and virus typing, determination of the status of immunization in population samples, epidemiological studies, and education and training.

These are the bases for a program which should be supported by all the Governments and be assisted by the Pan American Health Organization upon request. If that were done, it would be possible to substantially reduce the incidence of poliomyelitis in the Americas in the next few years.

**Recommendations**

1. That in order to achieve an adequate reduction in the incidence of poliomyelitis in the Americas, the Governments establish national and regional poliomyelitis vaccination programs.

2. That the goal of the program should be the immunization of 80 per cent of the susceptible population in the shortest possible time.

3. That PAHO/WHO collaborate with and advise the countries in carrying out their poliomyelitis programs when so requested.

4. That PAHO/WHO help the countries to establish good laboratory resources for the diagnosis and typing of poliomyelitis viruses.

5. That PAHO/WHO help the countries by promoting the large-scale production of poliomyelitis vaccine to ensure that control programs have adequate supplies of the vaccine.

**4. MEASLES**

As in the case of poliomyelitis, the production of a modified live virus vaccine with considerable immunizing capacity has opened up the possibility of controlling measles. In some countries in the Americas, as has been demonstrated by the Inter-American Investigation of Mortality in Childhood, measles is a major cause of death in children under 5 years of age and is aggravated by the generalized malnutrition of the population. The large-scale use of measles vaccine makes it possible to interrupt the epidemic outbreaks which occur every two or three years. The seriousness of respiratory complications, in particular laryngitis and pneumonia, and of encephalitic complications has become apparent. The more undernourished the children, the greater the lethality of measles.

We hope that vaccine production will be increased and the unit cost reduced, so that a...
larger proportion of susceptible persons in each country can be covered.

**Recommendations**

1. That the Pan American Health Organization assist the Governments in the planning and conduct of national measles vaccination programs to protect the largest possible number of susceptible children under 5 years of age.

2. That the Pan American Health Organization promote the production of measles vaccine so as to reduce its cost and thereby permit the routine use of this vaccine to protect susceptible persons.

5. **TUBERCULOSIS**

Tuberculosis is still a serious health problem in Latin America and in the Caribbean area, despite the advances made as a result of modern chemotherapy, BCG vaccination, and the public's better knowledge of the disease and of the possibilities of preventing and curing it. The present mortality rate gives an indication both of how much has been done and of how much still remains to be done. The reduction in mortality, which was rapid in the period 1948-1954, has continued more slowly in recent years in the three regions of the Americas. In 1966 the mortality rate was 3.8 per 100,000 population in Northern America, 19.8 in Middle America, and 27.9 in South America. The available morbidity data also reveal the seriousness of the problem.

It is estimated that in Latin America there are at present 85 million infected persons and 1,250,000 active cases. Assuming that, each year, one out of every 625 previously infected persons will develop active tuberculosis, there would be 156,000 new active cases under present epidemiological conditions.

The low level of performance of most tuberculosis control programs has been attributed to lack of resources. However, since the cost of detecting and curing a case of infectious tuberculosis in a developing country has been brought down to between US$10 and $20, and each BCG vaccination costs from US$0.10 to $0.20, it is clear that in actual fact all the countries are in a position to carry out activities that will substantially reduce the incidence of the disease, regardless of social, economic, and epidemiological conditions.

The fact is that there is still a gulf between our knowledge and its application. Unfortunately, it has not been possible to completely change traditional ideas or to prevent the influence of methods used in developed areas. Institutional treatment continues to be emphasized to the detriment of preventive and curative activities in the community. The result has been the continuation of an exceedingly costly structure which has not been even capable of coping with the expected demand from the community. This reluctance to change outworn approaches and to apply scientific advances has led to expensive programs with little epidemiological effect, which concentrate specialized units in large cities at the expense of rural areas.

On the basis of the Charter of Punta del Este the Governments undertook to reduce tuberculosis mortality to half the rate it was at the beginning of the decade starting in August 1961. In the ensuing five years tuberculosis mortality did not fall to the extent expected in either Middle or South America, so that it is possible to forecast that, if the present regimen is not changed, the above-mentioned goal will not be reached. In Northern America the reduction has been more substantial and the possibility is greater.

Under present circumstances, the developing countries will have to increase their resources for BCG vaccination, diagnosis, and outpatient treatment, and the education and training of professional and auxiliary personnel. For this purpose, they must reduce their expenditure on the costly maintenance of existing hospitals and other low-performance services. Today the construction of facilities exclusively for tuberculosis patients is to be considered only exceptionally. As a general rule, tuberculosis control activities should be incorporated into those of the general health services.

This new approach will be accepted and applied the sooner the education of general practitioners and public health officials includes the elements of the epidemiology, diagnosis, and control of tuberculosis, with due emphasis given to the ethical aspects of the treatment of patients and the responsibility for preventing their condition from becoming chronic. In turn, specialists who deal with tuberculosis problems must master the principles of public health and of the organization, administration, and evaluation of tuberculosis control programs.

As the Ministers of Health declared at their meeting in April 1963:

... the aim pursued is to attack tuberculosis effectively and economically by the most rational application of available knowledge and resources, in accordance with the local technical, social, and economic conditions, within a broad public health program. The objective is to eliminate tuberculosis as a public health problem as rapidly as is compatible with the over-all public health needs in each country.  

Recommendations

1. That the Governments of the countries of the Americas continue to give the highest priority to the control of tuberculosis in national health programs.

2. That they place greater emphasis on immunization, diagnosis, and outpatient treatment and reduce expenditures on hospital services and others with little epidemiological effect.

3. That they extend tuberculosis control activities to cover the whole country and incorporate them into the work of the basic health services.

4. That they continually evaluate the results of activities so as to ensure that the most effective methods and techniques are used.

5. That they strengthen the training of professional personnel specialized in tuberculosis epidemiology and in the formulation, execution, administration, and evaluation of tuberculosis control programs.

6. That medical schools give the necessary importance to the teaching of tuberculosis and provide the general practitioner with a knowledge of modern concepts of prevention, epidemiology, diagnosis, and treatment of that disease, including the basic principles of health education which ensure the continuity of the treatment.

7. That the Pan American Health Organization and the World Health Organization continue to assist the Governments in the formulation of programs, conduct of operations, research, and personnel training.

6. LEPROSY

Leprosy exists in all the countries of the Americas with the exception of continental Chile. The true magnitude of the problem is unknown because the available information is deficient.

It has been estimated that there are more than 400,000 cases in the Western Hemisphere. Nevertheless, according to the data reported to the Pan American Health Organization by 26 countries and territories, there were 174,615 leprosy patients on the active register at the end of 1967. Of this total, 77 per cent were under control. In only 69 per cent was the clinical form known; of these, 64,531 (53 per cent) were of the lepromatous type, which is the form with the greatest transmission potential; 26,283, of the tuberculoid type; 27,910, indeterminate; and 1,735 came under other clinical forms. The number of registered contacts in 16 countries was 325,940, of whom half were under control. In 1967 a total of 5,510 new cases of leprosy were discovered in 19 countries.

Ignorance of the real magnitude of the problem is due in some measure to important gaps in our knowledge of the characteristics of Mycobacterium leprae, and of the pathogenesis and the epidemiology of the disease. Only recently has it been possible to cultivate the leprosy bacillus in certain laboratory animals. So far, it has not been possible to cultivate the causative organism in vitro. The period of incubation, modes of transmission, and the factors and circumstances determining the infection are unknown. A drug belonging to the sulfone group (DDS) has proved to be the most effective for treatment and has few side effects.

Trials of new long-lasting products, which will facilitate ambulatory treatment, are under way. This is the background to present and future research on the biology, therapy, and epidemiology of leprosy.

Despite lack of knowledge of the essential facts for interpreting the dynamics of the disease, sufficient knowledge and effective methods are available to extend leprosy control in the countries in which it is prevalent. Our concept of the disease and the attitude of communities toward leprosy patients has radically changed. Today we speak of hospitals and not of leprosaria, of patients and not of lepers. The period of isolation of patients has been considerably reduced, and once the period of infectivity is passed they return to their communities to lead a normal life. Leprosy control has been accepted as a routine activity of health services. The periodic supervision and health education of patients and their contacts is regarded as essential to the early diagnosis of new cases, which is designed to break the chain of infection and to prevent deformities. Renewed emphasis has been placed on physical and social rehabilitation, which should now be an integral part of any leprosy control program.

Generally speaking, the Governments are confronted with three types of problems in leprosy control: to ascertain the extent and characteristics of the disease and to formulate a program; to organize technical and administrative structures for achieving the program objectives, bearing in mind the factors involved in the dynamics of the disease in each country and region; and finally, to train professional and auxiliary personnel in all aspects of diagnosis, control methods, and program administration.

Leprosy control programs as at present conducted are unable to change the natural course of the disease. However, we believe that this can be done if programs are planned, formulated, organized, and evaluated in accordance with methods that ensure that the resources used are the most efficient, that they produce the maximum return at the lowest cost, and that activities are carried out at a useful level and in a relatively brief period of time. If this is done, it is to be expected that the incidence and prevalence of the disease will be reduced. In this connection the experience acquired by Argentina, Ecuador, and Venezuela has been very valuable, and was analyzed at the Seminar on Administrative Methods for Leprosy Control Programs which was held in July 1968 in Guadalajara, Mexico, under the auspices of the Pan American Health Organization. The conclusions reached by that Seminar can serve as a basis for programs designed to systematically and progressively reduce the incidence of leprosy in all the countries of the Americas and other regions of the world in which the disease is prevalent.

Recommendations

1. That the mere presence of leprosy in a country should justify its consideration as a high priority public health problem since control is feasible even with limited resources when its prevalence is not too great; and this opportunity should not be missed.

2. That the Pan American Health Organization and the World Health Organization should collaborate with the countries of the Americas by giving them technical and material assistance in the planning, conduct, and evaluation of their national leprosy control programs; endeavor to coordinate the activities being carried out in the various countries; and request assistance from the United Nations Children’s Fund (UNICEF).

3. That basic and applied research aimed at solving substantive questions concerning the bacteriology, epidemiology, treatment, and control of leprosy should be encouraged and supported.

4. That due emphasis should be given in schools of medicine to the prevention and control of leprosy, for which diagnosis, treatment, and knowledge of its epidemiology are essential.

7. PARASITIC DISEASES

Apart from malaria, the parasitic diseases are widely distributed in the Americas and are often very prevalent. A vast majority of the people harbor parasites and very many of them harbor more than one species. Aside from infections with schistosomes and the parasite causing Chagas’ disease, which will be mentioned later, there are millions of persons
infected with Ascaris, Amoeba, Onchocerca, Leishmania, Toxoplasma, hookworms, and a number of other parasites. The parasitic infections are often so inapparent that some health authorities may ignore them, seemingly because they are so familiar. They are often insidious in their effects, weakening their victims rather than causing obvious disease or death. Nevertheless, they take an immense toll especially among the poor and neglected. The parasitic diseases demand much more attention than they have been receiving.

Some countries have sound control programs for one or more of the parasitic diseases but others have no really effective program for any of them. Indeed, in some areas the prevalence of the most important parasitic diseases is scarcely known and in few has their public health significance been adequately assessed.

One of the main obstacles to progress in the control of the parasitic diseases is the possible underestimation by some health planning authorities of the public health and economic importance of these diseases.

Programs for the prevention of parasitic diseases should be given increased consideration. Control of some of them, such as ascariasis and hookworm disease, could be accomplished through community health services where the specific measures can be integrated with sanitation and health education programs. Others, such as schistosomiasis, Chagas' disease, and onchocerciasis, which require campaigns using special techniques against the vector over a large area, must be prevented by a special organization operating on a regional or national basis.

Countries not having preventive programs should consider pilot projects for the more important parasitic diseases. These can serve as demonstration areas and as centers for in-service training.

Since research is absolutely essential for an effective long-term control program, provision should be made to aid research, especially when it is oriented toward the solution of the problems involved. Personnel devoted to a research program can be used to great effect in collecting basic data leading to a well-conceived program and they can also provide objective evaluation of its results.

Because the number of well-trained and experienced specialists in the parasitic diseases has fallen far behind the number needed, means should be found to attract, train, and retain high-grade people.

Since schistosomiasis is one of the two most important parasitic diseases in the Americas, after malaria, it is appropriate to record certain facts concerning it. Schistosomiasis affects between 6 and 7 million people in the Americas. Recently it has been said that about 119,000 persons are totally disabled by it and that about 1.5 million are partially disabled. A conservative estimate has placed the economic loss due to this disease in Brazil at about $60 million per year. The disease continues to spread, and development schemes will undoubtedly increase the problem greatly in the future unless countermeasures are taken.

Recommendations

1. That increased support to parasitic disease control programs be given by Governments and by the Pan American Health Organization and the World Health Organization.

2. That training in the diagnosis and prophylaxis of the more important parasitic diseases be encouraged.

3. That research on the parasitic diseases, especially that directed toward a better understanding of preventive measures, be encouraged.

4. That the countries of the Americas in which schistosomiasis is a major health problem review the control programs for the purpose of accurately measuring progress and discovering more effective techniques.

5. That the Pan American Health Organization and the World Health Organization assist countries to determine the magnitude of the problem of schistosomiasis, to collect the data necessary for a control program, and to plan a control program.

6. That the Pan American Health Organization collaborate with Governments at their request in the training of personnel in schistosomiasis survey and control methods.
8. CHAGAS' DISEASE

Chagas' disease occurs in almost every country of the Americas, although its distribution and prevalence are far from well known. Its prevalence varies greatly from one locality to another, but reaches almost 100 percent in some places. It is estimated that 7 million persons are infected with Trypanosoma cruzi. However, this figure may be an underestimate.

The morbidity and mortality caused by Chagas' disease are even less well known than its prevalence, although there can be no doubt that in some countries it is a major cause of illness and death. It is probable that at least 900,000 persons in the Americas have cardiopathy due to the infection. Many are doomed to die in the prime of life from cardiac failure; others are handicapped by cardiac insufficiency. Congenitally transmitted Chagas' disease affects the development of young children and is a cause of death. Thus, to a public health problem of first magnitude are added economic effects of no small consequence.

Although infection is usually a rural problem, it is a threat even in urban centers since it can be transmitted through blood transfusion by donors infected in a rural environment.

Since the disease is aggravated by ignorance, poverty, and insanitary housing conditions, the basis of its control is education and economic and social development. Improved housing and the construction of new houses unsuitable to triatomids should considerably reduce the frequency and seriousness of transmission of the disease. The enormous investment this entails is to be seen in the fact that the estimated number of dwellings in the area affected by Chagas' disease in Latin America is about 7 million. A proportion of these can be repaired, and efforts in this direction are under way in some countries. It is necessary to determine the method which produces the maximum effects at the lowest cost since the objective is to protect the population from the attacks of triatomids. Due consideration must be given to the customs of the community with respect to the type of housing and the nature of the building materials used. In any event, this is a program in which a well-motivated population will cooperate, and their cooperation is essential to the success of the program. Furthermore, priority should be given in the house building policy of Governments to areas in which Chagas' disease is endemic, and either domestic resources or external capital should be used for such programs.

Chagas' disease can be controlled, using the information and weapons that we have at this time. The preventive measure that gives the most rapid result is destruction of the vectors by spraying insecticides in and about the houses. This method has been shown to drastically reduce the insect population and transmission of the infection even when done at widely spaced intervals.

Nevertheless, a number of matters need to be investigated in connection with the distribution and prevalence of the disease, the morbidity it causes, and its dynamics and ecology. Methods of diagnosis and control need to be improved, an effective drug developed, and the immunity mechanism and the pathogenesis elucidated. Meanwhile, to the extent funds are available, control programs must be extended to at least the highly endemic areas.

Recommendations

1. That all countries be encouraged to determine by standard sampling methods the distribution, prevalence, and biology of the vectors; the distribution and prevalence of human infections; and the significance of domestic and wild animal reservoirs.

2. That all countries, after collection of the data mentioned, determine the morbidity caused by the disease by study of a sample of those found to be infected (seropositive).

3. That PAHO/WHO assist countries on request in the planning, execution, and evaluation of their control programs.

4. That research workers be encouraged to develop new information on all aspects of the problem, but especially on subjects related to the prevention of the disease.

5. That PAHO/WHO take the lead in the development of sufficient basic information on the subject and on the bases for more adequate preventive programs.
6. That PAHO/WHO stimulate country projects for the epidemiological study of the disease, including standardized diagnostic techniques and evaluation criteria.

7. That PAHO/WHO consider the possibility of designating reference laboratories for training technicians to produce standard reagents and to advise on technical problems.

9. VENEREAL DISEASES

A study conducted by the World Health Organization on world trends in the venereal diseases during the period 1950-1960\(^{35}\) showed that there had been a significant persistent increase in the incidence of early syphilis and gonorrhea in all parts of the world during later years of that decade. Out of 105 countries and areas 76 showed an increase in early syphilis, and out of 111 countries and areas 53 showed an increase in gonorrhea.

The Americas are no exception to this trend, although the true magnitude of the frequency of the venereal diseases is not known. The reason for this is that data are incomplete, reporting practices vary from country to country, diagnostic facilities are inadequate, and investigation and prophylactic methods are often antiquated.

Nevertheless, it is clear that both syphilis and gonorrhea rank among the 10 principal notifiable diseases in the Americas. Samplings of data from outpatient clinics indicate that there are about four cases of gonorrhea for every case of syphilis. Because of the effectiveness of treatment, however, mortality from syphilis has been considerably reduced, the figures for 1966 in Northern, Middle, and South America being 1.1, 0.7, and 1.3 per 100,000 population, respectively.

As in other countries of the world, chancroid, lymphogranuloma venereum, and granuloma inguinale occur in the Americas, but relatively less frequently. The chancroid rate amounts to half of that for syphilis.

The increase in syphilis and gonorrhea in recent years—in some countries it has exceeded the peak reached in the years immediately following the last World War—is the more serious because it is concentrated in the younger age groups. Many of the factors involved in this problem are social in nature and derived from changing patterns of behavior.

In spite of the existence of very effective drugs, it has proved impossible in both the developed and the developing countries to discover and treat enough patients in the communities to achieve control of syphilis and gonorrhea. Contributing factors in this situation are a certain degree of complacency in the population, persuaded of the value of the treatment available; the greater mobility of the people, which increases the spread of the disease and makes notification difficult; and the lack of systematic control programs which should be based on the same principles as govern those on communicable diseases in general. These factors were carefully analyzed in the Seminar on Venereal Diseases sponsored by the Pan American Health Organization and the National Communicable Disease Center of the United States Public Health Service held in October 1965 at PAHO Headquarters.\(^{36}\)

Present experience makes it possible to expand preventive programs, at least in the large urban centers of the Americas, where the incidence, especially of early syphilis, is for obvious reasons higher. Meanwhile there is a need for more research, coordinated internationally, on methods of diagnosis and treatment, as well as for epidemiological studies.

**Recommendations**

1. That the Governments of the countries of the Americas unite their efforts with a view to establishing a continental venereal disease program to significantly reduce the incidence and prevalence of those diseases, especially syphilis, in a relatively short period of time.

2. That countries that are more advanced in their knowledge and control of venereal diseases give countries that need it technical assistance for initiating or improving their respective programs.


\(^{36}\)Scientific Publication PAHO 137, 1966.
3. That the Governments give special attention to the training of personnel at all levels in venereal disease epidemiology and methods of control, and more particularly in contact investigation as an important tool for the prevention of the disease.

4. That the Pan American Health Organization and the World Health Organization collaborate with the countries of the Americas by providing them with technical and material aid, to the extent funds permit, in the planning, programming, organization, execution, and evaluation of venereal disease control programs; and that at the same time they serve as the coordinating agency for the programs of the countries, so as to ensure that they attain the same level throughout the Hemisphere and move forward in a coordinated manner.

5. That Governments be requested to undertake health education activities directed toward changing the patterns of those habits which are responsible in part for an increase in the incidence of these diseases.

10. ZOONOSES

Among the many zoonoses those that will be considered because of their importance for human health and for the economy are rabies, brucellosis, hydatidosis, and bovine tuberculosis. Their importance and the great interest Governments have in combating them are explained by the economic losses for which they are responsible, the loss of essential proteins for adults and children, and the possibility of controlling them, as well as by their high frequency. Not only do they have grave socioeconomic consequences, but they also present a serious obstacle to the free movement of animals and animal products between the countries of the Hemisphere. They will be considered separately in the order given above.

10.1 Rabies

In the last 10 years 2,203 cases of human rabies have been reported in all the countries of the Hemisphere. In domestic animals the average annual incidence is approximately 10,000 cases, not including bovines, and this figure is estimated to represent 20 per cent of the true incidence. A contributing factor in this undernotification is the lack of adequate means of diagnosis. Of the cases reported 90 per cent were caused by dog bites, dogs being the most important carriers and the chief reservoir of the disease. The risk of dog bites, and particularly bites by stray animals, has been increased by population movements from the rural areas to the towns, which has been accompanied by an increase in the dog population. That this is the situation is shown by the administration of antirabies treatment to more than 25 per cent of those bitten because of the impossibility of identifying the animal involved. It is estimated that approximately half a million persons are vaccinated annually in the Americas, and the cost of administering human antirabies treatment in many cases exceeds the outlay for control of the disease in animals.

Human cases transmitted by Chiroptera have also been reported in five countries. It is also estimated that cattle mortality from paralytic rabies transmitted by vampire bats exceeds 500,000 head annually, the losses being approximately $50 million each year. These facts justify the organization of programs based on the immunization of susceptible animals and on vector control. Such programs should, as far as possible, be self-financing, as should programs to prevent human rabies by immunizing at least 70 per cent of the dog population, controlling stray dogs, and carrying out effective education of the public—these activities being integrated into the health services. In some countries considerable experience has been acquired in the employment of these principles in the campaign against rabies.

10.2 Brucellosis

Because of its wide distribution, the number of human cases, and the economic losses it causes, brucellosis is perhaps the most

Important zoonosis in the Americas. Approximately 8,000 human cases are reported annually, a figure that represents a mere fraction of the actual number owing to the lack of adequate diagnosis of the disease in man. Most cases occur in countries where brucellosis in goats exists, transmission of the disease taking place frequently through the ingestion of fresh milk or cheese or through contact with infected animals. In cattle the disease mostly affects milch herds in areas adjacent to the large cities in Latin America, where more than 60 per cent of the herds have been shown to be infected. Swine brucellosis is a source of infection for man, but its effects on the economy and on the livestock industry have been very little studied.

Strain 19 vaccine is effective against bovine brucellosis, and Rev. 1 (Elberg) vaccine is effective against caprine brucellosis. Both reduce the infection rate, producing resistant herds, and this makes it technically and economically possible to eliminate brucellosis by the slaughter of reactors. This situation justifies the organization of a systematic self-financing program based on domestic resources supplemented by international credit. We underline the need, in the control of brucellosis, to have standardized antigens for diagnosis, common systems for the control and use of vaccines, and common health regulations and methods throughout the countries of the Americas. It was suggested that the Pan American Zoonoses Center be responsible at the international level for coordinating the programs, advising national laboratories, training and preparing professional and auxiliary staff, and carrying out research.

10.3 Bovine Tuberculosis

Because it is a source of infection to man and other species, causes great protein losses, and is a serious problem for the livestock industry, bovine tuberculosis should be the subject of control programs. At present the only control method that has stood the test of time is the slaughter of reactors to the tuberculin test. Even though it may not be possible, owing to the economic effects, to apply that method throughout the whole country, programs for the control of animal tuberculosis should include: an assessment of the magnitude of the problem; protection of herds and parts of the country free of the disease; eradication of infection in herds with low reactor rates so as to furnish sources of replacement; and control and/or elimination in heavily infected areas.

Countries are justified in seeking international credit in order to attempt to solve these problems, and they can count on the collaboration of the Pan American Zoonoses Center.

10.4 Hydatidosis

The existence of this disease in one or both of its clinical forms—unilocular and alveolar—has been confirmed in almost the whole Hemisphere. Control of the disease involves first the education of the public, the hygienic slaughter of meat animals, and the sanitary control of dogs. The disease is responsible for heavy economic losses which greatly affect the livestock industry and reduce the supply of foodstuffs of animal origin. Human infection persists for many years, and its prevalence is favored by low cultural, social, and economic conditions. The high cost of hydatidosis is shown in the few existing studies of the losses it causes to patients, their families, and the community, as calculated on the basis of hospital expenses and partial or total working incapacity. The seriousness of the problem makes it necessary to implement programs envisaging the most appropriate control measures as quickly as possible.

Recommendations

Zoonoses

1. That, in view of the social and economic impact of the zoonoses, the Governments should develop appropriate measures to combat them. National health services should include in their organization a department of veterinary public health that will maintain closely coordinated working relationships with the ministry of agriculture and its animal health services in order to provide for coordinated planning, control, and research activities.

\[39\text{Ibid., pp. 171-173.}\]
2. That countries should formulate plans of a permanent and continuing nature for the control of the major zoonoses and that, where necessary, they seek loan funds from the international lending agencies. In this planning and development process the countries are urged to make maximum use of the facilities and services of the Pan American Zoonoses Center, first in the planning and later in the training of personnel and in the development of techniques during the operational phases.

3. That, to coordinate activities against the zoonoses, countries should group together areas that are of like nature because of their geographic relationships, similar ecology, and close relation in animal movements and establish a firm regional cooperation with a view to mutual protection against the spread of and future reinfection by those diseases.

**Rabies**

1. That, considering the importance of the rabies problem in both its effect on public health and its economic impact, the Governments should extend or initiate their rabies control programs in accord with modern methods and give them high priority in their national health programs.

2. That Governments should implement national programs for the control of rabies in which the following measures are included: mass vaccination covering a minimum of 70 per cent of the canine population; elimination of ownerless and control of stray dogs; and an energetic health education program. These programs should, if possible, be self-financed and provide for the participation of the agricultural and educational services and the municipal authorities. As a rule, they should receive material and economic support from the community.

3. That the countries should be assured of the production of antirabies vaccine of good quality and in sufficient quantity to provide for the development of the required intensive vaccination campaigns. The public health and animal health services should be more closely coordinated in order to combine their resources and efforts in the campaign against rabies.

4. That the Governments increase and improve services for the diagnosis of rabies in order to improve case reporting and to avoid the indiscriminate prophylaxis of humans. The Pan American Zoonoses Center, at the request of Governments, will collaborate in the training of a large number of professional personnel in this field and lend assistance in the diagnosis, production, and control of vaccines and in practical research.

**Brucellosis**

1. That each country institute a program for the control of bovine and caprine brucellosis in terms of its own ecological areas, using the methods that are most efficient and best adapted to its conditions and possibilities. It is suggested that as the agency specialized in the subject, the Pan American Zoonoses Center be requested to assist.

2. That stress be laid on the need to standardize the brucellosis antigens and vaccines used in the various countries. For this purpose the collaboration of the Pan American Zoonoses Center should be requested.

3. That each country establish a system, supported by appropriate legislation, for the quality control and utilization of brucellosis vaccines produced in national and foreign laboratories.

**Bovine Tuberculosis**

1. That the Governments implement programs to control and/or eradicate bovine tuberculosis in accord with the human and economic resources available.

2. That for the planning, execution, and future financing of these programs, use be made of the experience gained in countries which have developed control programs, as well as of the collaboration of the Pan American Health Organization through the Pan American Zoonoses Center.

3. That for the development of these programs special attention be given, among other things, to the education and training of personnel; the conduct of surveys to determine the prevalence of the disease; coordination of the activities of the public health and the animal health authorities; the use of approved
and uniform tuberculin tests; the elimination of reactors; and economic incentives for producers, which are necessary to obtain their support in the development of these programs.

**Hydatidosis**

We recommend to the Governments that they implement programs for the control of this disease which will include a continuing, intensive program of health education aimed principally at communities in rural areas, the sanitation and veterinary inspection of slaughterhouses, and the sanitary control of dogs. These programs should be coordinated at the highest level between the health, agricultural, and educational authorities as well as other public and private organizations.

### 11. AEDES AEGYPTI

In the time that has elapsed since the 1963 Meeting of the Task Force on Health, the program for the eradication of *Aedes aegypti* has remained stationary in the countries and territories where the mosquito was present and has regressed in other countries, which have again become reinfested. Among the former are the United States of America, Venezuela, Guyana, Surinam, French Guiana, and a few localities in Colombia and in the Caribbean area where, apart from Trinidad and Tobago and certain islands, all the countries and territories are extensively infested.

In Argentina, Brazil, Guatemala, Honduras, and Mexico the vector has appeared in recent years in foci of variable size, but in the case of El Salvador the whole country is infested. The Governments of all these countries have again begun to take action to eradicate the vector.

In this same period no cases of urban yellow fever have been notified, but an extensive epidemic of dengue was reported affecting Venezuela, Jamaica, Puerto Rico, and some territories in the Caribbean area. An enormous number of cases were confirmed, with the consequences to be expected for the economy of the areas where the incidence was highest.

There is at present no technical obstacle to the eradication of *A. aegypti* from the Americas. The reasons why the campaigns are not proceeding satisfactorily are administrative and financial in nature. Removal of those obstacles depends on whether Governments are prepared to give eradication of the vector the priority the problem deserves. The protection of infected areas solely by yellow fever vaccination is not to be recommended. In addition to the improbability of being able to maintain a sufficient level of immunity in the population indefinitely, this type of protection could turn out in the long run to be more expensive than the eradication of the vector. It is most desirable that biological and ecological research should be stimulated, and new methods be found of eliminating *A. aegypti* that would be comparable in effect to those used at present but would cost less.

*A. aegypti* has already been eradicated from nearly 80 per cent of the areas ecologically favorable to it in the Americas. That undertaking has cost millions of man-days of work in repeatedly inspecting and treating millions of houses, and represents an immense outlay of funds and efforts that has been of vital importance to the Hemisphere. It is our responsibility to complete that undertaking without further delay, in accordance with the successive resolutions that have been passed by the Governing Bodies of the Pan American Health Organization and the Regional Committee of the World Health Organization for the Americas.

**Recommendations**

1. That the Pan American Health Organization assume, with the highest priority, leadership of the *Aedes aegypti* campaign, in order to achieve coordination of the national programs and collaborate with the Governments, so that they may have available the necessary personnel and equipment, as well as the required financial resources.

2. That the Governments use their influence with international lending agencies to have them include in their credit policy the provision of loans for the eradication of *A. aegypti*.

3. That the countries, directly or through the PAHO, provide one another with mutual

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help for the eradication of the vector, in the form of loans or subsidies or the supply of material and equipment for the campaign.

4. That the countries now free of *A. aegypti* maintain strict vigilance to prevent reinestation of their territories, and that the PAHO provide such countries with the aid they require for the establishment and maintenance of their vigilance services, as well as for their periodic review to correct any defect that may be hindering their satisfactory operation.

5. That encouragement be given to research aimed at increasing knowledge of the biology and ecology of the mosquito and at developing new methods that can make its eradication easier and more economical.

6. That countries which are still infested make every effort to overcome the difficulties which up to the present have prevented the completion of programs which all the countries of the Americas agreed to carry out and approved in repeated resolutions of the Governing Bodies of the PAHO; and that they fix a time limit for completion of the programs and notify the PAHO accordingly.

### IV. STATUS OF MALARIA ERADICATION IN THE AMERICAS

During the period 1963-1968 great headway was made in the continental program against malaria. The commonest and most comprehensive indicator of progress is the distribution of the population in the malarious areas, according to the phase of the eradication program. Thus, in the above-mentioned period, leaving aside the population of the countries that had eradicated malaria before 1955, the population of areas in which malaria eradication has been achieved has doubled, from 6,737,000 to 13,220,000, an increase of 96 per cent; the population living in areas in the consolidation phase has tripled, from 13,879,000 to 41,581,000, an increase of about 200 per cent. Numerically these two groups are equal to half the population in the regions of the Hemisphere that were exposed to endemic malaria in 1955 when the continental program began. The population living in areas in the attack phase has increased by 15 per cent and that living in areas in the preparatory phase has fallen by 69 per cent. It is expected that, by the end of 1968, there will be no programs with areas in the preparatory phase, and that all the inhabitants of the Americas will be to some degree protected as a result of activities designed to reduce or interrupt malaria transmission. In the period under review (1961-1967) the total population in the originally malarious areas increased by 12 per cent from 100,672,000 to 112,401,000.

Activities in the problem areas, where vector resistance to insecticides made it necessary to adopt more expensive and supplementary attack measures, were seriously handicapped in recent years by lack of funds. This difficulty has now been overcome, and almost all the programs have resumed coordinated attack-phase operations buttressed by the necessary special measures. Research on the various negative factors in the problem areas continues to be sponsored by the World Health Organization. At present new insecticides, new drug formulations, and a long-lasting injectable antimalaria product are being tried out. Systems analysis with computers is being used to coordinate operations and to rapidly obtain information on the epidemiological situation.

Experience in recent years confirms the conclusion of the Meeting of the Task Force on Health in 1963 that the "immediate crucial problem in our Hemisphere is still the financing of local costs." It is clear that, if eradication is to be accelerated, sufficient funds must be assigned to it and they must be supplied on time by the Governments and international agencies. Deficiencies have also come to light in administrative services and these have a serious negative effect on the conduct of programs. It is therefore extremely important for Governments to take the necessary interest to ensure the highest possible degree of efficiency.

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In this program, which involves a huge investment, we must promote research on the benefits that are expected from eradication, not only in terms of a reduction in mortality and morbidity but also in its effects on other aspects of community life. With this end in view, PAHO/WHO has initiated a study on the socioeconomic impact of malaria and its eradication in Paraguay.

Further efforts must be made to maintain the progress already achieved in the campaign. For that purpose, there must be increased coordination of the malaria eradication services with the general health services, and the training of the staff of the general health services in malaria vigilance operations must be stepped up. At the same time, the staff of the malaria campaign must be trained in multipurpose health activities.

The results obtained from operational research indicate that national and international agencies should continue to promote it. Experience has shown the usefulness of the exchange of information between neighboring countries as it usually deals with the solution of common problems.

Recommendations

1. That stress be laid on the need to intensify the efforts of Governments to speed up malaria eradication in the Americas.
2. That the need to provide funds which are sufficient and are delivered on time be emphasized.
3. That special attention be given to the improvement of administrative services, until the highest level of efficiency is attained.
4. That the Governments and international organizations carry out or encourage basic studies, in carefully selected areas, concerning the impact of malaria and its eradication on the population and on economic development.
5. That the record show our satisfaction with the increase in the population now living in areas in the maintenance and consolidation phases and the shifting of new areas into the attack phase.
6. That the Governments accelerate the training of personnel of the malaria eradication services in multipurpose public health activities, and the personnel of the general health services in malaria vigilance activities, so that they can assume the corresponding responsibilities in the maintenance phase.
7. That the need be emphasized to increase the coordination of the national malaria eradication services with the general health services, to improve existing services, to increase coverage in the rural areas, and to give multipurpose health responsibilities to personnel in the malaria eradication services in areas in the maintenance phase.
8. That the Governments and international organizations conduct or encourage research for the solution of the problems of persisting transmission of malaria.
9. That the Governments give priority in eradication activities to areas affecting the programs of neighboring countries so that their activities can be coordinated.
10. That the attention of PAHO/WHO be drawn to the desirability of having periodic technical and administrative evaluation of the malaria eradication programs made by independent groups, and that the Governments implement the recommendations resulting from these evaluations.

V. SANITATION, ENGINEERING, AND ENVIRONMENTAL SCIENCES

The Charter of Punta del Este and the report of the 1963 Meeting of the Task Force on Health gave priority consideration to environmental sanitation and, within this field, to the needs of the people for water supply and sewerage services. In the Charter goals, the signatory Governments undertook to meet the water and sewerage needs of 70 per cent of urban and 50 per cent of rural populations. These pledges, reaffirmed by the American Chiefs of State at the Punta del Este summit meeting in April 1967, recognize that
community systems of water supply and sewerage are basic to the health and the economic and social well-being of the peoples. Further, that safe water, in adequate amounts, available in homes, will reduce enteric infections and related illnesses; will decrease infant mortality; will promote cleanliness of the person, the home, and the community; and will stimulate self-respect and enhance the dignity of man.

Since 1961, the Governments of the Region have responded promptly and effectively to this public need. Progress reports by the Director of the Pan American Sanitary Bureau reflect the unprecedented achievements of the continental water supply program, especially in urban areas, and the uniformly good progress being made in the technical, management, and financing aspects of these public works.

Under the stimulus of this program, 18 countries have already achieved the Punta del Este goal of providing water for at least 70 per cent of their urban population; others are relatively close. Since 1961 about US$1.4 billion has been committed for water supply and sewerage works. Sixty per cent of this is current national funds, and the remaining 40 per cent represents international loans (75 per cent from the Inter-American Development Bank). In terms of the human equation, these improvements benefit 62 million urban and rural residents. On a regional basis, the urban water supply program is on schedule. The Charter goal will be achieved. On a lesser priority scale, the provision for urban sewers is progressing in reasonably good order.

With respect to rural areas, progress has been much less spectacular in providing water services in small towns and villages. While all the Governments have initiated rural water programs, rates of progress vary widely among countries, and the total continental program is lagging behind the desired time schedules. At present, 16 per cent of the 118,000,000 rural population have water services. This represents about one third of the target goal for the Alliance Decade. We urge the Governments to accelerate their efforts to promote the rural water program, with emphasis on the community self-help concept; to develop local water co-ops; and to stimulate, in each country, the establishment of a revolving-fund mechanism as stated in the Declaration of the Presidents of America. Special emphasis should be given to community organization and to mass-approach techniques.

In the Americas, man’s physical environment is undergoing rapid and profound changes. Pertinent influences include population growth, increased urbanization, greater intermingleings of people, and widening technological industrialization. As cities grow and industry expands, problems of water, air, and soil pollution will become more pronounced and more important. While some deterioration of these resources must be accepted as the price of progress, environmental pollution must be kept below levels which would endanger the personal health of people. Beyond the health parameter, such pollution should not reach levels which would seriously deteriorate the values and uses of these resources, particularly where the economics of an area and the general well-being of its people would be adversely affected. The changing complexities of man’s environment require much broader concepts to keep in reasonable balance the total ecological system. More attention must be given to remedial measures to prevent the creation of environmental hazards, with less dependence on corrective or control actions. Each country must face the difficult task of establishing standards and control practices that will meet the needs and aspirations of the people.

Region-wide programs are well advanced to strengthen engineering education and to develop a network of university-based training and research centers. The Pan American Health Organization is stimulating and supporting these activities. Partnerships are being formed between the agencies responsible for water and sewer works and the universities. Search is on for new approaches which will be more economical and more adaptable to mass applications. New legislative, administrative, financial, and institutional patterns and arrangements are emerging. The logistics of river basin development are under study, with special attention to health-related implications. Within the framework of stern economic realities, priorities and alternatives become necessities. The PAHO is developing in Peru a Pan American Sanitary Engineering Center to

provide the Governments with expert scientific and research assistance.

In the years ahead the Governments will have to cope with environmental problems of greater magnitude and complexity. Advancing technology will leave in its wake a more sophisticated array of human stresses. Environmental contaminants will increase and will broaden from microbiological pollutants to those having their origin in chemical substances. Long-term exposure to toxic substances will be more significant and more difficult to diagnose, with wide separation of cause and effect. The growth of cities will aggravate problems of traffic congestion, accidents, and noise hazards. Population densities and poor housing will increase the hazards of communicable diseases and problems of mental health. In industrial complexes, occupational health will require more focused attention and remedial measures.

In the future, health agencies must expand their activities to include the health-related considerations of slums, poverty, and filth; of ignorance, delinquency, and crime; and of the effects these have on the total health of people.

**Recommendations**

1. Noting that technological advances in an urbanizing society are creating unprecedented changes in the physical environment of man; and that the magnitude and complexity of these changes intensify traditional problems and create a host of new stresses affecting the health and well-being of man, we propose to modify programs and practices to meet new trends. We urge the Pan American Health Organization to continue to intensify the attention it is giving to new problems, and to adjust and utilize its resources to broaden its assistance to the Governments.

2. We urge the Governments to continue to give the highest priority to programs to provide community water supply and sewerage services, in order to maintain the unprecedented progress now being made. Special considerations include:
   a) In urban areas, actions should be intensified to ensure that the goals established in the Charter of Punta del Este are attained.
   b) For rural areas, these programs should be made more adequate and intensified, where necessary, and accelerated so as to approach the goals established in the Charter.
   c) Newly developed methods and procedures in management and administration, initially devised for water agencies, should be applied in the management of sewerage systems.
   d) Water and sewerage agencies should be given sufficient authority and autonomy to enable them to carry out assigned responsibilities, including proper coordination with appropriate ministries.
   e) In order to provide for effective organization and management, the Governments are urged to modify policies, if necessary, in order to use international funds to strengthen the administrative structure responsible for water and sewerage programs.

3. In order to improve planning and methods of financing for water and sewer systems, the PAHO should broaden its assistance to the Governments in developing mass-approach techniques and in establishing and using revolving-fund mechanisms. Studies should be made to determine the percentage of the gross national product that might be adequate and appropriate for investment in community water and sewerage systems, especially in rural communities.

4. We request the Governments to give greater emphasis to programs of education and training of professional, technical, and auxiliary personnel in the field of environmental health. We recommend to the universities that they intensify teaching of public health engineering in their engineering, architecture and related departments, for the purpose of satisfying the growing demand for the human resources needed to design environmental engineering works, and for the application of practical and efficient methods of control. We urge that the PAHO continue to support the programs of education, training, and research that are going forward in the countries.

5. The ministries of health should play a leading role in developing policies and practices to control air and water pollution; to reduce occupational hazards through stronger programs of industrial hygiene; and to promote the execution of housing programs, including revolving-fund systems and appropriate integration of essential sanitary services and vector control practices.

6. In the more densely urbanized areas, the ministries of health should broaden their
traditional programs to include the health effects of such problems as noise, congestion, accidents, and poisoning. Where practical, preventive measures should be used to minimize adverse effects on the ecological system, rather than depending entirely on corrective or control actions.

7. The programs should take into consideration the health implications of slums, poverty, and filth; of ignorance, delinquency, and crime; and the effects these have on the total well-being of people.

8. In order to cope with the expanding health and economic problems of solid waste management, the PAHO should encourage international lending agencies to make to the Governments, under favorable terms, loans for financing equipment and installation of facilities.

9. In order to facilitate the financing and ensure the continuity and effectiveness of the programs of environmental sanitation, it is necessary to strengthen community participation, especially in rural areas.

10. The ministries of health should have enough competent technical personnel and adequate regional and national laboratories to supervise water quality and related sanitary controls.

11. The Governments should undertake activities at the national level in connection with the problem of pollution caused by the expanded use of chemicals, especially pesticides, which should be coordinated especially by region.

VI. MATERNAL AND CHILD HEALTH AND THE HEALTH ASPECTS OF COMPREHENSIVE FAMILY EDUCATION

In the Charter of Punta del Este the Governments pledged themselves to halve mortality in children under 5 years of age during the decade. In their Declaration the Presidents of America, in addition to reaffirming that commitment, decided to foster maternal and child health services and comprehensive family education.

The information provided by the ministries of health shows that more progress has been made in reducing mortality in the age group 1 to 4 years than in the group under 1 year of age. Indeed, in Middle America the mortality rate for the former fell from 14 per 1,000 population in the period 1960-1962 to 11.6 in 1966; in other words, by 17.1 per cent. The target figure to be reached by the middle of the decade is a 25 per cent reduction. In South America, in the same period, the rate fell from 13.3 to 10.2 per 1,000. This represented a 23.3 per cent reduction, which means that 93 per cent of the target has been achieved.

With respect to infant mortality, the rates in Middle America were 71.3 per 1,000 live births in 1960-1962 and 63.4 in 1966, representing an 11 per cent reduction in the five-year period.

For South America the rates were as follows: 83.9 and 73.6 per 1,000 live births, or a 12.3 per cent reduction in the five-year period. The target for both regions is a 25 per cent reduction by the end of 1966, 50 per cent of the goal for the decade.

An analysis of the causes of death shows that diarrheal diseases in infancy and infections of the respiratory tract as well as a few communicable diseases—such as measles, tetanus, whooping cough, and malaria—and also accidents, are the main causes of death after the first 28 days and through the first 5 years of life. Certain diseases of early infancy which are related to congenital factors, pregnancy, confinement, and the environment surrounding the newborn, are the most important cause of mortality during the first 28 days of life.

Undernourishment, which does not appear among the principal causes of death but which affects a large proportion of children under 5 years of age, is influenced by the age of weaning and the economic and cultural status of the family. Research studies under way, including those being carried out by the Institute of Nutrition of Central America and Panama (INCAP), point to a direct relationship

44Ibid., pp. 261-280.
between nutritional deficiency and mental retardation.

In some countries there has been a rapid change in the age of weaning, which is becoming more and more early in the life of the child, a development that can be of serious consequence to the child's physical and mental development.

In addition to the biological factors we have mentioned, social, economic, and demographic factors are also very important, for they all affect the health of the child, the mother, and the family.

Demographic factors are also important, especially when the growth of the population is rapid, as is the case in many countries in Latin America, which as a whole has the highest annual population growth rate in the world. This causes sudden increases in the absolute and relative number of children at the most vulnerable age, who are exposed to the environmental hazards which they are unprepared to resist, a situation which leads to increased morbidity and mortality. It is very difficult for the Governments to satisfy medical, social, and educational needs when these sudden increases in the child population occur. Many of these needs therefore remain unsatisfied. Furthermore, it is noted that in low-income families the higher the infant mortality, the higher the birth rate, and vice-versa.

Observations made in several countries in the Americas show the higher biological risk involved in large families, a risk that weighs heavily on those segments of the population most vulnerable from the standpoint of economics and medical care. In some countries induced abortion and complications following abortion, including a high maternal mortality, are observed among those sectors of the population.

These findings have led some Governments to consider the participation of the health sector in the formulation of family planning policy and programs. In doing so they have taken into account the resolutions of the World Health Assembly and the Directing Council of the Pan American Health Organization. On the basis of these resolutions some Governments have already prepared maternal and child protection and family planning programs aimed at reducing the risk of death and disease to which children and mothers are exposed and at the same time to improving conditions of family life.

In order to achieve the target of the Charter of Punta del Este, which is to reduce mortality in children under 5 years of age to half of the 1961 rate, a considerable effort is necessary even though much progress has been made in the first five years. Of course we shall refer essentially to the technology of health and its immediate effects. There is no doubt that not much is to be hoped for if levels of living are not improved at the same time, particularly in rural areas and in the shanty towns where environmental hazards are greater for the child, the ecological equilibrium is more critical and, therefore, the risk of disease, stunted growth and development, and death are higher.

Most of the preventive and curative problems of maternal and child health do not call for expensive equipment. Manpower, whether professional or auxiliary, is the critical input. Auxiliary personnel have a very defined responsibility which, in the rural areas of Latin America today, is fundamental. The damage caused by malnutrition, childhood diseases, ignorance, and deficient sanitation are so serious that they call for urgent action by the communities and their leaders in cooperation with the health services.

Recommendations

1. That the Governments which have not done so promote development and the raising of living standards in areas where the health situation of children and families is most critical, namely, in rural areas and in the shanty towns ringing rapidly growing cities.

2. That we intensify social welfare activities on behalf of needy children and families, such as health insurance schemes covering the family, grants to nursing mothers, help with food for children and indigent pregnant women, etc., thus contributing to the improvement of their situation and the redistribution of wealth.

3. That integrated health care for mothers and children be rapidly extended to wider sections of the population, through continuing activities, with special emphasis on those sections most exposed to risk.
4. That maternal and child health, nutrition, and comprehensive family education activities, programs, and services be adequately coordinated at all levels, with a view to achieving the maximum employment of resources through mutual support and coordination and avoiding at all costs the duplication of services.

5. That due priority be given to health promotion and restoration and disease prevention activities for mothers and children.

6. That the training of personnel be stepped up at all levels, especially training of experienced administrators, on the one hand, and, on the other, of auxiliary and empirical personnel to carry out the less complicated technical tasks in the worst equipped areas.

7. That universities be encouraged to expand the pediatric and obstetrical training of physicians, nurses, midwives, social workers, and nutritionists, inculcating a more profound knowledge of the fundamental biological processes of reproduction and growth and development and their interrelationship with social and demographic factors.

8. That studies on growth and development at critical ages be promoted with a view to establishing reference curves both for measuring this phenomenon in the various communities and for guiding and evaluating child nutrition programs.

9. That, with the technical advice of PAHO, the countries undertake studies relating the growth and development of children and their educational achievements with family size, food consumption, and income level.

10. That community action be promoted so as to achieve the informed and effective participation of the community in maternal and child health activities through leaders, neighborhood units, natural and organized groups, etc.

11. That, in coordination with the education and social welfare sectors and with help from the universities, we undertake large-scale educational activities based on the findings of socio-anthropological studies, with a view to promoting the adaptation of the family to the conditions of modern life resulting from general development.

12. That the means for ensuring breast-feeding for an appropriate period be promoted and facilitated.

13. That international agencies concerned with child health and welfare coordinate their activities so as to improve the results obtained.

14. That with the technical advice of PAHO the countries undertake studies to periodically establish, in each economic region, the minimum expenditure in relation to the income of the family necessary to safeguard the life and health of its members, bearing in mind the number of children in the family. Wide circulation should be given to these data in the countries.

15. That, in those countries whose Governments have officially adopted a policy of family planning, these services should be integrated and coordinated with existing maternal and child health programs and made available to all members of the community who wish to utilize them.

16. That PAHO attend, to the extent budgetary funds permit, to the requests of the Governments for advisory services and assistance in connection with maternal and child health programs and with family planning programs, whether these be aimed at increasing or reducing the number of pregnancies.

17. That the Governments, through their ministries of health, give their full support to the Inter-American Investigation of Mortality in Childhood sponsored by PAHO. The aim of this investigation is to study the mortality of infants and of children in their early years, taking into account nutritional, infectious disease, sociological, and environmental factors. This investigation will produce findings which should serve as the basis for the improvement of maternal and child protection and medical education programs.
VII. FOOD POLICY AND NUTRITION

It has been shown that there has been substantial progress in our approach to the diagnosis and treatment of nutritional disease. However, preventive aspects have not received the same emphasis, chiefly because the provision of an adequate food supply, particularly in terms of calories and protein, for the vulnerable segments of the population lies outside of the responsibility of the health services. In turn, this situation results from the lack of a specific government policy on food and nutrition which will harmonize the biological needs of the population with the demands for economic development, especially those relating to the import and export of foodstuffs.

We have recognized, in principle, the need to create a nutrition data retrieval and analysis center for this Hemisphere which would provide information on all aspects of the food chain. Such information would enable the Governments to establish the above-mentioned food and nutrition policy and the intersectoral plans that would emerge from this. It would also make possible a comparative study of the problems and programs of the different countries of the Americas as a basis for continental action.

An analysis of the progress in nutrition programs since the 1963 Meeting of the Task Force on Health shows that a wide variety of activities are being pursued to meet the broad range of nutrition problems. These include the establishment of norms for optimal population nutrition; the incorporation of nutrition in national health plans; the reduction of food losses by more effective control of rodents as well as of enzootic diseases; the iodization of salt for the control of endemic goiter; the enrichment of cereals to improve their nutritional value and to prevent specific deficiencies; and research into industrial production, distribution, and utilization of new sources of low-cost, high-protein foods. The development of Incaparina, a mixture based on vegetable proteins, has stimulated corresponding investigations in six countries which have now produced similar protein-rich products suitable for use in infant and preschool feeding. In this context mention was made of the research programs on high-protein foods, currently being carried out, which involve fish protein concentrate, sunflower seed, and rapeseed.

Reference was also made to the importance of intensifying the training and education of professional health workers specialized in nutrition. In this respect, progress has been made, though there is need for greater efforts in the future. Improvement in the quality of training for nutritionists and an increase in the number assigned to health services and to teaching will be required.

From available information, it is evident that considerable progress has been achieved in nutrition activities in the past five years. Much, however, remains to be done. The problem in Latin America is not a static one; on the contrary, it increases in proportion to the growth in population and the associated demand for more and better foodstuffs. In the majority of Latin American countries, per-capita food production levels have remained low and stationary for the last 10 years, while food imports have progressively increased in order to compensate for the deficit. National food supplies have thus been maintained; however, owing to problems of distribution and purchasing power, large sectors of the population do not consume sufficient calories and protein to achieve normal nutritional status.

What the Americas produce today represents only a fraction of the potential capacity of its great natural resources. And even the land at present under cultivation can produce much more in terms of quantity and quality. The losses of protein through animal diseases and the destruction caused by rodents and insects can and should be controlled. This cycle of scarcity is completed by the limited purchasing power of the greater part of the population; ignorance of the principles of basic nutrition as reflected in patterns of food purchasing and preparation, which results in a further reduction of available nutrients; and the interaction of other environmental factors such as infectious and parasitic diseases which contribute to, or precipitate, malnutrition.

This problem is essentially multidisciplinary.  

and requires coordinated action by different government agencies, together with the active cooperation of the community. Basic responsibilities lie with the health sector, on the one hand, in stimulating and participating in the formulation of a national food and nutrition policy and its application to the community and, on the other, in the prevention and control of nutritional diseases as a routine activity of health services.

Recommendations

1. That the planning units of health agencies stimulate and participate actively in the formulation of national food and nutrition policies and intersectoral plans designed to assure an adequate food supply to all sections of the population in order to fulfill defined biological requirements.

2. That we establish a center for the retrieval and analysis of nutrition data for the Americas, preferably utilizing existing institutions. This center should collect, collate, analyze, and distribute relevant nutrition data on a country-by-country basis in order to provide the basic information upon which a food and nutrition policy could be established. In addition, the center should provide training of national staff in the approach to policy formulation and program planning.

3. That the Governments increase studies on the food and nutrition status of their populations and thus provide a sound and objective basis for the establishment of their national food and nutrition policies.

4. That the health sector clearly define its responsibilities within the national food and nutrition policy and that these be incorporated in the health planning process to provide for specific activities to be carried out at the regional and local levels. Such activities should contemplate a coordinated effort involving maternal and child health, environmental sanitation, health education, and other relevant services.

5. That increased support by national and international agencies be given to schools of nutrition and dietetics in order to provide more qualified professional personnel in this field.

6. That schools of public health, medicine, dentistry, and nursing, as well as teacher training institutions, be assisted in strengthening nutrition instruction in order to ensure the active participation of their graduates in local programs.

7. That the Governments continue to enact suitable legislation that will ensure the utilization of existing technology in such fields as salt iodization, cereal enrichment, and the commercialization of low-cost, high-protein foods, and to provide consumer protection against false advertising of weaning foods. It is important that such legislation be planned in close collaboration with the private sector in order to assure effective implementation.

8. That the Governments give increased support to research institutes to enable them to find effective methods of applying existing knowledge of food and nutrition science under the restricted socioeconomic conditions that exist in many areas of the Americas.

VIII. NATIONAL HEALTH PLANS AND STRENGTHENING OF THE ORGANIZATION AND ADMINISTRATION OF HEALTH SERVICES

The title of this item reveals the logical sequence which should characterize national health plans, that is to say, a rational scheme of priorities and investments for the solution of problems and within the integrated services that must carry them out. In other words plans are made to serve a need, which in this case is a vital one, and this is done by coordinating the present and potential resources of a country, regardless of their origin, in order to achieve the measurable objectives of the plan. It is only for administrative reasons that a distinction is made between medical care and rehabilitation and health protection and promotion. They are stages in the same biological and social process whose exclusive beneficiaries are human beings and the societies they compose.

Planning is a result of a policy decision
without which the plan cannot be instituted; it is not an end in itself; it is the beginning and condition of a process. Today planning is acknowledged to be a fundamental tool for achieving the continental objectives of the Charter of Punta del Este as well as the national objectives of Governments.

The data collected\(^{46}\) show that, in the interval between the two Meetings of Ministers, undoubted success has been achieved in planning efforts but that at the same time critical problems which must be overcome in the short, medium, and long-term have arisen. These include the fact that in the health sector only a few State institutions are included in the plan, which frequently does not cover the social security institutions. The integration of health plans into economic and social development plans is in some cases purely formal and is limited to investment programs and determined by budgets. Program execution has revealed the weakness of the administrative and technical infrastructure, which impairs the continuity of planning and the possibility of improving it.

Nevertheless, what has been done in the interval shows that in all countries the formulation and execution of national health plans has been the beginning of positive change, despite the short time that has elapsed. The method used, in addition to being instrumental in bringing about this change, has also been of use in establishing the above-mentioned limits and in suggesting means of modifying and improving the whole process.

A fundamental obstacle has been the inadequacy of biomedical and accounting statistics which, generally speaking, are incomplete, irregularly recorded, and not always processed in sufficient time to enable health activities to be planned and evaluated. This has been especially serious in the case of hospital statistics. It is also necessary to further develop the methodology to include substantive activities such as nutrition, sanitation, community organization, and the like.

We are of the opinion that efforts must be made to ensure the active and systematic participation of the health sector in the formulation and execution of economic and social development projects which involve the movement or settlement of considerable numbers of persons as well as appreciable changes in their living and working conditions. Furthermore, our lack of knowledge of the dynamics of the phenomena conditioning health per se, and in the context of development, must also be considered.

Fundamental factors in planning are the policy decision and the capacity to carry out plans and programs.

There was general agreement that the coordination of health resources is essential and that it would be pointless to continue to talk about health planning unless there is a mutual understanding among institutions in the health sector to coordinate their resources. It was noted that several countries have taken a decisive step toward coordination but it was also recognized that these efforts are still insufficient to ensure the fulfillment of the goals of an integrated health plan. The diverse nature of health activities and the part played in them by private and semi-independent agencies, the high cost of medical care, the shortage of available resources, and the pressure of the increasing demand make it both urgent and essential to set up national systems for the effective coordination of the preventive and curative services of the health ministries and of these, as a whole, with those of social security institutes, universities, and other public and private agencies.

Coordination will make it possible to raise the level of medical care, expand coverage as much as possible, and promote the active participation of the local community in the planning and administration of services. The administrative regionalization of services will prevent duplication of effort. Highly specialized resources should be concentrated in facilities for the care of patients drawn from the entire country or from a given region, according to the situation. Guided by common standards provided by the central organization, activities for disease prevention, health promotion, and health restoration can be carried out through a network of integrated services which should achieve the widest possible national coverage.

The regionalization and coordination of programs for the building of hospitals and other health facilities is even more important when such programs are covered by the investment

\(^{46}\textit{Ibid.}, pp. 244-260.$
plan which, in turn, is one of the components of the national health plan and of the economic and social development plan. The enormous capital investment necessary to implement a construction program has a major impact on the distribution of financial resources, and its effect on the national economy is such that it must reflect a strictly functional and economic standpoint, since the capital invested in hospitals could, as an alternative, be invested in schools, roads, or industrial machinery, and thereby benefit other areas of economic and social development.

To promote the coordination of health services at all levels, we recommend that permanent interinstitutional commissions or committees be set up to collaborate in the establishment of technical standards for the systematic improvement of the quality of medical care and of the effectiveness of activities covered by the plan and of other activities arising from their intersectoral relationships.

We also deem it advisable to undertake programs of operational and administrative research for the purpose of developing and improving the methods to be used for formulating and evaluating plans, programs, projects, and activities, thereby facilitating the formulation of sectoral policies. This includes the analysis of expenditures and sources of income, and of available and potential resources.

Another factor that we consider to be important as a first step toward planning is a review of the juridical and legal aspects bearing on closer interinstitutional links and the establishment of a common administrative system designed to ensure better use of the available resources.

In the light of the foregoing considerations, we recognize that, in order to increase coverage and make better use of the available resources, each country should adopt the coordination system best adapted to its historical tradition, its juridical and administrative system and the degree of development of its health resources. What is important is that the system chosen should guarantee and respect the policy-making, coordinating, and supervisory function of the technical agencies of the ministries of health.

The financing of medical care services should essentially be based on health insurance, as a method whereby those using the services contribute to the costs according to their economic capacity. Those members of the community who are not in a position to contribute should be entitled to the services free of charge.

We have reaffirmed our intention of persisting in the formulation of health plans and their periodic adjustment and in increasing the training of professional health planners with a view to creating a common language, guided by the general and specific objectives, and improving the quality and performance of resources.

The experience acquired so far shows once more that, in all health activities, manpower is the critical input and, at the same time, that there is a lack of consistency between the content of the training programs and actual needs, between their costs and benefits, in addition to a failure to make the necessary provision for putting human resources to the most effective use.

These facts which reveal progress, as well as others, are to be found in the working document for our meeting. As a whole they reflect the improvements made in the general health and medical care services and are milestones in the process of planning and integration.

**Recommendations**

1. It is recommended that, in those countries in which planning has not been instituted, the Governments take the pertinent steps to formulate and implement national health plans, geared to economic and social development. For that purpose, it is first necessary to establish a health policy.

2. It is essential that those countries in which planning is in any of its stages of development strengthen activities designed to improve planning. For that purpose, the following is proposed:

   a) To extend the geographic, technical, and institutional coverage of health plans. Planning envisages the coordination within the plan of at least the State institutions, including the social security institutions.
b) To undertake periodic evaluations of the plans and of their consistency with the health policy of which they are the expression, in order to develop a long- and medium-term sectoral strategy. These evaluations should be made in the light of economic and social development.

3. It is important for health plans to be periodically revised in order to adjust them to the changes that have occurred. They should also be the means used for preparing budgets for health activities.

4. It is essential to improve the operational capacity of the sectoral system in order to ensure the realization of plans and the fulfillment of goals. In this connection we recommend the incorporation of specific medium- and long-term programs for the development of the sectoral infrastructure, in particular programs for:

a) The strengthening of the administrative structure in accordance with the needs of the plan.

b) The adaptation of statistical systems to enable them to measure not only the health level, but also the use and the output of the resources of the health sector. We recommend that use be made of surveys and research in order to obtain this information in due time.

c) The establishment of accounting systems, cost appraisal systems, and control systems to ensure maximum efficiency in the operation of plans.

d) The conduct of operational and administrative research for the development and improvement of the methods for formulating and evaluating plans, programs, projects, and activities. This also involves the analysis of expenditures and sources of income as well as of other available and potential resources.

e) The training of personnel for the sector, according to the needs of the plan and its relationship to other specific areas of the general socioeconomic development plans.

f) The clear definition of a policy for the recruitment, retention, and promotion of the manpower needed to ensure the best utilization of investments.

g) The establishment of permanent interinstitutional committees to assist in the preparation of technical standards for systematically improving the quality and output of the activities covered by the plan and those derived from its intersectoral relationships.

h) The review of juridical and legal aspects to facilitate closer interinstitutional links, the operation of the administrative system, and better utilization of the resources available.

i) The formulation of sectoral investment plans that provide for the necessary means for evaluating the projects included in them and for analyzing their intrasectoral relationships.

5. We deem it essential that the health plans encompass those areas related to nutrition, environmental sanitation, and community organization which are the direct responsibility of the health sector, and that action be taken to promote the formulation and implementation of policies in those activities, the programming and development of which are intersectoral and interdisciplinary in nature.

6. Since the health sector is a component of the social development infrastructure, efforts must be made to ensure that health workers actively and systematically participate in the formulation and execution of development projects that involve large-scale migration or land settlement and major changes in living and working conditions.

7. Systems should be set up in each country without delay for the effective coordination of the health services of ministries of health with those of social security institutions, universities, and other private and public bodies. To assure that coordination is effective, it should be a permanent activity of all those who participate in the process of planning, administration, and provision of services under the guidance of the health ministries or the corresponding agencies. In this way, closer institutional links will be forged at the central level, regionalization will be achieved at the intermediate level, and integration of curative and preventive services at the local level.

8. We recommend that the countries prepare, as an integral part of their national health plan, a program for the construction, remodeling, and maintenance of hospitals and other health facilities, geared to the available resources and in consonance with the economic and social development investment plan.

9. With the exception of the indigent, all patients should contribute to the costs of medical care according to their ability to pay.
IX. THE ROLE OF HEALTH SERVICES IN PROJECTS FOR THE MODERNIZATION OF RURAL LIFE

For the development of health services in projects for the modernization of rural life, mention was made of the need to consider at the same time the improvement of the economic situation through changes in the system of land tenure, credit facilities, education, housing, and mechanization so as to increase agricultural output.

Other points we considered were the importance of an adequate distribution of human resources, improvement in communications, and a progressive policy in environmental health.

In spite of the difficulties of defining the rural population, it is essential to do so. While it is difficult to define what is considered to be "rural" within any one country, it is still more difficult to compare the term as it is construed in different countries. In one country an attempt is being made to classify the rural population into indigenous, scattered, and grouped. The first category consists of traditional communities; the chief feature of the second is that it is scattered over extensive geographic areas and over parts of the country where its isolation is dictated by the topography; and the third category comprises small populated centers.

The need was expressed for bearing in mind the social and cultural characteristics of the indigenous group. In the case of the scattered group, it was considered desirable to employ staff from special campaigns such as that against malaria to assist with other health activities while at the same time carrying out their specific duties. In the case of the small centers of population, it was proposed that all kinds of facilities should be held out to induce medical personnel to settle in them—credit to help them acquire a house, periodic refresher courses—thereby satisfying their economic needs and alleviating any scientific anxieties they might feel, and providing them with agreeable social surroundings.

Mention was made of the need to improve, expand, or build hospital installations when required and to offer their services to social security organizations as a way of achieving interinstitutional coordination. In this way a broader utilization of health facilities could be reached.

It was suggested that, to obtain maximum coverage, it would be desirable to provide services through minimum-sized health care teams.

Stress was placed on the use of extension workers for community development, so that social change and active community participation in the solution of its problems might be achieved with all due respect for its cultural characteristics.

The need to integrate health programs, especially in the rural areas, with general economic and social development programs was emphasized, so that all the programs of the various sectors contributing to the progress and modernization of the rural areas can be carried out simultaneously.

To make the best use of the physician's professional abilities and to achieve greater coverage by the health care services, it is desirable that physicians should delegate certain activities to auxiliary medical personnel under strict periodic supervision.

In accordance with that principle, permanent services could be set up for scattered populations, staffed by auxiliary personnel duly instructed in what they can and what they cannot do. In this way health promotion, protection, and restoration programs, with clearly defined activities and permanent supervision, can be carried out.

With regard to the problem of physicians living in the rural areas, the responsibility of the university in medical training was emphasized, in relation to the preparation of the physician for working in rural areas. It is necessary and desirable that medical students should become equally well acquainted with both urban and rural areas throughout their medical studies.

and, before qualifying, do practical work in rural health services with due guidance and under due supervision. This would be one way of offsetting to some extent the intense pressure for the creation of highly differentiated services, and of achieving instead a rational distribution of human and material resources for the benefit of the community, in terms of priorities established on epidemiological and administrative grounds. The appropriate place for first influencing the future physician in this direction is the university.

Another need mentioned was that the rural areas should contain at least a minimum of facilities such as education, electricity, water, housing, and communications, so that the health services can be put to more productive use. It is also important to make use of schoolteachers and other public servants for health work, especially for vaccinations and health education.

To prevent the migration of the rural population to the cities, it is desirable that there should be a labor code providing equal guarantees to all workers, whether urban or rural, as well as effective social security services for rural dwellers.

Reference was made to the importance of the administrative regionalization of services in preventing duplication of efforts. Highly specialized resources should be concentrated in institutions for the care of patients drawn from the country as a whole or from each region, as the case may be. Guided by common standards issued by agencies at the central level, disease prevention and health promotion and restoration activities can thus be carried on through a network of integrated services designed to achieve the highest possible level of coverage.

**Recommendations**

1. That health programming be an integral part of all economic and social development planning for rural areas.

2. That health programs be carried out simultaneously and in coordination with programs for agrarian reform, education, and agricultural improvement and, in general, all programs contributing to rural progress.

3. That, in determining activities in health programs, attention be paid to social and cultural conditions, especially in traditional rural communities.

4. That, in order to achieve a better distribution of human resources and retain professional personnel in the rural services, the economic and social status of professional personnel be improved and attempts be made to keep their scientific knowledge up to date.

5. That, to awaken the medical student's interest in the study of health problems in rural areas in terms of their ecology, cultural characteristics, and implications for the social development of the country, universities afford medical students during their studies, within the context of their teaching systems, the opportunity of becoming acquainted with the rural areas of the country.

6. That activities carried out through vertical mass campaigns be integrated with the general health services in order to make better use of existing resources.

7. That the health infrastructure be organized as an integral part of the national health plan within a system of administrative regionalization, due attention being paid to the seriousness and urgency of the problems, the resources available, and the social and cultural characteristics of the population.

8. That the countries study the question of the better utilization of auxiliary personnel who, when duly trained and supervised, can carry out certain work delegated to them by physicians and so increase the coverage of the health services.

9. That health education activities be strengthened in all programs that contribute to the economic and social development of the rural community.
The planned development of manpower is today one of the essential conditions of socioeconomic progress. One of the most serious obstacles encountered by most development programs in the Latin American countries is the shortage of qualified personnel of various categories. Health programs are no exception; indeed, in them the shortage seems to be more marked than it is in other sectors.

Education and training effectively contribute to the improvement of the ability and skill of personnel, an effect that is seen in increased output and in the efficiency of the labor force. They have a great multiplier effect on development in general and assume a high priority in health programs.

The situation in the health field tends to grow progressively more acute because the demand, needs, and cost of services increase at a greater rate than resources. Demand rises with progress in medicine and with the expansion of scientific possibilities. In some Latin American countries, the problem is made more acute because of the selective emigration of qualified manpower to other countries in search of better working opportunities and better facilities for specialization.

A health manpower development policy should come out of studies providing a greater knowledge both of the existing situation and of the training needs of health personnel which should be met within the frame of reference of national health plans. It should be pointed out that such studies should mainly pursue programming purposes and not exclusively research purposes. They should also go beyond the limits of a mere statistical analysis of present and future demand and supply and furnish criteria for the use of those who take decisions about the quantitative and qualitative aspects of the education and training of health personnel. These objectives may be helped by the application of new techniques of operations research for the identification of systems enabling human and material resources to be used to the maximum advantage.

Recognizing the importance of this, some countries have institutionalized this activity, conducting it on a permanent basis through the national manpower units they have set up.

From what has been said it follows that there should be joint planning of education and training programs by the health authorities and by those in charge of medical and paramedical university education, at both the professional and the auxiliary level, with a view to forming a multidisciplinary team with an ecological approach to health that will look after the needs of communities for their greater welfare.

We emphasize the need for the establishment of interinstitutional relationships for the preparation of plans and execution of programs for the training of health personnel, and point to the desirability of closer links between ministries of health, universities, social security institutes, and national professional associations.

We recognize that properly trained and supervised auxiliary staff can substantially multiply the activities of professional personnel. We underline the need to define these terms in greater detail with a view to standardizing the nomenclature.

We draw attention to the trials being carried out involving the training of health personnel intermediate between nursing auxiliaries with few qualifications and university trained nurses.

Attention was drawn to the inadequate geographic distribution of health personnel and to the discrepancy between the distribution rates of professional medical personnel and of paramedical personnel, which appears to be linked with the lack of definition of their functions as well as with shortcomings in present systems of medical care.

It was emphasized that the teaching programs in medical and other professional training schools should be revised so as to bring the training of health personnel more into accord with the needs of their respective countries. This multidisciplinary or team approach to health as a way of meeting the needs of the services has led to experiments with new teaching structures such as the faculties of health sciences which some countries are establishing and which are intended to train personnel responsible for health protection, promotion, and restoration.
These teaching schemes will undoubtedly make the work of teaching institutions more efficient, by making better use of resources.

It follows from what has gone before that present teaching programs should be revised to adapt them better to the needs of the health services and to place at the disposal of students teaching materials that will facilitate their training. Among such materials special mention should be made of high-quality, low-cost textbooks and of library consultation services. The program PAHO has instituted for the supply of textbooks to students of medicine and other health professions through a self-financing system is intended for that purpose, and the welcome it has received from universities suggests the desirability of extending the scheme to its full extent and of trying similar schemes for supplying other teaching aids.

We draw attention to the need for health personnel to receive more training in those aspects of administration that would be of value to them in carrying out their functions as administrators either of hospital centers or of other health services.

In considering the preparation of auxiliary and paramedical personnel, it is also important to note that there are some fields that require greater attention. Laboratory technicians for clinical analysis, X-ray technicians, physiotherapists, and technicians to help in the collection and analysis of statistical data are badly needed.

FELLOWSHIPS

Collaboration in the training of health personnel through fellowship programs continues to be one of the most effective ways of strengthening health services. This is shown by the increasing demand by countries for this kind of cooperation, and it is essential that the manner in which the Organization is fulfilling this responsibility should be reviewed by a continuing evaluation of the procedures followed and of the centers used for training.

New programs of collaboration should be tried for the preparation of health personnel, with special features, as in the case of the preparation of high-level personnel in teaching or research. Such programs might include interinstitutional exchange of teaching staff and research workers at the national or international level.

Many teaching and research institutions in Latin America have reached such a high level that it is desirable that they should be used more often for the preparation of professional health workers.

It has been said that the education of a university professional man is a process that continues throughout the whole of his life. The need to add to his intellectual equipment the fresh advances of science and technology, now developing at such a rapid pace, prolongs the responsibility of the educational institution well beyond the mere grant of a degree or a diploma, and this is recognized by the programs that have been called “continuing education.” Such programs should be provided not only for physicians but also for other members of the health team.

PROGRAM OF TEXTBOOKS FOR MEDICAL STUDENTS

With respect to this program, we believe that the selected textbooks for medical students should be periodically revised to keep them abreast of advances in science and technology. The textbook selected should not be regarded as the only text; it should be supplemented by a program to strengthen the medical libraries of professional training institutions and to place at the disposal of students and teachers bibliographic resources that will supplement the textbook.

We emphasize that textbooks should be regarded as valuable working tools for the student, that they should reflect the main problems that the future doctor would meet in the practice of his profession, and that they should preferably be written by authors steeped in Latin American problems. Translations into Spanish and Portuguese of works written in other languages should be of the latest edition in the original language.

MIGRATION OF HEALTH PERSONNEL

The migration of physicians and other health personnel is a cause of serious concern in many countries and in some cases is alarming in its extent. We consider it desirable that Governments should study the problem more
thoroughly. Basing themselves perhaps on the study made on the subject by PAHO in 1966, the Governments themselves might carry out thorough studies in their own countries, with the collaboration of associations of medical schools and other health professions and the cooperation of PAHO or other international bodies.

The causes of this migration do not seem to be purely economic in nature. Attempts should be made both by the countries receiving the health personnel and by the countries from which they emigrate to ascertain the causes and to moderate this "brain drain."

Recommendations

1. That PAHO assist the countries with manpower studies designed to obtain a better knowledge of the existing situation and of the training needs of health personnel which must be met within the time period and reference limits of national health plans. The countries would then be in a position to continue such studies on their own initiative.

2. That institutions for the training of the manpower needed for the health services should be strengthened and their development encouraged.

3. That countries jointly program for the education and training of health personnel at different levels, keeping in mind the need to prepare a multidisciplinary team to meet the needs in the field of health.

4. The multidisciplinary or team approach to meet the needs of the health services has led to experiments with new teaching structures. Some countries are establishing faculties of health sciences, intended for the teaching of the various disciplines responsible for health protection, promotion, and restoration. Such schemes appear to make the work of teaching institutions more effective. It is recommended that PAHO encourage, promote, and strengthen initiatives of this kind. This will necessitate a revision of the organizational and administrative systems of the teaching institutions.

5. That PAHO continue to assist Governments in improving teaching methods, advising on the design of curricula better adapted to the needs of the country concerned, establishing centers for the training of medical educators, and cooperating in the provision of the materials required by students in their studies, especially low-cost textbooks of high quality and library consultation services. The PAHO program for the supply of textbooks to medical students and other professional health personnel through a self-financing system has this aim, and it is desirable that it should be put into effect. Similar systems can be tried out for the supply of other teaching aids.

6. That Governments tighten the bonds that should exist between the agencies dealing with health and the institutions that train the personnel working in those agencies and, through joint planning, promote programs for the training and employment of health manpower.

7. That PAHO collaborate with Governments and universities and institutions of higher education in programs to keep health professional personnel abreast of new advances in science and technology through "continuing education" and, in the specific case of physicians, through programs such as hospital residencies that will both provide education and help improve hospital care.

8. That programs for the education and training of auxiliary health personnel be strengthened, new types of auxiliary personnel be developed, the responsibility of various categories of such personnel be clearly defined and, if possible, some attempt be made to standardize the nomenclature of the types of auxiliary personnel, for which purpose, it is hoped, the PAHO will provide assistance.

9. That the causes of the migration of health personnel continue to be investigated, with the aim of adopting measures to remedy the present situation which constitutes such a serious problem to some countries. For the moment, it appears desirable to promote training and research programs in the countries as a method of inducing professional personnel to remain there.
XI. RESEARCH AND TECHNOLOGY FOR HEALTH AND WELFARE

In previous pages we have emphasized that research is essential for socioeconomic development and that scientific and technological advances should be adapted to the social and cultural characteristics of each country. This was acknowledged by the American Chiefs of State in their Declaration that "science and technology offer genuine instruments for Latin American progress and must be given an unprecedented impetus at this time."50. Scientific advances are changing the patterns of disease in many parts of the world, including Latin America. Whatever the objectives of an institution, if it fails to keep itself abreast of such advances and such changes, it will gradually lose its vigor and its effectiveness.

In the biomedical disciplines research is necessary for the development of the scientists of the future, for the maintenance of a tradition of learning, and for the encouragement of a spirit of inquiry in university students.

We have noted the contributions of the Pan American Health Organization 51 to the study of the phenomena and circumstances conditioning health and disease, and assessed the work of its Advisory Committee on Medical Research. We have been informed of the plan to expand the Organization's activities by establishing multinational programs with a view to making the most effective use of specialized skills and equipment in research and research training programs. This plan also includes support for carefully selected research workers and the study of the existing health problems in the Region. Another aim of the plan is to improve communication between biomedical scientists in the Americas, inter alia, by the PAHO Regional Library of Medicine, which will facilitate access to the most recent knowledge in the health sciences. Part of the plan is for operations research, for which there is a wide field of application in the Hemisphere because of the low output of human and material resources, studies on high-risk age groups and groups with other characteristics; epidemiological surveys in the preinvestment phases of large-scale development schemes and those dealing with disappearing diseases; and methods of establishing priorities and investing resources in health plans.

Taken as a whole, the proposed plan will strengthen and stimulate the health sciences community in the Americas.

Recommendations

1. We recommend that national and international efforts in health research be expanded, and be specifically designed:

a) To increase the capacity of the peoples of the Americas to protect themselves against the major diseases that affect them.

b) To contribute to the attainment of the health goals defined at the Meeting of American Chiefs of State in Punta del Este.

c) To help improve the effectiveness of health expenditure in the nations of the Hemisphere.

d) To improve the quality of the training of physicians and other health workers and to strengthen the institutions that educate them.

e) To establish conditions that will encourage more physicians and health-related scientists to remain in their own countries.

f) To promote and support health research in priority areas and to coordinate these programs with activities sponsored by international and national bodies.

g) To support research programs relevant to the health problems of the Hemisphere.

h) To strengthen the existing biomedical research and teaching capacity of institutions in the countries, and to tie them together more effectively.

2. We recommend that Governments:

a) Recognize the profound influence of the health of their people on the attainment of national goals.

b) Weigh with the utmost care the risk involved in delaying the solution of health problems that reduce the capacity of the peoples to be fully productive.

c) Consider the consequences of a lack of scientific and technical knowledge as to how to solve certain health problems and how to apply it.

3. Since the major expenditures in health
research are those of Governments, we recommend that Governments review at the ministerial level the substance and magnitude of their national investments in research and research training, with a view to making such modifications as may be indicated to secure the greatest possible national benefits, including the maximum contribution to economic and social goals, and to expand their efforts in this area.

4. We recommend that high priority be given under both national and international programs to study of the major health problems that reduce the productive capacity of the population, such as virus and parasitic diseases, environmental sanitation, housing, occupational hazards, and malnutrition.

5. We recommend that under both national and international programs support designed to make health research most efficient and productive be provided. This includes project grants for research and research training, multinational collaborative programs, operations research and improved communication—including library resources—among Latin American scientists.

6. With respect to international activities, it is recommended that all agencies with resources and competence in the area of health research be invited to intensify their efforts.

7. With specific reference to PAHO, we recommend:

a) That Governments contribute to the Special Fund for Research established pursuant to Resolution XVI of the XVII Pan American Sanitary Conference to facilitate the achievement of the social, economic, and health objectives described in Chapter V (Section C) of the Declaration of the Presidents of America.

b) That the Director of the Pan American Sanitary Bureau continue with a sense of urgency his efforts to secure additional support for health research at the international, national, and private levels.

XII. THE ROLE OF HEALTH SERVICES IN THE LATIN AMERICAN COMMON MARKET

We recognize that it is still very early to assess the effects of the Latin American Common Market on the health of the population concerned. However, the process of economic integration that has effectively begun in Central America and the formation of the Latin American Free Trade Association should stimulate countries to analyze their possible consequences in the field of health.

From experience of what has happened in other parts of the world we anticipate the following types of problem:

a) Those arising from the increased exchange of goods between countries, especially foodstuffs and drugs.
b) Those caused by population movements, stimulated by the development of centers of intense economic growth.
c) Those arising from the increasing demand for health services by the migratory population in the centers of economic growth.
d) Those due to disparities in the training and utilization of medical and paramedical personnel.
e) Those due to the absence of harmonious and uniform inter-American legislation.

Recommendation

That, with advice and assistance from PAHO, the countries study such health problems as may arise in connection with the Latin American Common Market and anticipate appropriate measures for their solution.

XIII. HEALTH LEGISLATION

The national and international repercussions of health legislation were examined, and it was stressed that the concept of health as an individual and collective right is clearly expressed in the constitution of some countries, and implicit in the constitution of others.

Reference was made to the need for
countries to give legal expression to those aspects of health that affect the political and administrative structure, in order to facilitate the implementation of measures designed to prevent disease and improve the well-being of the population.

It was agreed that, in the international sphere, it is urgently necessary to modernize health legislation, since it has suffered a double effect—on the one hand from the increased speed of transport, which has virtually eliminated national frontiers as a means of defense against disease and, on the other, from the advance of science, which makes it possible to take positive measures to control diseases at their place of origin and so prevent them from spreading. It might also be advisable to study the possibility of obligatory assistance in the event of proof being offered of the external origin of the situation that is to be corrected, in order to reduce the financial burden it represents for the country concerned.

In connection with this point, we note that it is very difficult to draw up uniform legislation. It is, however, to be recommended that an attempt be made to make new legislation flexible so as to facilitate interchange among countries.

In Latin America we note that the integration movement—and especially the Common Market, which is one of its expressions—requires the creation and operation of a legal instrument contributing to the increase in the exchange of people and materials among countries. Such an initiative conforms to and confirms the ideas expressed by the Presidents of America at their last Meeting.

We unanimously agree, after examination of the present Pan American Sanitary Code, that it is not realistic in relation to Western Hemisphere health matters, or in matters related to the economic and social development of countries; that the Code is not in accordance with other international provisions; and that in some cases it has created problems for international agencies in carrying out their functions.

Recommendations

1. That Governments—even though some have begun or are beginning to modernize their health legislation—take the necessary steps to revise their health legislation and keep it abreast of scientific advances as well as the needs of economic and social development. Such legislation should contain provisions related to the individual and collective right to health.

2. That careful studies be made and the appropriate steps be taken to achieve a degree of uniformity in national health legislation or sufficient flexibility to ensure international cooperation.

3. That PAHO arrange, with all due urgency, for a thorough study to be made of the Pan American Sanitary Code in the light of advances in science and technology, existing problems, and the effects of social and economic development. Such a study should decide whether or not it is desirable to replace or modify the Code to provide a flexible instrument which can be periodically brought up to date and thus be brought into accordance with national and international legal instruments concerned with health and development.

XIV. REFERENCE LABORATORIES—QUALITY CONTROL OF DRUGS

The use of pharmaceuticals in modern therapy continues to increase and the consumption of drugs in Latin America is now at the level of US$1,500,000,000 per year (estimated cost at retail).\(^5^4\) Because of the many technical difficulties in making good drugs, protection of the public health requires government action to ensure that only well-made drugs reach physicians and the public. The need for improving the quality control of drugs has been expressed on a number of occasions by the World Health

\(^5^4\)Ibid., pp. 310-317.

Effective control of the quality of drugs requires that each country have a modern drug law, a well-coordinated government agency staffed with highly trained inspectors, analysts, and administrative officials, plus adequate funds for the agency to carry out a high level of drug control activity.

PAHO has aided the countries by providing training fellowships for analysts and drug law administrators and by sending experts to the countries to advise them on drug control problems. On a regional basis, PAHO helped to establish a testing laboratory at the University of Panama to serve the countries of Central America and Panama.

PAHO recently conducted a continental survey which showed that many countries have useful programs for controlling the quality of drugs. However, this study revealed the need for advanced training for the drug control personnel, unification of the drug control activities under a single agency in each country, testing of a larger number of samples taken from the various levels of distribution down to the pharmacy itself, uniform laws and regulations to support the common market principle, and increased funds to enable the drug control agencies to be more active and effective.

PAHO is working with officials of Uruguay on plans for a regional drug institute to be established in Montevideo. This institute will provide advanced training for analysts and other personnel from the drug control agencies of the countries and will distribute drug information to the countries, but it will not serve as the drug control agency for any country. When in operation, the institute will have a major beneficial effect on the drug quality control exercised by the Governments throughout Latin America.

ARGENTINA has shown the way to obtain adequate funds for drug control purposes by applying a small tax on the sales of drug manufacturers and importers and using this money to finance the country’s drug testing unit.

In addition, the money paid to the Governments by drug firms for registering their products for sale could be used to finance the Governments' drug control activities.

We recognize that some countries are unable, because of technical limitations, to establish their own national drug testing laboratory. These countries might send their samples to the Special Analysis Laboratories of the University of Panama for testing, or form a regional association which would establish a control testing laboratory to serve those countries.

The countries should consider deleting from their registration lists drugs which are no longer used. Argentina recently eliminated 20,000 questionable drugs from sale.

There is a possible problem of overuse of drugs, as suggested by the very large volume of drugs consumed in many countries. Physicians should receive more intensive training, to improve their knowledge of the uses and hazards of drugs. The public should also be made aware of the harm caused by excessive use of drugs. The countries should exercise supervision over the advertising of drugs in order to prevent unwise use of drugs.

The problem of high prices for some drugs is a matter of great concern. A good national drug control agency would have a leveling effect on such drug prices by enabling agencies to buy generic drugs from firms that sell at relatively low prices, provided the drugs are fully satisfactory when tested.

It is important that the countries perform good control tests on the drugs they export as well as on the drugs sold within the country.

We suggest that the reference laboratory at Montevideo could assist the countries by issuing information on drug standards and help the national drug laboratories select the most useful pieces of drug-testing equipment.

The actions of the World Health Organization to assist in achieving good drug quality control by issuing the International Pharmacopoeia and providing samples of pure drug substances for use as reference standards have been very useful. WHO should be commended for these actions.

**Recommendations**

Recalling Resolution VII.C.2 of the 1963
Meeting of the Task Force on Health at the Ministerial Level, and recognizing that technical difficulties in manufacturing good drugs require the Governments to exercise close supervision over pharmaceutical production in order to assure a safe and satisfactory drug supply, we recommend:

1. That each country make a detailed study of its national drug control agency and take whatever action is necessary to assure that the agency is well coordinated and staffed with a sufficient number of highly trained administrators, inspectors, and analysts.

2. That increased emphasis be placed on testing drug samples at all points, from production to consumption.

3. That each Government provide adequate finances for its national drug control agency by supplying an amount of money commensurate with the volume of drugs that must be checked by the agency, i.e., the volume of drugs consumed in the country plus those exported.

4. That where technical considerations prevent a country from establishing its own national drug testing laboratory, the country should arrange to have its samples tested by a recognized agency such as the Special Analysis Laboratories at the University of Panama, or form a regional association with a testing laboratory to serve the countries of the particular area.

5. That the Director of the Pan American Sanitary Bureau continue the actions to improve drug quality control in the Americas, in particular the plans to create a regional drug institute in Uruguay which will assist all of the countries by:
   a) Providing advanced training for drug analysts.

6. That thanks be expressed to the Government of Uruguay for its cooperation and offer of funds for establishing a regional drug institute in its country, and that the other countries be requested to provide financial support for this regional institute when such financial assistance becomes necessary.

7. That, to the extent feasible, the countries adopt uniform drug control laws and regulations in order to achieve a uniformly high quality for drugs throughout the Region.

8. That the countries examine their lists of registered drugs and eliminate those that serve no useful purpose.

9. That medical students receive increased training, and physicians be provided with more information, on the effects and uses of drugs.

10. That the population be educated in the dangers of self-medication and that the Governments enact legislation on the subject.

11. That the Governments exercise a high level of quality control over the drugs they export, as well as the drugs consumed within the country.

12. That the Governments exercise close supervision over drug advertising to prevent misrepresentation of drugs to both physicians and the general public.

XV. MENTAL HEALTH–ALCOHOLISM

At present there are many serious mental health problems in the Americas. Suffice it to mention the results of epidemiological studies on alcoholism (in one country affecting 5 per cent of the population over 15 years of age, while another 15 per cent are heavy drinkers), and the available data on homicides, suicides, accidents, acts of violence, family

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break-up, and various types of drug dependence. Allied to this is the relative shortage and the inadequacy of services for mental patients, especially children, and the lack of psychiatrists, psychiatric nurses, and other professional health workers. Finally, there is a distorted approach to the problem whereby treatment of the mentally sick is separated from general health activities.

Mention must be made of the positive interest demonstrated by some countries in the last five years in improving the quality of psychiatric care; in constructing or renovating psychiatric hospitals; or in making arrangements for other establishments to care for mental patients. Mention was made of army barracks which were in good physical condition and which, being unoccupied, were adapted for the above-mentioned purpose, thereby making it possible to close down a corresponding number of beds in institutions providing poor-quality care. This arrangement was mentioned as an example of how a more rational use could be made of the installed capacity of the countries, regardless of the purpose of the buildings used and the government department to which they belong. In addition, a number of occupational therapy programs must be mentioned, since they have had outstanding results in the rehabilitation of patients and in the reintegration into society of an increasing number of mental patients. They are capable of the most varied activities and carry them out with great skill and efficiency; and these activities, in addition to providing a therapeutic benefit, help make the persons concerned financially independent.

There are enormous gaps in our knowledge of the origin and dynamics of the most prevalent mental diseases in the Americas. While advances are being made in etiological research—and much remains to be elucidated—epidemiological studies are very useful in developing working definitions for formulating programs and assigning the scant resources to the most widespread diseases. There are excellent examples of this in the history of medicine. Transcultural psychiatric studies are also necessary, as are behavioral studies and operational research based on the same approach to which we have referred.

According to the modern conception of health, services for the care and rehabilitation of mental patients, and for the prevention of mental disease, should be extended into the community, a system that goes beyond the limits of the outmoded psychiatric hospital.

Special attention was given to alcoholism, in particular its high incidence, which is reflected in the direct risks of falling ill and dying, and as a basic disturbing factor in all health, medical care, maternal and child health, and nutrition activities. It is also reflected in low work output, accidents, absenteeism, illegitimacy and population growth, child neglect, and criminality. It was pointed out that there is no aspect of life in a country in which the negative effects of alcoholism are not making themselves felt.

It was suggested that an international center responsible for research, education, and technical assistance to the countries of the Hemisphere, should be established as a means of furthering our knowledge and working toward the solution of this serious problem.

Recommendations

1. That mental health units be set up in ministries of health, or existing units expanded and given a greater voice in planning the services.

2. That mental health programs be extended to the community, the quality of psychiatric hospital care be improved, psychiatric units be established in general hospitals, or other types of establishments be adapted for psychiatric care purposes, and occupational therapy programs for the cure and rehabilitation of the mentally ill be organized or expanded.

3. That professional staff be trained for existing services, as well as for those to be established in the immediate future, and that the principles and methods of psychiatry and mental health be included in the medical curriculum, and, for that purpose, use be made of the mental health units of the ministries of health.

4. That research be encouraged, especially on the clinical, epidemiological, and cultural aspects of mental diseases and on the mental health problems peculiar to each country.
5. That alcoholism control programs be organized or expanded as part of the health services, in view of the seriousness of the disease in the countries of the Americas, and that the active and informed participation of the communities in these programs be encouraged through their natural leaders.

6. That the Governments intensify research on problems of alcohol and alcoholism, within duly coordinated plans, with the cooperation of the PAHO, to which would be entrusted the function of providing adequate information.

7. That the Governments utilize all possible means to control publicity for and the distribution of alcoholic drinks.

XVI. A TENTATIVE APPRAISAL OF WHAT HAS BEEN ACHIEVED AND OF WHAT REMAINS TO BE ACHIEVED

In this chapter we shall attempt an over-all assessment of the steps taken and the measures adopted by our Governments to cope with the major health problems we have referred to in preceding chapters, and we shall outline the general policy guiding our endeavors.

During the interval between the signature of the Charter of Punta del Este and this present Meeting, most if not all of our countries have tended to assign economic progress and social welfare the highest priority; of major concern have been efforts to assimilate marginal groups of the population into the body of society and there has been a more marked interest in formulating national plans designed to achieve the objectives set forth in the Ten-Year Public Health Program of the Charter and in the Declaration of the Presidents of America.

The document we are considering—Facts on Health Progress, prepared by the Pan American Sanitary Bureau—summarizes the advances made. We deem it pertinent to point out that the headway made was insufficient to meet the steadily increasing demand, whose growth in the years ahead will accelerate as a result of the stimulation of the expectations of our peoples by scientific and technological advances and social changes.

Our Governments have also kept a close eye on scientific and technological advances and have adopted and applied them to health programs, as and when resources were available.

In our opinion health work is not and cannot be merely one more activity among the myriad state activities. It is as great an endeavor as education, to which it is closely linked and which it precedes, for it is difficult to educate sick people. Hence the high priority which we believe our Governments should give to the allotment of “earmarked” or specific funds for the implementation of health plans and programs. They are essential for dealing with the accelerated population growth of many of our countries, the steadily increasing demand for medical care, and the incorporation of the rural population into the process of economic and social development.

In the above-mentioned interval our countries have embarked on programs for the construction, acquisition, and improvement of housing based on the encouragement of savings and the expansion of credit facilities. In the field of education giant strides have been made in reducing the number of absolute illiterates and of functional illiterates and in increasing educational opportunities. For that purpose, our Governments have increased educational budgets; the methods used in the education and training of manpower have been improved; and enrollment in educational institutions at all levels has considerably increased. For their part, social security agencies have expanded their services and thereby extended their coverage. In some of our countries programs to change land tenure and bring about a fairer distribution of income through a more rational taxation system have been instituted. Some steps have been taken to encourage credit unions and to promote the development of depressed areas of the economic sector. With a view to encouraging participation by the public, community efforts to carry out works for the public good have been promoted. We also intend to enact laws designed to strengthen the

57Scientific Publication PAHO 166, 1968.
Fundamental tools for implementing the general health policy of our countries are planning, the improvement of administrative structures, and the organization of the ministries of health. We are concerned about the unsatisfactory utilization of resources due to the great number of State, semiofficial, and private institutions that have similar ends in view. In many of our countries these institutions have not been integrated into a single health system, although progress has been made in setting up coordinating commissions as a first step toward establishing common standards and preventing dispersion of effort through parallel and duplicate activities.

We have learned with concern that in certain countries there is a marked contrast between the independence of and amount of money available to certain semiofficial or private agencies, and the restricted legal powers of the ministries of health for implementing a higher health policy. That is why we believe it is essential to enact a series of legal measures which, in addition to emphasizing the policy-making, coordinating, supervisory, and evaluating function of health ministries, will facilitate interinstitutional coordination and the establishment of a common system and thereby ensure more effective utilization of available resources. This is perhaps the most urgent task for the immediate future.

We are also interested in strengthening machinery for the coordination and liaison of the ministries of health and integrated preventive and curative services, with universities and medical schools and with other schools providing training in the health sciences. This step will enable us to promote studies on the professional personnel needed for implementing health plans. Thus we will be able to make a sound and objective determination of the number and the caliber of the professional health workers we need. In the same way we must encourage the gradual and progressive introduction of the concepts of preventive and social medicine into the curricula of university schools and make future professional health workers familiar with the basic principles of the administration of services and the part they will play in the health team. We also believe it is essential to encourage the establishment of programs for the advanced in-service training and continuing education of
all professional health workers, through regionalized systems of medical care and education. Schools of public health will have to step up the training of epidemiologists and administrators and prepare them not only to manage programs but also to undertake health planning. Special emphasis will have to be given in those schools to all aspects of the life of man in society.

We were gratified to note that, in their Declaration, the Presidents of America stated that “we will lay the physical foundations for Latin American economic integration through multinational projects,” including the joint development of international river basins.\(^5\) We are inspired by the same thought, and the countries included in the plan for the over-all development of the River Plate basin intend to unite their efforts to solve problems concerning water-use that have a direct or indirect bearing on health conditions. A similar spirit has inspired other joint projects such as those for the control and eradication of certain communicable diseases or their vectors (smallpox, malaria, *Aedes aegypti*, yaws), certain zoonoses, and others.

To take an example from malaria: we believe that in order to safeguard the success already achieved in eradication, the result of immense efforts in vast areas of our countries, we should give priority to malarious areas whose epidemiological situation influences areas in neighboring countries and should coordinate intercountry and interregional activities as much as possible. Furthermore, convinced of the interdependence of our countries in health matters, we intend in the future to emphasize reciprocal assistance. So far, generous assistance has been provided in the matter of donations of vaccine and other technical equipment but we believe that we can also extend it to the provision of technical assistance in such a way that the health personnel of some countries that have gained great experience and a high level of knowledge can assist in controlling infectious and parasitic diseases in other countries where such control is needed. By joining our efforts we will be able to accelerate the achievement of the objectives of eliminating those infectious diseases and protecting the health of our peoples.

Until very recently, health policy in many of our countries tended to assign more resources to medical care services while allotting too little to programs for health promotion and disease prevention. We believe that this situation should be changed and in the future we intend to strike a better balance when preparing draft budgets.

We have already said that we consider the publication *Facts on Health Progress* to be an evaluation of the progress made in reaching the objectives of the Charter of Punta del Este. It analyzes each of the goals in terms of what has been done so far in the decade beginning in 1962. In some cases it contains a projection up to 1970 or beyond, assuming that the number and type of activities will be the same and investments will continue at the same level.

The general objective of the Charter of Punta del Este was “to increase life expectancy at birth by a minimum of five years, and to increase the ability to learn and produce, by improving individual and public health.”\(^5\)

We noted that in the interval mentioned above there was an increase in life expectancy in Latin America from 60.2 years in 1960 to 62.5 in 1966, or 2.3 years. The increase should have been 3 years, so that only 80 per cent of the target was fulfilled. Of course, some countries did achieve the objective; others did not. In any event, this increase was in large measure the result of the reduction in mortality in infants and children under 5 years of age to which we have already referred. In this respect, although substantial progress has been made, much remains to be done.

The specific objectives of the Charter were “to provide adequate potable water supplies and sewage disposal to not less than 70 per cent of the urban and 50 per cent of the rural population; to reduce the present mortality rate of children less than 5 years of age by at least one half; to control the more serious communicable diseases, according to their importance as a cause of sickness, disability, and death; to eradicate those illnesses, especially malaria, for which effective


\(^5\)OAS Official Records OEA/Ser.H/XII.1, Rev. 2 (Eng.), 1967, p. 11.
techniques are known; to improve nutrition; to train medical and health personnel to meet at least minimum requirements; to improve basic health services at national and local levels; and to intensify scientific research and apply its results more fully and effectively to the prevention and cure of illness.”

The publication *Facts on Health Progress* shows simply and graphically the progress made in solving each problem and the most important human and material resources for solving them. The data it contains have been examined by us in connection with various items on the agenda, and we shall therefore not repeat them here.

We shall only add that, in the discussions on the topic “Health aspects of comprehensive family education,” it was emphasized that this was but one area of a general governmental policy and, as such, it was the responsibility of each Government to make its decision in the light of the circumstances in its own country. Closely related to this topic are nutrition problems. Our discussions indicate that it is difficult to solve the problem of nutritional deficiencies unless the appropriate activities are linked to programs designed to increase the availability of foodstuffs and make it easier for the population to obtain them, especially the large segments that have limited economic resources and are isolated from the main production and consumption centers. So far during this century the rural areas have received the least benefit from technical and scientific programs. We are therefore paying particular attention to this situation.

We emphasize the desirability of integrating the activities of specific programs with those of the general health services so as to ensure better use of available resources and to extend services to cover more persons.

It is evident that the quality of the statistical information provided by the Governments of the Americas has improved in recent years, thanks to the training of an increasing number of professional and auxiliary workers and the improvement of systems for the registration, analysis, and distribution of data.

In our recommendations we have repeatedly referred to the need to increase biomedical research in our countries, since we consider it essential to the solution of our health problems.

International collaborative studies have been of great value; outstanding among them has been the Inter-American Investigation of Mortality, which has revealed the main characteristics of causes of death in 10 major cities in Latin America, in San Francisco (U.S.A.), and in Bristol (U.K.). In addition to being a study in comparative epidemiology whose method can be applied to other similar studies, its conclusions must be the beginning of new investigations of the causes for the differences in relation to the same disease in the various participating countries.

As we have said, health planning has brought out the need for the countries to take the necessary steps to ensure that health and population statistics are as complete and exact as possible and that they are recorded, analyzed, and published in due time so that they can serve as an essential tool in the programming, execution, and evaluation of health activities.

Above all, the publication *Facts on Health Progress* shows what remains to be done in order to directly benefit a great number of human beings who have the same right to health. That publication will be useful for the periodic review of the general and specific activities of ministries of health of the Hemisphere, in accordance with the principles, standards, methods, and procedures outlined in the report of our Meeting.

XVII. SPECIAL RESOLUTION

It is recommended that Governments consider the possibility of making contributions to a Fund whose income would be assigned exclusively to health programs in the form of long-term, low-interest loans. The Pan American Health Organization would be responsible for exploring the feasibility of this proposal.

60Ibid., p. 11.
XVIII. THE PARTICIPATION OF WOMEN IN HEALTH PLANS
IN THE AMERICAS

(Special Item)

The Special Meeting of Ministers of Health of the Americas, considering that the participation of women is essential for the better implementation of national health plans, since they are the central point of the family and responsible for the health and education of the children, decides:

1. To confirm Recommendation C.3 of the Meeting of the Task Force on Health at the Ministerial Level, held in Washington, D. C., in April 1963, and to suggest that it be implemented in all the countries in a real and effective form.

2. To recommend to the Governments of the Americas and to inter-American and international organizations, both governmental and nongovernmental, interested in or concerned with problems of the family, of women, or of children, that they strengthen their activities for the promotion and care of health and everything related to the well-being of the family group.

XIX. FINAL DECLARATION

Viewed in their historical perspective, the aims of this Special Meeting of Ministers of Health of the Americas constitute an extension of and a step forward from those of the Meeting that took place in April 1963. That Meeting took its inspiration from the objectives of the Charter of Punta del Este and from the possibility of achieving them within the context of economic and social development. At this Meeting we have been guided by the decisions of the Chiefs of State, signatories of the Declaration of the Presidents of America, and by the experience acquired and the specific achievements won during the five years that have elapsed since then.

We are, however, fully aware that there are still millions of human beings in the Americas who are awaiting the benefits that accrue from the implementation of health plans and the attainment of the proposed goals. We acknowledge that, whatever their origin, ideas, beliefs or aspirations, these people are entitled to such benefits by the mere fact of their being inhabitants of our countries. It can now no longer be denied that health is a right and not a privilege. This concept has gradually been becoming a tangible reality with the multiplication and improvement of health services and the considerable increase in the demand for medical care from urban and rural public medical services.

The social demand for health services has grown more clamant, and because we consider it to be a just demand we have agreed to redouble our efforts to make more rational use of the material resources available for them, obtaining the assistance of external capital whenever it is considered justifiable, and applying modern scientific and technological advances to meet the aspirations of our peoples. In this way persons who play a part in this crusade for health will have better opportunities for placing their knowledge and experience at its service.

Although our proposals are essentially humanitarian in nature, we agree that they should be put into practice within a harmonious process of economic development and social welfare.

We have given special attention to the problems of populations living in rural areas, because of their seriousness and because of the need to bring these people into the mainstream of modern life and economic progress. The achievements since the last Meeting have clearly shown their will and capacity for collaborating in work for the common good when they observe that it is being carried out from disinterested motives. We propose to encourage the modernization of rural life, integrating health techniques with all those improving social welfare and community life. This proposal should have the effect of reducing migration to the large cities and of alleviating the situation created by the shanty towns of the cities, wherein live groups of human beings totally destitute of the most elementary sanitation and material necessities, uprooted from their places of origin, unadapted to their new situation, and lacking the technical or occupational training that will assure them an acceptable level of income. These communities constitute focal problems which, because of the serious consequences to health involved, must be solved through a concentration of effort and resources.

An analysis of the whole picture reveals, within each country and within the Hemisphere, as a whole, the coexistence of traditional problems with those characteristic of industrial society, urbanization, the effects of modern science and technology on attitudes and customs, and the social imbalances implicit in the life of the large cities. As we move toward the solution of the traditional problems, the other type will become proportionately more marked, acquiring the characteristics of each society and reflecting the mutual relationships between human beings and the environment in which they live and which they in turn help modify. We cannot disregard this kind of problem for the more development proceeds the more it will obtrude itself. It will also make its presence felt in the programs concerned with the economy of geopolitical zones of the Americas, such as the river basin projects and infrastructure projects involving several countries. As was decided by the Chiefs of State, health activities should be an integral part of projects as early as the preinvestment phase. By preparing specific projects we can further the inflow of outside capital that will be needed because of the immensity of the tasks to be carried out.

This is the way, we feel, that health trends will continue until the end of the century. We are confident that economic development will substantially reduce present problems and enable the measures recommended by modern science to be put into operation, while at the same time preventing or reducing the impact of the problems that are beginning to arise and will be the heritage of society in the immediate future. In this order of ideas, we have not failed to consider opinions about the size and structure of the population. We continue to advocate the desirability of a harmonious development genuinely directed toward the general welfare and not centered on investments for economic gain that postpone social benefits, for—it bears repeating—man is the sole protagonist as well as the beneficiary of all development.

A basic factor in the success of this socially important task of health is the preparation by the universities of the human resources that are most valuable from the point of view of intellectual capacity for the study and solution of the problems posed by the increasingly complex and differentiated needs of individuals and societies. Education for development should be the theme of the whole teaching process. By this we mean that education should be oriented toward questions relating to the life of man in society, with special attention to questions affecting the largest number of people for which rational solutions exist, as well as toward questions for which research is required. The universities should train professional men in accordance with the features implicit in any given moment of history and its prospects for the future, with a harmonious balance between science, technology, and culture and with a holistic sense of the knowledge that inculcates in them humanism and an over-all understanding of man and his role in
contemporary society. We are confident that, through their work for the public weal, graduates will return to society what was imparted to them in their academic years.

In accordance with the ecological approach to health, and in full awareness of the sufferings and burdens of our peoples, we reaffirm our intention to unite our efforts and our resources with a view to prolonging the life and promoting the happiness and well-being of our populations. We are encouraged to do so not only by our moral responsibilities but also by the cultural wealth of the American peoples and their intrinsic value as the repository of all economic progress, persuaded that a sound and dynamic community life arises, \textit{inter alia}, from the fulfillment of its health needs.

IN WITNESS WHEREOF, the Ministers of Health of the Americas, or their Representatives, and the Director of the Pan American Sanitary Bureau, Secretary of the Meeting, sign the present Final Report in the English and Spanish languages, both texts being equally authentic.

DONE in Buenos Aires, Argentina, this eighteenth day of October, nineteen hundred and sixty-eight.

\begin{flushleft}
\textit{Dr. Ezequiel A. D. Holmberg}  
Minister of Public Health of Argentina

\textit{Dr. Basil D. B. Layton}  
Principal Medical Officer for International Health of Canada

\textit{Hon. Cuthbert Edwy Talma}  
Minister of Health and Community Development of Barbados

\textit{Dr. Ramón Valdivieso}  
Minister of Public Health of Chile

\textit{Dr. Jorge Rojas Tardío}  
Minister of Public Health of Bolivia

\textit{Dr. Antonio Ordóñez Plaja}  
Minister of Public Health of Colombia

\textit{Dr. Leonel Tavares Miranda de Albuquerque}  
Minister of Health of Brazil

\textit{Dr. Alvaro Aguilar Peralta}  
Minister of Public Health of Costa Rica
\end{flushleft}
Meeting of Ministers of Health

Dr. Mario Antonio Fernández Mena
Minister of Public Health and Social Welfare of the Dominican Republic

Dr. Francisco Parra Gil
Minister of Public Health of Ecuador

Dr. Salvador Infante Díaz
Minister of Public Health and Social Welfare of El Salvador

Dr. Raymond G. Hyronimus
Inspector-General of Social Affairs and Public Health of France

Dr. Emilio Poitevin
Minister of Public Health and Social Welfare of Guatemala

Dr. Fritz Audouin
Minister of Public Health and Population of Haiti

Dr. José Antonio Peraza Casaca
Minister of Public Health and Social Welfare of Honduras

Dr. Maurice A. Byer
Principal Medical Officer of Jamaica

Dr. Baltus F. J. Oostburg
Minister of Health of Surinam—Kingdom of the Netherlands

Dr. Pedro Daniel Martínez
Deputy Minister of Health of Mexico

Dr. Francisco Urcuyo Maliño
Vice-President of the Republic and Minister of Public Health of Nicaragua

Dr. Dionisio González Torres
Minister of Public Health and Social Welfare of Paraguay

Dr. Maxwell P. Awon
Minister of Health of Trinidad and Tobago

Dr. Simon M. Frazer
Chief Medical Officer, Department of Health and Welfare of Bermuda—United Kingdom

Dr. William H. Stewart
Surgeon General, Public Health Service of the United States of America

Dr. Walter Ravenna
Minister of Public Health of Uruguay

Dr. Armando Soto-Rivera
Minister of Health and Social Welfare of Venezuela

Dr. Abraham Horwitz
Director of the Pan American Sanitary Bureau, Secretary
Addresses by the Participants
ADDRESS BY THE MINISTER OF PUBLIC HEALTH OF ARGENTINA,
DR. EZEQUIEL A. D. HOLMBERG

Presented at the Inaugural Session
14 October 1968

In welcoming on behalf of the Government of Argentina the distinguished representatives of so many friendly sister countries and of the institutions that cooperate with their Governments in the international sphere, we venture to predict that this Meeting will not only bring forth positive achievements but will also reaffirm the will of our peoples to walk together along the path of our common destiny.

This distinguished gathering will witness the expression of aspirations and the formulation of recommendations on the most effective and up-to-date measures to be taken in relation to that most important subject—health.

The scientific and technical advances of modern medicine are so obvious and the methods and procedures for their application so exact that it would seem superfluous to mention them. Nevertheless, our experience shows that great difficulties are encountered in carrying health programs to completion. Some programs have been started and have soon lost their drive; others have been only partly formulated and have quickly had to lower their sights; and many have remained at the paper stage.

Health administrators today, however, are well aware of the many difficulties in carrying out their tasks. They know that programs must be planned so as to achieve the maximum results with the minimum of resources in a short period of time.

Among the methods and techniques that are available, major importance is attached to the planned development of the health services, although it is admitted to be of some complexity and relatively slow in producing results. Scarcity of resources, mainly financial, and lack of qualified personnel and adequate facilities in the initial stages restrict the aims and make a choice of objectives necessary. In these circumstances, programming necessarily involves the selection of those aspects that will ensure the achievement of health standards in keeping with requirements, resources, and local conditions. The people must also, at the appropriate time, be encouraged to use the services provided and even take part in an organized and appropriate way in the administrative activity of the services. In this connection, we believe that one of the ways of meeting the needs and requirements of the health services is to make use of the efforts of private groups of people; in other words, positive solutions can be found in community development, in integrating the efforts of private citizens with those of the authorities. There is no doubt that many new developments in health are possible only through an extensive joint effort of the community. Because of cultural and technical advances, there is an imperative need for organized, conscious action by the entire population so as to change man’s relations with his physical and social environment in his favor.

We hope that planning will harmonize all aspects, not only to achieve the orderly, efficient, and economical use of the resources available but also to introduce rational criteria for change, with a view to attaining higher and broader levels of satisfaction.

One of the most obvious restrictions is the lack of trained manpower. Whatever the nature of a plan, it creates a demand for skilled personnel available at the proper time, and this governs the rate at which the plan is implemented. The training or teaching of staff nearly always requires a great deal of time, and many of our countries need qualified personnel trained within the national environment. For certain technical workers, it is also very important that they should receive further training in an international environment.
The responsibility of universities for the education and training of professional and technical personnel should be exercised in full awareness of the need for a close link with national conditions and needs. It is therefore essential that the universities be in permanent relationship and close coordination with the services actually carrying out the programs.

We repeat a view we have already expressed in various papers—the establishment of medical care services is the most suitable way of channeling integrated health activities. We can think of no better method of meeting the health needs of the community.

All activities should fan out from a modern hospital, so that the health system can reach the patient in his own home or the population receive care in its family or occupational setting. This calls for the concentration of the more specialized resources in the base hospital and progressive decentralization of the component activities of a comprehensive medical care program.

To bring modern technical facilities to a larger population, especially to the scattered population of rural areas, programs for simplifying the delivery of medical care services should be planned and carried out by adequately trained personnel at various coordinated levels. What is required at the outset is to provide simple health services that will, in addition, channel a hitherto unexpressed demand toward medical centers.

Regardless of the authorities the medical centers come under, their service capacity will undoubtedly have to be planned at an early stage and properly.

In various extensive areas of our countries infectious and parasitic diseases continue to be prevalent in large population groups. Specific programs and intensive campaigns initiated by the central health authorities have effectively reduced the prevalence of some of those endemic diseases, but for most of them the control targets laid down are still very remote. These activities are unilateral in character and maintained at high cost. Because they are continuing for periods of time beyond what was originally anticipated, the funds needed to finance them are enormously increased. It is therefore reasonable to convert these so-called vertical campaigns into duly planned activities of the local health services, integrated with local health programs and carried out by the health departments. Technical and financial help should be provided by the national authorities in accordance with pre-established norms.

The obligation to remove the causes of suffering and disease to the extent that the community's needs and technical resources allow implies making an effort to change the structure of the services so as to increase the services offered and also provide integrated responses to qualitative needs. There is, however, no doubt that the health standards sought cannot be achieved through the efforts of health departments alone. It follows that, as was stated in the Declaration of the Presidents of America at Punta del Este, it is imperative that health plans should be duly included in economic programs.

Because of the increasing demand for medical care, the various reasons for which are fully understandable, health service administration is obviously growing in complexity. To base program activities on rational foundations, it is necessary to make studies and analyses of the quantity and quality of the variables involved in health problems, and especially of the many methodological questions that, if solved, would improve the operational design of programs.

For all these reasons, and because of modern technological requirements, it is clear that research into health is a national responsibility. We believe that a central body is needed to coordinate efforts—preventing resources from being spread too thinly—to plan the best use of the resources available so as to gain a wide knowledge of national problems, and even to cooperate in the study of questions of international scope affecting wide regions or whole areas of the world.

An acute social problem that must be solved with the participation of the health sector is the growing concentration of people in urban centers and their surroundings, which brings in its train distressing situations for large numbers of the inhabitants. It should be our duty to prevent or to limit what has been described as the export of rural poverty to urban squalor. To alleviate or set bounds to the harm that uncontrolled urbanization causes, health departments must prepare and carry out joint emergency programs.
Owing to the progressive increase in the technical complexity of medical care, its cost is rising at a staggering rate. On the other hand, total health expenditure is conventionally restricted, since the limit of its scope cannot be established, although at the same time it is universally accepted that health is an inalienable right of the people and that it is a duty of Governments to foster it.

This question is a matter of serious concern at present to even the most developed nations, since increasing difficulties in financing health are foreseen for the coming years. The solutions proposed fall within the category of planning techniques, and among them, to pay for health services, is the partial transfer of funds from other sectors sharing jointly in projects to increase the well-being of the community.

We believe that the management of funds from financing sources specifically intended for the establishment or improvement of health installations and equipment and for health action to better the environment and the community should be reserved to the health sector.

At times, science is observed to be taking a path so remote from everyday life that one suspects it has lost touch with social realities. We all of us here wish to assert the true aim of science. Its origin is in man and its destiny is man, and our high aspiration is to use it in good faith for the greater advantage of society.

ADDRESS BY THE DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU, DR. ABRAHAM HORWITZ

Presented at the Inaugural Session
14 October 1968

If one takes an over-all view of the Americas of today and of the future, with all the risks of over-generalization entailed, some remarkable features can be singled out. Among them are: the tendency of aspirations to become institutionalized; the increasing persistence and organization of social demands; and the creation in Governments and organizations of an awareness of the need to satisfy what are regarded as the vital requirements of societies.

Another remarkable feature is the establishment of a strategy for development at the highest decision-making levels in the countries. With different approaches—for the nature of the problems and existing and potential resources differ—the countries of the Americas are seeking a more distributive justice, greater social mobility, and an increase in the opportunities open to each and every individual, enabling him to fulfill his possibilities. These are very large aims, and probably will always be so, but they are nevertheless of immediate importance, for there is much to be done before more just societies are achieved—in the sense that the great majority of people have what is essential for their well-being.

It is also a distinctive feature of today that human resources are accepted as fundamental for economic development—accepted with much more fire and conviction in political circles than in the organizations where the financing of programs and undertakings is proposed and analyzed. The best statement of this view is to be found in the Declaration of the Presidents of America. Those who signed that historic document acknowledged the significance of the so-called social factors in the economy, in production, and in productivity. That was how they put into words the feelings of the peoples who, uninstructed in the complexities of theory and not always able to understand practical applications that do not reduce suffering or open up opportunities, want for themselves only what is vital. Hence the interest of people in individual and collective health, which they consider a good, a felt
aspiration, an inalienable right, and one of the moral values characterizing a civilized society. Without falling into disquisitions of the subject of the economy, they are convinced that there can be no productivity without health, that production will not attain the desired levels if sickness keeps people away from work.

Nor do they see any justification for reducing or even not increasing funds for care of the sick on the sole ground that the percentage of unemployed workers is high. They consider that arguments of this kind ignore elementary moral principles.

There are, however, promising signs that indicate revision of important economic theories. People are beginning to talk of “investment in man,” which they call at times “investment in human potential” or “investment in human resources.” The reasoning behind these terms runs as follows: “Experts in health and education have long been aware that expenditure to improve the quality of the population may often be more important for development than physical investment. The failure of recent generations of economists to respond to this type of argument until recently is explained by their habitual way of thought. For one thing, the argument cuts across the traditional distinction between investment and consumption. Consumption has an instrumental as well as an independent value... and economists have tended to ignore its instrumental value. Moreover, programs to improve the quality of the population have effects that are widely diffused, spread over a long time, and not easily measurable—a characteristic which has been regarded as justifying their exclusion from ‘economic policy.’ This is not, however, a good reason for neglect. Widely diffused effects may be more important than highly concentrated ones. Long-term effects may be much greater than immediate ones. And effects that are difficult to measure may be greater than the more easily quantifiable effects of physical investment.”

So Gunnar Myrdal said in his monumental study, Asian Drama, An Inquiry into the Poverty of Nations. These ideas should appeal to the Ministers of Health of the Americas and to those who collaborate with them, ourselves included, since they coincide with what they have been advocating in the past decade. We agree with them in desiring that they should become financial realities. The question now arises whether the time has not come to consider new economic mechanisms, complementing domestic resources and foreign capital, to hasten the attainment of health goals and satisfy the aspirations of the peoples—aspirations that they feel to be urgent. Because we have been consistent in our views, we do not proclaim that social investment should come before physical investment; we have on the contrary stressed the need for a balanced development genuinely orientated toward the well-being of the peoples.

There are indications of progress in health in the Americas, which are unmistakable if the objectives of the Charter of Punta del Este are taken as a starting point, and are even greater than the figures and their interpretation show. It is enough to consider how difficult it is to measure the effects of education, particularly of university education. Even if the goal is attained of creating independence of judgment enabling each item of knowledge to be assessed at its true worth and so of moulding a thinking mind, evaluation of the teaching process is still of the utmost difficulty. The same is true of research.

But there has been clear progress in the last six years, as measured by the reduction in mortality and morbidity rates, the increase in the basic health and environmental sanitation services, the greater number of professional and auxiliary personnel and the improved quality of their training, and the conscious administrative search for a more rational use of available resources in investment on specific objectives, thereby cutting down excessive expenditure, that veritable disease of both developed and developing countries. It is also clear what goals remain to be achieved, that is, what has still to be done, especially when expressed in terms of the millions of human beings who are awaiting similar benefits. One need only mention that 44 per cent of all deaths in Latin America and the Caribbean area are still in the group under 5 years of age and that the conditioning factors in this grave situation are both a cause and a consequence of underdevelopment.

As we understand it, the aim of this Meeting
is to speed up steps for the solution of the most important health problems of the Americas. On the basis of what has been achieved and the valuable experience acquired, and in the light of the contributions of modern science and technology, an attempt will be made to redefine and or reaffirm policy and methods. The goals continue to be those laid down by the Charter of Punta del Este, strengthened and expanded by the decisions of the American Chiefs of State. For this reason the agenda is a mixture of the traditional and orthodox with the modern and advanced; of old problems with new patterns; of a vision of the future with a look at the possibilities of making it come true. In all the discussions there should be present one final aim: the well-being of all the human beings inhabiting the Americas, which should be the result of a genuine development respecting their life styles, their cultural characteristics, their beliefs, and their spiritual manifestations as reflected in art. We should not try to imitate what is modern and fashionable but adopt what is in keeping with our nature and mode of being.

That is why we are sure that from this analysis in depth of health conditions in the Americas will emerge a picture of their development in the forthcoming decades of this century. There will certainly be some mention of the problems of industrial society, of environmental hazards in the large cities, of the influence of technology on customs and attitudes, and of the consequences of the “scientific revolution.” But the stress must be on such immediate, urgent, and practical objectives as the reduction of the number of deaths, which is excessive by comparison with that in developed countries—deaths that could be avoided because the knowledge and even the resources to avoid them exist, if only they could be better applied.

The resolutions that you pass, Gentlemen, will be a basis and a guide to the World Health Organization and the Pan American Health Organization in the accomplishment of their task in the Americas as a whole and in each country in particular. This is the reason for our presence here and for our great interest in the Meeting.

We should like to express our gratitude to the Government of the Argentine Republic for its kindness and for the excellent facilities it has provided for the Meeting. What we said at the Fifth Conference of Directors of Schools of Public Health of Latin America still holds good and indeed is strengthened by our experience: “It is evident that, through the inspiration of His Excellency the President of the Republic and the work of the Minister of Public Health and his collaborators, efforts are being made to refashion old moulds, modernize obsolete structures, incorporate present-day knowledge and techniques, and increase the output of the installed capacity of the health resources. But, most importantly, an attempt is being made courageously to confront problems in their true magnitude, to point out mistakes, and to reject ideas when unsupported by facts. What is being done, in sum, is to face obstacles, whatever their nature, and encourage progress in an objective and dedicated way.”

The time and circumstance in which we live are ours, and we are dependent on our passions and illusions, which must govern our building of the future. And the future will be promising to the extent that the common weal, the general welfare, is uppermost in our intentions and our actions.

ADDRESS BY THE DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION, DR. M. G. CANDAU

Presented at the Inaugural Session
14 October 1968

The honor you confer on us, Your Excellency the President of Argentina, by attending this Inaugural Session of the Special Meeting of Ministers of Health of the Americas is clear evidence of the importance of the Meeting for the health and well-being of all the peoples of the Hemisphere and for that essential cooperation which will make possible an earlier solution to all the problems that will be considered.

It is a pleasure for me to convey the greetings of the World Health Organization to the Ministers of Health and other representatives of the countries of the Americas, and to express my best wishes for the success of the Meeting.

We are celebrating this year the twentieth anniversary of the World Health Organization, and this gives us the opportunity to look back at the past and also to take a glimpse into the future. With the passage of time many of the health problems that the world had to face from 1940 on have met with solutions—sometimes complete but more often partial ones. It is nevertheless true that many of them still persist and that fresh problems are emerging to confront us.

Some of the changes that have occurred have merely served to render still more evident the growing differences between the developed and the developing countries. So as to solve the problems progressively, a considerable proportion of the national budget in all countries is allotted to the activities and sectors in which modern methods of planning, implementation, and evaluation are most suitably applied.

Health administrators must not fail to establish satisfactory administrative practices in order to make the best use of the scanty resources available. This is exactly the reason why they take an ever-increasing interest in the experience and knowledge gained by adapting modern administrative techniques to constantly expanding programs that are implemented in environments with very different characteristics. The changes that have taken place have often been the result of an integrated multidisciplinary approach to human problems that has been able to combine the theoretical contributions of ecology, sociology, economics, mathematics, and operations research. The process is a developing one of particular importance at a time when the policy and plans that have to be applied in the health sector are being formulated and the health sector is being regarded as an integral element of a country’s development; for it must not be forgotten that medicine is both a biological science and a social science and seeks as its principal aim to improve the health of man.

In seeking a solution to health problems we are compelled to adopt a criterion that we might call ecological, i.e., the consideration of human beings as part of an ecosystem, inseparable from their environment.

The forces acting in the environment influence the health of man. Many of his physical and mental defects must to a large extent be attributed to the fact that he has not reached the stage of understanding and controlling those forces, which are often hostile.

There is still much research to be done on the ecology and natural history of disease. We need, for example, to learn much more about the role of disease in the dynamic balance of nature. We also need to determine to what extent the epidemiological structure of human disease is changed by the transformations man has brought about in the biosphere—not only such dramatic transformations as the disappearance of a forest or of a valley submerged under an artificial lake, but also those caused by the building of roads or the extension of a suburban area into the countryside. Naturally we need to have a more thorough knowledge of the ecology of certain diseases and of their fluctuations. Lastly, it is essential that we should be able to measure ecological variables with greater precision.
All genuine changes for the better in human health depend on the economic development of the agricultural and industrial sectors, on the training of competent personnel, and on the organization of health activities, as well as on solving such environmental problems as water supply and the provision of sanitation services. They are all prerequisites to progress in the prevention of disease, the reduction of mortality, and the promotion of health, and each of them in turn poses ecological problems and compels us to make selective use of the available resources.

For this reason, everything in relation to better administration and use of resources is of fresh interest in modern health theory. The origin of the trend is to be sought in the increasing influence of economic thought in the development of countries. Poverty, hunger, and disease are indissolubly linked for most of the billions of people in the developing countries, and it would be useless to make an assault on one of the scourges without tackling the others at the same time. The foundation of any real improvement in the health situation has always been a general advance in socioeconomic conditions, and preventive medicine has greatly contributed to it.

Man has dwelt in urban and rural areas for thousands of years, but it is only in the present century that he has taken the decisive step of abandoning the traditional rural structure for an intensely urbanized way of life. Today industry is the source of earnings for an increasing number of people. Throughout the world, and especially in developing countries, populations are migrating in an uninterrupted flow from the rural to the urban areas, particularly to the great urban agglomerations.

The material and social consequences of this situation are very well known. There is a process of general deterioration characterized by overcrowding, bad living conditions, inadequate public services, traffic congestion, shortage of even the most elementary sanitary installations, squalor, and disease. This combination of circumstances explains the frequent repetition of the saying that the problem of the large cities is perhaps the most serious of those confronting mankind in the second half of the twentieth century. Meanwhile, there are still many countries where the difficulties of rural communities have scarcely received any attention.

The complexity of the world's health problems in this second half of the century cannot fail to stimulate Governments and organizations to seek fresh solutions based on the fuller use of new scientific discoveries and technological advances.

The improvement of the health standards of present and future generations, economic and social development, the raising of living standards, and intellectual development depend largely on the action taken in planning and education. Those are among the main objectives that all countries, developed or developing, are pursuing and the World Health Organization, which has the privilege of serving those countries, cannot fail to make those objectives its own.

I have followed with great interest the progress made toward a solution of the health problems of the Americas, which is in keeping with the ideas I have ventured to express. The traditional problems obviously remain, but already the problems that are a consequence of industrialization and of life in large cities are beginning to appear. These are the problems that your Meeting will be analyzing. The conclusions that it reaches will be of great importance to the World Health Organization.

Allow me again to give you my very best wishes for the complete success of this Meeting.
In greeting Your Excellency the President of Argentina at the opening of this Special Meeting of Ministers of Health of the Americas, I have three commissions to carry out.

The first is to interpret the thoughts of my colleagues, who have honored me by asking me to speak in their name in this ceremony.

The second is to transmit to you a message entrusted to me by the President of my country, His Excellency Arturo da Costa e Silva, wishing all happiness to you and your family. With this he transmits the thanks of the Government of Brazil for the achievements of our two countries, made possible by your clarity of vision and public spirit. I refer in particular to the joint work in the field of public health, especially the control of endemic diseases in the border zones without which, as is well known, national programs would be seriously impaired.

My third commission is to express the hopes that Brazilian health workers have placed in the outcome of this important Meeting. The road that has brought us to the present stage in the concept of health has been long and arduous, proceeding from the view that health was a mere field for philanthropy or simply a passive by-product of economic progress, to the view that it is a component of economic and social development. Nor is such a view the result of the tendency to overrate things, which specialists sometimes fall prone to.

The history of the American nations in relation to health, culminating in the Act of Bogotá and the Charter of Punta del Este, shows the position of the health sector in the Hemisphere; nor is this the view of specialists but the expressed opinion of statesmen.

In addition to this essential endorsement, other no less important considerations should be borne in mind as a justification of the historic character of this Meeting.

In 1902 we established the Pan American Sanitary Bureau, the oldest international health organization in the world. In 1949 it became part of the World Health Organization, as one of its Regional Offices. Its total budget for the fiscal year 1967 is more than 22 million dollars.

Health activities have gradually become the subject of international interest at the highest levels. In April 1963 in Washington, just as they are doing today in Buenos Aires, the nations of the Hemisphere contributed to the growing prestige of the national, bilateral, and international health organizations in the Americas in a way, I believe, that has no parallel in any other part of the world. The reason for this is faith and a deep-seated conviction that health is an investment and not merely a non-productive expenditure.

My colleagues who appointed me their spokesman and the health workers of Brazil are convinced that this Meeting of Ministers is an important step forward in the long journey to increase man's humanity through health.

The kindness of Your Excellency's Government in receiving us as guests merits not only acknowledgment but, because of its present and future implications, our respect and warmest gratitude as well.

It is our unshakeable conviction that the struggle against disease and for improved health conditions is the most effective common denominator in relationships between countries.

Our joint efforts will not only open the way to success in our common mission but will also remove differences, reduce political tension and, especially, teach us a way of living together in which thinking of other people will be on the same level as thinking of ourselves.
ADDRESS BY HIS EXCELLENCY LIEUTENANT-GENERAL JUAN CARLOS ONGANIA,
PRESIDENT OF THE REPUBLIC OF ARGENTINA

Presented at the Inaugural Session
14 October 1968

The Ministers of Health of the Americas who are beginning this Special Meeting today will consider the control of the most serious diseases that affect our peoples, the most suitable food policy to feed them, and national health plans to improve their physical and mental health. In sum, they are meeting to agree on how to protect human life in our Hemisphere, applying in each country the scientific and technological advances developed by civilization in its age-old struggle against disease.

The preamble to the Constitution of the World Health Organization says that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

The nations of the Americas possess enormous natural riches and persistently try to obtain and increase the capital needed to exploit and develop them. But they have also understood what the economists have discovered and emphasized in recent years: that more important than investment in material capital is investment in the health and education of the peoples, in the development of human resources, the most precious of a country's riches. Studies in the last 10 years in America and Europe show that this has been the factor of greatest influence in the economic growth of the most developed countries.

Argentina therefore warmly welcomes the Ministers of Health, who will concern themselves in this Meeting with subjects of such importance for the future of the Hemisphere. We are anxious that, in facing these problems, ideas and policies should be based on the concept of the development and distribution of material goods so that they reach all men and not just a few who will accumulate them for perhaps inappropriate ends.

The key to the problem is that those countries which in the future have a larger and more effective population will ensure a greater degree of well-being for themselves and a wider margin of freedom—that is, of sovereign control over their own affairs.

According to the strategy it adopts in developing its human resources, the Latin American community of nations will either be a simple provider of riches for other nations or it will take a leading role in the world.

Argentina can be said to sum up to some extent the situation and problems of all American nations. It is a predominantly urban country, and its characteristics resemble those of the more urbanized regions of the Hemisphere. But those characteristics do not clearly reflect the problems of many areas in the interior of the country, which suffer from evils similar to those of other rural parts of America.

It is true that, from the point of view of food and nutrition, our country is one of the greatest consumers of calories in the world. Nevertheless, the problem of regional imbalance that affects the Hemisphere also affects us internally, and we have made great efforts to ensure that the population in all the provinces attains the nutritional level that the country's food resources make feasible.

That will be one of the results of the policy of territorial integration that is a main pillar in the achievement of our objectives. This policy aims at industrial decentralization through the establishment of development poles in the peripheral parts of the country, the transfer of services and financial and technical resources to the provinces to strengthen their administrative structure and, finally, the promotion of living conditions that will make it possible to settle and encourage the expansion of human communities in areas where there is relatively less development. Plans for the increased development of the food industry are also being prepared.

Our countries should not be mere producers of raw materials for export and of foodstuffs at a very low level of processing. Their industry should be capable of diversification and improvement so as to produce processed food of
high quality. It can also absorb a considerable amount of manpower, which in its turn will be in a position to create a greater demand for all kinds of goods. Thus countries will be able to meet their own food needs and at the same time help reduce the world's food deficit.

The control of disease is of special interest to our countries. In Argentina, for example, the mortality rate is moderate—of the order of 8 per 1,000 population—but there are still certain areas where serious deficiencies should be remedied. In some provinces the mortality in infants under 1 year of age is over 100 per 1,000 live-births. This is a vital question for our country which, unlike other sister nations, is facing the problem of a serious fall in population growth. The annual birth rate has dropped to 21 per 1,000 population, so that the natural increase in the population is only 13 per 1,000.

The demographic problems that these trends create now and will create in the future for our country give rise to serious thought and to reservations about suggestions that birth control is the way to prevent the population explosion.

An increase in the average life expectancy is a goal unanimously sought by all countries. But if the achievement of this desirable aim is combined with a sharp fall in the birth rate, a serious distortion of the demographic structure will take place because of the aging of the population. This will have grave consequences for the vitality of the countries affected and for their future prospects. These consequences will be partly economic, because of the growing burden on the active population of age groups that have ceased work. But perhaps the most serious consequences of the trend toward a fall in the population are social; according to demographers and sociologists it is associated with stagnation, with a weakening in initiative and the spirit of enterprise, with an excessive concern for security, and with a clinging to things as they are. In the America of today, pledged to modernize itself, such a situation could present an obstacle to the fulfillment of its future vocation.

The problem of insufficient resources can be solved by means that, given the technical levels reached in our times, are no longer beyond our reach. The most appropriate methods should be adopted, with the more developed countries assuming a twofold responsibility: a spiritual responsibility toward their fellow human beings and a political responsibility for the maintenance of peace and the values of civilization. In these circumstances the trends toward international integration must take a practical shape, and there will be a gradual rechanneling of funds into productive investment wherever it is needed—a system that is already accepted and practiced at the national level and should be applied at the international level.

In no case have progress and development been achieved on the basis of egotism and self-destructive attitudes, but rather in a spirit of enterprise, generosity, and creativeness. History teaches that the suppression of life leads to decadence. If America wishes to fulfill its destiny as the Continent of the future, it must not artificially curb the human resources that will enable it to do so.

The process of urbanization inherent in development itself causes a gradual and spontaneous fall in the birth rate. Although this trend is difficult to reverse, it can be attenuated by a policy of family welfare, making child-bearing not a burden but, because of the spiritual satisfaction it brings, an advantage. This has been the reaction of the leading countries in Western Europe toward decadent trends, a warning to countries still in a position to maintain their national vitality.

It is in this spirit that the Argentine Government conducts its social policy, which involves real structural changes in a society that was on the path to a destructive individualism. It must be so organized that revenues and services conform to the social characteristics of a population in which the family is the basic unit.

The challenge we must face today, therefore, is that of improving our human resources, protecting them through their basis in the family, and investing money to improve instead of impair their health and education.

May I, in declaring this Meeting open, ask the help of God, the Source of all life, in guiding the Ministers present here in their efforts to alleviate human suffering.
ADDRESS BY THE MINISTER OF PUBLIC HEALTH OF COSTA RICA,
DR. ALVARO AGUILAR PERALTA

Presented at the Second Plenary Session
14 October 1968

The statement I should like to make will summarize the health activities in my country that we consider to be related to the Declaration of the Presidents of America signed at Punta del Este.

General

Costa Rica's size and population and the circumstances of its inhabitants give it its own special characteristics, in which are mingled resources and situations that sometimes facilitate health activities, sometimes make them more difficult; some conditions are very satisfactory while others demand our full attention.

As a result of this position, and of the ever-present shortage of financing, we have been impelled to undertake programs that will solve some of our most serious health problems at the lowest possible cost or, if the worse comes to the worst, enable us to maintain the levels reached in the hope that more favorable opportunities will arise.

Immunizations

In our population the highest mortality and morbidity rates are caused by communicable diseases for which vaccination is available. Because of this, and because the resources usually deployed were not providing the protection needed, it was considered desirable to make a special effort to raise the immunization figures to levels that would not only provide adequate protection to all individuals but could also be maintained by the routine vaccination programs.

An intensive vaccination campaign was begun in 1967, immunization against measles and smallpox being carried out simultaneously. The aim was not only to achieve wide coverage but also to obtain valuable experience as a basis for organizing a campaign against tuberculosis in 1968. The vaccination rates achieved in the susceptible population in both campaigns were really high: 54.6 per cent for measles in the age group 9 months to 6 years and 38.7 per cent in the age group 9 months to 10 years; and for smallpox, 40.4 per cent of the total population of the country. It should be mentioned that smallpox was eradicated in Costa Rica 50 years ago and there is no strong awareness in the population of the need for immunization against the disease. In the tuberculosis vaccination campaign 72.4 per cent of the age group 1-39 years and 100 per cent of the school population up to 15 years were immunized. The time taken for the simultaneous vaccination campaign was 28 days, and for the tuberculosis campaign, which was completed in May 1968, one month.

In both campaigns jet injectors were used and were a decisive factor in the coverage achieved and in the low cost per dose. In practice, only the personnel usually responsible for vaccinations in the health services was employed, since we did not intend to disturb the functioning of the other programs.

It should be made clear that this method of intensive vaccination was adopted because of the low coverage in previous immunization campaigns. We are convinced that intensive vaccination should be the initial phase of immunization programs in the developing countries. It should be accepted only as a method of rapidly raising the immunity levels of the population to an adequate degree; thereafter normal vaccinations should continue, or the new susceptible population should be immunized and revaccination should be carried out. The vaccination campaigns were carried out in large part through generous contributions from various institutions.
Nutrition

As with our other sister nations in the Central American Isthmus, it has been of great interest to Costa Rica to discover the real nutritional status of our population, especially—because of its low social and economic status—of our rural population. As is well known, malnutrition is a common denominator in a considerable number of impairments to health that have a wide incidence, especially in the more vulnerable groups such as mothers and children.

A nutrition survey covering most of the population was carried out in 1966, and another was completed in 1967 in the city of San José. These surveys were conducted under the sponsorship of the Ministry of Public Health of Costa Rica, the Institute of Nutrition of Central America and Panama (INCAP), and the Office for International Research (OIR), and they included clinical, physiological, anthropometric, dietetic, biochemical, parasitological, and immunological investigations as well as socioeconomic studies. We hope that the final results, which will undoubtedly be of great importance, will be presented toward the end of 1968; they will help to guide us in our future program in this field of health.

Because of our concern with this problem, which has such a profound effect on most of the impairments to health from which we suffer, we have tried to reinforce the diet of mothers and children with additional foods rich in protein and other nutrients that are in insufficient amounts in their normal diet.

Through this program 19.3 per cent of infants under 1 year of age, 5.9 per cent of preschool children between 1 and 6 years, 90.5 per cent of schoolchildren from 7 to 14 years, and 2.4 per cent of pregnant women have been served, mainly through school dining rooms and nutrition centers. Except for schoolchildren, who receive the supplementary food irrespective of their economic situation, the groups mentioned are given help in accordance with their nutritional state.

To treat children suffering from an advanced degree of malnutrition, a new nutrition rehabilitation clinic was established in 1967. Along with the three already existing (two local and one regional in character), it enabled valuable work to be done in rehabilitating a large group of children, and it also served as a training center for personnel.

Mobile Units

In the endeavor to provide a greater health service coverage, some time ago a medical care program was instituted for the purely rural areas, using mobile units staffed by minimum-sized teams headed by a physician. These units travel by land, sea, or air transport to reach small communities that are isolated from the health units of larger towns and therefore difficult to serve regularly. In this way our health services have been extended to an estimated 21.9 per cent of the total population which either had no medical attention at all or had great difficulty in getting any.

We considered it essential to take advantage of the splendid welcome that this type of program received from the beginning in the rural population. At the same time we provided purely medical care (vaccinations and consultations), we embarked on an environmental health campaign—especially the installation of latrines and drinking-water wells—and we profited from the interest and efforts of the inhabitants to vigorously promote community development. The effect was to bring forth innumerable works for the good of the community, which are the pride of the inhabitants of these areas, otherwise to some extent left behind in general socioeconomic development.

In cooperation with the Ministry of Education and with the help of UNICEF, we increased to an appreciable extent in 1967 the program of school nutrition and school gardens, the aim of which is to improve feeding practices and the diet of families in the future, taking advantage of the fact that a high proportion of the rural and urban population of Costa Rica attends school. Even though its results are essentially long-term, this program has begun to transform some aspects of the dietary habits of the families, the children having succeeded in convincing their parents of the excellence of the new methods.
Food Control

In our concern to ensure the safety of the food intended for human consumption, we have imposed strict control both of foodstuffs produced within the country and of imports. On two occasions we have been in danger of serious poisoning from insecticides from an outside source, since it would appear that the minimum requirements for ensuring the safety of foodstuffs are not observed in the ships carrying them. We consider that it has become essential to revise whatever international regulations may exist on the subject.

Dental Health

In view of the fact that the highest dental mortality and morbidity are among school-children, we have begun an active dental health program that receives the support and energetic participation of parents and of the educational authorities. In addition to the fixed and mobile services already established, we have installed small dental clinics in a fair number of schools, a measure that will have far-reaching effects on the health of the children and future grown-ups.

Malaria

During 1967 we succeeded in infusing new life into the work of the malaria eradication program, to such an extent that we can now say with satisfaction that it has returned to the path leading to the eradication of this parasitic disease. The Government's support has been expressed not only in a larger economic contribution but also in an obvious improvement in administrative procedures and in material facilities, since we built premises that made it possible to bring various of the activities of the campaign together as well as equipping the laboratory with adequate facilities.

Maternal and Child Health

In this program our activities are shaped by the extent to which the health services cover the country. During 1967, 27 per cent of all births occurring in the country were supervised through prenatal consultations, with an average of four consultations per pregnancy.

Hospital Care

To achieve coordination between the Government's health activities and those of the social security institutions, we created by executive decree a national commission at the highest level which has been distinctly successful in coordinating the work, especially in relation to compensation for medical services and the construction of buildings for the care of the public. In this latter respect, it is very satisfactory for us to have available at present a relatively large number of hospital beds, amounting to a national average of 3.9 beds per 1,000 population.

Water Supply and Sewerage Systems

In Costa Rica priority has been given for years to the construction of water supply systems, and this has enabled us to achieve the targets of the Charter of Punta del Este. Direct water supply service is provided to 90 per cent of the urban population, and 50 per cent of the rural population has water supplies either in their houses or nearby. The sewerage system reaches 21.4 per cent of the urban population, but another 26.6 per cent have an adequate system through septic tanks and drains. Because of its high unit cost the sewerage system does not serve the rural areas, but we have conducted a vigorous campaign for the installation of latrines and succeeded in covering 30.4 per cent of the rural population. In our view, individual service for the urban inhabitants and the installation of latrines for the rural population are the best way to meet the shortage of funds for achieving the Charter of Punta del Este goals in relation to sewage disposal.
ADDRESS BY THE MINISTER OF PUBLIC HEALTH AND SOCIAL WELFARE OF HONDURAS, DR. JOSE ANTONIO PERAZA CASACA

Presented at the Second Plenary Session
14 October 1968

Because of the limited amount of time available, I shall confine myself to general remarks summarizing the work accomplished in Honduras during 1967. Full details of these activities can be found in a document that has been distributed.

General

The birth rate in the country has risen progressively in recent years and in 1967 reached the figure of 45.1 per 1,000 population.

The general fertility rate per 1,000 women between 15 and 49 years of age is 212.7.

As regards the general mortality, the number of deaths in 1967 was 27,009. In the same year deaths of children under 1 year of age numbered 4,886, and those of children under 5 years, 9,200, the rate being 18.1 per 1,000.

In the seven health districts of the country, there are seven district health centers in operation, three of them integrated with the old district hospitals, as well as a health and training center, two non-district hospital health centers, 67 health subcenters, 49 health posts, and 10 mobile health units.

Maternal and Child Health

In prenatal care, the proportion of pregnant women treated in the areas served by the health establishments rose from 20 per cent of the total in 1963 to 39 per cent in 1967 and to 37.5 per cent in the period from January to June 1968.

Postpartum care between January and June 1968 covered 42.2 per cent of the target.

The proportion of infants under 1 year of age that were given care was 61.6 per cent in 1967 and 42.2 per cent during the period January-June 1968.

The services for the care of preschool-age children covered 44.3 per cent of the target in 1967 and 45.4 per cent during January-June 1968.

Outpatient medical care in hospitals, centers, and subcenters increased considerably, the number of consultations reaching 786,888 in 1967 and 396,871 during January-June 1968 (52.2 per cent of the target).

Immunization Programs

There was an appreciable increase in vaccination programs in 1967 and up to June 1968. In the smallpox vaccination campaign, which is in full operation, the aim is to protect 80 per cent of the population within the area served by the health services; 40 per cent of the established target was achieved in 1967 and 33.6 per cent during the first half of 1968. As for DPT immunizations, 89 per cent of the target was reached in 1967 and 20.6 per cent up to June 1968. Ninety per cent of children under 5 years of age were given poliomyelitis vaccine in 1967, and during 1968, 43.8 per cent. TAB vaccinations reached 50.2 per cent of the target. A total of 19,911 doses of measles vaccine were administered to infants under 1 year, 100,154 doses to children 1-6 years, and 157 to those 7 years and above.

Infectious and Parasitic Diseases

No case of smallpox has been notified since 1932. Immunity in the population, however, still has not reached the desired level.

_Aedes aegypti_ was declared eradicated in 1958, and since then vigilance operations have been continued. Unfortunately, reinestation has occurred during 1968 in two important localities in the country.

Typhoid and paratyphoid fever are endemic in the country and some epidemic outbreaks occur. In 1967 there were 847 cases. About 23 per cent of the cases were in the age group 5-14 years.
Few cases of diphtheria have been reported in recent years. In 1967 there were 8, the morbidity rate being 0.3 per 100,000 population.

Whooping cough is endemic. In 1967 there were 1,923 cases, the rate being 78.6 per 100,000 population. The cases were distributed as follows: 528 in the age group under 1 year; 1,017 in the group 1-4 years; 326 in those aged 5-14 years; and 52 in those over 15 years.

In 1967 there were 4,450 cases of measles, the rate being 181.9 per 100,000 population. There were 842 cases in the age group under 1 year; 2,626 in the group 1-4 years; 847 in the group 5-14 years; and 135 in those over 15 years.

Polioymelitis is endemic in the country; there were epidemic outbreaks in 1962, with 667 cases notified and a rate of 43.7 per 100,000 population; in 1965, with 265 cases and a rate of 11.6; and in 1967, with 79 cases and a rate of 3.2. Most of the cases occur in children under 4 years of age, the most affected group being between 1 and 4 years, in which more than 50 per cent of the cases occur.

We shall indicate only the most important of the zoonoses on which we have information. In 1967 there were 2 cases of human rabies and in 1968 one. In animals there were 26 cases. On brucellosis, there is no information for 1967. As for bovine tuberculosis, it is estimated that in 1967 and 1968, 1.6 per cent of the total animal population was affected by this disease. Regarding cysticercosis, a total of 1,974 hogs were confiscated in the slaughterhouses of the country, 1,415 (70.6 per cent) of them for cysticercosis.

In 1967, 145 cases of leishmaniasis were recorded, giving a rate of 6.1 per 100,000 population. Because notification is so deficient, these figures give only the smallest idea of the problem.

Intestinal parasitic diseases are a very great problem, especially in childhood, because of the poor environmental health conditions that exist.

In 1967 the existence of 243 cases of leprosy was known, 214 of which were under surveillance and 29 not.

Because of incomplete notification of venereal diseases, only the following figures can be given: 2,844 cases of syphilis were reported in 1967, the rate being 116.2 per 100,000 population. In comparison with previous years there has been a steady increase in the number of cases. In 1967, 5,008 cases of gonorrhea were reported, giving a rate of 204.7 per 100,000 population.

With regard to tuberculosis, 150,060 tuberculin tests were administered in 1967. Of those persons returning for a tuberculin reading 28,508 were found positive and the infection rate was 27.3 per cent. The population X-rayed consisted of 186,113 persons of both sexes and all ages. The number of cases diagnosed was 2,103, which gives a morbidity rate of 1.1 per cent.

Implementation of the revised three-year malaria eradication plan was started in the second half of 1967, on a gradual basis because of the need to train a large number of personnel and to await the receipt from outside sources of some supplies and equipment considered necessary for the successful operation of the program.

Other Activities

In 1966 Honduras had 247 water supply systems, 60 of which are of recent construction and fall within the program of the National Water and Sewerage Service, a body that began its operations in 1962.

The activities related to the national nutrition program were continued, the stress being on the establishment of nutrition rehabilitation services, education, and collaboration with the Higher Economic Planning Council in drawing up a national nutrition policy. Seven courses on applied nutrition have been held, as well as 12 courses for nurses and five for auxiliary personnel.

We embarked on community development activities two years ago and are now working with 111 communities in nine departments. The field staff promoting the development numbered seven up to the end of 1967, each field worker thus having 16 communities under his charge. The total number of projects was 168, of which 66 have been completed.

The services continue to be expanded so as to strengthen the health infrastructure in the
country, chiefly in the rural areas. Sixty buildings for health establishments have been constructed and provided with basic equipment, staff, and other necessary facilities. The Integrated Hospital at Yoro and the Psychiatric Hospital are in the process of completion, their respective capacity being 60 and 600 beds. The plans for building the Leonardo Martínez Hospital at San Pedro Sula and the Atlántida Hospital at La Ceiba have been finalized, and studies are being made of the economic feasibility of the Teaching Hospital in Tegucigalpa.

I should like to express our gratitude for the help we have received from international agencies, especially the Pan American Sanitary Bureau.

ADDRESS BY THE MINISTER OF PUBLIC HEALTH OF CHILE, DR. RAMON VALDIVIESO

Presented at the Second Plenary Session
14 October 1968

You will have received a document giving details of what has been achieved in the five years that have elapsed since the last Meeting of Ministers of Health. I shall consequently merely make a few observations on that document, so as to stress some points that seem to be of interest.

With reference to biostatistical information, the outstanding fact of this period is the fall in the rate of population increase in Chile, the increase at the end of 1967 being 1.96 per cent, while in the same year the mortality rate reached its lowest point. This shows how different the situation is in the various countries of our Hemisphere, especially if one compares it with the situation as described by the Minister of Honduras.

I should like to explain briefly what the birth control program in Chile consists of, and what grounds my Government has had for instituting it. It is an undeniable fact that the increased population growth rate is an important problem for many countries; it is a complex and many-faceted problem, with economic, social, ethical, religious, and also health aspects.

It is also held that excessive population growth is an important cause of underdevelopment, and some people go further and say bluntly that it confronts us with the dilemma of choosing between population growth and development. I do not think that there is any agreement on this point, and I personally disagree with it.

Our view is that the only thing that is so far certain is that the increased or explosive growth of the population is not a problem in nations with a high level of economic development but, with a very few exceptions that merely prove the rule, is a problem in poor countries with underdeveloped economics. This, however, as you can well understand, is quite different from saying that increased population growth is an important cause of underdevelopment, since quite the opposite thesis could be maintained, i.e., that economic stagnation creates the conditions—cultural deficiencies, inadequate housing conditions, etc.—that tend to raise the birth rates. If the first view is the right one, there is no doubt that the only logical solution would have to be a policy of birth control and family planning. If, however, the second one is correct, the only way in which the problem could be tackled would be to promote the social and economic development of the backward countries.

We have little or no doubt that, if we provide suitable housing giving the parents and
the children privacy, i.e., the opportunity for the full development of the family unit, and if we give people basic education and better paid work, we shall have responsible parenthood and family planning worthy of the human condition. On the other hand, birth control programs and activities will be ineffective—even if the methods used are ethical—in a wretchedly poor and ignorant population. The imperviousness of this social stratum to family planning programs is a well-known phenomenon. The result is that the people most resistant to such programs are the poorest and those who most need them.

Then comes the problem of the solution to be sought. In Chile we have no serious problem in relation to population growth; Chile is an intermediate position, equidistant, it might be said, between Argentina and Honduras. But the differences in the three countries are indicative of what happens in the countries of this Hemisphere as a whole; the situations are different and require different solutions.

What is the Chilean solution? Social development after all needs financing. Until economic underdevelopment has been overcome the problem must be stated in other terms. How can increased social development be financed? In my view, in two ways only. One, by internal methods—by an adequate distribution of wealth; as long as a few people retain a large part of the national income for themselves many people will be left behind in the march of progress. The other way is by looking for funds outside the country, i.e., foreign loans. Both ways involve solidarity: between the people within a nation, and between peoples at different economic levels.

That is what Chile is doing in what we might call the national domain of family planning. It is nothing other than seeking to achieve the indirect effect of which I was speaking, i.e., the improvement of conditions through increased social development, without hoping that economic development will come to provide the means, since then we would be going backwards.

The tax policy of the present Government has greatly encouraged an equitable distribution of the revenue and allotted the greater part to social development.

In my view the best birth control program is simultaneous social and economic development. But we have another problem, which we are tackling with the properly called birth control programs. It is abortion, and it's a health problem. At present 20 per cent of beds in maternity hospitals are occupied by septic abortions, and two-fifths of maternal deaths are caused by septic abortions. In the medical care of these women we are spending more than 8 million escudos, or about a million dollars, according to the figure for two years ago.

Abortion is an inhuman method of birth control that low cultural groups employ when they have economic difficulties to face. In Chile, therefore, the birth control program is exclusively a health program and its field of health is exclusively maternal and child care. The required information is given, the couple has full freedom of decision, and the grand multiparas are exactly the people the program is aimed at. This indicates the real size and scope of our program.

I should also like to stress briefly the drug policy that my country is carrying out. We are at the last phase in its implementation and its object is to rationalize the use of drugs. We have heard this morning about the increasing demand for health services for the population, which is out of step with the growth of the population because the demand far exceeds population growth and is largely owing to the prestige of medicine. This prestige is based on the fact that in the last 20 years or so curative methods have begun to be effective. But, as is well known, this progress and effectiveness have been brought about not by four or five thousand drugs but by a handful among them. There is no doubt that absolute freedom in the use of drugs leads to abuse, and abuse leads to economic waste. For this reason we have drawn up a national formulary, which is a selection of essential drugs prepared by a highly qualified committee.

In this connection, I should like to emphasize the need to hasten the establishment in Montevideo, Uruguay, of the reference laboratory for the quality control of pharmaceutical products, for which approval was given by the XVII Pan American Sanitary Conference.

I shall refer very briefly to our national

health system. When the health infrastructure in a country like ours is scattered through various institutions, the result is that the infrastructure and medical manpower are not put to fullest use. Coordination is necessary, but cannot just be left to the goodwill of those who administer the institutions. In Chile, coordination has been institutionalized through the establishment of the National Health Consultative Council, which is settling many problems of this kind that have been postponed for years.

It is easily understandable that the basic tool of the Council is the National Health System. Important legislative work has been done in this period. A law has been passed on medical care for salaried workers; there had been one previously only for wage earners. There is also a law on occupational accidents and diseases, and we have brought health legislation up to date and given it a new focus.

I shall end by mentioning a problem that is serious for us: alcohol and alcoholism. This problem is directly related to the risks of illness and death and is almost always a disturbing underlying factor in all our public health activities—medical care, maternal and child health, nutrition, environmental health, etc.—and outside the field of health, in work output, accidents, work absenteeism, illegitimacy and the population increase, abandonment of children, and crime. It can be said that there is no aspect of the life of a country in which alcoholism does not play an adverse part.

Epidemiological studies carried out in Chile indicate that alcoholism is prevalent in 5 per cent of the population over 15 years of age and that excessive drinking occurs in another 15 per cent, so that the number of persons suffering from the disease can be estimated at 250,000.

Action is being taken to cope with the problem, but it is still insufficient. There are about 30 centers for the treatment and prevention of alcoholism in the country; in them secondary and tertiary prevention is carried out and from them primary prevention is projected to the community through the organized efforts of schoolmasters, social and sporting institutions, the Chilean Red Cross, and other bodies, so as to educate the public on the subject. Encouragement is being given to the grouping of the patients treated into associations of rehabilitated alcoholics. About 50 of such groups exist at present throughout the country. Experimental as well as clinical and epidemiological studies on the problem are continuing.

It should be added that in Chile there are no restrictions on the advertising of alcoholic beverages. As for health education in schools in connection with alcoholism, we have started a program directed primarily to instructing the teachers, but we are still considerably behind in this work.

I should like to suggest that we include among our recommendations a proposal for the creation of a body to undertake the study of and the campaign against alcoholism. The field is so vast and the consequences of alcoholism so serious that we should face it unitedly in harmony with the spirit that brings us together here.

There are at least studies that, if continued, might fruitfully open the way to the prevention of alcoholism. For example, mention has been made of a genetic trait and of change in color vision; if this were proved, it would have invaluable results. A body such as the one I propose would be of great help to us. There is no question of oversimplified solutions, prohibitionist laws, or destruction of the vines, which would be like closing down the mines to prevent silicosis. I would ask you, Gentlemen, to give a favorable reception to my proposal.
ADDRESS BY THE DEPUTY MINISTER OF PUBLIC HEALTH OF ARGENTINA, DR. ALBERTO F. MONDET

Presented at the Second Plenary Session
14 October 1968

The Ministry of Public Health of Argentina has formulated new policies and outlined the plan of action to implement them. We are very pleased because the targets are being achieved, in spite of the difficulties arising from the changes in which we are engaged.

We have established three stages for our objectives, in accordance with the policy of organization and reform promoted by the Government and to cope adequately with the technical modernization required in the health sector. The first stage, which is in the process of implementation, is that of organization and covers the two years 1967-1968. The second, of adjustment and consolidation, covers the years 1969-1970, and the third, of expansion and development, from 1971 on, in conformity with the approved plan.

The first part of our activities was the concentration of efforts on many and diverse questions where regulation had become a necessity. Important changes were needed to make the administrative structure of the Ministry efficient, in accordance with the principle of centralizing standards and allotting responsibility for the execution of programs to the operating levels. Through the changes, it was made a central function to fix norms, provide supervision, give aid, and carry out evaluation, while peripheral bodies and services programmed their own activities and implemented them according to approved methods. As a result of these changes, agreement was reached with various jurisdictions to transfer services and institutions, and this administrative process has largely been carried out and is continuing in accordance with the appropriate standards. It is worth mentioning that, out of approximately 400 establishments that were under the National Ministry, 80 per cent have been transferred to provincial authorities.

This reorganization by levels was paralleled by the establishment of close coordination among the various regional authorities and between all of them and the central level. The regional coordination services thus have the important function of being the link to the national coordinating body.

To buttress this administrative structure, it was necessary to speed up the preparation and training of staff. This made it possible to bring in a large number of professional and technical personnel whose training had equipped them for what is being done.

In statements made at previous meetings, including that of the Task Force on Health in 1963,1 Argentina publicly declared that it was in practically no position to produce accurate statistics, i.e., the basic information. We can now state that the national plan for statistics, which was started in 1966, is now being implemented in perfectly defined terms. We now have, for example, five mathematical statisticians who were trained in 1967 in a regular public health course in the country; 68 statistical technicians; and 204 statistical auxiliary staff. Four have taken the complete biostatistics course at Columbia University in the United States of America.

We must however point out that we have insufficient nursing personnel, and it will take a long time to meet this great need.

We are extremely pleased to say that a close link has been established with national, provincial, and private institutions for higher studies. This is to be seen in the inclusion of public health subjects in the regular training courses for future professionals.

Another subject that we consider of vital importance in the development of public health in Argentina is that of a substantial change in the curricula of medical schools. Thanks to a spirit of understanding and to the work carried out jointly with the Ministry, the curricula are going to be completely revised, on the basis

that students entering the medical schools today will be the doctors of 1980 and planning must therefore be for the future.

Another fact much to the point is that the deans of the medical schools have played a most active part in the discussions on health problems. There has been very good support for the employment of electronic data-processing methods in developing the informational infrastructure and in meeting the need for better and quicker adjustments to the requirements of the health organization.

We are today more convinced than ever that no genuine public health activity can be accomplished in a country and that coordination and all the efforts made can have no results unless the administrative infrastructure of the public health ministry is properly organized. We venture to stress that point, because we are fully persuaded that it is very difficult to conduct integrated public health activities in any country unless the ministry is perfectly organized in the fundamental parts of its infrastructure.

I should like to say that these innovations, along with others, have found an expression in health activities that are achieving the desired aims. There are obvious advantages in integrating programs hitherto conducted from the central level by converting them into subprograms functioning locally, under the responsibility of the local authorities.

The quality and quantity of installed capacity, especially in the functional aspects, have also been defined by special studies. New techniques for determining the services available and the expected demand have been used with obvious advantage in preparing the programs of the health establishments and the services that must meet those requirements.

Using those important criteria and others, we have started to discuss a plan for the concentration of resources in base establishments, attempting thereby to bring together nationally personnel and equipment previously scattered in single-purpose centers with a scanty coverage and output, which really represented the fragmentation of a barely functioning system.

The single-purpose systems such as the Institute of Allergy or the Institute of Nutrition are distorting elements in a general system for they are little by little losing their monovalent character and becoming transformed into multipurpose centers; but while losing their former character they have not succeeded in becoming wholly multipurpose. It has been a hard struggle with these systems, but they are being integrated at present.

The studies also led us to deal with the urgent tasks of putting back into operation some hospitals that were not being utilized and to rehabilitate others whose performance was poor. The mental health program has similarly carried out a thorough reform of its services, adjusting the hospitalization and treatment of acute cases to modern standards. Although it is on the way to being solved, the problem of mental health is a source of constant concern. We are at the first stage of expansion of the services, which does not mean that we are increasing the number of beds but that we are transforming the beds. We have, for example, fitted out an army barracks that had not been used for some time, and there established a psychosocial rehabilitation colony attached to a hospital for acute cases.

This type of search for buildings and equipment that exist in the countries is very important in any sector. In this case it was the armed forces that handed over the barracks, and with these facilities we have been able to bring 1,400 mental health beds into use in one year, but we have not increased the number, for when we opened them in one place we closed others of the type you will recognize under the term "insane asylums," which are not rehabilitation centers.

For mental health work we have also made use of tuberculosis establishments whose bed capacity was not being utilized.

We feel very satisfied with the acceptance and consequent extension of the plan for providing drinking water to populations of rural areas. The Ministry is also increasing its technical support and arranging financial assistance to environmental health programs, especially for solid waste disposal and excreta disposal, which are permanent problems in many urban and rural areas. In small communities it is of fundamental importance to begin to define exactly what system is to be used for waste disposal and treatment. In most communities the waste-pit is the limit of development and
the place where the expansion of the town is going to stop. Where a waste-pit exists, the town stops expanding. All possible waste disposal methods should be used as, for example, sanitary land fill; but there should be no question of very expensive methods, which are beyond the reach of most of our communities.

Coordinated studies and research on air, water, and soil pollution are being strongly encouraged in order to solve the important immediate and even pressing problems they are now causing.

The National Ministry is very concerned with adjusting the medical services offered to the public so that, through its programs, they correspond to what is now technically available and what the public needs. Ranging as they do from immunization to the most complex medical care, the services are the subject of constant review and of technical discussions with representatives of the various specialties at all levels, the aim being to find the best way of applying modern medicine in accordance with the principle of integration we seek to apply in all our activities.

The campaigns against the prevalent communicable diseases are being actively maintained, all activities that can be integrated into the local services being included in their programs.

As we have said, the present stage of change and regulation is to be followed by one of adjustment, correction, and consolidation. In view of the increase in costs and in the demand for services, there is an urgent need for carrying out studies on new methods of complementary financing. This is a difficult matter, but a solution is a matter of great consequence if we are to ensure that our goals will be attained and our objectives gained in due course. We consider that part of our economic requirements can come from the joint financial participation of all the sectors working for the welfare of the community, especially for medical care expenditure. But we again assert that it is highly desirable that the specific sector organization should be responsible for the determination of norms for the services rendered, the administration and technical supervision of those services and, in general, activities for community health protection and promotion.

For the consolidation phase we propose to properly classify the existing services and fix sites for the health establishments that will serve as base centers for technically complex medical services and will provide the widest possible coverage. For that stage, too, we propose studies of technical coordination that will lead to the integration of the programs of the health sector with the medium-term programs of other sectors.

We should like, finally, to explain very briefly the broad lines of our intended activities from 1971 on. Studies have shown that 76 per cent of the existing beds belong to the health authorities, and that these beds are underused and are progressively deteriorating. Consequently a program of bed recovery must be carried out, in depth and over time and linked with the economic resources available, in an endeavor to restore full working capacity. This line of policy involves channeling into this effort the greater part of the new financing obtained. In any event, it is essential to achieve the operational unity of the health sector by coordinating the various components, administrations, and resources now providing health services.

In the national health plan that will implement the policies I have mentioned there will have to be a program designed to adjust existing manpower to health care needs and to train any additional personnel required. We hope to formulate and carry out a plan that can provide high quality care and coverage for the whole population, linking together all the services that form part of each sector and establishing or arranging coordination of the activities belonging to each.
If we examine our health problems in the light of the goals and objectives of the Charter of Punta del Este, we cannot omit consideration of the transformation our societies have undergone in recent years. The history of disease is nothing else than the history of the individual and the environment in which he lives. But the subject of public health is not the individual but society. Everything that happens in society therefore becomes motive and reason for our interests and aims.

The thought of the leaders of our times seems to be dominated by the so-called explosion phenomena: the population explosion, the explosion of demand, the explosion of knowledge. The first of these has acquired remarkable importance, its results already being recognized, particularly in the developing countries, in which birth rates exist that, if they continue at their present high levels, must affect unfavorably the balance between resources and needs.

The explosion in demand is seen in the most diverse fields: in medical care, environmental health measures, food supply, accessibility of educational resources, the constant creation of sources of work and social security, and others of the same order.

We observe at the same time how the field of science and technology is widening and the extent to which we are incapable of making use of the benefits it provides. We are aware that we should transmit the new knowledge to those who have to apply it to society, but we are not sufficiently prepared to convert it into effective and easily applied measures.

In the field of health, we have in the past few decades witnessed the rise of health planning as an instrument full of hope and promise. We have not, however, been able to give it the primacy it deserves as the perfected expression of classical health administration. Administration and economics have become sciences that the public health officer must know. When we speak of administration we understand it in its most pristine scientific meaning, although it must in part be adjusted to the characteristics of each political society; and when we speak of economics we must invoke its humanitarian meaning, since its subject must be man, the primary and basic reason for every economic system. Health planning must therefore essentially be the art, science, system, and process of placing healthy and vigorous men at the service of total development.

The most ambitious part of the plans in the Charter of Punta del Este is perhaps the targets fixed for water supplies and sewage disposal. In our country we have succeeded in attaining the target in relation to water supplies before the end of the 10-year period fixed. In the urban areas approximately 4,500,000 people—72 per cent of the urban population—and in the rural areas approximately 1,950,000 people—55 per cent of the rural population—have water supplies in their homes, which means that 65 per cent of the total population is supplied with drinking water.

The picture in relation to sewage disposal is not so encouraging, since only 38 per cent of the urban and 4 per cent of the rural population are served by sewerage networks. An additional 8 per cent of the urban inhabitants are served by septic tanks and drains and a little more than 30 per cent of the total population by latrines.

However, the construction of healthful housing, water supplies, sewerage systems, and the disposal of solid wastes are not the only components that we must take into account today in an environmental health program. Noise and air pollution from various sources are, for example, factors which tend to make the environment a hostile one for human life, especially in the large urban agglomerations, and which are apt in general to deteriorate and later present worse features.
We also believe that the concept of environmental health should go beyond the mere correction of the adverse factors that have hitherto been our main concern. The time has now come to broaden the concept; we think that there is now an imperative need to exert full control over the biosphere, as the sum of the resources that must be regulated, maintained, developed, and protected from any change for the worse that man himself may be responsible for.

Another of our great concerns is the dilemma of social priorities. An example of the distortion of priorities that may bring about undesirable results is to be found in the poor development of the agricultural and livestock industry in Latin America. The share of this sector in the gross national product of Latin American countries is very low and shows a downward trend. As a result, the imbalance already existing between food production and the consumer population is accentuated and so are the effects on the nutrition of our peoples and therefore on their health.

In this field the situation in Venezuela is in general somewhat more encouraging. Year after year we have been seeing an increasing development of the agricultural and livestock industry in absolute terms, although its share of the gross national product is not increasing proportionately, undoubtedly because of the greater growth of other sectors. The nutrients available per person per day are satisfactory in both calories and total proteins, but the proportion of proteins of animal origin is below what is to be desired and shows no tendency to increase.

The amount spent on medical care is better appreciated if considered in relation to per-capita income and not only in absolute terms. The World Health Organization has done this already and the results are very significant. In Venezuela the cost of hospitalization for one day is apparently the equivalent of nearly seven times the daily per-capita income, and the cost of an average stay in hospital for 10 days about 18 per cent of an individual's annual income.

In the last six years 4,400 new hospital beds have been brought into service, but not all of this number is a real increase, for about 1,200 are replacements for old beds that could no longer be used.

Of the 3,200 really new beds, 2,615 are in general hospitals and the others in special hospitals. Although these figures seem to be satisfactory, it is important to stress the fact that, notwithstanding the increase, the bed/population ratio continues in general to be low (2.5 per 1,000) and did not change during the period under review, undoubtedly because of the much greater population increase.

It is therefore essential to establish a policy of financing medical care that pursues the double aim of reducing costs and increasing service capacity. A factor influencing the first would undoubtedly be improvement of the administration of the health services, and one influencing the second would be extension of the social security systems so as to provide an increasing coverage. In this connection, in our country a new social security law has been enacted that includes new population groups receiving medical care and also establishes long-term financial assistance for retirement, disability, old age, and death. This law came into force in January 1967.

I must again stress the urgency of coordinating the various programs at the national level. This is a measure of imperative necessity and high administrative policy, and requires the Government's decision without delay. In Venezuela such a measure was taken in 1967, when a Preparatory Commission for a Single National Health Service was set up by presidential decree. It is at present concerned with the basic studies that are needed for an organization of this type.

A characteristic common to the countries that are undeveloped from the health point of view is the high prevalence of communicable disease. In this field, observations in our country have led us to a preliminary pessimistic conclusion, which is that, in spite of the powerful weapons we possess for the control or eradication of these diseases, we have not been in a position where we could employ them properly for that purpose.

In some of these diseases the existence of a complex etiology has to a considerable extent offset the efforts made, but in those that can be prevented by immunization the effect of control measures has already made itself felt. This is the case with smallpox, poliomyelitis, diphtheria, and others. There have been no
indigenous cases of smallpox in Venezuela since 1956, as a result of the campaign launched in 1949.

Malaria eradication merits special mention, because here the administrative and financial difficulties assume particular significance. The biological problems, which still need a great deal of study, could be solved if at the same time, with knowledge of the new methods of combating the disease, those other difficulties could be overcome. The area where malaria has been eradicated is still, in terms of size, the largest in the tropics and the third largest in the world; in it live nearly 96 per cent of the population that lived in the originally malarious area. Since 1961, the year of the Charter of Punta del Este, 42 new municipalities have been added to it, making a total of 519. In the two areas where the problem of malaria still exists there are 23 municipalities in the attack phase and three in the consolidation phase. The reason for the persistence of transmission in these areas is the migratory habits of the population in one and the habits of the vector and the constant importation of cases in the other.

To turn to cardiovascular diseases and cancer, the health programs include the early detection of cases and the institution of appropriate therapeutic measures. The implementation of these programs—as was the case previously with tuberculosis, leprosy, venereal diseases and others—is the responsibility of the health services already established, the specific activity required being completely integrated in their programs. Thus, through appropriate organization, a network of peripheral case-detection services is available, linked with higher diagnostic and treatment centers. So far the functioning of this network has been very satisfactory.

The expressions "human resources" and "medical education" tend today to have acquired one and the same meaning in the eyes of health administrators. A few years ago it was difficult to understand how they could be synonymous. At present medical education and public health form an indivisible field of joint interests, although assigned in practice to independent organizations. In the light of this concept, we have promoted systems of fruitful cooperation with our universities. Our first action was to develop departments of social and preventive medicine in the medical schools; then we established a harmonious system of interinstitutional relationships so as to make the best use of the hospitals as teaching centers.

At present the number of physicians in the country is 8,500, and for a population of 9.8 millions this produces a ratio of one physician per 1,140—a figure which is fairly satisfactory and which it will be possible to maintain in the future with an annual graduating class of 500 in our seven medical schools. The creation of new medical schools is not being envisaged for the moment, but every effort is being made to achieve a better use of the admission capacity of 1,000 first-year students that the present schools have. As are other countries, we are faced with the problem of the distribution of physicians, since important sectors of the population, especially in the rural areas, are far from having physicians available to the same extent as the country in general.

The situation in the field of nursing is much less satisfactory, so much so that we are very far from reaching the minimum ratio of one graduate nurse per physician. As in other parts of the world, we meet the needs for nursing services by using auxiliary personnel. Programs are being developed to improve the situation in relation to both the numbers and the professional level of such personnel.

The new discoveries in medicine have created fresh problems for the health services. A good example of them is Chagas' disease; its real damage to the population has only recently been revealed—and then incompletely. Although low, the death rate from Chagas' disease is tending to rise, but the number of people infected or suffering because of it from heart damage is very high. The principal vector is present in 75 per cent of the national territory, which indicates the enormous degree to which people are exposed to the disease. The campaign against the vector includes spraying of the houses where it is to be found. Entomological evaluation activities have already shown the value of spraying. Before spraying the vector was present in 18.2 per cent of the houses examined; after spraying the percentage fell to 1.9. At the same time a vigorous rural housing program is attempting to replace unhealthful and unsafe dwellings by comfort-
able, cheerful, and hygienic ones. In March of this year, by when this program had been going on for 10 years, the 70,000th house was inaugurated. The program has been assisted through international loans.

In speaking of medical care we did not mention the immense problem of preserving and maintaining buildings and equipment. We have invested an enormous amount of capital in hospital buildings and equipment, but without at the same time creating the organization needed to ensure their full operation, prolong their active life, prevent their rapid deterioration, and avoid the need for their partial or total renovation within a short period. To fill this gap, we have been occupied for two years in preparing an ambitious program of hospital engineering and maintenance, and the participation of the United Nations Special Fund in this program is being negotiated. The program includes training facilities for various categories of professional and technical personnel and workmen, the publication of maintenance manuals in nearly 20 diverse areas, and operations research studies into problems of administration, costs, output, and the care of the installations. We hope that within a few years this program will come to be used by other countries in the Americas in which the same situation exists.

In this summary we have obviously not been able to cover all the health problems and programs of our country, and some have not even been mentioned. On the other hand, we have stressed those activities and initiatives that may provide useful experience to our sister nations and indicated some of the prospects for the immediate future in our efforts to achieve health. In all these activities we have had the benefit of the collaboration of the international health organizations, particularly the Pan American Health Organization, whose clear understanding and constant help I warmly acknowledge. We understand international solidarity to involve a mutual obligation to render service, each country always having to offer something to the other countries. As the coordinating center of such lofty pledges in the Americas, the Pan American Health Organization has achieved an outstanding place that should fill us with pride and satisfaction. Let this, then, be the moment for us solemnly to reaffirm the need to unite our efforts round that Organization and its single great objective: the attainment of the highest possible level of health for the peoples of America.

ADDRESS BY THE MINISTER OF PUBLIC HEALTH OF URUGUAY, DR. WALTER RAVENNA

Presented at the Second Plenary Session
14 October 1968

I should like to begin my address by expressing my satisfaction—which I think is unanimously shared by all my colleagues—with the very appropriate resolution adopted at the XVII Meeting of the Directing Council of PAHO,1 which through the intermediary of the Director of the Pan American Sanitary Bureau has made this important Meeting possible. It is also our duty to express our thanks to the Republic of Argentina, which has welcomed us here fraternally with its traditional courtesy.

Uruguay is linked by indissoluble historic and cultural bonds not only with the countries of South America but also with those of the whole of America. In setting out its present

health situation in this Special Meeting, it hopes to make a modest contribution by recounting its experiences, whether as successes in the field of health or as failures. The failures we reckon as of positive value, since they have strengthened our resolve to confront our health problems using modern methods of planning, rationalization of procedures, and organization of the curative and preventive medical services.

In Uruguay, we consider the recommendations of the Charter of Punta del Este of fundamental importance for the development of health, inasmuch as they entrust the Pan American Health Organization with the evaluation of the main health problems and propose general guidelines for immediate health action. Our country, because of its very special geographic and climatic conditions and its limited size—so that there are no problems about getting to any part of it—and because too of its ethnic uniformity, has from its beginnings been suitable for the development of effective action in the field of health. Nevertheless, in specialized technical fields the need has been recognized to review the national health situation with a view to applying new methods based on universally accepted modern standards.

In this connection, Uruguay thanks the countries present here for the help they have given in the training of our technical personnel, who have had an opportunity to participate in the various experiences of other countries and have thus been better able to determine the main causes of health problems in our own country.

The basic general information Uruguay obtained in 1963 through the work of the Commission on Investment and Economic Development provided a general diagnosis of the situation in the health sector that we still consider valid. The following conclusions emerged from a study of the graphs for death and birth rates over the years.

1. Both the birth rates (21.2 per 1,000) and the general mortality rates (8.7 per 1,000) are very low.
2. Infant mortality is high (48 per 1,000 live births) and a study of the rates over the years shows no trend toward improvement.

This strongly suggests the direction in which health action might be taken, since infectious diseases are tending to disappear and the mortality is basically in the interior of the country—where the rate reaches as high as 61.6 per 1,000, as against 33.6 in Montevideo and 22.4 in the United States of America in 1967.

3. Maternal mortality is similarly high, with a tendency in recent years to fall.
4. The incidence of infectious and parasitic diseases is high: 39.7 per 100,000 population, increasing in the rural areas and especially high in the case of hydatidosis.
5. The death rates for suicide and mental diseases are high, with a considerable increase for the latter due especially to alcoholism.
6. There is a persisting trend toward an increase in deaths from geriatric diseases.

The data from the same source also reveal three health problems which are inadequately dealt with: dental health, environmental health, and control of the manufacture and sale of foodstuffs, drugs, and medicaments.

From these statistical data of the Commission it might appear that the reason for the problems in the health sector is the inadequacy of the funds allotted to that sector. However, a study of the total allocations to health in Uruguay reveals that 5.26 per cent of the gross national product goes to health—a figure that places us among the comparatively more advanced countries. Of this percentage the public sector receives 34 per cent and the private sector 66 per cent.

A comparison of international indices shows that the use of social resources for health purposes is characterized by: low output, poor geographic distribution, and poor distribution by specialties.

Private expenditure on health is largely concentrated in the capital, and it amounts to twice that of the rest of the country. Redistribution of the resources is thus needed. Public expenditure, on the other hand, is distributed in a uniform way. I should make it clear, in relation to private expenditure, that 50 per cent of it is through mutual insurance systems and the rest through family expenditure.

The Ministry of Public Health is the most important body functioning in the field of
health, both because of its budget and because of its national network of services and the wide range of functions assigned to it by its Organic Law. Thirty per cent of total expenditure in the health sector is the responsibility of other State and semi-State bodies outside the Ministry; these bodies have services parallel to those of the Ministry but there is no coordination between the two. We consider that the most important reason why our health level is below that of other nations which allot the same or fewer resources to health is precisely the lack of coordination in our present system of health organization.

In the formulation of any health plan there are basic factors that we do not fail to recognize, such as work areas, objectives, means, and datelines. But, as has been well said, health problems do not by themselves determine decisions. Sometimes the quantity and quality of the resources available in the present or future impart a definite direction to the programming, for in certain conditions only the concentration of scant resources can with any certainty of success enable us to control serious diseases that affect our communities.

It often happens in developing countries which have extensive health experience that the formulation of health plans or programs may be conditioned by pre-existing circumstances making it necessary to adapt existing structures without weakening them, since they are the only means available for implementing the plan or program. In such situations the programs are customarily framed in a somewhat unorthodox manner, but always rationally and in full awareness, because those framing them have to bear in mind that their solutions must be conceived as an integral part of a national reality as well as of a necessarily larger context.

On the basis of that national health reality, the Government of Uruguay, through the Ministry of Public Health, has drawn up a plan in which the distribution of the resources of the public health sector is adjusted and the best use made of them. The private sector is to be coordinated with and integrated into the public sector, and its activities channeled preferentially toward the social and geographic areas where the greatest shortage is to be found.

According to the plan, our Ministry will be responsible for the general organization and administrative operations. The following measures have been taken:

1. There is decentralization of program execution and centralization of policy-making. This has been clearly set out in the program budget in force since 1 January 1968.
2. There is delegation of functions and responsibility based on departmental executive units.
3. Coordination is being initiated, with a view to avoiding duplication of work and overlapping of the various health bodies, both public and private.
4. Training programs at all levels have been intensified, with the cooperation of appropriate specialists, and the sending of selected technical staff abroad for training is being stimulated by fellowship programs.
5. A Standing Planning and Budget Commission has been set up at the level of the Public Health Ministry, and a National Division of Health has been established.
6. Active measures are being taken to improve the human, material, and economic resources of the health sector, and to complete an inventory of the services and establishments of the Ministry of Public Health.
7. A Hospital Planning Commission was created, its work being coordinated by decree with that of the Department of Planning and Investment of the Ministry of Public Works. In close coordination with the latter Ministry, the Ministry of Public Health is carrying forward its program for the construction and renovation of hospitals throughout the country; this we think can be completed within the next four years. When this investment plan has been carried out, it is expected that our hospital network will have buildings and equipment suitable for our times that will make the hospital services more effective.
8. The reorganized rural public health program will, since we have given it central control and standards, acquire fresh impetus, and we are continuing to strengthen it by appropriate budgetary methods.

As we stressed earlier, much can be done to improve our health standards through the
coordination of services, better use of existing resources, and proper redistribution of those resources.

Of great interest in our country is the question of the introduction of national health insurance. We are not opposed to this, but we feel that we still have many preliminary stages to go through in order to make the necessary adjustments in the existing system. We have mentioned the reorganization we are carrying out, and we are establishing the foundations for a serious study of the private sector through a double technical auditing of servicing standards and of financial resources. We are having success in obtaining coordination in the general services of the private sector.

We have established effective control of the quality, manufacture, and cost of drugs, and a series of basic low-cost drugs is being promoted through the Drug Control Committee and the Ministry of Public Health.

On the basis of concrete facts and suitable adjustments that will take a certain time to achieve, we shall promote a health insurance system on secure foundations. We do not wish to leap blindly into this matter, which is very complex, for a failure in a system covering the whole country—whether because of a draining away of the capital or because it did not function harmoniously—would create a chaos that we are not disposed to inflict on our population in relation either to medical or to preventive care.

We consider that our health plan is in accordance with our present conditions and with our present economic possibilities. It is a realistic and dynamic plan, and it is as such that we present it to this Meeting of Ministers.

ADDRESS BY THE SURGEON GENERAL OF THE UNITED STATES PUBLIC HEALTH SERVICE, DR. WILLIAM H. STEWART

Presented at the Third Plenary Session
15 October 1968

The written report which I delivered to the Secretariat is on the subject of planning and the beginning of planning in the United States. In my brief remarks, I shall refer to some parts of the written report, and will include also some mention of the health movement in the United States in the last five years.

The pattern of disease in the United States has changed very little in that period, with three exceptions. Measles immunization has changed the epidemiological curve of that disease, as can be seen in the chart included in the document published by PAHO.1 Secondly, the group of chronic respiratory diseases—lung cancer, chronic bronchitis, and emphysema—is the only group of diseases which shows an increase in the mortality rate in the last five years, and we are confronted with the problems of the etiology and control of these diseases. Finally, there are the occupational diseases. The problem is not an increase in the incidence of these diseases but the emergence of new ones resulting from the daily and massive introduction of new chemicals, new processes in manufacture, particularly in mining, and petrochemicals and plastics. The principal concern in the last five years, however, has been with the phenomena of increased demand for preventive and curative services and the rising costs of medical care. These costs have been increasing at about twice the rate of the general rise of costs. This situation has forced attention, almost sole attention, on the organization and method of providing health services, in order to find a new structure which will make it possible to rationalize costs and ensure maximum efficiency.

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Indicative of the change that has occurred in the last five years is the fact that more health legislation was passed by the Congress in that period than in the entire history of our country. This signals the emergence of the Federal Government as a principal force in the field of health.

There were four major types of legislation. First was that concerned with the development of resources, principally manpower. Second, new laws were enacted to protect consumers against products which emit radiation or contain chemicals from which the individual by his choice cannot protect himself. Third, was the emergence of social insurance for medical care and the expansion of public assistance medical care programs. To give some idea of their magnitude, it can be mentioned that these two programs now pay for about 35 per cent of all general hospitalization in the United States.

And finally, planning, which I wish to discuss in some detail. I believe that the legislation in this field is the beginning of a movement toward a new structure in organization and a method of rationalizing costs and regulating capital expenditures. The law and the program stemming from it are based on four principles. The first of these, a truism, is that planning is essential for the assignment of realistic priorities for the use of health resources. The second is that since health needs and resources differ from place to place within our country, planning can be most effective if it is done locally and regionally, that is, within our 50 states in the individual communities large and small. Thirdly, effective planning for health cannot be conducted in a vacuum apart from the interrelated realities of human life, but requires active participation not only by providers of health services but also by consumers, and by a wide variety of disciplines, such as economics, urban planning, and so on. Fourth, the role of the Federal Government in relation to the allocation of health resources should be twofold: to stimulate and support the development of effective planning, and to permit considerable flexibility in the use of Federal grant funds to help meet the priorities determined by these local and regional planning activities.

It is too early at this time to evaluate this extremely complex program with any degree of certainty. I can report on some promising developments and also on some problems which are emerging. On the positive side, it is already apparent that groups of individuals in our country are talking about health services and how they can be developed, about what is important and what can be given second priority—groups that never discussed these matters with one another before. They include hospital administrators, physicians, private citizens, engineers, architects, sociologists, economists, and many others.

The result has been that health is being seen for the first time in many areas, not as an isolated problem of interest only to doctors but as one that cannot be solved apart from the other problems of human living.

One of the problems that has emerged is the need for data. We have seen a move toward the collection of more data of the kind that is useful in planning. Another problem is the shortage of trained people in planning. They are very scarce, and we cannot pinpoint exactly what a planner is, so that training must be built on many disciplines.

I hope that in this brief time I have conveyed to you a feeling of the health movement in the United States, which is new, full of uncertainties and problems, but also full of promise for better health services. As we work together on the health problems of the Hemisphere, I believe that all of us will be aspiring to the same goal that underlies our health planning effort: the best possible use of our limited resources to meet the most urgent health needs of all the people of the Americas.
Health problems are inseparably linked with the characteristics of the environment; in addition to the biological substratum, there exist elements of the physical, social, and economic environment which are causal factors.

Owing to the close relationship between health, social, and economic elements, any change in one part of the system inevitably leads to changes in the remaining parts. Inequality in social and economic conditions is therefore reflected in inequality in health conditions.

Hence, in order to understand health problems and the importance of the plans and achievements in this sector, those problems must be viewed in the context of the action taken to promote economic development and social well-being.

In Colombia a top priority has been given to economic progress and social well-being in the conviction that "the first and chief purpose of a good policy is to incorporate the marginal groups in the community." For this reason, before presenting the plans and achievements in the health field, I shall mention the main economic and social activities promoted by the Government.

In the economic sector—"the indispensable basis of social well-being"—land reform is radically changing the structure of land tenure, promoting or stimulating production over vast unexploited or low-yield areas, and so far more than 2,236,000 hectares have been reallocated benefiting 62,501 families. Cooperative credit has encouraged the development of depressed areas of the economic sector, and 350,000 loans amounting to approximately 2 billion pesos were granted in 1967 to agricultural workers. Tax reform, through the revision of the tax systems and the organization of fiscal administration, is lessening the inequalities created by disequilibrium in incomes.

In the social sector, programs have been initiated for the construction, purchase, and improvement of housing through savings and credit facilities. The budgets have been increased, the techniques for educating and training manpower have been improved, and the proportion of enrollments at all levels has risen substantially. The official and semiofficial social security organs have assumed new risks, and sound financing has thus been forthcoming for extending their coverage. The community integration program, under which the community's efforts are involved in carrying out projects for improving its well-being, has so far enlisted the support of 15,000 community action boards and the participation of approximately 8 million people.

In addition, the Government has placed a bill before Congress for the purpose of strengthening the juridical regime of the family, establishing a legal economic and social framework for the concept of responsible parenthood, providing institutional and economic resources for comprehensive maternal and child health and introducing compulsory women's social services in order to promote health, educational, and social service activities.1

Health Policy

In the health field, a policy designed to amplify and improve the integrated medical care services has been formulated, priority being given to the marginal population groups and to programs which will yield a greater benefit per unit of cost more quickly and efficiently.

As a first step toward identifying the problems that deserve priority attention and revising the order of priority for allocating resources, an analysis was made of population characteristics and trends, of health problems,

1 A bill to amend and supplement Acts 45 of 1936, 83 of 1946, and other legislative provisions on filiation, to found the Family Welfare Institute, to organize the maternal and child health campaign and to promulgate other provisions.
and of the available human and material resources, defined with the help of the Study of Health Manpower and Medical Education in Colombia,\textsuperscript{2} the 1964 national population census, and the regular statistics of the services.

The analysis of the health situation shows that communicable diseases and malnutrition are the most serious public health problems. Half of the deaths occur among children under 5 years of age, and 10 to 20 per cent are caused by infectious and parasitic diseases, which also place the heaviest demands on the medical care services as regards consultation and hospitalization.

As a logical result, 15 communicable diseases, malnutrition, and abortion have been selected as priority targets for health action, taking into account the order of their frequency and severity, the demands for services which they generate, and the technological and operational capacity available for reducing them.

The following have been established as the main ways and means of implementing the general health program: the National Health Plan for the decade 1968-1977, integration of State health organs and their coordination with other welfare and social security organizations, and the reorganization of the services as part of the administrative reform promoted by the Government.

Instruments of Action

\textit{National Health Plan, 1968-1977.} The Plan lays down the main guidelines for the orderly and coordinated direction of health activities; it presents figures and solutions for the country as a whole and provides the requisite information necessary for the formulation of regional health plans, having regard to the facts of the budget and the priorities set at the national level.\textsuperscript{3}

Conceived as a continuing operation, the National Health Plan will lead to the more productive and more efficient utilization of our limited resources.

The programs have been planned on the basis of the regionalization of services, for which purpose the country has been divided geographically into program areas. Under this system, the university medical centers constitute the apex of a pyramid which continues with the regional and local services, so that the patients can be referred to more complex care units as the nature of their problems dictates.

The advantages of this system—which streamlines the distribution and utilization of resources, raises the scientific level of the personnel through the association of specialists with various levels of services and of rural doctors with university hospitals, and supplements the programs of integration with the social security and medical education institutions—are obvious.

\textit{Integration.} The lack of a unified health system has made it difficult to extend the services further, thus contributing greatly to the under-utilization of resources. For this reason, efforts have been made to solve the problems of the sector with the close collaboration of State, semi-State, and private bodies pursuing similar aims.

In 1965, at the first stage of this process, a start was made by organizing sectional health services in each of the departments, intendancies, and commissaries, as technical subdivisions of the Ministry. This made it possible to gather together, in almost all the subdivisions, the budgetary funds for health earmarked by the nation, departments, municipalities, and charity institutions, so that they could be administered uniformly, thus avoiding a dispersal of effort through duplication.

At the second stage, standing coordinating committees at the national and regional level, in which the Ministry of Public Health, the Colombian Association of Medical Schools, and the Colombian Social Security Institute were represented, were set up to study joint programs of medical care, personnel training, and long-term and short-term research.

Recently, the Higher Council of Public Health, the National Council of Health Research, and the Planning Committee of the health sector were established. They are responsible for advising the Ministry on the formula-

\textsuperscript{2}Study carried on since 1964 by the Ministry of Public Health and the Colombian Association of Medical Schools, with the support of the Pan American Health Organization and the Milbank Memorial Fund.

\textsuperscript{3}The following may be consulted as an example of regional health plans: Sectional Health Service of Antioquia; Four-Year Health Plan (1968-1971), Medellín, 1968.
tion and implementation of its policy and other institutions are represented on them.

Many joint undertakings have been carried out as part of this policy. They include the integrated programs of applied nutrition with the participation of the health, educational, and agricultural sectors; the population studies and medical education and research programs developed in conjunction with the Colombian Association of Medical Schools; and the programs executed jointly with the Colombian Navy, Civil Aviation, and other institutions in order to bring medical and dental preventive and curative services to regions which are difficult of access.

In this connection, special mention should be made of the establishment in 1967 of the National Hospital Fund, which was a decisive catalytic agent in initiating and completing the extension, staffing, and improvement of the medical care and social assistance services. The Fund's capital consists of 10 per cent of the disability, old age, and death insurance premiums of the Colombian Social Security Institute, and it is administered jointly with the Ministry of Public Health.

Lastly, other more specific but not less important joint programs were also developed. The most recent was the Health Plan for the International Eucharistic Congress, directed and coordinated by the Ministry with the participation of many institutions.

Administrative reform. The foregoing developments led to changes in the internal structure and administrative machinery aimed at formalizing the integration of the services, strengthening planning activities, and providing the Ministry with the facilities necessary for controlling, evaluating, and directing the programs.

Achievements and Prospects

The following are the main achievements of the Ministry of Public Health in the last few years. They are introduced by quotations from the recommendations on health formulated by the American Chiefs of State at their Meeting held at Punta del Este, Uruguay (1967).^4

When it is remembered that the achievements were possible without any increase in the proportion of the national budget allocated to the Ministry, it will be realized what can be done to solve a common problem with efficient planning, cooperation, and coordinated work, and with assistance from international sources and private enterprise.

"Control of communicable diseases and eradication of those for which methods for total elimination exist."

Since almost all the priority problems in the National Health Plan are created by diseases which can be controlled by vaccination, environmental sanitation, and supervision of the sick, investments in programs for the control and eradication of communicable diseases have grown.

A graduated immunization plan has therefore been drawn up, designed to achieve useful levels of protection through mass vaccination programs followed by consolidation programs, independently of the local programs which will continue to cover demand.

As the initial part of the program, mass vaccination against smallpox was started in July 1967. In one year, well over 6 million vaccinations were administered and by the end of 1968 it is hoped to achieve a total of 13 million vaccinations.

In the following years similar attack and consolidation programs will be undertaken with intradermal DPT and BCG, and measles and poliomyelitis vaccines, as well as consolidation programs with smallpox vaccine.

In implementation of the malaria eradication program, one quarter of the malarious area containing 75 per cent of the population has been brought into the consolidation phase; the remaining three quarters of the area, with 25 per cent of the population exposed, is in the attack phase.

In addition, emphasis continues to be laid on the tuberculosis, leprosy, yaws, and yellow fever control campaigns.

Lastly, the reorganization of the National Institute of Health includes measures which will enable maximum use to be made of its facilities as a producer of biologicals to meet the demand.

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of the National Health Plan and international commitments.

"Acceleration of programs for providing drinking water supplies, sewerage, and other services essential to environmental sanitation in rural and urban areas, giving preference to lower-income groups."

In order to cope with the demand generated by population growth and to reduce the deficit accumulated in previous years, the programs for providing potable water and adequate sewage disposal service for the population which is scattered or living in centers with less than 2,500 inhabitants, constituting approximately 50 per cent of the country's total population, have been strengthened to the maximum.

Furthermore, with the recent incorporation of the Municipal Development Institute in the Ministry of Public Health, our coverage will be extended to the larger localities and coordination of the environmental sanitation programs will be greatly facilitated. (The Institute was formerly a decentralized body belonging to the Ministry of Development; it provided basic sanitation in localities with more than 2,500 inhabitants. It was incorporated in the Ministry of Public Health by Decree No. 2561 of 7 October 1968.)

In spite of population growth, 23 per cent of the rural population has now been provided with water service, as compared with 16 per cent up to 1965. On the other hand, the proportion of population supplied with adequate systems of sewage disposal has remained constant at about 23 per cent.

The foregoing was possible thanks to a 600 per cent increase in the funds allocated for these programs in the last few years. They amount at present to 7.8 per cent of the total health budget, as compared with 2.4 per cent in 1965. If this rate of investment growth is maintained, 50 per cent of the rural population will be covered in 1976.

The rural basic sanitation programs have at all times enjoyed the cooperation of the community in satisfying its own needs, executing the projects, and maintaining and utilizing the services.

Moreover, the Declaration of the Presidents of America recommended that the relevant programs should have the necessary international coordination when circumstances so required. In accordance with this policy, an agreement on border health cooperation between Colombia and Venezuela has been signed for the programs concerned with tuberculosis, malaria, yellow fever, leprosy, venereal diseases, smallpox, and rural water supplies. In the near future, it is hoped to extend this type of agreement to other neighboring countries.

Although not specifically relevant to the control of communicable diseases, the agreement signed between the Colombian Social Security Institute and the National Welfare Institute of Ecuador should be mentioned here as an encouraging example of international collaboration. This bilateral agreement, signed in January 1968, guarantees protection against risks in respect of sickness, maternity, work accidents, and occupational diseases for members of one country who are temporarily sojourning in the other.

"Greater and more rapid progress in improving nutrition of the neediest groups of the population, taking advantage of all possibilities offered by national effort and international cooperation."

With the programs of applied nutrition, personnel training, and research which are being actively carried out by the National Institute of Nutrition, a subsidiary organ of the Ministry of Public Health, the scientific foundations have been laid for dealing with the problem, and some important changes have occurred in the nutritional condition of the population, such as the approximately 80 per cent decrease in the incidence of endemic goiter through the iodization of salt.

Having twice the budgetary resources of the previous year, the National Health Plan expects to undertake the following in 1968: supplementary feeding programs; the establishment of additional nutrition rehabilitation services and food demonstration units; the training of specialists and monitors in nutrition and feeding; and the organization of new integrated programs of applied nutrition with the participation of the health, educational, and agricultural sectors.
Colombia's nutrition activities will also be greatly strengthened by the incorporation of the National Institute of Nutrition in the Family Welfare Institute. The latter will coordinate maternal and child protection programs.

"Promotion of intensive mother and child welfare programs and of educational programs on over-all family guidance methods."

In conformity with the Government's general policy, particular attention has been given to the programs for providing better medical and paramedical care for the entire population, especially that which lacks adequate protection and suffers from major health problems.

As an initial step, the programs of rural health promotion have been reorganized and intensified, for which purpose use is made of rural leaders permanently residing in the villages who have been trained according to Ministry standards to carry out minimal health promotion, protection, and rehabilitation activities. So far some 700 rural community workers have been trained and it is expected that there will be 4,000 of them in two years' time.

Concurrently with the foregoing, the program for the progressive extension and improvement of comprehensive health services for mothers and children has been initiated, with special emphasis on the rural areas, using the normal structure of the health services and making maximum use of professional as well as auxiliary and volunteer personnel.

The aim of the program is to reduce maternal and child morbidity and mortality and to improve family welfare through education and the provision of health services. For this purpose targets have been set for covering prenatal and childbirth assistance, control of the growth and development of the child, prevention of induced abortion, early diagnosis of cervico-uterine cancer by vaginal cytology, and the demand for medical information and services for family planning.

"Priority for basic and advanced training of professional, technical, administrative, and auxiliary personnel..."

The training of personnel, at both the professional and the intermediate levels, has been actively promoted in different programs which were developed jointly with the Colombian Association of Medical Schools and are based on the results of the Study of Health Manpower and Medical Education in Colombia.

The budget for personnel training activities has been doubled each year since 1965. During 1968 4,000 persons at the professional and the intermediate levels are being trained in public health, and it is planned to train a further 5,500 in 1969.

These activities have been supplemented by exchange programs between the various national and foreign schools for furthering the training of teaching personnel, by programs for training physicians and nurses in aspects of family planning and the prevention of abortion, and by continuing education programs for strengthening the professional education of physicians by stressing the preventive and social aspects of the practice of medicine.

Furthermore, in the next few weeks the plan of economic, professional, and scientific incentives designed to attract health personnel to the rural areas and to retain them there, and to extend training activities, will be completed.

Lastly, throughout the year the Advisory Committee on Planning and Development of the Colombian Association of Medical Schools has been studying various educational policies for medicine and some paramedical professions and expects to formulate final recommendations on this highly important subject in the course of the present year.

"...and support of operational and administrative research in the field of health."

Research programs are regarded as an indispensable supplement to the evaluation and supervisory activities of the Ministry and as a method of raising the scientific level of the programs and of those who carry them out.

For this purpose, the National Institute of Health, the Study of Health Manpower, the Biostatistical Section and other subdivisions of the Ministry have become permanent units for promoting and developing scientific research and training and technical assistance in research in the public health and biomedical fields.
In order to improve the systematically collected information, the central Government, for its part, has undertaken to expand and modernize the National Administrative Department of Statistics.

As part of these programs, the Experimental Survey of Health Services is being carried out at present as an extension of the Study of Health Manpower. It is intended to show the effects which the delegation of certain specific functions of professional personnel to auxiliary personnel has on the provision of services, and at the same time to show how the reference and supervisory functions which the professional personnel should assume for that purpose are being performed.

ADDRESS BY THE DEPUTY MINISTER OF HEALTH OF MEXICO,
DR. PEDRO DANIEL MARTINEZ

Presented at the Third Plenary Session
15 October 1968

Mexico has tried to adapt its national health programs so as to attain the targets set in the Ten-Year Public Health Program of the Alliance for Progress and the Declaration of the Presidents of America.

It is an honor for me to avail myself of this unique opportunity to inform the distinguished Ministers of Health of the Americas of the results achieved and the methods used to achieve them, as well as the obstacles which in some cases have prevented our programs from being developed to the best advantage.

The Charter of Punta del Este specified five main projects for progressive implementation. The first is to provide water supplies and sewerage services for at least 70 per cent of the urban population. In 1960, before the period of the Charter began, Mexico had 18,300,000 inhabitants living in urban communities, of whom 59.2 per cent (10,820,000) had water service. In 1968 the urban population reached 26,930,000, of whom 64.3 per cent (17,280,000) were served. It should be added that these figures refer to people whose houses are connected to the public water system. On the other hand, the sewerage program has been left for the local authorities to deal with, especially by means of specific taxes which can be introduced following the provision of the water supply. Nevertheless, the proportion of sewerage is certainly smaller than was expected.

The same Charter project aims at supplying at least 50 per cent of the rural population with water during the decade. Our rural population in 1960 was a little under 18 million inhabitants, of whom only 7.8 per cent had water service. In 1968 the rural population rose to 19 million, of whom 25 per cent now have water service. However, communities of less than 500 inhabitants (almost 70,000 villages) are included in this percentage. Considering only the 10,416 localities with between 2,500 and 500 inhabitants, to which priority is given, it will be seen that 4,370 of them, or 40 per cent, already have water supplies.

The second point in the Charter prescribes as a target the reduction of mortality among children under 5 years of age to half the rates for 1960. In Mexico, preschool mortality in that year was 14.5 per 1,000 and is now 9.2, which means a drop of 0.75 per year. This makes us hope that the target will be fully reached.

Another objective is that of increasing every-
one’s life expectancy at birth by five years. In 1960 we had a life expectancy of 58.9 years and it is now 62.7, which means an increase in life expectancy of 0.54 per year; in other words, the rate is slightly higher than necessary to reach the target.

As regards the improvement of nutrition, especially among the most vulnerable groups, Mexico has concentrated on a policy of stepping up food production. In 1955 its inhabitants had only 2,277 calories and 62.6 grams of total protein per capita. In 1967, in spite of intensive population growth, the number of calories per capita rose to 2,625 and total proteins to 76 grams. Moreover, animal proteins increased from 16.1 grams per capita to 22.9. These statistics refer to food produced and consumed in the country, in other words, they do not include exported foodstuffs.

Through the National People's Food Supply Company, our country has formulated a national policy for the production, storage, distribution, and pricing of food. This Company has 1,500 retail shops and has drawn up a program for setting up one shop in every one of the country’s municipalities.

In the health centers, nutrition services have been developed employing professional and technical personnel, who are used for nutrition education and for improving the feeding services in social and medical institutions. Again, under the Program of Rural Cooperative Projects, 7,123,000 family rations are issued each year in 1,637 communities as an incentive to encourage collective self-help projects during periods of agricultural unemployment. Moreover, the National Institute for Child Protection distributed 170,000 lunches daily in the Federal District and 526,000 in the states to school-age children. The Ministry of Health and Welfare provides 125,000 daily rations of milk to children under 6 years of age living in 1,292 rural localities.

The Charter stresses the need to improve and expand medical care services. In this connection our country used to suffer from severe limitations especially as regards hospital care. Fortunately, the Mexican Institute of Social Security, which had 8,460 beds in 1960, had 20,580 by the end of 1967. The Ministry of Health and Welfare has also increased the number of health centers, many of which have hospital beds, from 1,111 in 1960 to 1,906 in 1968. The number of beds has risen from 16,520 to 24,734.

The last specific point in the Charter refers to malaria. We have to report that, while our program is continuing, the increase necessitated by eradication has been curtailed for financial reasons. Under the national development plans, it was considered preferable to accept this pause rather than throw the economic plans already formulated off balance. We think that the necessary resources for reintensifying our eradication program as planned will soon be forthcoming.

In addition to malaria, the Charter draws attention to the important subject of the control and eradication of communicable diseases. In Mexico we have given top priority to maintaining an adequate level of immunity against smallpox, which was eradicated in 1953. We have thus administered 45,200,000 vaccinations since 1960 and believe that we now have 50 per cent of the population immunized.

In 1963 we managed to eradicate Aedes aegypti and since then we have had five reinfestations, all originating in the southern part of the United States of America. Luckily, our surveillance services detected them in good time and they have therefore been eliminated.

Our country still suffers from a few cases of epidemic typhus, the only quarantinable disease. In 1960 typhus occurred in 15 areas of the country and now it occurs in only two states in an area with a population of no more than 800,000. Intensive DDT-spraying programs are in full operation and we thus hope to be able to eliminate this disease by 1969.

We also think that next year we will be able to eliminate poliomyelitis. In addition to the routine immunization programs, we recently completed an intensive program in six areas of the country, with a population of 1,475,000 children under 5 years of age, 81.3 per cent of whom have already received the three doses of vaccine. In October 1968 we are initiating our second stage covering 18 units with 3,750,000 inhabitants under 5 years of age, and by the end of the first half of 1969 we will have covered the remaining states. As a result of this program we believe that the disease will virtu-
ally disappear. We have also stepped up our vaccine output and, at the suggestion of the Pan American Sanitary Bureau, we are prepared to produce sufficient quantities in order to supply countries which need it, through the PASB itself, under agreements to be negotiated. We hope to produce 50 million doses per year, instead of the 12 or 14 million now being produced.

Measles is another major disease because of its high rate of mortality and morbidity. Before the end of this year, the first lot of measles vaccine we are manufacturing at our Institute of Vaccines and Biologicals will leave the plant, and this will shortly enable us to draw up a national program for protecting children against this danger.

Another scourge we hope to eliminate in 1970 is pinta. In 1960 the zone of Mexico in which pinta is prevalent had an outbreak amounting to 58 cases per 1,000 inhabitants. The present figure is only 7.9, and in two areas the rate fell to 0.9 and 0.5 per 1,000.

Endemic rabies among the dog population is responsible for many cases of human rabies every year. Moreover, derriengue has serious economic repercussions on the livestock industry. With the valuable collaboration of the PASB, we are engaged in a dog vaccination program on the northern border with the United States of America. Under this program, up to 80 per cent of the dogs in the chief border towns have been successfully vaccinated. We also recently completed a program in the Federal District under which we vaccinated 194,000 (40 per cent) of the animals. We hope that, once the routine work has been intensified, we will finally reach the percentage necessary to break the chain of transmission.

We have already completed the careful exploration of the 16 leprogenous areas in Mexico; we have 13,590 patients registered, 10,070 of whom are under surveillance. Although the disease exists in other areas, its incidence is very low there.

As regards the important problem of tuberculosis, we have stepped up our programs on the northern border, in the southeast, and in the Federal District, and we are detecting an annual average of more than 20,000 cases. We are also carrying out a routine BCG vaccination program and an intensive program was recently launched in the leprogenous states of the country in the hope that it will at the same time contribute to the antileprosy campaign.

Finally, I must point out that, in addition to improving the organization and administration of the health services, Mexico is giving priority attention to the systems of coordination between the governmental public health programs and those of the social security institutions through a coordinating committee at the national level, the results of whose activities have been increasingly rewarding.

We attribute at least equal importance to strengthening the coordination of our activities with those being carried out by the other countries of the Americas on common problems. We wish to convey our most heartfelt thanks to their distinguished health authorities for their fraternal understanding and support, and to congratulate the Director of the Pan American Sanitary Bureau and his staff on their efficient and enthusiastic collaboration.
I should like first to express appreciation to the Government of Argentina for having offered to host this Meeting, and to express my congratulations to Dr. Holmberg on his election to the Chair.

In Trinidad and Tobago, of the six quarantinable diseases, only yellow fever poses a threat. Even so, the last outbreak occurred in 1954, when there were 15 cases and five deaths. In 1959 there was a single case in a forest worker, who survived. Since 1960 we have been free of Aedes aegypti, apart from periodic reinfestation from neighboring countries which harbor the mosquito. These reinfestations are always promptly and effectively dealt with. Our freedom from dengue in recent years is a reward for vigilance in this respect. Dengue exists in almost epidemic proportions in countries around us.

In regard to tuberculosis, the number of cases reported has reached a satisfactorily low level, having dropped from 610 in 1949 to 239 in 1967. In the same period recorded deaths fell from 560 to 36. All inpatient treatment of tuberculosis is now concentrated in one hospital; it has a bed capacity of 338 but the average daily occupancy is now less than 200 patients, a significant number of whom are nontuberculous chest cases. This favorable position has resulted from a combination of fewer admissions and a considerable reduction in the average length of stay in hospital.

A new approach to leprosy control is at present under consideration. This has been stimulated by the attendance of one of our senior technical advisers at the Seminar on Administrative Methods for Leprosy Control Programs held in July in Mexico, and by the visit of an expert from the American Leprosy Relief Missions Inc., who did a survey in Trinidad and Tobago and produced a most comprehensive and valuable report which is being used as a blueprint for reorganizing our leprosy control programs and legislation.

A new Division of Epidemiology is being established to incorporate all activities in this field. Included will be the activities of the Insect Vector Control Division, whose main concern has been malaria and A. aegypti control. Trinidad and Tobago was declared free of malaria in 1966 and we have also eradicated the A. aegypti mosquito. This section of the Ministry is now mainly concerned with vigilance activities to ensure against reintroduction of malaria and yellow fever.

Other proposals for the Division of Epidemiology include the setting up of a public health laboratory and strengthening of the quarantine and port health activities.

Venereal disease control is another area in which we have received valuable help from the Pan American Health Organization through the services of two short-term consultants who examined our existing program and submitted a report which contained comprehensive recommendations. On the basis of this report, reorganization of our program is now in progress. The most important recommendations relate to the integration of venereal disease control with other public health activities, liaison between the Government's program and private practitioners, training of personnel, education of the public, and contact tracing.

The need for the establishment of a division of environmental sanitation within the Ministry of Health has long been recognized. We have recently been able to secure the services of an experienced public health engineer to head this division. Implementation of the requirements in this field are now in progress. The activities of the Water and Sewerage Authority, established with the assistance of PAHO, also have resulted in considerable advances in this area, the details of which have been included in the paper which we have submitted.

The most significant advance in maternal and child health has been the incorporation of family planning in the Ministry's program in
this field. A comprehensive program has been formulated, which incorporates not only government activities but also those of the Family Planning Association and the Roman Catholic Marriage Advisory Council. The consultant provided by PAHO has been of valuable assistance in helping us set up this program.

Our applied nutrition program, which involves four Ministries—Health, Education, Agriculture, and Community Development—continues to progress. Considerable assistance has been received from the Pan American Health Organization, the Food and Agriculture Organization (FAO), and the United Nations Children’s Fund (UNICEF). The World Food Program has also recently offered help and this is being pursued. Trinidad and Tobago is a cosponsor of the recently established Caribbean Food and Nutrition Institute. The other sponsors are the Government of Jamaica, the University of the West Indies, PAHO/WHO, FAO, and the Williams-Waterman Fund. One of the two centers of this Institute is located in Trinidad.

Canadian technical assistance to our psychiatric program, channelled through the Clark Memorial Institute of Toronto, is in its third year of operation. This assistance is now centered mainly in the Psychiatric Unit at the Port-of-Spain General Hospital. Medical and other technical staff are provided from Canada and training is arranged in Canada for Trinidad and Tobago staff at various levels.

Since the approval by our Government of the first National Health Plan for Trinidad and Tobago prepared with the assistance of PAHO advisers, the World Health Organization has sent various groups of health planners to Trinidad and Tobago to participate in indoctrination courses. In addition, individual officers from other countries have visited our country to discuss with us our health plans. Some of these officers have been on WHO fellowships.

This would indicate that Trinidad and Tobago’s efforts in this connection have received a considerable measure of recognition. The impression should not be created that implementation of our National Health Plan has not presented difficulties. Two areas of difficulties in particular are worthy of mention. The first is the financing of the Plan. One of the basic postulates of the Plan is that no significant increase in recurrent expenditure is envisaged initially, provided there is considerable capital expenditure to render the existing health facilities adequately effective. The problem here is to find the necessary capital required for the essential capital expenditure. The second problem of implementation which must be mentioned is the difficulty in establishing the organizational structure and in finding suitable staff, administrative and professional, to achieve the objectives of the Plan. This is to some extent a problem of training and indoctrination which, of necessity, will take time. On the positive side, note should be taken of a pilot experiment in the implementation of the concepts of the Health Plan in a localized area. A well-equipped, modern 50-bed hospital at Point Fortin in South Trinidad has been made available to the Government recently. It is being utilized as a focus for an integrated health project for a population of some 20,000. All elements of the health service, as well as other social services of the area, are integrated and community involvement is ensured by inclusion of appropriate representatives of the Area Advisory Committee. It is hoped that the experience gained in this pilot project will assist in the establishment of an effectively integrated health service throughout Trinidad and Tobago.
Addresses by the Participants

ADDRESS BY THE VICE-PRESIDENT OF THE REPUBLIC AND MINISTER OF PUBLIC HEALTH OF NICARAGUA, DR. FRANCISCO URCUYO MALIAÑO

Presented at the Third Plenary Session
15 October 1968

National Health Institutions

The health sector is administered by several institutions which are organized independently of each other and work in coordination under a single National Health Plan, pooling their efforts to form a common front, to a single unity of purpose, and aiming at the improvement of health and prevention of disease. These institutions are the following: the Ministry of Public Health, the National Assistance and Social Welfare Board, the National Institute of Social Security, the Managua Local Social Welfare Board, the Military Hospital and dispensaries, private hospitals and polyclinics, and the dispensaries of industrial undertakings.

These institutions have the following facilities: 38 hospitals, 24 of which are national and 14 private, with approximately 4,000 beds. There are 68 health centers in operation and 11 mobile rural assistance units which have established 110 health posts. There are approximately 50 private dispensaries. Nicaragua has, in round figures, the following personnel resources: 700 physicians, 300 nurses, 50 dentists, 40 health educators, 1,500 nursing auxiliaries, and 200 health inspectors. The organization of the Ministry of Public Health is shown in the report distributed to the participants.

Analysis of the Health Situation

The primary causes of death are: gastroenteritis, accidents, heart diseases, pulmonary infections, and malaria. The highest death rate is among children under 5 years of age. The most widespread disease is parasitism (90 percent of the population), the hospital beds are used most frequently for abortion and childbirth and the heaviest demand for consultations is from people with respiratory ailments, infectious diseases, and diseases of the stomach and intestines. The highest incidence of sickness is found in the age group 1 to 5 years and the largest group of hospital patients is between 20 and 30 years of age. The commonest accidents are caused by falls and traffic.

Population

Half the country's total population consists of children under 15 years of age. Every year 75,000 children are born (birth rate: 41.6). The rural population constitutes 60 percent of the total population of 1,800,000 inhabitants in 1968.

Environment

Only a very low percentage of the population has water service. The only cities with partial sewerage are Managua, Chinandega, León, Corinto, Estelí, Jinotega, Matagalpa, Ocotal, Rivas, and San Marcos. Nicaragua has 250,000 housing units, half of which have neither water nor sewerage service. The average Nicaraguan family consists of six people per house.

Nutrition

Nicaragua produces large quantities of food and yet there is a nutrition problem because the people are not taught to balance their diets and choose the most suitable foodstuffs. We might cite, by way of example, the fact that children prefer to spend their money on soda drinks instead of a glass of milk.

The country produces 800,000 metric tons of food, to which 35,000 tons of imported foodstuffs should be added. Thus the amount of food available per capita in Nicaragua is sufficient. For example, there are 300 grams of milk per capita, 45 grams of cheese, and 40 grams of meat, which is adequate by international nutritional standards. There are also adequate quantities of eggs, fish, vegetables, root crops and tubers, fruits, cereals, sugar, and oils. The average number of calories consumed
per capita is 2,325, which is considered a good figure. But these calories are not evenly distributed among the population. In summary, we can say that Nicaragua produces sufficient proteins, sufficient carbohydrates, fats, vitamins, and minerals for its population's needs. It is the task of the Ministry of Public Health and the Ministry of Education to teach people to eat properly and select their food.

Programs Under Way

The National Health Plan indicates the programs and targets for the 10-year period 1965-1974. The main programs being carried out by the Ministry of Public Health are designed to reduce mortality and satisfy the demand for medical care services. They include: maternal and child health and school hygiene; nutrition; family planning; potable water supply and sewerage; health inspections connected with food; vaccination against infectious diseases; control of drugs, pharmaceutical products, and processed foodstuffs; malaria eradication; tuberculosis control; control of venereal diseases, leprosy, and leishmaniasis; and medical consultations in all health centers.

Every year the targets for specific activities to be carried out by the health centers are readjusted. The targets for consultations, visits, inspection, vaccination, and feeding for 1968 have been set and the relevant figures can be seen in the document that has been distributed.

Policy of the National Health Plan

The main objectives of Nicaragua's National Health Plan are the following: (a) reduction of mortality, including preventive medicine programs; (b) covering demand (consultations and hospitalization); (c) training programs (medical, paramedical, auxiliary, and postgraduate personnel; in-service training, etc.); (d) research programs (chemico-biological laboratories, epidemiological surveys, etc.); (e) investment programs (construction of health centers, improvement of the health infrastructure, improvement of equipment, etc.); (f) rural health service programs (PUMAR).

The implementation of the National Health Plan was begun in 1965 and 85 per cent of the targets are being fulfilled.

The results we anticipate from the National Health Plan are the following: (a) reduction in the general mortality rate; (b) reduction in the child mortality rate; (c) reduction in the birth rate; (d) eradication of malaria, smallpox, and poliomyelitis; (e) reduction to the minimum of cases of infectious diseases controllable by vaccination; (f) reduction in abortions; (g) improvement of medical care for all the population; and (h) attainment of the targets of Resolution A.2 of the Charter of Punta del Este.

The programs now under way are helping to improve the Nicaraguan people's welfare and hence to promote the nation's economic and social development.

Education and Training

Training courses are conducted for nursing auxiliaries, health inspectors, laboratory technicians, statistical assistants, antimalaria sprayers, and many other auxiliary workers.

The Nursing School turns out 40 nurses per year and the National University 50 physicians per year.

We also have special training programs in environmental sanitation, nutrition, epidemiology, and in the work of the mobile rural assistance units. The health education sector is broken down into six divisions: training, audiovisual aids, national supervision, education for special programs, publicity, and library.

All the Ministry's health programs are preceded by an intensive community publicity and public relations campaign.

General Comments on Public Health Programs

The data on the infrastructure program were as follows: in 1965 there were 44 health centers; in 1967, 35 new health centers were added; and in 1968 six more were under construction, making a total of 85 health centers. The 1969-1971 plan provides for the construction of 56 new health centers with the help of a US$2,200,000 loan from the U.S. Agency for International Development.

The National Department of Water Supply and Sewerage Services (DENACAL) was founded to deal with the water supply problem and it is now under the Ministry of Public
Health and is an interministerial agency. The first Inter-American Development Bank loan, for $2,000,000, has been obtained for 75 rural water supply systems which will benefit a population of 65,000 inhabitants. The Managua Water Board provides 85 per cent of the water service to the population.

Sewerage in the city of Managua is the responsibility of the Local Social Welfare Board. The second tender has been invited to provide the piping for the system to be completed in 1969. The request for a loan for the main sewer and the treatment plant was submitted to IDB.

Since 1965 immunizations against communicable diseases in the country have been intensified. These immunizations include smallpox, poliomyelitis, DPT and TAB, and in 1968 an intensive vaccination campaign against measles was launched. There are also tuberculosis control, malaria eradication, and Aedes aegypti surveillance programs.

With regard to institutional coordination and integration, increasing efforts have been made since 1966 to ensure more effective utilization of human and budgetary resources. The maternal and child program has become a routine and principal activity of the health centers. The program includes two major activities: recruitment and training of lay midwives in rural areas, begun in 1966 (approximately 100 are cooperating, and each is given a UNICEF bulletin); and family planning.

As to the medical and hospital care program, coordination between health centers and hospital services is just beginning. PAHO is furnishing technical advice to the Managua General Hospital and to the country’s hospital nursing services. General Regulations for Hospitals have just been approved. Professional personnel have been receiving training in hospital administration abroad since 1967.

The basic functions of the local health centers are linked directly with the health promotion, protection, and rehabilitation programs.

The graph included in the report that has been distributed shows clearly that since 1960 the health budget in Nicaragua has been rising, as the activities of the National Health Plan have expanded.

On behalf of my Government, I wish to express our thanks for the advice we are receiving, in connection with all the different programs we are developing, from the Pan American Sanitary Bureau, under the distinguished and efficient leadership of Dr. Horwitz, and also from AID and the Government of the United States of America, which have granted us financing loans, and from UNICEF, which is also helping us substantially in these programs.

ADDRESS BY THE MINISTER OF PUBLIC HEALTH AND SOCIAL WELFARE OF PARAGUAY, DR. DIONISIO GONZALEZ TORRES

Presented at the Third Plenary Session
15 October 1968

I shall refer only to the most important information bearing on the changes which have taken place in Paraguay in the health sector since the Meeting of the Task Force on Health held at Washington in 1963, without going into details which you will find in the reports distributed.

At the national level, the Government of Paraguay has laid the foundations for its economic and social development in the political, economic and financial, and infrastructural sectors: social and political peace; a new and modern constitution based on a National Constituent Convention at which, following free
general elections, the country's four legally constituted parties were represented; improvement of the democratic institutions; monetary stability; guarantees for work and capital and for the inflow of foreign capital; a hydroelectric plant; a petroleum refinery; a cement factory; a merchant fleet; appropriate land settlement; roads, and other activities.

As an institutional framework, and for the purpose of studying our problems, the national Government and ministries have national, bi-ministerial and multi-ministerial bodies, such as the Technical Planning Secretariat of the Executive Branch, the National Economic Coordinating Council, the National Health Coordinating Commission, the National Social Development and Progress Commission, the National Commission for the River Plate Basin, the National Nutrition Council, and the National Committee for Coordinating the Campaign against Communicable Diseases. In addition, the Health Code and Organic Law of the Ministry have been drawn up. All this enables us to prepare plans for the future with optimism and confidence.

All the ministries have prepared a Five-Year Plan which will be implemented during the Government's new constitutional term (1968-1973). Thus our Two-Year Health Plan of 1965-1966 is now followed by the Five-Year Plan, the chief parts of which include: diagnosis; programming, priorities, general and specific objectives, long-term strategy, action plan, and programs; execution of the plan, available resources (human and material); new essential services; and evaluation.

A point worthy of mention is the full cooperation, in the execution of all our programs, of the communities and the civic action of our armed forces. The collaboration extended by international organizations, such as the PAHO, UNICEF, FAO, and the U.S. Agency for International Development, in the form of fellowships for personnel training, advisory services, provision of equipment, materials, drugs, vaccines, and long-term financing and loans, is also fundamental and we are extremely grateful for it. Our particular thanks go to the Ministry of Public Health of Argentina for supplying vaccines and for the cooperation extended in various development programs, especially in the border areas. In this connection, I must also thank the Brazilian health authorities for their valuable collaboration in border projects.

Special circumstances sometimes result in changing health situations. Paraguay, whose progress and development are in full swing as a result of the factors I have mentioned, has experienced such changing circumstances in the health field. For example, as we developed the plans to open up roads and settle areas of the country formerly abandoned and isolated from the main population centers, large-scale internal migration and movement from the Brazilian frontier adjacent to those areas were observed; and since leishmaniasis and malaria are endemic in those areas, there occurred some epidemic outbreaks of leishmaniasis, especially among road and forest workers, and of malaria throughout the population. This is a price to be paid for progress.

I wish to emphasize in particular the auspicious beginning of the malaria eradication campaign, in which our national effort and financing are supplemented by technical and financial assistance and by aid in the form of equipment and supplies from PAHO, UNICEF, and AID. This campaign constitutes the greatest public health effort ever made by the Government of Paraguay. It gives me great pleasure to report that the entire malarious area is at this moment in the attack phase. From the outset we have been seeking and effecting the close and constant coordination that is necessary between the general health services and the malaria eradication service.

In cooperation with PAHO, the Ministry of Public Health is now engaged in a special survey which we regard as highly important: it is designed to measure, in the areas where malaria is particularly prevalent, the damage which this disease causes to the country's economy.

In order to protect our livestock population—our most important source of food and, because of our meat exports, also a source of foreign exchange earnings—an intensive vaccination campaign is now being waged against foot-and-mouth disease and paralytic rabies. We have also improved the administrative structure and extended the area of action of the food and nutrition education program.

The Sanitary Works Corporation has completed its studies and is negotiating a loan from
the Inter-American Development Bank for the purpose of expanding Asuncion's water system, by increasing the capacity of the processing plant, new connections, new reservoirs, and other installations. It has also completed the engineering surveys for supplying water to eight rural centers and to 10 other communities in the central zone, as well as for the capital's sewerage system expansion project and the storm drainage projects.

In order to develop our programs and with an eye to the future, we have placed emphasis on the basic and specialized training of technical personnel. Thus in the last five years we have trained, in regular courses, 162 nurses, midwives and social workers at the university level, and 207 nursing auxiliaries at the secondary level. Training abroad has been given to 141 technicians at various levels and for various periods, and 468 technicians have been trained at courses in Paraguay. We have also attached importance to the training courses for lay midwives and the training of personnel in vital statistics at the central, regional, and local levels; 24 persons have attended courses abroad and 226 courses in Paraguay.

The period of service in rural welfare centers of the Ministry of Public Health, which is compulsory for all physicians, nurses, and midwives graduating from the University, is of fundamental importance for acquainting them with the country's health problems and illustrates the coordination between the Ministry and the National University.

In the last two years we have experienced difficulties—temporary, we hope—such as occur in other countries, in increasing our public health budget and the budgets of other ministries. Although we have stepped up our production, we have encountered problems in foreign trade and with prices on the international market, and this has led to a drop in our earnings. Concurrently with the question of improving our system of taxation and internal administrative organization, the need to improve the economic position of our countries, in order to carry out our health, educational, social progress and other programs, is discussed at all international meetings. That is why the anxieties and complaints of the relatively less developed countries have been voiced in all international bodies and meetings in recent times. These countries have appealed to these bodies to intensify their efforts to find as quickly as possible formulas for improving, and especially stabilizing, prices and making them fair for our primary commodities and raw materials. It is common knowledge that 88 per cent of our countries' export earnings come from exports of raw materials—often of only one or two of them. Appeals are also made to exempt Latin American production and trade from the restrictions and protectionism imposed by the more industrialized countries, to introduce tariff cuts, and to eliminate discriminatory practices. Similarly, the more developed countries are urged to increase the flow of capital to the less developed countries.

One of the most important results of the recent joint meeting of the International Monetary Fund and the World Bank is a plan in which great hopes have been placed and which is to be completed by mid-1969. Its purpose is to protect, and stabilize at equitable levels, the relatively less developed countries' earnings from exports of raw materials. This will result in more earnings for those countries and enable them to use part of them to strengthen the budgets of the ministries concerned with social activities.
ADDRESS BY THE MINISTER OF HEALTH AND COMMUNITY DEVELOPMENT
OF BARBADOS, THE HON. CUTHBERT EDWY TALMA

Presented at the Third Plenary Session
15 October 1968

Allow me first, Mr. President, to congratulate this assembly, your colleagues and you, Sir, on the choice of officers for this Meeting. At the same time we should acknowledge the meritorious work of the Director of the Pan American Sanitary Bureau and his staff in making the preparations for the Meeting. I should also like to thank the Government of Argentina for its invitation to hold our gathering in this famous city.

My country is now working through the final year of our 1965-1968 Development Plan, which follows the previous three Plans of 1951-1956, 1956-1961, and 1962-1965. We are utilizing this year to complete our projects, take stock of the general situation, and examine the proposals for the future. As usual the Ministry of Health has fully participated in the over-all plan. I may make the point that we are full members of the Central Planning Committee, established in early 1962 as a sub-committee of our Cabinet with the Government Economic Planning Unit functioning as its secretariat. We are not dissatisfied with our performance in general, although, like everywhere else, there is always much more to be done and seldom adequate resources to cope with the demands. We are therefore very grateful for the considerable assistance which we have received from PAHO in hospital administration, reorganization of our School of Nursing, expert assistance and fellowships in several fields, and in the organization of regional seminars and training courses. We have also to acknowledge assistance in the provision of personnel in under-supplied categories from the Overseas Service Aid Scheme and Voluntary Service Overseas Scheme of Britain, from the Canadian University Services Overseas, and from the Kennedy Peace Corps. This year too we received a welcome gift of ambulances from West Germany in celebration of our attainment of independence.

It is not likely that many members of PAHO will know much about Barbados, as we were admitted to membership only a year ago. We therefore will circulate a booklet giving information about our health services in 1967. From this it will be seen that our population passed the mark of 250,000 last year in an island of 166 square miles. Because of our reliance on the tourist industry we have always had to be vigilant about our health conditions. The activities of our government-aided Family Planning Association, along with other supporting factors such as island-wide literacy, emigration, a good road system, improved health services and public utilities, have enabled us to reduce our birth rate from 33.5 in 1960 to 22.2 at the end of last year. The Family Planning Association has always been willing to place its experience at the disposal of those interested in population control.

There are other achievements which should be mentioned. Our central General Hospital of 600 beds is now, like hospitals in Trinidad and Tobago and Jamaica, one of the centers of clinical training of medical students of the University of the West Indies.

We have begun a community health project which aims at providing medical students with experience in the care of patients in the home and at demonstrating the role played by the District Services in medical care and in the general prevention of disease; at providing the basis for the development of a community medical department at the central hospital with a view to the after-care of patients; and at providing also training for nurses, public health inspectors, and social workers in the prevention and after-care of diseases—in other words, another step toward the integration of the health services.

The establishment of a National Nutrition Committee and the encouragement of local research in this field have considerable importance for us.

During the past two years the number of inpatients at our single Mental Hospital has decreased while the number of outpatients has
increased. This appears to be in keeping with modern trends in psychiatric care. During the past month we have also been making plans for the introduction of a psychiatric unit at the General Hospital.

The Leper Hospital, which was enlarged some 60 years ago to accommodate 175 patients, now holds only six patients of whom only two are active cases. It is planned to close this institution at an early date. It may be noted, too, that the incidence of tuberculosis in Barbados is decreasing steadily and is now quite low. The plans to reduce the number of small and inefficient institutions have been proceeding satisfactorily. At this date the 11 infirmaries which the erstwhile Local Government Councils used to keep have been reduced to seven. Within the next month we shall have attained the goal stated in the 1965-1968 Development Plan for reduction to five only. At the same time four new multipurpose outpatient clinics embracing curative work and preventive medicine should be in full operation by the end of the plan period.

I am pleased to report a good start with the new three-year program for the eradication of *Aedes aegypti*, a start which owes much to the advice and assistance provided by PAHO. We have also recently made a similarly successful beginning with a poliomyelitis immunization campaign for children under 7 years of age.

We still, however, have to face a number of problems. The collection and disposal of refuse is not satisfactory; sewage disposal likewise needs urgent attention in some areas; infant mortality rates are higher than they should be; and there is need for improvement in our health laws and our health statistics. Some difficulty has been experienced in the recruitment and retention of qualified staff, particularly in the middle grades of medical staff; and indeed the quality of our clerical and executive staff sometimes appears to be not quite as good as it was. It is of course to be expected that a small overcrowded island is likely to lose a large portion of its more active and intelligent people by emigration. It is therefore necessary for plans to take this into account. I feel, too, that it would be a wise policy on the part of those larger countries which benefit from our manpower to assist in the establishment or extension and improvement of institutions in our country which are responsible for the training of health personnel.

It is urgent, in my view, for the Caribbean area to get together on the question of the training of paramedical staff at the various levels—aides, technicians, supervisory technicians, administrators, and tutors—and to construct a plan for local and regional institutions working toward qualifications that can have regional acceptance. At the same time our central training units, assisted by the universities, will have to redouble their efforts for the improvement of clerical, executive, and administrative staff. A vigorous approach to the development of our human resources is the only sure foundation for any plans which we may write for the improvement of the health of our community, whether those plans be of the 10-year visionary variety or of the three- or four-year feasible type for which the Government of Barbados has shown a clear preference.
I shall outline very briefly the health conditions in the French Departments in America. The situation is now generally good. We have no major endemic diseases; tuberculosis is under control; there has been no more malaria either in Guadeloupe or in Martinique for a long time, nor is there any on the seaboard of French Guiana, although I would hesitate to say that there is none in the jungle where tribes still live who are not under our proper control and who move from one territory to the other. However, there are still some infectious diseases which worry us, mainly parasitic infections: hookworm disease and schistosomiasis. These infections are in many cases linked with living conditions and the lack of environmental sanitation. As is happening in many countries, we are witnessing very rapid urbanization in our Departments; the towns are developing—often in bad conditions—so that the road works, sewerage improvement, and water supply projects do not always keep pace with urban development. Hence, during our last development plan we concentrated on sanitation, the extension of sewerage, and water supply services. That should help to curb as far as possible the spread of parasitic diseases. In Martinique, Guadeloupe, and French Guiana hookworm disease is also a cause of very severe anemia which attacks a large number of the population and complicates most other diseases. We are therefore at present focusing our efforts on this parasitosis.

Vaccinations are the rule; we vaccinate regularly against diphtheria, tetanus, and smallpox. Several years ago we began to vaccinate against measles and poliomyelitis. Vaccination is now very widespread so that these diseases no longer cause us serious problems.

One source of concern still remains: the state of our hospital establishments. Our hospitals are old and need to be improved. We have therefore decided to build a modern hospital in each of the Departments: a hospital with 800 beds at Pointe-à-Pitre, in Guadeloupe, and a hospital with approximately 1,000 beds in Martinique. We could have renovated our old establishments but we realized that it would be much more expensive to have a relatively inefficient facility by renovating an old hospital rather than to construct a new one. This will be a rather long-term process. The work will start at Pointe-à-Pitre in 1969 and in Martinique probably at the same time. We thus hope, in the course of the next 10 years, to provide each Department with a new modern hospital in which all the necessary types of treatment can be administered in favorable conditions.

We have eliminated malaria, but there is still the problem of eradicating *Aedes aegypti*. We eradicated this vector in French Guiana 15 years ago but it came back again in 1958. We had hoped to eliminate it from Martinique more quickly than events have shown to be possible, and we will relaunch the campaigns. We expect to achieve eradication, but the resistance to insecticides which we have encountered has obviously slowed down our efforts. Moreover, the hurricanes which periodically ravage these islands have hindered our efforts by bringing the campaigns to a halt and encouraging reinfestations.
Whenever an international body in this Hemisphere plans a gathering anywhere in the Americas, as at present in this large and magnificent capital of Buenos Aires, Haiti is always delighted to join the circle of the great Pan American family.

Today, when in other branches of human endeavor international understanding seems as if it were dispensed by means of a dropper to feed the relations between peoples and between continents, it is already a cornucopia in the public health sphere.

If international understanding has been the compass by which PAHO/WHO has steered its course in its effort to meet national needs, the growing importance of planning has been the searchlight cast on activities coming within the orbit of technical cooperation with the public health departments of the countries Members of this Organization.

In conformity with the statement in the Declaration of the Presidents of the Americas at Punta del Este that the "improvement of health conditions is fundamental to the economic and social development of Latin America," the Pan American Sanitary Bureau has mobilized to this end the two essential factors of "available scientific knowledge" and the task of extending "within the framework of general planning, the preparation and implementation of international plans that will strengthen infrastructure in the field of health."

It is in this propitious and highly stimulating context, and in the light of the directives arising therefrom, that the action programs of the Ministry of Public Health and Population of Haiti have been conceived and are being implemented.

The Planning Committee of the Ministry which I have the honor to direct has borne carefully in mind, in drawing up the National Public Health Plan, the directives on health issued in the Declaration of the Presidents. It has in fact mobilized the available scientific knowledge calculated to produce concrete results commensurate with the needs of our country. Similarly, the objectives assigned and the priorities established in the Charter of Punta del Este have been borne in mind.

**Training of a Professional Elite**

To this end, WHO and PAHO have furnished substantial assistance to help Haiti to meet some of its essential needs. At present, some 12 fellowship-holders are pursuing or have already completed specialist studies related to the following: public health administration; sanitary engineering; health statistics; water analysis laboratory; health education and community development; and manufacture of orthopedic appliances.

**Eradication of Diseases for which Methods of Total Elimination Exist**

Yaws was completely eradicated in the course of the mass campaign which was begun on 16 March 1943, and is already a thing of the past, though due vigilance on this score prompted the subsequent establishment of a maintenance organ known as SANDOR (*Service de Santé Domiciliaire Rurale*), whose task is to detect isolated cases and keep records.

The present malaria eradication campaign is already at a fairly advanced stage. The incidence of malaria has fallen to 0.2 per cent, and the program is on the point of reaching the consolidation phase. The Ministry is already planning arrangements for the operation of the health infrastructure in the maintenance phase.

**Control of Communicable Diseases**

The main communicable diseases in Haiti are under control. Responsibility for this, from the
point of view of both prevention and cure, rests with a network of institutions forming part of the infrastructure of the Ministry of Public Health such as maternity hospitals, hospital-dispensaries, dispensaries proper, rural clinics, sanatoria, tuberculosis clinics, and others.

Among these diseases, very special attention is paid to tuberculosis, which in Haiti, as indeed in all countries suffering from underdevelopment, exists in chronic form. Thus, BCG vaccination is practiced in all the maternity hospitals under the Ministry, in the Maternal and Child Health Center, and in all pediatric clinics and other private institutions.

In accordance with the new guidelines disseminated widely by WHO, the Ministry has organized a tuberculosis campaign which gives priority to treatment in the home.

Sanitation

The Public Hygiene Division of the Department of Public Health takes charge of the bulk of the environmental health functions in the main urban areas. Thanks to the vigilance it exercises, the epidemiological level of most diseases is no higher than it is elsewhere.

However, there is a growing sense of the need for structural reform in the sanitary police corps. This project, which is now under study and is due to enter into force on 1 January 1969, will substitute for this corps an agency strengthened by a staff of "sanitarians" who have had a more intensive training either at the Sanitary Police School or in advanced centers overseas as fellows of Haiti or of international organizations.

The project for speeding up the provision of water supply services—the second in importance of the recommendations in the Charter of Punta del Este—entered the operational phase in Haiti a few months ago. The execution of the program implies a corollary, which is in fact provided in the Declaration of Punta del Este, namely the "acceleration" of programs for providing "sewerage and other services essential to environmental sanitation," as such as drains and adequate systems of sewage disposal. In that connection, the Delegation of Haiti would like to draw your earnest attention to the following:

From the two great social upheavals of 1946 and 1957 to today, in other words within a space of 22 years, Port-au-Prince and Pétionville have witnessed a development which has increased their habitable area tenfold. Forty percent of the increase in size of these two main cities has been achieved by encroachment on the two surrounding heights, which has involved large-scale deforestation of the hills with its inevitable consequences of erosion and torrential downpours during the rainy season. As a result, the sewers and open drains, constructed more than 20 years ago and of a capacity never intended for such a large volume of water, regularly burst open or simply overflow.

Following the constant heavy rainstorms from May to September it is a tremendous operation, a really herculean task, which sometimes keeps the Sanitation Division busy every two or three days, to restore sanitary conditions in the lower end of the town and the suburbs. The disposal of household garbage and other waste matter from these two urban built-up areas is an equally serious problem. These are two major sources of insanitary conditions. They are a matter of grave concern to the Government of my country. During his recent visit to Port-au-Prince, Dr. Horwitz had the importance of this question explained to him.

In view of all this, the Government of the Republic of Haiti, through the Ministry which I direct, appeals for maximum support from this Special Meeting of Ministers of Health in urging the Directing Council of PAHO to include in its proposed program and budget estimates for 1969, in accordance with the recommendations of the Charter of Punta del Este concerning health, such funds as may be needed to carry out preinvestment operations with a view to undertaking, as speedily as possible, a program of sewerage and systems of waste disposal in Port-au-Prince and Pétionville.

Still in connection with the Charter of Punta del Este, I should like to inform this assembly that the Government of Haiti has set up by decree of 22 February 1968 an agency to be called the Cooperative for Potable Water Sup-

plies (COALEP) for the more remote communi-
ties of the interior, its function being to supply
the rural communes and districts with small-
scale water supply systems.

Rural Health

In the matter of rural health the Govern-
ment is most anxious to be able to furnish
adequate medical coverage to the rural inhabi-
tants in Haiti, representing more than 80 per
cent of the population and occupying more
than two-thirds of the area of the country. To
achieve this, a pilot project has been under way
for nearly four years, in conjunction with WHO
and UNICEF, for the purpose of discovering
the most appropriate ways and means of
meeting the needs of the rural population in
respect of both preventive and curative medi-
cine.

These are the main points of the statement
which the Delegation of Haiti wished to make
to this Special Meeting. My comments will have
made it quite clear just how far public health
problems represent a major concern for the
Government of my country. His Excellency Dr.
François Duvalier, Life President of the Repub-
lic and ruler of the nation's destinies, although
at the present time preoccupied with the
extensive infrastructure projects he is having
carried out in the interests of his people, e.g.,
the hydroelectric plant dam at Péligre and the
concreting of a vast road network, is still at
heart a medical man and a public health
specialist who has a special interest in the
sanitary conditions of the most remote villages
in the nine geographic departments into which
the Republic is divided. Like the great
Jefferson, he likes to repeat a phrase which
constitutes the whole raison d'être of the Pan
American Health Organization: "The clean-
liness of my neighbor's house is my concern."

ADDRESS BY THE MINISTER OF HEALTH OF BRAZIL,
DR. LEONEL TAVARES MIRANDA DE ALBUQUERQUE

Presented at the Fourth Plenary Session
16 October 1968

I cannot help but say how pleased I am to
be taking part in this Meeting of Ministers,
convened on the initiative of the Directing
Council at its Meeting in Trinidad in 1967 to
consider and approve a concrete program of
action designed to implement the Declaration
of the Presidents of America.

I should like to single out one or two of the
objectives relating to the health sector and to
explain what we are doing about them in Brazil.
Our endeavors are based mainly on the premise
that the fundamental objective of any health
program is the coordination of action in the
field of disease prevention and health promo-
tion and restoration.

We are devoting particular attention to the
planning of these activities, with a view to
gearing our main efforts to the needs of a
community which has its own peculiarities and
hence calls for solutions appropriate to it. We
do not believe in the efficacy of cut-and-dried
reforms which can be introduced overnight to
produce miraculously efficient health services.

There are many factors to be considered
which taken as a whole can provide an ideal
assessment of the services required. It is not
overstating matters to insist on the importance
of planning, since it is the only means of
avoiding improvised procedures.

The Federal Government has responsibility
for determining the goals of the Ministry of
Health's policy and determining how they
should be achieved, using all the technical and
financial means available for the purpose. Here
is where the establishment of a system of priorities for the various programs is important.

Activities of the Health Subsectors

The Ministry of Health is engaged in intensive activities in the sphere of collective health, especially action to combat communicable diseases, basic sanitation measures, and the training of health personnel. Other tasks entrusted to the Ministry, as part of its regular work, include medical and health care, health education, treatment of deficiency diseases, maternal and child health, cancer and tuberculosis campaigns, research, staff refresher courses, treatment of mental illness, and production of biological, therapeutic and other products.

At this time I should like to emphasize the high priority accorded to those activities, which involve long-range action for the protection of a considerable section of the Brazilian population.

Communicable Diseases

I shall single out the action taken and the results being obtained in the campaigns against malaria, smallpox, schistosomiasis, and Chagas' disease, which together affect millions of Brazilians.

Malaria. In 1956 a new strategy was adopted in international circles for combating malaria, which was to be pursued until the disease was stamped out. The strategy, as recommended by the Eighth World Health Assembly, consists of four phases:

Preparatory phase: planning (from the time of delimiting the area), administration, and logistics.

Attack phase: spraying of all dwellings with insecticide and treatment of patients.

Consolidation phase: halting of transmission and epidemiological surveillance.

Maintenance phase: prevention of the reintroduction of the disease once it has been eradicated.

Simultaneous treatment of the whole of the malarious zone in Brazil, the largest in the world, was not feasible because of its enormous size. It would require material resources and manpower beyond our capacity. A process of gradual and progressive attack on the malaria zone was therefore adopted. In this way, by 1966 we had completed spraying operations (maintenance phase) covering a million dwellings and providing protection for nearly 5 million persons. In that year itself, spraying operations covered 2 million houses over an area of 2,560,000 km$^2$ with 18 million inhabitants. The budget for the purpose was 26 million new cruzeiros, and 9,500 persons were employed in the campaign.

In accordance with the timetable drawn up at that juncture, it was anticipated that by 1970 the entire malarious zone in the country would be in the attack phase, assuming that all the circumstances were favorable; that the earmarked funds were used at the proper time; that there was no reintroduction of the disease in large areas already treated; and that no new epidemic outbreak of major proportions took place to deflect resources in men and materials from the activities programmed. Another consideration was that there were international commitments vis-à-vis the neighboring countries, which with a single exception are at a more advanced stage than Brazil in their malaria eradication campaigns.

The feasibility was considered of shortening the duration of the phases established for the malaria campaign, or as they say, introducing a crash program. All the arguments were placed before the President of the Republic, who accepted the suggestions made and decided on a new operational timetable. Accordingly, the operations programmed for 1970 will now be carried out by the end of 1968. The end of the attack phase was pushed forward by two years.

In 1967 the allocation for the malaria eradication campaign was 33 million cruzeiros, all of which was duly forthcoming, and according to plan. An area of 3,430,000 km$^2$ was covered, providing protection for 25 million inhabitants, with the spraying of 2.7 million houses; and the services of 11,000 campaign workers were enlisted.

The training of manpower for the program was stepped up. In all, 86 courses were held, the number of enrollments being 1,741. Intermediate-level personnel working in the campaign undergo a training course. Those at the higher level attend postgraduate courses and do field training before they are taken on definitely. At the moment there are 100 malariologists (higher level) active in the campaign.
For 1968, allocations are in the neighborhood of 44 million cruzeiros. The number of people given protection will be 37 million, in an area of 7.5 million \( \text{km}^2 \); the number of houses sprayed will be 4.3 million; and the staff employed will number 13,000. For the first time, the entire malarious zone in the country will be in the attack phase.

To summarize the situation, the figures covering the three-year period are as follows: (1) area covered \( \text{km}^2 \) (DDT)–1966, 2,560,000; 1967, 3,430,000; 1968, 7,500,000; (2) houses sprayed–1966, 2,000,000; 1967, 2,700,000; 1968, 4,300,000; (3) population given protection–1966, 18,000,000; 1967, 24,900,000; 1968, 37,000,000; (4) staff employed–1966, 9,500; 1967, 11,000; 1968, 13,000; (5) funds (new cruzeiros)–1966, 26,000,000; 1967, 33,000,000; 1968, 44,000,000.

International organizations are collaborating in the Brazilian program: the U. S. Agency for International Development has granted a new loan for the campaign, amounting in all to US$10 million, to be furnished in installments until 1971; and PAHO and WHO are providing advisory and technical auditing services, laboratory materials, etc. The governments of the States of Amazonas, Pará, Maranhão and Piauí are contributing 100,000, 120,000, 200,000 and 25,000 cruzeiros, respectively, and the Superintendency of Development of the Northeast (SUDENE) 500,000 cruzeiros.

Mention must also be made of the contribution made by voluntary workers, who man the 16,000 malaria notification posts. They take blood samples, forward the slides to one of the 86 field laboratories, and administer medicines to suspect cases. In 1967 voluntary workers collected 600,000 blood samples.

To cover the territorial area of the campaign by the end of 1968, including the whole of the Amazon region, we shall have six airplanes, used for surveillance, technical assistance work and emergency operations; 1,350 motorized vehicles; 400 motor boats, two of them built in 1968; 750 bicycles; and 3,000 beasts of burden.

The administration of the campaign is decentralized. The functions of the central Superintendency are normative, supervisory, and financial. The regional Coordination Centers, five in number, are also normative agencies and they have responsibility for the Sectors, whose functions are executive. The Sectors correspond, in nearly all instances, to Federal administrative units.

The rate of mortality from malaria is, generally speaking, not very high, but morbidity is extremely high. Malaria incapacitates the individual, preventing him from working efficiently for a long period, during which he does little else but subsist.

It is interesting to note that infrastructure projects for development, such as hydroelectric plants and dams, which involve the construction of artificial lakes, may favor the proliferation of the vector; and roads, which increase the migratory flow, can help to spread the disease, as has been the case with the Belém-Brasilia Highway.

We have only to look at the devastation caused by malaria epidemic outbreaks in areas which formerly were economically prosperous to realize the importance of eradicating the disease. Conversely, the way in which economic recovery follows the disappearance of malaria is a well-established fact, not only in Brazil but in other countries as well.

Smallpox. The smallpox eradication program, carried out with the cooperation of the PAHO and WHO, provides for vaccination of the Brazilian population over a period of three years. Brazil has the highest incidence of smallpox of any South American country, with more than 3,000 registered cases a year.

In 1967 more than 6 million persons were vaccinated. Some states have already completed the vaccination campaign, with assistance from the Ministry of Health in the form of technical personnel and supplies.

With the cooperation of the local authorities of the various states, the smallpox eradication campaign during 1968 is undertaking the vaccination of part of the population of the north and northeast territories and the entire State of São Paulo. In the course of 1969, 39 million persons will be vaccinated in the south, central, and part of the northeast divisions of the country, and for 1970 vaccination of another 18 million persons is planned.

With the training of supervisory staff, vaccinators, and other auxiliary personnel in the target region itself, the campaign is carrying out an operation on a national scale, instructing
staff not merely in the various vaccination techniques but also in health education.

As soon as the vaccination operation is completed, the Ministry of Health proposes to place the whole country under surveillance, giving specific functions to the state and municipal health sectors, including the supervision of immigrants.

To cope with the needs of the program, the Ministry began in 1967 to step up production of smallpox vaccines, and the Oswaldo Cruz Institute is now the third largest producer in the world.

Schistosomiasis. This is a world health problem, affecting nearly 200 million persons. The number of Brazilians infected is estimated as high as 8 million. Thus in point of size it is coming to be our most serious health problem.

The disease was brought to Brazil with the African slaves, and there it found the snail intermediate host. Schistosomiasis spread from the northeast in the direction of the other states with succeeding waves of migrants.

The disease is endemic along a wide coastal strip, stretching from Rio Grande do Norte to Bahia, and it even reaches certain parts of Minas Gerais and Espírito Santo; there are also isolated foci in Pará, Maranhão, Ceará, Guanabara, State of Rio de Janeiro, São Paulo, Paraná, and Goiás, and it seems likely that it exists in other areas as well. The index of prevalence reaches 100 per cent in places such as Medina and Pedra Azul (Minas Gerais), Limoeiro (Pernambuco), and Pureza (Rio Grande do Norte).

Schistosomiasis has a high morbidity rate, but there is still no effective method of breaking the chain of transmission, either by dealing with the vector, the snail, or by using medication to treat the infected person. The best method available at present is environmental sanitation, in the form of installation of water supply systems and efficient sewage disposal, and the construction of public baths and wash-houses to prevent contamination.

Experiments are now being carried out to develop uniform procedures applicable to the great variety of ecological conditions found in the wide strip where the disease is endemic. Areas were selected which represented the different geographic and socioeconomic characteristics of the disease-infected part of the country. They include the municipality of São Lourenço da Mata (Pernambuco), typical of the sugar cane region of the northeast; Caatinga do Moura, in the sertão of Bahia, where the high indices of prevalence and the virulent forms of schistosomiasis indicate what happens when irrigation is introduced into arid-zone agriculture without the necessary prophylactic measures; Belo Horizonte, which represents a typical situation where the disease has penetrated at the periphery and the center of large growing towns; Sumidouro, in the Pagueque River valley (State of Rio de Janeiro), representing an isolated focus; Jacarezinho and Londrina, representing recent foci; and Guanabara State, where the disease is transmitted almost exclusively through foci in watercress beds.

In these areas experiments are going ahead and an appraisal is being made of the efficiency of the various prophylactic weapons available: the rational use of molluscicides and their effectiveness, chemotherapy as a supplement to the methods for controlling transmission and an important factor in combating the disease; and environmental sanitation measures designed to assess the degree of specific efficiency. The results so far encourage us to continue with the research.

As regards prevention of the spread of the disease, attention must be paid to projects for water power exploitation (reservoirs and dams) and irrigation. Irrigation produces suitable conditions for the snails in areas where they appeared to be virtually non-existent. Hence agriculture irrigation projects must be given technical advice by specialized health organs.

Chagas' disease. This is another serious public health problem which now calls for special attention, because of the large number of persons affected in Brazil—nearly 3 million.

From being a simple epizootic infection, Chagas' disease has become an endemic disease difficult to control and already covering a large area as a result of the adaptation of the vector to ill-kept houses. It is found predominantly in the northeast and south-central areas, mainly in the major producing states of the country: São Paulo, Minas Gerais, Paraná, Rio Grande do Sul, Pernambuco, and Bahia.

The disease is caused by Trypanosoma cruzi and transmitted by a bloodsucking bug of the triatoma family commonly known as the barbeiro or "kissing bug." The disease greatly
reduces the work capacity of the person infected and the condition becomes chronic at the end of one to three months. At the acute stage, the trypanosome is found in the bloodstream, but in the chronic phase it establishes itself in the tissue in leishmania form; 30 per cent of infected cases have serious forms of the disease, including chagasic myocarditis, which can cause sudden and premature death.

Interruption of transmission of the disease is achieved through the elimination of the vector by spraying with a residual-action insecticide (BHC) and improving the condition of dwellings.

A pilot project for improving dwellings is being carried out in Planaltina (Goiás), where the mutual aid system is used. The results will be transmitted to the areas of high incidence with a view to protecting dwellings against invasion by the vector.

In 1967, 1,282,000 houses were sprayed with BHC in 513 municipalities in 15 states. In 1968, by July, 570,000 dwellings had been so treated.

Basic Sanitation

From the sanitary point of view, one of the measures which by itself is of considerable benefit to the health of the population, whatever its level of economic development, is the installation of water supply systems and adequate sewage disposal.

The Ministry of Health is carrying out a number of programs in this field, mainly in connection with the small communities worst affected by health problems. Sanitary engineering activities were given a decided boost in 1967 with the “Program for the supply of water to small communities,” undertaken with the collaboration of the Inter-American Development Bank; it will benefit 188 towns with between 5,000 and 40,000 inhabitants.

If we lump together the activities of the two agencies of the Ministry of Health responsible for sanitary engineering projects—the Special Public Health Service Foundation (FSESP) and the National Department of Rural Disease Control (DNERU)—we find that 424 water supply services are due to be completed by 1970, and between 1967 and the end of 1968, 140 systems will have been installed. The governments of the various states, and the municipal prefectures, are taking part in these programs.

Adequate sewage disposal, a matter of great importance, especially in combating worm diseases, has been taken care of in 18 Federal units by the installation of cesspits.

Training of Health Personnel

In the health field specifically, the problem of staff training is aggravated as a result of the multiplicity of activities under way. The age-old method has been an arbitrary division of responsibilities. At the undergraduate stage, university institutions train the various types of professionals for work on a particular aspect of the process of attainment, maintenance, or improvement of health. At the postgraduate stage, they undergo further training designed to give them what is commonly spoken of as “an integrated picture of the problem of health and a uniform approach to the tasks involved.”

This departmental outlook is not only artificial and arbitrary, but it tends to distort the view of what the health phenomenon entails. If the tradition is to change, a number of theoretical questions must be elucidated, such as the question of the optimum health level at a given stage of development, mechanisms calculated to promote health, and the qualitative and quantitative staff needs. These prerequisites will only be forthcoming once there is an awareness of the need to establish formal machinery for the study and solution of the existing problems, without any division into watertight and artificial compartments.

A school of health must be more than a mere factory for the mass production of professionals; it must be an institution for analysis, critical appraisal, and creative synthesis. Its function is not merely that of supplying an existing or future market. It should be par excellence a body establishing rational bases for coordination between the community which utilizes health services, the institutions which provide the services, and the sectors which produce the manpower and the material resources required.

This is the approach now being studied in the institution attached to the Ministry of Health responsible for the education and advanced training of health personnel in Brazil.
I should like to take this opportunity to congratulate the Argentine Government on the admirable organization of this Meeting, and to thank the people of Argentina as a whole for the welcome given us on our arrival in this beautiful country.

The Ministry of Public Health and Social Welfare of El Salvador, bearing in mind the decisions of Punta del Este and of the Meeting of the Task Force on Health at the Ministerial Level held in 1963, decided to plan and develop a system of integrated health services in the country, covering both prevention and cure, by means of a National Health Plan. I shall try to give some data on the results achieved.

Population

The health situation in El Salvador has not deteriorated, judging by the figures which serve as health indicators. A comparative study shows that general mortality, which was 11.5 per 1,000 population in 1962, is at present 9.2.

The principal causes of death in El Salvador are the same as in previous years. First come accidents, poisonings, violence of all kinds; next come gastroenteritis, tumors, tetanus, measles, and acute respiratory infections.

The child mortality rate prior to the 10-year plan of 1962 was 71.4; by 1967, five years later, it had dropped to 63.4.

Although the birth-rate figures show a slight downward trend—48.4 in 1962 as compared with 44.3 today—the fall in the death rate means that the population figures are rising, with the consequent repercussions on nutrition, schooling, labor, and medical care. With the decline in the death rate, life expectancy for men in El Salvador is 54.4 years and for women 58.2 years.

Medical care in connection with childbirth is rendered to one out of every four expectant mothers.

Communicable Diseases

With regard to communicable diseases, I am glad to be able to say that there are none of the so-called pestilential diseases; that smallpox was eradicated in El Salvador 40 years ago; that we have not had any yellow fever in the country over the last 50 years, and no outbreak of the plague or cholera for the last 70 years.

Malaria eradication campaign. The problem of combating malaria is similar to that in the other countries, if not worse. Research, financing, administration, and means of attack are a complicated maze, and on such a vast and important scale that the WHO has been considering the need to carry out a complete review of the strategy adopted to combat the disease. Since, after all, it is man who allows the vector mosquito to emerge and thrive, and since it is man who suffers or dies of malaria, the problems must be tackled as a national issue and not just sectorally.

El Salvador initiated in 1967 a three-year plan to combat malaria. The success of the plan is already beginning to become apparent, the number of malaria cases in 1968 having declined by 50 per cent as compared with previous years.

Tuberculosis campaign. Efforts to combat tuberculosis have been stepped up in the direction of technical work in the field and protection of the public; increase in the number of X-ray screenings; more frequent treatment in the home and fewer patient/days in specialized and general hospitals; and maintenance of the rate of BCG vaccination.

It is of interest to mention that the pilot plan for the Department of Usulután was completed in August 1967 and subsequently evaluated. This was a special program carried out in conjunction with UNICEF and PAHO, its objective being to cover the urban and rural communities which had no such services in
their particular zones. The experience gained will be applied to the rest of the country.

In 1967 the program of preventive treatment using BCG vaccine covered 216,746 persons, and 13,771 cases are under control; 4,000 tuberculosis patients were discharged from hospitals.

Epidemiological data. The weekly reporting of cases of communicable diseases by all the public health services and autonomous and private institutions enables the Epidemiology Division to maintain an epidemiological surveillance service for the prompt detection of any epidemic outbreak.

There is a permanent program of vaccination against the communicable diseases. It may be pointed out that in 1962 the number of persons vaccinated was 151,679, and five years later, in 1967, we were vaccinating an average of 700,000 persons. Thus there has been some improvement in this direction.

Environmental Sanitation

When the National Health Plan was drawn up, the situation was diagnosed as follows: "The environment is hostile to the health of the inhabitants of El Salvador, since the main causes of death and disease—gastroenteritis, diseases of the new-born, and tetanus—are bound to arise in an environment where the majority of the urban and rural population have deficient sanitation services."

The Ministry of Public Health and Social Welfare is engaged in promotion, coordination, and operational activities with the help of 169 health inspectors distributed in the proportion of 1 per 20,000 inhabitants in 158 of the 261 municipalities in the country today.

A study was made in 320 communities of 2,000 inhabitants, and 90 of these communities were singled out in which water supply systems constructed between 1942 and 1960 were found to have deteriorated or to have become unusable. The program is being carried out in collaboration with the National Water Supply and Sewerage Administration and UNICEF, the former taking care of the technical and operational aspects and the latter furnishing materials and equipment.

Iodization of Salt

Special mention should be made of the first steps taken to set up a program for the control of goiter, a major disorder in El Salvador, affecting between 14 and 29 per cent of the population in both urban and rural areas. A law has now been passed requiring the iodization of salt, and it is estimated that at least 70 per cent of the urban population is now covered and benefiting.

Coordination with Other Institutions

There is coordination with the Committee for the Protection of the Milk and Dairy Products Industry; with the Ministry of Agriculture and Livestock in regard to the preliminary draft of a bill relating to sanitary inspection of meat and in regard to the study of the utilization of insecticides; and with the Ministry of Public Works in regard to the draft building regulations and the regulations governing land development and urbanization. The Ministry has representatives in the Institute for the Regulation of Procurement, the Institute for Urban Housing, the Institute for Land Settlement, the National Water Supply and Sewerage Administration, the Salvadorian Institute for Rehabilitation of the Disabled, and the National Benevolent Fund Lottery.

Medical Care

The Ministry under my charge has been particularly anxious that prompt medical attention should be available for emergency cases, as well as for preventive consultation, curative treatment, and hospitalization. It is also concerned to extend such services to sectors of the population which lack them.

In 1962 El Salvador had only 82 health services, including hospitals, health centers and health units; by 1967 it had 178. In other words, there was an increase of more than 100 per cent. The number of personnel employed in these services was 5,000 in 1962 and rose to 7,500 in 1967. But the most important point is the proportion of the population covered. Prior to the initiation of the Ten-Year Health Plan in 1962, only 57 per cent of the inhabitants of the country had access to consultation services. By
1967 the proportion had increased to 85 per cent and it is hoped that the figure will be further improved as time goes on. But in any case, to go from 57 per cent to 85 per cent in five years can surely be regarded as a decided success in this direction.

It can also be pointed out that in 1962, 42 patients per 1,000 were hospitalized; the figure today is 50 per 1,000. The same trend is observable in medical consultation: the rate rose from 375 per 1,000 to more than 500.

**Social Welfare**

Assistance to creches, child protection services, and day nurseries for small boys and girls are the responsibility of the Social Welfare Department. The welfare program provides grants and subsidies for 11 children’s homes, six homes for the aged, and 27 day nurseries.

I am gratified to be able to report that during the past year 50 health centers (32 posts and 18 units) were completed and inaugurated; they will cover 50 communities.

I have tried to give you the general picture of the health situation as it is today in El Salvador. There are aspects about which we still know little, as has been pointed out in previous statements, as for example the extent of unsatisfied demand for services. But I should like to point out that the increasingly rapid growth in our population calls urgently for more and more resources, since an ailing population, like an ailing person, cannot produce the output which the economic and social development of the country requires.

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**ADDRESS BY THE MINISTER OF PUBLIC HEALTH AND SOCIAL WELFARE OF GUATEMALA, DR. EMILIO POITEVIN**

*Presented at the Fourth Plenary Session*

16 October 1968

I propose to take a somewhat novel angle in my statement. I shall not present a report, which would not contain anything original or spectacular; instead I shall spend the time at my disposal outlining the way in which the Ministry of Public Health of my country approaches the major health problems.

With regard to the major programs, in Guatemala we are doing roughly what the other countries are doing. This means that we are following the problems closely and doing all we can, especially in relation to what for us are the main health issues: malaria, tuberculosis, malnutrition, water supply, etc. From this point of view, we are keeping a close watch on technological and social progress and, as far as our means permit, we are endeavoring to carry out all our programs.

I have had occasion during this Meeting to listen to impressive reports, extremely well documented, concerning what is being done in various countries. However, it seems to me that the main problem, which is becoming somewhat of an obsession with us, is that of funds. In this matter, the Ministry of Public Health of Guatemala is engaged in what seems to us to imply a veritable revolution in thinking.

The Ministry has in the past been regarded as a State body whose function was more or less to beg for funds to carry out health programs. We felt that this situation was untenable. We cannot go on operating as an institution simply begging for resources from the various other State organs. In this I feel we are engaged in a revolution, not an original one, perhaps, but a determined one, and I think we are on the right path. We need resources, and to implement our programs we are trying to break down the tradition of a Ministry perpetually trying to convince the other State bodies that
the problem of health is not a local government affair but a national issue. This must be appreciated by all social strata, and all must understand it and give their support.

Our administrative structure places us, economically speaking, completely under the thumb of the Ministry of Finance. We have no intention of fighting with that Ministry; what we want to do is convince it that this situation, this idea, is quite simply wrong. We are looking for understanding and assistance from all quarters, and in this we are making progress; but we have still a long and difficult road to travel.

We have succeeded in creating an awareness of the need to earmark specific funds for public health, through our conviction that we cannot remain a body depending exclusively on the charity of others to provide us with the funds to carry out our work. Public health is, after all, a matter of vital importance, and the decisions taken at Punta del Este were surely not made lightly by our Presidents but are, genuinely, principles of health of great value and international in scope.

We have been busy persuading our higher authorities that the statements made at Punta del Este were not mere empty words, and that we must set up machinery to ensure that health is not simply an effort to be made at local government level, a task to be left to the individual states with limited resources in the face of a population which calls every day for more. This is not fanciful; it is practical and realistic. The demand for assistance we have been seeing in all the countries is tremendous.

When I had the pleasure of listening to the report of the Republic of Argentina and when I heard the representatives of the other large South American countries say that they had the same problems, it struck me that if they have them, how can we help but have them too, we smaller Latin American countries fighting to obtain funds for our health programs? And in the light of these factors and of what was declared at Punta del Este, we have succeeded in convincing the authorities at home, making them understand that public health is not merely a matter of public interest, but one for which resources are needed. We have to be very realistic, and in this way we have managed to make some headway.

The long-range programs are under way, and so are the small ones. Thus the problems are to some extent finding a solution. But like all the Latin American countries, Guatemala has experienced the population explosion, bound up as it is with problems of birth control, and of course our medical care programs are on a very large scale, which militates against health programs proper. What has happened in our country is that for several decades we devoted what scanty resources we have possessed to medical care programs instead of to the health infrastructure. And this is precisely why we are now in the midst of a revolution in thinking, or perhaps in political outlook, and the conclusion is being reached that the health of the people must be built up.

Improvisation will not do; nothing is possible without adequate funds. Health has to be built up like any other edifice, and the base of the pyramid must be the infrastructure of the major programs we are now trying to put into operation, using our resources flexibly, stretching them to construct this infrastructure and increasing the meager resources we have at our disposal as little as possible for medical care as such.

Nearly all of us are too much concerned with medical care and too little with promotion and prevention, so that from this angle we feel we are working on something which, if not original, is vital, at any rate for us. Our whole problem is that of obtaining funds to carry out our programs. We know that the planning has been well thought out. The larger countries, with their hospitals and experts who have given their lives to research, have placed the answers in our hands; but how are we to cope with them unless we have the means to do so?

This is why the Ministry of Public Health of Guatemala is concentrating all its energies on this revolution designed to bring home to the authorities whose responsibility it is to provide the resources we need that the major national problems have to be solved. We cannot regard health as just one more government scheme. For us as health specialists, with responsibility for the ministries of health in our countries, health is just as important as education, nor are we prepared to accept any status inferior to that given to education. In fact we consider that the effort which has to be made in regard to public health is of fundamental and supreme
importance, since quite clearly you cannot educate a sick people. This is how we intend to approach our problems.

I hope you will excuse me for speaking in terms of general ideas rather than producing statistics. The fact is that in that direction we are really not doing anything spectacular. We have heard a good deal of what is being done in countries better organized than ours and better off than we are. But our thinking is very much the same on the major problems and this is how Guatemala is trying to improve the health of the people, taking its inspiration from the principle salus populi suprema est lex, and regarding it not as a mere slogan, but as something very real.

Before concluding, I should like publicly to express my thanks, first of all to the international organizations which are constantly furnishing us with help and advice, and then to this wonderful country, Argentina, which has received us with so warm a welcome and made us feel completely at home and members of the family.

ADDRESS BY THE MINISTER OF PUBLIC HEALTH AND SOCIAL WELFARE OF THE DOMINICAN REPUBLIC, DR. MARIO ANTONIO FERNANDEZ MENA

Presented at the Fourth Plenary Session
16 October 1968

I should like to congratulate Dr. Holmberg on his election as President of the Meeting, and to express our thanks for the many cordial tokens of hospitality we have received, both from the President and his colleagues and from all the people of the Argentine.

I should like to outline the Three-Year Plan for the Development of Health Services in the Dominican Republic, and to present an account of the efforts being made and the projects being planned by the Government, under the Presidency of Dr. Joaquín Balaguer, with a view to fashioning a health policy applicable to the country as a whole.

While no precise assessment can be made of the various dangers to the health of the Dominican people, nor of the return which can be expected on the resources now available for health, it can be stated that the prevalent health problems are those peculiar to and deriving from unsatisfactory conditions and basic sanitation, in both the urban and the rural environment, and from the lack of resources to deal thoroughly with the various aspects of health promotion and protection.

Out of 113 urban areas, 80 have water supply services, but only 49 per cent of this urban population has water connections in the home. In the rural areas, the situation is more serious still: only 13.2 per cent out of a population estimated at 2.6 million have water supply services.

Sewerage services are provided partially in three of the cities in the country; that is to say, they cover 10 per cent of the urban population. But there are no such services for rural communities.

These two facts explain why problems like those of gastrointestinal diseases and intestinal parasitosis are so common throughout the country.

If we analyze the mortality situation by age groups, we find that 53.2 per cent of deaths occur in children under 5 years of age, and one third of these are infants under 1 year of age.

Among the causes of death, diseases of early infancy take first place, accounting for 21.8 per cent of all deaths. Next come diseases of the digestive system, with 15.5 per cent, and then infectious and parasitic diseases, with 6.4 per cent. Deaths from ill-defined causes or from old age constitute 27.3 per cent.
The resources for the health sector generally consist of those of the budgets of the Ministry of Public Health and Social Welfare, the Dominican Social Security Institute, the Armed Forces Medical Services, and private establishments. The extent to which these various institutions are involved in health problems is reflected in the amount of funds at the disposal of each institution for this purpose. Of a total of 270 establishments for inpatient treatment, 53 come under the Ministry of Public Health, with a total of 6,178 beds; 14 under the Dominican Social Security Institute, with 1,382 beds; 15 under the Armed Forces Services, with 578 beds; and 188 are private establishments or clinics, with 2,637 beds.

There are 1,935 physicians in the Dominican Republic, or five for every 10,000 inhabitants. Of these 67 per cent are concentrated in the National District, which includes the capital, and here the ratio rises to 17 physicians per 10,000, whereas in some provinces it fluctuates between 0.6 and 4.6 per 10,000.

There are 183 nurses in active service; 146 work for the Ministry of Public Health, which also has 408 nursing auxiliaries and 1,191 nursing aides.

During the period 1966-1967 considerable progress was made over a wide field of activities aimed at improving the health services. Definite improvements are being made in vital statistics; the high degree of under-registration of deaths has been reduced by 30 per cent, and births are being registered more regularly and more promptly. Data concerning causes of death are starting to improve, as a result of the more efficient medical certification of deaths and the improvement in diagnosis. A survey has been made of the resources in hospital beds, and better information is now available on the degree of utilization and the effectiveness of these resources.

Personnel training is being carried out at various levels. Special mention must be made of the mass training given to nursing personnel (nurses, auxiliaries, and aides), 721 of whom were given instruction in a single year, with substantial help from PAHO and WHO; of the courses for statistical technicians; and of the academic fellowships awarded by PAHO. The increase in the number of schools of nursing and the training of health educators, nutrition specialists, and blood bank officers form part of a policy for improving the quality and training of personnel on an increasing scale.

Studies on the regionalization of medical care services in the country and on the splitting up of the National District into sectors have been carried out on the basis of extensive background information.

Specific programs such as maternal and child care, nutrition, and control of intestinal parasitosis are being started in accordance with a work schedule geared to the resources available, the conditions and features peculiar to the country, and the problems involved.

Special attention has been given to medical care for rural communities, in accordance with a program sponsored by the President of the Republic.

A program for construction of hospitals, renovation of existing establishments to provide comprehensive medical care, and construction of maternity subcenters and rural clinics has been undertaken, on a coordinated basis, as part of a national plan. In the course of 1967 five maternity subcenters, 15 rural clinics, and 30 dispensaries were constructed and made ready for use.

The plan for rural water supply, involving the construction of 650 systems over four years, has begun its first phase, during which 89 systems will be completed in one year.

The direction and approach of the plan is in line with the firm conviction that services must be devised and developed to tackle the problems of health promotion, protection, and restoration in an integrated manner; that these services must benefit the urban and the rural populations alike; and that they must form coordinated systems or networks which will gradually spread until they cover the whole of the national territory. The agency in charge of these various activities is the National Health Service, whose technical and administrative structure comprises the usual levels: central, intermediate, and local.

Each health area will have on an average one integrated center or base hospital, three or four maternity subcenters, and five or six rural clinics. The minimum number of establishments for the whole country is 28 integrated centers or base hospitals; 107 maternity subcenters, and approximately 180 rural clinics. In the
The health picture in Bolivia is in some respects a depressing one. In part this is due to the ethnic composition of the country; 60 per cent of the population are Indians, which means focusing and placing the emphasis on educational programs designed to change ingrained habits and customs, in other words to create a new mentality.

I should like to present a very brief, but at the same time a very sober and factual account of the situation in my country.

Malnutrition is a grave problem in large sectors of Bolivia, especially because of the low level of consumption of animal proteins. The tuberculosis rate is following an upward trend. Chagas' disease is endemic in large areas of the country. Typhus, after having been virtually eradicated, has again appeared, one might almost say because the rural dwellers are too apathetic to go on combating the vector. Intestinal parasitosis in the tropical and sub-tropical zones is more or less the rule throughout the population. Bolivia can almost lay claim to the unenviable title of world champion in child mortality; and we have an extremely grave problem in the matter of manpower.

Bolivia has an area of more than 1 million km$^2$, with an average density of population of 2.3 inhabitants per km$^2$, a figure that rises to 10 per km$^2$ in some zones and falls to only 0.3 in the east and northeast zones. It also faces the problem of the "brain drain." To give an example, the School of Medicine of Cochabamba (of which I was the Dean two years ago) has since its establishment graduated 720 physicians, and of this number 600 are now outside Bolivia, working in other countries, especially in the United States of America.

But not every aspect of health work in Bolivia is quite so depressing. We used to have the reputation—and we still find vestiges of this rumor in ill-informed circles—of being the country which exported smallpox. Actually we have the highest vaccination coverage of any people in the Hemisphere, with 85 per cent of the entire population immunized; and we have not had a single case of smallpox for more than five years. Malaria was eradicated three years ago, but there have been a few minor outbreaks in the north on the border with Peru, close to the highway under construction along the edge of the jungle, on the northern border with Brazil, and on the southern border with Argentina. Aedes aegypti has been eradicated completely.

With regard to health care, Bolivia has 17 different agencies handling these services. The Ministry of Public Health takes care of the bulk of the population, but there are private and semi-public institutions and funds which likewise deal with the problem. The total population given protection is 55.8 per cent; of these, 75 per cent are covered by the Ministry of Public Health; close to 16 per cent by the National Social Security Fund; 5.5 per cent by
the Bolivian Mining Corporation (COMIBOL), which combines all the nationalized mining undertakings; 1.4 per cent by the railways; 0.98 per cent by the Armed Forces Health Services; 0.83 per cent by the Bolivian Petroleum Company; and 1.4 per cent by other institutions. The unprotected population reaches the enormous proportion of 44.2 per cent.

Among the institutions concerned with health care are the banks, which spend the equivalent of US$71.89 per capita annually; the Bolivian Petroleum Company, with $59.41 a year; and so on down until we reach the figure for the Ministry of Public Health, which spends only $1.33 per capita.

We are anxious to coordinate and integrate the various services so as to avoid costly and unnecessary overlapping. Fortunately, there are interministerial committees which are working effectively on the study of this problem.

The total budget of the Public Health Ministry amounts to 11.2 per cent of the national budget. We are well aware that there is no likelihood of appreciably increasing this budget, but since the problem is fundamentally one of education, we are trying to arrange for the Ministry of Education, the Ministry for Rural Affairs, which deals with rural education, the Ministry of Defense, and the Ministry of Planning to contribute not only ideas but funds, with a view to attacking Bolivia's health problems from various angles in a coordinated campaign. Integration and coordination of services involve the dovetailing of various interests, so that we are seeking the help of international organizations and the advice of friendly neighbor countries which have already carried out such integration, with a view to popularizing the measure in Bolivia and bringing it to fruition.

We have a plan for hospital construction which is of paramount importance, and to carry it out we hope to have the cooperation of the Inter-American Development Bank and of private enterprise.

Bolivia is making headway, without political interference and on the basis of a certain economic autonomy, with the Ten-Year Plan begun in 1965. This Plan comprises clear-cut programs of health care for those sectors of the population having access to the permanent health services; care programs for sectors not within reach of the health services, with special reference to health promotion in the rural areas; programs of centralized control; investment programs; and personnel training.

We members of the Bolivian Delegation associate ourselves wholeheartedly with the Chilean views on alcoholism and on family planning.

In greeting all here present on behalf of the Bolivian Government and people, and in my own name, I appeal to the Ministers of the five countries having common frontiers with Bolivia and written agreements with us, to cooperate in bringing these agreements up to date and giving them dynamic force. We feel that the frontier should not be a moat dividing the countries, but a permanent symbol of cooperation from both sides.

I would like to thank the Republic of Argentina, in the person of the President of our Meeting, Dr. Holmberg, for all the courtesies extended to us, and to thank the international organizations—PAHO, WHO, and UNICEF—for all the aid they have furnished my country up to the present.

I am confident that with courage, decisiveness, and discipline, we shall make steady progress with the Bolivian Ten-Year Health Plan. We trust that we shall have the cooperation of all of you, and that what are at present dreams and aspirations will one day come to pass.
ADDRESS BY THE PRINCIPAL MEDICAL OFFICER OF THE MINISTRY OF HEALTH OF JAMAICA, DR. MAURICE A. BYER

Presented at the Fifth Plenary Session
18 October 1968

The Hon. Minister of Health for Jamaica, Dr. Herbert W. Eldemire, has asked me to express his very profound regrets at his inability to attend this Special Meeting of Ministers of Health. However, he wishes to convey to you his very sincere wishes for a successful meeting and his very deep interest in all of the proceedings. For my own part, I wish very sincerely to report my thanks and appreciation for the warm welcome which has been extended to us in this delightful country.

In Jamaica very remarkable progress has been made in the field of communicable disease control. Deaths from infectious diseases no longer appear at the top of our list of principal causes of deaths. With regard to tuberculosis, the morbidity and mortality rates recorded for Jamaica in 1965 were, in fact, better than those recorded for Northern America. Nevertheless, we are not permitting these figures to lull us into an attitude of complacency. We know that the proportion of tuberculin positive reactors among the 5- to 6-year-olds who enter our schools is approximately 10 per cent in certain areas and this indicates that there are sources of infection which we have not yet found. A full program of immunization is offered at all of our health clinics and the protection that is provided for those who attend regularly is quite good. However, these regular clinics do not, in many of the parishes, cover 80 per cent of the children under 5 years of age. It has therefore been necessary each year to arrange special immunization campaigns in which poliomyelitis vaccine is offered to those under 5 years who have not been regularly attending the clinics. In this manner most of our parishes are able to record an 80 per cent protection for poliomyelitis and some also offer this degree of protection in respect to the DPT vaccine. Smallpox vaccination is carried out at all infant clinics and revaccination on entering school is the regular procedure.

A very large program for the extension of water supplies to the rural areas has been making good progress over the past three years. We have had very generous assistance from UNICEF in the supply of materials and from WHO in the provision of the necessary technical advice and assistance. Plans for the extension of sewerage systems to meet the demands of the rapidly growing city of Kingston are at present being prepared by a team of Canadian consultant engineers. Another large sewerage scheme for the town of Montego Bay is now nearing completion.

Having successfully eradicated malaria some six or seven years ago, Jamaica entered into the period of profuse breeding of a wide variety of mosquitoes which were resistant to all of the available insecticides. As a result, the consultants assigned to us by WHO had to carry out careful studies and trials of new insecticides over the past two years, before we could prepare a plan for the eradication of the *Aedes aegypti* mosquito. The elimination of this mosquito is a matter of vital concern to Jamaica, not only for the protection of its own population but also on account of the great importance of the tourist trade to our country.

The maternal and child health services continue to be accorded very high priority. These services have been strengthened recently by the addition of staff recruited specifically for the family planning program. This staff has been carefully integrated into the general health services of the country and the new personnel have been carefully instructed in the true meaning of the word integration.

It is very necessary that I should make a clear and distinct statement on this important subject of family planning. The Hon. Minister of Health, when he announced the policy of his Government on the occasion of the opening of the new Hospital at Savanna-la-Mar, stated that the information, advice, and necessary facilities for the practice of family planning would be made available to all of the people in Jamaica.
who wished to make use of this information and these facilities. He made it abundantly clear, however, that the religious beliefs of all sections of the community would be respected and that the acceptance of, or the refusal to use, these facilities was an option which every individual has an inalienable right to exercise. I should also add that this decision of the Government of Jamaica to include family planning in the general health services was taken only after the most careful consideration of all the available data as they are applied specifically to Jamaica, and after it had been clearly demonstrated that family planning was a matter of vital importance to the future development of the country.

As to nutrition, Jamaica has received very generous supplies of milk, and more recently of corn-soya mixture (CSM), from the Government of the United States of America. This food is distributed through the agency of our clinics to from 80,000 to 100,000 infants and pregnant and lactating mothers. The school feeding program also receives, from the same source, generous assistance with their school needs. Although we recognize that subclinical malnutrition is still an important factor which retards development of our youngsters, there is today in Jamaica very little evidence of any gross malnutrition.

Regionalization of the hospital services has been an accepted fact for the past three years, and regionalization of the public health services will shortly be brought into line. A very large hospital building program is at present in full swing. The turning of the first sod for a new 400-bed regional hospital in Montego Bay took place only a few days ago. This hospital will offer a full range of specialist services to residents in the northern sections of the island. Another regional hospital to serve residents in the southern section is in the advanced planning stage.

On the industrial front, we are faced with the familiar dust control problems; a large cement factory on the outskirts of Kingston and an asbestos cement factory in Montego Bay both present problems which are causing some concern to the Health Department. Rapid development of the bauxite industry has presented its own problems in connection with housing and sanitation for the workers. The increasing use of radioactive sources in our hospitals and in industry opens yet another field for early preventive action by the Government.

In the midst of all this activity and development, our well-trained professional and technical personnel have been leaving Jamaica in numbers large enough to make their absence felt. No one wishes to stand in the way of these well-equipped young men and women who wish to seek the best opportunities for their own personal advancement in larger and more wealthy countries. We wish them well and we assure them that on their return to their native country they will receive a warm and hearty welcome. This “brain drain,” however, has made it necessary for the Government to embark on extensive training programs for all categories of medical and paramedical personnel.

Jamaica, therefore, is at present experiencing all of the growing pains which are associated with rapid industrialization and an unprecedented rate of development in all sectors. These rapid changes are placing a very heavy strain on all of the available services. We are, however, not afraid of these strains and stresses; we are confident that these changes will lead to substantial improvements in the standard of living of our people and in the general health standards of the country, and we are therefore also confident that our health services in the country will successfully meet these new challenges.
ADDRESS BY THE MINISTER OF PUBLIC HEALTH OF ECUADOR,
DR. FRANCISCO PARRA GIL

Presented at the Fifth Plenary Session
18 October 1968

I should like first to quote some statistics reflecting the health situation in Ecuador and then to give a very brief summary of the plans of the present Government.

Our health services cover only 35 per cent of the country's total population—urban population with access to permanent services. This coverage is inadequate and is a source of serious concern to the Ministry of Public Health.

The usual health indices are low, in keeping with the country's general level of development. For instance, we have 2.3 hospital beds for each 1,000 inhabitants, and the average stay was 13.9 days in 1966, representing a turnover of 17 patients per bed-year. We have 39.7 hospital discharges per 1,000 inhabitants, and the bed occupancy rate is 64.8 per cent. The country has 3 physicians, 1.2 dentists, and 0.7 nurses for each 10,000 inhabitants.

In 1967 the public health budget was 4.1 per cent of the total national budget, and only 21 per cent of the allocation went to the Ministry of Public Health itself, the other 79 per cent being divided among various autonomous institutions providing public health services of one kind or another. For 1967 the public health expenditure per capita, including those of autonomous and semi-private institutions, was equivalent to US$7.74.

The level of health, measured by negative values—mortality and morbidity—is characterized by a strong predominance of communicable diseases, some of which are endemic. Mortality caused by these diseases accounts for 50 per cent of the total number of deaths. The general mortality rate is 11.8 per cent; infant mortality has declined to 93 per 1,000.

The birth rate was 44 per 1,000 in 1965 and mortality has been decreasing rapidly; population growth is 3.4 per cent at the present time.

Sixty-two per cent of the country's inhabitants live in communities with fewer than 2,000 inhabitants, which indicates that the urban population explosion has not yet assumed significant proportions in Ecuador. Although the rate of population growth is higher in the urban than in the rural areas, the latter rate continues to increase.

Seventy per cent of the urban population is served by water supply systems, and 52 per cent by the sewerage systems. In the rural areas, 97 per cent of the people are without water supply or sanitation service.

The new Government decided that increasing the coverage of the health services by extending them to the rural areas was a top-priority goal. To achieve this purpose it organized a national health team composed of health workers from the different parts of the country, from the National Planning Board and from the schools of medicine, and of representatives of the various agencies active in this field. The organizing team also included architects and sanitary engineers.

The main objective is to improve the health of the population, in deference to an ethical principle of human rights and as an integral part of the socioeconomic development of the country. The specific goals are: to reduce the general mortality rate and the morbidity rates for infants and mothers; to promote better health for infants and for preschool and school-age children and pregnant women; to improve conditions in the rural environment; to control communicable diseases at all age levels; and to provide better dental care for children, mothers, and adults in general.

The means to attain these ends are infrastructure improvements (buildings and equipment), increased manpower, and financial resources. Infrastructure improvements include hospital construction, construction of health centers, and provision of equipment for both.

The medical subgroup took the following decisions with regard to national health policy.
First of all, no effort should be made to increase the number of beds, in spite of the low national ratio, except to the extent required by population growth. Secondly, existing beds will be replaced as needed, the initial program being aimed at replacing 15 per cent of the beds according to an order of priorities. The emphasis is on building new hospitals capable of providing quality service and so organized and designed as to serve twice the number of persons per bed that the present facilities are serving, while also reducing the costs of construction and operation. The third goal is to avoid the construction of hospitals with less than 100 beds because their rate of utilization is very low and their operating cost is high. And the fourth policy objective is to build health centers in towns which are seats of cantonal or parish governments, the former having a population of 5,000-50,000 and the latter of 1,000-5,000. By this means, it is hoped to increase the coverage of the population from 35 to 70 per cent if the health centers are provided with mobile units that can reach even the smallest towns.

The health centers will vary in size according to the number of people to be served, but since the population is growing rapidly (at 3 per cent per annum, equivalent to a twofold increase in 30 years) they will be so designed that they can be enlarged without discarding what is already built. These centers will offer inpatient service for obstetrical patients only, since barely 15 per cent of all births in Ecuador are now attended by physicians or auxiliary workers.

The health centers in the cantonal seats will provide medical and dental service, nursing care, and environmental sanitation service. Where there are no physicians, the center will be staffed by suitably trained nursing auxiliaries. In the parish seats, which are likely to lack physicians for many years to come, the center will also be staffed by nursing auxiliaries but will be visited periodically by a physician.

For the mobile units, the program will require the participation of students and recent graduates of medical schools, and proper training of established physicians, dentists, and nurses for service in rural areas. It will also be necessary to train nursing auxiliaries for providing what is known in my country as "simplified medical care."

A sanitary engineering subgroup is at present determining the water supply and latrine construction needs under this program.

It is hoped that international organizations will support this program by furnishing advisers and fellowships, helping to provide equipment, and even by supplying financing for the infrastructure projects; it has already been arranged for in part. Our national institutions are more than ready to do their share by meeting the operating costs, partly through more productive use of existing resources.

The cost of this program is US$37,000,000, an amount which the country can easily raise within a reasonably short time, since a substantial 20 per cent of this total cost is represented by existing investment.

The program is based on a policy of coordinated planning, supervision, and operation of health services or, in other words, integration of health services throughout the country, except for those in the provincial capitals, and even here it is hoped that increased understanding in certain quarters will make it possible in the not-too-distant future to bring the provincial capitals into the integrated system.

In closing, I should like to express my Government's appreciation and my own to the staff of the Pan American Sanitary Bureau and representatives of the Argentine Government for the many courtesies they have shown the members of the Ecuadorian Delegation.
ADDRESS BY THE CHIEF MEDICAL OFFICER OF THE DEPARTMENT OF
HEALTH AND WELFARE OF BERMUDA, UNITED KINGDOM,
DR. SIMON M. FRAZER

Presented at the Fifth Plenary Session
18 October 1968

It had not been my intention to attempt a
report as the United Kingdom Representative
because it is such a complex task. This is not
really a report; it is an intervention or disser-
tation—or whatever one might call it—to
explain some of the problems that we expe-
rience and to beg the other countries to be
long-suffering with respect to one problem in
particular: *Aedes aegypti*. At this Meeting I am
representing 13 small units, 13 small territories
with a total population of 650,000. That means
that the average population per territory is
50,000, and there are some units that have as
little as 3,000 inhabitants. The remarkable
thing about these small communities is the
variety of their problems. One of the basic
problems is, of course, the matter of economic
viability. Some of these territories are wealthy
and prosperous, while others are very poor. The
other striking variety is the ecology of the
various territories in relation to parasites and
vectors of disease, and the last problem is their
present stage of political development.

They all have within recent years adopted
various constitutions, which I shall not attempt
to explain here, other than to say that they all
have forms of ministerial self-government,
ministerial responsibility. We are very lucky,
though, we have our good fortunes; the former
countries and territories which are now fully
independent are very kind to the various units
that we have. We are able to use their facilities,
and I am thinking particularly of curative
facilities. Barbados is very helpful to us with
their hospital, and the University College Hospi-
tal of the West Indies is equally kind.

But there is a problem of course, when, as
many of us know, there is what in political
development I will call the “talking phase.”

While this phase is on, very little practical
advance occurs in the field, and I think that the
sad thing is that preventive medicine probably
slides to the bottom of the list of priorities. I
am not complaining about this, for I can fully
see that the question of economic viability
must be of the first and prime importance to
the new leaders of these small units. But we do
have these advantages: we are nearly all
English-speaking and we get together. The
technical officers meet generally once a year or
more often. The Pan American Health Organi-
zation and the World Health Organization in
this region have been extremely good to us in
the promotion of seminars and helping the
meetings of senior technical officers, and also
very, very helpful in the training of technical
staff of the various branches. For instance,
laboratory technicians are being trained, and
this task is much easier in small localities, now
that we have the simple empirical test methods
which do not really require a very high degree
of training. The way we are hoping to advance,
in the general field, is through the meetings of
senior technical officers and by very frank
discussions of our different problems, and in
this we are making progress. When things
appear to be at a standstill in one's own field or
even, at times, appear to be going backwards, it
is difficult to maintain enthusiasm and I do
think that these meetings of technical officers
are of an enormous value in maintaining and in
encouraging enthusiasm in each of our own
fields, which are quite remarkably varied. So,
perhaps there is a future and perhaps we—these
various small units—will behave like that
remarkable sea creature, the Portuguese man-
of-war, and produce from a series of non-viable
units an animal which survives and can even
make itself felt.
Annexes
Annex 1

OFFICERS OF THE MEETING AND
OF THE COMMITTEES

President of the Meeting
Dr. Ezequiel A. D. Holmberg
Argentina

Vice-Presidents of the Meeting
Dr. Francisco Urcuyo Maliaño
Nicaragua
Dr. Maxwell P. Awon
Trinidad and Tobago

General Rapporteur
Dr. Amador Neghme R.
Chile

Chairman of Committee I
Dr. Armando Soto-Rivera
Venezuela

Vice-Chairmen of Committee I
Dr. Dionisio González Torres
Paraguay
Dr. Maurice A. Byer
Jamaica

Rapporteurs of Committee I
Dr. Raymond G. Hyronimus
France
Dr. Mervyn U. Henry
Trinidad and Tobago

Chairman of Committee II
Dr. William H. Stewart
United States of America

Vice-Chairmen of Committee II
Dr. Salvador Infante Díaz
El Salvador
Dr. Francisco Parra Gil
Ecuador

Rapporteurs of Committee II
Dr. Manoel José Ferreira
Brazil
Dr. Carlos M. Imaz
Uruguay

Drafting Committee
Dr. Amador Neghme R.
Chile
Dr. Raymond G. Hyronimus
France
Dr. Mervyn U. Henry
Trinidad and Tobago
Dr. Manoel José Ferreira
Brazil
Dr. Carlos M. Imaz
Uruguay
Dr. Abraham Horwitz
Director, Pan American
Sanitary Bureau
Annex 2

LIST OF PARTICIPANTS

Argentina

Dr. Ezequiel A. D. Holmberg  
Minister of Public Health

Dr. Alberto F. Mondet  
Deputy Minister of Public Health

Dr. Victorio Vicente Olguín  
Director of International Health Affairs,  
Chairman, Organizing Committee of the  
Meeting

Dr. Carlos J. García Díaz  
Secretary of Public Health, Municipality of  
the City of Buenos Aires

Dr. Andrés A. Santas  
Dean, School of Medicine, National University of Buenos Aires, and President,  
Association of Medical Schools

Dr. Horacio Rodríguez Castells  
Technical Director, Antituberculosis  
Campaign

Dr. Virgilio Alonso  
Director, National Medical and Health  
Standardization

Dr. Osvaldo H. Arroyo  
Director, National Health Control

Dr. Jorge O. Badaracco  
Director, Operational Coordination

Mr. Salvador Benaim  
Director General of Administration

Dr. Antonio M. Vilches  
Director, National Institute of Microbiology  
“Carlos G. Malbrán”

Dr. Julio Ricardo Estevés  
Superintendent, National Institute of Mental Health

Dr. Carlos Enrique Ottolenghi  
Professor of Orthopedics and Traumatology,  
School of Medicine, National University of Buenos Aires

Mr. Osvaldo García Piñeiro  
Counselor, Ministry of Foreign Affairs

Dr. Marcelo J. Vernengo  
Director, Institute of Pharmacology and  
Bromatology

Dr. Abraam Sonis  
Director, School of Public Health, National University of Buenos Aires

Dr. Rogelio Trelles  
Director, School of Sanitary Engineering, National University of Buenos Aires

Dr. Carlos E. Álvarez Herrera  
Director, Department of Medical Care

Mr. Luis U. Jáuregui  
Director, Department of Environmental Sanitation

Dr. José I. Frugoni Zavala  
Director, Department of Legal Affairs

Dr. Saúl M. Biocca  
Director, Department of Health Education

Dr. Alfredo Rabinoovich  
Director, Department of Health Planning and Evaluation

Dr. Julio C. Blaksley  
Director, Department of Zoonoses, Vectors, and Reservoirs

Dr. Ernesto Escudero  
Director, Department of Health Emergencies

Dr. Jorge Braun Cantilo  
Director of Manpower and Research

Dr. Juan E. Navarro Clark  
Director, Inspection of Pharmaceutical and Food Industries

Dr. Luis H. Vera Ocampo  
Director, Department of Health Economics

Dr. Jorge R. Montero  
Director, Establishments and Program Areas Organization

Dr. Carlos M. Brusco  
Director of Dermatology

Dr. Julio H. Ousset  
Director of Malaria and Yellow Fever
Dr. Carlos Ferrero  
Director of Health Statistics

Dr. Juan Martín Baracat  
Consultant, National Security Council

Mr. Horacio A. Cerrutti  
Coordinator of the Health Sector, National Development Council

Dr. Elbio E. Schenone  
Director, Department of National Defense

Dr. Néstor Rodríguez Campoamor  
Regional Health Coordinator for the Northwest

Dr. Valois Martínez Colombres  
Federal Health Delegate, San Juan

Dr. Oscar B. Sonzini  
Regional Health Coordinator, Central Region

Dr. Carlos M. García  
Federal Health Delegate, Jujuy

Dr. Jorge A. Seoane  
Adviser, Ministry of Public Health, Municipality of the City of Buenos Aires

Dr. Rodolfo U. Carcavallo  
Director, Regional Pathology Center

Mrs. Astrid M. C. Bögédam de Debuchy  
Assistant Director, Department of Planning and Architecture

Dr. Marcelo Díaz Cano  
Director, Training Hospital “José de San Martín”

Dr. Roberto M. Ceruti  
Coordinator, Metropolitan Health Area

Dr. Plácido E. Noziglia  
General Coordinator, Latin American Center for Medical Care

Mr. Luis Segura  
Acting Chief, Personnel Department

Mr. Rodolfo J. Rodríguez  
Director, Finance Department

Mr. Hipólito A. Fleitas  
Director, Supply and Maintenance Department

Mr. Leonardo E. Dimase  
Director of Public Relations and Press

Mr. Jorge A. Labella  
Director of Administration

Dr. Carlos Adlerstein  
Federal Health Delegate, San Luis

Dr. Alberto Álvarez de Toledo  
Chief of Human Development, National Commission of the River Plate Basin

Dr. Juan C. Rojas  
Adviser, Office of the Minister of Public Health

Dr. Luis F. Rodríguez Querejazu  
National Commission of the River Plate Basin

Barbados

Mr. Cuthbert Edwy Talma  
Minister of Health and Community Development

Mr. Carlisle A. Burton  
Permanent Secretary

Dr. Alfred V. Wells  
Chief Medical Officer

Bolivia

Dr. Jorge Rojas Tardío  
Minister of Public Health

Dr. Luis Gallardo Alarcón  
Deputy Minister of Public Health

Brazil

Dr. Leonel Tavares Miranda de Albuquerque  
Minister of Health

Dr. Murillo Bastos Belchior  
Executive Director, International Affairs Commission

Dr. Achilles Scorzelli, Jr.  
Director General, National Department of Health

Dr. Edmar Terra Blois  
President, Foundation for Specialized Public Health Teaching

Dr. Manoel José Ferreira  
Technical Adviser to the Minister of Health

Dr. Olympio da Silva Pinto  
Director, National Department of Rural Endemic Diseases

Dr. Saulo Goulart Alves  
Adviser to the Minister of Health
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<th>Country</th>
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<td>Chile</td>
<td>Dr. Nelson L. Araujo Moraes</td>
<td>Superintendent, Special Public Health Foundation</td>
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<td>Dr. Ramón Valdiviesco</td>
<td>Minister of Public Health</td>
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<td>Dr. Bogoslav Juricic</td>
<td>Secretary, National Advisory Council</td>
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<td>Dr. Horacio Boccardo</td>
<td>Chief, Health Protection, National Health Service</td>
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<td>Dr. Fernando Monckeberg</td>
<td>Professor of Nutrition, School of Medicine, University of Chile</td>
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<td>Dr. Amador Neghme R.</td>
<td>Professor of Medicine, Institute of Chile</td>
</tr>
<tr>
<td>Colombia</td>
<td>Dr. Antonio Ordóñez Plaja</td>
<td>Minister of Public Health</td>
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<td></td>
<td>Dr. Carlos Agualimpia</td>
<td>Director, Study of Health Manpower and Medical Education</td>
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<td></td>
<td>Dr. Raúl Paredes</td>
<td>Chief, Division of Education, Colombian Association of Medical Schools</td>
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<tr>
<td>Costa Rica</td>
<td>Dr. Alvaro Aguilar Peralta</td>
<td>Minister of Public Health</td>
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<td>Dr. Víctor M. Hernández Asch</td>
<td>Director General of Public Health</td>
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<td></td>
<td>Dr. Alvaro Monge</td>
<td>Minister Counselor, Chargé d'Affaires, Embassy of Costa Rica in Argentina</td>
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<tr>
<td>Dominican Republic</td>
<td>Dr. Mario Antonio Fernández Mena</td>
<td>Minister of Public Health and Social Welfare</td>
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<td>Ecuador</td>
<td>Dr. Francisco Parra Gil</td>
<td>Minister of Public Health</td>
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<td></td>
<td>Dr. Alfonso Roldós</td>
<td>Professor of Internal Medicine, University of Guayaquil</td>
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<td>El Salvador</td>
<td>Dr. Salvador Infante Díaz</td>
<td>Minister of Public Health and Social Welfare</td>
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<td></td>
<td>Dr. José M. Díaz Nuila</td>
<td>Director General of Health</td>
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<td>Dr. Juan Allwood Paredes</td>
<td>Executive Secretary, Central American Public Health Council</td>
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<td>France</td>
<td>Dr. Raymond G. Hyronimus</td>
<td>Inspector General of Social Affairs and Public Health</td>
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<td>Guatemala</td>
<td>Dr. Emilio Poitevin</td>
<td>Minister of Public Health and Social Welfare</td>
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<td>Dr. Oswaldo Chinchilla Aguilar</td>
<td>Director General of Public Health</td>
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<td>Haiti</td>
<td>Dr. Fritz Audouin</td>
<td>Minister of Public Health and Population</td>
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<td>Honduras</td>
<td>Dr. José Antonio Peraza Casaca</td>
<td>Minister of Public Health and Social Welfare</td>
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<td></td>
<td>Dr. Carlos A. Pineda</td>
<td>Chief, Health Planning Unit</td>
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<td>Jamaica</td>
<td>Dr. Maurice A. Byer</td>
<td>Principal Medical Officer, Ministry of Health</td>
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<td>Kindom of the Netherlands</td>
<td>Dr. Baltus F. J. Oostburg</td>
<td>Minister of Health of Surinam</td>
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<td>Dr. Ernest Voges</td>
<td>Minister of Public Health of the Netherlands Antilles, Curaçao</td>
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List of Participants

Dr. Joseph I. Chang Sing Pang
Deputy Director of Health of Surinam

Dr. Willem J. A. Oostendorp
Director, Department of Public Health of the Netherlands Antilles, Curaçao

Mr. Roberto F. de Roos
Counselor, Embassy of the Netherlands in Argentina

Dr. Pedro Daniel Martinez
Deputy Minister of Health, Ministry of Health and Welfare

Dr. Francisco Urcuyo Maliaño
Vice-President of the Republic and Minister of Public Health

Dr. Orontes Avilés
Director of Health Planning and Evaluation

Dr. Carlos H. Canales Altamirano
Director General of Public Health

Dr. Dionisio González Torres
Minister of Public Health and Social Welfare

Dr. Julio Martínez Quevedo
Director of Planning and Standardization

Dr. Ramón P. Delmás
Director, Epidemiology and Zoonoses Department

Dr. Alcides Almada López
Director, National Malaria Eradication Service

Mr. Juan Vargas Quintanilla
Minister Counselor, Chargé d’Affaires, A.I., Embassy of Peru in Argentina

Dr. Gustavo Lembcke
First Secretary, Embassy of Peru in Argentina

Dr. Maxwell P. Avon
Minister of Health

Dr. Mervyn U. Henry
Principal Medical Officer

United Kingdom

Dr. Simon M. Frazer
Chief Medical Officer, Department of Health and Welfare of Bermuda

United States of America

Dr. William H. Stewart
Surgeon General, Public Health Service

Dr. Leo J. Gehrig
Assistant Surgeon General, Director, Office of International Health, Public Health Service

Dr. Benjamin D. Blood
Associate Director for International Organizations Affairs, Office of International Health, Public Health Service

Dr. David Frost
Chief, Health Division, Agency for International Development

Dr. Otis E. Mulliken
Chief, Division of Human Resources, Department of State

Uruguay

Dr. Walter Ravenna
Minister of Public Health

Dr. Adolfo Morales
Director, Health Division

Dr. Elbio Fernández Capurro
Director General of Services, Central Family Allowances Council

Dr. Carlos M. Imaz
Director of Health Units

Dr. Leonel Pérez Moreira
Deputy Director of Epidemiology

Dr. Solón Veríssimo Feijó
Program for the Control of Chagas’ Disease

Venezuela

Dr. Armando Soto-Rivera
Minister of Health and Social Welfare
Annex 2

Dr. Carlos E. Castillo
Director of Public Health

Dr. José M. Carrillo
Deputy Engineer, Department of Malaria and Environmental Sanitation

Dr. Daniel Orellana
Chief, Office of International Public Health

Canada

Official Observer

Dr. Basil D. B. Layton
Principal Medical Officer, International Health, Department of National Health and Welfare

World Health Organization

Dr. M. G. Candau
Director-General

Dr. Lucien Bernard
Assistant Director-General

Mrs. Y. Warner
Assistant to the Director-General

Pan American Sanitary Bureau

Dr. Abraham Horwitz
Director, Secretary ex officio of the Meeting

Dr. Charles L. Williams, Jr.
Deputy Director

Dr. Alfredo Arreaza Guzmán
Assistant Director

Dr. Stuart Portner
Chief of Administration

Mr. Luis Larrea Alba, Jr.
Chief of Personnel

Observers

Organization of American States

Mr. Luis Olivos
Assistant Director, Department of Social Affairs, Washington, D.C.

Mr. José María Cosentino
Acting Director, Office of the OAS in Argentina

Inter-American Commission of Women

Mrs. Lucía L. de Calot
Delegate of Argentina

Inter-American Children's Institute

Dra. María Eloísa Lorenzo
Mental Retardation Section

Inter-American Development Bank

Mr. Carlos A. Paz
Representative of the IDB in Argentina

United Nations

United Nations Development Program

Dr. Miguel Albornoz
Resident Representative of the UNDP in Argentina

Miss Noël J. Dawnay
Assistant to the Resident Representative of the UNDP in Argentina

United Nations Children's Fund

Mr. Roberto Esguerra-Barry
Director, Regional Office for the Americas, Chile

Nongovernmental Organizations

Milbank Memorial Fund

Dr. Alexander Robertson
Executive Director

Dr. Per G. Stensland
Senior Member of the Technical Staff

Dr. Edward M. Backett
Consultant

Pan American Federation of Associations of Medical Schools

Dr. Amador Neghme R.
President

Pan American Medical Confederation

Dr. Carlos P. Seltzer
President, Argentine Medical Confederation
Annex 3

AGENDA

1. Plenary Sessions

1.1 Opening of the Meeting
1.2 Election of the President and Two Vice-Presidents
1.3 Designation of the representative of the Ministers to speak at the inaugural session
1.4 Statement by the Director of the Pan American Sanitary Bureau, Dr. Abraham Horwitz, on the organization and conduct of the meeting
1.5 Adoption of the Rules of Procedure (Document REMSA/3)
1.6 Election of the General Rapporteur
1.7 Adoption of the agenda (Document REMSA/1, Rev. 2)
1.8 Adoption of the program of sessions (Document REMSA/2, Rev. 1)
1.9 Addresses by the Ministers on health programs in their countries
1.10 Consideration and approval of the recommendations of the Committees
1.11 Adoption and signature of the Final Report

2. Committee I

2.1 Election of Chairman, Vice-Chairman, and appointment of two Rapporteurs
2.2 Present status of communicable diseases in the Americas (Document REMSA/4)
   2.2.1 Quarantinable diseases
       2.2.1.1 Smallpox
       2.2.1.2 Yellow fever and Aedes aegypti
       2.2.1.3 Plague
   2.2.2 Viral diseases
       2.2.2.1 Poliomyelitis
   2.2.3 Bacterial diseases
       2.2.3.1 Tuberculosis
       2.2.3.2 Leprosy
   2.2.4 Parasitic diseases
       2.2.4.1 Schistosomiasis
       2.2.4.2 Chagas' disease (Document REMSA/4, Add. I)
   2.2.5 Venereal diseases
   2.2.6 Zoonoses
2.3 Status of malaria eradication in the Americas (Document REMSA/5)
2.4 Environmental sciences and sanitary engineering (Document REMSA/6)
2.5 Maternal and child health and health aspects of comprehensive family education (Document REMSA/7)
2.6 Food policy and nutrition (Document REMSA/8)
3. Committee II

3.1 Election of Chairman, Vice-Chairman, and appointment of two Rapporteurs

3.2 National health plans and strengthening of the organization and administration of health services (Document REMSA/9, and Add. I)

3.3 The role of health services in projects for the modernization of rural life (Document REMSA/10)

3.4 Development of health manpower (Document REMSA/11)
   3.4.1 Program of textbooks for medical students (Document REMSA/11, Add. I)
   3.4.2 Fellowship program (Document REMSA/11, Add. II and III)

3.5 Research and technology for health and welfare (Document REMSA/12, Add. I and II)

3.6 The role of health services in the Latin American Common Market (Document REMSA/13)

3.7 Health legislation (Document REMSA/14)

3.8 Reference laboratories—Quality testing of drugs (Document REMSA/15)