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TASK FORCE ON HEALTH AT THE MINISTERIAL LEVEL IN ACCORDANCE WITH RESOLUTION A.4 OF THE CHARTER OF PUNTA DEL ESTE

Resolution A.4 of the Charter of Punta del Este entitled Task Forces for Programming acknowledges that the adequate national programming is essential for basic fields such as public health. It further recognizes that in certain areas such as public health the subjects are of a highly specialized nature so that they need detailed consideration by experts in order to provide guidance to Governments in the formulation of national plans and programs. The Resolution then recommends that "The Secretary General of the Organization of American States immediately establish task forces to undertake investigations and studies and drawing on the experiences of the member states, to prepare reports and adopt conclusions of a general nature for Latin America in the fields of education, land reform and agricultural development, and public health that may serve as a basis for the member states in preparing their national development programs..." It further requests in Recommendation 4 "That the task force on health, organized through the Pan American Sanitary Bureau, appraise prevalent problems and suggest general lines of action of immediate effect relating to: the control or eradication of communicable diseases; sanitation, particularly water supply and sewage disposal; reduction of infant mortality especially among the new-born; and improvement of nutrition; and that it also recommend actions for education and training of personnel and improvement of health services."

In conformity with the recommendation, the Director of the PASB acting on behalf of the Secretary General of the Organization of American States convoked a meeting of the Task Force at Ministerial Level in Washington, D.C., from the 15th to the 20th of April, utilizing funds for this purpose provided by the Organization of American States. In preparation for this meeting, study groups on Environmental Sanitation, National Health Planning, Medical Education, Nutrition, Medical Care, Health Statistics, International Classification of Diseases, and Medical Research were called to consider the problems of health in relation to the goals of the Alliance for Progress and to recommend measures to be taken to achieve the goals. In addition staff studies were made to provide further background information. All of this material was made available as background documentation for the Task Force Meeting.

The Report of the Task Force on Health, which was transmitted through the Director of the Pan American Sanitary Bureau to the Secretary General of the Organization of American States, in accordance with paragraph 8 of Resolution A.4 of the Charter of Punta del Este, is submitted for the information of the Directing Council and for action as deemed appropriate.

Enclosure

ALLIANCE FOR PROGRESS

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

TASK FORCE ON HEALTH AT THE MINISTERIAL LEVEL*

WASHINGTON, D.C., 15 - 20 APRIL 1963

TFH/14, Rev. 1 (Eng.)
14 May 1963
ORIGINAL: ENGLISH-SPANISH

FINAL REPORT

* Organized through the Pan American Sanitary Bureau in accordance with Resolution A.4 of the Charter of Punta del Este, signed at the Special Meeting of the *Inter-American Economic and Social Council at the Ministerial Level on 17 August 1961.*

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CONTENTS (Cont.)

I. TERMS OF REFERENCE

Resolution A.4 of the Charter of Punta del Este recommends that the Secretary General of the Organization of American States establish task forces to undertake investigations and studies of the most important problems in various areas of economic and social development and to make recommendations for their solution that might serve as background information to, and be taken into account by, the Governments in preparing their national development plans. In the matter of health, this resolution recommends that the pertinent task force, organized through the Pan American Sanitary Bureau, "appraise prevalent problems and suggest general lines of action of immediate effect relating to: the control or eradication of communicable diseases; sanitation, particularly water supply and sewage disposal; reduction of infant mortality, especially among the new-born; and improvement of nutrition and that it also recommend actions for education and training of personnel and improvement of health services." (Resolution A.4.4)

In view of the variety of problems mentioned in this resolution the Pan American Sanitary Bureau first convened a series of advisory groups composed of experts from the Continent to examine the present status of each problem and to suggest practical measures for achieving the goals of the Charter of Punta del Este, in particular the Ten-Year Public Health Program set forth in Resolution A.2. The reports of these committees, as well as those prepared by the technical personnel of the Bureau, were made available to Governments and constituted valuable background material for the organization of the Task Force on Health.

It was deemed advisable for the task force to be at the ministerial level in order to harmonize the opinions of those who are responsible for the health of the Americas.

The Task Force on Health, composed of the ministers of health of all the signatory Governments of the Charter of Punta del Este, or their representatives, met at the International Inn in Washington, D. C. from 15 to 20 April 1963. A list of participants is attached (Annex I). The Task Force held eight plenary sessions, four sessions of Committee I and three sessions of Committee II. During the course of the meeting the items contained in the attached agenda (Annex II) were considered.

II. THE ROLE OF HEALTH IN THE ECONOMIC AND SOCIAL DEVELOPMENT OF THE AMERICAS

The Act of Bogota and the Charter of Punta del Este reflect the determination of the Governments of the Americas to unite in a common effort to accelerate social welfare and economic growth simultaneously. This decision emphasizes that the fundamental aim of development is the well-being resulting from a higher level of living. An alliance for progress is being born, progress being understood to mean the enhancement of man's ability to improve his social environment and to live in harmony with it. The measures proposed for the attainment of that end are those aimed at expanding the economy and at increasing both production and productivity; in social matters, measures for the improvement of health, education, housing, nutrition, work, and recreation are most important. It is generally agreed that, in the allocation of national and external resources, economic development and social progress should be equitably treated, and needs and resources should be matched in a single program aimed at definite targets.

A healthy and active population is essential for economic growth and social progress. Health is therefore a basic component of development and level of living. Resources devoted to health care are an investment, a source of productivity, not an expenditure. The return on that investment can be measured in terms of the improved capacity of the members of a community to create, produce, invest, and consume. It may likewise be measured by the greater yield obtained from natural resources as a result of health work.

Seen from another viewpoint, improvement of health implies a raising of living standards that basically benefits the low-income groups of our communities. Consequently, it contributes notably to the attainment of one of the most important goals of the development process, that is, to bring about a better distribution of an increasing real income.

It is fitting to recall that international cooperation in the field of health was initiated for the purpose of reducing the losses due to the great epidemic diseases that were restricting commercial exchanges between countries. The International Sanitary Bureau - now the Pan American Sanitary Bureau - was established towards the end of 1902 as an agency to advise governments on such health matters. The combination of a humanitarian purpose with an economic one shows the vision of the statesmen and experts of that time, and is an example, a harbinger, of the intimate and reciprocal relations between health and development.

At the present time large-scale epidemics occur only exceptionally. Health problems tend to reflect the characteristics of each environment and the influence of that environment on the human beings that live in it. Health work, which has not always been considered in the light of its reciprocal relations with other social phenomena, must be regarded as peculiar to each community, with specific techniques for the prevention and cure of diseases, adapted to the social and cultural conditions of the population. As yet, there has been no integration of activities either in the services or at the level of the theoretical work unit,

i.e., the family. Only a very feeble attempt at coordination has been observed. In any event, if it has been achieved in any social environment, it has been done without relation to the other activities that generate community welfare. Nor has any careful attention been given to balancing needs against resources on a national basis. Health budgets have not included the essential activities for achieving definite objectives, but have been only a list of probable expenditures unrelated to a program of work. Because of this, the total investment in services of this type has not reached its proper proportion of the national income.

Moreover, the health investment is utterly inferior to the manifest needs in all the countries. For this reason, a substantial and progressive increase in the health budgets is recommended, in accordance with rationally formulated plans.

It is recognized that, in some countries, such plans will require an investment of at least twice the current level of support.

Only in recent years has the idea been making headway that advances in health come to a stand still and retrogress after a time if economic growth is not fast enough to finance activities intended to meet the basic needs of the population. There is an awareness today that health programs are part of --not separate from-- general development planning. This is the method recommended in the Charter of Punta del Este. In theory and in practice a plan should be based on social needs and the necessary economic resources. When the latter are insufficient, an order of priority must be established among the problems in each sector. This involves setting up criteria for assigning priorities to each social activity, which will facilitate the allocation of resources within the general development plan. As the economy expands, the

national resources will be redistributed in accordance with these priorities, and these, in turn, will be translated into specific objectives to be attained within a specified time.

Since health is defined as a state of complete physical, mental and social well-being, we interpret it, in the light of the **Charter** of Punta del Este, as a fundamental factor in development. This proposition reaffirms that man is the sum of all the efforts of a society, the object, the end, and the measure of all things; and that it is therefore of the utmost importance to improve his living conditions and ensure his personal, material, and moral well-being. Health has come to be regarded as a "right", on a par with the other basic human rights. The thesis that society is responsible for the health of its members and should actively intervene in order to improve it may be of recent origin, but it is incontrovertible. Because of this, it has already been recognized that "improvements in health conditions are desirable in themselves, that they are an essential prerequisite for economic growth, and that, therefore, they must be an integral element in any meaningful development program for the region." (Resolution A.2).

On signing the Charter of Punta del Este the Governments of the Continent agreed to work towards the achievement of the health goals set forth in Title I, entitled "Objectives of the Alliance for Progress", and in Resolution A.2 containing the Ten-Year Public Health Program.

It is therefore fitting to examine the health problems of the Americas as well as the practical possibilities for gradually solving them in accordance with the spirit and the letter of the Charter.

III. THE PRINCIPAL HEALTH PROBLEMS OF THE AMERICAS

For a given constitution and nutritional status the biological phenomena that condition health and disease hardly vary from one person to another. Their social manifestations, on the other hand, are for the most part the result of environmental factors that vary in time and place. For some, health is the capacity of every human being to adapt to his continually changing environment. In turn, the environment changes and improves with development, that is, with the application of modern technology for the promotion of well-being. Consequently, any improvement in the environment has a favorable effect on health.

The Americas are no exception to this rule, so that the health problems in each country reflect the trend of its development.

Thus an analysis of demographic indicators, such as morbidity and mortality rates, the population structure, the rate of growth of various sectors of the population, the distribution of the population between the rural and urban areas, and the main features of the labor force, makes it possible to deduce the nature of the prevailing health problems. If these background data are related to economic data -- such as industrial and agricultural production, national income, average per capita income, and environmental conditions, especially sanitation, nutrition, and housing -- these health problems can be even more accurately defined.

It is clear that degenerative and mental diseases and accidents are more frequent in the countries that have a higher socio-economic level,

the industrialized and urbanized areas of the Americas. In the remainder of the Continent, that is, most of Latin America, acute diseases, especially the communicable diseases, prevail. Health protection and health promotion techniques, together with the early treatment of patients, can produce effects comparable to those obtained in the technologically advanced countries. The scientific knowledge exists, but its application is hampered by economic and social factors.

In the world of today economic and material values so outweigh cultural and spiritual values that there is a tendency to characterize countries solely by their degree of development. Those who do so, overlook the fact that development can only be achieved if the way of life and dignity of the individual citizen is respected and his collaboration is enlisted. Social progress will not endure if it is imposed in defiance of the customs and mores of the people.

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 the 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, unhealthy housing and working conditions, illiteracy, unsuitable clothing, and a low per capita real income. These factors together produce a high mortality in children,

especially those under five 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 school children; low productivity; not to mention a pessimistic outlook on life. The distribution of these health 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.

IV. CRITERIA FOR ESTABLISHING PRIORITIES IN HEALTH PROBLEMS

An order of priority among health problems clearly cannot be established unless the problems themselves, both their magnitude and their social, cultural, and economic repercussions are fully known. This background information will make it possible to decide which problems should be dealt with first, so that health, as a social function, may make the contribution needed for the balanced development of the country.

Criteria for establishing priorities include the nature and extent of the problems, their present or potential danger, measured in terms of mortality and morbidity, and their bearing on development. This approach emphasizes the social impact of each problem.

Attention must likewise be given to the scientific knowledge available for preventing or reducing the seriousness of each problem. This knowledge can be applied through techniques that are reliable, relatively simple to use, and inexpensive when compared with the financial consequences the problem has for the community. This approach is closely linked to the one mentioned earlier.

Another indicator for establishing priorities is public demand. When a problem is of the utmost importance, an actively interested community eager to collaborate in its solution is one of the most powerful factors in applying the techniques recommended. This active and informed community participation becomes an educational process generating further cooperative efforts towards progress.

Finally, the agreements the Governments have entered into in connection with specific health problems are in themselves a criterion of priority. The Charter of Punta del Este is an outstanding example of such an agreement. Its objectives are continental in scope. It is up to the Governments to translate them into national terms by deciding which health problems are of the greatest importance for economic development and social progress in their countries and how best to solve them progressively. Malaria eradication is another good example.

The starting point for the establishment of priorities is an accurate knowledge of the problems. That calls for epidemiological investigation and reliable statistical data, a field to which urgent attention must be given in Latin America. Vital and health statistics are still incomplete. Yet such data are essential for formulating sound programs, establishing targets, and evaluating results.

In applying the above-mentioned criteria for establishing priorities, it should be borne in mind that specific programs related to specific goals can more readily be seen and understood. Popular support can more easily be mobilized. Further, results are more quickly obtained, and progress takes a form that is more readily felt by public opinion, which is stimulated to continue cooperating in other health programs.

Three types of approach to health problems are suggested: First, to organize health services and provide them with facilities for the protection of the physical environment, such as community water supplies, refuse and

waste disposal, and food and pollution control. Second, to concentrate on specific diseases, such as malaria and other parasitoses, smallpox, diarrhea and enteritis, malnutrition, tuberculosis, among others. Third, to work on the health problems which are related to specific economic objectives. If a country cannot reach the targets set in its agricultural and industrial policy because poor health is draining the productivity of its workers, then the health problems involved must have priority. All of these approaches are visible and concrete. They provide a basis which allow political leaders and health workers to work together without sacrifice of principles.

V. THE PRESENT HEALTH SITUATION IN THE AMERICAS AND THE OUTLOOK FOR THE FUTURE

In the course of this century, and especially in the last twenty years substantial progress has been made in the prevention and treatment of diseases and in the promotion of health in Latin America. As to the prevalence of diseases in the countries, Latin America may be considered a Continent in transition, in which the great epidemic diseases are in the process of disappearing. It is illustrated by the fact that in 1962 only 3,082 cases of smallpox, 556 of epidemic typhus, 527 of plague, and 48 of jungle yellow fever were reported. There was no case of urban yellow fever. Not a single case of cholera has been reported in this century.

The incidence of other communicable diseases such as malaria, tuberculosis, leprosy, Chagas' disease, certain zoonoses, schistosomiasis, typhoid and paratyphoid fevers, whooping cough, diarrheal and enteric diseases, remains high, despite the fact that tried and tested control methods are available.

Nevertheless, chronic diseases are emerging as a major cause of death in most of the countries. In 1960, cancer, cardiovascular diseases, and accidents were among the ten principal causes of death, and in some countries among the first five.1/ This is the reflection of increased life expectancy, which is closely related to the growing industrialization and accelerated urbanization of the Continent.

1/ Summary of Four-Year Reports on Health Conditions in the Americas, 1957-1960.

The above-mentioned social changes that influence health problems and are in turn influenced by them are ocurring in a population of 206 million whose natural growth rate is 2.5 per cent each year, the highest in the world. It is a young population, 40 per cent of which is under 15 years of age; it has a birth rate of 40 per thousand and a mortality rate of 12 per thousand. Mortality is high in children and in infants under five years of age. According to available information, the former ranges from 50 to 130 per thousand live births, whereas in technologically advanced countries it is currently only about 15. Mortality in infants in the 1-4 age group is between 3 and 32 per 1,000 population, whereas there are eight other countries in the world where the index is 0.8 per thousand. As already stated, this age group accounts for more than 40 per cent of the deaths that occur each year in Middle and South America. The fact that infectious diseases, malnutrition, lack of sanitation, particularly of pure drinking water; are among the factors influencing mortality in children aged under five, justifies the fundamental role of health activities in preventing this excessive loss of life, since it represents a loss of brains and hands needed to achieve social progress and economic growth.

There has been a gradual increase in life expectancy at birth in the course of the century. The data available show that in 1950, it was 33 in one country, between 40 and 50 in several others, and over 50 in a few. Few countries have been able to compute life tables based on the 1960 census, but these show a rapid increase in the last

ten years with a life expectancy of about 60 years or slightly more. In the economically developed countries the average life span is in excess of 70 years. It must be pointed out that in 1960, the Americas, which occupy one third of the total land surface of the globe, had a population of 405 million or 13.5 per cent of the world population. Of the total population in Latin America, 52 per cent live in rural areas. The average density in Latin America is 10 persons per Km^2.

According to the 1950 census the economically active population in the region of the Americas was distributed as follows: agriculture, 56 per cent; industry, 18 per cent; commerce and services, 26 per cent. In North America at the same date, not more than 15 per cent of the total labor force was engaged in agriculture, yet these countries export foodstuffs. In Latin America, on the other hand, according to the reports of the Food and Agriculture Organization of the United Nations (FAO), agricultural production declined approximately 2 per cent during the period 1960-1961. Food production also dropped below that of the previous year.1/ This differentiation between total agricultural and food production is relevant, since there are large areas in Latin America given over to the production of cash crops such as coffee, cocoa, sugar, tobacco, and cotton, not all of which are food.

Other important factors are deficient land use and land tenure, and inadequate storage and distribution of foodstuffs,

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1/ IDB. Social Progress Trust Fund. Second Annual Report, 1962.

because of insufficient use of modern food technology, which increases production costs. Both the quality and the quantity of the food consumed is below par, and this gives rise to one of the fundamental problems in Latin America: malnutrition.1/

Per capita income in Latin America is very low, ranging from 100 to 1,000 dollars a year. This figure must be viewed in terms of its power to purchase the necessities of life: health, housing, clothing, drinking water and sanitation, working conditions, education, food, and recreation. Despite the advances made, 40 per cent of the population over 15 years of age is still illiterate, that is, about 50 million persons can neither read nor write. The average length of schooling is 3 to 4 years.

"...there are no statistics showing an appreciable improvement in rural income levels. Indications are to the contrary and show that as a result of economic and demographic factors most 'campesinos' are now in a worse plight than they were a few years ago. The backwardness of the agrarian sector continues to represent the principal obstacle to Latin American growth, and is a major cause of social and political tensions and of many of the region's economic problems." 2/

1/ Document CSP16/6, Nutrition.

2/ IDB. Social Progress Trust Fund. Second Annual Report, 1962.

This quotation emphasizes the importance that must be given to the rural problem in development programs, including health programs. The fact is that, despite industrialization and efforts to diversify production, the Latin American economy is predominantly agricultural. Generally speaking, each country is dependent on a single export crop, the price of which, according to statements made by our Ministers of Finance, fluctuates sharply in the world market. That has in large measure been the cause of the economic difficulties of the countries, and has had an unfavorable effect on the rate at which investments are made and has inhibited development. It is this fact which justifies the cooperative effort envisioned in the Act of Bogota and the Charter of Punta del Este, an effort essentially intended to improve living standards in proportion as revenue increases and is redistributed among the priorities that have a social effect.

The economic and social facts we have cited explain the nature of the health problems prevailing in Latin America. They are peculiar to a young population, which is growing at an accelerated rate, produces less than it needs, and supplies less that it demands. The population structure, its age distribution, environmental and health conditions, are reflected in reduced working capacity, low productivity, and absenteeism.

Four tools are used to protect, promote, and restore health: planning; the organization and administration of services; the education and training of technical personnel; and research.

Planning is the method recommended by the Charter of Punta del Este for achieving its fundamental purpose: to promote a sustained growth of the economy and translate it into social well-being. To this end each sector must formulate its own programs, covering the most important problems; the techniques and procedures to be used to solve them, depending on their urgency and the experience acquired; the professional and auxiliary workers needed; equipment and supplies; and financing.

The formulation of a program calls for the most accurate knowledge possible of the problems, their magnitude, nature, and influence on individual and collective health. Hence the importance of scientific and epidemiological research, as well as of statistical information which, as pointed out earlier, is notoriously deficient in Latin America. Nevertheless, it is possible to draw up plans with the data available at present and to establish specific targets and objectives for each activity, within each population. At the same time, measures must be taken to ensure that the quality and quantity of data is continuously improved. Statistical services must therefore be organized, and professional and auxiliary personnel must be trained for specific jobs in them.

Planning is only a means, not an end, and is even more necessary for countries where there is a great disparity between needs and resources, a situation which necessitates the scheduling of problems and the channeling of investments to ensure that they will benefit the greatest number of people. Planning, in essence, is the mobilization of people, resources, and facilities to the best possible effect so that problems are solved. Planning that is not specifically related to the problem at hand is, at

best, unrealistic, and at worst, sterile. Planning is not only knowing needs; planning is doing. It is a continous process that leads to the evaluation of what is available against what is needed, and to the mobilization of all the resources that can help.

At the present stage, sectoral plans must be prepared and related to economic growth. There is reason to believe that, as yet, a complete knowledge of the over-all planning of development and welfare has not yet been attained. It is therefore essential to try out various simple and suitable methods in communities selected for that purpose. Until this is done, it seems advisable to invest funds according to the priorities established in each sector, that is health, education, agriculture, and so forth. When definite criteria are lacking, there is little to recommend attempts to increase investments in one sector at the expense of the priorities and others on the pretext of achieving greater social and economic effects. Health, however, should always have a high priority, because of its effect on productivity and development.

Preventive and curative activities already under way should not be interrupted while plans and programs, which are only a means of achieving progress, are being prepared. This amounts to carrying out the immediate plans and the long-term measures referred to in the Charter of Punta del Este in such a way as to fuse them into a continous process.

The organization and administration of health services, both at the local and at the national level, constitutes, together with trained personnel, the most important tool for carrying out activities for the

prevention and treatment of diseases. Medicine and public health can only attain their ends if their techniques are adapted to the needs and resources of the peoples and to the special conditions created in each community by the local environment.

Organization and administration must not be static or definitive. They must be subject to permanent review so as to facilitate the attainment of the objectives of the health plan and its different programs. The Charter of Punta del Este has emphasized the need for revising structures, legislations, institutions, rules, and regulations so as to translate its general purpose into reality and improve the standard of living.

Development in Latin America will progress in proportion to the number and caliber of the expert and auxiliary personnel available for various activities. Health work is no exception to this rule, for one of its characteristics is that its functions are as diversified as social life is complex. Depending on the level of its development, a country requires a series of professionals for each health problem. The training of such personnel is a rather lengthy process. It is generally agreed that large numbers of auxiliary personnel must be trained so that as large a proportion of the population as possible can be covered by the health services. Training must be programmed; in other words, the technicians needed for the various health activities must be prepared, posts for them must be included in the budget, and they must be paid adequate salaries, commensurate with their dignity and lofty mission.

As to research, the following quotation is relevant:

"The immediate purpose of supporting research in Latin America is to solve problems related to health in a manner which will promote human welfare. ... The long-range goal is to promote the upgrading of the community in its most human aspects through the cultivation of science. Indeed, science, if understood properly as a form of culture, is a means of eventually providing the whole community with an objective awareness of the proper context of man; it gives a holistic view of the universe, in keeping with man's intellectual nature; it will eventually provide a basis for mutual understanding; and it is in any case a proper basis on which to build education."1/

The nature and distribution of diseases and of the phenomena that condition health have special characteristics in the Americas, as they have in other regions of the world. The social environment is varied and constantly changing, as are the relations between each environment and the human beings that live and develop in it. There is, therefore, so to speak, a pathology peculiar to the Americas, which obliges the health experts to adapt and not simply to copy knowledge and technique which have been worked out in other geographical areas. This fact justifies the need for investigating the phenomena that condition health and disease in the countries and communities of the Continent. To this must be added the possibilities of contributing to the analysis of the origin of biological phenomena, as well as ecological variations in different environments

1/ Document TFH/3, page 2.

resulting from attack procedures. Scientific research is not the antithesis of pragmatism; on the contrary, they are two facets of the same purpose.

An over-all view of the health conditions in the Americas makes it possible to make certain affirmations. There is a more precise definition of the prevailing problems and their influence on economic life and development. Nevertheless, the need for further knowledge of their magnitude and real extent has become evident. It is possible to show that there is a better understanding on the part of the urban communities. Furthermore, where social security systems have been organized, the people have become conscious of a right. It is now fitting to stimulate the same attitude in the rural areas.

The techniques and procedures used to solve the problems are in accord with modern principles. However, all the population does not yet have access to them and at times those who benefit are still very few.

In spite of the progress achieved in the training of health personnel, the number and quality of those available are not sufficient to satisfy present needs and those arising out of the growth of the population. That is reflected in the distribution of health services, which shows an excessive concentration in urban centers and an absence or shortage in the rural areas.

In theory, activities for the protection, promotion and restoration of health are acknowedlged to be parts of the same process,

which makes it advisable for them to co-exist in the same organization. This is the thesis of the integration of health services to solve the problems affecting the work unit -the family- and communities. Examples of the translation of this theory into practice in the Continent are few. Curative and preventive services function as independent and uncoordinated authorities, and this leads to a duplication of activities, waste, and poor utilization of the few resources available. If the law puts the responsibility for these activities on the ministries of health, it is logical to concentrate in them all the activities that are now dispersed among other public and private institutions that receive large financial contributions from the State. Among these, the medical services of the social security system should be mentioned, as its role should be limited to financing social benefits.

An administrative conscience and proper competence must be developed to assure the efficient and economical use of limited resources. In this area many of the health institutions in the Americas are very weak in terms of organization, regulations, procedures, and practices. Recognition must be given to the fact that public administration is essential to technology, and it must be given the structure, the staff, and the equipment that modern methods demand. Administrative rationalization increases efficiency, decreases expenditure, and facilitates the attainment of the objectives of every program.

Health investments in Latin America are less than what is needed for programs, as is shown by the vital and health statistics, despite

the progress made in this century. According to a recent report of the Inter-American Development Bank, 5,8 per cent of the public expenditure of the Continent is allotted to health.[1/] This figure varies markedly from country to country since in some of them it includes the cost of social services. This fact will make itself more felt, when the governments formulate their national health programs on the basis of priority of problems and programs for each of their communities. Only in this way can they determine the necessary funds that must be invested in health in each period. However, it is clear that domestic resources are not sufficient for prevalent problems, although it is recognized that with better organization and administration there is a relatively better return.

In view of their fundamental importance for economic development, agricultural and industrial development, and health, the governments have obtained long-term credits at low interest rates from international banks with a view to financing water supply and sewage disposal programs and housing programs. It must be pointed out that urban communities have shown themselves ready to pay higher water rates in view of the security that comes with proper water systems. The governments are investing matching amounts of their domestic resources and at the same time have guaranteed the amortization of the credits and their interest and the maintenance of the service. In sum, properly organized public utility enterprises are being set up. It is estimated that the same

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1/ IDB. Social Progress Trust Fund. Second Report, 1962.

method can be applied to other health problems that can be solved by international credit. The first annual meeting of the Inter-American Economic and Social Council held in Mexico in October 1962 endorsed this opinion. The improvement of rural welfare, the eradication of malaria, the construction of hospitals and health centers, the production of vaccines, sera, and biological substances for human and animal use, and urbanization programs can be cited as examples. It was recommended that national and international credit institutions include various health programs in their investment policy, in addition to water supply for urban, sub-urban, and rural areas, with a flexible financing system to cover the various items in these programs.

There has never been a sustained effort in Latin America to organize voluntary collaboration for health objectives either at the community or at the institutional level. It is urgent to do so because there is a latent motivation and a desire of many people to contribute their efforts and even their goods for higher purposes.

International organizations, both governmental and private, bilateral and multilateral, have given technical advice and effective and humanitarian assistance to Latin America. This has made itself felt in the formulation of programs, organization of services, the construction and equipping of hospitals and health centers, and especially in the education and training of technicians.

In the Alliance for Progress, we specialists in health feel that we are a part of "a vast effort to bring a better life to all

the peoples of the Continent." We must devote our best abilities to making that goal a reality. We recognize that what is essential for this purpose lies in our countries, in the present and potential ability of the inhabitants, as well as in the natural resources. Nevertheless, it is indispensable to carry out the legal and institutional reforms called for by the Charter of Punta del Este in order to obtain the greatest benefits for the country from the national resources. External capital is needed in order to catalyze the process of development and complement the national efforts. And it is likewise needed for economic and social welfare programs. The last mentioned are stimulated by the aspirations of the human beings in whom the Alliance for Progress has placed justified hope. The Task Force on Health would like the administrative machinery of the Alliance to show greater agility and flexibility for carrying out programs for social progress and economic development.

In order to accomplish the objectives of the Alliance for Progress and to carry out the Ten-Year Public Health Program, Latin America has a solid basis whose most valuable factors are the spirit of its people, its universities and teaching and research centers, and its professional and auxiliary workers. It is necessary, however, to accelerate the process of training and to formulate plans and programs to rationalize public administration and to make services more efficient, to increase investments, both of domestic resources and of external assistance, according as the economy becomes stronger, to intensify

the active and informed participation of the people for the common good, which is public health. These general measures are essential for the support of the specific measures related to each particular problem.

In sum, the Alliance for Progress represents an additional contribution to the efforts and programs in the field of health which each country is promoting to solve its own problems.

VI. MEASURES RECOMMENDED FOR THE IMPLEMENTATION OF THE TEN-YEAR PUBLIC HEALTH PROGRAM OF THE ALLIANCE FOR PROGRESS

The Ten-Year Public Health Program of the Alliance for Progress set forth in Resolution A.2 of the Charter of Punta del Este contains both long-term measures and those to take immediate effect for the purposes of reaching its objectives.

The former relate to the means habitually used to secure the protection, promotion, and recovery of health: planning, organization and administration of services; education and training; and research; the latter refer to specific problems that are prevalent in Latin America.

The committees established by the Task Force gave priority to an analysis in depth of those measures. They discussed the background to each problem, which was available to them in the working documents prepared by the advisory committees of the Pan American Sanitary Bureau and by its technical staff. This information made it possible to distinguish the aspects of each problem which at present constitute the greatest obstacles to a solution. The committees centered their attention on those aspects and proposed practical measures that experience has shown to be advisable for Latin America.

This chapter of the report contains a summary of each problem, together with a justification of the recommendations approved by the Task Force:

A. SPECIFIC MEASURES

A.1 Malaria Eradication

While notable progress has been made in the malaria eradication campaign, much remains to be done in order to free the Hemisphere of this disease.

As of the end of 1962, of a population estimated at 153.7 million living in areas of the Hemisphere that were originally malarious, 59.3 million are now living in areas in which the disease has been eradicated; 30.4 million are living in zones already free of transmission and now in the consolidation phase; 49.3 are living in areas that are in the attack phase; and 14.7 million are living in areas where the start of the campaign is still awaited. It can be said that 58.4 per cent of this population in the Hemisphere is now living in areas free of transmission.

The attack phase is still to be started in Cuba and is paralyzed at present in Argentina and Paraguay. In several countries the campaign is not advancing because of a lack of funds to intensify the attack measures. Before analyzing this special situation, some other no less important factors are worth considering.

Inasmuch as the goal sought is the eradication of malaria, the problem is concentrated for the moment on the 64 million remaining inhabitants who are still subject to the disease. Of these inhabitants, the Pan American Sanitary Bureau estimates that close to 6 million are living

in so-called "problem areas", that is, areas in which it has been established that the application of DDT or dieldrin is not by itself enough to eradicate malaria.

In order to achieve the objective in such areas it will be necessary to employ larger financial resources in order to apply supplementary control methods such as peridomiciliary fogging, mass medication, and antilarval campaigns, according to conditions in the individual area. Where the population is concentrated, and the breeding grounds of the Anopheline mosquitoes are limited, antilarval efforts can be successful at a relatively low cost. Where the population is scattered, or where there are many and extensive breeding grounds, mass medication of the inhabitants will be more efficient.

At the present time, to produce satisfactory results in mass medication the antimalarial drugs must be administered orally at short intervals. If the rate of transmission is high, this interval should be of not more than two weeks, which will require a large number of distributors of the drugs. This cost can be reduced in the future if new drugs having prolonged residual action are discovered.

For the problem areas in which there is no extradomiciliary transmission and the vector is resistant to DDT and dieldrin, new insecticides can be applied. Organo-phosphorus and carbamate compounds are already available commercially. However, these insecticides are expensive and must be applied at least three times a year.

When the habits of the vector require it, it is advisable to spray houses to a level above ten feet, including ceilings, and other related structures.

The priority needed for the campaign is not limited to the financial sector. In order to have a chance of success, the campaign must be well planned, adequately financed, well administered, and directed by competent professional personnel. Failure to meet any of these four conditions may endanger the possibility of attaining the goal agreed upon.

It is also essential for the administration of the campaign to be protected against interference from outside interests. The appointment of incompetent personnel will be fatally reflected in the discipline prevailing at all levels. The campaigns that have been most successful so far are those in which the director has authority to select and manage personnel in accordance with specially prepared regulations in which the minimum qualifications required for each duty are clearly established.

It has likewise been observed that when the directors of the campaign share the administration with a national council under the chairmanship of the minister of health and including representatives of the national and international authorities directly interested in the matter, the problems that arise are solved more quickly and suitably. The council helps the director perform his duties, always maintains a high standard of efficiency and conduct, should have authority to approve the annual budget, and is responsible, jointly with the director, for the coordination of the campaign with the other departments of the government

and the existing medical care institutions. To attain these objectives, the council should meet at regular intervals.

An attack to interrupt transmission of a disease must be continous and progressively increasing. Every malaria eradication campaign must be accompanied by epidemiological investigations that will make it possible to assess the variations or changes that are occuring in the ecology of the disease as advances are made in the plans of attack. One important condition that should be carefully investigated after the first spraying of the houses with any residual-action insecticide is the speed with which the transmission of malaria is reduced. Once the reasons for delay in such reduction are known, proper supplementary measures must be applied. These measures, however, must not be at the expense of the evaluation operations, which are as important as those of attack.

Unfortunately, it has been observed that the epidemiological studies made in the malaria eradication campaigns now under way have not always been adequate because of the lack of a sufficient number of competent personnel. It is therefore considered advisable that additional efforts be made to increase the number of epidemiologists and other auxiliary technicians, taking care to improve the quality of their biological and scientific training.

The evaluation operations will be less costly in proportion as cooperation is increased between existing public and private medical care services in case-finding activities, reinforced by a network of volunteer

workers. Unfortunately, medical care for the rural population in Latin America is rather poor, especially in malarious areas, which makes it necessary for the campaigns to support a large number of employees to detect cases.

As one of the principal objectives of the Charter of Punta del Este is "to encourage ... programs of ... agrarian reform ... so that the land will become for the man who works it the basis of his economic stability, the foundation of his increasing welfare, and the guarantee of his freedom and dignity," it is to be hoped that governments will give priority to the extension of their health services to the rural areas which, at such great financial expense, have been or will be liberated from malaria.

This care can be begun by utilizing the same auxiliary malaria evaluation personnel to provide other simple but essential health benefits to the rural population .

The immediate, crucial problem in our Hemisphere is still the financing of local costs. As yet the credit institutions have maintained a certain reserve, even those that have been created to assist in the economic development of the most impoverished nations.

For their part the governments consider that if they are to maintain a balance between all the responsibilities incumbent on them,

they cannot possibly increase the allocations for the malaria eradication campaigns above their current level.

One solution would consist in mutual assistance; the governments of the countries that have had the most success in eradicating malaria from their territories-- or have reached a very advanced stage in such eradication-- might give economic and technical assistance to their less favored neighbors.

Inasmuch as malaria eradication is a continent-wide program, its objective can be considered reached only when no more indigenous cases of the disease occur in the entire Region of the Americas, including North, Middle, and South America. The presence of autochthonous malaria in any country constitutes a threat to all the countries that have achieved eradication of the disease from their territory. Under the circumstances, it is of interest to the Hemisphere for each Government to assign the highest priority to this program, not only for its own benefit but for the benefit of the other countries as well.

Because of the fact that in a large part of the malarious areas this disease is a predominant factor in general mortality, and particularly in the deaths of children under five years of age, it is clear that in those areas the first priority for attaining the objectives of the Ten-Year Public Health Program adopted along with the Charter of Punta del Este belongs to malaria eradication.

Border coordination should be increased in some countries and if participation of the Pan American Sanitary Bureau staff is considered desirable for this purpose, it should be requested. Such coordination seems more essential for certain groups of countries, as in the case of the Central American countries.

The budgetary allocation available in some countries at present are not sufficient to cover the expenditures needed for the malaria eradication campaign, but since the disappearance of malaria brings with it economic improvement of the area, it is felt that a country may request foreign aid when it needs it, in the form of loans to help it meet its needs in this field. For this reason it is suggested that approaches be made to the credit agencies to urge them to grant loans of this sort.

A.2 Tuberculosis Control

The lack of complete and reliable information in most of the countries makes it impossible to determine satisfactorily the prevalence and incidence of tuberculosis in the Americas.

Document TFH/11 includes tuberculosis morbidity and mortality statistics obtained from the Governments of the Hemisphere for the period 1956-1960. Deaths from this cause in 17 Latin American countries averaged 34,000 a year during that period. Taking as a basis the data from certain countries that have "registration areas", it can be estimated that the number of deaths from tuberculosis each year was at least 54,000. The death rate declined in only 7 of these countries during the five-year period; it remained the same in 8, and increased in 2. The number of cases notified each year during the same period averaged 107,000. On the basis of the same "registration areas", it can be estimated that there were at least 270,000 new cases per year. The number of cases notified each year increased in 9 countries; remained broadly the same in 6; and decreased in 3.

When there is a good case-finding program, it is possible to trace up to 11 cases for each death during a year, which would produce an estimate of some 600,000 cases.

Even within the limitation of the available statistical information, it can be said, as the Charter of Punta del Este indicates, that tuberculosis continues to be an important problem in Latin America, because

of the harm it causes to the population and because the lack of services necessary for applying the already proven techniques to all persons suffering from the disease.

Thanks to the rapid advance in scientific knowledge in recent years, specific means have now become available for combatting tuberculosis. Notwithstanding their intrinsic limitations they are sufficiently effective to make a substantial contribution to the solution of the problem. The difficulty arises when these procedures have to be put into practice.

At present tuberculosis can be regarded as a communicable disease that can be brought under control by using the specific means available and by methods that, generally speaking, are applicable to the control of highly prevalent, protracted diseases. Existing and potential sources of infection must be found, the tuberculosis cases must be found and rendered noninfectious, the follow-up of patients must be organized, and secondary chemoprophylaxis and BCG vaccination must be administered.

In practice, this means a program of case-finding and treatment and of vaccination and chemoprophylaxis. Case-finding must be based on the simplest diagnostic methods now available: miniature X-ray examinations, sputum examinations, and tuberculin tests. For treatment to be economically feasible it must be based on ambulatory or domiciliary chemotherapy.

It should be kept in mind at all times that the aim of tuberculosis control is to reduce the spread of the disease in the community and

ultimately in the whole population, and, therefore, insistence should be laid on the use of standardized objectives and the cheapest possible diagnostic and treatment methods, although they are undoubtedly not so satisfactory as the best and most elaborate that are now available. Should other more effective means not be available, sputum examinations are recommended for the discovery and treatment of cases.

Antituberculosis activities should be programmed in a continuing and long-term manner, and consequently should have the benefit of permanent services. Moreover, since tuberculosis is one of many problems that affect a community and since many of the activities undertaken to combat it are the same as or similar to other health activities, the antituberculosis services (whatever their level of development) must be integrated within the existing public health agencies and services, including those for medical care.

While it is not possible to establish general guidelines or outlines for the progressive application of this concept, it is emphasized that it must be applied in each country as an effective way of carrying out continuing and long-term work, through permanent services established in the community.

In summary, 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.

A.3 Smallpox Eradication

Despite the excellent results obtained by the various countries which have achieved eradication, or are in the process of gradually reducing the incidence of smallpox, the disease continues to be a serious public health problem in the Continent, as is shown by the fact that it is present in several countries and a considerable number of cases occur each year.

Between 1947 and 1962 the countries and territories of the Americas reported 168,957 cases of smallpox, as shown in Table 1 of Document TFH/11 (page 23).

As national smallpox vaccination campaigns were carried out, the disease disappeared or was rapidly reduced in areas where it was formerly prevalent; it now remains only in the countries that have not yet begun their eradication programs or in which such programs have been either interrupted or not carried out rigorously enough.

Table 1 of the above-mentioned document shows the situation in 1962. At the present time Brazil and Ecuador are the two most important foci in the Americas. Since in many of those areas the number of vaccinations given is low, most of the population is susceptible to the disease.

The resounding success achieved by most of the countries of the Americas in eradicating smallpox is endangered as long as foci of this disease persist in the Continent. For their own protection, those countries

which have no smallpox must continue to maintain a high level of immunity by means of regular smallpox vaccination programs covering annually a fifth of their population. The high costs of this measure can be reduced only when smallpox eradication has become continent-wide.

The hemisphere-wide eradication of smallpox requires the joint efforts of all interested countries, both for the protection of their population and for the protection of those countries that have already adopted the necesary measures to eradicate the disease.

In numerous resolutions, the Governing Bodies of both WHO and PAHO have voiced their concern over and interest in the smallpox problem in the Americas and have recommended that the countries that have not yet eliminated the disease should accelerate or initiate eradication programs, as the case may be.

The delays in carrying out these recommendations are due to both financial and administrative difficulties. It is to be hoped that the Governments will make every effort to overcome these difficulties and to give the smallpox eradication program the importance and priority it deserves from the point of view of national and of international health.

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.

A.4 Chagas' Disease

Recent investigations on Chagas' disease [1/] have shown its great clinical and epidemiological importance, which justifies its inclusion in the health plans of the countries in which it is prevalent. The disease may affect the fetus, and especially afflicts infants under five. It also causes important cardiac and gastro-enteric pathologic changes in adults.

The problem arises from the poor quality of rural housing in areas where Chagas' disease is endemic, and from the population's ignorance of the part played by the vector in transmitting the disease. On the other hand, only exceptionally have the national plans for new construction or renovation of housing been extended to rural areas in Latin America.

Undoubtedly, the renovation of dwellings brings about a radical change in the ecology of the vectors and reduces their density. Nonetheless, stress should be laid on the urgency of expanding and intensifying the use of insecticides, because of the immediate results that can be obtained in applying them.

It also appears to be highly advisable for health education programs to be urgently carried out with a view to getting the population to cooperate in the campaign against the Triatoma.

1/ Document TFH/3, page 83

A.5 Nutrition

Today in Latin America it is estimated that more than one half of the population is suffering from malnutrition to a greater or losser degree. Malnutrition exists in many forms; however, our principal interests are protein-caloric malnutrition, endemic goiter, anemias, and certain specific vitamin deficiencies.

This situation is in part due to insufficient or misdirected agricultural production, a failure to apply modern methods of technology to food storage and distribution, low purchasing power of the individual, widespread ignorance of good dietary practices, and the presence of certain other endemic and enzootic diseases.

With regard to food supply, production in Latin America has risen steadily during the last two decades by a total of 69 per cent. However, population increases have been so rapid that per capita food production is now 1 per cent below pre-World War II levels, which in themselves were considered unsatisfactory.

Population growth continues rapidly and it has been estimated that the world's population will double itself by the year 2,000. Considerable increases in agricultural production will have to be achieved, therefore, even to maintain the "status quo". Actually to improve the existing and future nutrition of the population will require even greater efforts.

Food production per se, however, will not improve the nutritional status of the population. The type of food produced is of considerable

importance and also its destination in terms of individual use and national economic planning. Food production should be oriented to supply all or most of the needs in terms of quality and quantity, and economic policy should aim to satisfy national food needs rather than to export essential food items.

One of the principal nutrition deficiencies in Latin America is that of protein. Today, many new sources of this nutrient have been developed such as fish, cotton-seed, peanut, and soy bean flow, which can to a great extent replace traditional animal proteins. To date, however, there has been little mass production and development of these sources and, consequently, they have not contributed significantly to the eradication of severe protein malnutrition.

In terms of development of sources of animal proteins, foot and mouth disease and hydatidosis diminish considerably the productivity of cattle herds. It is estimated that, with the control of these diseases alone, live stock production would be increased by more than 25 per cent.

Every year considerable losses of crops and stored foods due to rodent and insect damage further diminish the supply of available foodstuffs.

In the field of health, malnutrition contributes greatly to existing problems, especially in the so-called nutritionally vulnerable groups of pregnant and lactating mothers and pre-school children. The age specific death rate in the 1-4 year group is a good indicator of nutritional status

in the population. Today in Latin America there are many areas where the moratlity rate in this group is 30 times higher than in well-nourished populations, while specific death rates from such diseases as measles and diarrheal disease are 100 to 200 times greater. In terms of health services, the high cost of hospitalization of severely malnourished children represents a considerable burden on the local health services budget. Malnutrition has been shown to cause considerable retardation in the physical and mental development of the child. This situation results in poor physique and low intelligence levels in the adult, which in turn have serious repercussions on the economic development of a country.

Widespread specific deficiencies of iodine and iron cause high morbidity rates from endemic goiter and anemia. Certain specific vitamin deficiencies also contribute to lower resistence of the individual to common infectious diseases. By means of such simple procedures as iodization of salt and cereal enrichment, much can be done to rectify the situation. However, few countries in this hemisphere have so far adopted such measures.

Food distribution programs are now widespread and serve to alleviate the existing food shortages. However, these cannot be regarded as a permanent or complete solution to the problem. Education in all aspects of food and nutrition science is the only effective and lasting means

of combating widespread malnutrition. At present there is a great lack of intermediate level specialists in nutrition to carry out such work. It has been estimated that approximately 2,000 non-medical nutritionists will have to be trained during the next five years in order to satisfy current needs.

A.6 Environmental Sanitation

The Charter of Punta del Este provides that potable water and sewage disposal shall be supplied for at least 70 per cent of the urban and 50 per cent of the rural population during the present decade. Recent studies indicate that 41 million inhabitants in urban areas lack water in their homes, and that this deficiency is even greater with regard to sewerage. Figures with regard to rural areas are very incomplete. It has been estimated, however, that about 70 per cent of the population which lives in communities of from 2,000 to 10,000 inhabitants lacks potable water. These data, along with the natural increase of the population, reveal that, in the decade from 1961 to 1971, it will be necessary to install water and sewerage services for at least 44 million inhabitants in the urban area, and 58 million who will live in the rural areas.

Besides the inherent economic losses, it is urgent to improve this situation because of the importance of water for industrial and agricultural development. This is even more important if one considers the high rate of infant mortality, and of those under 5 years of age, as well as the morbidity from enteric infections, which are due to the contamination of water, of the soil, and of products in general. While it is estimated that water services have been installed for over 25 million inhabitants in the last decade, the rate of construction of new services and of expansion of existing services has been very low in relation to the demographic increase.

There are very marked differences in the extent and effectiveness of the water and sewerage services in the various Latin American countries. In general, they have been established in the central areas of the most important cities, and the highest income groups are the principal ones who benefit from them. Furthermore, the services are deteriorating rapidly since the equipment has been used beyond its normal capacity.

In the opinion of the Advisory Committee on Environmental Sanitation of the Pan American Sanitary Bureau (Document TFH/2), the goal established for the supply of water in urban areas in the Charter of Punta del Este is a realistic one and can be attained or surpassed in most of the countries.

The effort of governments and of the inhabitants during the past two years is worthy of high praise, as is the interest of international credit organizations, particularly the Inter-American Development Bank, in financing water services. Recent reports from the Bank show that since the beginning of its operations it has approved loans for 157 million dollars, which along with a similar amount from domestic resources will benefit about 15 million persons in 12 Latin American countries. In addition to good organization and business administration, due importance must be given to water rates in order to assure the maintenance and expansion of services, as well as the amortization of capital and interest. Experience shows that the urban communities of the Continent are ready and willing to contribute reasonable amounts in order to obtain an element which is vital for them.

These developments are a part of the policy established by the Governments of the Americas in the World Health Organization and the Pan American Health Organization and represent the standard which must be applied during this decade in order to carry out the objectives of the Charter.

With regard to rural areas, the above-mentioned Advisory Committee of the Pan American Sanitary Bureau considers that it is possible to make potable water accessible to 50 per cent of the rural population. If the population is concentrated, measures should be taken to make water available in homes. The cooperation and participation of the community is basic and, if well motivated, it may lend its own efforts or even funds for carrying out projects. Basic capital, a real welfare fund, is needed, however, if it is desired to carry out the above-mentioned objective of the Charter. This fund may be financed by the Governments of the Continent, including contributions from the Alliance for Progress. Governments might obtain credits, which they would, in turn, lend to organized communities for the purpose of carrying out sanitation works in the first place, and then other projects aimed at improving living conditions in the rural areas. Through a reasonable installment system it might be possible to recover a high proportion of the capital outlay, which could then be loaned to other communities as if it were a revolving fund. The Pan American Sanitary Bureau might be entrusted with the study of this proposal and the means for carrying it out, following consultation with the interested Governments.

In view of the magnitude of the problems of urban sanitation and the responsibilities which have been acquired by institutions organized for this purpose, it is felt that the ministries of health must have the responsibility for the planning, construction, and maintenance of projects in the rural areas when the necessary financing is forthcoming. On the other hand, they must maintain the right to supervise the sanitary conditions of all the water and sewerage systems, as well as to approve plans for new installations before construction is begun. To this end, Governments should strengthen their environmental sanitation departments not only by adding the necessary personnel but by strengthening the position of the department within the ministry, its budget, and its responsibilities.

Recent possibilities of speeding up the supply of water in the Continent have given particular urgency to the training of sanitary engineers and auxiliary personnel. Their present number is less than the requirements for the programs which have been financed. Particular attention must be given to this problem if it is desired to fulfill the sanitation objectives in the Charter of Punta del Este. In civil engineering courses the teaching of basic notions of sanitary engineering should also be strengthened, as it should in courses for other professionals, such as those concerned with housing construction.

It is estimated that more than half of the population of Latin America is living in insanitary housing. The ministries of health must take a more active part in the sanitation aspects of housing projects. For this purpose a closer coordination between the responsible

State organizations is needed. The rapid industrialization of many areas is creating problems of occupational health, as well as of air and water pollution. Where these problems are given priority in the health plans, it will be essential to deal with them in accordance with existing knowledge.

One measure that can help to solve the problems created by industrialization is decentralization. In fact, it is believed that if industries were to be transferred to rural areas, not only would the amount of investments needed for water supply and sewerage systems be reduced, but new incentives for developing the rural areas would be created.

B. GENERAL MEASURES

B.1 National Planning for Health

The Charter of Punta del Este recognizes that in order to achieve the objectives of the Alliance for Progress it is necessary to prepare national programs of economic and social development. These plans should incorporate the countries' efforts towards the improvement of human resources and the widening of opportunities through raising levels of health and education, improving and expanding technical training and education.

The Ten-Year Public Health Program contained in Resolution A.2 of the Charter recommends the preparation of national plans among the long-term measures for the prevention of disease and promotion of health.

This will require taking a series of steps forming a continuing process that begins with the formulation of a general health policy within the framework of a national development plan. This general formulation should be followed by a study of the problem and their quantification, an analysis of the physical and human resources available, assignment of priorities, establishment of goals, selection of the most suitable techniques, and development of methods of reporting and evaluation for the purpose of periodically readjusting the objectives to conform to experience.

Statistics of most Latin American countries are incomplete, so that existing plans have been but a statement of policy with regard to specific problems. As problems become better known, it will be possible to formulate precise goals referring specifically to regional or local needs. National

plans will, in the end, be expressions of intent with regard to health in a specific period. In this way it will be possible to define the objectives of the plan more precisely. For this reason, it is said, that a national health plan is a means, an instrument, part of a continuous process, in which the original proposals are improved as experience accumulates, and performance is evaluated.

There is therefore ample justification for establishing planning and evaluation units at the level of the Ministries of Health, as recommended in Resolution A.2 of the Charter of Punta del Este. These units should be staffed with experts especially trained in planning. It is also essential for the Ministries of Health to be represented on national boards or agencies responsible for planning economic and social development, in order to ensure coordination.

The methodology of preparing plans and programs should be known to the largest possible number of health experts. Training in this field is particularly urgent. It is therefore recommended that such training be intensified. The courses begun by the Latin American Institute of Economic and Social Planning in cooperation with PASB, and at certain universities of the continent, are very useful. Experts so trained should organize planning units within the ministries, and guide those responsible for regional and local health agencies in the techniques of planning.

Without a suitable statistical basis it will be difficult to improve the process of planning. This is the reason for a recommendation to the Governments "to improve the compilation and analysis of vital and health statistics as a basis for formulating and evaluating national health plans".

In spite of training programs in statistics and the progress made in some countries, there still exist serious deficiencies in the quality and quantity of data. For this reason, knowledge of health problems is incomplete. Only 14 Latin American countries took censuses in 1960; 7 are making preparations to do so in 1963; and one country has not as yet reported its plans. The absence of data from recent censuses makes the analysis of health problems extremely difficult. Systems of birth and death registration are often inadequate in both quality and coverage. The same applies to statistics on health services and basic data for programing at all levels of health organization. Moreover, statistical services are not always located at a suitable administrative level in the Ministries of Health.

One of the objectives of the Charter is to increase life expectancy at birth by at least five years during the decade. To measure progress toward this end, it is essential to construct life-tables; only those countries which have had a recent census and keep suitable death records will be able to do so. It is recommended that "registration areas" be established in each country, in which it will be possible to compile and analyze vital and health statistics. These data will permit more precise formulation of national plans and the determination of life expectancy. Such demonstration areas may be progressively extended throughout the country as statistical experts are trained and local health organization improves.

It has been pointed out that, according to the spirit and the letter of the Charter of Punta del Este, health is an essential component of

national development, and that health programs should be incorporated into economic and social plans for each country. It is therefore necessary to achieve close coordination between experts in the various sectors, in order to assign resources so as to attain the greatest social progress. The methodology of planning, however, still needs a lot of research and analysis, especially for establishing priorities for each locality and region, which will make it possible to distribute resources within each social sector.

The collaboration of international agencies has proved useful in this field, both in the training of experts and in advisory services to Governments preparing plans. It is recommended that coordination among the several international agencies be improved. It is also suggested that joint missions requested by governments should include health experts.

Resolution A.2 of the Charter of Punta del Este recommends:

> "To adopt legal and institutional measures to ensure compliance with the principles and standards of individual and collective medicine for the execution of projects of industrialization, urbanization, housing, rural development, education, tourism, and others."

This proposal points to the responsibility of Ministries of Health in all projects undertaken by countries to promote economic growth and social welfare. Health programs have not always been included in projects mentioned in this recommendation.

Good organization and administration of services is basic to every health program and, therefore, to the fulfillment of the objectives of the Alliance for Progress. It is essential to create an administrative conscience, a true motivation for obtaining better results at lesser cost. Public administration is therefore a basic function at the service of the technical field. Regrettably, in the health ministries in Latin America, public administration is often inadequate to meet the complex operations of the various institutions. This explains why the personnel and knowledge available is not always effectively used.

It is therefore necessary to improve the administrative systems being used by applying known scientific principles. Special attention should be given to structure, finance, budget, personnel, purchasing, and operation and maintenance of buildings and installations.

It will further be necessary to train administrative personnel. Senior administrators require university preparation: other categories can be given in-service training. Health administrators must apply the principles of administration and be able to delegate responsibility, along with the authority to exercise it.

B.2 Improvement of Health Services

The American Republics, in adopting the program of action to establish and carry forward the Alliance for Progress, agreed on certain goals for the present decade, among them "to improve basic health services at national and local levels" (Title I, paragraph 8, Charter of Punta del Este).

In the Ten-Year Public Health Program of the Alliance, it was recommended that the Governments, among other measures:

> "Improve the organization and administration of national and local health services by combining the functions of prevention and cure; to obtain a better return from medical care services; to create the necessary services gradually; and to ensure financial accessibility to therapeutic agents and means for the prevention of diseases" (Resolution A.2, paragraph 1-e).

Among the measures to take immediate effect, the same resolution recommended that the Governments:

> "Take measures for giving increasingly better medical care to a larger number of patients, by improving the organization and administration of hospitals and other centers for the care and protection of health."

These goals reflect the importance attributed by the signers of the Charter of Punta del Este to the need for viewing the prevention of disease and restoration of health as a continuous process, harmoniously planned, and carried out on a coordinated basis, to produce the greatest results in terms of efficiency and scope of action.

The documents compiled by the PASB Secretariat include the Final Report of the Advisory Group on Medical Care, convened by the Director of the Bureau in May 1962, and the working documents and report of the Technical Discussions at the XVI Pan American Sanitary Conference, held in Minneapolis, Minnesota, in August-September of the same year. These documents reflect the same purpose, and the fact reinforces and reiterates the aspirations of those who conceived the Alliance for Progress and established its goals and guidelines for action.

The doctrine of integration admits of no separation between prevention and cure. Among the social functions of medicine, it points to those that are carried out in the community, including the services brought to bear to protect, promote, and restore health. This concept implies that there is a mutual dependence between individual and collective medicine. Both tend to sustain the individual in the best state of health.

It can be said that the impact expected form the services furnished to increase the level of community health depends fundamentally on three different, but interdependent factors: the program, the coverage, and the resources.

Modern research techniques have, in the past few years, greatly increased our knowledge of ways and means of preventing disease and restoring and improving man's level of health. Unfortunately, the utilization of this knowledge to the degree necessary to obtain the desired results encounters serious obstacles because the practical application is costly and complex.

Moral, political, and economic reasons make it necessary for the State to concern itself with the well-being of the population in general as well as with that of certain specific groups in particular, and thus to participate in the planning for, and distribution of, services for the prevention of diseases and the promotion and restoration of health.

In vast areas in the Americas it has been observed that the number of beneficiaries of both preventive and curative services represents but a portion of the population, frequently a much lower proportion than is necessary or desirable.

On the other hand, in light of the demands of other sectors, it may not be possible to obtain the optimum assignment of human and financial resources which are needed in the health sector to increase both the geographic coverage and the totality of program of activities required to achieve health levels comparable to those of countries with conditions different from those in Latin America.

A judicious selection of the measures and procedures, which are most highly productive in terms of decreasing morbidity and mortality,

will permit the formulation of a program ensuring a progressively increasing coverage and maximum utilization of both present resources and those which it is hoped may later become available.

A critical study of present programs may well reveal the advisability of modification of projects in operation so as to correct, limit, and even interrupt those that are not in keeping with the health priorities of a country or region.

An inventory of human and material resources available might serve as a basis for a redistribution of responsibilities aimed at obtaining better utilization of these resources. Particular attention should be given to the present network of restorative service, especially hospitals, the benefit of which could be greatly expanded if they were to furnish community services through out-patient departments and if their programs of action was modified to provide preventive services to both individuals and families. The advantages which might be expected from effective coordination or, better still, integration of preventive and curative services furnished by the State and, at least, from the establishment of a harmonious and cooperative relationship with other institutions that furnish medical care to the community or to a part of it, are self evident. The establishment of the basis for formal coordination would require the revision of the pertinent laws and regulations and possibly the enactment of legislation.

Experience has shown that the best, least expensive, and most effective results are obtained when preventive and curative services are organized at three levels at least --national, regional, and local-- each under a single direction and incorporating medical care as a part of basic health services.

It is very probable that the revision of priority criteria and the consequent change in the content of the health program will indicate the advisibility of reorganizing the present administrative machinery as well as of introducing modifications into the organizational structure of the ministries so as to ensure the implementation of highest priority activities. On the other hand, the campaigns for the solution of certain health problems have produced or are about to produce results. The responsibility for the maintenance of the gains of the special campaigns should be primarily transferred to the general network of health services. The assimilation of these new activities, resulting from special campaigns against tuberculosis, smallpox, yaws, and malaria, make it necessary to plan the extension and enlargement of these local health service programs to absorb the increased responsibilities.

Although very justifiable, the idea of full-time employment of health service personnel has not been applied as is required by the functions of certain professional groups. A careful study of the training received by the technical staff of each country and the actual utilization of their services might serve as a criterion for the assignment of functions and the selection of posts that should be full-time and therefore enjoy corresponding remuneration. Moreover, with a view to economizing time and effort of personnel it is desirable to revise the curriculum of local training courses for staff so as to adjust their content and duration more closely to the needs of the services for which they are intended.

Worthy of mention are the serious disadvantages that have been evident when the expansion of the health services network --particularly hospitals-- is not done gradually and progressively over the reasonable period required to permit implementation with personnel and operational budget. The huge investment in the construction and equipping of these services is not very productive unless they are used to their maximum capacity.

Once more it has been recognized that adequate statistical information with particular attention to data on resources, services, and results of programs and services are essential.

There is evidence that the administrative machinery in many of the Ministries of Health in the Americas is inadequate to support the large and complex operation, and to utilize existing resources effectively. The need for better administration and management is declared at several points in the Charter of Punta del Este and stands as an imperative.

In order to obtain maximum efficiency of operations, systems of administration must be adopted to provide for orderly planning, budgeting, allotment, and allocation of funds; career service conditions, full-time service, with recruitment and promotion based on merit; full utilization of personnel trained at public expense; and provision of supporting services required for the effective utilization of technical and professional staff.

The principles of scientific management should be applied in the administration of health services, with particular attention to organizational structure, finance and budget procedures, personnel policies, procurement and supply functions, and the efficient operation and maintenance of buildings and installations.

It is necessary to establish close cooperation between technical and administrative personnel at all levels. In view of the scarcity of well-trained professional personnel it is necessary to organize work so as to obtain the greatest yield from professional skills. Adequate programming will make it possible to obtain the maximum yield from professionals and auxiliaries. It is thus desirable to review, the techniques of in-service training and of education at all levels.

Above all it is indispensable to create an administrative conscience and a sense of responsibility in all officials, in keeping with the right purpose of the health services.

B.3 Education and Training

Resolution A.2 calls for action necessary to increase the numbers and quality of the health manpower required to permit achievement of the goals of the Charter of Punta del Este in the following terms:

> "d. To give particular importance to the education and training of professional and auxiliary personnel to engage in activities related to the prevention and cure of diseases. To this end it will be necessary:
>
> (1) To determine the number of experts required in the various categories for each activity or profession;
>
> (2) To provide in-service training to present staff members, and progressively train a minimum number of additional personnel; and
>
> (3) To expand or create the necessary educational centers."

Most Latin American countries currently do not have sufficient personnel available to provide medical and health services to their people. There is a deficiency in quantity, and particularly in over-all technical preparation.

Educational opportunities must be improved and increased in order to provide personnel for public health services. Professional health workers will emerge principally from the ranks of those who enroll in schools of higher education to prepare for a career in one of the health

specialities. The number of persons with secondary education must be increased, and better opportunities for university studies must be made available. At the same time, it is necessary to augment the number of auxiliary health workers, who require less extensive academic education, especially in the fields of nursing and environmental sanitation. Measures for their training and supervision are also part of the necessary planning to meet health personnel needs.

In the case of physicians and others, faulty utilization of personnel is due principally to poor distribution. For example, in Latin America there is one physician for every 2,000 persons. Relatively speaking this is not an unfavorable figure. However, their concentration in the cities leaves a ratio in the rural areas that is far from desirable. Each year some 8,000 physicians are graduated, and are more and more absorbed into municipal health services. The discrepancy between the type of training they are given and the training they require must be reduced to a minimum. The physician's training should stress the relationship of health and disease to the structure and the organization of the community. This involves the essential principles of health administration in addition to the usual training in basic and clinical sciences.

Graduate nurses in Latin America are scarce due to lack of certain elements for the recruitment of candidates. Important among these are secondary education for women and facilities for professional training. Salaries often are not equal to those earned by women in other professions for which the same number of years of training is required.

Graduate nurses currently in service are in the approximate proportion of one per 5,000 population, which does not permit the proper development of necessary nursing services or adequate supervision of auxiliary nursing personnel.

Surveys made in several countries on nursing resources have shown that at least 50 per cent of nursing services are provided by auxiliary personnel who have received no formal training and are under no medical or nursing supervision. In the rural areas of many countries, auxiliary nursing personnel without formal training are frequently in attendance at activities traditionally carried out by physicians, such as attendance at childbirth, minor surgery, or others, with consequent greater risks.

It is therefore necessary to increase to the greatest extent possible the number of trained nurses who have special instruction in the techniques and methods of training and supervision of auxiliaries, and in health education, without extending the training to longer than three years.

In the field of environmental sanitation, it is estimated that there are 2,000 sanitary engineers in Latin America, or one for each 100,000 persons. Currently about 100 sanitary engineers are graduated each year in Latin America, and more are needed to develop environmental sanitation programs. Civil engineers and other professionals taking part in these programs should be taught the basic principles of sanitation and health education.

The programs of water supply for urban and rural areas and the development of other environmental health services now require a better utilization of the services of professionals, and, from the long-range point of view, additional numbers of such professionals.

As for sanitary inspectors, of whom there are currently one for each 25,000 persons, the basic educational requirements have not always been met. Training in the methods and techniques of teaching and supervision could enhance the value of those who receive formal training, and would increase the potential capacities of the auxiliary health workers.

Dentists and veterinarians in Latin America exist in the ratio of one per 5,000 and one per 50,000 respectively. These figures do not represent absolute numbers, and the large urban areas absorb an excessive proportion of these professionals.

The figures relating to sub-professional personnel in general are even less favorable, and the needs in supervision are greater. Consideration should be given to the need for a good secondary educational background for health inspectors, nursing auxiliaries, statisticians, etc.

A close relationship and collaboration between public health university, and basic education institutions could solve some of the current problems. Collaboration between professional schools and ministries of health, which are the "consumers" of the product of those schools, with a view to improving that product will be an essential step in the development of health programs.

Constant contact between government agencies responsible for health, basic education, higher education is a requisite for planning for the human resources needed to improve health in the Americas.

Since the physician assumes an executive role in the program and is in charge of guiding the other professional workers in the health team, there is a need for the Ministries of Health to collaborate more closely with programs for the training of physicians in Latin America.

The training of physicians should be conceived as a systematic process directed toward specific objectives, an inseparable part of any health program, and therefore the object of careful planning. It therefore seems advisable for a careful review to be made of the present medical education programs. This review, and the planning of the future activities of these educational centers, should be made jointly by those who are responsible for planning medical education, in close collaboration with representatives of the institutions providing medical and health care in the countries. When necessary, the advice of national or international agencies with experience in the field should be sought.

This planning group would be responsible for drafting short-term or long-term plans; for determining the most pressing needs and available resources; and for indicating priorities. The training of physicians cannot be disassociated from the "medical demand" of the population, from resources for training physicians, nor from maintenance of services in accordance with current knowledge. The planning group should analyze aspects affecting productivity and output, working conditions, and the

degree of satisfaction physicians obtain from their work. Attitudes of para-medical personnel, the ratio of physicians to para-medical personnel and the organization of agencies responsible for health care should also receive attention. Nor can the attitude of the population toward sickness and health, and its behavioral response to medical services, be overlooked.

It is often supposed that a higher physician/population ratio means better medical care. This is not necessarily the case, since the utilization of health services depends also upon social and economic factors. In fact there is no evidence that an increase in the number of physicians in proportion to population, beyond a certain limit, will be reflected in a lowering of the mortality or morbidity rates of a community, or even in better health.

The number of physicians required to care for a population varies according to the burden represented by disease, the organization of medical care services, the number of nurses and auxiliary personnel available, and the varied social and economic factors that influence the utilization of physicians' services.

It is not possible, at present, to suggest the establishment of a single uniform ratio applicable to all countries. Therefore, it is urgently necessary to determine the number of professional medical personnel essential for each individual country. Use continues to be made of ratios derived from countries that have a different culture, different ways of life, different political and administrative structures, and that have

already reached a stage of consolidated economic development, unlike most of the Latin American countries. The quality of resources should be taken into account, as well as the relative urgency of medical and social problems. The solution of this problem requires a careful analysis of the medical resources of each country and of the trends and magnitude of the medical demands of the population. Due attention should also be paid to the productivity and output of the physicians, which in the final analysis is the point of greatest interest.

The development of medical education is considered to be essential to the success of programs for the protection, promotion, and restoration of health at the local level, as well as in national health plans. This aspect takes on special importance with the new efforts the Hemisphere is making to accelerate economic and social development.

Indeed, in addition to professional and technical work, the physician accepts the role of leader, teacher, and guide for other professionals, and of administrative personnel. The physician's position is one of great responsibility, not only because of his mission but also because of the resources entrusted to the technical group which he heads.

Without sufficient competent physicians, no health program can be successful; therefore, ministries of health and their components responsible for carrying out programs should take an interest and collaborate in the basic and advanced training of physicians. For this purpose it would be highly desirable for closer relations to be established between

the ministries of health and medical schools. Ministries of health are urged to give their moral support to medical schools and, when possible, financial assistance essential for strengthening their services and their educational programs. Such cooperative efforts could assist the agencies responsible for health care to meet their responsibilities to provide medical care to the population. In addition, medical schools make a powerful contribution to the improvement of health conditions through their programs of scientific research.

In order to facilitate plans for the expansion of medical education, Ministries of Health are urged to make all the resources under their supervision available to medical schools. This includes hospitals and health centers, which may serve as models because of the high quality of care they provide and their influence on the communities they serve.

The Ministries of Health should also make available duly selected urban and rural health services in which to provide students, interns, and residents with practical experience. This should be gained under the constant supervision of the professional staff of the institution and the teaching staff. Requiring that students face up to the real health situation in the rural areas, would help to intensify their sense of responsibility and give them a broader view of medicine. It would also provide them with incentives, once they graduate, to practice their profesion in such areas. This could help to bring about a better distribution of physicians.

B.4 Research

Resolution A.2 emphasizes the contribution that research can make to the health of the individual and community in the following terms:

> "g. To make the best possible use of knowledge obtained through scientific research for the prevention and treatment of diseases."

Any systematic program for health progress in the Alliance for Progress must rely heavily on improved knowledge of the life sciences, and medical, engineering, and social research is needed to provide the necessary knowledge.

Basic fields of inquiry are the causes, treatment, and control of disease, the application of known principles and methods of control of environmental conditions relating to health, and the adaptation of existing knowledge of the provision of medical care within the socio-economic context of different countries, regions, and localities.

The intensification and expansion of research in these fields depends on skilled professional and sub-professional manpower, which is in short supply in all fields of research in the life sciences in the Americas. The overriding necessity, therefore, is to mobilize available scientific manpower for research within the framework of health development in general and to accelerate research training programs for promising professional personnel to meet future needs. Each Government should evaluate existing research and research training resources with the objective of expanding these resources to meet the requirements of health programs.

The utilization and coordination of research and training capabilities of schools of medicine, veterinary medicine, dentistry, public health, and sanitary engineering, research institutions, and government departments should be encouraged.

Particular areas of research interest within the framework of the Alliance for Progress are the following: The control and eradication of communicable disease and malnutrition; engineering studies in the fields of environmental sanitation, housing, industrial hygiene, and air and water pollution; economic and statistical studies of the organization and administration of medical care and public health services; studies of requirements for professional and auxiliary manpower in the health sciences.

Finally, it is important that research in the biomedical, bioengineering, and biosocial fields be closely coordinated with the operational and information requirements of health services, health planning agencies, and the institutions engaged in the education and training of health personnel. The effectiveness and efficiency of health planning and health service activities depend on the assembly of accurate basic health information.

Research is needed to develop better methods of acquiring the necessary health information data, its processing, analysis, and use in the administration of all pertinent programs.

B.5 Increase in Life Expectancy at Birth by a Minimum of 5 Years During the Decade

The programs for construction of water supply and sewage disposal systems, environmental health, eradication and control of communicable diseases, and improvement of nutritional status, influence the state of health of the population by the prevention of illness and death. In these programs the specific goals established are to complete eradication of malaria and smallpox from the Hemisphere and for the provision of potable water and sewage disposal systems.

One measure of the combined effect of the health programs and other advances for social progress is the reduction of mortality and the extension of life.

In countries with excessive death rates, marked improvements through extension of health programs combined with socio-economic developments are usually evident in an increasing life expectancy at birth. Reduction in mortality, especially of children under 5 years of age, produces a rapid increase in life expectancy as demonstrated by data from Chile, Mexico, and Venezuela. By reducing the death rate under 5 years in many of the Latin American countries by one-half, theoretically the increase in the life expectancy would be 5 to 6 years. Since major improvements in environmental conditions and nutritional status, and the extension of programs to prevent communicable disease , would also reduce the number of deaths in older children and adults, such progress could be expected to increase life expectancy at birth by 5 to 10 years.

Calculation of life tables requires accurate data of the population by age from a census, and of deaths by age from the registration system.

These statistical data are essential for many aspects of planning and evaluating programs as well as for devising the instrument to measure the results. Censuses have not been taken in seven countries of the Americas in the period around 1960. Thus, the population base for the calculation of a life table is not available. These censuses should be taken as soon as possible in order to obtain data for many phases of planning for social and economic progress.

Unfortunately, registration of deaths is incomplete in many areas of the Americas; moreover, deaths in infancy and early childhood are not as well registered as those in other age groups. Therefore, careful planning should be carried on in each country with a view to obtaining an accurate measurement of mortality at the present time. Representative areas which adequate studies have determined to have good death and birth registration should be selected. If registration is incomplete, corrections need to be applied to existing dead rates in order to obtain an estimate of the life expectancy at birth which represents the true situation at the beginning of this decade.

Thus, in each country, efforts should be directed at once to obtaining the population figure from the census and corrected death rates for use in calculating a life table for 1960 or 1961, or as early as possible in the 1960's.

In addition to the establishment of the baseline, the life expectancy at the beginning of the period, sound planning includes the current and continued development of essential data for measurement of progress through the decade.

A selection will be made from the deaths by age group of those groups whose mortality differs most from that in countries which, as regards health, are more advanced. Once these groups have been determined, a study will be made of the principal causes of death, either on the basis of all death certificates or by sampling other sources, if necessary.

Among the diseases constituting the principal causes of death, a selection will then be made of those for which effective procedures exist. In this way the health program may be directed against these specific causes of death, a procedure that will yield benefits far more quickly than has been possible heretofore.

Provisions should be made for a census in each country in or around 1970. In the representative registration areas, procedures should be established to ensure satisfactory registration of births and deaths, and such methods should be extended as rapidly as possible to the entire country. By the end of the decade, it is hoped that both census and registration data will be available for accurate assessment of progress.

The goal of increasing the average life expectancy at birth by five years in the decade appears to be a practical and useful measure of the success of programs for the improvement of health conditions in the Americas.

VII. RECOMMENDATIONS

A.1 Malaria eradication

(a) In large areas of the Americas, the presence of malaria is still an important negative factor in relation to the attainment of the short-term and long-term economic and social objectives approved by the Governments in the Act of Bogotá and amplified in the Charter of Punta del Este. Consequently, it is imperative that the Governments continue to give fundamental priority to the malaria eradication campaigns.

(b) Larger financial resources are needed to intensify antimalaria activities and their evaluation. It is advisable that the international institutions increase their contribution and that the international banks offer the Governments the necessary credits.

(c) It is essential to improve the administration of the eradication campaign, in order to give it greater flexibility and speed in action. It is advisable to avoid interference by outside interests insofar as possible.

(d) Closer coordination between the existing health services and the malaria eradication programs is to be recommended; although such coordination must be established from the beginning of antimalaria activities, it becomes even more essential in the consolidation phase.

(e) It is highly advisable that the countries affected by malaria aid each other reciprocally, through interchange of resources and/or regional use of these resources, especially in border areas of difficult access.

(f) The training of a larger number of epidemiologists and entomologists having a firm scientific and biological foundation is essential.

(g) It is suggested that the production of new insecticides that have prolonged residual action, as well as of antimalarial drugs that have a radical curative and prolonged suppressive effect, be encouraged.

(h) It is recommended that further research be done with a view to clarifying the mechanism of action of insecticides and its relation to the phenomenon of insect resistance.

(i) It is suggested that UNICEF and other organizations that have been contributing funds to the eradication campaign, be requested to continue their contributions until the Pan American Sanitary Bureau certifies that eradication has been completed.

A.2 Tuberculosis

1. The Governments should take the necessary measures to intensify tuberculosis control in accordance with Resolution A.2 of the Charter of Punta del Este, and to give it the priority it deserves in a national health program.

2. The Governments should orient the antituberculosis programs toward the application of the simplest and cheapest modern diagnostic, treatment, and prophylactic methods to the greatest number of people, the basic idea being that, since it is a communicable disease, efforts should first be directed at breaking the chain of transmission.

3. The Government should recognize the importance of incorporating the antituberculosis services into the general health services, including the so-called medical care services, and should facilitate this integration as a practical way of maintaining tuberculosis control as a continuous, long-term activity.

4. The Government should increase the training of the physicians of the health services in the techniques of diagnosis, treatment, and chemoprophylaxis, in the interpretation of epidemiological information, and in the administration of antituberculosis programs within the general health services. They should also increase the training of the auxiliary personnel of the general health services in the specific techniques employed in the prevention and control of tuberculosis. This training is urgently needed in order to be able to cope with the problem, but it

also represents an important step towards the integration of the health services and the implementation of the program with non-specialized personnel.

5. The Governments should ensure that the necessary budgetary allocations will be provided for carrying out their antituberculosis programs, which are long-term programs, and they should encourage community cooperation in specific activities complementary to the national program.

6. Recognizing that tuberculosis control requires ample resources of funds and personnel it is especially requested that the international organizations intensify their cooperation in both technical assistance and the provision of funds to expand the control programs throughout Latin America.

A.3 Smallpox Eradication

(a) The Governments of the countries where foci still exist should intensify and accelerate their national programs of smallpox eradication, give them a high priority within national health plans, and such seek additional funds and resources as are needed from national and international sources.

(b) The Governments that have already eradicated smallpox should establish procedures within their health services which will guarantee the maintenance of adequate levels of immunity, as well as continued vigilance to avoid possible re-occurrence of the disease. This can be accomplished through the annual vaccination of one fifth of the population.

(c) The Governments should coordinate their efforts and assist each other in developing programs of smallpox vaccination aimed at eradicating smallpox in the Americas in the shortest possible time. Collaboration among countries is of special importance in border areas.

A.4 Chagas' Disease

1. It is recommended that at the end of the malaria eradication program the spraying teams undertake spraying programs for the purpose of eradicating or diminishing triatomes in the houses, particularly in those where, as a consequence of the insecticides used in the eradication of malaria, the density of such insects has increased; such sprayings should be extended to other areas infested with the vector of Chagas' disease. Community cooperation should be required for such programs.

2. It is recommended that, in the countries where the magnitude of the problem of Chagas' disease is still not known, epidemiological surveys be undertaken as a part of the regular activities of the health services and, if necessary, in cooperation with university research institutions.

3. It is recommended that, with international cooperation, the Governments strengthen and expand research on the pathogenesis, diagnosis, epidemiology, and treatment of Chagas' disease.

4. In view of the relationship between poor housing and Chagas' disease, it is suggested to Governments that housing agencies give special priority to programs of replacement, repair, or refitting of houses in areas where triatomes are prevalent. The desirability of obtaining community collaboration in carrying out such housing programs is self-evident.

5. It is recommended that international cooperation be utilized for present and future programs of Chagas' disease control.

A.5 Nutrition

1. It is suggested that Ministries of Health should establish minimum standards for adequate nutrition of the population, both for the individual and for the total population and, on this basis, national policies with respect to agriculture, including livestock and exploitation of other source of protein, should be rationalized in order to assure the fulfillment of these requirements.

2. It is recommended that Ministries of Health should participate actively in the planning and development of national nutrition programs and that nutrition should be effectively integrated into health programs in such a manner as to become a basic service at the local level.

3. It is recommended, in order that national nutrition programs may be more effective, that a greater degree of coordination should be established between the health, agricultural and education services as well as with other national and international agencies.

4. It is recommended that the education in nutrition of personnel at all levels be considerably increased in order that such personnel may work in applied nutrition programs at regional and local levels.

5. Environmental sanitation programs must give more attention to the control of rodents and insects which cause losses in food production and storage and greater efforts must be made to control enzootic diseases in order to achieve greater production of animal proteins.

6. It is suggested that the Governments introduce and implement practical legislation with reference to salt iodization and cereal enrichment.

7. It is recommended that Governments increase their research and development programs on the mass-production, distribution, and utilization of new sources of inexpensive foods, especially those with a high protein value.

8. It is suggested that Governments conduct studies to acquire information on food consumption as well as on national food production.

A.6 Environmental Sanitation

1. Among health programs the highest priority should be given to environmental sanitation and, within this field, to water supply and sewage disposal systems in urban and rural areas of Latin America. This priority should be reflected in the programs of national development, particularly as regards the allocation of funds and the establishment of the agencies necessary to achieve the objectives set forth in the Charter of Punta del Este.

2. Programs for the construction of water supply and sewage disposal systems should be intensified to the maximum in urban areas; they should be self-financing through the establishment of rational water rates and should be well organized and administered. The ministries of public health should stimulate and coordinate their activities with those of other national or local agencies in charge of urban water supply and sewage disposal services.

3. In order to fulfill the objective of the Charter of Punta del Este in rural areas, the Pan American Health Organization should study the possibility of establishing a Special Fund, which might be called the Special Rural Welfare Fund, to be financed by contributions from the countries themselves, from the Alliance for Progress, and other international agencies. This Fund would make it possible for Governments to draw up and carry out environmental sanitation projects, with the cooperation of organized communities, priority being given to water supply projects.

The ministries of health will be those responsible for the programming and execution of rural sanitation courses. They could lend or assign organized communities the necessary funds for such works. It is believed that with a suitable installment system a high percentage of the capital outlay could be recovered and used as a revolving fund that could benefit other communities.

4. Rural environmental sanitation programs should be initiated in areas where there is the greatest concentration of population and where the system could serve groups of houses. When the economic condition of the community permits, it would be possible to carry the water lines into the houses; the ministries of health could be responsible for the domiciliary connections.

5. It is recommended that environmental sanitation units be given sufficient authority to permit them to exercise their proper advisory functions within the ministry of health, and also those of coordination and supervision of all governmental bodies that are also responsible for such works.

6. The ministries of health should take an active part in the planning and execution of housing programs sponsored by the Governments, especially those that are developed in rural areas and, in the matter of the construction or improvement of housing, should encourage self-help efforts and the development of cooperatives to achieve this objective.

7. The ministries of health should intensify occupational health programs as well as those for the control of water and air pollution. Special attention should be given to the protection of the health of the agricultural worker, particularly to the danger inherent in modern agricultural practice. Industrialization programs should include industrial safety and health measures.

8. It is suggested that international banking agencies include in their loan contracts to public or private enterprises a clause making it an obligation to take measures to reduce work hazards in accordance with the legislation of each country. It is requested that the Pan American Sanitary Bureau undertake the pertinent negotiations.

9. The urgent need for training of professional and sub-professional personnel in the field of environmental sanitation is recognized to be of the utmost importance. It is recommended that the international agencies award the largest possible number of fellowships for this purpose and collaborate in the training of experts in the countries.

B.1 National Planning for Health

1. It is essential that the Governments proceed to establish planning and evaluation units within the Ministries of Health, staffed by specially trained personnel. These units should be represented in the national agencies or commissions for development planning, if possible with the personal participation of the Minister of Health or his delegates.

2. The necessary changes in health organization and administration should be made in order to guide the process of planning through the technical and administrative channels it requires. This involves administrative rationalization of the services; training and proper utilization of personnel; improvement of the financial systems; and preparation of program budgets.

3. Changes and improvements should be made in the statistical systems in order to adapt the collection of data and their analysis to the requirements and methodology of planning. For this purpose, it is recommended that the Ministries of Health have statistical units at the most appropriate level. The advisability of taking population censuses, of improving vital and hospital statistics, and of preparing statistics on resources and other basic elements is emphasized. However, it is accepted that planning should be undertaken at once, with the presently available data, even though they are insufficient, and without waiting for the improvement of the statistics of the taking of censuses. Attention is called to the desirability of finding indices that would make it possible to express the relative values of each program objectively, without forgetting

that, since what is aimed at is the improvement of health, the indices that are used should basically be those that will indicate that progress, and not merely indices of administrative objectives.

4. It is recommended that "registration areas" which cover a representative sample of the population, and in which it will be possible to organize the collection and analysis of vital and health statistics, be selected in each country; these data will serve as a basis for formulating national plans and calculating life expectancy.

5. The training of the personnel in planning should be intensified. Not only must experts responsible for formulating the plans and evaluating them be trained, but the methodology must be taught to all the personnel participating in the planning process.

6. The Governments should define a health policy suitable for the country in the light of the development plans, the growth of the population, and other factors.

7. Systematic planning for the national territory should be undertaken; it should be studied area by area, an appraisal of the situation in each of these areas should be made, the priorities of the problems should be defined, and the most suitable or feasible solutions should be put forward and submitted to a higher level for decision.

8. The Governments should conduct research in experimental areas in coordination with the universities in order to gain a more accurate knowledge of the nature of the problems, of the standards that

should be adopted in accordance with the existing national conditions, of the best way to take full advantage of the resources that the country has available, of the attitude and response of the community, and of other aspects that are essential to planning on a national scale.

9. Such is the importance and variety health needs as compared with the limited resources available to meet them, that they need to be arranged in accordance with priorities which themselves should be established in the process of planning in the light of all the considerations indicated by the national interest.

The criteria for establishing priorities are indicated in Chapter IV of this report.

10. It is recommended that the Governments complete their national economic and social development plans, including the public health programs, as soon as possible, so that the over-all plan may be submitted, if they so desire, to the evaluation procedure of the Organization of American States, in order that that plan, and particularly the health program, may be put into operation with their own resources and with necessary external financial aid.

B.2 Improvement of Health Services

1. When planning for new services or for the expansion of existing ones, it is necessary to carry out a study and analysis of existing programs. It is further necessary to make an inventory of personnel, facilities, and budget so as to be able to develop programs which will give the greatest yield in terms of diminution of morbidity and mortality.

2. Special campaigns carried out by the central level are necessary under certain circumstances. However, it is recommended that they should be incorporated with the framework of the general health services at the earliest stage of development.

3. It is necessary, when planning for the expansion of health services, especially in the case of medical care, to take into account not only the cost of construction and equipment, but also the quantitative and qualitative personnel requirements and the budget for operation. Such expansion should be prudently phased; at the same time existing resources should be fully utilized. Construction plans should form an element of national health plans.

4. The Ministries of Health must take steps to secure the legal and institutional instruments required for the effective coordination of the planning and executive elements responsible for preventive and curative services. These include private, semi-autonomous, and autonomous organizations providing health services of any type. The aim is to incorporate medical care activities of those institutions,

including hospitalization, into the basic health services at all levels with the final objective of attaining a progressive integration of these activities. Preventive and curative services are but parts of an integrated whole.

5. It is recommended that the regionalization of services be promoted on the basis of technical resources adequate for the protection, promotion and resteration of health.

6. It is recommended that national and international sources of financing adopt policies adapted to the characteristics of the health sector, and ajust their requeriment to the stages planned by health agencies.

7. It is suggested that Governments take steps to review and revise legislation and related administrative instruments so as to provide a legal structure which will permit the most effective utilization of the resources now available, as well as those which may later become available to countries through the Alliance for Progress.

The specific measures which are recommended are:

A. Critical review of administrative structure and procedures, including budget and fiscal practices, and their relation to national health needs, programs, and resources so that appropriate and necessary changes may be made which will assure the best use of the funds budgeted for health as well as of personnel and equipment.

B. Adoption of modern techniques and tools of management such as program budgeting, mechanical systems, etc.

C. More effective use of administrative personnel along with technicians in the formulation, execution, and evaluation of programs.

D. Establishment of career and merit systems for health service personnel.

B.3 Education and Training of Professional Health Personnel

1. A more detailed study of current human resources in the field of health, and the planning of both short-term and long-term needs, are required.

The basic short-term need is to achieve better utilization of human resources to achieve objectives, together with planning and establishment of necessary priorities at the national level. All this includes health and educational institutions. Supervision and training of auxiliary personnel and the availability of educational supplies and equipment are essential.

Long-term requirements are increased quantity and better preparation of professionals, as well as their distribution in keeping with the needs of the population. Better utilization of resources can be achieved by maintaining greater flexibility in the movements of personnel. As to sub-professional personnel, academic training as well as better quality of supervision are deemed fundamental for the carrying out of national public health plans.

Methods for financing the provision and utilization of resources and facilities are part of the planning for the education and training of personnel to be utilized by the public health services.

2. It is recommended that inter-agency committees be established, representing ministries of public health, authorities of university schools, and leaders of organized professions, to study the training of professionals required for health programs.

3. It is recommended that the concept of the relationship of health and disease to the structure and organization of the community, as applied in public health administration, be incorporated into the teaching programs of university schools that train personnel working in the health field.

4. It is recommended that primary and secondary education incorporate into their curricula the basic ideas of health promotion and disease prevention, as a means of facilitating the training of auxiliary personnel for health services.

5. It is suggested that closer coordination be established between ministries of health, ministries of education, and the universities, in order to improve financing and to ensure that the functions of medical schools are more in line with the health needs of the countries.

6. It is suggested that medical schools be encouraged to plan their work programs in collaboration with ministries of health, in such a way that the teaching offered includes a more balanced presentation of the curative aspects of medicine and of those related to disease prevention and health promotion.

7. It is recommended that health ministries cooperate with medical schools by providing means whereby hospitals and health centers may serve as institutions of apprenticeship in medicine in the broadest sense.

8. It is essential that ministries of health collaborate with medical schools to extend their teaching functions to the postgraduate period through residencies in hospitals and public health institutions, programs of specialization and training in certain medical disciplines, and refresher courses to keep practicing physicians abreast of advances made in medicine.

9. It is suggested that studies be carried out to serve as a guide for obtaining a better geographical distribution of physicians.

10. Ministries of health and university schools should collaborate in medical education programs directed toward the training of teaching staff for medical schools.

11. It is essential to promote and encourage joint research work by ministries of health and medical schools to find solutions to the health problems that are of greatest importance in the several countries.

12. It is urgently necessary to promote the establishment of education and training centers for teaching personnel at all levels in our countries with financial contributions from the Governments of the Continent and private or inter-governmental institutions whose programs include medical training.

13. It is suggested that full advantage be taken of the fellowship programs offered by international organizations, and that the countries give priority to fellowships for health studies.

B.4 Research

1. That Governments make an assessment of their national research and research training resources in the health sciences, and give appropriate attention to expanding these resources to meet the requirements related to health priorities established in national development plans.

2. The research resources for health should be directed towards the solution of social problems, which have been given the highest priorities for action by national plans.

3. It is desirable that Ministries of Health increase research activities, in accordance with the objectives established in the Charter of Punta del Este, in the field of control and eradication of communicable diseases, nutrition, environmental sanitation, housing, occupational health, as well as in economic, administrative, and statistical aspects of the programs and services required to promote and protect individual and community health.

4. Research programs in the medical, social, and engineering fields should be planned with full knowledge and attention to the operational requirements of health services, health planning units, and the institutions engaged in the education and training of health personnel.

5. It is recommended that programs should be developed to assure rapid dissemination of research information, that fuller use be made of existing facilities and new systems be developed, if found necessary.

6. It is suggested that necessary steps should be taken to assure exchange of information on programs of research, training of research manpower, construction and equipment of facilities, and on financing by national and international, governmental and nongovernmental agencies, so as to permit and assure appropriate coordination of efforts and maximum utilization of all resources.

7. It is suggested that programs of applied research should be developed to establish realistic national and international standards for manpower needs and utilization, construction of health-related facilities, equipment, etc., for the guidance of both the health administrator and the planning and fiscal agencies.

B.5 Increase in Life Expectancy at Birth by a Minimum of 5 years During the Decade

1. The Task Force recommends that the Member Governments obtain accurate data on population and on mortality rates. If registration is not complete, representative birth and death registration areas should be established in each country. Life tables for large representative registration areas based on accurate mortality and census data are preferable to those for the entire country when there are deficiencies in registration.

2. It is recommended that completeness of registration be determined in each country and that programs which envision complete coverage of the country by 1970 be undertaken. The Pan American Health Organization is requested to explore the possibility of support for this activity from international sources and from the Alliance for Progress.

3. It is recommended that health programs based on specific and direct measures should attack the diseases responsible for the excesive mortality in children under 5 years of age, such as gastroenteritis, respiratory diseases, measles, whooping cough, and other infectious diseases, and nutritional deficiency, that constitute the principal causes of death in this group and which are more responsive to public health measures, in order to accelerate the attainment of the goals.

4. It is recommended that full support be given to the improvement of vital and health statistics essential for planning and for the annual measurement of progress. It must be recognized that health progress can only be accurately measured through sound bio-statistical methods and the use of reliable and complete vital statistics.

C.1 Latin American Common Market for Biological Products

The Task Force on Health at the Ministerial Level considering that it is essential for the health care of the people of the Americas that all countries have available to them biological products for the diagnosis, prevention, and treatment of certain human diseases,

1. Recommends that the capacity of Government agencies to produce such biologicals be increased as soon as possible, in accordance with the continental needs, and that the interchange of such products be began immediately.

2. Recommends the establishment of regional laboratories to set standards and carry out necessary studies for the quality control and the manufacture of such new products as may be necessary.

3. Recommends that technical and auxiliary personnel be prepared and trained for this purpose.

4. Recommends that Governments eliminate custom duties and exercise taxes in order to facilitate the free interchange of these products, when they are needed for public health programs.

5. Recommends that the Director of the Pan American Sanitary Bureau take the necessary technical and administrative measures to put this program into effect.

6. Recommends that, once the interchange of human biological products has been established, efforts be made to initiate a similar program for veterinary products.

C.2 Quality and Cost of Essential Drugs

The Task Force on Health at the Ministerial Level, deeply concerned over the obvious disparity between the high price of drugs and the low purchasing power of large sectors of population in the Continent, which creates a serious health problem and impedes the execution of preventive and curative health programs,

1. Recommends that an impartial technical study be made by the Governments so as to enable them to gain a clear picture of the costs involved in the production, distribution, and sale of drugs.

2. Recommends that industry be stimulated through legislative and administrative measures to produce essential drugs which, while of optimum quality, can be produced, distributed, and sold at substantially reduced prices.

3. Recommends that an active campaign be initiated to improve the flexibility and the technical quality of systems for the control of drugs, in the course of both production and marketing, in order to assure purity, therapeutic efficacy, and quality.

4. Recommends that current legislation governing the control of drugs be revised in the light of the needs of each country.

C.3 Role of Women in the Ten-Year Public Health Program of the Alliance for Progress

The Task Force on Health at the Ministerial Level, considering that the active participation of women in national health plans is essential, since they are the central point of the family; and that the Charter of Punta del Este recognizes that the participation of women in the formulation and execution of national development plans is essential to the attainment of the objectives of the Alliance for Progress,

1. Recommends to the Governments of the Americas and to inter-American and international organizations that, in all activities aimed at the execution of the Ten-Year Public Health Program of the Alliance for Progress, full consideration be given to the contribution that can be made by women.

2. Recommends to Governments, inter-American organizations, and international organizations, both governmental and non-governmental, interested in or concerned with problems of the family, of women, or of children, that they exhort their members to be more active and to work more positively towards the solution of public health problems.

C.4 National Committees for the Alliance for Progress

The Task Force on Health at the Ministerial Level, considering that in accordance with Resolution E of the Charter of Punta del Este the Organization of American States is carrying out a public information program aimed at promoting the interest of the peoples of the America in the Alliance for Progress; that one of the measures adopted is the establishment of National Committees for the Alliance for Progress in the countries of the Member States of the Organization of American States; and that the Charter of Punta del Este points out the intimate relationship and interdependence between economic and social development and the improvement of health conditions,

Recommends to the Organization of American States and the Governments of the Member States that, when establishing National Committees for the Alliance for Progress, they take into consideration the advisability of including representatives of the ministries of health in such committees.

C.5 Coordination with International Organizations

The Task Force on Health at the Ministerial Level suggests that international organizations should program their activities and coordinate their efforts with the national plans of the Governments.

VIII. Final Declaration

One fact has dominated the spirit of all the participants in the Task Force on Health: the great hopes of the people of the Americas and the sense of urgency to see the promises of the Charter of Punta del Este fulfilled. The people are not satisfied with what they have; they think of what they could have, and they do not want to wait for the hour indicated in the slow course of history. This aspiration is the hope of the future; it is the clamor of the present. The success of this hemisphere-wide undertaking will depend upon the conviction with which we hold to our conceptions and ideals and upon the firm and determined will to carry them out within the period that has been set.

In our discussions we have been alive to the historic meaning of this meeting. Since the International Sanitary Conference, in December of 1902, at which the Pan American Sanitary Bureau was created, there has not been another occasion in this century, in the Americas, in which the highest authorities in the field of health have met to discuss purely technical matters of such importance to our time. Perhaps there has been no other occasion when the importance of man, on whom all the efforts of society are focused, has been more clearly brought out. Those who have the moral authority to do so, have pointed out the humanitarian core of every economic system and never before either in the Hemisphere or in this century, has a sense of national purpose been made manifest through the recognition of health as a fundamental factor in social progress and economic development.

In the light of the Charter of Punta del Este, we have considered health in the Americas in its technical, social, economic, juridical, and cultural aspects. The important advances made have been examined, the present problems have been defined, and those that should have priority have been selected. We have recommended a number of practical measures for fulfilling the health objectives of the Charter. Their execution will mean greater well-being; failure to do so may lead to discouragement or frustration.

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

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.

IN WITNESS THEREOF, the Ministers of Health of the signatory countries of the Charter of Punta del Este, 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 Washington, D. C., United States of America, this twentieth day of April nineteen hundred and sixty-three.

Signatures: Dr. Tiburcio Padilla, Minister of Social Welfare and Public Health of Argentina; Dr. Francisco Torres Bracamonte, Representative of the Minister of Public Health of Bolivia; Dr. Paulo Pinheiro Chagas, Minister of Health of Brazil; Mr. Benjamín Cid, Minister of Public Health of Chile; Dr. José Félix Patiño, Minister of Public Health of Colombia; Dr. Max Terán Valls, Minister of Public Health of Costa Rica; Dr. Samuel Mendoza Moya, Secretary of State for Health and Social Welfare of the Dominican Republic; Dr. Luis Pallares, Minister of Social Welfare and Health of Ecuador; Dr. Ernesto R. Lima, Minister of Public Health and Social Welfare of El Salvador; Dr. Roberto Arroyave, Representative of the Minister of Public Health and Social Welfare of Guatemala; Dr. Louis Mars, Representative of the Secretary of State for Public Health and Population of Haiti; Dr. Carlos A. Javier, Representative of the Secretary of Public Health and Social Welfare of Honduras; Dr. José Alvarez Amézquita, Secretary of Health and Welfare of Mexico, President; Dr. Constantino Mendieta Rodríguez, Representative of the Minister of Public Health of Nicaragua; Dr. Bernardino González Ruiz, Minister of Labor, Social Welfare and Health of Panama;

Dr. Dionisio González Torres, Minister of Public Health and Social Welfare of Paraguay; Dr. Víctor Solano Castro, Minister of Public Health and Social Welfare of Peru; Dr. James A. Watt, for Dr. Luther L. Terry, Surgeon General of the United States of America; Dr. Aparicio Méndez, Minister of Public Health of Uruguay; Dr. Arnoldo Gabaldon, Minister of Health and Social Welfare of Venezuela; and Dr. Abraham Horwitz, Director of the Pan American Sanitary Bureau, Secretary.

LIST OF PARTICIPANTS
LISTA DE PARTICIPANTES

ARGENTINA

Dr. Tiburcio Padilla
Ministro de Asistencia Social y Salud Pública

Dr. Julio C. Blaksley
Médico Jefe de la Dirección de Enfermedades Transmisibles

Dr. Alfredo Rabinovich
Secretario Técnico de la Dirección de Enfermedades Transmisibles

Dr. Alberto F. Mondet
Secretario de Salud Pública de la Municipalidad de Buenos Aires

Sr. Florentino Alén
Director General de Finanzas de la Municipalidad de Buenos Aires

BOLIVIA

Dr. Francisco Torres Bracamonte
Director General del Servicio Nacional de Salud Pública

Dr. Julio Bustillos
Director de los Servicios Normativos del Ministerio de Salud Pública

BRAZIL

Dr. Paulo Pinheiro Chagas
Ministro da Saúde

Dr. Henrique Maia Penido
Superintendente da Fundação do Serviço Especial da Saúde Pública

Dr. Carlos Modesto de Souza
Diretor Geral do Departamento Nacional de Endemias Rurais

CHILE

Sr. Benjamín Cid
Ministro de Salud Pública

Dr. Alfredo Leonardo Bravo
Jefe del Departamento Técnico del Servicio Nacional de Salud

Ing. Raúl Peña Larraguibel
Asesor Económico del Ministerio de Salud Pública

Sr. Edgardo Boeninger
Asesor Económico de la Dirección de Presupuestos del Ministerio de Hacienda

Dr. Amador Neghme
Secretario de la Facultad de Medicina de la Universidad de Chile y Consejero del Servicio Nacional de Salud

COLOMBIA

Dr. José Félix Patiño
Ministro de Salud Pública

Dr. Alberto Escobar
Secretario General del
Ministerio de Salud Pública

Dr. Alfonso Mejía
Jefe de la Sección de Coordinación Ejecutiva del
Ministerio de Salud Pública

COSTA RICA

Dr. Max Terán Valls
Ministro de Salubridad Pública

Dr. Charles Chassoul
Jefe del Departamento de Administración
de Hospitales

Dr. Claudio Orlich
Director General de Asistencia Médica

Ing. Jorge Carballo
Gerente del Servicio Nacional de Acueductos y
Alcantarillados

DOMINICAN REPUBLIC - REPUBLICA DOMINICANA

Dr. Samuel Mendoza Moya
Secretario de Estado de Salud Pública y
Previsión Social

Dr. Miguel A. Ortega
Planificador
Secretaría de Salud Pública

Ing. Frank J. Pineyro
Director Ejecutivo, Instituto Nacional de
Aguas Potables y Alcantarillado

Dr. Luis Emilio Mainardi
Epidemiólogo
Secretaría de Salud Pública

ECUADOR

Dr. Luis Pallares
Ministro de Previsión Social y Sanidad

Dr. Roberto Nevárez Vázquez
Director General de Sanidad

Sr. Gonzalo Ayora
Asistente Especial del Director del Servicio
Cooperativo Interamericano de Salud Pública

EL SALVADOR

Dr. Ernesto R. Lima
Ministro de Salud Pública y Asistencia Social

Dr. Tomás Pineda Martínez
Director General de Sanidad

Dr. Alberto Aguilar Rivas
Secretario-Coordinador del Departamento Técnico
y de Planificación
Ministerio de Salud Pública y Asistencia Social

GUATEMALA

Dr. Roberto Arroyave
Jefe de Cirugía, Director de Educación Médica,
Hospital Roosevelt
(en representación del Ministro de Salud Pública
y Asistencia Social)

Dr. Carlos Waldheim
Jefe del Departamento de Planificación en Salud
Ministerio de Salud Pública y Asistencia Social

Lic. Ramiro Bolaños
Economista de la Secretaría General del Consejo
Nacional de Planificación Económica

Sr. José Antonio Palacios
Consejero Financiero
Embajada de Guatemala
Washington, D.C.

HAITI

Dr. Louis Mars
Embajador de Haití
Washington, D. C.

Sr. Fern D. Baguidy
Embajador ante la Organización de los Estados Americanos
Washington, D. C.

Dr. Felix Colimon
Jefe del Departamento de Clínica Externa del
Servicio de Salud Pública

Dr. Jean Bartoli
Jefe Auxiliar del Departamento de Medicina
del Hospital General

HONDURAS

Dr. Carlos A. Javier
Subsecretario de Salud Pública y
Asistencia Social

Dr. José Rodrigo Barahona Carrasco
Director General de Salud Pública

Ing. Gilberto Bendaña
Gerente del Servicio Autónomo Nacional de
Acueductos y Alcantarillados (SANAA)

Dr. José M. Lagos Blancos
Jefe de Administración del Ministerio de
Salud Pública

MEXICO

Dr. José Alvarez Amézquita
Secretario de Salubridad y Asistencia

Dr. Miguel E. Bustamante
Subsecretario de Salubridad

Dr. Felipe García Sánchez
Asesor Técnico de la Secretaría de Salubridad
y Asistencia

Sr. Gerardo de Isolbi
Director General de Relaciones Públicas y Prensa
Secretaría de Salubridad y Asistencia

Teniente Coronel Jesús Mercado Sixtos
Ayudante del Ministro

NICARAGUA

Dr. Constantino Mendieta Rodríguez
Viceministro de Salubridad Pública

Dr. Carlos H. Canales
Director de Servicios Locales
Ministerio de Salubridad Pública

Dr. Orontes Avilés
Director de los Servicios Administrativos
Ministerio de Salubridad Pública

PANAMA

Dr. Bernardino González Ruiz
Ministro de Trabajo, Previsión Social y
Salud Pública

Dr. Alberto E. Calvo
Director General de Salud Pública

PARAGUAY

Profesor Dr. Dionisio González Torres
Ministro de Salud Pública y Bienestar Social

Dr. Julio A. Martínez Quevedo
Director de los Servicios Normativos
Ministerio de Salud Pública y Bienestar Social

Dr. Roque J. Avila
Director de los Servicios Médicos de la Capital

PERU

General de Brigada Dr. Víctor Solano-Castro
Ministro de Salud Pública y Asistencia Social

Dr. Carlos Quirós Salinas
Director General de Salud

Dr. David A. Tejada de Rivero
Jefe de la Oficina de Planificación
Ministerio de Salud Pública y Asistencia Social

Mayor Dr. C. Enrique Pitta López
Ayudante del Ministro

UNITED STATES OF AMERICA - ESTADOS UNIDOS DE AMERICA

Dr. Luther L. Terry
Surgeon General
Public Health Service

Dr. Leona Baumgartner
Assistant Administrator for Human Resources and Social Development
Agency for International Development

Dr. M. Allen Pond
Assistant Surgeon General for Plans
Public Health Service

Dr. James Watt
Chief, Division of International Health
Public Health Service

Dr. Philip R. Lee
Director, Health Service
Office of Human Resources and Social Development
Agency for International Development

Mr. C. H. Atkins
Chief, Sanitary Engineering Officer
Public Health Service

Dr. Charles L. Williams, Jr.
Chief, Division of International Relations
Public Health Service

Mr. Howard B. Calderwood
Foreign Affairs Officer
Office of International Economic and Social Affairs
Department of State

Dr. Paul Q. Peterson
Chief, Division of Community Health Service
Public Health Service

Dr. Arthur E. Rikli
Medical Director
Division of International Health
Public Health Service

Dr. Edward O'Rourke
Deputy Director, Health Service
Office of Human Resources and Social Development
Agency for International Development

Dr. Frederick Vintinner
Regional Health Adviser
Bureau for Latin American Affairs
Office of Human Resources and Social Development
Agency for International Development

URUGUAY

Dr. Aparicio Méndez
Ministro de Salud Pública

Dr. Adolfo Morales
Director de la División de Higiene
Ministerio de Salud Pública

Dr. Mario Pareja
Director del Centro de Salud Pública Integral,
Las Piedras

VENEZUELA

Dr. Arnoldo Gabaldon
Ministro de Sanidad y Asistencia Social

Dr. Alejandro Príncipe
Jefe del Departamento de Demografía y Epidemiología
Ministerio de Sanidad y Asistencia Social

Dr. José Antonio Jove
Ingeniero Adjunto
Dirección de Malariología y Saneamiento Ambiental
Ministerio de Sanidad y Asistencia Social

Dr. Alfonso Giordano
Secretario encargado del Instituto Nacional
de Obras Sanitarias

ORGANIZATION OF AMERICAN STATES
ORGANIZACION DE LOS ESTADOS AMERICANOS

Dr. José A. Mora
Secretario General

Dr. Walter Sedwitz
Subsecretario Interino para Asuntos Económicos y Sociales

Dr. Jaime Posada
Subsecretario para Asuntos Culturales, Científicos y de Información

Alternates:
Suplentes:

Sr. Francisco S. Céspedes
Subdirector del Departamento de Asuntos Culturales

Sr. Beryl Frank
Especialista Principal en Seguridad Social

Sr. Alvaro Magaña
Director Auxiliar del Departamento de Asuntos Económicos

Sr. José Carlos Ruiz
Colaborador del Subsecretario para Asuntos Científicos, Culturales e Información

Sr. Howard Salzman
Jefe de los Servicios de Asesoramiento
Departamento de Cooperación Técnica

Coordinator:
Coordinadora:

Sra. Alzora H. Eldridge
Oficial de Enlace de Organismos Internacionales

INTER-AMERICAN DEVELOPMENT BANK
BANCO INTERAMERICANO DE DESARROLLO

Sr. Felipe Herrera
Presidente

Ing. Humberto Olivero
Encargado, Servicios de Agua Potable y Alcantarillado

UNITED NATIONS CHILDREN'S FUND (UNICEF)
FONDO DE LAS NACIONES UNIDAS PARA LA INFANCIA (UNICEF)

Dr. Oscar Vargas Méndez
Director de la Oficina Regional para las Américas

ECONOMIC COMMISSION FOR LATIN AMERICA (ECLA)
COMISION ECONOMICA PARA LA AMERICA LATINA DE LAS NACIONES UNIDAS (CEPAL)

Sr. Nicasio Perdomo
Jefe Interino de la Oficina de Washington, D. C.

INTER-AMERICAN CHILDREN'S INSTITUTE (OAS)
INSTITUTO INTERAMERICANO DEL NIÑO (OEA)

Dr. Victor Escardó
Director General

DRAFT AGENDA

1. PLENARY SESSIONS

1.1 Opening of the meeting

1.2 Election of President and two Vice-Presidents

1.3 Designation of the representative of the Ministers to speak at the inaugural session

1.4 Statement on organization and development of the meeting by the Director of the Pan American Sanitary Bureau, Dr. Abraham Horwitz

1.5 Adoption of the Rules of Procedure (Document TFH/12)

1.6 Adoption of the Agenda (Document TFH/1)

1.7 Adoption of the Program of Sessions (Document TFH/13)

1.8 Establishment of the Drafting Committee

1.9 Establishment and adoption of the terms of reference for Committees

1.10 Statement by the Ministers of Health on the prevalent health problems of the Americas and on policies for solving them in relation to the objectives of the Charter of Punta del Este

1.11 Consideration and approval of the recommendations of the Committees

1.12 Approval and signature of the Final Report addressed to the Secretary-General of the Organization of American States and the Inter-American Economic and Social Council.

2. COMMITTEE I

2.1 Election of Chairman, Vice-Chairman, and two Rapporteurs

2.2 National Planning for Health (Document TFH/5)

- 2.2.1 Summary Account of the Present Situation
- 2.2.2 Planning Units Within the Ministries of Health
- 2.2.3 Coordination with National Planning Bodies
- 2.2.4 Improvement of Collection, Analysis and Reporting of Basic Data

2.3 Improvement of Health Services

- 2.3.1 Summary Account of the Present Situation
- 2.3.2 Strengthening of Organization and Administration to Bring About Better Utilization of Existing Human and Material Resources
- 2.3.3 Coordination of Preventive and Curative Programs and Services
- 2.3.4 Long-Term Financing for Construction and Equipment of Hospitals and Other Health Facilities

2.4 Education and Training of Personnel (Document TFH/6)

- 2.4.1 Summary Account of the Present Situation
- 2.4.2 Summary Statement on Needs and Resources
- 2.4.3 Professional Personnel
- 2.4.4 Sub-professional Personnel

2.5 Research (Document TFH/3)

- 2.5.1 Summary Account of the Present Situation
- 2.5.2 Presentation of the Status of the Program
- 2.5.3 Recommendation on Research Needed to Support Health Programs

3. COMMITTEE II

3.1 Election of Chairman, Vice-Chairman and two Rapporteurs

3.2 Environmental Health (Document TFH/2)

- 3.2.1 Review of the Situation in the Americas
- 3.2.2 Strengthening of Environmental Health Services
- 3.2.3 Assignment of Responsibilities for Urban and Rural Water Supply and Excreta Disposal System
- 3.2.4 Administration of Urban Water and Sewage Systems
- 3.2.5 Organization and Administration of Rural Environmental Health Programs
  - 3.2.5.1 Community Organization and Development
- 3.2.6 Financing of Urban and Rural Environmental Health Programs
- 3.2.7 Hygiene of Housing
- 3.2.8 Water and Air Pollution Control

3.3 Communicable Diseases (Document TFH/11)

- 3.3.1 Malaria Eradication (Document TFH/7)
  - 3.3.1.1 Report on Status of Program
  - 3.3.1.2 Technical Problems
  - 3.3.1.3 Administrative Problems
  - 3.3.1.4 Financing
- 3.3.2 Smallpox Eradication (Document TFH/11)
  - 3.3.2.1 Review of the Problem in the Americas
  - 3.3.2.2 Administrative Obstacles to Eradication

3.3.3 Control of Tuberculosis (Document TFH/11)

3.3.3.1 Summary Account of the Present Situation

3.3.3.2 Application of Modern Concepts and Methods of Control

3.3.3.3 Extension and Intensification of Case Finding

3.3.3.4 Ambulatory Treatment

3.3.3.5 Chemoprophylaxis and Vaccination

3.4 Nutrition (Document TFH/10)

3.4.1 General Considerations

3.4.2 Establishment of a National Policy of Food Production and Consumption as a Function of the Nutritional Requirements of the Population

3.4.3 Role of the Ministry of Health in Formulating and Implementing National Food Policies

3.4.4 Nutritional Programs of Local Health Service

3.4.5 Iodization of Salt

3.4.6 Production and Utilization of Low-Cost Protein Preparations

3.4.7 Programs to Prevent Loss of Proteins through Disease Affecting Livestock

3.5 Increase in life expectancy at birth by a minimum of 5 years during the present decade (Document TFH/8)