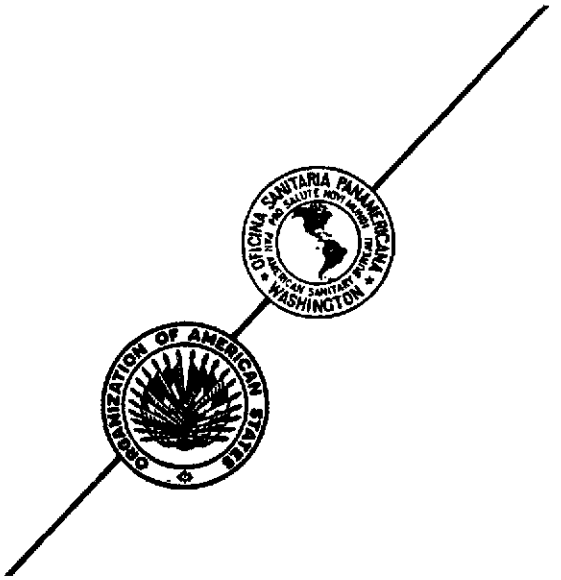

TASK FORCE ON HEALTH AT THE MINISTERIAL LEVEL

Washington, D.C.

15-20 April 1963

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

Official Document No. 51

April 1964

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION
1501 New Hampshire Avenue, N.W.
Washington, D. C. 20036

PREFACE

This volume contains an historic document, historic because of the ideas it sets forth and the experience it reflects; because of the import of those ideas for the nations of our Hemisphere, and the authority of those that expound them; because of the pledge to put those ideas into practice that the signature of that document represents; and because of the importance of those ideas in the economic and cultural panorama of our time. That document is the Final Report of the Meeting of Ministers of Health, which served as the Task Force on Health in accordance with Resolution A.4 of the Charter of Punta del Este.

Its contents reveal the prime reason for the Meeting—to examine the intrinsic purposes of health activities and their future perspectives within the general process of development, to which the nations of the Americas have resolved to devote themselves with increasing vigor.

Experts from the signatory countries of the Charter, presided over by the Ministers of Health of the majority of those countries, met in Washington from 15 to 20 April 1963. The Pan American Sanitary Bureau was given the responsibility for organizing and facilitating the discussions of some one hundred health experts. For this purpose, it convened Advisory Committees prior to the Meeting of the Task Force, and the working documents prepared by those Committees, together with those drawn up by the staff of the Pan American Sanitary Bureau, served as the basis for an examination of the scope and importance of the problems discussed and the adoption of practical measures for their solution. They made it possible for the Task Force to define the current health situation in the Americas and to forecast its future, as well as to examine the points to which efforts should be directed to achieve the goals of the Alliance for Progress.

During the plenary sessions, the Ministers presented their views on the health goals of the Charter of Punta del Este and voiced their opinions on the possibility of carrying out the Ten-Year Public Health Program mentioned in Resolution A.2. They highlighted the basic problems; the criteria for deciding on their priority in each country; general and specific measures for solving them; and the meaning of health as an investment for promoting economic progress and social development. Their statements depicted the present situation in the health field, in both its positive and its negative aspects, and delineated what remains to be done and how to do it. A summary of the leading ideas of the addresses of the Ministers is to be found in the first four chapters of the Final Report.

In theory, the fundamental problem of the technicians will be to show the significance for development of each program in particular; this involves competition for the assignment of scanty resources to meet growing and imperious needs. They will have to defend the thesis of health as an investment; they will have to show that the be-all and end-all of economic systems is man; they will have to offer evidence of the contribution, in terms of both natural wealth and increased productivity, which health programs make to development and welfare. All this without losing sight of the fact that man is the synthesis of all the efforts of society and that it is a collective duty to respect his dignity, his sense of values, and his cultural characteristics.

Two committees, organized by the Meeting, worked simultaneously. The first examined prevalent problems such as communicable diseases, sanitation, nutrition, and the general objective, namely, to increase the average life expectancy at birth by five years during the decade. The second committee dealt with the fundamental tools for achieving the goals of health care, such as planning; training of professional and auxiliary personnel; organization and administration of health services; and research. Each theme was subjected to a thorough and careful analysis based on the information and ideas contained in the documents prepared by the Advisory Committees and the technical staff of the Pan American Sanitary Bureau. For each subject, the committees made both theoretical and practical recommendations which, amended where applicable, were approved by the Meeting in plenary session. These are to be found in the second half of the Final Report. The measures proposed are, of course, regional in character and need to be translated into terms appropriate to each country, depending on the characteristics of the problems and possible solutions. By and large, the examination may be said to have been made with an eye to the future, in the light of the present, so that emphasis was given to what remains to be done rather than to the successes already achieved. The Meeting was aware that there was an undertaking to be accomplished within a period of ten years, and that in order to make progress it was essential to determine the situation in each country, the additional resources needed, and means and methods of financing. Hence the importance of the proposals concerning the tools which technicians use to protect, promote, and restore health. In the Americas today the major communicable diseases, namely, the quarantinable diseases, have disappeared or are disappearing and among the factors contributing to morbidity and mortality are the acute and chronic infectious diseases, poor sanitation, malnutrition, insanitary housing, illiteracy, and a very low per-capita income.

Most of these diseases can be overcome by proven methods of prevention and treatment. And since the great urban centers already show, as far as health is concerned, some of the features of industrial societies, is it not clear that the application of known techniques, the organization of services, the formulation of programs, the education and training of professional and

auxiliary workers, and research will also be of help to the Americas in attaining the objectives of the Charter of Punta del Este?

Justifiable priority has been assigned to the preparation of national health plans. The plans and their programs will facilitate the allocation of domestic and external resources, for the purpose of achieving proposed goals; they will provide the technicians working for the social development and economic progress of each country with a common language and thus promote their mutual understanding; and they will give each sector its own perspective within the over-all plan. Hence the urgency of preparing more health planners and of spreading a knowledge of simple methods, so as to enable the technicians of each country to collaborate with the planners in collecting data, assigning priorities, and formulating plans.

Among the recommendations of the Task Force, special mention should be made of that relating to the establishment of a Rural Welfare Fund, whose purpose is to supplement what organized communities need in order to satisfy essential civic needs. The Meeting was aware of the fact that 50 per cent of the population of Latin America live in rural areas and that their level of living is low compared with that of the inhabitants of the more populated centers. Moreover, the importance of agricultural development for the economy of the Hemisphere, and the fact that about 50 per cent of the labor force is engaged in agriculture, shows how primitive are the methods used. More important than funds is the communities' desire to help themselves by contributing both labor and money to specific projects. The Pan American Sanitary Bureau is to make a concrete proposal to the Governments on how to translate the Rural Welfare Fund into reality.

Another proposal made was to create a Latin American common market for biological products, the idea being to improve the quality of those products and increase the production of them in certain countries, and thus establish standards for a healthy interchange for a humanitarian purpose.

What is not included in the Final Report is as important as what is written therein. Since the establishment of the International Sanitary Bureau—today known as the Pan American Sanitary Bureau—in December 1902, the Meeting of the Task Force marked the first time in this century that distinguished experts of the Americas convened to discuss purely technical matters, in all of which progress has been sustained. There could not have been a more favorable moment. The Hemisphere is pervaded with a spirit of renewal, of transforming expectations and hopes into the reality of well-being. It was this spirit that animated the Meeting of the Task Force, and stimulated official and extra-official exchanges of ideas and of experience between Ministers, with a view to averting errors. The desire of the Ministers and the Governments to give direct assistance to one another further strengthened the solidarity of the Americas, which because of their culture

and the worth of their people must play their appointed role in the concert of nations.

The Final Declaration is not only a simple expression of faith; it gave the following answer to the basic question which the Task Force met to deal with, namely: Can the Ten-Year Public Health Program of the Alliance for Progress be put into practice?

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

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

Dr. Abraham Horwitz
Director, Pan American Sanitary Bureau

CONTENTS

CONTENTS (*cont.*)

Annexes

Final Report

TASK FORCE ON HEALTH AT THE MINISTERIAL LEVEL

Final Report

I. TERMS OF REFERENCE

The Charter of Punta del Este, in Resolution A.4, 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 may serve as a basis for the Member States in preparing their national development programs." In the matter of health, the 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 newborn; 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 Americas to examine the present status of each problem and 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 staff of the Bureau, were made available to the 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. The list of participants appears in Annex 2 (page 152). The Task Force held eight plenary sessions, four sessions of Committee I, and three sessions of Committee II, and considered the items contained in the agenda (Annex 3, page 156) as approved at the second plenary session.

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

The Act of Bogotá 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 of the standard 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 toward 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 relation 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 relation to 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 small 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 standstill 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 Americas agreed to work toward the achievement of the health goals set forth in Title I, "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 socioeconomic level, the industrialized and urbanized areas of the Americas. In the remainder of the Hemisphere, 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 be achieved only 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, unhealthful housing and working conditions, illiteracy, lack of proper clothing, and a low per-capita real income. These factors together produce a high general mortality, as well as a high mortality in children, especially those under 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 schoolchildren, for 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 toward 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 and 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 allows 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 20 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 dis-

eases are in the process of disappearing. This 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, and 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 10 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 Hemisphere.

The above-mentioned social changes that influence health problems, and are in turn influenced by them, are occurring in a population of 206 million (1960) 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 1,000 and a mortality rate of about 12 per 1,000. Mortality is high in infants and in children under five years of age. According to available information, the former ranges from 50 to 130 per 1,000 live births, whereas in technologically advanced countries it is currently only about 15. Mortality in children in the 1–4 age group is between 3 and 32 per 1,000 population, whereas there are other countries in the world where the index is 0.8 per 1,000. 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, and 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 years 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 10 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 should 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 square kilometer.

According to the 1950 census, the economically active population in the Continent 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 United Nations Food and Agriculture Organization (FAO), agricultural production declined approximately 2 per cent during the period 1960–1961. Food production also dropped

[1] *Summary of Four-Year Reports on Health Conditions in the Americas, 1957–1960. Scientific Publication PAHO* **64**, 1962.

below that of the previous year, when there had also been declines relative to the prior 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, because of insufficient use of modern food technology, which results in increased production costs. Both the quality and the quantity of food consumed are below par, and this gives rise to one of the fundamental problems in Latin America: malnutrition.[2]

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 three to four years.

> . . . There are no statistics showing any appreciable improvement in rural income levels; indications are to the contrary, showing 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 the major cause of social and political tensions and of many of the region's economic problems.[3]

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 the 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 Bogotá 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 than it demands. The population structure, its age distribution, and 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 profes-

[1] Inter-American Development Bank. *Social Progress Trust Fund. Second Annual Report, 1962,* p. 122.

[2] *Official Document PAHO* **48**, 105–111.

[3] Inter-American Development Bank, *op. cit.,* pp. 122–123.

sional 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 health 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 the quantity of data are 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 it 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 for the solution of problems. 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 continuous 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 health 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 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 in 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 continuous process.

The organization and administration of health services, at both the local and 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 attain their ends only 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, legislation, 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 techniques which have been worked out in other geographic areas. This fact justifies the need for investigating the phenomena that condition health and disease in the countries and communities of the Hemisphere. 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 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 the 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 acknowledged to be parts of the same process, which makes it advisable for them to coexist in the same organization. This is the thesis of the integration of health services to solve

[1] Document TFH/3 (Eng.), 4 February 1963, p. 2.

the problems affecting the work unit—the family—and communities. Examples of the translation of this theory into practice in the Hemisphere 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,[1] 5.8 per cent of the public expenditure of Latin America is allotted to public health. 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 plans 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 should 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 method is applicable to other health problems that can be solved through 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, suburban, and rural areas, with a flexible financing system to cover the various items in these programs.

[1] Inter-American Development Bank. *Social Progress Trust Fund. Second Report, 1962*, p. 167.

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, the 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 awakened 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.

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 factor is 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; to formulate plans and programs; to rationalize public administration and make services more efficient; to increase investments, of both domestic resources and external assistance, as the economy grows 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 back-

ground of each problem, which was available to them in the working documents prepared by the Advisory Groups 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 Final 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.

By the end of 1962, of the estimated population of 153.7 million in originally malarious areas of the Hemisphere, 59.3 million were living in areas in which the disease had been eradicated; 30.4 million were in zones already free of transmission and now in the consolidation phase; 49.3 million were in areas that are in the attack phase; and 14.7 million 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.

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 antimalaria 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. Organophosphorus 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 so require, it is advisable to spray houses to a level above 10 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 governmental departments 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 continuous 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 occurring 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 comprehensive 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 assistance can be begun by utilizing the same auxiliary malaria evaluation per-

sonnel 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 given economic and technical assistance to their less favored neighbors.

Inasmuch as malaria eradication is a hemisphere-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 especially 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 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 allocations 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 1955–1960. Deaths from this cause in 17 Latin American countries were 35,000 in 1958. Taking as a basis the data from the countries that have registration systems, it can be estimated that the number of deaths from tuberculosis in a year was at least 54,000. The death rate declined in only 7 of these countries during the period; it remained the same in 8, and increased in 2. The number of cases notified in 1958 was 100,500. 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 active 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 of 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 combating 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 an infectious 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 for the majority of cases.

It should be borne 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 insistence should therefore be laid on the use of standardized objectives and the cheapest possible diagnostic and treatment methods, although some of them 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) should 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 should 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 Hemisphere, 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 the working document.[1]

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 Hemisphere. 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 at least one fifth of their population. The high costs of this measure can be reduced only when smallpox eradication has become hemisphere-wide.

The eradication of smallpox from the Americas 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 necessary measures to eradicate the disease.

[1] Document TFH/11 (Eng.), 8 March 1963, p. 23.

In numerous resolutions, the Governing Bodies of both the World Health Organization and the Pan American Health Organization have voiced their interest in and concern over 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 requires.

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 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 [2] have shown its great clinical and epidemiological importance, which justifies its inclusion in the health plans of the countries where it is prevalent. The disease may affect the fetus, and especially afflicts infants under five years. It also causes important cardiac and gastroenteric pathological changes in adults.

[2] Document TFH/3 (Eng.). Report of the First Meeting of the PAHO Advisory Committee on Medical Research, pp. 83-98.

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 highly advisable for health education programs to be carried out on an urgent basis with a view to enlisting the population's cooperation in the campaign against the triatomes.

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 lesser 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 2000. 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, as is 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 be aimed at satisfying national food needs rather than exporting essential food items.

One of the principal nutritional deficiencies in Latin America is that of protein. Today, many new sources of this nutrient have been developed, such as fish, cottonseed, peanut, and soy bean flour, 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 elimination 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, livestock 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 vul-

nerable groups of pregnant and lactating mothers and preschool 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 mortality 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 service's 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 resistance 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 the 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 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 1961–1971 it will be necessary to install water and sewerage services for at least 44 million inhabitants in the urban areas and 58 million 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 mortality of infants and of children under five 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 past decade, the rate of construction of new services and of expansion of existing ones 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 that 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,[1] 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, especially 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 Americas 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 they 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 abovementioned 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 in villages or hamlets, measures should be taken to make water available in homes. The cooperation and participation of the community is basic and, if well motivated, the community may lend its own efforts or even funds for carrying out projects. Basic capital, a true fund for rural well-being, 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 Hemisphere, 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 Hemisphere have given particular urgency to the training of

[1] Document TFH/2 (Eng.), 5 February 1963, p. 10.

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 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 toward the improvement of human resources and the widening of opportunities by raising the general levels of health and education, and by improving and expanding technical training and professional 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 the promotion and restoration of health.

This will require taking a series of steps, forming a continuous 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 problems 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 for most Latin American countries are incomplete, so that existing plans have been but a statement of general 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 health ministries 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 an especially urgent need. It is therefore recommended that such training be intensified. The courses begun by the Latin American Institute for Economic and Social Planning in cooperation with PASB, and at certain universities of the Americas, 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 the recommendation to the Governments "to improve the collection and study of vital and health statistics as a basis for the formulation and evaluation of national health programs" (Resolution A.2 of the Charter).

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 12 Latin American countries took censuses between 1960 and 1962; in seven countries they are scheduled in 1963; one country has not as yet reported. The absence of data from recent censuses makes the analysis of health problems extremely difficult and affects plans and programs. 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 programming 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 great deal 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 for the preparation of 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, urbani-

zation, 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 the Americas public administration is often inadequate to meet the complex operations of the various institutions. This explains why the personnel and the knowledge available are 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 and 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, par. 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; obtain a better return from medical care services; create the necessary services gradually; and ensure financial accessibility to therapeutic agents and means for the prevention of disease (Resolution A.2, par. 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 (par. 2-b.5).

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 March 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.[1] These documents reflect the same purpose, reinforcing and reiterating 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

[1] Document TFH/9 (Eng.), 8 March 1963.

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 from 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 the 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 that 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 making a careful revision 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 curative services, especially hospitals, the benefit of which could be greatly expanded if they were to furnish community services through outpatient departments and if their programs of action were 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 furnishing 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 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 advisability 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, for economic reasons, be primarily transferred to the general network of local health services. The assimilation of these new activities, resulting from special campaigns for tuberculosis immunization, smallpox vaccination, yaws eradication, and the present malaria campaign, makes 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—especially hospitals—is not done gradually and progressively over the reasonable period required to permit implementation with the necessary 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.

Again in this field, it has been recognized that adequate statistical information, with particular attention to data on resources, services, and results of programs and services, is essential.

There is evidence that the administrative machinery in many of the health ministries 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, and 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 establishment 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, the work must be organized 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 high 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, as follows (par. 1-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 especially 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 greatly 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, owing to the 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 sanitation workers.

Dentists and veterinarians in Latin America exist in the ratio of one per 5,000 and one per 50,000, respectively. These figures represent only absolute numbers, and the large urban areas absorb an excessive proportion of these professionals.

The figures relating to subprofessional personnel in general are even less favorable, and the needs in supervision are still greater. Consideration should be given to the need for a good secondary educational background for sanitary inspectors, nursing auxiliaries, statistical auxiliaries, etc.

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

Constant liaison between government agencies responsible for health, for basic education, and for 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 health ministries 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 dissociated from the "medical demand"

of the population, from resources for training physicians, or 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 paramedical personnel, the ratio of physicians to paramedical personnel, and the administrative 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 medical 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 the health programs, in addition to professional and technical work, the physician accepts the role of leader, teacher, and guide for technical and paramedical workers, for other professionals, and for 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 health ministries and the 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 intensify their sense of responsibility and give them a broader view of medicine. It would also provide them with incentives, once they are graduated, to practice their profession in such areas. This could help bring about a better distribution of physicians.

B.4 *Research*

Resolution A.2 of the Charter of Punta del Este emphasizes the contribution that research can make to the health of the individual and community, in the following terms (par. 1-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 advancement under 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 socioeconomic context of different countries, regions, and localities.

The intensification and expansion of research in these fields depends on skilled professional and subprofessional 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, and of 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 diseases 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 plan-

ning and health service activities depend on the assembly of accurate basic health information.

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

B.5 *Increase in Life Expectancy at Birth by a Minimum of Five 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 the eradication of malaria and smallpox from the Hemisphere and to provide 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 that have excessive death rates, marked improvements through the extension of health programs, combined with socioeconomic developments, are usually evident in an increasing life expectancy at birth. Reduction in mortality, especially of children under five years of age, produces a rapid increase in life expectancy, as is demonstrated by data from Chile, Mexico, and Venezuela. By reducing the death rate under five years in many of the Latin American countries by one half, theoretically the increase in the life expectancy would be five to six years. Since major improvements in environmental conditions and nutritional status, and the extension of programs to prevent communicable diseases, would also reduce the number of deaths in older children and adults, such progress could be expected to increase life expectancy at birth by five to 10 years.

For the calculation of life tables, it is necessary to have accurate census data on the population, by age, as well as data on deaths, by age, obtained from the registration system. These statistical data are essential for many aspects of the planning and evaluating of programs, and for devising the instruments to measure the results of programs. 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 death 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 figures from the census as well as 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—life expectancy at the beginning of the period—sound planning includes the current and continuing development of essential data for measurement of progress through the decade.

From the deaths by age group, a selection

will be made of those groups whose mortality differs most from that in countries which are more advanced from the viewpoint of health. Once these groups have been determined—and they include especially those under five years—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.

Provision 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*

i. 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.

ii. 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.

iii. 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.

iv. 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.

v. 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.

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

vii. It is suggested that the production of new insecticides that have prolonged residual action, as well as of antimalaria drugs that have a radical curative and prolonged suppressive effect, continue to be encouraged.

viii. 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.

ix. 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*

i. 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.

ii. 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.

iii. 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.

iv. 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 toward the integration of the health services and the implementation of the program with non-specialized personnel.

v. 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.

vi. Considering 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*

i. 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 seek such additional funds and resources as are needed from national and international sources.

ii. 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 recurrence of the disease. This can be accomplished through the annual vaccination of one fifth of the population.

iii. 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*

i. It is recommended that at the end of the malaria eradication program the spray-

ing teams undertake spraying programs for the purpose of eradicating or diminishing triatomes in the houses, especially 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 vectors of Chagas' disease. Community cooperation should be required for such programs.

ii. 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.

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

iv. 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. Rural communities, properly organized and informed, should participate actively in the repair and improvement of their housing.

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

A.5 *Nutrition*

i. 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 that on this basis agricultural policies with respect to livestock and other sources of food production should be rationalized in order to assure the fulfillment of these requirements.

ii. It is recommended that ministries of health should participate actively in the planning and development of 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.

iii. 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.

iv. 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.

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

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

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

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

A.6 *Environmental Sanitation*

i. 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, especially 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.

ii. 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 rates and should be well organized and administered. The ministries of 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.

iii. In order to fulfill the objectives 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 Rural Welfare Fund, to be financed by contributions from the countries themselves, from the Alliance for Progress, and from 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 works. 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.

iv. 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.

v. 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.

vi. 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, they should encourage self-help efforts and the development of cooperatives to achieve this objective.

vii. 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 agricultural worker against occupational hazards, especially those inherent in modern agricultural practice. Industrialization programs should include industrial safety and health measures.

viii. It is suggested that international banking agencies include in their loan contracts to public or private enterprises a clause providing for 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.

ix. The urgent need for the training of professional and subprofessional 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 collabo-

rate in the training of experts in the countries.

B.1 *National Planning for Health*

i. 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.

ii. 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.

iii. 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 or the taking of censuses. Attention is called to the desirability of finding indices which will 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 used should basically be those which will indicate progress toward that goal, and not merely represent indices of administrative objectives.

iv. 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.

v. 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.

vi. 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.

vii. 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.

viii. 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 the country has available, of the attitude and response of the community, and of other aspects essential to planning on a national scale.

ix. Such is the importance and variety of health needs as compared with the limited resources available to meet them, that they must be arranged according to priorities which themselves should be established, during the planning process, in the light of

all the considerations indicated by the national interest.

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

x. It is recommended that the Governments complete their national economic and social development plans, including the public health program, 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 this plan, and especially the health program, may be put into operation with their own resources and with necessary external financial aid.

B.2 *Improvement of Health Services*

i. In planning for new services or for the expansion of existing ones, it is recommended that a study and analysis be made of existing programs. It is further recommended that an inventory of personnel, facilities, and budget be made so as to be able to develop programs which will give the greatest yield in terms of reduction of morbidity and mortality.

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

iii. 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.

iv. The ministries of health should 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 of the State, as well as coordination between these and private, semiautonomous, and autonomous organizations providing health services of any type. The aim is to incorporate the medical care activities of those institutions, including hospitalization, into the basic health services at all levels—local, intermediate, or national—with the final objective of attaining a progressive integration of these activities. Preventive and curative services are but parts of an integrated whole.

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

vi. It is recommended that national and international sources of financing adapt their loan policies to the characteristics of the health sector, and adjust their requirements to the stages planned by health agencies.

vii. 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 in order to assure the best use of the funds budgeted for health as well as of personnel and services.

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*

i. 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 obtain 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 urban and rural population. Better utilization of resources can be achieved by maintaining greater flexibility in the movements of personnel. As to subprofessional 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.

ii. It is recommended that interagency committees be established, representing ministries of education, authorities of university schools, public health leaders, and representatives of organized professions, to study the training of professionals required for health programs.

iii. 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 who will work in the health field.

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

v. 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.

vi. 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.

vii. 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.

viii. 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.

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

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

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

xii. It is urgently necessary to promote the establishment of education and training centers for developing teaching staff, at all levels in our countries, with financial contributions from the Governments of the Hemisphere and from private or intergovernmental institutions whose programs include medical training.

xiii. 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*

i. It is recommended 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.

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

iii. 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 fields 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.

iv. 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.

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

vi. It is suggested that necessary steps 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 agencies, governmental and nongovernmental, so as to permit appropriate coordination of efforts and maximum utilization of all resources.

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

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

i. The Task Force on Health at the Ministerial Level 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.

ii. 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.

iii. It is recommended that health programs based on specific and direct measures should attack the diseases responsible for the excessive mortality in children under five years of age, such as gastroenteritis, respiratory diseases, measles, whooping cough and other infectious diseases, and nutritional deficiency, which 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.

iv. 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 be accurately measured only through sound biostatistical 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:

i. 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 begun immediately.

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

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

iv. Recommends that Governments eliminate customs duties and excise taxes in order to facilitate the free interchange of these products, when they are needed for national public health programs.

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

vi. Recommends that, once the interchange of biological products for human use 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 Hemisphere, which creates a serious health problem and impedes the execution of preventive and curative health programs:

i. 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.

ii. 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.

iii. 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.

iv. 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 social and economic development plans is essential to the attainment of the objectives of the Alliance for Progress:

i. 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.

ii. Recommends to the Governments and to inter-American and international organizations, both governmental and nongovernmental, interested in or concerned with problems of the family, of women, or of children, that they exhort their members to work more actively and positively toward 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 the Organization of American States, in accordance with Resolution E of the Charter of Punta del Este, is carrying out a public information program aimed at promoting the interest of the peoples of the Americas in the Alliance for Progress; that one of the measures adopted is the establishment of National Committees for the Alliance for Progress, in the Member States of the OAS; 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 in relation to 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 Convention, 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 carry them out may lead to discouragement or frustration.

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

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 WHEREOF, 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:

ARGENTINA—*Dr. Tiburcio Padilla, Minister of Social Welfare and Public Health*

BOLIVIA—*Dr. Francisco Torres Bracamonte, Representative of the Minister of Public Health*

BRAZIL—*Dr. Paulo Pinheiro Chagas, Minister of Health*

CHILE—*Mr. Benjamín Cid, Minister of Public Health*

COLOMBIA—*Dr. José Félix Patiño, Minister of Public Health*

COSTA RICA—*Dr. Max Terán Valls, Minister of Public Health*

DOMINICAN REPUBLIC—*Dr. Samuel Mendoza Moya, Secretary of State for Health and Social Welfare*

ECUADOR—*Dr. Luis Pallares, Minister of Social Welfare, Labor, and Health*

EL SALVADOR—*Dr. Ernesto R. Lima, Minister of Public Health and Social Welfare*

GUATEMALA—*Dr. Roberto Arroyave, Representative of the Minister of Public Health and Social Welfare*

HAITI—*Dr. Louis Mars, Representative of the Secretary of State for Public Health and Population*

HONDURAS—*Dr. Carlos A. Javier, Representative of the Secretary of State for Public Health and Social Welfare*

MEXICO—*Dr. José Alvarez Amézquita, President of the Meeting, Secretary of Health and Welfare*

NICARAGUA—*Dr. Constantino Mendieta Rodríguez, Representative of the Minister of Public Health*

PANAMA—*Dr. Bernardino González Ruiz, Minister of Labor, Social Welfare, and Public Health*

PARAGUAY—*Dr. Dionisio González Torres, Minister of Public Health and Social Welfare*

PERU—*Dr. Víctor Solano Castro, Minister of Public Health and Social Welfare*

UNITED STATES OF AMERICA—*Dr. James Watt* FOR *Dr. Luther L. Terry, Surgeon General*

URUGUAY—*Dr. Aparicio Méndez, Minister of Public Health*

VENEZUELA—*Dr. Arnoldo Gabaldon, Minister of Health and Social Welfare*

Pan American Sanitary Bureau—*Dr. Abraham Horwitz, Director, Secretary of the Meeting*

Addresses by the Participants

ADDRESS BY THE SECRETARY GENERAL OF THE ORGANIZATION OF AMERICAN STATES

DR. JOSE A. MORA

Presented at the First Plenary Session
15 April 1963

On behalf of the Organization of American States, it is my privilege to extend to you a cordial welcome on this occasion of the inauguration of the Special Task Force on Health, which is meeting to work toward the achievement of one of the fundamental goals of the Charter of Punta del Este. Most significant and of special importance is the fact that this Meeting of Ministers of Health is being held during Pan American Week. This week is the symbol of the unity of the Republics of the Americas and commemorates the anniversary of the First Conference of our community of free nations held in this same city of Washington in the year 1890.

That first Conference marked the beginning of the inter-American system. From that time onward our Organization has improved continuously; it has established the role of law in inter-American relations, made it the mutual obligation of the American States to maintain peace and security, and striven to induce respect for human rights.

RELATIONSHIP BETWEEN ECONOMIC DEVELOPMENT AND SOCIAL PROGRESS

To these accomplishments in the political sphere are now added the responsibility of providing the peoples of the Americas with a better and fuller life. Aware of this responsibility, and inspired by the principles set forth in Operation Pan-America and in the Act of Bogotá, the American Republics on 17 August 1961 signed the Declaration to the Peoples of America and the Charter of Punta del Este, which approved the Alliance for Progress. That Alliance was conceived as a great cooperative effort of the peoples and Governments of the American Republics to accelerate the economic and social development of the countries of Latin America so that they might achieve maximum levels of well-being, with equal opportunities for all, in democratic societies adapted to their own needs and desires.

In April 1959 the Special Committee to Study the Formulation of New Measures for Economic Cooperation, in Resolution VII adopted at Buenos Aires, recommended that Governments, in planning and negotiating the financing of their economic development, should include public health programs essential and complementary to their economic programs.

The Act of Bogotá, signed in 1960, advanced matters even further and established that measures for social improvement and economic development as part of the general process should be simultaneous, complementary, and progressive.

The high humanitarian ideals which inspired the Declaration to the Peoples of America and the Charter of Punta del Este, in defining the objectives of the Alliance for Progress, echoed the same aspirations as those already voiced in Operation Pan-America and in the Act of Bogotá. With all these efforts, the American Republics have for the first time in their history recognized the close and mutual interrelation-

ship between economic development and social progress.

HEALTH—AN IMPORTANT OBJECTIVE OF THE ALLIANCE FOR PROGRESS

The Charter of Punta del Este, in defining the main objectives of the Alliance for Progress, included the following in Title I, item 8:

> To increase life expectancy at birth by a minimum of five years, and to increase the ability to learn and produce, by improving individual and public health. To attain this goal it will be necessary, among other measures, to provide adequate potable water supply and sewage disposal to not less than 70 per cent of the urban and 50 per cent of the rural population; to reduce the present mortality rate of children less than five years of age by at least one half; to control the more serious communicable diseases, according to their importance as a cause of sickness, disability, and death; to eradicate those illnesses, especially malaria, for which effective techniques are known; to improve nutrition; to train medical and health personnel to meet at least minimum requirements; to improve basic health services at national and local levels; and to intensify scientific research and apply its results more fully and effectively to the prevention and cure of illness.

The importance of these goals is explicitly defined in the Charter when it lays it down that national development plans should incorporate the self-help efforts of the countries directed toward improvement of human resources and widening of opportunities by raising general standards of education and health.

Resolution A.2 annexed to the Charter recommended to the signatory Governments certain long-range measures for the prevention of disease and the protection and recovery of health. For the preparation and execution of these plans, it recommended that the Governments utilize the technical advisory services of the Pan American Sanitary Bureau and other means of technical assistance available to them. It was acknowledged that for the national planning of these and other basic activities, detailed consideration by experts was needed, and the Secretary General of the Organization of American States was therefore authorized to establish Task Forces to undertake investigations and studies and prepare reports and adopt conclusions of a general nature that might serve as a basis for Governments in preparing their national development programs.

With regard to the Task Force on Health, it was specified that it should be organized through the Pan American Sanitary Bureau and that it should "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 newborn; and improvement of nutrition;" and that it also "recommend actions for education and training of personnel and improvement of health services."

This is the great responsibility that has been laid on the present Task Force, a responsibility whose scope and importance appears staggering when one considers the needs and problems of Latin America.

NATIONAL DEVELOPMENT PLANNING AND HEALTH PLANS

National programming of economic and social development is an essential prerequisite for achieving the goals of the Alliance for Progress. In view of the mutual relationship that exists between health, economic development, productive capacity, living standards, and well-being, the importance and need for preparing a national health plan is clear. The plan must establish general guidelines, in the light of an accurate appraisal of current problems and of the economic and administrative possibilities of the country. It should also set forth the objectives to be attained in a specified time;

the priorities in the solution of problems; methods of implementation and alternatives; specific programs and their cost; and a realistic estimation of the funds needed both from domestic and from external sources.

A health plan should be drawn up on the basis of current experiences and data, and while the plan is being executed it should be subject to periodic evaluations in order to ensure its improvement. Through this procedure of planning, the problem of putting the available human and financial resources to the best possible use should be solved.

This process is a complex task that must be carried out through planning and evaluation units staffed by qualified officials. The units, by their very nature, should form an integral part of ministries of public health, as is recommended in the Ten-Year Public Health Program of the Alliance for Progress.

When these health plans have been duly prepared, they should be incorporated in the national economic and social development plans. For this reason, it is obvious that the planning units of the ministries of health must have appropriate representation in the national agencies for over-all planning of development, in order to ensure due coordination. It would also be advisable for such representation and cooperation to be extended to all government agencies whose activities have a bearing on public health, such as those concerned with social security, housing, potable water supply, sewerage, rural development, and so forth.

The Organization of American States has provided technical assistance in the field of development planning to almost all the countries of Latin America, both in drawing up special projects and sectoral planning and in the formulation of over-all economic and social development plans. In providing technical advisory services in the field of health, the OAS has had the full collaboration of the experts of the Pan American Sanitary Bureau, who have cooperated with the Joint OAS/IADB/ECLA Technical Assistance Missions.

NEED FOR A UNIFORM PRESENTATION OF NATIONAL REPORTS

I should like now to mention certain points concerning the procedure for the periodic review of economic and social programs, the objective of which is to ensure that development is dynamic, progressive, and adaptable to the situation existing in the country.

To this end the Act of Bogotá and the Charter of Punta del Este specified that each country would present to the Inter-American Economic and Social Council (IA-ECOSOC) an annual report on the status of the economic and social programs, the progress achieved, the problems encountered, and the outlook for the future. The examination of these national reports by IA-ECOSOC will serve as a basis for evaluating the general situation of Latin America and will make it possible to prepare suitable recommendations for intensifying economic and social development.

It is therefore of the utmost importance that such annual reports be as comparable as possible, in order to facilitate their general study and evaluation. The Executive Secretariat of IA-ECOSOC has therefore decided to prepare, as it did last year, a set of standards aimed at bringing uniformity into the form of presentation of such reports. Standards for presenting the public health aspects have been prepared by the Pan American Sanitary Bureau in collaboration with the Executive Secretariat of IA-ECOSOC. As a matter of information, these standards are being submitted to the present Task Force for consideration, and it is hoped that as a result proper coordination in the presentation will be achieved.

It might also be of interest to you to know that the Special Committees of IA-ECOSOC, which met in Buenos Aires last

February and in Bogotá early this month (April), considered similar standards for the formulation of planning projects, agricultural development and agrarian reform, financial and fiscal policy and administration, industrial development and financing by the private sector, education, housing, and community development.

The General Secretariat of the OAS hopes that with the cooperation of the Ministers of Health it will be possible to receive the national reports before 15 May, so that the Special Committees of IA-ECOSOC may examine them during their second period of sessions to be held next June. In this way the Executive Secretariat of IA-ECOSOC will be in a position to prepare the report.

NEED FOR TRAINED PERSONNEL

One of the most serious health problems our countries face is the need for trained professional personnel in medicine and sanitary engineering. The seriousness of this problem is shown by the fact that at the present time ministries of health and other government agencies directly concerned with public health have approximately 2,400 sanitary engineers, whereas the minimum immediate needs are estimated at 4,050, and up to 8,000 such engineers could be used. On the other hand, the personnel available is not being used to best advantage, and the situation is further aggravated by the fact that on the average only 100 sanitary engineers are being graduated from Latin American schools each year. It is estimated that during the next 20 years an average of 400 sanitary engineers per year will be needed, and that figure does not take into account the current deficit.

With regard to medical personnel, the present number of physicians in Latin America is estimated at 101,390, or an average of five per 10,000 population. While it is true that conditions vary from country to country and that the physician-population ratio does not in itself determine the level of health of the people, the need to increase this ratio is recognized, as is the need to improve the distribution of physicians between the urban and the rural areas, to raise the quality of their training and of the technical equipment at their disposal, as well as to increase the number of paramedical personnel.

The urgent need to solve this problem makes it imperative that our Governments make every possible effort to utilize the available personnel to the maximum and take all necessary steps to increase this personnel, both professional and auxiliary, in the future by enlisting the collaboration of universities and other institutions of higher education, and by utilizing the opportunities for training offered by the international agencies. In this regard mention should be made of the excellent work being done by the Pan American Health Organization and the Latin American Institute for Economic and Social Planning, under whose joint auspices the first course for the training of health planners was begun last year. In collaboration with the Center of Development Studies (CENDES) of the Central University of Venezuela, a guide for formulating national and regional health plans is being prepared. It would also be highly advisable for the Ministers of Health to make maximum use of the opportunities offered by the OAS fellowships program for the training of professional and auxiliary personnel.

WATER SUPPLY AND SEWAGE DISPOSAL

The Ten-Year Public Health Program of the Alliance for Progress recommended to the Governments certain projects for gradual development, including those to supply potable water and sewage disposal for at least 70 per cent of the urban population and 50 per cent of the rural population during the present decade, as a minimum.

The Third Meeting of the Advisory Committee on Environmental Sanitation, which

met in Washington in November 1961, reached the conclusion that the objectives of the Charter of Punta del Este on water supply in urban and rural areas could be reached if maximum efforts were made; however, it considered the objective of providing sewerage systems for 70 per cent of the urban areas more difficult.

From that time to date, the efforts of the Pan American Health Organization to fulfill the plan for water supply and sewage disposal services are known to all. The OAS and several other international development agencies have cooperated and continue to provide technical advisory services in that regard. Other agencies have provided financial assistance to supplement the local resources for these activities. Outstanding among these is the work done by the Inter-American Development Bank, which to date has granted loans totaling more than 160 million dollars for that purpose, and these loans are being complemented locally with funds in about the same amount. However, there is concern over the fact that most of the financing is being channeled toward improving the urban services. It is regrettable that the rural areas have not received the same attention.

It is to be hoped that during the present decade it will be possible to attain the objective set forth by the Charter of Punta del Este as regards the supply of potable water to at least 70 per cent of the urban population. Similar efforts must be made to attain the other objective of the Charter, namely, the supply of these same services for at least half of the rural population, for they represent between 60 and 70 per cent of the total population of Latin America. I am sure that, in view of these circumstances, the ministries of health will redouble their efforts in this field. It will be highly desirable for this Meeting to embark upon the study of the rural problem with a view to finding ways and means of solving it.

There is no need to insist upon the fact that health is one of the decisive factors in economic and social development. It is for that reason that ministries of health must ensure the accomplishment of the sacred mission entrusted to them: to protect the health of the people. With that end in view, health ministries must take an active part in all those programs such as social security, housing, community development, agrarian reform, and industrial development, where their assistance is essential in order to ensure that proper attention is paid to health at all stages of development.

Special efforts must be made to ensure that the activities of ministries of health are duly coordinated with social security programs, a goal that must be reached in most Latin American countries. The need for this coordination was clearly brought out in a study on the organization of medical services recently completed by the OAS General Secretariat in collaboration with the Pan American Sanitary Bureau. This study, which covers five Latin American countries, shows the variety of agencies providing medical care to different sectors of the population.

In 18 countries social security programs are providing medical care to a large part of the population, and have made a substantial contribution toward increasing the health resources of the Americas; nevertheless, in most of those countries there is no proper coordination between the ministries of health and social security agencies, either in the planning or the execution stage.

It would be most advisable that the Task Force on Health turn its attention to this situation and make recommendations aimed at encouraging such cooperation, so that the greatest possible return may be obtained from the existing resources.

It is also necessary for health ministries to collaborate in programs for housing and agricultural development, since these must be preceded by environmental sanitation

and provision must be made for water supply, sewage disposal, and other services necessary for health protection. In many other fields, in both government activities and the private sector, due consideration must be given to measures conducive to the improvement of health conditions. In this connection, Resolution A.2 of the Charter of Punta del Este recommends that Governments "adopt legal and institutional measures to ensure compliance with the principles and standards of individual and collective medicine for the execution of programs of industrialization, urbanization, housing, rural development, education, tourism, and others." It is in these terms that is defined the responsibility of our Governments, and particularly of our ministries of health, for maintaining a constant regard for the well-being of the individual and of the community, throughout the planning and execution of national development programs.

ERADICATION OF INFECTIOUS DISEASES

It is worthy of note that, to the extent their resources allow them, the Governments of the Hemisphere have undertaken simultaneous programs to protect, promote, and restore health. There is no doubt that one of the results of the national planning of development will be the better utilization of resources for the solution of problems according to the priority attached to them.

The large-scale systematic efforts to eradicate or control communicable diseases made by all countries of the Americas, with the advice and assistance of the Pan American Health Organization and of other international organizations, are proof that a real job is being done in the Americas. Although much has already been done in this respect, there is no question but that even more remains to be done. Yet it is clear that there is complete awareness of the problem. Conditions will improve immensely if self-help efforts are redoubled and the mutual aid provided for in the Alliance for Progress is utilized.

For almost two years now, all the countries in the Americas have had malaria eradication programs under way. In 1961 regions with more than 5 million inhabitants had been rid of malaria, and at present the disease is being attacked in areas with a population of more than 50 million.

Rapid progress has been made in smallpox eradication, and when this campaign is completed there will be a smallpox problem in only two countries of the Americas.

As for tuberculosis control, the statistical data are relatively incomplete. However, there is no doubt that this disease is one of the main causes of death in some countries of the Americas. Scientific advances now make it possible to attack the tuberculosis bacillus directly; and these advances, together with mass vaccination campaigns, constitute the most powerful means of intensifying the control of this disease in all parts of the Hemisphere.

REDUCTION IN CHILD MORTALITY

In conceiving the Alliance for Progress as "a vast effort to bring a better life to all the peoples of the Continent," the peoples and Governments of the Americas showed the nobility of their aims and aspirations by establishing the goal of reducing "the present mortality rate in children under five years of age by one half."

All the afore-mentioned measures and many others, all the efforts that will be made in the social, economic, and health fields will lead to a substantial reduction in child mortality, which now records the loss of 1,100,000 lives every year. Yet those measures, which will enhance the well-being of the family and provide it with a more healthful environment, better nutrition, and greater accessibility to medical and hospital services, must also include an over-all campaign specifically aimed at combating the

causes of this awesome, excessive child death rate.

If we bear in mind that out of every seven children born one dies before reaching the age of five, and if the aim is to reduce this high death rate by half, it is clear that in the decade of the Alliance for Progress the countries must formulate and execute plans for solving the child mortality problem, in the light of the national planning goals and the available resources.

This noble task which the Americas have undertaken will be greatly dependent on political, social, economic and technological factors, but in any event it must encompass such important aspects as improvement of nutrition, environmental sanitation, and preventive and curative medical care.

Children represent the future of the Americas and embody the hopes of its peoples. If we are endeavoring today to create greater well-being by satisfying man's desire for work, home and land, school and health, within the framework of liberty and through democratic institutions, we must complete those efforts to ensure that the children will grow up to enjoy that better life.

It should be pointed out here that within the Organization of American States effective cooperation is being given by a specialized agency, the Inter-American Child Institute. This Institute has helped, to the best of its ability, to foster child welfare. It has made interesting studies and issued publications on a variety of subjects, especially health, in close collaboration and coordination with the Pan American Sanitary Bureau.

WORK OF THE PAN AMERICAN SANITARY BUREAU AND THE TASK FORCES

The health objective of the Charter of Punta del Este is set forth in Title I, item 8, and Resolution A.2 establishes the Ten-Year Public Health Program and the types of measures for implementing it.

The responsibility for formulating standards to establish systems of health planning in Latin America, and for providing the countries with technical advisory services in the preparation and execution of their health plans, was laid on the Pan American Sanitary Bureau. The Bureau was also entrusted with the organization of the Task Force on Health to appraise prevalent problems and suggest general lines of action of immediate effect.

In placing this responsibility on the Pan American Sanitary Bureau, the Governments of the Americas have once again given it a well-deserved vote of confidence, which it fully merits by reason of what it has done to promote health in Latin America.

With the object of preparing studies and analyses in depth of almost all those health activities that should find a place in national plans, the Pan American Sanitary Bureau has convened several Advisory Groups of experts who have produced a series of important reports on environmental sanitation, nutrition, medical education, health planning, medical care, health statistics, and medical research.

In this hour of pressing needs, we must boldly face new situations and the problems they present. We must urgently initiate the changes necessary to adapt national structures to the time we are living in. It has been said that the twentieth century will be defined as that stage in civilization when the concern to conquer underdevelopment was aroused. It is the century in which a gigantic effort is being made, deliberately and with the aid of revolutionary technological means, to eliminate poverty and combat disease. Of all the resources available for economic, political, and social development the most important is man. He is the protagonist as well as the beneficiary of all development. Human potential is thus the basis of all our aspirations for progress.

To carry out health programs is to protect this human potential. On this solid basis we can work for both moral improvement and the preservation of spiritual values.

For that reason, Gentlemen, the conclusions reached by this Task Force and the way in which our Governments make use of them will be of decisive influence in the struggle to achieve happiness for America, a struggle which unites us all.

MESSAGE OF WELCOME FROM THE PRESIDENT OF THE UNITED STATES OF AMERICA*

Presented by
DR. LUTHER L. TERRY

Surgeon General, Public Health Service of the United States of America

I am happy to have this opportunity to speak to you briefly and to welcome the members of the Task Force and all the participants at the Meeting.

It is gratifying to learn that at least fourteen of the Ministers of Health and most of the key health personnel from the Americas are meeting here to discuss this most important subject.

It gives me particular pleasure to announce to you that President Kennedy has indicated that he expects to meet with the group later in the week, but in the meantime has sent a personal message which he would like me to deliver to you. His message is as follows:

"I warmly welcome the Ministers of Health of the American Republics now meeting with you in Washington. As the leading health officials of this Hemisphere, you are met in a significant cause to plan the programs which will give full meaning to the words and ideals of the Charter of Punta del Este.

"The Ten-Year Public Health Program of the Alliance for Progress, which appears as Resolution A.2 of the Charter, is a statement of principles to which the Government of the United States wholeheartedly subscribes.

"The Charter contains objectives which are quite specific and no less important to the future health of our peoples than the current campaigns under the Pan American Health Organization against malaria and smallpox. It envisions an increase of five years in the life expectancy at birth of every person within the present decade, and it calls for a 50-per-cent reduction in the present mortality rate of children under five years of age. The Hemisphere looks to you to specify the means by which these objectives may be reached.

"We in the United States have already pledged our interest and resources. We rely on you, as experts in this field, to point the way."

* Presented at the first plenary session, 15 April 1963.

ADDRESS BY THE PRESIDENT OF THE INTER-AMERICAN DEVELOPMENT BANK

MR. FELIPE HERRERA

Presented at the First Plenary Session
15 April 1963

I bring to you most cordial greetings from the Inter-American Development Bank, its Board of Governors, and its officials. During the past two years all of us have had the good fortune to be closely associated with many of you present in this room, where I see so many friendly faces. Our most cordial greetings to all of you.

I also want to express particular appreciation for the kind invitation extended to me by the Director of the Pan American Sanitary Bureau to be with you at this Meeting. This specialized conference is perhaps the most important event in the public health sphere since the Punta del Este Meeting in August 1961, for we are convinced that improvement in health conditions is an essential prerequisite to economic growth. We have especially welcomed this opportunity to explain to you how the Inter-American Development Bank has come to be connected with the matters that concern you, and for our part, to learn, through the work that you will do in the course of this week, of your special problems and points of view, since these will have a basic influence on the Bank's future policy in this field.

Before turning to the specific work of the Inter-American Development Bank, I want to make special mention of the preparatory work done by the Pan American Sanitary Bureau. I recall that even before the Agreement Establishing the Bank was signed, early in 1959, Dr. Abraham Horwitz worked assiduously with the delegates from the countries negotiating the Agreement to convince them that the new financing agency would play a limited role if it could not attend to the health needs of the Hemisphere. He believed that the new financing agency should be free to act in conjunction with other organizations which had materially aided economic development, but which had not been in a position to cooperate with our communities to achieve higher health levels.

I believe that it was due to Dr. Horwitz's concern, a concern voiced for decades by the Bureau, that a flexible and constructive operating formula was established for the Bank. Besides our basic capital resources, the Fund for Special Operations was established by means of an additional $150,000,000. This was done to permit the institution, when it announced its disbursements in February 1961, to meet certain requests that bankers would not consider strictly orthodox and recoverable financing.

Later there was a new development which perhaps not even Dr. Horwitz and his associates could have foreseen. The eight officials responsible for examining the first requests for loans agreed to apply to the financing of loans for water and sewerage systems the same criteria that they apply to the financing of loans for electric power supply, development of transport systems, or improvement of national industrial capacity. So, with the cooperation of your technical experts, the Bank was able to transform many applications from your countries for improvement of their water

supply systems into financially feasible projects. One must realize that to take care of such requests, we could use our ordinary capital only to meet the needs of the largest cities or those communities where a satisfactory organization and water-rate system could be established and the improved public service administered on a strictly business basis.

Let us recall that the Bureau, as well as the Bank, attributed special importance to our first operation, a loan to improve water service—both potable and industrial—in the city of Arequipa in southern Peru. This was not only our first health undertaking, but also our first banking undertaking. It is interesting to note that for this operation—in spite of the prophesies of the ever-present sceptics—we obtained the support of U.S. commercial banks. So we could prove that the financing of projects of this sort may be not only a possible object of interest to a development bank, but under certain conditions may arouse the interest of the commercial bank. However, we should have been very limited in our sphere of action had we not held the historical meeting at Bogotá.

The Act of Bogotá established, in September 1960, the basis of what is today the Social Progress Trust Fund. You will recall that the generous decision of the Government of the United States of America to place 500 million dollars at the disposal of the inter-American system had a far-reaching effect, as Dr. Mora has just pointed out in his interesting and constructive remarks, when he noted that there is no economic development without social development. This statement, which seems very obvious to us today, received very tardy acceptance in all our countries, especially in the field of inter-American relations.

It was only in September 1960 in Bogotá that our countries agreed that every effort toward economic development aimed at direct improvement in production would inevitably be limited if it were not accompanied by a parallel effort to improve social conditions and link these two aspects of development which, in practice, are but one.

However, as bankers, we are well aware of the fact that, from the purely financial and technical point of view, we cannot treat the two aspects as one unless we take cognizance of the origin of each, for it is obvious that the financing of social projects calls for much more flexible terms as regards repayment periods, interest rates, and type of currency acceptable for repayment.

As for development procedures, all of us know that our financial agencies unfortunately possess limited resources and have no means of increasing these other than by resorting to the private capital market, where the interest rates are such that it is not easy for our agencies to channel the funds obtained into the financing of social needs.

That is why the contribution to this Social Fund of 500 million dollars by the Government of the United States of America, from public funds and at the expense of the taxpayers, is of such far-reaching significance.

The Bank became the principal administrator of the Social Progress Trust Fund. We had practically 80 per cent of these resources at our disposal, to be used in four basic fields: first, rural development; second, housing; third, sanitation works, especially potable water systems and sewerage systems; and finally, education.

As Dr. Mora also pointed out, the foregoing situation has made it possible for the Bank, after little more than two years of operation, to finance out of its own resources and the funds which it administers, more than 160 million dollars worth of projects. This outlay created, in turn, expenditures of similar amounts from the domestic resources of the countries concerned. In practice, then, our action—I venture to say our catalytic action—has precipitated the investment of more than 300 million dollars

in Latin America for water supply and sewage disposal systems, and other sanitation works.

What I have said does not mean that we are completely satisfied with the work done. We know that we still have much to do. We know that from now on we must improve internal and technical administration of the Bank in order to adapt it to the needs of the countries. We know that we must maintain an even closer contact with you, with the ministries in the different countries, with the specialized agencies. But we are sure of one thing: that the great Latin American dedication of our personnel, joined with your enthusiasm for serving your communities, will enable us to put into prompt operation programs that Latin America has never before known. I can say, without fear of exaggeration, that this is the first major endeavor in the field of international relations in which the countries have become associated with international financing organizations and technical agencies in order to assist the national effort of their respective Governments.

It is worth emphasizing that the Bank has carried out important operations and is now concerned with taking care of projects for financing water supply and sewerage systems. Someone remarked to me that perhaps the Bank is becoming too *liquid;* this need not disturb a banker, of course. This expression reminds me also that a few months ago in a small community in Guatemala called San Lucas de Sacatepéquez, on the occasion of opening the waterworks in the presence of 600 or 700 people of the community, the mayor said, in the course of a witty speech thanking us for our work: "Sir, we thank the Inter-American Health Bank for its interest in us." It is fortunate that Dr. Horwitz was not there, for he might have thought that our agency was trying to take all the credit.

By December 1962 we had financed 933 water supply and sewerage systems, which benefited 15 million people in 855 small communities. By the same date we had helped to create new national or regional agencies which took charge of these activities, and we had worked with the Governments in reorganizing seven similar agencies.

The Bank has devoted an important part of its resources to this work, committing them to long-range plans. It would be idle to think that we could continue to do this, as bankers, unless more funds are placed at our disposal for meeting the needs of the countries. That is the reason why the Bank is now working actively to increase its own resources. A few days ago our Board of Governors approved an increase in the capital of the Bank that would practically double its resources.

We hope that between now and the end of the year the various Congresses will have ratified this change in the Agreement Establishing the Bank, which will be of benefit to all our countries. I also think it appropriate to recall that only a few days ago the President of the United States of America proposed to the Congress of that country new forms of foreign aid for the fiscal year 1964, and pointed out the advisability of increasing the Social Progress Trust Fund by another 200 million dollars, suggesting that this sum also be put under the administration of the Inter-American Development Bank.

I believe that in this way the Bank will be in a position to continue drawing up projects in agreement with the countries and within a few months will be able to make new commitments for loans.

All of you know that a request for funds for foreign aid by the Chief Executive of the United States to Congress is one thing, and the final decision is another—as is the case in the constitutional machinery of our own countries. However, we have reason to hope that this proposal to increase our resources will not meet with objections and

will enable us to take care of the needs of some countries.

Since we are speaking of new funds for foreign aid, I deem it a duty, since I share your interest and your objectives, to tell you of the difficulties that we face just now. In contacts made with our respective countries, whether on trips or in the course of conversations with authorities or with businessmen, we have often found misunderstandings about the character of aid from abroad. There is a belief that there is some sort of open bank account on which countries may draw freely. What is not always understood is that, unfortunately, a negative sort of attitude toward foreign aid is arising in the more developed countries. Influential groups are asking, for example, what sense it makes for the more advanced countries to continue giving financial aid to less advanced countries for economic and social development.

Happily, these voices are in the minority, and happily too, the leaders of the western world understand that the new countries need strong support in this decade of development. It is evident that without this aid they will not perish, but it is also obvious that conditions dangerous to their collective life may be accentuated and that without help from abroad it will be much harder for them to strengthen their democratic institutions.

We believe that aid for development will continue, but it must go hand-in-hand with internal effort. I think that in this connection a splendid step has been taken in the formulation of national development plans, especially the new technical approach whereby the plans contain special chapters devoted to public health, which should receive priority.

It is interesting to see that the committee of nine experts, in reviewing the programs already submitted to it, has in the case of most programs, whether of short or long range, given public health the priority which it deserves. I believe that this fact is important, for it gives some clue to the amount of foreign funds that we may possibly have at our disposal. It is even more important to you because these programs are going to aid your work and that of specialized agencies, inasmuch as they represent a promise of the Governments to allocate annually, in budgets or through their agencies, sufficient internal resources, without which these collective programs cannot advance.

Before closing, Gentlemen, I also want to refer to other tasks undertaken by the Bank in cooperation with the Pan American Sanitary Bureau. I shall mention especially our mutual desire that the specific water and sewerage programs be integrated with the broader programs of urban and rural sanitation.

Dr. Mora has rightly noted that one of the limitations of the inter-American action in this field is the delay, to a certain degree, of work in rural areas. I daresay this postponement is not peculiar to the field of public health; by virtue of being widespread, it constitutes one of the tragedies of Latin America. Even though we are a typically rural continent, our economic and financial policy has been directed for the most part at the most important urban centers. You are well aware that before now, when anyone discussed plans for water and sewerage systems, he had only the large cities in mind. But fortunately, thanks to the sizeable effort of the officials of the Bureau, a growing trend in favor of rural communities is noticeable, and is increasingly reflected in the requests for technical advice and financial aid received by the Bank.

Among matters relating to the rural environment, I must also mention our technical participation in veterinary health programs designed to better the general health of the population. The Inter-American Development Bank has financed numerous livestock programs in Latin America, but in many places it has encountered a situation that you are familiar with: the pres-

ence of livestock diseases and other disabling biological factors which create serious obstacles to meat and milk production. Consequently, we are trying to develop, in cooperation with the Pan American Sanitary Bureau and the countries, an integrated type of program which will make it possible to derive the most effective results from the livestock programs.

Officials of the Inter-American Development Bank look upon the Pan American Sanitary Bureau as a sister organization. We have reaped great benefits from working together during these three years. That is why we do not fear Latin America's population explosion. When we are told that by the year 2000 there will be 600 million people in Latin America, we regard this development as a really great dynamic force for the Hemisphere, not as a deterrent factor, for we are sure that the population explosion in Latin America has a totally different meaning and connotation from that which it has in other already overpopulated regions. After studying the conditions of underdevelopment in our countries, we believe that by means of our work and our natural resources, the Hemisphere can sustain a population greatly in excess of the present one. What is more, we think that it is this very increase in population and the resulting great markets which are going to give Latin America a decisive position in international affairs. But in the Inter-American Development Bank we also realize that a numerical estimate has little meaning. Six hundred million Latin Americans will be of little avail if a large proportion of them are illiterate or sick. Thence springs our aspiration to build a firmer economic foundation for the future—it is your aspiration, too—in order that the future population may be happier, better educated, healthier, a population that feels itself continuously participating in and linked to the collective endeavor and the strengthening of the most precious values.

ADDRESS BY THE SECRETARY OF HEALTH AND WELFARE OF MEXICO, ON BEHALF OF THE MINISTERS

DR. JOSE ALVAREZ AMEZQUITA

Presented at the First Plenary Session
15 April 1963

We live in a time of rebellion. In past times man accepted scarcities and evils as fruits of an irremediable fate, inherent features of human existence. Today he rebels against these scarcities and ills; he tirelessly seeks ways to conquer them and wipe them out.

America, this Hemisphere that a great European thinker called the land of the future, could not remain apart from this battle; it united in the Alliance for Progress, a union of ideals to better the lot of the American peoples. The Alliance for Progress faces crucial economic problems; and it would be impossible to accomplish its aims if those problems were not solved. The Alliance means that improvement in the lot of our peoples will convert them into both producers and consumers, and that great markets will stimulate the industrial growth of areas now submerged in economic underdevelopment. It seeks the well-being of man and the community.

All the countries of the Americas want and need to better their living conditions, to raise the levels of cooperation, which are now high and in some respects exemplary, while in others they leave something to be desired and could be considerably improved. But our ideals and desires would be of no avail if we did not translate them into action —just, human, sincere action. Above abstract ideas, statistics, and scientific studies looms the sad reality that the majority of the Latin American peoples are sunk in poverty, ignorance, and ill health. These are all common problems in this part of the Hemisphere. It is not merely a theoretical question, a matter for cold analysis and arithmetical calculations. We deal with human tragedy of immeasurable scope, with an outrageous misery that oppresses our peoples.

I think that we in the public health ranks must take priority, for it is we who best understand these truly human aspects of the Alliance for Progress. The Charter of Punta del Este looks upon public health as one of the principal factors in the accomplishment of its goals. But this factor has not been rightly weighed by some economists who merely manage figures and abstract ideas. The scope of our task and the intensity of our effort really come from contact with the people, a sincere approach to their problems, and an understanding of the human drama of every individual.

And this effort should be, must be, of multiple origin. From now on we must devote all our ability to the pressing task of drawing up realistic programs of immediate application which will bring health to our most backward rural areas and to the belts of poverty that surround our cities, so that there will no longer be disinherited men in America, but men capable of exercising liberty with dignity.

But this will not be enough. We must see to it that the economists and politicians draw near the people, not only through curtains of figures and statistics which chill and mechanize everything, but across the thresh-

old of sincere solidarity, man to man, American to American, which is the finest ideal of the Alliance for Progress. From this point of view, and as servants of the humble man of our Americas, not as politicians, we must appraise all the efforts made, no matter where or how they are made. Other countries have drawn near the individual man and are already reaping the fruit of their work. We do not deny it.

For us, the war is against poverty, ignorance, and ill health within the framework of democracy. We therefore proclaim that our fight is of an essentially peaceful character, for it is not directed against man but to his supreme advantage. Allow me here to recall the struggle of President Adolfo López Mateos for peace, the indispensable base of progress, in the absence of which we should not be meeting here in our common desire for the betterment of man. President López Mateos brought to the world his message of peaceful coexistence, founded on the traditions of mutual respect and social justice of the Mexican Revolution. Social justice, because there will be no peace so long as deep gulfs exist between peoples, so long as there are rich peoples and poor peoples.

These humanistic ideals of the Mexican Revolution—we say it with pride—in great measure give shape to the Alliance for Progress. We were the first in America to bring about a social revolution, and we are happy that now the entire Continent will follow this road. The distinguished President of the United States of America, John F. Kennedy, creator of the Alliance for Progress, shared this conviction. He expressed it during his visit to Mexico, when he said that our country is enjoying the benefits of our Revolution and that the North American people are also the offsprings of a revolution. The Alliance for Progress is a constructive social revolution which, when realized, will plot a new course for the American Hemisphere.

Therefore, we dedicate all our enthusiasm, all our effort, to achieving the ideals of the Alliance for Progress. We know that all the Latin American countries are eager to push on in a true, sincere, honest joint effort which will lead to the total betterment of the American peoples. Our resources are limited, but this fact should not stand in the way. It is vital to begin basic programs of health, sanitation, water supply, housing improvement, nutrition, etc., however limited their range may be. The important thing is that there should be practical plans, easy to develop, which will contribute to the general welfare, and that we should not sit idly waiting for the achievement of large programs which call for resources now beyond our scope.

We are sure that this is the right road, the road of sincere and immediate cooperation. We have faith in America, in our destiny, and in liberty. And for that reason we put our trust in our own possibilities to achieve a brilliant future.

STATEMENT ON THE ORGANIZATION AND DEVELOPMENT OF THE MEETING *

DR. ABRAHAM HORWITZ

Director of the Pan American Sanitary Bureau, Regional Office of the World Health Organization for the Americas

Resolution A.4 of the Charter of Punta del Este specifically entrusted the Pan American Sanitary Bureau with the organization of the Task Force on Health, as the Secretary General of the Organization of American States pointed out this morning at the first plenary session.

The resolution gives the Task Force the specific responsibility for analyzing the health provisions of the Charter of Punta del Este and for indicating what, in its opinion, are the practical means of reaching the health objectives of the Charter. It is, then, a matter of planning, for both the immediate and the more distant future, how the progress already made in Latin America in the field of health may be continued. Those who represent the highest authority for solution of the health problems of the Hemisphere—that is, the Ministers and their senior advisers—must assume responsibility of this sort within the general process of development now under way. Their opinions, transmitted to the Organization of American States, will be of the greatest possible aid in advancing public health throughout the Hemisphere to the state of excellence necessary to all social progress and economic growth. It was for this reason that I had the honor of inviting the Ministers to the present Meeting. The diversity of health problems covered in the Charter of Punta del Este was taken into account, as was the necessity of preparing basic documents to clarify them. The need for drawing up authoritative recommendations and suggestions that would permit the Ministers to make an exhaustive analysis of the problems was also borne in mind. Thanks to the generous contribution of the Organization of American States, it was possible during the past year to organize Advisory Committees on health planning, medical care, medical education, research, sanitation, malaria, nutrition, and statistics. The conclusions they reached were sent to the Ministers together with other studies prepared by technical experts of the Pan American Sanitary Bureau. They represent the opinion of more than 100 experts from the Hemisphere, some of whom are present at this Meeting. They reflect the views now current in the Americas on the solution of every basic health problem mentioned in the Charter of Punta del Este.

As I have stated previously, we believe that these studies will be a valuable basis for your discussions. It is well to keep in mind, Mr. President, that the Governments have approved the Charter of Punta del Este and the Ten-Year Public Health Program it embodies. So it is now a question of how to implement it, what the practical measures are that each Government can carry out, short-range and long-range. There is no doubt that we are witnessing a new change in the concept of health, which it will be worth while to state once more, because your voice, Gentlemen, is the one which will ring out in the Hemisphere with

* Presented at the second plenary session, 15 April 1963.

the greatest resonance in all spheres of action. That concept holds that health is an indispensable component of development. It calls attention to the influence of health on economic growth. It again points out that, besides being a good thing, perhaps the most precious of good things, health is also a mechanism essential to the furtherance of the economy and its progressive growth. It shows to those who do not wish to view the problem from a purely spiritual standpoint that health also contributes to economic advancement—on the one hand because it allows people to find and develop new sources of wealth, and on the other, because in the absence of healthy men there can be neither economic growth nor technical progress.

Therefore, with all due respect, Mr. President, I should like to propose that in the Final Report of this Task Force reaffirmation be made of a concept which perhaps is not new, but which at this time has acquired particular significance.

The outstanding health problems in the Americas and the criteria to be used in establishing priorities in each country should also be defined, as the Charter of Punta del Este points out. Our societies are different; our environments are diverse; their influence on our inhabitants is likewise different; therefore, our problems vary in nature and extent. The statements of the Ministers during the plenary sessions will aid in working out this aspect of the Final Report: the basic health problems of the Hemisphere and the criteria for establishing priorities. The Charter also states that the Ministers, as I have mentioned, must indicate what measures should be adopted to reach the health goals. To this end, we considered it expedient to propose two committees. The first will devote itself to an analysis of the prevailing problems mentioned in the Charter, as well as such other matters as the Ministers consider worthy of consideration. This committee will have the task of discussing the problem of disease and its characteristics; its most prevalent aspects in the Americas; the problem of nutrition; the problem of sanitation; it will also be called upon to examine the basic health objective of the Charter—an increase in life expectancy at birth by an average of five years per person during the decade. The second committee will have the task of analyzing the basic means that public health employs to attack and solve its specific problems. Therefore, we include among the topics for this committee the planning, organization, and administration of public health services, education and training, and research. In each of these committees the Ministers will be able to analyze the more pertinent aspects of the prevailing problems.

We think that the opinion of the experts of the Hemisphere, which met in the course of last year at the Pan American Sanitary Bureau, can be of significance for scrutinizing these problems in the committees. The committees should propose recommendations of a practical nature for each problem; these should be considered in plenary session for their inclusion in the Final Report. They will present the measures which should be adopted in order to reach the health objectives of the Charter of Punta del Este; these will be both general and specific measures. The summary of the discussions will be embodied in the Final Report, for the preparation of which the President has seen fit to appoint a Drafting Committee; the text of the Report will be approved in plenary session.

This Report, as the Charter of Punta del Este stipulates, will be sent through the Pan American Sanitary Bureau to the Secretary General of the Organization of American States.

This, Mr. President, is how we have conceived of the work of this distinguished Task Force and the manner in which its work is to be carried out. All that I have

proposed is only a respectful suggestion. The Task Force has full authority to carry out its work in the way that it deems most advisable. But the Bureau believes that if this method is followed a very arduous mission can be completed in a very short time. We cannot forget the historic import of the present Meeting. Perhaps since December 1902, when the International Sanitary Convention gave birth to the Pan American Sanitary Bureau, there has not been another occasion in the Americas when the highest health authorities have assembled to discuss exclusively technical affairs of such importance and influence, at a time so unique as that which the Hemisphere is now witnessing. Perhaps at no other time in this century has the significance of man, as the synthesis of all the efforts of a society, been more remarkably demonstrated. In the twentieth century there has been no other opportunity for those who have the moral and intellectual authority to do so, to emphasize the humanitarian purpose of every economic system, whatever the political regime to which they are subject. Nor has there been, either in America or in this century, another opportunity for giving expression to a sense of national purpose by recognizing health as a fundamental component of social progress and economic development.

Mr. President, we of the Pan American Sanitary Bureau have tried to fulfill our duty in the best possible manner. In offering the fruit of our efforts, we wish to state that we are at the service of the Task Force and of all the participants in the Meeting.

ADDRESS BY THE MINISTER OF SOCIAL WELFARE, LABOR, AND HEALTH OF ECUADOR

DR. LUIS PALLARES

Presented at the Second Plenary Session
15 April 1963

In the course of this important conference, I am sure that repeated emphasis will be placed on the basic theme that the development of peoples is contingent upon the development of public health, for it is impossible to conceive of material and economic progress of a nation or a State if it is not based on higher levels of health.

In the Americas we have pathetic cases which prove this assertion and which, by highlighting this concept, enable us to deduce the standards and principles we must pursue in search of better conditions of life and, ultimately, a better future for our peoples.

Let us call to mind the importance, for the destiny of America, of the eradication of yellow fever in Panama and the Canal Zone. By virtue of its special geographic situation, that area then constituted one of the keys to the economic and social development of the countries located on its flanks.

Besides the shining example in that area, I can also mention a similar case in my own country. Some years ago, when Ecuador had not succeeded in eradicating yellow fever and plague from its territory, its economic and social development was at a virtual standstill because the level of public health was so low.

These experiences show that the organization and development of health campaigns for the elimination of the principal communicable diseases bring about, as a logical consequence, the concomitant organization and development of the countries that carry them out. By increasing production they clear the way for progress and, with it, for higher aspirations in every sphere of life's activities. Even today we are witnessing unparalleled situations; regions formerly unhealthy because of malaria are being progressively incorporated into the economic life of countries and settled at an accelerated pace.

Such past experiences have, in turn, spurred the American countries on to make all the necessary efforts to draw up and establish public health plans in consonance with the means available to put them into effect, in order that States and their Governments may devote their best endeavors to the preservation of human capital. This is because they are sure that only if they carry out the programs planned can they reach the goals that they have set for themselves, thereby promoting the formation of a population ready for harmonious and well-planned economic and social development.

And the conviction that the united effort of the Latin American Republics in this field would give the best result in achieving definite aims and better public health goals, led them to join together under the Alliance for Progress and to establish those goals in the Charter of Punta del Este. We are here today in that connection, for the purpose of discussing and fixing the most suitable and expedient avenues to pursue and the most advisable and practical methods to employ.

But allow me to say that, in my judgment,

the policy of subordinating the development of health plans to the execution of agrarian and tax reforms in the countries of the Hemisphere has serious disadvantages, since these reforms, by their very nature, must be carried out at a pace that is not comparable with the urgency that the health plans call for. Thus, while I believe it essential that the Alliance for Progress emphasize the need to bring about these reforms, it must in turn, and in a parallel, though not complementary manner, establish and execute health plans for the American countries that cannot wait for the necessarily slow evolution of those other reforms.

In light of these considerations, the Government of my country, through the National Planning and Economic Coordination Board, is now drawing up a National Public Health Plan, as a part of the general plan of economic and social development which aspires to achieve the goals of the Charter of Punta del Este. It will also set up a Health Planning and Evaluation Office to appraise the results of this Plan as it is put into practice.

The formulation and execution of the Plan will reinforce and invigorate our health institutions, and will encourage the most prompt pursuit and completion of the programs now under way. Among these, the eradication of certain communicable diseases such as malaria and smallpox, which in the past have lowered human potential, takes preference. In Ecuador, as in other Republics of the Hemisphere, these campaigns are well advanced, and their results are easy to verify in terms of collective benefit.

In Latin America we are witnesses to the dramatic spectacle of high morbidity and mortality in children, which reduce to inconceivable figures the life expectancy of its inhabitants, especially that of children —morbidity and mortality resulting from environmental conditions, since the principal causes are gastroenteritis and other infections of the digestive tract. It is essential to eliminate these basic causes, insofar as possible, by promptly implementing programs of water supply, sewerage, excreta and garbage disposal, and programs to improve other environmental factors that have a direct influence on the life and development of the human being.

In Ecuador, as in all the countries of America, the provision of water supplies and of sewerage and excreta disposal systems calls for great financial outlays, which are undoubtedly beyond the present state or fiscal capacities. It is enough to cite the fact that, if my country is to achieve the goals of providing water and sewerage for 70 per cent of the urban and 50 per cent of the rural population by 1971, it will be necessary to invest not less than $300,000,-000, which will require an appreciable increase in the resources now available for these purposes, to be obtained perhaps by a marked increase in the percentage which the national budget now allocates to health care.

The effort is enormous, but it must be made. I have no doubt that the other countries of the Americas will have to do the same. Henceforward they will have to assign those higher percentages to health, when it is necessary, just as they are now assigning them to education, national defense, etc. Otherwise, in the matter of health, they will not be able to create the financial conditions necessary to ensure that their own efforts are supplemented by external aid.

What I have said does not mean that, in order to lower the frightful infant mortality rates, we must depend exclusively on the benefits furnished, in middle or long run, by environmental sanitation. We must make a realistic appraisal of the true needs of our children for medical care and exhaust all efforts to satisfy them, since it is not practicable to speak of reducing child mortality

when medical services are incapable of satisfying the needs of children.

We know full well that in our countries many children die because of the inadequacy, especially in quantity, of medical care. Consequently, we must realize that in this kind of work the closest cooperation among public and private institutions devoted to the same purpose is indispensable.

Let us make the Governments and the peoples aware, then, that each of our countries must devote its best efforts and allocate greater financial resources to the protection of public health.

We must also focus our attention on the undeniable fact that the execution of health programs in America will call for real and effective aid from external sources of finance. In this respect, I want to stress the indisputable fact that, in order to be successful, the Alliance for Progress must allot to the nations of America, in this field more than in any other perhaps, the greatest technical assistance and the consequent financial aid, which from now on must lead to the accelerated fulfillment of these public health plans and programs. It must endow the institutions charged with providing the assistance with such flexibility and efficiency as give unmistakable assurance that the resources of each country will be rapidly rounded out with this external aid, since the goals of the Charter of Punta del Este can be achieved in no other manner.

Technical knowledge has made great headway and banished empiricism from public health affairs. It must be so increased in Latin America that, with it as a foundation, feasible plans and programs of immediate effect can be carried out. The countries of the Hemisphere definitely need a greater assistance from international organizations in order to increase rapidly the human resources that are to speed up the programs of environmental sanitation, those of preventive and curative medicine in general, and all other kinds of programs which, in the essential field of health, are to assure a better life to the population of the Americas.

Thus, if this is the real issue that faces Latin America today, our fundamental task should be to aim primarily at bettering environmental conditions, giving the highest priority, in any ten-year public health plan, to the programs I have just mentioned. Naturally, we must not forget that the creation of demand for these benefits and their use by the people, will depend on an essential concomitant task, namely, that of health education to be carried out from the first years of school. Only by requiring the inclusion of minimum instruction in health education in the general curriculum, by familiarizing children and adults with the requisite habits of hygiene and public health, can we assure the success of such programs. This instruction should never be sporadic or weak, but should be the constant hammering away that makes for awareness in the child and which, like language or other learning, becomes a part of his very life, so that the number of people influenced by this kind of teaching and these principles may constantly increase.

Finally, we must note that the peoples who conquer health problems not only gain the intrinsic benefits derived from health, but also acquire political stability, which in our Hemisphere is a basic ingredient for continuing progress.

The peoples of America rightfully demand better opportunities for leading a useful and productive life, which must be based on better health conditions, on better educational opportunities, and on better housing conditions, which must raise human dignity, bestow peace as well as justice, and make for a Hemisphere of equal aspirations and equal rights, a Hemisphere with full faith in democracy.

ADDRESS BY THE MINISTER OF SOCIAL WELFARE AND PUBLIC HEALTH OF ARGENTINA

DR. TIBURCIO PADILLA

Presented at the Second Plenary Session
15 April 1963

The Delegation of Argentina accepted the invitation to participate in this type of discussion because from the outset we have been inspired by and identified with the aims of the Charter of Punta del Este, which supposes a common effort on the part of all the peoples of Latin America to improve health, living, and economic conditions.

In our country this need is even more urgent than in others. Two dangers threaten us: totalitarianism from the right, which injured our country for 12 years, and totalitarianism from the left, with which all of you are acquainted. The precarious situation of the Argentine worker means that he is fertile ground for doctrines which I prefer not to pass upon.

Because of all this, I believe it necessary to aid our population as soon as possible, with the Alliance for Progress.

As for specific public health motives, the growth of our population and culture has resulted in a greater need of our people for medical services. Therefore, it is imperative to take advantage of the present advances in technical procedures in the health field and to apply them with efficiency.

It is also essential to create an awareness in the private practitioner, whose collaboration is indispensable. Up until now, in our country the clinician looked down a bit on the public health physician. Now all this is changing.

We consider the cooperation of the private practitioner indispensable, for the reason that the State alone does not have sufficient resources to achieve health education. Moreover, because of the high cost of all these modern procedures, planning is essential. Therefore, the suggestions of the Pan American Sanitary Bureau were very well received, and we have embarked on planning. But it is not enough to draw up plans; it is necessary to have the means to implement them, and when I say "means" I do not refer to financial means alone, but also to personnel.

Consequently, we are devoting ourselves enthusiastically to the training of health personnel. In formulating our plans, we realized that the Ministry of Public Health could not do all this alone, so we enlisted the collaboration of other Ministries—Education, Public Works, Housing, Industry, and Agriculture—because sometimes it is easier to build a new road than a new hospital. We have taken all these factors into consideration in order to obtain greater efficiency.

What has the Ministry done about planning? For the short-range plan a committee of experts was appointed in order to do the job quickly, but for the long-range planning I thought that committees were not suitable. Therefore, by decree-law, an office or department devoted exclusively to planning was set up. It will be a permanent office, which will not suffer the consequences of changes of government. It will be manned by statistical and other personnel, who will not be subject to changes in orientation by reason of political changes, which unfortunately occur frequently in my country.

This planning office will work on the programming of national plans tied in with provincial plans. It will try to furnish the basic information for improving statistics, etc. It will standardize methods and procedures in order to establish and maintain collaboration among the different planning offices at different levels throughout the country. In our country any plan encounters difficulties under our form of organization, modeled as it is on that of the United States of America, in that each province is a state responsible for public health. Health planning is thus much more complex in our country than in others in which the national government exercises jurisdiction over all the territory.

Therefore, I proceeded to organize a conference of the Provincial Health Ministers, similar to this one, in order to convince them of the need for what I am saying. In this way it was possible to establish a planning department in each province; these furnished the bases for a general orientation in the matter of planning. Furthermore, I supplied them with a glossary containing an explanation of all the terms in current use, in order to standardize the terminology.

For the organization of these provincial planning departments, we requested the assistance of experts of the Pan American Sanitary Bureau and also used other experts trained in the School of Public Health of the University. Our School of Public Health was transferred to the University in order to avoid overlapping of functions. Today the School is producing good results, furnishing experts who give us satisfactory aid. With the assistance of the personnel of the School, we intend to organize a seminar, or planning course, for the training of all experts of the province. We must use somewhat uniform techniques and, thanks to this seminar, we expect to be successful.

There is an Argentine Public Health Association in our country, made up not only of public health physicians, but also of engineers, dentists, and all the technical personnel engaged in public health work. The Ministry has asked for the collaboration of this Association in organizing another seminar, on national and regional planning.

I attribute the greatest importance to this planning, for I believe that unplanned programs lead to a waste of economic resources and of energy. In order to carry out the planning we have intensified publicity, with a view to obtaining compulsory reporting on preventable diseases. A law that I drafted thirty odd years ago has recently been reenacted, because it was not being fully complied with. It is very hard to convince the private practitioner that he should at least cooperate by reporting cases of preventable disease in order that the health authority may follow up immediately with its aid.

The Ministry which I head has also been concerned with improving death certification. If we do not have satisfactory information on the causes of illness or death, it is impossible to go ahead with planning or to set up priorities. We want the notification to be recorded on the international certificate. Persons who do not use it properly are summoned to the Civil Registration Office and are given an explanation of the case. In this way awareness is increasing, and the doctor will be able to serve public health needs.

We work with the Municipality of Buenos Aires in planning courses for experts in health statistics. We actively promote these courses, two of which have already been given.

In general, the work of the Ministry is limited to the following functions: drawing up general health standards and bringing them into general use; coordinating regional plans; fulfilling international commitments; fostering scientific research; promoting health education among private practitioners and among the general public; and planning, executing, and evaluating the control of endemic and epidemic diseases. The Fed-

eral Government directs these campaigns, for endemic and epidemic diseases take no account of provincial boundaries. However, they always call for the collaboration of provinces and municipalities, for the latter, too, must understand what their duties and responsibilities are.

We have transferred to municipal jurisdictions, such as that of Buenos Aires, and to the more important provinces, medical care departments which belonged to the Federal Government. We believe that the municipalities and the provinces should devote themselves to medical care of individuals, leaving public health care to the National Ministry. We recommend especially that the hospital not be limited to personal care, but also be a health center where preventive medicine is practiced, since, as you know, this is the most effective sort of medicine.

All these health measures will not avail to foster better individual conditions if education is not increased. First comes education and later health, or perhaps, health care and finally the economy. A person who cannot read or write cannot follow the advice given him; nor can he work or produce. Before attending to the economic problem it is necessary to attend to health. This is what Dr. Horwitz, Director of the Pan American Sanitary Bureau, has been saying for a long time.

Among conditions which it is desirable to improve, such as education, work, nutrition, and housing, it is essential to add the improvement of recreational activities for the individual. In my province the farmer and the worker have adequate dwellings, a good income, and good food. However, when Sunday comes they have no means of amusement, and they go to the bars and drink to excess. The next day they do not go to work. Alcohol brings with it domestic tragedy. It not only damages the individual, but also injures the family and society. Therefore, I consider it imperative to give more emphasis to recreation, to the promotion of sports among the less well-to-do classes, as a means of preventing alcoholism.

Geographic conditions in our country vary widely. Argentina extends from semi-tropical zones to the south polar region, a fact that gives rise to completely different health problems. We have had to draw up regional plans and try to coordinate them with those of the neighboring regions. Of course, in our planning we have been and still are giving special attention to the matter of priorities. I believe that greater attention ought to be paid to the rural zone. Our country is essentially concerned with agriculture and livestock; that is the source of its production. We must improve housing and health conditions among our people, since in them lies the origin of our wealth. I think that what we call "city slums"—masses of people in insanitary dwellings in the large cities—are of much less importance than the betterment of housing conditions in rural areas. The former are located around the large cities, and it is much more possible to control their sanitation and police them than is the case with rural areas.

Argentina's chief health problems are those connected with public water and sewerage services, although 75 per cent of the urban areas have them. But Argentina has the peculiar characteristic of having a large head and a feeble body. Large cities such as Buenos Aires, Córdoba, and Rosario have all the services. On the other hand, in the rural zones, where 33 per cent of the country's population dwells, running water and sewerage systems are completely lacking. Consequently, the mortality rate due to typhoid fever is still about 9.5 per cent, and that of gastroenteritis 7.5 per cent. As for mortality in the first year of life, the average is 62.6 per 1,000, but there are cities, such as Buenos Aires, where it amounts to only 20. In some provinces the rate is as high as 133 per 1,000. The problem of mortality in the first year of life is very im-

portant for us. We believe that the child is the most precious potential capital that any country possesses, and we accord it our best efforts.

Tuberculosis has decreased greatly in our country. We have a mortality rate of 15 per 100,000. The most important parasitic diseases are Chagas' disease, ancylostomiasis, and malaria. About two million people are infected with the first; and of these some 15 per cent have clinical symptoms that lead to cardiac deficiency before the age of 50. Ancylostomiasis comes next in order of importance; a million and a half people are infected with it, with a resultant decrease in their productive capacity. As to malaria, during the past year we have had only 4,528 cases. We are trying to stamp out two foci of infection, the large one in El Chaco, where work is going on with the help of the Pan American Sanitary Bureau, and another small one on the northern border of the same province.

There are about 22,000 leprosy cases in the country. A very well directed campaign has been initiated, also with help from the Pan American Sanitary Bureau, in the Province of Entre Ríos; it will soon be extended to other provinces.

As to smallpox, I must make one comment on the report[1] of the Pan American Sanitary Bureau which ascribes two cases to Argentina, one indigenous and the other imported. I believe that both are imported, for the one considered indigenous was found right on the frontier and no other cases occurred. This leads to the conclusion that immunization in the surrounding region is satisfactory.

The distribution of physicians is an important problem in Argentina, where it is most uneven. It is estimated that in the capital there is one physician for every 220 inhabitants; in five provinces, on the other hand, there is one physician for every 2,000 inhabitants. In the country at large there is an average of one physician for every 657 inhabitants, which is not a bad proportion. What we are weak in—and for this reason we are promoting the School of Public Health—is public health physicians; there are only about 200 accredited ones in the country, which is an insufficient number. It is the same with nurses; in the entire country there are 28,000. However, the worst aspect is not their small number but their low level of competency. Consequently, various nursing schools are now in operation, and the situation is slowly improving.

There are 6.2 hospital beds for every 1,000 inhabitants. In the polyclinics there are perhaps too many beds; in Buenos Aires, for example, there is a daily average of 2,400 unoccupied beds. This really means that distribution is unsatisfactory, since beds are lacking for some hospital patients, while for others there is an excess of beds. For this reason I requested and obtained the transfer of regional hospitals to the municipality; this will permit rationalization. We are trying to establish wards for the mentally ill in all the hospitals, and many now have them. We believe that the only way to relieve congestion in the hospitals is to establish wards for the mentally ill, as well as diagnostic centers in order to avoid accumulation in the former.

With respect to housing, we have only 50 per cent of the dwellings we need. According to estimates made in 1952, there was a shortage of about 1,300,000 dwellings. With the population increase and the lack of building construction resulting from the inflation, I believe that the present need is for 2,500,000 houses.

A related factor is capacity to pay for medical services; we have made special studies of this. Fifteen per cent of the population is capable of paying fully for care when they are sick. On the other hand, we

[1] Document TFH/11 (Eng.), 8 March 1963, pp. 18-27.

estimate that about 60 per cent of the people depend upon mutual insurance plans. Let me say in passing that the aid given by the mutual firms is never complete, but only partial. National health insurance is indispensable, but it is a complex matter, and a Ministry, transitory as mine is to a certain extent, has not been able to achieve it. Twenty-five per cent of the sick are treated without charge by the State, the provinces, or the municipalities, but I have now imposed fees, on the premise that some people can pay something in order that others may get better care. We have established fees in all the national hospitals in order to create in the people an awareness that it is necessary to buy health because it, too, is important as is bread, the movies, and anything else.

The total financial resources at the disposal of the Ministry amount to no more than 4 per cent of the national budget. That is a very low figure, but no matter how hard we press the Ministers of Economy and Finance, it is never increased.

Finally, the most important zoonoses are hydatidosis and brucellosis, which have repercussions not only on the economy but also on human life. The Pan American Zoonoses Center is located in the Azul region; it operates very well. I have asked the Ministries of Economy and of Agriculture to grant it funds, for it is rendering an extremely important service, both to Argentina and to other Latin American countries.

I have limited myself to a summary statement, but I do not want to end it without giving special thanks to the Pan American Sanitary Bureau for the way in which it has strengthened our mutual relations and for the very effective help it has furnished us in attaining our goals.

ADDRESS BY THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE OF THE UNITED STATES OF AMERICA*

Presented by
DR. JAMES WATT

Chief, Division of International Health, Public Health Service

I have the honor to present some thoughts which the Surgeon General, Dr. Luther L. Terry, has asked that I express to the Ministers here. It is a great privilege for me to present Dr. Terry's text, which reads as follows:

"It is an honor to participate with you in this highly important Meeting. My distinguished colleagues from the Americas represent the spearhead of a dynamic movement to improve the health of the people of this Hemisphere. No other group has so clear a perception of the true significance of public health measures to our mutual progress. Indeed, we share a long-standing mutuality of interest which has grown stronger and deeper over the years.

"Our purpose here is to plan the steps which need to be taken over the next ten years to achieve the goals of the Charter of Punta del Este. It is a very serious purpose. It is very necessary. And it is by no means simple.

"We must ask ourselves some searching questions. What do we need in order to reach our health goals? Which goals should be met first and which need to await further developments? What are our economic and social capabilities? How do these factors affect rational planning?

"These are not easy questions to answer. But they must be faced squarely if we are to substitute forethought for chance, direction for haphazard activity. Planning is the most effective method we have for achieving national and international health goals in the present period.

"I want to share with you today some of my thoughts on planning health programs, based on the experiences of the United States of America in recent decades. Not that we have any magic formulas or that we have uniformly applied the principles of planning to achieve fully our stated health goals. Certainly we in this country fall short of providing our people with the full range of high quality health services now possible through the application of scientific knowledge. We have discovered, however—largely through trial and error—that some things work well and produce desirable results.

"There is one observation that underlies all our discussions this week: the levels of expectation of people everywhere are rising. People are no longer satisfied with things as they were, or as they are. This soaring aspiration is the hope of the future; it is also the challenge of the present.

"Nowhere is this challenge sharper than in the field of health. People want good health for its own sake—so they can be free from haunting fears, so they can see their children grow strong and vigorous, so they can live a full life. And health is also a resource which permits the realization of other goals and aspirations.

"It is little wonder, then, that health has come to be regarded as a *right* on a par with the other basic rights of mankind. The concept that society has a stake in health and

* Presented at the second plenary session, 15 April 1963.

should intervene actively to improve it may be of recent origin, but it is unmistakable.

"There is widespread recognition among American statesmen that health is a major concern of the American people. It ranks with education and economic security as a public good to be sought through national action.

"This has been an accelerating trend over the past decades; it received its greatest impetus, perhaps, during World War II. Wartime health research, pursued on a scale never before attempted, opened new trails for peacetime exploration. New departures —in medical care, in emergency health measures, in professional training—demonstrated what could be accomplished.

"It is difficult to overestimate the impact of these accomplishments on the popular mind. Leaders throughout the country were quick to perceive the great shifts in popular aspirations for health. They sought the advice and cooperation of professional health personnel and of hospital and medical leaders on new health plans and programs.

"Even as the war was ending, national programs for the construction of hospitals and the expansion of medical research were enacted into law. Both these programs have grown and broadened over the years. They have had the highest priorities in our national health policy. They have gained in popular and professional support year by year.

"Within five years after the close of World War II, Federal legislation had been enacted or proposed to provide national impetus in many other areas—heart disease and cancer control, for example. And in the past decade, a series of programs have been started or greatly expanded to meet the health problems of our increasingly complex physical environment.

"In the pursuit of these national health goals we have uncovered large areas of unmet needs. From the point of view of planning for health programs, however, several lessons can be drawn.

"First, health is an important element in a nation's drive toward a better and a more abundant life for its people. The best possible use of the nation's health resources and health agencies represents the highest type of statesmanship. Sound health programs reflect sound leadership. And they promote economic and political stability.

"Second, national health problems call for national action. If a job is important enough to be done, if a problem affects a considerable portion of the people, then the decision to meet it must be made at the highest levels of government. It must be a national decision, arrived at by political leaders and health leaders and concurred in by many groups which have a part to play in its implementation.

"Let me illustrate from the experience of my organization, the U. S. Public Health Service. In 1955, after considerable study and discussion, a decision was made to devote concentrated national attention to the health problems of American Indians. Health conditions among these people were similar to those which prevailed in the general population half a century ago. There was agreement that this posed a serious problem which was of importance to the entire nation. Congress enacted legislation which made the Public Health Service responsible for administering a comprehensive program of preventive and curative medical service for American Indians and Alaska natives. The Service became, in effect, the family doctor, community hospital, and local health department for the Indian people.

"After the decision was made, the other steps in the planning process were begun: survey and analysis of the situation; development of a planned program; arrangements for funding; and actual operation of the program. New hospitals, health centers, and clinics were built. The professional

health staff was expanded. Preventive health measures were put into effect. Water supply and waste disposal methods were improved.

"In the eight years since this program was begun, the infant mortality rate among Indians has declined 40 per cent. Tuberculosis, once the leading cause of death among Indians, dropped to eighth place, with a 50-per-cent decline in the death rate in the last eight years. And there are other equally gratifying results, and perhaps of greater long-range significance. More and more Indians are presenting themselves to hospitals and clinics; are assuming more individual responsibility for improving their health; are participating in program planning; and are being trained as practical nurses, sanitation aides, and community health educators.

"I do not want to leave the impression that all the problems have been solved. Even with the advances that have been registered, American Indians rank far behind the general population in the general death rate and in life expectancy. The low economic levels, the barriers of language and culture, the problem of vast distances are formidable obstacles. But a good beginning has been made. There are brighter prospects for liberating these Americans from the bondage of illness and for a future when they may well assume the major responsibility for their own health services.

"The third observation I would make from our experience is the merit of the categorical approach to the solution of health problems. Most of the health developments in this country have been of a categorical nature.

"The health charter is very broad, whether we look at the World Health Organization definition of health or at the goals of the Punta del Este declaration. As one of our first steps, therefore, we need to determine what is involved in the term *health*. The yearning for better health is certainly real. Yet people are not always clear as to the meaning of health, especially in terms of the measures that organized society might take to improve it. Health needs vary from place to place, from country to country, from region to region.

"There is a great deal to be said, therefore, for breaking down our health problems into 'bite-size' packages. Specific programs, related to specific goals, can more readily be seen and understood. Popular support can more easily be mobilized. In this country, in fact, voluntary citizens' associations have arisen to generate action by both governmental authorities and private institutions against specific problems.

"In categorical programs, too, results may be obtained more quickly and progress measured more easily. We can move, for example, in an orderly series of steps from disease control, to containment, to eradication.

"There are at least three types of categorical approaches to health problems:

"1. Concentrating on specific diseases, such as malaria, tuberculosis, or smallpox.

"2. Working on the health problems which are related to specific economic objectives. If a country cannot reach the goals set for its farms and factories because poor health is draining the productivity of its workers, then the health problems must have first priority. This was the situation, you will recall, in the initial stages of the program of the Institute of Inter-American Affairs, which had as one of its major purposes the expansion of the rubber, tin, and mica industries. Much of the program had to be concentrated on the solution of health problems.

"3. Building the services and facilities which safeguard the physical environment, such as community water supplies, food sanitation, refuse and waste disposal, and pollution control.

"All of these approaches are visible and concrete. They provide a focus of effort on which political leaders and health workers can work together without sacrifice of principles. The demands of expediency need not throw sound planning out of balance. They can actually be incorporated into the planning process. There are, of course, administrative hazards in piecemeal growth. But if health leaders keep their organizations flexible they can, on the one hand, take advantage of all opportunities for improvement; and, on the other, they can work toward a synthesis to direct their attention to the whole man, the whole community, and the whole nation.

"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. We are not planning for the sake of planning, we are planning for something.

"Planning is doing. It is a continuous administrative process. How many 'sound plans,' drawn up by knowledgeable and well-intentioned people who are distant from operations, have gathered dust? Planning must be closely related to day-to-day operations. Such planning, plus a deep understanding of the problems, will make any solution easier to arrive at. It will enable health leaders and health administrators, for example, to look beyond a specific way of working or a particular kind of organization. Instead, they can evaluate what is available against what is needed and mobilize all the resources that can help.

"There is not a country in this Hemisphere which does not contain untapped resources and competencies which can be focused on health needs. If these resources are not used, many programs which look sound on paper may face insurmountable difficulties or, worse yet, may be doomed to early failure.

"The caliber and kinds of personnel available also play an important part in program planning and administration. Almost everywhere, we find professional health manpower to be in short supply. Certainly, the shortages have hampered health services in this country. This suggests two important steps in sound program planning. First, the training of auxiliary and nonprofessional workers should have a high priority in all organizations. Second, the organization should be such that maximum use is made of highly trained professional personnel. Routine details should be delegated to auxiliary or less highly specialized workers. We in this country still have a great deal to learn in using these workers more effectively. And the need is no less significant in other countries of this Hemisphere.

"I have tried to indicate some of the principles and practices of planning that have worked well for us. I know many others will be considered during the course of your discussions this week.

"Above all, we must move forward with all possible speed to meet the historic health goals envisioned under the Alliance for Progress. The Charter contains both specific and general objectives. During the course of this conference, we should dedicate ourselves particularly to achieving the categorical goals and to plan continuing and long-range programs to meet the more general objectives. If we devise a system for setting priorities, if we decide which diseases we can nominate for extinction, if we identify the health projects we wish to concentrate on in an orderly progression over the course of the ensuing decade, then we can achieve the goals which have been set.

"We have the professional and technical knowledge to do the job. We have numerous examples in this Hemisphere of nations

which mobilized quickly to meet and to conquer health problems. We have vast popular support among people who are eager for better health.

"We all share a solemn responsibility. All of us in the health and health-related fields are, in the words of the Charter, part of a 'vast effort to bring a better life to all the people of the Continent.' We must now do our utmost to make that effort a reality."

ADDRESS BY THE UNDERSECRETARY OF STATE FOR PUBLIC HEALTH AND SOCIAL WELFARE OF HONDURAS

DR. CARLOS A. JAVIER

Presented at the Second Plenary Session
15 April 1963

We are now gathered in this First Meeting of the Task Force on Health at the Ministerial Level to discuss far-reaching matters concerning the health of the peoples of the Western Hemisphere. Faced with repeated frustrations, people are earnestly seeking fresh hope through the promising horizons opened by the Alliance for Progress. They put once more in the hands of their leaders their trusting faith in the eternal postulates of human rights, which have not yet come to full fruition in most of our countries, keenly hoping that this time positive plans for their well-being will result.

At this Meeting we are going to discuss Resolution A.2 of the Charter of Punta del Este relating to the Ten-Year Public Health Plan of the Alliance for Progress. Representing our countries, we bring with us the hopes and good faith of our fellow citizens who rightly aspire to the betterment of the general conditions of their lives and to the permanent enjoyment of the good things nourished by the doctrine of democracy, the beacon which sets the course of this conference. Resolution A.2 of the Charter establishes a series of ideal principles for improving the health of the inhabitants of Latin America, not only as a concept of natural law, which establishes complete well-being as the right of every human being, but also as a factor of high priority in the social and economic progress of our countries.

Pursuing these lines of thought, our country has already presented to the appropriate organization an initial plan for immediate action to be developed within two years, with plans for the ten-year period that the Alliance for Progress embraces. It is clear to everyone that to draw up a ten-year public health program is an enormous task. It demands extraordinary resources, from the technical as well as the economic point of view. With this in mind, our Government believes that the aid offered by the Pan American Sanitary Bureau and the Alliance for Progress should be taken advantage of immediately in order to plan this project in a speedy and efficient manner.

It is undoubtedly true that work planned in detail offers surer and more definite results, but the solution of our health problems permits of no delays, so pressing is the character they have assumed. The problems are so acute that we must face them immediately. We must avoid insofar as possible excessive bureaucratic transactions and reduce to a minimum the technical requirements that frequently hold up the execution of projects planned and studied by specialized institutions of our countries, even with the aid of international experts.

We speak in this manner because we have had that very experience, for example, in connection with the system of potable water supply in Tegucigalpa, a pressing problem. As such, it was the object of urgent studies, and its solution will be possible, thanks to the attention accorded it by the Inter-American Development Bank, which set a

reasonable time for meeting the requirements and furnished the necessary loan. This speed should be the hallmark of all operations aimed at solving social and economic problems, since undue delays will seriously affect the objectives which the Alliance for Progress plans to achieve.

The demand for extraordinary funds to supplement the financial credits granted our projects also gives our budding economies some concern. It is not always possible to obtain additional funds because of the tightness of internal credit.

For the Government of Honduras, the completion of projects now being executed, as established in Resolution A.2 (par. 2-a) of the Charter of Punta del Este, means that the international aid it has been receiving will continue, as will its own commitments, without any loss of the resources that the Alliance for Progress might possibly give it. Thus, programs previously initiated in accordance with specific agreements will not be combined with new programs.

Since this is a high-level conference, it does not seem idle to express these general considerations. Stated at an opportune time, they could be useful in accelerating the Alliance for Progress. And since we have come here to present the health problems of the Americas, permit me to outline to the Ministers present at this Meeting the outstanding problems that my Government considers possible of solution within the time embraced by the programs of the Alliance.

ENVIRONMENTAL SANITATION

In the matter of environmental sanitation, our country faces the problems of potable water supply and of disposal of sewage and waste. It can be said that up until 1961 only 15.8 per cent of the total population was directly benefiting from potable water supply systems. Since the total population, according to the 1962 census, is 1,886,440, there are still 1,588,383 inhabitants who do not enjoy this important service, and 298,057 are supplied with water whose potability we cannot guarantee. The urban population is the most favored, yet this group represents scarcely a fifth of the total population. Although the distinction between rural and urban population in our area is virtually nonexistent, the distinction has been made for purely administrative reasons. In order to carry out national plans for water supply systems, the Government of the Republic has two technical organizations: the Division of Environmental Sanitation, under the National Department of Public Health, which is responsible for water supply and the installation of latrines in communities of up to 1,000 inhabitants; and the National Autonomous Water Supply and Sewage Disposal Service, which is responsible for the same task in communities of more than 1,000 inhabitants. Viewing the task in its national dimensions, both organizations have drawn up pilot programs, for immediate execution within their respective spheres, which can serve as precedents for other projects covering the needs of the rest of the country.

The Division of Environmental Sanitation intends, if it obtains adequate financing, to install potable water services and latrines in 80 rural communities, the financing for a two-year plan being as follows:

	Lempiras
Grant from UNICEF.....	209,050.00
Grant from Alliance for Progress	548,022.27
Municipal grant	243,011.28
Grant from Ministry of Public Health	158,000.00
Total	1,158,083.55

The Division of Environmental Sanitation proposes to develop this program in the first two years, beginning this year, provided the financial aid becomes available in time. This program will benefit about 50,000

inhabitants in 1964, and its capacity will allow it to service the normal increase in the population until 1972.

In addition, the Division will carry out, at the same time as the water supply program for 80 rural communities, a program for the installation of latrines for these communities at a cost, for the two-year period, of 78,477.50 lempiras. The financing will be as follows:

	Lempiras
UNICEF	12,000.00
Municipal	3,027.50
Ministry of Public Health	17,850.00
Private (sale of latrine slabs)	45,600.00
Total	78,477.50

It is interesting to note the share that the local communities will have in carrying out these programs.

The National Autonomous Water Supply and Sewage Disposal Service is a decentralized institution of the Public Administration of Honduras, especially created as a technical organization to represent the State in the functions within its purview. As it was recently created, in 1961, it has not yet had time to make the necessary surveys. However, fully aware of its responsibilities to the programs of the Alliance for Progress, it has drawn up construction plans for water supply systems, and for extensions and improvements of potable water systems for a group of nine urban communities included in our two-year plan. The cost of 8,520,000 lempiras will be financed as follows:

	Lempiras
Alliance for Progress	2,100,000.00
Inter-American Development Bank	4,800,000.00
Government	1,620,000.00
Total	8,520,000.00

COMMUNICABLE DISEASES

Malaria eradication. The campaign for eradication of malaria continues its normal pace in accordance with the agreements concluded by our Government with the Agency for International Development, the United Nations Children's Fund, and the World Health Organization. This program is included in the two-year plan and complies with one of the objectives set forth in Resolution A.2 of the Charter of Punta del Este. The cost for 1963 and 1964 is 2,678,000 lempiras, to be financed as follows:

	Lempiras
Government of Honduras	1,200,000.00
AID	1,478,000.00
Total	2,678,000.00

These figures do not include the valuable aid given by the World Health Organization and the United Nations Children's Fund.

Tuberculosis control program in the rural area of Honduras. On the basis of biostatistical research on this disease, the Government of Honduras drew up, at the time when it introduced improvements in the pneumology services of the health centers, a collective program employing methods advised by experts for the investigation and control of tuberculosis in rural areas, and beginning with a selected area of the country, as the first step of a national campaign. The specifications and other details are outlined in the two-year plan we have mentioned. We wish merely to note that the selected area has a population of 150,000 inhabitants who, we hope, will be covered within two years.

Funds to finance this program will be obtained as follows:

	Lempiras
UNICEF	170,000.00
Alliance for Progress	371,056.18
Ministry of Public Health	402,112.36
Total	943,168.54

Campaign against leprosy. In 1960, the Government of Honduras began a program for the investigation and control of leprosy in the southern part of the country, with the technical advisory assistance of the World Health Organization. The Government created a mobile unit with a leprologist, the Choluteca Health Center being used as a base of operations. Appraisal of this program showed that leprosy is an insufficiently investigated problem; larger funds are needed for its study. Our two-year plan contemplates an approximate expenditure of 39,074 lempiras.

Smallpox control. In 1962 the Government of Honduras intensified mass vaccination against smallpox, with the aid of the Pan American Sanitary Bureau, which furnished smallpox vaccine. The application of vaccination has now been systematized and goals have been set for each health center. In spite of the Government's interest in this campaign, lack of funds and personnel has prevented it from undertaking a formal eradication campaign. I might note that fortunately no case of smallpox has been recorded in the country in the last 35 years.

Diphtheria, pertussis, tetanus vaccination. The prevention of pertussis, tetanus, and diphtheria has not reached a satisfactory level either, because of lack of resources for acquiring the vaccine. The same applies to vaccination against poliomyelitis.

NATIONAL NUTRITION CAMPAIGN

The incidence of the syndromes of malnutrition in the country is alarming, especially among children. The problem is closely related to the lack of health education among the people and to general poverty, factors that work together to produce the tragic situation.

The solution at the national level calls for enormous financial and technical resources, together with a long period of systematic activities capable of changing the mental attitude of the inhabitants, who do not know how to take advantage of existing resources. Nevertheless, a program has been drawn up, at the local level, and included in our two-year plan; that is, a coordinated nutrition program in the execution of which the Ministries of Public Health, Natural Resources, and Education take part.

The program has been formulated by an interdepartmental coordinating committee, with the aid of the Food and Agriculture Organization and the World Health Organization and a financial grant from the United Nations Children's Fund.

Financial resources for the development of this program are as follows:

	Lempiras
UNICEF	121,904.00
Government of Honduras.	191,330.00
Total	313,234.00

The time available to enumerate our problems here is limited, but I should not fail to point out, even though in summary form, other basic factors in the success of the Alliance for Progress. Our health programs will suffer if careful attention is not given to the integration of the general public health services; to the training of personnel at all levels; to health education of the public; and to continuing the National Health Plan by establishing other physical entities to execute the general services, setting up mobile units for medical care in rural areas, and constructing the new general hospitals—San Felipe in Tegucigalpa, Leonardo Martínez in San Pedro Sula, Atlántida in La Ceiba, and Occidente in Santa Rosa de Copán. All this has been included in our two-year plan.

The Government of Honduras estimates that to accomplish the minimum plan set forth above, a total of 21,099,948.17 lem-

piras will be required. The details of the costs are as follows:

	Lempiras
Water supply construction in rural areas	1,158,083.55
Water supply systems in urban areas	3,520,000.00
Latrine program	78,477.50
Tuberculosis campaign	943,168.54
Leprosy campaign	39,074.00
Nutrition campaign	313,234.00
Training of personnel	103,200.00
Construction of health centers	712,000.00
Rural mobile units	959,200.00
Water supply for Tegucigalpa	5,000,000.00
Hospital construction and study of project for San Felipe General Hospital	5,127,400.00
Antimalaria campaign	2,678,000.00
Health education	468,110.58
Total	21,099,948.17

Financing

UNICEF	521,148.00
Alliance for Progress	9,164,548.55
Municipal	246,038.78
Central Government	6,322,612.84
Inter-American Development Bank	4,800,000.00
Private	45,600.00
Total	21,099,948.17

I wish to state in this assembly the deep interest that the Government of Honduras has in bettering health and general conditions in Puerto Cortés, which may be considered the best Central American port on the Atlantic coastline. In this connection, the Ministry of Public Health has been receiving for some years both technical assistance from the Pan American Health Organization and the aid of the United Nations Special Fund for preliminary studies on the sanitary fill in this port.

The Government of Honduras is anxious for the problem of Puerto Cortés to have priority in the list of solutions that the Alliance for Progress is trying to reach. We must not fail to note that, as a result of road development and economic integration in Central America, Puerto Cortés will inevitably become a center of commercial transport for the Republics of Guatemala, El Salvador, and Honduras. This fact gives emphasis to the importance of whatever effort is made to better conditions there.

In the name of the Government of Honduras, I take this opportunity to express our great interest in this Meeting of the Task Force on Health and our appreciation to the Secretary General of the Organization of American States, Dr. José A. Mora, and to the Director of the Pan American Sanitary Bureau, Dr. Abraham Horwitz, its organizers. On behalf of my Government, I should also like to state our gratitude to the Inter-American Development Bank for the favorable reception it has accorded our requests for financing for development. And before closing, I wish to express once more to the Government of this great nation, the United States of America, our acknowledgment of its continuing aid to our health programs, and to voice our fervent hope that the ideals of President John F. Kennedy, supported by the programs of the Alliance for Progress, may take root in a form that will preserve the peace and lead to the attainment of well-being in the Hemisphere.

ADDRESS BY THE MINISTER OF PUBLIC HEALTH OF URUGUAY

DR. APARICIO MENDEZ

Presented at the Second Plenary Session
15 April 1963

In order to facilitate the task of the committees, we shall give an account of the situation in Uruguay with respect to health conditions. Our accomplishment is small, measured by the yardstick of our duty as government officials, and less still measured by our aspirations as citizens of America.

The status of health in Uruguay can be put in optimistic terms from the continental standpoint if we take into account the fact that, by virtue of its geographic location and climate, the country is not exposed to any of the tropical diseases, and the terrane, the mode of life, and the homogeneity of the population facilitate the carrying out of curative and preventive plans.

Public health services, basically under the Ministry of Public Health, represent 9.8 per cent of the general budget, which allocates to health 278,000,000 pesos, broken down as follows: administration, 13,000,000; research, 9,000,000; and care and prevention, 256,000,000. It is of interest to note that the public health budget, which has now reached the figure of 278,000,000 pesos, was barely 74,000,000 pesos in 1959.

By means of continued efforts we have brought about maximum immunization against smallpox and have virtually eliminated typhoid fever and diphtheria, and last year we carried out mass poliomyelitis vaccination of the susceptible population with Sabin vaccine.

We have at our disposal a special and highly efficient system for handling tuberculosis control, by means of care and by preventive and social measures. For this purpose the Ministry of Public Health has 2,742 beds throughout the country; for these patients, care is wholly gratuitous. In recent years the number of deaths has decreased to below 500 a year (a rate of 15.9 per 100,000 inhabitants), giving a proportion of six beds for each death. As is evident, tuberculosis is declining throughout the world, but there is one difficulty, of relatively recent appearance, the resistance of Koch's bacillus to modern therapeutic methods. The Ministry is giving this problem particular attention, and coordinated activities are being organized through joint research in the different specialized laboratories.

As to venereal diseases, in spite of the increase in the incidence of primary syphilis witnessed in recent years, advances in therapeutic methods and in health education lead us to hope that this group of diseases will remain limited and decline in importance. For many years the country has had a law that provides for free antivenereal treatment, without discrimination by reason of the financial means of the individual, and even permits concealment of the individual's identity, so as to ensure that reasons of a social nature do not prevent treatment.

The nutrition survey made last year with the aid of the U. S. Interdepartmental Committee on Nutrition for National Defense has shown that we exceed the average quotas of the National Research Council with respect to calories, proteins, calcium, iron,

and minimum vitamin A. We are deficient only in vitamin C, thiamin, riboflavin, and niacin.

Measures have now been undertaken for the iodization of salt, in order to make a definite attack on endemic goiter, which occurs in three northern departments (out of the 19 departments of the Republic). Plans are also being made to initiate campaigns at the national level against hydatidosis, Chagas' disease, and leprosy, which is a regional rather than a national problem.

Perhaps the problem of greatest importance is infant mortality, in spite of the fact that Uruguay has one of the lowest rates in this field. An important national committee, composed of representative technical personnel from all the specialized services and institutions, has been set up to make preparations for an advisory congress that will lay plans for a large-scale campaign to combat this problem.

We can say that once the medical care stage is completed and preventive measures have been energetically initiated, we shall enter fully into this campaign, expanding it at all levels. In this connection, mention should be made of the work done in five northern departments, with the aid of UNICEF; the experience there enabled us to do a great deal of health education and furnished us with valuable statistical material needed for undertakings of greater scope. In the city of Las Piedras, near the capital, a jointly sponsored pilot center has been set up and is already yielding results.

With respect to medical care, we have at our disposal 14,000 beds in 30 primary centers, including departmental centers, and more or less the same number of auxiliary centers, as well as first-aid stations. In the capital the services must be completely reorganized, for in general they are located in old or inadequate buildings. In this field the psychotherapeutic services are the most pressing problem; these must be completely reorganized in a form compatible with the technical needs of a group of about 5,000 patients.

It is important to mention the fact that our country has a low birth rate (less than 20 per 1,000 inhabitants) and a low mortality rate (about 8.5 per 1,000 inhabitants). Thus there is the problem of the aging of the population, with the concomitant increase in the prevalence of diseases characteristic of advanced age. This explains the number of those being cared for in psychotherapeutic services. Furthermore, studies are being made in geriatrics, a field to which the Ministry is devoting special attention.

Throughout the country, which covers 187,000 square kilometers, the Ministry of Public Health maintains maternity services, providing free care. With a total of 605 beds, they handle deliveries which represent more than a third of the total annual births in the country (55,000). With this number of maternity beds, and on the basis of 85 per cent occupancy, the number of deliveries attended can be raised to more than 31,000, or more than 50 per cent of the births. This figure can be reached through intensified health education work, as is now being done.

Through special efforts, the campaign is being equipped with modern medical care services, including polyclinics, which will enable us to keep up to date.

As to personnel, in spite of the fact that Uruguay has one physician for every 800 inhabitants (2,600 in all), it is necessary to increase the number of technical staff in the official medical care services and to obtain a suitable proportion of specialists, as well as personnel in the auxiliary services: dentists, midwives, nurses, health visitors, and sanitary engineers. The shortage in nursing personnel (nurses and nursing auxiliaries) is the most serious. As to figures, we can say that we need nursing personnel to fill about 3,000 positions in all. The expansion of the School of Health, which trains nursing personnel, is under study. Isolated courses undertaken by way of ex-

periment will be completed by setting up permanent and higher-level organizations designed to train personnel in hospital administration and management and to establish further training courses for auxiliary personnel.

The preventive services, which are the responsibility of a division of the Public Health Ministry, are in the process of organization and need a new structure. More than 130 polyclinics call for properly trained health personnel and plans of work that will avoid interference by a series of parallel services which have been established without any uniform standards.

We need to reorganize our laboratories in order to be able to carry out a sound nutrition policy in accordance with the new Bromatological Code, which is now under study in Parliament, and to increase the production of BCG, smallpox, tetanus, and rabies vaccines, as well as the training of research personnel.

Rural health services are to be gradually extended in accordance with a plan under study. There is now under consideration in Parliament a social development plan in conformity with the Alliance for Progress program. It covers school and hospital construction, including 18 regional polyclinic health centers in the departments of the interior and 22 of different categories for the capital, at a cost, for public health, of 78,000,000 pesos. When this step is completed, we shall be able to tackle the construction of modern centers for psychotherapeutic services.

The large-scale road construction plan carried out by the Ministry of Public Works will obviously have repercussions on every aspect of national life, and especially the health aspects. In this connection, the installation of water supply and sewage disposal service, over and above the general plan under way, is urgent for a group of important population centers that have sprung up near the capital without due provision having been made for these services. Nevertheless, it is gratifying to note here that Montevideo (the capital, with 1,000,000 inhabitants, representing 42 per cent of the population) has potable water service for 90 per cent of the population and sewerage service for 75 per cent. In the cities of more than 10,000 population, 60.6 per cent of the people have potable water service and 33.6 per cent have sewerage service. In towns of 2,000 to 10,000 population, the proportion is 35.7 and 2.7 per cent, respectively. In all, 56 per cent of the country's population has potable water service and 39.7 per cent has sewerage service. There are 25 cities of more than 10,000 inhabitants and 49 towns with from 2,000 to 10,000 inhabitants.

As to standardization, studies are being made for the revision of legislation governing medical care, which, though generous, is incomplete, and for the changes required to complete the preventive services. Finally, plans are under way for drafting a Code of Private Medical Care with the aim of fostering activities in this field, solving some of the serious difficulties that affect private institutions, and establishing a uniform system that will enable us to deal with the problems on an organized basis.

We conclude by noting that the current work of the Ministry of Public Health of Uruguay is made up of the following three basic elements:

1. Technical planning of all activities.
2. Raising the technical level of the procedures for organization and administration of the present services and of those being created.
3. Placing medical care and preventive services within reach of people living in villages or isolated in rural areas. If this is a basic principle that ought to be carried out in every country, it is especially important that Uruguay, whose production consists of livestock and farm products, should improve the environment of the farmer, since he is the basic factor in increasing production.

ADDRESS BY THE MINISTER OF PUBLIC HEALTH AND SOCIAL WELFARE OF PERU

DR. VICTOR SOLANO CASTRO

Presented at the Third Plenary Session
16 April 1963

I have the honor to extend the most cordial greetings to the distinguished representatives of the sister nations of the Americas, on behalf of the Government of Peru and in my own name. We are gathered here today for the noble purpose of studying how the plans of the Alliance for Progress can be made a reality in the field of public health. Health is a pillar basic to the structure of the economic and social development we all desire so fervently. That development will constitute a solid barrier protecting the Christian ideals of freedom and democracy of the peoples of America, who so fervently desire social justice and a decent standard of living.

Health and well-being know no frontiers. They are propitious fields for international cooperation. Their basically human aspect has led to the long continuance in our Hemisphere of that fruitful cooperation of which the Pan American Health Organization is the living symbol. This agency has been an example to the world, throughout the 60 years of its existence, of what can be done when the ideals are pure and the sole objective is the happiness of the people.

Peru, a country which traditionally respects its international commitments, has adhered decidedly and enthusiastically to the crusade which the Alliance for Progress represents. Peru is determined, in preparing its plans and programs, to solve its problems, such as lack of sanitation, ignorance, malnutrition, and in sum, poverty. Despite their magnitude, these problems will not break the spirit of the peoples of America, who are now vigorously rising to the challenge of overcoming them.

The main health problems of the Hemisphere are set forth in the Charter of Punta del Este, and especially in the Ten-Year Public Health Program of the Alliance. It will be necessary to concentrate on them both our national efforts and the financial and technical assistance provided by international agencies. Each country should establish its health priorities, according to its social and economic status and its own cultural and anthropological characteristics. In this way it will be possible to devote the resources available, both actual and potential, to those health activities that meet the true needs and whose results will be the most effective. The existence of great and numerous problems that must be urgently solved with limited resources is precisely the drama and the challenge of the developing countries and the factor that motivated the Alliance for Progress. In the circumstances, it would be inadvisable to attempt to solve all of them at the same time. For this reason it should be scientifically determined which problems are the most important, which are capable of being solved, and on which the limited resources will have the greatest effect. Such is the basic orientation of Peru's public health policy, which seeks to realize the aims of the national plan for economic and social development the Government has established.

The criteria preliminarily followed to

determine the priorities under the objectives of Punta del Este are as follows:

1. The extent of the damage represented by the health problem;

2. Its social and economic importance, or impact on social and economic development, and its place in our scale of cultural values;

3. The possibility of solving the problem, in terms of present conditions and the existing fund of medical and public health knowledge and techniques;

4. The cost of the activities needed to eliminate or control the damage represented by the health problem.

Seen from this viewpoint, Peru's priorities as regards the Hemisphere's main health problems, as set forth in the Charter of Punta del Este, are as follows:

1. Environmental sanitation deficiencies: More than four fifths of the entire population, and 99 per cent of the rural population, lack drinking water services. Five sixths of the total population and practically all of the rural population likewise lack sewage disposal services. Only 2 per cent of the working population is protected against occupational hazards.

2. Malnutrition: The average diet in the country is deficient in calories, proteins, minerals, and vitamins. Large sectors of the population are affected by nutritional disturbances and diseases.

3. High prevalence of communicable diseases, especially of the enteric type and the water-borne communicable diseases.

4. High mortality in infants and preschool children: Despite poor statistical records, it is known that infant mortality constitutes one third of the country's total mortality, and that deaths of children under 5 years of age account for more than half of the country's mortality.

5. Tuberculosis: The morbidity rates for this disease are still high and the infection is still widespread.

6. Malaria: More than 2,000 cases of malaria per year are still being recorded.

7. Smallpox: Although the disease has been eradicated since 1954, the immunity level in 1962 was only 35.24 per cent of the susceptible population, not counting the non-immunized population in the immediately preceding years.

The close link between the first four health problems is obvious. Some are both the cause and the effect of the others. The measures aimed at the control of some will partially or completely control the others. From a purely pragmatic point of view, therefore, these four problems may be considered as a complex that constitutes the highest priority both for the entire Continent and for each individual country.

The Ministry which I have the honor to direct is tackling these problems in the following manner:

1. Negotiations are under way to finance a basic rural sanitation plan, with the goal of providing drinking water to at least 50 per cent of the rural population in 15 years. The Institute of Occupational Health will extend its sphere of action to other fields, including mining. It will be possible to provide water supply and sewage disposal services to 70 per cent of the country's urban population through the Ministry of Public Works.

2. A study is under way to manufacture and market a local dietary supplement aimed at overcoming the more severe nutritional deficiencies. A national school nutrition plan is also under way.

3. An intensive program to improve local health services has been undertaken and will provide better care for the pregnant mother and the child. This will be a most important step toward reducing high infant mortality.

4. A national tuberculosis program is under way to make it possible to eliminate the disease as a public health problem in three years.

5. The malaria eradication campaign begun in 1957 continues in operation and, on

the coast, either the maintenance phase has been reached or the fifth year of total coverage is being completed; in the jungle area, the fourth year of total coverage is either under way or being completed.

6. In smallpox immunization, the aim is to reach the level of immunity needed to maintain the eradication achieved eight years ago.

The printed report which was distributed to the Ministers contains more detailed information on all these problems and the measures being taken to overcome them.

Although all these activities are no doubt of a positive nature, it must be recognized that it is possible, necessary, and even urgent to concentrate all efforts and resources on the problems previously indicated, and to avoid dispersion of activities and make better use of existing facilities. Now that the priorities have been established, it has become possible to do this. For the first time a national health policy has been drawn up; it is in keeping with the country's health needs, forms part of an integrated, continent-wide action, and tries to keep in line with the measures and objectives established at Punta del Este.

On this occasion I should like to report briefly on the main points of our health policy, especially as it relates to the Alliance for Progress.

A. *General Remarks*

1. If the spirit of the Act of Bogotá and of the Charter of Punta del Este, translated into the Alliance for Progress, consists in the countries of the Americas making a common effort to achieve a better life for all inhabitants of the Hemisphere, and if the commitment undertaken at the time lies in developing health programs to defend the human potential, then it is logical to assume that the national health policies must to a certain degree be coordinated on a hemisphere-wide basis. This implies that the countries must pool their efforts and resources on common problems, and that regional agencies directly or indirectly involved in public health must concentrate their financial and technical aid on those problems in a rational, planned, and coordinated manner.

In addition to the national health policy, a continent-wide policy will therefore have to be formulated; it will have to serve as a general guide to national policies and contain a clear definition of the problems to be attacked and of specific feasible goals; and it must aim at activities planned and coordinated at the highest technical levels.

2. These national health plans should be integrated within the broader national plans of economic and social development. Many of the health problems have effective solutions which lie beyond the sphere of action of health activities. Yet a national health policy should be in harmony and compatible with the national development policy. The latter will necessarily limit the actions of the former, especially in cases where a developing country is taking the initial steps to promote its development. International technical agencies should therefore give careful and serious consideration to this aspect in order to concentrate as much technical advisory services and financial aid as possible on such special areas.

3. In each country's plan for achieving the general objectives of the Charter of Punta del Este full consideration should be given to the needs for social development, especially in the areas of health, education, and housing, without, however, detracting from the resources and investments required for the initial impulse toward development. So long as the effects of social investments are not quantified and expressed in terms of their contribution to economic productivity, it will not be possible to justify greater emphasis on social development. Moreover, the intensification of scientific research, as referred to in Title I, item 8, of the Charter,

should be basically oriented toward a methodology of social programming, and more specifically, in our case, of health. Within this frame of reference, then, a national policy for solving the main health problems should be the result of a process of planning which arises from the confrontation of such problems with the facts of the local situation and which is directed toward making maximum use of the resources available.

B. *Most Important Measures*

In the Ten-Year Public Health Program of the Alliance for Progress it is stated, on good grounds, that to attain the objectives of increased life expectancy at birth by at least five years, certain measures will be necessary, such as:

1. Preparation of national health plans for the decade.
2. Creation of planning and evaluation units.
3. Improvement of collection and analysis of vital and health statistics.
4. Education and training of professional and auxiliary health personnel, ascertainment of the number needed, expansion or creation of training centers, and promotion of in-service training.
5. Improvement of the organization and administration of health services at the national and local levels by integrating preventive and curative services and ensuring improved performance and better utilization of available technical knowledge.
6. Adoption of legal and institutional reforms aimed at integrating health activities into the economic and social projects.

The Government of Peru, through its Ministry of Public Health and Social Welfare, has put into effect a system which will enable it to fulfill each of these measures.

In order to formulate and periodically adjust the national health plan, a technical, advisory, and coordinating body is needed to integrate the planning activities at all times and at all levels. Without discontinuing plans and projects already formulated or under way, it was considered that the first step should consist in establishing a Planning Office in the Health Ministry which could cover the health aspects in close coordination with the national planning agency charged with integrating the national economic and social development plans. According to its purpose and functions, this Office will continuously formulate the necessary recommendations for improving the collection and analysis of vital and health statistics and the organization and administration of the health services. Only in this way will it be possible to comply technically with the measures recommended in items 1, 2, 3, 5, and 6 of the Ten-Year Public Health Program.

In order to train the personnel needed to execute the national health plan, a Training Center for Public Health Personnel has been established; the Center's activities appear in part 4 of Peru's report. The Planning Office, in conjunction with the School of Hygiene and Public Health of Johns Hopkins University, is conducting a survey on human resources to determine personnel needs. In this way Peru will be complying with the measure recommended in item 4 of the Ten-Year Program.

We are firmly convinced that only complete development planning—not restricted to the national level but rather at the international level, in which such social aspects as public health are not overlooked—will make it possible to achieve the objectives on a continent-wide scale and make the aspirations of the American peoples come true.

We are confident that the conclusions reached and the recommendations made at this important Meeting will make a positive contribution to improving health conditions and hence the level of living in our respective countries.

ADDRESS BY THE MINISTER OF HEALTH OF BRAZIL

DR. PAULO PINHEIRO CHAGAS

Presented at the Third Plenary Session
16 April 1963

The changes that are occurring in the Latin American scene are the reflection of the serious tensions which accompany the development process in our countries. Latin America has the highest rate of population growth in the world and a tremendous potential in its natural resources, yet it lacks the capital and techniques with which to develop them, and this circumstance, added to its historical heritage, prevents it from achieving progress at a more rapid pace. But in spite of these adverse conditions the peoples of Latin America are anxious to improve their lot and to do so within the framework of this prodigious "revolution of rising expectations" that is taking place, which makes the attainment of social well-being an imperative if the democratic system is to prevail, expand, and become consolidated in our countries.

The idea of progress is the strongest motivation of the Latin American people, who are now claiming their fair share in the conquests of modern science and technology that have become available to mankind. At the present stage, economic development has become the most effective means of reaching levels of living commensurate with human dignity. This fascinating revelation, based on the historic examples of development in recent decades, has transformed into a clamor the desire for progress of the impatient masses of Latin America who are no longer content to await the hour appointed by the slow clock of history.

In the realm of perspectives offered by economic development we learn two lessons from the behavior of our people. The first shows that the struggle for development is forced by a conglomerate of forces that govern the social processes of each of our countries; and the second reveals how imperative it is that development respect national values, with a minimum of infrastructure costs, and an equitable distribution of development's benefits.

The anxieties and perplexities characterizing the panorama of the Latin American revolution found in the Alliance for Progress a vast estuary into which to discharge the impetuous flow of our suffering but no longer submissive peoples. The Charter of Punta del Este, with its objectives to achieve a better way of life for all inhabitants of the Hemisphere, aims at reducing the great difference between levels of living in Latin American countries and in industrialized countries through accelerated economic and social development and continued substantial increase of the per-capita income, as well as such structural reforms as will make it possible for the people to attain their just aspirations of improving their living conditions.

The defense of the human potential through the promotion of health programs to prevent disease and combat epidemics is among the main points of the Charter, which embodies such principles as inspired common agreement among the American Republics. The resolution that accompanies that basic document sets forth the Ten-

Year Public Health Program to be achieved through immediate and long-term measures.

Among the main recommendations is the one that health programs should be considered and financed under the heading of "essential and supplementary" to economic programs.

The main health objectives are: expansion of water supply and sewage disposal services, reduction of infant mortality, eradication of malaria and smallpox, control of the most prevalent communicable diseases, improvement in the diet and nutrition of the most vulnerable groups of the population, and improved medical care for the less privileged.

In establishing the principal objectives of the Alliance for Progress, the Latin American countries agreed that it would be essential to development to achieve an annual per-capita economic growth of not less than 2.5 per cent, the diversification of national economic structures, and the allocation of larger portions of the national income to productive investments.

The most interesting point in these ambitious objectives is the concern for ensuring a fair share in the fruits of development to the peoples, through a redistribution of the national income so as to provide a better living standard for all. Starting from the premise that the attainment of a better living standard rests mainly on a modernization of the economic system, and the expansion of production through economic development, the countries of Latin America in the Punta del Este Charter went on record to state that they were in favor of an effective participation of the people in the results of development through the expansion of benefits arising from so called "social development." Development includes health, education, healthful housing, clothing, employment, and recreation. The attempt of some theoreticians to separate social development from economic development finds no support in historical analysis, and can give rise to confusions and distortions that would damage the generous ultimate objective of development, namely, an increase in the general level of living.

Other aspects of the program of the Alliance for Progress deserve to be pointed out, for not to do so might lead to misunderstandings or the untimely and dangerous sidetracking in the execution of programs. The commitment under the Alliance rests on the conviction that: first, social, economic, and cultural reforms can come about only through each country's "self-help" efforts, so that any outside assistance received is supplementary and auxiliary to the domestic effort; second, that development activities in our countries must be organized in step with plans to mobilize national resources which, together with structural reforms, will ensure a more equitable distribution of the benefits arising; third, that the establishment of emergency programs of strategic scope and immediate execution, together with social measures to decrease existing tensions, are needed; and last, the execution of programs will be multilateral, i.e., by mobilizing the joint efforts of all Latin American countries and the other countries, within the framework of the specialized agencies of the United Nations.

Twenty months have now elapsed since "Operation Alliance" was begun, and an objective glance at the activities shows both the difficulties encountered and the remedies needed to increase its effectiveness.

The delay in applying the machinery for determining the activities required and the excessive bureaucracy for their control is the objection most frequently found, and those in charge of executing the program are fully aware of this.

Lack of experience in planning, and the absence of institutions that would permit the Latin American countries to plan their own economic development and put the administration of their public services in order is another obstacle which only time and

persistent effort will overcome. In this regard, government agencies find it tremendously difficult to prepare technically acceptable projects, which is a condition required by the Alliance for obtaining financial aid for specific programs. In some countries this becomes an especially serious problem, since inflation prevents a realistic estimate of the expenditures that will be required for a given project. To overcome this obstacle in Brazil, the Ministry of Health decided to create a planning unit whose purpose it is to remove such obstacles by drawing up a national health plan according to recognized modern programming techniques.

The idea of self-help or internal efforts is not well defined and therefore gives rise to doubts and mistaken notions as to its meaning and scope. Since external assistance is to be marginal, due importance has to be given to the participation of the benefiting countries. This includes considerations of a political nature which need not be gone into on this occasion. The proper and logical attitude would be to derive inspiration from the principles of the Charter of Punta del Este, which aim at arousing national energies in favor of development, in the awareness that they can do it "through application of the principle of self-determination by the people," as set forth in the Declaration to the Peoples of America. According to these directives, the most important efforts will have to come from the country which benefits from the program that is to be established, by an order of priorities to be determined by the conditions in each and according to the sovereign decision of each independent nation. The amount of the international aid should be fixed in global terms, and the recipient country should have the power to assign specific amounts to the various sectoral programs, following the basic criterion of promoting development to attain a better level of living for the population. In this way, the criticism of "welfare" levelled at the Alliance could be avoided, a criticism that is justified to the extent to which a program to promote consumer activities is imposed from the "outside," to the detriment of productive investments which could be more effective in promoting development. This reversal of the order of priorities—as suggested by some projects which attempt to point up the merits of the wealthy countries—emphasizes the "demonstration effect," aggravates social tensions, and retards development, all of which is detrimental to the objectives hoped for by those who formulated the Alliance for Progress.

The substitution of the multilateral concept for a bilateral program is another source of difficulty in carrying out the Alliance for Progress. In preventing a new experience in cooperation among Latin American countries, in doing away with the collaboration of other developed countries toward promoting the development of the less developed ones, and in exchanging planning efforts for a casuistic discussion which makes it impossible to look at national problems from an over-all view of development, the bilateral operations place a tremendous burden on the United States of America, which is faced with the possibility of such programs failing and the natural resistance provoked by the suspicion that the offer of assistance is of the nature of tutelage and that standards for solving the problems of beneficiary countries are being imposed on them.

If on the one hand foreign aid could possibly be considered an instrument for imposing plans unsuitable for the development of Latin American countries, then on the other hand, it becomes necessary to warn against the danger of paralyzing the fighting spirit of our people should they come to believe that progress can be obtained through the generosity of the wealthy countries.

These are some of the obstacles to execut-

ing the Alliance for Progress programs; they must be removed to smooth the road ahead.

The health function in economic development programs is beginning to be properly defined, bearing in mind the need to ensure an increase in real per-capita income, which is their objective.

The fact that the developed countries have a high level of health owing to the wealth produced by the country and to the sharing of it by diverse population groups, has led to the belief that such levels can be attained exclusively through an expansion of the health care system, and the exclusive use of health techniques. This fallacy led to the adoption of unrealistic plans for solving the health problems of developing countries and to the automatic use of transplanted programs, which is also a fallacy.

A study of the process of economic development and the stage at which each country finds itself is a basic prerequisite to the formulation of suitable plans, which must be adjusted to the social and economic situation of the country and to its structure and organization.

The developing countries have their own nosology, a peculiar complex of resources, and a series of health problems linked to poverty and backwardness, which therefore require different solutions and programs suitable to their underdeveloped condition.

Formulas for meeting the needs with the available resources, determination of priorities, relationship between costs and benefits, contributions to programs for increased production, all are useful in drawing up health plans. Finally, the health policy must be integrated into the general economic development plan so that health may become a dynamic element in its execution. Because of this it will be advisable to prepare health plans that are subordinated to the directives of the general economic and social development plan, once the perfect compatibility of the objectives of both has been assured.

This is the main idea which inspired the recent Three-Year Plan for Economic and Social Development established by the Government of President João Goulart. The development policy set forth in this Plan pursues the following objectives:

1. To ensure a rate of growth of the national income commensurate with the Brazilian people's aspiration to better living conditions;
2. To gradually reduce inflationary pressure so that the nation's economy may regain a suitably stable level of prices;
3. To achieve a more equitable distribution of the fruits of development by raising the people's real income;
4. To intensify government activities in research and training;
5. To reduce regional disparities by increasingly using the natural resources available and by reorienting the location of economic activities;
6. To eliminate institutional obstacles to reorganization so that productive factors may be used to better advantage and new techniques may be assimilated;
7. To attempt to refinance the external debt and to reduce the deficit in the balance of payments; and
8. To introduce suitable planning methods in the administrative activities of the government agencies.

The Three-Year Plan includes general directives on economic policy and standards for the various administrative sectors, including health.

On the basis of recognized improvement in the past two decades in the Brazilian people's general health conditions as a result of the process of industrialization, the Three-Year Plan establishes guidelines for the policy to be followed to ensure further advances in this regard.

In the plans prepared for health care, special consideration was given to cost of programs, number of population benefited, and target dates. Among the general principles of Brazil's new health policy special

emphasis was placed on protecting the communities from communicable diseases, and on the prevention and cure of major endemic diseases which affect large sectors of the rural population. Such supplementary measures as nutrition, basic environmental sanitation, housing, and the creation of new jobs are expected to exert a decisive influence in the campaign against diseases prevailing among large population masses who migrate from the rural areas to the cities.

A study of resources available for care purposes shows the increasing expansion of the existing network of services, which are characterized by low output, poor utilization of resources, and general waste. There is great concern over having sufficient personnel available, since most services tend to be concentrated in the large urban centers.

Some of the measures contained in the Three-Year Plan are as follows:

a. Decentralization of health activities and their transfer to municipalities;

b. Expanded assistance in providing pharmaceuticals, together with intensified drug production by official laboratories;

c. Promotion of private medical care agencies by assistance to enable them to perform supplementary care activities for the underprivileged classes;

d. Coordination with social security agencies to increase the benefits provided and reduce costs;

e. Promotion of medical care programs for rural inhabitants by using the health and hospital units in the interior of the country;

f. Improvement of the existing hospital network and of its administrative methods with a view to increasing performance and reducing maintenance costs;

g. Improvement of the system for the collection of statistics in order to provide better evaluation of programs;

h. Support of maternal and child health projects by furnishing nutritional supplements for vulnerable groups;

i. Reorganization of the Ministry of Health and establishment of guidelines governing the preparation, coordination, execution, and evaluation of health programs.

As to the financing of health programs, the Three-Year Plan provides for a substantial increase in public services, i.e., from 1.4 per cent of the gross national product in 1960 to 1.8 per cent in the current year. In this year's federal budget 42 per cent of the funds allocated to health are earmarked for water supply and sewage disposal systems, which is indicative of the high priority accorded to this public service.

The poor health conditions of the Brazilian people are reflected in low levels of living which are the consequence of underdevelopment. Communicable diseases have been virtually eradicated from our nosological picture. But the diseases that affect large sections of the population are those that constitute the nub of the problem. They include the rural endemic diseases that afflict the poor sectors of the population.

Leprosy, yaws, trachoma, tuberculosis, filariasis, Chagas' disease, hookworm disease, and leishmaniasis are being energetically combated, and results are already evident in the clear regression of the first two diseases. Malaria and schistosomiasis are now the two diseases that call for major efforts. As for malaria, epidemiological surveys made in the Amazon region revealed a change in the prevalence of *Plasmodium* species, there being a high percentage of *P. falciparum* with highly virulent strains resistant to schizonticides. And as for schistosomiasis, because of the complexity of its clinical manifestations, the great damage it causes, and the fact that it is spread over vast areas of the country, it is a disease which represents a great challenge to both medical and health agencies. Some of the steps being taken against the disease are the use of effective molluscacides to destroy the intermediate host, and health education aimed at changing the habits that result in

water contamination and the expansion of environmental sanitation services.

The expanded water supply and sewage disposal program is receiving the attention it merits because of its importance in improving the health conditions of the people. The high cost of the installations, the limitations on charging water rates because of the low per-capita income, and the inability to maintain existing systems, have led to the establishment of priorities for selecting the location of projects according to population density and their ability to absorb the corresponding investments.

As to nutrition, the Government of Brazil is attempting to correct by suitable measures the more severe food deficiencies, particularly those of animal protein. The production of other sources of protein, such as fish, chickens, and milk, is being encouraged and supported by government agencies.

In order to train the personnel needed to intensify the program, measures of great scope must be adopted and these are being examined within the framework of the basic reforms now being undertaken in Brazil.

Finally, activities aimed at reducing high infant mortality rates are being included in the campaigns against underdevelopment and backwardness. The aim is to prevent premature deaths in children, and to help them grow up and live so that they may cooperate in building the new and progressive country which Brazil wishes to be.

This is the message I bring to this Meeting as a token of Brazil's fraternal feelings toward the sister republics in all America. On behalf of the Delegation of Brazil, I express the hope that this Meeting will be crowned with success, and I salute the distinguished representatives of the American nations and of the sponsoring agencies, who are gathered here to work for the progress and welfare of our peoples.

ADDRESS BY THE MINISTER OF PUBLIC HEALTH OF CHILE

MR. BENJAMIN CID

Presented at the Third Plenary Session
16 April 1963

I bring you cordial greetings from the Government of my country, the Government of President Jorge Alessandri Rodríguez.

In formulating a health policy, consideration must be given to the multiple aspects of such a complex problem.

Health is, in the first instance, a technical and administrative problem. We have in Chile the National Health Service, on which a 67-page pamphlet has been distributed to the representatives, giving all the necessary information. In addition, we have the private employees' medical service, the workmen's accident fund, and private hospitals and clinics.

In order to provide the best possible health care with the human and material resources available, we have since 1952 integrated medical care services with health promotion and protection services, within the National Health Service. In the course of the last eight years there has been an increase of 1,442,000 in the number of persons benefited (or 27.3 per cent).

A Hospital Construction Association was established in August 1945, and from that year to 1958 it built 30 hospitals with a capacity of 5,438 beds and covering a surface area of 179,496 m². During the present administration, the Association has built 31 hospitals, with a capacity of 1,772 beds and covering 77,462 m². In addition, 58 hospitals with 3,885 beds and covering 193,356 m² are under construction. The country therefore has a total of 119 hospital establishments, with 11,095 beds, in an area measuring 450,314 m², which makes an average of more than 90 beds and 3,784 m² per hospital.

I take this opportunity to thank the Government of the United States of America for the generous assistance given to us in the area devastated by earthquakes.

A study of the principal causes of death shows that the very origin of risks of illness and death is to be found in causes which are not strictly medical. These relate to the shortage of healthful housing, lack of environmental sanitation, and a national food production rate that does not keep pace with the population growth. For this reason attention is being given to housing construction and agrarian reform, a fact of which we are justly proud.

Health is also an educational problem. Chile has come to realize that in order to fulfill its health plans and objectives the quantity and quality of its technical and administrative personnel will have to be improved. Therefore, a National Tripartite Commission was established, composed of representatives of the National Health Service, the Schools of Medicine, and the Medical Association, to take maximum advantage of existing resources with which to overcome the shortage of professional personnel. This Commission will plan medical education and training after making studies of: personnel resources; demographic, economic, and educational characteristics;

trends and scope of demands for medical and health care by the population; and medical work output and its increase through good administrative practices.

In addition to this joint endeavor, attention is also being given to the education and training of recent graduate physicians by means of residency fellowships and positions in which general practitioners from the zones can be trained or in which training in the most needed specialties can be given. The problem is not only one of medical and personnel training, but one of general education. Owing to the population's greater knowledge about public health, its increased awareness of its legal rights, and its concern for health care, the demand for services is constantly increasing and has reached the point where it can no longer be satisfied with the present human and material resources.

Health is also a matter of research programs, of planning, and of methods. Research is being carried out on various health problems, either in institutions attached to the Ministry of Health or in conjunction with other institutions under the Ministries of Education, Economy, and Agriculture. In this way studies have been undertaken on various diseases, on nutrition, and on planning methodology.

It has become apparent that the specific health problems to be solved are as urgent as they are varied. It has also become evident that in many instances the solution lies beyond the sphere of medicine or public health and calls for the efforts in such other fields as education, agriculture, and housing. The resources with which to carry out these activities are limited and have to cover the goals established in other fields of economic and social development as well. This fact makes the need for establishing priorities all the more urgent and calls for a maximum efficiency in the operation. Hence the need for preparing health plans which subsequently must be integrated with the social and economic development plans.

We have a complex task ahead of us. The technique of planning, still a relatively new one, arose out of the concern over problems of economic development. Its application to health requires considerable adjustment if there is to be achieved an effective methodology that will make it possible to prepare and execute realistic plans for mutually compatible goals with the kind and amount of resources available.

This consideration becomes the more important if one bears in mind that planning does not mean merely drawing up a document which establishes certain objectives to be achieved by a given time and at an approximately estimated cost. Planning must rather be understood as a continuous process with stages of diagnosis, prognosis, and programming as such, and discussion and decision at the policy level must be followed by execution, evaluation of results, and revision of initial goals, so that the objectives will be attained through adjustments to varying circumstances. When a General Plan of Economic and Social Development is approved, it contains a chapter called the Health Plan. It must be borne in mind that the community is making a choice between alternatives and in so doing it unavoidably formulates value judgments. We who know the priority of the health problems have the duty to explain the objectives in our area with the utmost clarity and precision, so that they may be given due consideration in the General Plan.

We therefore believe that this conference, which will echo the studies already begun on this matter in well-known research institutions, must give special attention to finding a concrete and practical methodology for health planning, and to the obstacles to its efficient use in our countries.

I should like to express thanks for the advisory services we have received from the Pan American Sanitary Bureau, which is

under the direction of my good friend Dr. Abraham Horwitz. Please accept the good wishes of the Minister of Health of Chile.

It is further evident that health is an economic and financial problem, in addition to being a human problem. Chile's National Health Service has provided milk to 70 per cent of the nursing babies, wet nurses, and pregnant women of the country, and to a lesser proportion of preschool-age children.

But health is also a cultural problem. The unity of our culture brings to mind the lessons of old colonial history. The ships of the fleet which carried treasures to Spain had to sail in plain sight of each other so as to watch each other and protect themselves from pirates and corsairs. The sailors knew from experience that the speed of the entire fleet depended on the speed of its slowest vessel.

Today more than ever, because of the unity of our culture, our countries must navigate in plain sight of each other. That is the direction of the Alliance for Progress. It is so understood by all our Governments, that of my country, the Government of President Jorge Alessandri Rodríguez, and by the Government of the United States of America, that of President John F. Kennedy. Let not the vessel that sails most slowly fall into the hands of pirates and corsairs.

Health is also a legal problem. At its highest level, the right to health should be guaranteed in the constitution. Health and education should be added to the classic principles of liberty, equality, and fraternity.

A free democracy is possible only within an Alliance for Progress based on health and education. Thus will true fraternity reign among men and peoples.

ADDRESS BY THE DIRECTOR OF THE NATIONAL PUBLIC HEALTH SERVICE OF BOLIVIA

DR. FRANCISCO TORRES BRACAMONTE

Presented at the Third Plenary Session
16 April 1963

In expressing regret at the absence of the Minister of Public Health of my country, who was unable to come to the Meeting, I should like first to extend cordial greetings to the distinguished representatives of our sister republics, and to state our thanks to the Pan American Health Organization for having made this event possible, and to the United States of America for the fine hospitality being offered to us.

Bolivia's public health problems have been presented simply, realistically, and sincerely in the text of the two-year plan that has been distributed to all, and which forms part of the ten-year health plan of my country.

I shall not present even a summary, which would necessarily be incomplete, but rather limit myself to some general aspects.

At the conference held in October 1941 in Atlantic City, New Jersey, and in Washington, D.C., the leaders of Pan American health signed a document that was to come to be known as the "biological defense" of the Hemisphere.

I must state that the document arose out of conversations among representatives of small countries to obtain effective aid from stronger nations. We stated the need for considering the Hemisphere as a living entity. As in the human body when one organ is sick and cannot function and develop normally, we stated that the Hemisphere could not fulfill its destiny so long as there were underdeveloped regions. From this was deduced the imperative need to help countries that had not yet developed sufficiently to protect the health and welfare of their population.

The United States of America, aware of its responsibility as the leading nation, after the approval of Resolution XXX in January 1942 at the Meeting of Ministers of Foreign Affairs in Rio de Janeiro, entrusted the Department of State with the establishment of an agency called the Institute of Inter-American Affairs, which in turn organized cooperative services in 18 Latin American countries.

The World Health Organization has defined health as a state of complete physical, mental, and social well-being, and not only the absence of disease or infirmity.

The Director of the Pan American Sanitary Bureau has mentioned mental health among the objectives planned for the present decade.

In the December 1943 issue of the *Boletín* of PASB,* which was devoted to Pan American Health Day, there is the following statement which we made: "While it is true that destiny is the automatic outcome of past causes, it is no less true that the incomplete education of a child is the essential origin of wars. . . . We must protect the children from evil thoughts as we protect them from contagious diseases. At the present time, therefore, there is nothing more important than to form the forces that will mold the future generations."

* *Boletín de la Oficina Sanitaria Panamericana*, Vol. XXII, No. 12 (December 1943), p. 1060.

Today, 20 years later, we are convinced that it is even more important to protect the children of this Hemisphere from evil thoughts. It is therefore necessary to prepare a program for the ideological defense of the Americas.

Psychological errors, tension, conflict, anxiety, maladjustment, produce far greater evils than do organic diseases, many of which are nothing more than the physical expression of such nervous states.

We attempt to change the world through more or less systematized ideologies, and we forget that we are the ones who create society, and that order or confusion will exist depending on how we live.

Our everyday thoughts, feelings, and acts must exert an influence on our environment; the world, therefore, is what we are; hence our problem is the problem of the world. The practical application of this concept is marvelous in its simplicity.

We cannot solve the problems of the world by looking toward Washington or Moscow. More important than any ideology is the transformation of the individual, and this transformation is possible only in an environment of freedom.

To understand the complex problem of life with its pains and conflicts there must be complete comprehension leading to full action. So long as we do not solve the problem of individual relationships, we shall not be able to solve the social problem, because society is nothing more than the extension of the thoughts, feelings, and actions of the individual.

If we could have the gift of fully understanding our relationship to things, persons, and ideas, we would not find it difficult to enjoy the beauty of a simple life. We would again become like children. In children the feeling of fraternity is natural. Children of different races and social strata can play together, completely unaware of differences.

The wisest teaching for humanity continues to be the maxim inscribed on the front of the temple of Apollo at Delphi: *gnothi seauton* (know thyself).

The leaders of nations should fully understand their responsibility in this hour and should endeavor to offer to coming generations the opportunity to enjoy a healthy body, a noble heart, and a clear mind, so as to make the advent of an era of fraternity possible, an era in which justice and peace will reign in the world.

ADDRESS BY THE MINISTER OF PUBLIC HEALTH AND SOCIAL WELFARE OF PARAGUAY

DR. DIONISIO GONZALEZ TORRES

Presented at the Third Plenary Session
16 April 1963

I should like to express the great pleasure with which my country is participating at this Meeting, from which we all hope to obtain the best results for the good of our peoples. We are aware of its importance, of the magnitude of the problems to be discussed, and we are each prepared to contribute the best that is in us toward this common effort.

Activities aimed at the progress and the more rapid development of our peoples are occurring in rapid succession, and they are indicative of the urgent need for meeting the just needs of human beings who are asking for a better, more meaningful, and longer life.

In August 1958 President Juscelino Kubitschek of Brazil launched the idea of "Operation Pan-America," which called upon the countries of the Americas to study, in mutual consultation, the problems that impede their development and to formulate suitable measures of economic cooperation.

In September 1960 the American countries signed the Act of Bogotá, which made provision for measures to improve their social and economic development.

Other meetings and declarations followed. In March 1961 President John F. Kennedy made his first declaration on the Alliance for Progress, to the effect that the United States of America would allocate funds to promote Latin American progress and development.

August 1961 saw the establishment of the Charter of Punta del Este, which outlined an action program and contained a definition of the philosophy of the Alliance, established the objectives and basic requirements for attaining development in the economic, social, educational, and public health fields, and also indicated the need for immediate action. It further contained the recommendation to the Governments and peoples of the Americas to resort to self-help, plan their programs, undertake tax and other reforms, attempt to achieve a more equitable distribution of the tax burden, a stabilized currency, balanced budget, better land distribution and use, fuller utilization of sources of production, planned resettlement, and so forth.

Also in August 1961 we Ministers of Health of Argentina, Brazil, Paraguay, and Uruguay met in Iguazú, Argentina, to discuss our common health problems.

However, before the Alliance for Progress, the Government of Paraguay was already instituting many of the recommendations made in that inter-American pact.

In fact, Operation Pan-America began to be practiced by Paraguay and Brazil around 1955, when the two Governments and their peoples joined efforts in building the road that leads from Asunción to the Paraná River, over which rises the monumental bridge linking that road with Paraná State and leading to the Atlantic Ocean, thereby opening up new opportunities to settlers and affording new prospects of progress to the two sister nations.

I shall not go into detail about our health

problems, which will be discussed more broadly in our committee meetings, but I should like to outline what the people and the Government of Paraguay have done in fulfillment of the recommendations of the Alliance for Progress.

Basic activities in the economy and financial infrastructure of the country are being planned and undertaken; foreign capital is flowing in, the established enterprises are being expanded, industrial plants are being modernized, and new industries are being created; the finances of the State are being put in order without inflation or an unbalanced budget, with a stable currency, and there is regular payment of the salaries of civil servants and regular funding of the public debt and of international financial commitments. Important public works are being carried out. There are more than 2,000 kilometers of roads that unite us with Brazil, Argentina, and Bolivia. The more important highways are being covered with asphalt, and landing fields, airports, bridges, barracks, schools, and health posts and centers are being constructed. There is also a new merchant marine fleet with some 30 boats. As to social and cultural works, there are schools, colleges, and university departments, with modern university statutes; there is equitable and planned land distribution, without bloody revolts occurring or anyone being deprived of his land holdings; land settlement is organized, working conditions are improved, and there is protection for the worker and his family. In the legal and spiritual realm, civil and political rights have been granted to women, and there is protection of the child, the elderly, and the needy. Our legal codes have been modernized and others that did not exist before have been drawn up. Our artistic heritage is protected; better conditions have been provided for our artists and their work.

In Paraguay there is a legality which provides full constitutional guarantees to the citizen without distinction or discrimination, and which governs the legal relations between the citizens of the Republic, between government institutions and agencies, and between the State authorities. In the international field, Paraguay fulfills its commitments, as evidenced by its clear line of conduct during the past decade. It is a nation respected by other free nations because of its firm anti-Communist attitude, without giving way to fears, because of its solidarity and friendship with neighboring countries and the higher interests of all the Americas, and because of its position in the line of defense of Christian and Western civilization and its respect for the policy of non-intervention in the internal affairs of friendly nations. Peace has been achieved, and law and order reign in the Republic. Peace was defended decisively and at the cost of sacrifices against those who wished to sow discord and chaos in our land. The Government and the republican party have definitively consolidated and improved our republican democracy.

We mention these facts to show the gigantic efforts made by the Government and the people of Paraguay, which had to do all this in less than 10 years, because everything needed to be done.

As to self-help, we have been practicing it for some time. All that has been done so far we achieved without overburdening the country with debt, since up to 67 per cent of the costs are being covered with our labor and the remaining 33 per cent with foreign loans, which are now being repaid. In many instances these loans were granted to us on a purely commercial banking basis, without bearing in mind the reality of the problems to be solved; but the contributions of the communities have been very important, in many places exceeding those of the Government, and these were in cash or in labor or in local materials and helped the Government to solve the problems of the population.

But the enormous efforts of these few short years have taken their toll and prevent us from achieving more rapid development, and despite the fact that the Paraguayan Government understands the importance of our health problems and the priority they require, it has not been possible to increase the funds allocated to the Health Ministry, which for years have been 6 per cent of the national budget.

In this regard I should mention something Dr. Horwitz already wrote about, namely, the economic cycle of disease—or the economic factors and their bearing on health. A serious problem not only in our country but in many Latin American countries, which merits special attention by the economic experts of the Alliance for Progress, is the fall in prices on the international market of the raw materials we export.

From this viewpoint Paraguay lost 87 million dollars of income in eight years, or some 11 million dollars per year, which represents 35 per cent of its total foreign exchange from exports in a given period. In 1952 we used to receive $122 per ton exported, by 1957 only $103.80, and by 1962 only $95.50—all for the same products—and that is a great loss for a developing country.

A study recently made by Dr. Lleras Camargo showed that the fall in prices on the world market in coffee, saltpeter, copper, fruit, meat, and so forth, meant a loss to Latin America of thousands of millions of dollars in the last 15 years.

The truth of the matter is that international monopolies have deprived us of capital; today we must work and produce more to obtain about the same amount of dollars as we did 10 years ago, yet we must pay increasingly more for the industrial products we buy. This tends to impoverish us more each time, with all the consequences this brings for progress and well-being, which stagnate or register at most only a very slow advance.

It is also true that we would not have needed to request so much from the Alliance for Progress had we received suitable prices for our raw materials and products. This is a matter which deserves to be studied by the economic experts with a view to finding an appropriate solution.

After the Act of Bogotá, in April 1961, Paraguay presented a four-year plan of public health to the Agency for International Development, some aspects of which are now being implemented.

As to planning, during and shortly after the Meeting at Punta del Este the impression clearly was that planning should consist of two stages: short-term planning and the long-term planning—at that time there was talk of a ten-year plan. Paraguay therefore presented a short-term plan and requested additional contributions for environmental sanitation (provision of water supply to 10 rural communities); for completion and remodeling of health centers, with provision of equipment, materials and instruments, especially in newly settled areas; and also for domiciliary child care, health education, personnel training, and malaria eradication, amounting all together to three and a half million dollars.

Studies for long-range programs, the ten-year public health program, were and are still being made. The Government set up the Bureau of National Planning attached to the Executive Branch, as well as a Ministry for Ministerial Committees, working in coordination.

The Planning Committee of the Ministry of Public Health has promoted meetings of the heads of health regions and of medical care centers to prepare the ten-year public health program.

I should like to report something very important to us and indicative of the extent of the assistance Paraguay has received from the international agencies. For the past two years, before the Alliance for Progress, we have been planning at several

levels in our country, at first with financial assistance from the United States of America, through the Inter-American Cooperative Public Health Service, and later with the assistance of PASB/WHO, UNICEF, and FAO.

Since 1957 our administration has been progressively decentralized through the integration of the programs in health centers, according to a five-year plan. In the course of eight or nine years we have sent 60 public health workers and technicians for training abroad through fellowships from the agencies mentioned. All top-level posts and 70 per cent of the posts in health centers are now filled by trained public health workers.

While we were waiting for a reply on the short-term plans presented to the Alliance, and while ten-year plans were being drawn up, we continued to carry out programs and to expand others, with assistance from the above-mentioned international agencies, in the following fields:

1. Environmental sanitation: This activity has been given high priority and importance, as we have running water supply and sewage disposal systems only in the capital. With the cooperation of the Agency for International Development, a pilot plan was established for providing drinking water service to three rural localities, later to be extended to 10. The engineering office for this project is now being installed and the first survey of water sources is being made. The socioeconomic study of the communities to be benefited has already been completed.

2. Food and nutrition education: A triministerial plan (Ministries of Education, Health, and Agriculture) has been expanded from 80 to 140 localities since last year. The purpose is to promote the production of basic foods, establish school and community farms and gardens, foster reforestation and the planting of fruit trees, provide health education, and distribute powdered milk to the most vulnerable population groups.

3. Communicable diseases: These continue to represent an important problem, being among the principal causes of high morbidity and mortality, especially in children and young adults. The picture has not changed substantially in the last five years, except for smallpox, of which no autochthonous case has occurred for the past three years.

A pilot plan for communicable disease control in the capital and neighboring areas has been prepared by national personnel trained by UNICEF and PASB/WHO staff, and has been submitted to UNICEF.

4. Malaria: Epidemiological surveys are being completed this year, as is the pilot plan of geographic reconnaissance and the house census, etc. The malarious area covers the entire national territory and, contrary to the original belief, *Anopheles darlingi* is autochthonous in the main sector because dieldrin did not succeed in interrupting transmission. A twice-yearly cycle of DDT sprayings is being planned instead of the present single annual dieldrin spraying.

Despite slight increases in the contributions of the Government and of UNICEF, the funds did not suffice and additional funds had to be requested from the Alliance.

5. Vital statistics: These data are improving, the reporting area having been expanded through changes introduced in the Statistics Department on the advice of a WHO expert. Statisticians have been trained both in the country and abroad.

6. Medical care services: In the capital, these services are being centralized by the Health Ministry so as to economize on personnel and materials, with benefits that are already noticeable.

7. Studies and agreements with other institutions providing medical care are being made by the Ministry to prevent duplication of efforts.

8. With the aid of the U.S. Agency for International Development and the W. K. Kellogg Foundation, the Ministry com-

pleted the installation of a plant for the production of drugs for use in the health centers. This has resulted in a great savings in costs.

9. The Ministry of Public Health also cooperates in the plans of the Ministry of Education for resettlement and rural welfare.

10. International contributions for the schools of nursing, obstetrics, and social service of the Ministry were extended and increased.

I state these facts only to show that, while a reply on the plans presented to the Alliance is being awaited, Paraguay is proceeding to carry out its programs, to do what it can, although much remains to be done that will require additional contributions from the Alliance. For it would take the country far longer to do all this with its own resources and the work would not keep pace with the natural growth of the population. I state these facts, above all, to acknowledge the valuable contribution in the form of fellowships, technical advisory services, materials, and equipment that we have received and continue to receive from the U.S. Agency for International Development, the Inter-American Cooperative Public Health Service (SCISP), PASB/WHO, UNICEF, FAO, the W. K. Kellogg Foundation, the University of Buffalo, and so forth. For this we wish publicly to thank these bodies on behalf of the Government and the people of Paraguay, and also to point out the need for the Alliance to take advantage of the long experience of these international agencies in planning and execution.

I believe that our purpose here is to study and propose practical measures with which to carry out the plans of the Charter of Punta del Este in the matter of health, and to prepare the inhabitant of Latin America, who is the object, the means, and the end of well-being and progress of our peoples, the foundation of the welfare to which we all aspire and are entitled.

We once more have before us new hopes whose attainment depends on us. The participants from Paraguay at this Meeting trust that we shall be able to revise the procedures so as to simplify slow-moving negotiations, see to it that our peoples are not disappointed, and faithfully interpret the thoughts of the great leader of the democratic world, President Kennedy. In that way we shall create a healthy and vigorous America that will fulfill its great destiny.

ADDRESS BY THE REPRESENTATIVE OF THE MINISTER OF PUBLIC HEALTH AND SOCIAL WELFARE OF GUATEMALA

DR. ROBERTO ARROYAVE

Presented at the Third Plenary Session
16 April 1963

In the matter of health, Guatemala aspires to the ideal expressed in the words: health is a state of complete physical, mental, and social well-being of an individual or a people.

In view of this basic, but also noble and ambitious objective, the *what, how much,* and *where* of immediate objectives comes to mind, as do the means by which to attain them. Guatemala is deeply concerned about health problems.

If one compares Guatemala with an industrialized country, it is clear that its economic and social development is only just beginning, and that good health conditions are enjoyed by but a few. The rest of the population do not enjoy these benefits, and this fact is aggravated by food shortages, poor quality foodstuffs, lack of financial means, and in sum, the absence of a suitable environment for every Guatemalan to be able to live happily.

High morbidity and mortality rates that still prevail in my country are the outcome of 400 years of living under poverty conditions, malnutrition, poor environmental sanitation, lack of health education, and insufficient health services to provide medical care and prevent disease.

Guatemala has conducted programs against certain diseases with varying results, which are always attributable to the following factors: (a) financial limitations; and (b) limitation on the number and training of medical and technical personnel with which to conduct the necessary health campaigns.

Nevertheless, technical and financial assistance from international agencies, added to the country's own efforts, have made it possible to eradicate typhus, yellow fever, smallpox (last case in 1953), and to conduct campaigns against malaria, malnutrition, gastroenteritis, whooping cough, and other diseases. All this was done at the national level, while we believe that it should be done at a higher level, so that a pooling of the resources will protect a greater area.

To this end, Guatemala has decided to concentrate its efforts on campaigns that are of equal interest to all six countries of the Central American isthmus, which have a similar geography, history, and economy and are the target of the same scourges.

We have numerous health problems, but existing limitations have forced us to accord priority to only some, although we are well aware of the importance of the others which will also gradually be attended to.

For this reason I shall refer to only four points which we consider basic for attaining a suitable environment for our people to live happily.

Since the purpose of this important Meeting is to prepare recommendations which will favor the health climate of America, I trust that by putting aside narrowly conceived nationalisms we shall be able to broach the solution to our problems from a solid foundation, the outcome of well-documented studies that are adjusted to the

environmental and economic realities of our countries.

Guatemala's general mortality index is 16.3 per cent, and the age group most affected is that under five years, which accounts for 49.3 per cent of the general mortality.

The country's poor environmental and health conditions make the 10 principal causes of morbidity and mortality those very diseases that can be controlled by health activities.

I. MALARIA

Even before 1955 there was a malaria control service attached to the Public Health Service in Guatemala, which was primarily engaged in the application of antimalaria drugs.

The Malaria Eradication Service was established on 10 January 1955; technical knowledge of the problem showed that eradication was feasible if residual insecticides were used. A Malaria Eradication Law was drawn up in July of the following year, with the technical advice of PASB/WHO; it was drafted in sufficiently flexible terms to allow any problems arising during the campaign to be solved.

The results have been encouraging. Before the campaign, the average number of malaria patients was 300,000 a year, according to hospital statistics, and the number of deaths was 7,348.

In 1962 only 5,996 malaria patients were registered, and there were no deaths from malaria.

A sum of 8.5 million quetzales was invested in this program, including this year's budget, and in addition to Guatemala, the Government of the United States of America, the Pan American Sanitary Bureau, and UNICEF cooperated in financing the program.

This has been the cost of reducing malaria morbidity and mortality, but it has also led to an increase in the population and to a rise in agricultural production in previously endemic areas to more than $8,000,000 in an area measuring 80,350 km^2, during the period 1960–1962. If the campaign is not completed and malaria is not eradicated throughout the country, we shall lose not only this investment but also some $150,000,000 in the next 15 years, calculated at the rate of a daily per-capita production of 2.50 quetzales; in addition, the agricultural production in the endemic areas would decrease because of the lack of workers. To this, the costs of hospitalization would have to be added.

Eradication will be completed by 1967, and an investment of $3,500,000 in the next four years will be essential. Plans have been completed for financing a long-term loan to avoid the disastrous results which an interruption of the campaign would bring.

In malaria eradication it is of vital importance to integrate efforts at the regional level, in order to prevent border reinfestations from endangering the achievements made in local campaigns.

II. CONTROL OF GASTROINTESTINAL DISEASES

In 1960 infectious and parasitic diseases of the digestive tract caused 20.1 per cent of all deaths, and the age group most affected was children under five years of age, accounting for 65 per cent of the total.

The close link between environmental conditions and the prevalence of these diseases make it essential to attempt to solve the problems of the lack of potable water service, of sewage and waste disposal service, and of poor housing. According to the recommendation of the Charter of Punta del Este that these services should be furnished to at least 70 per cent of the urban and 50 per cent of the rural population in a period of 10 years, studies were made and plans drawn up to expedite this task. In Guatemala 25 per cent of the population

live in urban areas and only 42 per cent have water service in the home; 600,000 persons in urban areas have no drinking water service. The most recent latrine program covered 44 per cent of the urban population.

In rural areas, which have a population of 3,010,513, only 12 per cent have this kind of public service. During the fiscal years 1960–1961 and 1961–1962 Guatemala invested a total of 2,352,500 quetzales, and for the fiscal year 1963–1964 a sum of 3,544,500 quetzales from the nation's regular resources.

These figures show the Government's concern for solving the problem of diseases arising from the environment, but it is in no way possible to attain the goals proposed at Punta del Este with these resources.

With the aid of a loan from the Inter-American Development Bank, Guatemala has initiated a program to provide water services in 41 villages, and sewerage will be provided to 15 others. The cost of this program is $5,000,000. Other projects are under way, but with the present resources, even if the programs are completed, they will barely keep pace with the natural growth of the population.

Studies have shown that when several agencies engage in constructing such services separately, there is useless expense and more general plans are frequently hampered. The creation of a semiautonomous agency is therefore necessary, not only to plan, but to build and supervise the administration of these services.

The provision of drinking water to the rural population is even more difficult and, in order to cover 50 per cent, as recommended at Punta del Este, Guatemala will have to invest 25 million quetzales.

According to a study made by the Pan American Sanitary Bureau, the provision of drinking water to 70 per cent of the urban and 50 per cent of the rural population in Guatemala will require an investment of 58.6 million quetzales in 10 years.

Some private and official bodies are at present attempting to cope with the housing problem. The Government has created the Institute of Insured Mortgage Promotion, which it is hoped will encourage private investments for housing construction. Changes made in the Savings and Loan Bank Law will make it easier for private persons to obtain funds for building purposes. The Rental Law controls rents in favor of low-income families.

The National Housing Institute was created to plan and execute housing programs for the needy. Finally, the Inter-American Cooperative Housing Service, through a system of mutual aid and self-help, has undertaken to build 2,568 houses at a cost of 6.1 million quetzales; 57.1 per cent of the capital for this program comes from foreign aid.

III. NUTRITION

It is difficult to determine from a study of the deaths what influence malnutrition has on the mortality rates in a country where only 13 per cent of the deaths are certified by competent personnel, but it can be calculated according to international standards. The figures are alarming. Guatemala has the highest mortality rate in the Continent for the under-five age group. The unfavorable influence of malnutrition on morbidity and mortality caused by infectious diseases gives the malnutrition problem indisputed priority.

In 1958 Guatemala issued a decree making salt iodization compulsory. A survey among 20,000 children made in 1951 showed that 32 per cent were suffering from endemic goiter; after only two years of operation of the iodization law the frequency went down to 16 per cent.

Protein deficiency is perhaps the severest form of malnutrition in Central America. INCAP has developed the vegetable mixture called INCAPARINA, which has proven effective in the laboratory and in practice, and is helping to overcome the problem of protein deficiency.

The Governments have not made enough efforts to bring INCAPARINA into general use, yet its production, which is in the hands of private manufacturers, does not meet the needs of the market.

IV. PLANNING OF HEALTH SERVICES

Guatemala's first National Plan of Economic Development, for the five-year period 1955–1960, included health programs as an important step in the implementation of that plan; they were to cost 250,000,000 quetzales.

When the Plan was revised, according to programming techniques, Guatemala allocated 13,355,000 quetzales in the present fiscal year solely to health programs.

Health planning activities were instituted after an investigation had shown that the basic requisites for initiating planning existed. A program of work consisting of the following points was established:

a. Preparation of a basic document for the creation of a Planning Unit at the ministerial level.

b. Production and utilization of statistical data in general, and of public health data in particular.

c. Organization of the services, and the changes necessary for planning.

As part of the health planning process, the Ministry of Public Health and Social Welfare will be completely reorganized, in such a way as to allow health services to be integrated and thus to obtain a higher yield from the present resources.

Another of our problems is the marked shortage of both professional and auxiliary personnel. On the basis of the physician/population ratio in other countries, Guatemala needs 3,000 more professional personnel. At present our School of Medicine is graduating 83 less physicians each year than are needed to keep pace with the natural growth of the population, so that the problem becomes aggravated with each passing year. The same holds true for auxiliary personnel. One of the more important aspects in reorganizing the national health services will be to increase the capacity of the School of Medicine and to create additional schools, or both. The same applies to training centers for other personnel.

To cover its planning needs, especially personnel training, Guatemala requires an increase in the technical and economic assistance it has been receiving from the international institutions and agencies.

In sum, it will not be possible to solve the health problems without the disinterested cooperation of all the countries of the Americas.

ADDRESS BY THE SECRETARY OF HEALTH AND WELFARE OF MEXICO

DR. JOSE ALVAREZ AMEZQUITA

Presented at the Third Plenary Session
16 April 1963

As already stated by the Director of the Pan American Sanitary Bureau, Dr. Abraham Horwitz, this is an historic Meeting, comparable to the one held in 1902 when the Bureau was established.

We are to join efforts here to solve the common problems of Latin America in the matter of health as it relates to the economy and in accordance with each country's characteristics.

Insanitary conditions, ignorance, and poverty are the common problems in Latin America and constitute perhaps its common denominator. Vigorous economic development cannot be thought of unless the American man is invigorated also, for he is not only the producer of consumer goods but also the basic instrument for attaining a better level of living and a higher degree of dignity as is befitting the people of America.

It can be said that any amount spent on public health is not an expenditure but an investment, from two points of view: an investment in man's happiness and an investment in his productivity. This is best exemplified by our malaria eradication programs.

Mexico used to lose 600 million pesos per year as the result of absenteeism and difficult working conditions in the malarious areas. And our country had many areas where man could not live, precisely because of malaria. In the seven years of planning and conducting our malaria campaign we have spent only 580 million pesos, 80 per cent of which was contributed by the Government of Mexico and the remainder by international agencies. In other words, by investing 580 million pesos in health and economic development we have spent less than we used to lose in a single year. This is perhaps the best demonstration of the fact that any money devoted to public health is an excellent investment.

Moreover, this action has opened up vast areas for agricultural development and for the establishment of industries as well. A place like Pemex City in Tabasco, Mexico, could never have existed, despite technical advances, without the malaria campaign which made it possible to exploit the underground oil and establish an oil-chemical complex.

Another important point is that our morbidity and mortality rates are decreasing, but we can almost categorically state that this is due not to the development of the country, but rather to the investments we made in public health. That is to say, the reduction of our morbidity and mortality rates is not the consequence of the country's plan for general development, but rather the consequence of the basic health care services we provided. I believe that this holds true for the other Latin American countries as well.

From the financial point of view there are three classes in our countries: the financially strong, who are able to satisfy their health needs and frequently go to other countries to seek a cure for their disease; those who are insured through systems

established by our Governments such as social security, which protects a special sector of the population; and finally, the financially weak, who are, so to speak, the concern of the Ministry of Health and Welfare and of our Public Health Service. Of the total population of approximately 38,000,000, at least 20,000,000 are the concern and responsibility of the Ministry because they are financially weak. We must pay greater attention to them because their urgent needs call for urgent care.

Where are the financially weak found? For the most part they live in the rural areas of Mexico, and in the rural areas of all America. In the belts of poverty that surround our cities live another set of people who also need our aid. But if we examine the relative needs of the man living in the country and the man living in the city slums, it is clear that the rural dweller's problem is the more urgent.

Nor should we forget that the *campesino* is the heart and soul of our America and that we owe him a great debt because, in spite of living under the most adverse conditions, he still takes care of our agricultural production. We have not yet gone beyond the agricultural stage in our countries, and our farmer—the *campesino* of all the Americas—continues to labor in an unhealthful environment, in extreme poverty and ignorance; and his ignorance is not only of public health, but of everything, even agriculture. That is the reason why in our countries agriculture is not advancing as rapidly as we would wish.

Moreover, it is not possible to conceive of programs which are not directly aimed at the well-being of man. By improving the human condition, therefore, the very economic development we are planning will come about, for man is its basic element. Another thought to be borne in mind is that we must strengthen the inhabitant of America, especially the farmer. The reason for this is obvious: our American *campesino* usually has a red-blood-cell count of less than three million, and a high percentage of his children suffer from proliproteinemic edema, resulting from deficient nutrition.

How can we expect the farmer of America to work efficiently with a red-blood-cell count of only two and a half million and with far less than 12 grams of hemoglobin? Obviously, he has neither the strength nor the capacity to work. Yet in spite of this he cooperates. How can we expect our race to become increasingly productive when undernutrition starts at the mother's breast and results in the retarded mental development of the infant, who later, even though he may receive food, can no longer recover? How can we expect our farmer to think and be active when, in addition to his inadequate food intake, he has no water?

I am convinced, and the other Ministers have already so stated, that each of our countries has its own program of development. The Alliance for Progress is not a paternalistic enterprise, and we must not expect everything to come from it. We must continue to promote our own programs and have recourse to the cooperation offered by the Alliance to accelerate the attainment of better levels of living for our farmers.

On the other hand, our America is growing at a truly extraordinary rate. The population growth is very high and is rising at a far faster pace than the rate of economic advance. Mexico's population growth rate, as stated in numerous publications and as reported also by many of the Public Health Ministers, is notable. This rate—about 3 per cent—means an additional 1.3 million Mexicans each year who have to be fed, clothed, housed, and educated. Unless this new population becomes a productive force for Mexico, or for any other Latin American country, making it possible to expand and increase economic development, it will become a problem. For this reason, many factors must be borne in mind, and the fact

that man is the basis of all activity must not be lost sight of.

We cannot conceive of the economist who places man at the end of a series of processes to attain the benefit; we see man as the basis of action from the very start of the development programs. To our mind, man should be happy and have his basic needs fulfilled, whether he is building a road, producing in a factory, or wherever he is working. In the final analysis it will not be his social position which will allow him to be happy. What needs to be thought of right now is how to solve the problem of his needs, the essential component for him to attain his dignity. To this end, we must attempt to satisfy his basic demands, and programs must therefore be begun without too much prior planning, for it may happen that, although a program may be admirable, it may yet be sterile. The basic concerns to be taken care of through programs revolve around water supply, food, housing, clothing, and education.

Water is essential to the farmer. We have heard that 90, 95, or 100 per cent of the rural population lacks water—and yet our body is made up of water, 80 per cent of it. And I am going to say something that may perhaps be revolutionary: Let us give them water, even if it is not potable; we shall find the means to make it potable later, because the man who is thirsty is the man who cannot live. A community which has water is a community capable of change, and it can acquire much happiness. Naturally, water is very important in large cities too, but it is even more important in rural areas. The occasion comes to mind when one of our collaborators was visiting a rural area where there was a little rural school with a puddle of water next to it; the visitor seriously recriminated the teacher and asked him to take steps to remove the puddle, as it was a health hazard. The teacher replied: If that puddle were dry, what would I drink? This may give you an idea of the drama, the extent of the thirst for water that is felt in the Americas.

Therefore, we should like to state that the provision of water—and basically, water for rural areas—demands a first priority in all our health and welfare programs.

Next, man has to eat. And here, too, I am going to state another revolutionary idea: For the moment, let us not seek a diet perfectly balanced in proteins, carbohydrates, fats, vitamins, and minerals, especially for our rural inhabitants. The important thing is to feed the people; so let us provide them with more beans and corn, or more corn and beans, for our people, at least in Mexico, are a corn-eating people. Once their basic need to eat has been satisfied, then all the special proteins of animal origin you wish can be added; and the suitable amounts of vitamin can then be added to make them strong.

Housing, too, is basic. Without decent housing, it is equally impossible to conceive of the dignity of man. Programs to improve existing houses and build new ones are absolutely essential, and should be allotted the third priority.

Clothing is also a basic need, for man has to cover his body. One of my country's achievements I want to tell you about is the program to furnish ready-cut clothing to the *campesino,* at cost price. With 15.50 pesos, a countrywoman can have a dress, which she can sew up under the auspices of a mother's club at the health center, where sewing machines are provided. In our rural areas the community is basically motivated by the women. When the woman has sewn the dress, she can either wear it herself or sell it. The market price of such a dress is 80 pesos. If she sells the dress she herself has sewn, she can earn from 10 to 15 pesos, which gives her that much more to buy food with and therefore to eat, or to otherwise help out with family finances.

We have sought the most economical

means with which to build houses where people can live in dignity, and we have found that such construction can be done, including windows, screening, and suitable roofs, for 8,600 pesos, or about US$700.

We also try to improve the activities of our people through our programs of education, which are included in the Government's general program for literacy and for educating the child; and through school textbooks prepared by the Government, which contain chapters on public health, so that children may begin to understand what it consists of and form a clear concept of it.

We must strengthen man, especially the man in the field who has hypoproteinemia, the man who is full of parasites. We can truly say that the miserable taenia is capable of stupefying an entire people, since the parasitic rate among our rural population is extremely high.

To carry out the programs in rural areas, along with the others and within the framework of a new public health concept, we need the cooperation of the people. That is basic. We must not give them a paternalistic gift. They must participate actively and assume the responsibility for establishing health care activities. I am so firmly convinced of this, because the poor farmers of Mexico contributed 3.5 million pesos last year; and they are now contributing 5,000 pesos to the establishment of a new, permanent health center which, with equipment, will cost no more than 65,000 pesos. In addition to money, the people also furnished part of the labor and have in that way come to feel that the center is theirs, and not charity or a gift from the Government; it is thus an active force in which they took part and from which the entire community can benefit. And this is important, because the sense of ownership and of giving service —even if small because it is rural—is replacing the health team that used to pass through the village every 6, 12, or 18 months, and has instead given the village a permanent health center, one in which they themselves cooperated actively to improve their situation. In this way, health centers have come to many places before roads and electricity, since it is the center that promotes the desire for community improvement. And the next step is to bring the miracle of water. All that is needed is a little prodding and guidance, and the community will improve its living standard. This is what we have achieved through the health center. This is why we have a sanitation and rural community organization service, since a rural health center in itself would not suffice to improve the community. The community needs to learn to meet its own basic needs, to take better advantage of available food resources, and to establish small industries so as to improve its economy.

Therefore, at each rural health center, in addition to the mothers' club, there is a mill where women can grind corn into *nixtamal*. On one of my tours I was surprised to find that one woman had walked four kilometers to the mill, where she paid 10 centavos for a kilo of ground *nixtamal*.

By organizing a consumer cooperative, with one mill for *nixtamal* at each health center, we have succeeded in dignifying the woman, who no longer needs to grind corn on her knees but can now do so standing up, because we have furnished a table on which she can place her *metate*. By providing this simple mechanical element with which to grind corn for the *masa* that is their daily bread, we have liberated women from kneeling at the *metate* for two to three hours each day, and have made it possible for them to use that time in other constructive pursuits.

Man's basic needs, therefore, are in the first place, water; then food, housing, clothing, and education. In the rural areas this will be the basis for a program which I should like to submit to your consideration. It is a program of basically rural

activities within a section of the Alliance for Progress, and is intended to meet these basic needs, in addition to our health programs, and to expand these activities until a level compatible with human dignity is reached.

In the second place I shall refer—not to hospitals, which are certainly important but require a great deal of money, nor to our need for many specialized technicians, which we do have, good or bad; I shall instead refer to the more urgent need for preventive programs, which will keep our hospitals from being filled up. Fortunately, hospital planning is based on the new concept of public health which combines preventive with curative medicine. Formerly there was the absurd situation in that no public health physician was permitted to cure and no general practitioner was permitted to practice preventive medicine. Now we have achieved the integration of the public health concept, and we have all become health soldiers. The general practitioner grows in stature by practicing preventive medicine, and the public health physician grows in stature when he practices medical care. It is absolutely essential for these two concepts, prevention and cure, to become a single unit, and this is already happening in Mexico. We have health centers and the enormous advantage of them is that preventive and curative medicine are housed in the same premises, and that the laboratory and X-ray equipment are shared by both specialities. You can verify this in your own countries: X-ray equipment which at the health center takes only some 50 X-rays per month at a very great cost, can be used to maximum advantage if it is utilized by both preventive and curative medicine in the same place and at the same time, with the sole aim of leaving hospital beds free and keeping them from becoming occupied. From the theoretical point of view this would be almost perfect, if it were to be done in the way I have described.

It is obvious that we need good products to conduct a preventive campaign. But if our biological products are poor in quality, we lose all the investment we have made in health administration. It costs exactly the same to apply a poor product as to apply a good one; the only difference is that the good product will bring favorable results, while the poor product will be useless, as will be the money invested in health administration. This means then that we need good and inexpensive biologicals, for cost becomes important when application to large numbers of people is intended. I therefore take the liberty of making the following proposal on behalf of Mexico: I should like to suggest the advisability of creating a Latin American common market for biological products. I do this on the basis of an experience we had: in order to speed up the poliomyelitis campaign in Mexico, we had to send one of our experts, Dr. Manuel Ramos Alvarez, for a three-year training course in methods of preparing the vaccine used by Dr. Sabin. Dr. Ramos Alvarez is a world authority in virology, and on completion of his training we installed the laboratory in which trivalent Sabin vaccine was to be prepared. It represented an investment of some 3.5 million pesos. Since that time the laboratory has produced 22 million doses of the vaccine, which at the commercial price of 10 pesos per dosis, totals 220 million pesos. This is an expenditure the Government could not have made without great difficulty. Moreover, it has enabled us to send this vaccine to other countries in the Americas as a token of Mexico's solidarity with its sister republics. It was then that I developed the idea of a Latin American common market for biologicals which, under the Alliance for Progress, would enable us to solve our own problems by bringing down the cost of these products.

The planning could be as follows: to draw up a list or catalog of our needs and to make

an inventory of existing facilities, since some countries are already manufacturing biologicals. In other words, to make a list of what at present is being produced at the government—not the commercial—level, in order to keep prices low and to exchange these products among the countries of the Region. Also of importance would be to train the necessary personnel and to plan the industry on a regional basis, so as to determine where new laboratories need to be set up; in this way Latin America would be supplied by its own production, with good quality products at prices without competition, and in amounts sufficient to meet the needs of an ever-increasing population. The products would be guaranteed by the Pan American Sanitary Bureau, through quality control by the National Institutes of Health.

The polio vaccine manufactured in Mexico is very good and inexpensive, and is being used to immunize the greater part of the financially weak population. But I am not referring only to Mexico's polio vaccine; there is also the yellow fever vaccine produced in Colombia, the vaccines produced in Chile, and the biological products of Brazil. I should like to point out the possibilities for personnel training in our countries, which could make us self-sufficient in the manufacture of biologicals, and thereby satisfy the need for strengthening the great masses of Latin American population which are financially weak.

I sincerely believe that the initiative which I am submitting to your consideration should be carefully examined by all, with a sense of solidarity, so as to plan the establishment, on the basis of our own resources, of a common Latin American market for biological products, to supply the rural population of Latin America with what they need to rid them of disease.

Personnel training is another concern expressed here by the Health Ministers. But personnel must be trained at all levels, not only at the Johns Hopkins University level. What we need are true health promoters in the rural communities, so we must urgently train rural nurses. In this regard, our experience has been as follows: a rural community nurse with 9 to 10 months' training is placed in a small rural health center, located in the Indian area. This nurse is a young, bilingual girl who speaks both Spanish and her native Indian language. She is thus in her own community and firmly settled there; she is contributing to its economic and social development, and she is able to do so because she has the advantage of speaking its language and hence inspiring confidence. By saying this I do not mean that I am opposed to having a graduate nurse in such a community, but we should utilize also any human resources we have among the population; we should avail ourselves of those people who can be interested in health problems, and with them form the basic elements which will promote in our communities an awareness of health and of organization.

Obviously, planning must be both regional and local, as our colleague from Guatemala has stated. We do not want a malaria mosquito from Mexico to go into Guatemala, but neither do we want a Guatemalan mosquito to come to Mexico. There is no way to put up a large net at the border with a sign reading: "Mexican or Guatemalan mosquitoes are not permitted to cross." That is precisely why regional programs should have a common ideal. In this regard, I should like to report that Mexico and Guatemala have exchanged the necessary information, and that malaria squads from Guatemala have crossed into Mexican territory, in order to re-enter Guatemalan territory at some other point in their campaign against malaria. It is absolutely essential that we regionalize our plans, for our needs are no longer simply geographic or political; our program is common to all Latin America.

The improvement which the Region expects from the Alliance for Progress should be closely linked with the establishment of sources of production. It is not a question of being given money, which will only partly solve our problems; it is a matter of our using our imagination to promote general economic development, which is not in our hands. For the moment, we can promote the improvement of our sources of production of biologicals, as I have just stated, and this may prove to be a basic measure.

Mention was made of death certificates. It is true that our statistics are often faulty. In Mexico one half of the death certificates are signed by physicians and the other half by Civil Registry officers who know nothing about medicine. Among the causes of death appearing on the certificates, therefore, at times a poor hysterical person is indicated as having died from yellow fever, simply because he looked yellow to the Civil Registry officer, and this in a place located at an altitude of 2,000 meters, where there is no *Aedes aegypti* and where no person could ever die of yellow fever. It is not that I am against statistics, but what we are interested in is knowing in general terms the situation under discussion without having to invest enormous amounts of money to obtain overly precise data which, by their very precision, might prove imprecise or incapable of guiding us in planning our action; and without a detailed investigation on morbidity such data will not be definitive and will therefore be wasted. It would be better to use that money on a more social and more effective program.

In conclusion, and to sum up what I have said, I should like to formulate two proposals for you to discuss.

The first is the creation of an agency to study the health problems in the rural areas of Latin America from a regional viewpoint. Thus, first of all, rural areas; and as for the agency, it might perhaps be closely linked to the Pan American Sanitary Bureau and reflect the wishes of each of our Governments in the matter of satisfying the basic needs compatible with human dignity. I would propose that the first program be water and nutrition, since they are of basic importance; and then housing, clothing, and education. But the basic one is water. We could then plan, with a special fund perhaps from the Inter-American Development Bank, a definite program aimed at meeting this basic need for strengthening the American population. First, water in rural areas; then, food in rural areas, which is equally important; and then housing, clothing, and education.

My second proposal concerns the need to plan, as soon as possible, a Latin American common market for good quality, inexpensive biological products. This should be at the government level, so as to cover most of the needs of preventive programs in the Americas, and the Continent should be divided into zones so as to obtain a logical and suitable exchange of these products. It would save us a lot of money, which could be used to better advantage for the benefit of the large masses of population.

Finally, I should like to state that I have faith in the destiny of America and in the man of Latin America; our farmer only needs us to give him a hand in order to develop. I have equal faith in the Alliance for Progress, not as an ideal panacea to cure all our ills or satisfy all our needs, but as additional aid in the efforts we all must make in order to develop our health plans and achieve economic progress, essentially for the benefit of the financially weak of Latin America.

ADDRESS BY THE SECRETARY OF STATE FOR HEALTH AND SOCIAL WELFARE OF THE DOMINICAN REPUBLIC

DR. SAMUEL MENDOZA MOYA

Presented at the Fourth Plenary Session
16 April 1963

We have assuredly assembled here for the purpose of continuing to give practical direction to the revolutionary calling of the American peoples. Never before have these peoples had ahead of them so magnificent a road as the one laid out by the idealists of Punta del Este, when the latter declared their decision "to unite in a common effort to bring our people accelerated economic progress and broader social justice within the framework of personal dignity and political liberty," as expressed in the Preamble to the Charter of Punta del Este.

We may say that the dreams of the American liberators are now fulfilled by this far-reaching document. It epitomizes the eagerness of the present democratic leaders of this Hemisphere, who are continually making greater efforts to give spiritual and material support to the peoples of the Americas.

In consonance with this historical mandate and its foreseeable accomplishments, the Dominican Republic has drawn up its National Public Health Plan, which encompasses the years 1963–1972, inclusive.

I am happy to lay this Public Health Plan before my American colleagues, in the belief that it can not only serve as a source of information but will also lead to encouragement and suggestions for countries like ours.

The bitter facts highlighted in our Ten-Year Plan serve both to reveal the situation in our country and to establish priorities for corrective action. They are an inhuman and cruel reflection of a political system which, thanks to God and to the efforts of good Dominicans, we left behind and to which we shall never return despite efforts to induce us to do so.

Obviously, during this sequence of political and social circumstances, it was difficult to make an exhaustive study of the most important aspects and of national needs. But during the few weeks which have passed since our Government took office, the National Health Plan has not been relegated to a secondary place. In this connection, I am happy to declare in the name of my Government, and in my own, as Secretary of State, that the sole aim of our health policy is to continue to put the Ten-Year Plan into effect.

Imbued with a truly American spirit, I am reporting, through this Plan, our efforts to solve each of the health problems which hold back economic and social progress in my country.

Today, unhappily aware of the lack of pure drinking water among two thirds of our people, I have recourse to a symbolical toast with a glass of water, asking my colleagues and men of good will of the different international organizations to pray that soon, thanks to the common effort, the men of America, both the country and the city dwellers, their wives and their children, may drink water as pure as that we are drinking in the capital of the United States of America.

Among the recommendations of the meeting of the Inter-American Economic and Social Council at the Ministerial Level, of

the Alliance for Progress, is that of supplying water and sewerage services to not less than 70 per cent of the urban and 50 per cent of the rural population in the next decade. Another major concern is to protect, among other groups, one of the most vulnerable segments of the population, namely, children under five years of age. But the subject we have chosen for our statement here is the water problem in Latin America.

It is no exaggeration to say that the sanitary engineering situation in Latin America is critical. We must make both the Governments and the peoples realize that, in order to advance in the field of health, we must face this problem, channeling all our national resources toward bettering the conditions prevailing in water supply and sewage disposal services.

In Latin America there are now 22.7 million inhabitants in urban areas and 86 million in rural areas without water supply.

Assuming a population increase of 2.5 per cent per year for the next 10 years in urban and rural areas, we find that the expenditures necessary to achieve the objective of water supply for 70 per cent of the urban and 50 per cent of the rural population within this period amount to 40 million dollars per year in urban areas and 51.6 million per year in rural areas. This amount is clearly beyond the economic capacity of the majority of the Latin American countries.

Consequently, we must adopt measures by which we can obtain the active participation of the communities. We must educate the masses so that, on accepting the obligation to contribute to the solution of the problem, they share jointly with the Governments in amortizing the investment.

With these achievements as the goal, we must encourage the creation of organizations which, at the national level, will polarize the government services and the people in facing this serious problem.

With respect to the water problem in the Dominican Republic, I shall describe the situation from the technical, economic, and health points of view.

According to statistics, 20 of the 95 urban communities of the country lack water supply systems. As for the rural areas, on the basis of scanty and inexact data, we may conclude that about 8 per cent of the inhabitants have water supply facilities, the majority being indirect supplies by windmill. The data on water service in urban communities indicate that about 40 per cent of this population has a direct supply through house connections, and that 60 per cent lack water service.

The initiation of a national program to increase the proportions of the population served to the minimum levels of 70 per cent in urban and 50 per cent in rural areas, by means of a ten-year plan, is under discussion. The problem is not the simple one of supplying a fixed number of inhabitants. Through progressive expenditure on sanitation works, we must extend these services in proportion to the rate of population increase, which varies, on an average, between 2.5 and 4 per cent per year.

With respect to sewerage systems, an effort is being made, within this total program, to furnish this service to cities with more than 10,000 inhabitants.

As for the economic problem, we shall begin by estimating the annual investment necessary to finance the program. Unit costs, on the basis of which the approximate amount of the investment is calculated, are drawn from projects recently completed in the Dominican Republic. We can take it, then, that these figures are representative of the cost of this type of work in our country. The additional population to be supplied by 1973 will amount to about 1,100,000 inhabitants; of these, 120,000 are in communities without this service. It is estimated that the number of inhabitants

in the rural areas to be supplied will be 3,000,000.

Taking into account these data and the predetermined goals as to the population to be supplied, the situation is as follows: population to be supplied, 4,100,000 inhabitants; total expenditure, $47,300,000; annual investment, $4,730,000.

As to sewerage service, the program will be limited to furnishing this service to cities whose present population is in excess of 10,000 inhabitants.

To sum up, these figures indicate that the annual investment for the program will amount to 6.55 million dollars, plus interest. Assuming that 80 per cent of the annual expenditure is to be borne by the urban population, the execution of the program implies an annual per-capita contribution of $5.70 for residents of urban areas and of $0.62 for inhabitants of rural areas.

However, this economic approach to the problem requires the establishment of institutions technically and financially equipped to solve the problem in a national plan, with the aid of the Governments and international credit institutions created for the purpose.

This fact led to the creation of the National Water Supply and Sewerage Institute in the Dominican Republic.

The sanitation measures that are most effective in helping to reduce mortality rates are those taken to increase water supply and sewage disposal services.

Among these measures the outstanding ones are those providing for technical control and regulation of methods used in the purification of water for human consumption and in the treatment of sewage.

In statistics for children under five years of age, the enteric diseases appear as the prevailing cause of mortality.

From all this, it is evident that changes in the methods used for control of the quality of water for the consumer must not be put off.

From what I have said, the following conclusions emerge:

1. That national programs to extend potable water supply and sewage disposal services to those parts of the population which lack them must be initiated.

2. That, because of the considerable cost involved, the people and the Government must share in financing these programs.

3. That in order to coordinate this work it is desirable to encourage the creation of technical organizations at a national level to plan, operate, and administer public water supply and sewage disposal services.

Before closing, I want to express the hope that the general considerations I have outlined will be a challenge to the collective effort to solve these very serious problems which give us concern.

ADDRESS BY THE MINISTER OF PUBLIC HEALTH AND SOCIAL WELFARE OF EL SALVADOR

DR. ERNESTO R. LIMA

Presented at the Fourth Plenary Session
16 April 1963

I should like first of all, on behalf of the Government of El Salvador, to commend the Organization of American States and the Pan American Sanitary Bureau in the persons of Dr. José A. Mora, Secretary General, and Dr. Abraham Horwitz, Director, respectively, as well as their colleagues. Pursuant to Resolution A.4 of the Charter of Punta del Este, this conference of health workers at the highest level has been organized to assess existing problems and suggest general lines of action of immediate effect, designed to achieve the following objectives: control or eradication of communicable diseases; environmental sanitation, primarily through provision of water supply and sewage disposal services; reduction of infantile mortality, especially of the newborn; and improvement in nutrition. We should also like to recommend health education, personnel training, and improvement of services.

I also want to thank the Government of our host country, represented by Dr. Luther L. Terry, Surgeon General of the United States of America, for the efforts it has made and the facilities it has provided for this important conference. I would ask Dr. Terry to convey to the President of the country, John F. Kennedy, our gratitude for the cordial and friendly words of his message of welcome.

El Salvador has such special characteristics that I want to mention them briefly, so that those participating in the Meeting will have a better understanding of our health problems.

Our country is situated in the center of Middle America; in surface area, it is the smallest country of our Hemisphere. Its geographic location puts it at the normal crossroads of migrations of the Central American people and the people of North and South America. It is bounded on the north and east by the Republic of Honduras, on the south by the Pacific Ocean, on the west by Guatemala, and on the southeast by the Gulf of Fonseca, which separates it from its sister Republic of Nicaragua. Its location and its tropical climate are factors of great importance with respect to the incidence of communicable diseases. Its territorial extent is about 20,000 square kilometers, and its population numbers 2,511,000, making it the third most densely populated country in America, with 125 inhabitants per square kilometer. This population situation is intensified every year by a 3-per-cent increase, which in round numbers means 70,000 more inhabitants every year. So we may predict that in 1970 El Salvador will have 3,345,000 inhabitants, with a population density of 167 per square kilometer.

The population of El Salvador is young; 33 per cent are under 20 years of age, while only 3.4 per cent are over 60. Forty-eight per cent of the population over 10 years of age may be considered illiterate, and 47.6 per cent, or about 806,590 inhabitants, are economically active. Sixty per cent of this economically active population is employed in agriculture, the basic activity in our country. While it is certain that the figures

for both general and child mortality have decreased in recent years, it should be pointed out that the greater proportion (54 per cent of the total) are accounted for by children under four years of age, and that these are conservative estimates, which would perhaps be higher if the statistics were complete. I should point out that only 22 per cent of the deaths are certified by physicians.

In order of decreasing importance, the principal causes of death are: gastroenteritis, infections of the newborn, acute respiratory infections, homicides, measles, tetanus, whooping cough, vitamin deficiency and other deficiency conditions, tuberculosis, and malaria.

We are glad to note that malaria, which was the first cause of death about 15 years ago, has dropped to a very low place on this list.

The Ministry of Public Health of El Salvador receives 11 per cent of the total budget of the nation to devote to health programs. In spite of the fact that this is the highest appropriation received in the history of the Ministry, a bare 46 per cent of the population in need of medical attention can be cared for with this amount. Moreover, for the medical care of the population there are 520 physicians, a ratio of one for every 5,000 inhabitants. The doctors live, for the most part, in urban areas; consequently, it may be said that the rural areas lack health care. There are also 160 dentists, one for about every 15,000 inhabitants; 150 engineers, 566 nurses, 1,700 auxiliaries, 128 sanitary inspectors, and a few ancillary personnel. There are two hospital beds for every 1,000 inhabitants; the beds are distributed in nine hospitals, nine health centers, and 59 health units.

I should not withhold the fact that the Salvadorian Social Security Institute, established eight years ago, now takes care of barely 40,000 insured workers living in three cities. The Institute has been conspicuous by its failure to develop and to reach new groups of the people, as well as to take care of the families of insured workers. So it is easy to see how scanty the aid of this institution is in solving our health problems. It was created for this purpose, but it has not achieved it.

The Ministry which I head is extremely interested in finding a solution to this problem, and believes that it is of prime importance to organize and coordinate social security services in such a way that they can discharge the functions within their competence throughout the nation, extending them to all the working population. So we are collaborating in the task of transforming national medical care, which traditionally was considered a benefactory service in Latin America, into an organization to whose support the citizens will contribute in accord with their economic resources, since we believe that no country in the world is capable of giving free medical care to 85 per cent of the population.

We understand that the solution of these problems is an obligation of our Government within the framework of the Alliance for Progress. I am happy to state that El Salvador is effectively fulfilling the obligations which it contracted when it signed the first title of the Charter of Punta del Este, in which the objectives of the Alliance are outlined. The top directors of the program have acknowledged it. In fact, in the last two years El Salvador has adopted the following institutional reforms: the law on paid Sunday rest for agricultural workers; protective regulations covering agricultural workers; the temporary law on food payments for agriculture workers; law to promote poultry raising; rural welfare law; drainage and irrigation law; law to promote the livestock industry; temporary law fixing minimum salaries for commercial employees; law on the promotion of industry; law reorganizing the central national bank; amendment to the law creating the Salva-

dorian Coffee Company; amendments, substitutions, and additions to the income tax law; creation of the Salvadorian Institute for Promotion of Industry; organic law pertaining to the Central Reserve Bank; fiscal law of El Salvador; civil service law; law creating the National Council of Planning and Economic Coordination.

In the health field, the Planning Unit was created at the ministerial level. This Unit has already begun its work and now keeps in close touch with the planning units in the Ministries of Education, Agriculture and Livestock, Public Works, and the Interior.

We are putting great effort into malaria control, since, as you know, this problem is of enormous importance to us. Because of unforeseeable biological phenomena, we have encountered great difficulties, to the point where we have had to attack the disease in the most integrated fashion; we are pursuing our eradication program with greater intensity than in the past and giving it absolute priority. In spite of our present economic situation, spraying operations have been renewed, and we have gone on to apply supplementary measures, such as the use of larvicides. On 15 April, Monday of this week, a program of supplying drugs to about 80,000 inhabitants was initiated.

In the malaria eradication campaign, about 1,048 voluntary collaborators are taking part; last year they sent us 127,293 blood samples, of which 7.9 per cent were positive. Three of the 14 departments of the country are already in the consolidation phase. We think that these data will be a matter of satisfaction to our Central American neighbors.

Smallpox was eradicated in El Salvador more than 30 years ago. However, this year a vaccination program designed to protect 80 per cent of the population within three years was initiated.

I want to take this opportunity to make public our thanks to the Government of Mexico for its aid in providing us with 200,000 doses of smallpox vaccine and 30,000 doses of poliomyelitis vaccine; the last-named was for the immunization of children up to two years of age in urban areas of the country.

Tetanus vaccination of pregnant women in rural areas was also begun this year, as a supplementary measure for controlling tetanus neonatorum. Our goal is to immunize 27,784 future mothers.

We have also established as an objective for this year the vaccination against diphtheria, whooping cough, and tetanus of 70 per cent of the children under one year of age in urban areas, and of 30 per cent of those of from one to four years.

As to leprosy, in April of this year the control of 228 known cases and the systematic investigation of their contacts were initiated with the help of the Pan American Sanitary Bureau. Soon a tripartite agreement between a private Salvadorian foundation, the Pan American Sanitary Bureau, and the Ministry of Public Health will be signed; it will greatly facilitate the eradication of this disease.

The nutrition problem is rather serious and complex, as is the case in our sister countries. In fact, we do not think it will be possible to solve it easily within a short period of time. A cooperative program is under development; it involves the Ministries of Agriculture and Livestock, Education, and Public Health, and the Food and Agriculture Organization, the United Nations Children's Fund, and the Pan American Sanitary Bureau. By virtue of its vast experience, the last-mentioned will help us to train personnel to extend the program throughout the country.

As for tuberculosis, the work of vaccination, research, and treatment continues. A pilot control program covering an area with almost 200,000 inhabitants is under discussion with the Pan American Sanitary

Bureau and the United Nations Children's Fund.

I deem it necessary to put into the record the thanks of the Government of El Salvador to the Pan American Sanitary Bureau for the technical aid furnished through its Zone Office in Guatemala.

With regard to Resolution A.2 outlining the Ten-Year Public Health Program of the Alliance for Progress—paragraph 2-b of which refers to potable water supply and sewage disposal for at least 70 per cent of the urban population and 50 per cent of the rural—El Salvador created ANDA (National Water Supply and Sewerage Administration), an autonomous organization which has assumed responsibility for carrying out this program.

As Dr. José A. Mora noted in his opening speech, it can be stated that, up until now, greater priority has been given to water and sewerage projects for urban communities. The Ministry of Public Health of my country has observed this development with deep concern. Our concern is especially strong for the reason that since the creation of the organization mentioned above—ANDA—the Ministry of Public Health has ceased to participate in this program; it previously directed it with satisfactory results.

We suggest that our sister countries which find themselves in a similar situation, because of the structure of the water and sewerage organizations, promptly study the changes necessary to allow the Ministries of Health to assume once more the necessary executive functions, for no program of rural sanitation can be carried out unless water is first supplied to the communities. This fact is so self-evident that we may remind ourselves that, to fulfill the minimum requirements of the Ten-Year Program of the Alliance for Progress with respect to water and sewerage, we have only 100 months at our disposal, and that we need to construct an average of 12 services a month in order to provide potable water to 50 per cent of the rural population of El Salvador. If we remember that our water authority has not begun any rural work of this character since it was founded, the problem is seen to be urgent. We call this point to the special attention of the directors of the Inter-American Development Bank, who have evinced great interest in the Ten-Year Public Health Program.

We are convinced that it is possible to solve our complex problems, so long as we can count on effective and practical international aid. In view of this, our present Government, headed by Col. Julio Adalberto Rivera, has emphatically declared—the last time at the conference of Presidents of Central America and the United States of America, held in San José, Costa Rica—that its principal concern was for the public health and education programs, since we cannot even think of economic development in our country if education and health conditions are bad.

Likewise, when we signed the Charter of Punta del Este, we did it in the conviction and certainty that this Alliance is founded on the principle that aspirations for work, housing, land, schooling, and health are, among other needs, best attained through preservation of liberty and the institutions of representative democracy. For that reason we accept confidently and enthusiastically the statement of the Group of Experts of the Organization of American States on Planning for Economic and Social Development to the effect 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 part in any meaningful development program.

At this time I want to repeat, in the name of the Government of El Salvador, that we do not believe it possible for a people who lack health to achieve economic development. Also, I wish to express at this Meet-

ing the surprise and dismay we experienced on hearing certain statements by some high officials of the Alliance for Progress, who consider programs of economic development more important for our countries than programs for the prevention, promotion, and restoration of health. These statements are epitomized in this sentence: "Industry produces hospitals, but hospitals do not produce industry."

I hope that what is said at this Meeting will convince the leaders of the Alliance for Progress of the great significance and economic value of human health in the economic and social development of the American peoples.

ADDRESS BY THE MINISTER OF PUBLIC HEALTH OF COSTA RICA

DR. MAX TERAN VALLS

Presented at the Fourth Plenary Session
16 April 1963

With my first words I wish to convey a friendly greeting from the Government of Costa Rica to the Ministers of our sister Republics, and to express to the Pan American Sanitary Bureau my Government's thanks for the aid and counsel the Bureau has been giving it.

I must take cognizance of our reason for being here: in my opinion we must manifest to the Organization of American States the recommendations agreed to in the Charter of Punta del Este through the Alliance for Progress.

We understand that the Alliance for Progress marks the beginning of a social revolution in our Hemisphere; an orderly democratic social revolution, of course. It is indeed clear that, to achieve the objectives spelled out in the Charter, we must agree on our contribution in the health field. It seems unnecessary in a Meeting of Ministers of Public Health to discuss what type of problems should have priority, when it is a question of the development of Latin America. However, it is certainly desirable to make clear to those who, as the Minister of El Salvador has said, still battle to place the economic and social factor first, that we must advance concurrently in all fields if we seek effective development of the region. Many obvious examples could be cited to prove that health is of prime importance in the process of our peoples' development. We must understand this accelerated, though orderly, social revolution; moreover, along with the objectives that we have in common, we must understand and make known the fact that each country has its special features. The respective development programs must be studied by the governing bodies of the Alliance for Progress. If the unceasing effort we are making is put to advantage, those objectives can be attained, taking into account the special conditions in each country.

I believe that our contribution to the Alliance for Progress is somewhat ideological, since, as free American men, we all resist any efforts to contaminate us with political ideas and concepts incompatible with the liberty of the American peoples. We shall oppose such invasions. Moreover, our collaboration in this undertaking has been made clear by the fact that all our Ministers, in accord with recommendations previously agreed to, have set their Ministries—and Costa Rica's, too—to the task of planning, and have gone on to an evaluation of our health problems which shows that we have done as much as possible to solve them and that, consequently, we deserve effective assistance.

I do not want to go into detail, but I do want to mention certain matters which have demanded attention in the course of our Government's work on health problems.

The principle, grounded in statistics, that health policy must be basically oriented toward rural populations has already been pointed out here. Our rural population, which makes up not less than 60 per cent of the Continent's population, needs immedi-

ate help in the plans for development. One must not forget that this rural population is the most impoverished and possesses the least economic resources. Accordingly, if we want to contribute to the speedy development of our respective countries, we must provide our workers and farmers with conditions that permit a greater productivity. Rich and well-fed peoples must understand that the production of our population cannot equal theirs.

In the rural field two problems demand attention. In the first place, water supply has been mentioned as the prime problem in environmental sanitation. I agree with this appraisal of the situation. While we are concerned about maintaining and bettering water supply services in urban areas, there is no doubt that the problem in the rural areas is a much larger one. But for the very reason that the economic resources of our rural peoples are much lower and also because it is easier to obtain credits to solve the problem of the lack of drinking water in urban areas—since the cost is recoverable in full—we must emphasize the fact that the greatest obligation is to establish suitable water systems in the countryside, and that it is the duty of the respective States to give their chief attention to this goal and increase the public health budget in order to be able to help these rural peoples effectively.

I want to submit to the consideration of the Ministers an idea which has been studied, so far as we are concerned, by the Water and Sewerage Institute of Costa Rica. We think that rural water-rate schedules ought to be fixed by a social criterion based on the average family income and ability to pay in the area, even though this capacity to pay does not permit of recovery of the total expenditure during the estimated amortization period. We also think that the deficit arising from these non-economic rates must be covered by the Government, which should use for that purpose funds intended for national sanitation programs in rural areas. We believe that in order to finance the ten-year plan for rural water service through Alliance for Progress funds, the credit institutions should defray the entire cost, except for the contributions that the communities themselves can make. Finally, we think that, for this financing, the minimum interest rates and maximum terms that the banks are authorized to agree to should apply, and that in no case should the terms be shorter than the applicable amortization period. I repeat that I am submitting this proposal for consideration by the Ministers.

Moreover, I think it timely to express the appreciation of the Government of Costa Rica to the Alliance for Progress for the aid that it has given the country in achieving, at the regional level, a project for rural aid based on a mobile health team, consisting of a general practitioner, a nurse, a public health physician, and a sanitary inspector. The results obtained are evident; we are reaping the harvest of health education. During the few months in which this mobile plan has been in effect, it has been able to reach sizeable sectors of the rural population, and when it is completely established, it will give medical aid to more than 300,000 persons.

As proof to offer the economists in support of our thesis that health problems should occupy first place in the plans for economic development of our countries, we may note that in the communities there was such a desire to work along the lines indicated that the committees which we established, together with the inhabitants, undertook sanitation works, and even built secondary roads, before the health team arrived. We emphasize the value of the rural plan, but only when it is fostered by education in public health and when the community is encouraged to aid, to the extent of its capabilities, in the solution of

the problems prevailing in the Latin American countryside.

The status of nutrition is another yardstick by which the gravity of the disease problem may be measured. Examining our statistics, we can declare that as between education and health, health takes priority. Allow me to praise the educational tradition of my country. Nevertheless, in spite of the educational level attained by Costa Rica, assessment of the nutrition problem shows the indisputable priority that health has over education. Here are statistics to prove it. Studying the great nutrition problem, which we must term the nutritional disease of our countries, we verified the fact that 14 per cent of the population of Costa Rica is malnourished; in a community we surveyed, we discovered that 44.5 per cent of the inhabitants suffered from malnutrition of the first degree; 13.3 per cent are menaced by malnutrition of the second degree and 10.8 per cent by malnutrition of the third degree. This shows that the first problem to solve is that of malnutrition. Its repercussion in the schools is well known; the fact that 30 per cent of the pupils in our classrooms repeat courses makes it evident. There come to our minds the words of the Secretary of Health and Welfare of Mexico in reference to malnutrition as the cause of certain organic damage. So it is necessary to emphasize that it is useless to try to raise the educational level in our countries if we do not first provide suitable health conditions for the inhabitants. This 30 per cent of repeaters in our schools clearly indicates the priority of health problems. Faced by these impressive figures we must realize that nutritional deficiency in our countries is a disease, a scourge, perhaps the greatest that is devastating us. It affects not only the rural areas, but it forms—and here I repeat what my friend, Dr. Alvarez Amézquita said—a belt of misery around our urban communities. In a survey made in our hospitals, 19 per cent of the children from urban areas enter with a diagnosis of malnutrition, as compared with 4 or 10 per cent from the rural communities; that is, malnutrition pervades the entire country. And since the child who comes to the hospital to recover often dies, we thought it advisable to establish, at strategic localities in the Republic, four or five centers as semi-hospitals or clinics for nutritional recovery. Our obligation as Ministers, as men dedicated to health, is to see that children do not perish because of malnutrition, that they do not arrive at the last stage of malnutrition if we can come to their aid in time.

As to the training of specialized personnel, it can be said that, thanks to UNICEF, we are on the way to achieving training of a national type that can certainly be converted into training at the regional level. We are interested, first of all, in training auxiliary personnel. Our countries, short of specialized personnel, cannot wait for the time necessary to train specialists. The few specialists that we have need the aid of auxiliary subprofessional personnel, especially since it is necessary to educate families and bring basic ideas into the home in order to combat nutritional disease. We cannot wait until we train specialized personnel, because hunger does not wait. We want to train professionals in their respective specialties, with a total concept of health. Because we desire to teach this concept of health, our work sometimes seems to be frustrated, although in other localities we find understanding; but there is no doubt that the cause is rooted in the lack of total training of our professionals in health matters.

The contacts with the University and the earnest desire of the Ministry to establish an ever-stronger affiliation with it, have led to the inclusion of preventive medicine in the curriculum of our School of Medicine for the five years of study. I believe that this is the greatest achievement of the School of Medicine of Costa Rica.

As for malaria and the communicable

diseases, the country's statistics indicate that an area of 31,000 km² is now in a stage of perfect consolidation, which leaves only about 7,000 km² to be tackled in order to eradicate malaria from our country. Our technical personnel from the Ministry declare that in 1965 malaria will have been eradicated from Costa Rica.

I believe, Gentlemen, that this indisputable victory, which we could boast of nationally, will turn out to be a Pyrrhic victory if our brothers, the Central American countries, do not achieve similar results. I regret the malaria that harms El Salvador, Guatemala, Honduras, etc., as much as the malaria that harms my own country. Since we, as men and brother Americans, want this victory to be total, we must recognize the regional character of certain communicable diseases. Malaria offers a perfect example of regional solidarity.

I wish that we could have a common administration and a common budget for the countries that make up the region, so that we could raise our neighbors to the same level and proclaim this victory in a regional and definitive form in our area, and not in a partial form, as perhaps will be the case in Costa Rica in 1965.

As for tuberculosis, we may possibly be deceiving ourselves. Our campaigns, well planned and positively pursued, are guilty nonetheless of excessive centralization, and it is possible that we still fail to recognize the epidemiological factor. This is why we propose, with the advice of the Pan American Sanitary Bureau, to set up a pilot area to study this disease, with special attention to epidemiology. We shall aid our doctors and convince them that it is better to devote themselves to preventive medicine than to cure tubercular lesions—often chronic and definitive—in hospitals.

We have dedicated ourselves to research, and we have established a virus laboratory for this purpose in Costa Rica. I should like to make it clear that this word "research" is not mere show on our part, for in this laboratory we do something more than abstract research; we study diseases that we do not have the power to combat.

Our struggle against child mortality, our firm dedication to preschool-age children—since we think that the child who reaches the classroom is a biological hero for having succeeded in surviving—forms a part of the environmental sanitation policy, which is admittedly deficient. In this respect, we must not forget that infant mortality often has its source in enteric diseases. The virus laboratory which I just referred to has as its first aim the investigation of the principal enteric diseases.

As for vaccination, I accept with pleasure the magnanimous idea of Dr. Alvarez Amézquita; to be able to count on a regional market in biological products would be a positive step forward for our countries. As we lack appropriations for vaccine materials, we must repeatedly thank—at least we in Costa Rica—the large countries, among them Mexico and the United States of America, for their generosity. But no country can live on the generosity of others, just as it cannot live in poverty. Consequently, the idea of manufacturing biological products on a regional basis for sale periodically at low prices would permit us to proceed at the national level to the task of vaccination; this is necessary to prevent many diseases which still affect our countries.

These are, in short, the chief aspects of the health problems of Costa Rica and the work that we are now doing to combat certain diseases.

ADDRESS BY THE MINISTER OF PUBLIC HEALTH OF COLOMBIA

DR. JOSE FELIX PATIÑO

Presented at the Fourth Plenary Session
16 April 1963

I brought a written report, in which the Delegation of Colombia presented some general aspects of the public health problem in our country and also touched upon some possible solutions of general application. However, these matters have already been treated in large measure by other Ministers in a more brilliant form, and I have decided to abstain from reading this document and to limit myself entirely to stressing some of the points that have been discussed and to presenting certain aspects of the public health problem in Colombia which are worth mentioning because of our special experience.

It is evident, as various speakers have said, that the mortality and morbidity rates of the Latin American countries indicate a frankly inacceptable situation. You have spoken of infant mortality, about the frequency of infectious diseases, especially the enteric and respiratory infections, which are the cause of the extremely high infant death rates. Reference has been made to the extremely bad environmental conditions, to malnutrition, factors that result in a state of physical and mental underdevelopment and a low work output. All this we ought to regard as grounds for achieving quickly the solution we are seeking; for beginning to plan some concrete steps which will permit us to draw up realistic plans and to obtain immediately effective solutions; for possibly thinking of drawing up somewhat more concrete plans, more in accord with reality, and avoiding insofar as possible the tragic paradox, which we often observe, of the over-elaborate plan—one full of details of an unattainable technical perfection, which can become an obstacle to the solution so urgently needed.

The Ministry of Public Health of Colombia considered it of interest to elaborate on certain important points, as follows:

First: We think that, on the basis of the Colombian experience, perhaps the most important means for reaching a rapid solution is the Ministry itself. The Latin American countries, almost without exception, are given to frequent changes as one Administration succeeds another. Presidents change, and even during the tenure of a single one, the Ministry may change four or five times.

If the structure of the Ministry is based on a technical plan, if the posts in the Public Health Ministry are occupied by individuals whose training and allegiance are entirely in the public health field, perhaps we can guarantee continuity of work. After promulgation of Law No. 19 of 1958, which gave authority to the Government of Colombia to reorganize Public Administration, the decentralizing process, which the Ministry of Public Health had embarked upon some years before through contracts with the departments or regions, was accelerated.

The reform brought about after the promulgation of this law—just a few years ago, that is—follows the plan of technical centralization and administrative decentralization. In effect, three levels have been established: the central level of technical direction (plans, programs, standards,

evaluation, supervision); the intermediate or administrative level, made up of the sectional or regional public health authorities; and the lower or executive level, composed of the agencies themselves.

The central level is composed of a technical and an administrative branch. In addition, there is a unit of supervision and executive coordination, and another unit of planning and evaluation.

It is important to note that the Ministry of Public Health now has completely trained personnel and that only the Minister himself is not a public health specialist. In the levels immediately below, all are public health specialists. We believe that this technical organization assures the continuity of work and that this is one of the goals to which the Latin American countries should aspire. The Minister may change, but if the organization of the Ministry is retained, the work will continue.

Second: For us, the training of personnel has been a fundamental concern and an important task. In 1948, with the advice and economic aid of the United States of America, the Ministry created an institution to take charge of training public health personnel. This school, then called the Higher School of Hygiene, grew with the years and in 1951 came to be part of the National University. It is now called the School of Public Health; it receives important financial support from the Ministry, which is responsible for protecting it, encouraging it, and keeping it free from political interests, within a purely academic framework.

We believe that this coordination between the Ministry of Public Health and the School of Public Health is a further guarantee that we shall obtain the personnel necessary to enable our health organizations to function effectively.

The allocation for the School occupies a place of first rank in the Ministry of Public Health budget; it has suffered no decrease in any previous budgetary period, but on the contrary is being increased each year.

We have considered medical education very important in our program of personnel training. The Government of Colombia views medical education, not as an isolated feature of education, but as a primary factor in the promotion of health. The Ministry of Public Health therefore demands participation in, and responsibility for, the medical education programs.

We have achieved close coordination in the medical education field in Colombia through the planning, establishment, and development of the Association of Medical Schools, which has been functioning for four years and grows stronger each year as the result of the grants, collaboration, and support given by the Government. This, we believe, is a very important instrument for bringing uniformity into medical education and enabling the Public Health Ministry to collaborate in a concerted effort to improve medical standards in the country.

Third: Another effort to obtain closer coordination with medical education—which we present for your consideration because we deem it important—was to delegate to each of the schools of medicine responsibility for administering one of the integrated health districts.

Colombia's ten-year health plan calls for the establishment of a series of integrated health districts, the organizations responsible for comprehensive health care, both preventive and curative, for a certain number of inhabitants—in our case, 100,000. The ten-year plan envisages the progressive extension of these organizations throughout the country, and high priority has been given to the so-called "university districts."

In Colombia there are seven medical schools, and a health district has been turned over to each of them to administer. In this way the University has complete charge of administering the district, while the Ministry is limited to financing its

operations. Thus we give the medical schools a new field of action, and the schools become thoroughly informed as to the real medical problems of the country. I myself did not realize, even when I was a university professor, that we were teaching medicine that was unrelated to the true situation in Colombia. Only when I entered the Public Health Ministry did I realize we were teaching medical theory often extremely refined in exact surgical techniques, but perhaps of limited use in the country. How far our medical students were from a real knowledge of environmental sanitation and nutrition and the true health problems of the country!

Through these university health districts, medical students will be able to study the medical problems of Colombia's different geographic regions, right on the spot rather than among patients in metropolitan hospitals.

So we have given these districts the highest priority in our health plan. The first will be opened next month, and we hope that within two years each of the medical schools will be administering a health district.

Fourth: Another important matter we deemed worthy of discussion is that of the presence of authorized representatives of the public health authorities within the national planning organizations. The organizations, councils, committees and boards for national planning are made up almost entirely of economists. All Governments, in our opinion, ought to make an effort to include on the national planning boards the Minister of Public Health, if possible, or at least a high official of the Ministry, an individual who is qualified to make decisions and has sufficient authority to influence the formulation of these plans.

All of us agree, after hearing the statements previously made, that one cannot conceive of economic development without social progress as a base, and that the protection of the people, our chief source of wealth, must not be forgotten. But what we say here will be of no avail unless we draw from it an important conclusion: that we must ask for the inclusion, in the national planning committees or boards, of a high authority from the ministries or secretariats of public health.

To summarize, then, I propose consideration of the following concrete points:

1. To make a continent-wide effort, preferably through unified action, to achieve the organization of the ministries of public health on a technical basis, through appropriate legislation.

2. To provide for the inclusion of the Minister of Public Health, the Secretary, or some high official, in the national planning organizations.

3. To request a high priority for programs of the ministries of health in the general development programs of the country and, of course, in the preparation of national budgets.

In Colombia we have found that a very effective way of winning Congressional support has been to create committees, which we call liaison committees, made up of Congressmen, usually doctors, who meet weekly in the Ministry to discuss health problems and the steps for solving them. This has been an expeditious means of gaining in Congress quick approval of laws, which otherwise would have been quite difficult to obtain. Even though my colleagues, the Ministers of the Hemisphere, are undoubtedly skilled parliamentarians, I believe that this method facilitates the task considerably.

4. To plan the training of personnel not only on the basis of sending individuals to more developed countries on fellowships. Certainly this is quite important, but I agree with our President that in the first place we should make better use of our personnel and study, in cooperation with

the medical, nursing, and public health schools, the creation of national and regional centers where the greatest benefit can be obtained and a greater number of people trained. We should consider especially the establishment of centers for training auxiliary personnel—schools for nursing auxiliaries and for regional laboratory technicians—in order to use, as our President has said, local personnel who speak the local language and who will be understood by their own people. In this way we shall solve the problem of keeping trained personnel in the rural areas as well as in the large cities.

Finally, I believe that, in connection with the recommendations that are to be made, this Task Force should express itself very clearly on the plans and projects presented to the Alliance for Progress and to the other organizations responsible for foreign aid. Although we certainly cannot envision foreign aid without technically-conceived plans, it is equally certain that excessive demands for detail in these plans can become an obstacle to speedy execution. I am a confirmed advocate of strictly technical criteria in plans, but I have observed that the requirements are often beyond the capabilities of our countries. After all, if we were capable of drawing up plans with this luxury of detail, our countries would not be underdeveloped and perhaps we should not need foreign aid.

ADDRESS BY THE MINISTER OF LABOR, SOCIAL WELFARE, AND PUBLIC HEALTH OF PANAMA

DR. BERNARDINO GONZALEZ RUIZ

Presented at the Fourth Plenary Session
16 April 1963

The Republic of Panama comes to this most important Meeting of Ministers of Health in the spirit of full cooperation and with the desire to profit by most valuable experiences. We bring to this convention, of such great prestige, our greetings and our best wishes that the discussions may be translated into victories and benefits for the American peoples, positive declarations of solidarity, and guarantees of democracy.

The problem is how to carry out this gigantic task of organizing health work among the American peoples in such a way that they may effectively participate in the economic revolution for the development of a free America. The battle is on, and the Pan American Sanitary Bureau, along with the United Nations Children's Fund, have been and continue to be catalyzing forces that have helped produce unquestionable progress. This struggle must go on, and new battles must be waged, for the objectives are clear and specific goals are attainable within more or less predictable periods of time.

Disease is common in our America; the state of physical and social well-being is extremely rare. If in other, already developed, countries man has attained high levels of production and consumption, it ought to be possible to achieve this goal in our America, provided the means are made available and plans are carried out to the necessary extent and with the methodology requisite to a large health undertaking.

In order to use advantageously the capital that we urgently need to invest in the health field, we must rationalize the medico-health undertaking with a view to getting the best returns, in accord with the common objective. Consequently, health planning, which we now pursue so logically and with such urgency in each of our countries, ought to be translated into extensive improvement of health in the Americas—with general and specific, immediate and long-range objectives—in which the great deficiencies of certain areas would receive the necessary priority, and in which the common deficiencies could be made up and duplication of effort and waste of resources avoided.

Health plans must be backed by available resources, which taken as a whole can produce a better yield in the undertaking throughout the Hemisphere. No plan, no matter how well conceived, can be put into practice successfully if the investment capital and the human capital are not soundly planned for. We are facing a difficult phase in the evolution of our sister Republics, and difficult situations must be met with practical, satisfactory decisions.

We have met here because, faced with the problem of health planning, we are seeking financing facilities. With all the backing that the Alliance for Progress can offer us for financing many areas of our health planning, supported directly or indirectly by capital investment, we believe that the rapid development of our institutions providing service, our programs, and our projects is going to call for so much human capital skilled in the carrying out of large undertakings that we see ourselves in

danger of changing course and taking alternative measures that will slow down the pace at which we proposed to achieve the desired goals.

In other words, there is going to be a demand, the extent of which is difficult to predict just now, for professional and technical personnel to give a strong initial drive to the health plans of our countries.

This is certainly more noticeable in the countries of the Central American Isthmus, but it is easy to foresee it in the sister countries of the Caribbean and South America.

We may raise the question as to whether we shall be able by ourselves to produce the quality and quantity of human capital needed for the medico-health undertaking in the Americas. Are there enough facilities in the Spanish language for teaching the diverse subjects that make up the public health field?

My country is very interested in this aspect of the planning problem. Because of Panama's privileged geographic position; because of the historic developments which took place there in the health field, when the heavy task of sanitation was carried out in the Isthmus to construct the Panama Canal; because our country has been the headquarters of organizations engaged in important medical research, such as the Gorgas Memorial Institute of Tropical and Preventive Medicine and MARU, the Middle America Research Unit of the U.S. National Institutes of Health; because of the presence of medical services of high quality in the Canal Zone; because of the National Health Plan (1962–1970), a copy of which I have the privilege of handing each of you; because of the collaboration offered by the University of Panama, designed as a nucleus for the future Pan American University—in short, by reason of all these valuable facilities in the field of training of personnel, my country will be happy to be the seat of a great institutional effort, at the disposal of all America, in the field of public health and other fields of medical specialization.

Capital investment would undoubtedly contribute to making development plans in the health field more practical and applicable. In this effort we would all participate in proportion to our economic resources. A plan of this nature would be of short range, but it would allow us to begin producing the personnel for the most pressing long-range needs of the countries in order to go on producing slowly, but with effective continuity, that great technological capital that America requires urgently and extensively for its health effort.

In closing, I should like to express to you, in the name of my Government, the most sincere wishes that this high-level conference in the health field will reach the desired objective of finding or pointing out the paths we must follow to redeem the American peoples from the lack of vitality which, at this time of great social tribulation, weakens the establishment of democratic ideals and social justice, to which the free men of the Hemisphere aspire.

ADDRESS BY THE MINISTER OF HEALTH AND SOCIAL WELFARE OF VENEZUELA

DR. ARNOLDO GABALDON

Presented at the Fourth Plenary Session
16 April 1963

In commenting on the principal problems affecting health and the measures that should be taken pursuant to the objectives of Punta del Este, I want to emphasize the need to focus on the epidemiological objectives of the Charter, that is, to increase, during the decade, life expectancy at birth by a minimum of five years and to reduce mortality among children under five years of age. This is important, because stress is often placed on administrative objectives without taking into account the fact that what we are really after is the reduction of some epidemiological problem.

When I took charge of the Ministry of Health and Social Welfare in 1959, I suggested that life expectancy at birth was the yardstick we should use to measure our progress. I did this in the report for that year presented to the National Congress. What had happened as a result of this approach from 1950 to 1958? We were achieving an increase in life expectancy at birth of six months per year of work, but what disturbed me was that many problems were being approached in a vertical manner, with the object of giving very complete care to small sectors of the population, while large masses, especially in the rural areas, were somewhat neglected. I stressed the fact that it was necessary to replace this vertical approach by a horizontal approach that would afford less intense protection but wider coverage.

I believe that, as a result of this approach and also the bettered economic situation of workers and farmers that the country has known in recent years, appreciable changes have been produced in life expectancy at birth. From 1959 to 1961, the latest period for which figures are available, its increase was 13 months per year of work. This confirmed the fact that the first objective we had set could be achieved and was not mere optimism. In a study we made of two population samples, one rural and the other urban, chosen because of their adequate death registration, the following figures were obtained: in the rural sector, life expectancy at birth was 53.6 years in 1958; in 1961 it rose to 59.2 years. In this brief period, then, the increase amounted to 5.6 years. In the urban sector, life expectancy at birth was 63.3 years in 1958; in 1961 it was 65.8 years. In this sector the increase was six months per year of work, while in the rural sector it was almost two years. However, in 1958 the rural population had a life expectancy almost 10 years less than that of the urban population, and in 1961 this difference was only six years, which shows that health conditions in the rural environment have improved considerably.

In our search for a mortality rate that was easy to calculate and would serve as a practical guide, we found that the rate for the group 1–4 years of age was of great importance, for it was the very one where the greatest difference showed up between the countries of backward health status and those of advanced health status. Here, too, we see that the improvement in health in

the rural sector has been substantial in the last four years. In 1958 the mortality rate of the group 1–4 years of age was 19.8; in 1961 it was 11.9, or a reduction of 7.9. In the urban sector the rate of 7.4 in 1958 dropped to 5.0 in 1961, a decrease of 2.4. These figures show that the rate of improvement in health conditions of the rural population was much greater than that of the urban population; they also show that it will be relatively easy to achieve the goal established in Punta del Este with respect to mortality among children under five years of age.

But there is one point to which I want to call special attention. The number of those who reach 15 years of age is of great importance in relation to the population in the age group 15–64 years, or the economically active group, although our life tables indicate that a considerably smaller percentage reach 15 years of age than in countries of more advanced health status. As the birth rates are almost double in our countries, the number of children reaching the age of 15 is also almost double the one recorded per 1,000 inhabitants of 15 to 64 years in countries of advanced health status. This means that the economically active population of our countries supports a scholastic burden almost double that which the economically active population in countries of more advanced health standards have to support, while they have a per-capita income considerably higher than ours.

Moreover, the medically backward countries have to create annually almost twice as many job opportunities per 1,000 inhabitants of the age group 15–64 years as do the medically advanced countries. This is a problem that I think we should examine carefully, for it can have unfavorable repercussions on future economic development; that is, we could come to a kind of impoverishment with a resulting decline in health conditions.

Among the administrative objectives in the Charter of Punta del Este are some that have the virtue of bringing with them epidemiological gains. I think it important to keep this in mind, for in planning one must make a distinction between administrative and epidemiological objectives. Since planning is governed by an economic criterion and gives great emphasis to purely administrative objectives, it can deflect us from the targets that we are really aiming at: a specific improvement in certain health problems.

From the economic viewpoint, I am interested in the amount of national income devoted to medical care in our countries. In the United States of America, 4 per cent of the national income is devoted to medical care, preventive as well as curative, including that provided by both official agencies and private practitioners. According to an estimate that we have made, 6 per cent of the national income in Venezuela is devoted to medical care.

As I am not an economist, I do not know the percentage of national income which countries now medically advanced were spending in the years from 1900 to 1910, the epoch corresponding, more or less, to the medical stage in which we live. I think that it is important to ascertain this, for I believe that with the skills now available, it is possible to work on health problems in our countries with relative speed and without spending a high proportion of the national income. This is of some importance, for the time might come when, in the effort to improve our systems, we would divert to medical care a share of the funds needed to improve the economy—the only means by which we can maintain the benefits we seek for the future. This does not imply that we should subordinate man to the economy; what it means is that perhaps, with the methods we have today, properly applied, we can make improvements that

formerly might have required more time and more money.

In order to establish the bases of the goals we are aiming for and suitably measure the advantages derived from our work, we must review our statistical problems. We undoubtedly need to improve birth and death registration. We must improve death registration so as to be able to know whether the figures we are obtaining in our life tables are realistic; we must make some assessment of the available statistics, whether by the sampling technique or by the use of statistical procedures to indicate how far we can rely on available figures.

Recently, I have been stressing the need to establish a representative death registration area by choosing a group of municipalities where registration has been proven to be reliable enough to serve as a basis for our statistical studies. I think it would be advisable that, through the Pan American Sanitary Bureau, more time be given to this type of study, since it is essential that each country have confidence in its statistics. It is important that we not fail to heed our statistics, as frequently happens as a result of deficiencies in the available data, and thus let our attention be diverted to administrative objectives instead of the epidemiological objectives that we should pursue.

Moreover, in examining the high mortality rates for each age group, we find that there is a specific number of causes of death which have produced the highest mortality in each of these groups, aside from some diseases of a regional character, such as malaria and others. But since we know that excessively high mortality in the selected age groups is due to causes that were brought under control in the medically advanced countries, we can direct the health measures against those diseases most susceptible of control, so as to achieve in a comparatively short time a measurable and favorable change in the death rates, which is what we really want.

If we concentrate in this way on the matter of removable causes, we must note that certain problems, susceptible of easy solution, still cause some damage in our countries. I refer in particular to smallpox; for this disease we have a method of keeping the population immune and hence free from epidemic, a method which can be applied even by volunteers. Moreover, tetanus in infants is still an important cause of death during the first week of life; perhaps this is due to the fact that we do not use the services of well-trained midwives.

I have mentioned these two diseases as an indication of what we could do at little cost to reduce our health problems. But public health officials have been dominated by the communicable diseases, and we are ignoring other problems that do considerable damage, especially in the economically active population. It is highly significant that in some of our countries homicides are the chief cause of death in the age group 20–40 years; in others, they are the second cause. Accidents, too, especially with automobiles, are already appearing as the first cause of death in this group, or the second cause in some countries. It is worth pointing out that an automobile accident causes a major economic loss, in that the person who dies in such an accident has already reached an economic level higher than that of the purely rural population.

Homicides and accidents are linked with alcoholism, and if, by virtue of the characteristics I referred to earlier, we have an economically active population with heavy responsibility for the young and thus confronted with the need to create a larger number of job opportunities, we must direct public health work toward the protection of this adult population, so that it can face its problems of child care and advance economically.

I think that it is impossible to say too

much about the importance of directing health planning toward improvements in morbidity and mortality rates, for I insist that in the planning field, where economists play a major role, the objectives we are really seeking can be forgotten, as has happened in some cases. In Venezuela, for example, the number of hospital beds per 1,000 population is lower than that in other countries. Nevertheless, our mortality rates are lower than in those countries. It would cost us a great deal of money to maintain as many hospital beds as the other countries; without them, we still have better health, though the medical care is inferior. Consequently, the goal must be, not to have a certain number of hospital beds per 1,000 inhabitants, but rather to reach definite epidemiological objectives by means of specific, direct measures against certain diseases.

As for organization, in these last years we have had a small revolution. We have separated environmental sanitation from the other public health work, and have entrusted these activities to two organizations at the same hierarchical level, in order to be able to give suitable attention to the development of environmental sanitation work.

For a long time we have heard health officers speak about the need for making environmental sanitation a basis for improvement of health. Nevertheless, when the budgets are drawn up, allocations have nearly always been made at the expense of environmental sanitation. The following figures indicate the change that has come about in Venezuela in this respect: from 1945 to 1958, or a 13-year period, 160 rural water systems were built; from 1959 to 1962, 136 were built. The figure for 1962 was 82, and in accordance with the plan we have submitted to the Inter-American Development Bank, from which we received a loan, we shall be able to comply with the Charter of Punta del Este.

It is true that Venezuela still has a scattered rural population to which it will be difficult to furnish water. But with the development work that we are carrying out, I think that the objectives of the Charter of Punta del Este can be achieved, so far as the communities of from 100 to 5,000 inhabitants are concerned; this is the group that we are now concerned with in the Ministry of Health and Social Welfare.

Moreover, the National Institute of Sanitation Works, which is concerned with communities of more than 5,000 inhabitants, has a program that will permit it also to carry out what was agreed on at Punta del Este.

As for the personnel responsible for environmental sanitation, there were 50 engineers in 1959 and 150 in 1962; that is, we have tripled the number. These figures indicate the change of direction that has been brought about by this separation of activities which, in reality, are quite different fields and call for different types of university training.

Moreover, we are glad to confirm not only the fact that the requirements of environmental sanitation in rural areas call for an organization of this type, but also that in the United States of America problems springing from industrialization and urban development have led, according to reports I have read, to a proposal for a similar form of organization.

On the other hand, we have taken a rather important step in the organization of the medical care services which are in the charge of the Ministry, the regional governments, and some other organizations, by creating, through agreements, cooperative public health services which integrate all these activities into a single organization. They have a director appointed by the Minister and an executive board chosen by the organizations participating in the cooperative program.

This service has already begun to operate

in several states, and there is reason to hope that the Social Security Fund will later be associated with it. Moreover, the Ministry of Public Works has asked that we, in the Ministry of Health and Social Welfare, take charge of their medical care services. This shows that by means of such agreements it is possible to attain a unified organization in countries where, because of certain factors, it has hitherto been necessary to maintain separate services. This is not a new idea; Mexico has had similar arrangements for many years, and perhaps other countries have them.

With respect to control of communicable diseases, we know that we have made considerable advances in the case of malaria, which used to be the basic health problem of the country, since the area where the disease has been eradicated was the first to be registered by the Pan American Sanitary Bureau. This area now consists of 432,000 square kilometers and is third in extent after that of the United States of America and that of the Soviet Union. On the other hand, Chagas' disease affects the inhabitants in rural areas. Careful studies have shown that damage to heart muscles, confirmed by electrocardiograms on infected individuals, is considerable, even in the early ages of from 5 to 20 years. So, if we are to increase the efficiency of human work, it is very important to attack this disease, as we have attacked malaria. Furthermore, because of the available knowledge of suitable insecticides, we obviously have powerful means for carrying our work to a successful conclusion.

Another disease worth mentioning, as an example of the great progress we have made, is gastroenteritis. With the introduction of rehydration by tablets that can be delivered to auxiliary personnel and to mothers, a radical change has come about in the number of deaths. In 1953 there were 157 deaths from this disease; in 1958 the number decreased to 140, and in 1962 it dropped to 75, thanks to the horizontal focus of the campaign which I referred to.

We see clearly that it is possible to reduce a serious mortality problem by satisfactory methods of medical care. This by no means indicates that we have reduced morbidity. We shall not succeed in this unless we achieve more effective fly control and have water supply in the majority of our population centers.

With respect to malnutrition, there is no doubt that its final solution will depend on an increase in agricultural production. Meanwhile, a product with a skim milk base, which has been given to undernourished children, has appreciably contributed to reducing the mortality from this cause.

We have made some advances worth mentioning in the training of personnel, but we should stress the fact that needs for health personnel must be taken care of to the extent that the economic possibilities of the country permit, and we ought not to have a greater number than that available, because we would have difficulty in maintaining such a number.

The Ministry has made agreements with all the universities so as to help finance improved teaching of medicine and sanitary engineering. The School of Public Health is responsible for all postgraduate courses, and all these courses are financed by the Ministry of Health and Social Welfare. The School of Malariology has been enlarged so as to take care of the other activities in environmental sanitation. As for auxiliary personnel, the use of appropriate and strict manuals has made it possible for individuals with a sixth-grade education to do effective work, especially in simplified medicine, which is the only type that can be applied in rural areas remote from centers where there are medical services.

We have also considerably increased the number of fellowships. We had hoped that the expenses of the fellowship holders would

be taken care of by the United States Agency for International Development once they had been accepted in North American universities. We did not succeed in making a satisfactory arrangement in this respect, and last year 83 fellows, supported by our scarce dollars, studied in that country in different specialties of great interest for us. On the other hand, the fellowships of the Pan American Sanitary Bureau have been satisfactorily increasing in recent years.

I believe that what I have said shows that the objectives established in the Charter of Punta del Este are attainable, and that what we have accomplished in Venezuela indicates that these objectives are feasible and will be brought to reality in all our countries.

I hope that this comes about in 1971.

ADDRESS BY THE DEPUTY MINISTER OF PUBLIC HEALTH OF NICARAGUA

DR. CONSTANTINO MENDIETA RODRIGUEZ

Presented at the Fourth Plenary Session
16 April 1963

I shall make a brief summary of the pressing public health needs of the Nicaraguan people which our Government is endeavoring to meet, although we shall present the technical problems to the appropriate committees at the suitable time.

With an area of 140,000 square kilometers and a population of 1,600,000, Nicaragua forms a part of the Central American block of countries. With a very few variations of origin and development, its racial, cultural, and economic characteristics are similar to those of the other five Republics. It has more or less the same health problems, as well as the same desire for progressive development to improve the living conditions of the people, Indo-Latin in origin, for the most part.

Nicaragua is essentially an agricultural country. A few years ago it started a few small industries capable of producing for local consumption, thus opening up opportunities for Central American commerce within the plan for economic integration of Central America.

Population density averages 10 inhabitants per square kilometer. Nicaragua is situated between latitude 10° and 15° north. The prevailing religion is Catholicism, although there is religious freedom. Its natural resources are forest products, woods, gold and silver; there are deposits of copper, iron, lead, and other minerals. The export of cattle, coffee, and cotton is an important source of national income. Fish abound.

Nicaragua is a democratic Republic with three sources of authority: executive, legislative, and judicial. Recently, a change in the Constitution has added a fourth—electoral power.

The economically active population of both sexes amounts to 31 per cent of the total—54 per cent of the masculine population and 8 per cent of the feminine.

Comparing fiscal receipts and the national budgets for the years 1950–1951 with the years 1962–1963, one notices a considerable increase. The first did not exceed 67 million córdobas, while the second amounted to 624 million.

Exports, as well as imports, have increased considerably in 10 years. In 1950 the value of exports reached 24 million córdobas; in 1960, 72 million. The increase in imports was from 21 million to 67 million córdobas, respectively.

The percentage of illiterates is very high. Sixty-eight per cent of the people have not finished a single year of primary education; 29 per cent have had some years of primary schooling. Two per cent have had some years of secondary education, while 0.3 per cent have taken university courses.

According to 1960 statistics, the principal causes of death were the following: gastroenteritis in infants, 13 per cent; gastroenteritis in children, 11 per cent; accidents, 6 per cent; malaria, 6 per cent; and influenza and pneumonia, 5 per cent.

Medical care and preventive medicine are separate; this constitutes a serious problem

for general health care. The hospitals of the country are subordinate to an autonomous organization, the National Social Welfare Board. There are 32 public and private hospitals, with 3,872 beds, which gives an average of 2 beds per 1,000 inhabitants. There are 600 physicians in all the country; they are concentrated in the chief cities, such as Managua, León, and Granada, which have about 350 physicians. The rest of the country, especially the vast Atlantic coastal area, our largest and most mountainous area, lacks medical care. There are 228 nurses in all, that is, 2 nurses per 10,000 population.

The status of the health campaigns which are being carried out by the Ministry of Public Health is as follows: The malaria eradication campaign is nearing completion, according to the latest reports. A zone containing 33 per cent of the population is in the consolidation phase. The area where the campaign is in the attack phase contains 67 per cent of the inhabitants. It is believed that the malaria eradication program will have been completed by 1964, which will be good news for the neighboring countries, because of the regional character of this disease. The only difficulty now being encountered is mosquito resistance to insecticides; in the cotton areas, especially, it seems that spraying of insecticides has been creating this resistance. A program of chemotherapy is also being undertaken as part of the effort to achieve complete eradication of malaria.

Smallpox is now wholly eradicated in the country; for more than 30 years no case has been recorded. However, vaccination continues. In 1956, 14,108 persons were vaccinated; in 1957, 10,248; and in 1962, 40,968. During the present year, 9,986 vaccinations have been given to date.

A campaign for the investigation and treatment of leprosy has been initiated, primarily in the Departments of Chinandega and León, the most affected areas. We have an establishment for the hospitalization of leprosy patients. The investigation and treatment campaign is now being conducted by a new unit under the direction of a leprologist.

Diphtheria-pertussis-tetanus (DPT) vaccination is also being used. Under an agreement with the neighboring Republic of Costa Rica, a campaign against rabies has been conducted jointly with that country. Moreover, poliomyelitis vaccination and typhoid fever vaccination are being carried out. In 1962 the work included 87,680 TAB vaccinations, 13,032 DPT vaccinations, and 1,599 BCG vaccinations; in this campaign, 5,018 tuberculin tests were made, with 29.13 per cent positive, and 28,320 poliomyelitis vaccinations were given. In this connection, I should like to express the gratitude of the Government and the people of Nicaragua to the Republics of Brazil and Mexico for their generosity in furnishing us smallbox, poliomyelitis, and typhoid vaccines. We ask the Ministers of Health of these countries, present at this Meeting, to be kind enough to convey the message to their Presidents.

The campaign against malnutrition has developed slowly for lack of suitable technical personnel. My country, like those of Central America in general, must intensify its nutrition campaign. Although we have the essential resources for full nutrition of the individual, our people lack knowledge of how to make the most of the land's resources. Consequently, we have established a pilot plan, covering the Departments of Carazo, Rivas, Masaya, and Granada, where the majority of the rural population lives—that is, 65 to 70 per cent of the total population. The Ministries of Public Education, Public Health, and Agriculture are cooperating in this pilot plan. Last week the first evaluation of the program's achievements was made, with rather encouraging results. Technical personnel teach children in the so-called "school gardens"; they teach them what they ought to plant and

what the nutrition requirements are. In this way, the education effort reaches the people.

On the basis of one year's experience, we shall soon be able to extend to the rest of the country this same system of interministerial cooperation for promotion of the people's health. We can supply the people with the products of the land, to the end that our farmer will learn to sow, not only in order to sell, but also to nourish himself.

The Ministry distributes milk, vitamins, and butter. In this milk distribution campaign, the children in all the schools and health centers were formerly given a glass of milk. The nutrition campaign is now being approached on more technical grounds, and milk is being supplied only to those who really need it, that is, to those who show subnormal development.

We have also organized a maternal and child health campaign, and we are beginning to give care to pregnant women, especially the poor, with the aim of bringing about better health conditions and greater resistance to attacks of the external environment, which are the bases for prolonging the life of the newborn and the child. This maternal and child health program provides consultation and periodic examinations for pregnant women and also furnishes nutrients such as vitamins and milk.

We are also conducting a coordinated program with the hospitals, whereby we transfer mothers from the health centers to the latter, in order that they may give birth in a hospital center, thereby avoiding the rather high mortality recorded among the newborn because of the lack of technical aid during delivery. The mother returns from the hospital to the health center; observation of the newborn continues there.

Among our human resources we have, of course, professional health personnel: physicians, nurses, health educators, health visitors, nursing auxiliaries, laboratory technicians, etc. However, the number that we have does not fully satisfy our country's needs.

The nursing auxiliaries are simply health visitors, but they now complete their study with courses for auxiliaries specialized in hospital nursing. According to the new plan, these courses, now lasting six months, will be extended to nine months, three months being devoted exclusively to public health aspects. Their purpose, especially in rural areas, is to better prepare the auxiliaries who visit homes to help the mother or the child in case of need.

A course for health educators is now being organized, since we have only 26 in the country. We believe that the health campaign must inevitably be based on the education of the public. We are guided by the belief that, from janitor to Minister, we must all be educators.

As for the technical structure of the Ministry, there is a trend toward converting it into a purely technical organization in order to prevent any delay or shifts in the health campaigns as the result of natural changes in Ministers or Government. This is also important so that the necessary planning may be carried out and the Ministry may function in accordance with the techniques established in each of the health branches. For the same reason, we aspire to the establishment of a career service.

As we do not have a civil service, health workers will find an inducement in the knowledge that they can gradually obtain promotions, with accompanying financial benefits, in accordance with the seniority system that will shortly be established.

The health campaigns to which our Government is striving to give priority because of the benefits they will bring to the people, call for analysis here, although you all know them quite well. They are as follows: environmental sanitation, which includes health education, potable water supply, destruction of parasites, and construction of privies; and the technically planned anti-

tuberculosis campaign, which includes case investigation, vaccination, and preventive and curative chemotherapy.

In the governmental program of the President Elect, who will enter into office on the first of next May, it is planned to give special emphasis to rural health campaigns. For many years we have been concentrating on urban areas and neglecting the rural zones which need attention more and where the great majority—65 to 70 per cent—of the total population of the country dwells.

As the first step for carrying out this plan next year, the areas with the largest number of inhabitants have been selected; they include the Departments of Granada, Rivas, Carazo, Masaya, and part of Managua (omitting the capital), where some 180,000 inhabitants will be given preferential attention.

Special attention will be given to a trial pilot plan; the most extensive work possible will be carried out in environmental sanitation, nutrition, and investigation and control of tuberculosis.

The urban population of Nicaragua is grouped in 125 municipalities; only 40 of these have water systems (five more are under construction), and 80 do not have any piped water supply. Moreover, we have 1,400 districts (*comarcas*), 3,304 villages, and 53,979 farms and ranches, containing small groups of people. As is clear, the percentage of rural population which lacks water is very high. The small rural groups obtain water from wells and rivers, and these are sometimes quite far away.

The country has two organizations responsible for solving the water supply problems: the National Department of Municipal Services, which is subordinate to the Ministry of Development and Public Works and conducts its activity in communities of more than 2,000 inhabitants; and the Department of Public Health Engineering Services, subordinate to the Ministry of Public Health, which works in communities of less than 2,000.

We are endeavoring to overcome the serious shortage of sanitary engineers, now that our country has engineering schools, where guidance is given to the young, and we shall request scholarships to prepare these professionals. Our goal is to assign at least one sanitary engineer to every region of the country.

Only 32.4 per cent of the urban population now has water service; it may be said that the rural population, or most of the country, has no potable water service.

If one bears in mind the high rate of infant mortality caused by gastrointestinal diseases which, even on the basis of deficient vital statistics, account for 20.8 per cent of the total mortality, and the fact that the average of intestinal-parasitic infestations and water-born infections is 85 per cent, it is not difficult to understand the significance of this problem and our Government's strong desire to give it priority among the campaigns of the Ministry of Public Health, in the hope that by 1973 the goal of taking care of 70 per cent of the urban and 50 per cent of the rural population will have been reached.

The minimum annual cost of this campaign is estimated at $1,678,600 for the urban areas, including the water supply and sewerage service, with a per-capita cost of $25 for water and $10 for sewerage. For the rural sectors, the minimum annual cost is $976,000, including water supply and excreta disposal, with an average per-capita cost of $10 for water and $5 for excreta disposal. We intend each year to install 10,000 privies and 10 small water systems and to dig 120 wells, furnished with hand pumps and the necessary sanitary protection.

We have three factories producing concrete privy slabs, at a cost of about 60 to 70 córdobas each, or almost $10. Since the public was not financially able to buy them,

they were at first given free, but during the pilot campaign it has been noticed that the people do not appreciate things that are given away, and consequently a price of 10 córdobas, to be paid within a year, has been set.

Owing to Nicaragua's budgetary limitations, the Ministry of Public Health has been allocated only 3.5 per cent of the country's total budget. Therefore, an increase of 10 million córdobas has been requested to begin this campaign. It is hoped that the future President will push this work forward, as he has indicated he would, and fulfill our hope that public health will have a place in the national budget second only to public education.

Within these budgetary limitations on carrying out the environmental sanitation campaign, an increase of $540,000 has been requested for next year. There is therefore a deficit of $436,000 in the estimated cost which in 10 years will amount to $4,360,000. This we hope to obtain through the Alliance for Progress. In making this request, we shall ask for facilities for obtaining six rotary drills with a depth capacity of more than 600 feet, since we have only two percussion drills, one assigned to municipal organizations, and the other, of only 600-foot capacity, belonging to the Ministry of Public Health.

As I explained, the urban plan is the responsibility of another body, which has already presented its requirements to the proper organization.

In the political plans for ministerial coordination to which I referred, the collaboration of the National Housing Institute and of the banking institutions is contemplated, for we understand that public health does not consist solely in the absence of disease, but includes also: suitable housing, well located and in good condition; the ability to obtain long-term building loans; opportunities for the acquisition of small parcels of land of high fertility; and access to small bank loans for agricultural purposes, so as to make the farmer independent of the large landholders and growers, and provide him with facilities for planting and for obtaining the means he needs to nourish himself and his family.

We believe, as all have stated, that the sale of health is the best business transaction. I wish to emphasize, too, the idea expressed by other speakers, the hope that we shall succeed in changing the criterion of the directors of the Alliance for Progress, according to which only the economic, and not the health, aspect is of importance. We would want them to understand that the best source of a people's income is its health, for a sick people cannot progress, cannot produce, cannot build factories or industries, or aspire to agricultural or total development; a sick people will always be a very poor people.

It is often remarked that our farmers are fully active during the first hour of work, but an hour later are tired out and have to sit down to rest; this is due to the lack of good nutrition and protein foods.

Sugar usually furnishes our farmer's energy, and corn is the basis of his diet. Before going out to work in the morning, he takes a cup of black coffee, with a few beans, and at noon he eats what he has brought with him—pinole and brown sugar candy. This is the basic diet of our people.

The aspiration of people, of course, as Dr. Alvarez Amézquita said, is full improvement of health. And the wide gap between their present situation and their aspiration—the concern of all of us and all our Governments—must be translated into activities leading to the betterment of this situation.

The rancher and the cattleman are well acquainted with the foods they must furnish to cows to make them give milk, and to hens to make them lay eggs. They also know what vaccines they must give to cattle and hens, but they do not know what food

the farm laborer who works for them needs or what their own families need. For this reason I, too, stress the need for a health education campaign at all levels; that is, it should not include solely the population groups of lower resources and lower skills, for as we know, even educated people may be ignorant of health problems, despite their responsibility for caring for their laborers, even if only for the sake of greater production.

I want to agree with what the Representatives of El Salvador and Honduras said regarding our earnest desire for prompt aid from the Alliance for Progress; this help must be timely, and therefore ought to be immediate. There is no land more fertile for the planting of alien doctrines than America, which is struggling to keep them out. People who live poorly, who suffer from hunger and illness, are very easy to conquer. We ought to remedy this situation, capitalize our human factor. We should recommend to the directors of the Alliance for Progress that, if they are going to give us their aid, they give it before very long—even if our countries do not satisfy all the required conditions because we do not yet have the technical personnel needed to meet them. We have not established statistics, but if help comes late, it will be unnecessary to do so.

On behalf of my Government, I should like to thank, through Dr. Luther L. Terry, the President of the United States of America, John F. Kennedy, for his statement, as well as the Pan American Sanitary Bureau, directed by the dynamic Dr. Horwitz, for having initiated and organized this highly important Meeting. We want to recommend to Dr. Horwitz that he express the wish of my people and, I think, that of the other American peoples, by suggesting to those responsible for the Alliance for Progress that they attend to our needs promptly.

ANNEXES

Annex 1

OFFICERS OF THE MEETING AND OF THE COMMITTEES

President of the Meeting:	
Dr. José Alvarez Amézquita	Mexico
Vice-Presidents of the Meeting:	
Dr. Luther L. Terry	United States of America
Dr. Paulo Pinheiro Chagas	Brazil
Chairman of Committee I:	
Dr. Ernesto R. Lima	El Salvador
Vice-Chairmen of Committee I:	
Dr. Alfredo Leonardo Bravo	Chile
Mr. Florentino Alén	Argentina
Rapporteurs of Committee I:	
Dr. Frederick J. Vintinner	United States of America
Dr. Adolfo Morales	Uruguay
Chairman of Committee II:	
Dr. Arnoldo Gabaldon	Venezuela
Vice-Chairmen of Committee II:	
Dr. Julio C. Blaksley	Argentina
Dr. Carlos Quirós Salinas	Peru
Rapporteurs of Committee II:	
Dr. Francisco Torres Bracamonte	Bolivia
Dr. Paul Q. Peterson	United States of America
Drafting Committee:	
Dr. Max Terán Valls	Costa Rica
Dr. Charles L. Williams, Jr.	United States of America
Dr. Amador Neghme	Chile

Annex 2

LIST OF PARTICIPANTS

Argentina

Dr. Tiburcio Padilla
Minister of Social Welfare and Public Health
Dr. Julio C. Blaksley
Chief Medical Officer, Department of Communicable Diseases
Dr. Alfredo Rabinovich
Technical Secretary, Department of Communicable Diseases
Dr. Alberto F. Mondet
Secretary of Public Health, Municipality of Buenos Aires
Mr. Florentino Alén
Director General of Finances, Municipality of Buenos Aires

Bolivia

Dr. Francisco Torres Bracamonte
Director of the National Public Health Service
Dr. Julio Bustillos
Director of Normative Services, Ministry of Public Health

Brazil

Dr. Paulo Pinheiro Chagas
Minister of Health
Dr. Henrique Maia Penido
Superintendent, Special Public Health Service Foundation
Dr. Carlos Modesto de Souza
Director General, National Department of Rural Endemias

Chile

Mr. Benjamín Cid
Minister of Public Health
Dr. Alfredo Leonardo Bravo
Chief, Technical Department, National Health Service
Mr. Raúl Peña Larraguibel
Economic Adviser, Ministry of Public Health
Mr. Edgardo Boeninger
Economic Adviser, Budget Department, Ministry of Treasury
Dr. Amador Neghme
Secretary, School of Medicine, University of Chile, and Adviser to the National Health Service

Colombia

Dr. José Félix Patiño
Minister of Public Health
Dr. Alberto Escobar
Secretary General, Ministry of Public Health
Dr. Alfonso Mejía
Chief, Executive Coordination Section, Ministry of Public Health

Costa Rica

Dr. Max Terán Valls
Minister of Public Health
Dr. Charles Chassoul
Chief, Department of Hospital Administration
Dr. Claudio Orlich
Director General of Medical Care
Mr. Jorge Carballo
Manager, National Waterworks and Sewerage Service

Dominican Republic

Dr. Samuel Mendoza Moya
Secretary of State for Health and Social Welfare
Dr. Miguel A. Ortega
Planning Officer, Ministry of Health and Social Welfare
Mr. Frank J. Pineyro
Executive Director, National Potable Water and Sewerage Institute
Dr. Luis Emilio Mainardi
Epidemiologist, Ministry of Health and Social Welfare

Ecuador

Dr. Luis Pallares
Minister of Social Welfare, Labor, and Health

Dr. Roberto Nevárez Vásquez
Director General of Health

Mr. Gonzalo Ayora
Special Assistant to the Director of the Inter-American Cooperative Public Health Service

El Salvador

Dr. Ernesto R. Lima
Minister of Public Health and Social Welfare

Dr. Tomás Pineda Martínez
Director General of Health

Dr. Alberto Aguilar Rivas
Secretary-Coordinator, Technical and Planning Department Ministry of Public Health and Social Welfare

Guatemala

Dr. Roberto Arroyave
Chief Surgeon, Director of Medical Education, Roosevelt Hospital (representing the Minister of Public Health and Social Welfare)

Dr. Carlos Waldheim
Chief, Department of Health Planning, Ministry of Public Health and Social Welfare

Mr. Ramiro Bolaños
Economist, General Secretariat, National Council for Economic Planning

Mr. José Antonio Palacios
Finance Counselor, Embassy of Guatemala
Washington, D. C.

Haiti

Dr. Louis Mars
Embassy of Haiti
Washington, D. C.

Mr. Fern D. Baguidy
Ambassador to the Organization of American States

Dr. Félix Colimon
Chief, Department of Outpatient Clinics
Public Health Service

Dr. Jean Bartholy
Assistant Chief, Department of Medicine
General Hospital

Honduras

Dr. Carlos A. Javier
Undersecretary of State for Public Health and Social Welfare

Dr. José Rodrigo Barahona Carrasco
Director General of Public Health

Mr. Gilberto Bendaña
Manager, National Autonomous Waterworks and Sewerage Service (SANAA)

Dr. José M. Lagos Blanco
Chief of Administration, Ministry of Public Health

Mexico

Dr. José Alvarez Amézquita
Secretary of Health and Welfare

Dr. Miguel E. Bustamante
Undersecretary of Health

Dr. Felipe García Sánchez
Technical Adviser, Ministry of Health and Welfare

Mr. Gerardo de Isolbi
Director General of Public Relations and Press, Ministry of Health and Welfare

Lt. Col. Jesús Mercado Sixtos
Assistant to the Secretary of Health and Welfare

Nicaragua

Dr. Constantino Mendieta Rodríguez
Deputy Minister of Public Health

Dr. Carlos H. Canales
Director of Local Services
Ministry of Public Health

Dr. Orontes Avilés
Director of Administrative Services
Ministry of Public Health

Panama

Dr. Bernardino González Ruiz
Minister of Labor, Social Welfare, and Public Health

Dr. Alberto E. Calvo
Director General of Public Health

Paraguay

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

Dr. Julio A. Martínez Quevedo
Director of Normative Services
Ministry of Public Health and Social Welfare

Dr. Roque J. Avila
Director of Medical Services for the Capital

Peru

Dr. Víctor Solano Castro, Brig. Gen.
Minister of Public Health and Social Welfare

Dr. Carlos Quirós Salinas
Director General of Health

Dr. David A. Tejada de Rivero
Chief, Planning Office
Ministry of Public Health and Social Welfare

Dr. C. Enrique Pitta López, Maj.
Assistant to the Minister

United States of America

Dr. Luther L. Terry
Surgeon General
Public Health Service

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

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

Uruguay

Dr. Aparicio Méndez
Minister of Public Health

Dr. Adolfo Morales
Director, Division of Health
Ministry of Public Health

Dr. Mario Pareja
Director, Integral Public Health Center Las Piedras

Venezuela

Dr. Arnoldo Gabaldon
Minister of Health and Social Welfare

Dr. Alejandro Príncipe
Chief, Department of Demography and Epidemiology
Ministry of Health and Social Welfare

Dr. José Antonio Jove
Assistant Engineer
Division of Malariology and Environmental Sanitation
Ministry of Health and Social Welfare

Dr. Alfonso Giordano
Secretary-in-Charge, National Institute of Sanitation Works

Organization of American States

Dr. José A. Mora
Secretary General
Dr. Walter Sedwitz
Assistant Secretary for Economic and Social Affairs
Dr. Jaime Posada
Assistant Secretary for Cultural, Scientific, and Informational Affairs

Alternates:

Dr. Francisco S. Céspedes
Deputy Director, Department of Cultural Affairs
Mr. Beryl Frank
Chief, Program of Social Security
Department of Social Affairs
Mr. Alvaro Magaña
Assistant Director, Department of Economic Affairs
Mr. José Carlos Ruiz
Collaborator of the Assistant Secretary for Cultural, Scientific, and Informational Affairs
Mr. O. Howard Salzman, Jr.
Chief, Advisory Services
Department of Technical Cooperation

Coordinator:

Mrs. Alzora H. Eldridge
Organizations Liaison Specialist

Inter-American Development Bank

Mr. Felipe Herrera
President
Mr. Humberto Olivero
Chief, Waterworks and Sewerage Services

Inter-American Child Institute (OAS)

Dr. Víctor Escardó y Anaya
Director General

United Nations Children's Fund (UNICEF)

Dr. Oscar Vargas Méndez
Director, Regional Office for the Americas

United Nations Economic Commission for Latin America (ECLA)

Mr. Nicasio Perdomo
Deputy Chief, Washington Office

Annex 3

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 Addresses 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 Subprofessional 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 Nutrition programs of local health services
  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 five years during the present decade (Document TFH/8)

Annex 4

PROGRAM OF SESSIONS

Washington, D.C., 15-20 April 1963

Monday, 15 9:00 a.m. First Plenary Session

1. Opening of the session
2. Election of President and two Vice-Presidents
3. Designation of the representative of the Ministers to speak at the inaugural session
4. Official opening by the President of the Meeting
5. Address by Dr. José A. Mora, Secretary General of the Organization of American States
6. Message of welcome from the President of the United States of America
7. Address by Mr. Felipe Herrera, President of the Inter-American Development Bank
8. Address by Dr. José Alvarez Amézquita, Secretary of Health and Welfare of Mexico, on behalf of the Ministers

3:15 p.m. Second Plenary Session

1. Adoption of the Rules of Procedure
2. Election of the Chairmen of Committees I and II
3. Adoption of the agenda
4. Adoption of the program of sessions
5. Establishment of the Drafting Committee
6. Establishment and adoption of the terms of reference for committees (item 1.9)
7. Statement on organization and development of the Meeting by the Director of the Pan American Sanitary Bureau, Dr. Abraham Horwitz (item 1.4)
8. Addresses 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 (item 1.10)

Tuesday, 16 9:00 a.m. Third Plenary Session

1. Addresses by the Ministers of Health (item 1.10, *continuation*)

9:00 a.m. FIRST SESSION OF COMMITTEE I

1. Election of two Vice-Chairmen
2. Appointment of two rapporteurs by the Chairman
3. National planning for health (item 2.2)

SECOND SESSION OF COMMITTEE I

1. Improvement of health services (item 2.3)

9:00 a.m. FIRST SESSION OF COMMITTEE II

1. Election of two Vice-Chairmen
2. Appointment of two rapporteurs by the Chairmen
3. Environmental health (item 3.2)

2:45 p.m. FOURTH PLENARY SESSION

1. Addresses by the Ministers of Health (item 1.10, *conclusion*)

2:45 p.m. SECOND SESSION OF COMMITTEE II

1. Malaria eradication (item 3.3.1)
2. Smallpox eradication (item 3.3.2)
3. Control of tuberculosis (item 3.3.3)

6:00 p.m. DRAFTING COMMITTEE

Wednesday, 17 9:00 a.m. THIRD SESSION OF COMMITTEE I

1. Improvement of health services (item 2.3, *continuation*)

9:00 a.m. THIRD SESSION OF COMMITTEE II

1. Chagas' disease
2. Nutrition (item 3.4)
3. Increase in life expectancy at birth by a minimum of five years during the present decade (item 3.5)

2:40 p.m. FOURTH SESSION OF COMMITTEE I

1. Improvement of health services (item 2.3, *conclusion*)
2. Education and training of personnel (item 2.4)
3. Research (item 2.5)

6:00 p.m. DRAFTING COMMITTEE

Thursday, 18 11:00 a.m. FIFTH PLENARY SESSION

1. Presentation of the chapters of the Final Report prepared by the Drafting Committee

2:30 p.m. DRAFTING COMMITTEE

4:15 p.m. SIXTH PLENARY SESSION

1. Consideration and approval of the recommendations of Committees I and II (item 1.11)

	5:00 p.m.	DRAFTING COMMITTEE 1. Preparation of definitive text of the Final Report
Friday, 19	10:00 a.m.	Visit of the Ministers of Health to Mr. John F. Kennedy, President of the United States of America (Rose Garden, White House)
	2:50 p.m.	SEVENTH PLENARY SESSION 1. Consideration and approval of the recommendations of Committees I and II (item 1.11, *conclusion*)
Saturday, 20	4:20 p.m.	CLOSING SESSION 1. Reading, approval, and signature of the Final Report