Whatever Happened to Health for All?  
25 Years Since Alma-Ata

Vaccination Week in the Americas
Primary Health Care: A Pending Debt

The first International Conference on Primary Health Care, held 25 years ago in Alma-Ata, Kazakhstan, focused worldwide attention on the responsibility of countries to address their peoples’ health as an issue of human rights. It is our fortune to publish a retrospective of Alma-Ata by David Tejada, former deputy director-general of the World Health Organization and the conference’s principal organizer. His firsthand account will be of great interest to many of our readers, as will his analysis of why we have not fully achieved the conference’s goal of “Health for All by the Year 2000.”

Those of us who, like Dr. Tejada, are long-time proponents of primary health care share his frustration at the misunderstandings and distortions surrounding the issue, both at Alma-Ata and in the subsequent quarter century. Fundamentally, primary health care refers to the first level of health care, that is, people’s first contact with their country’s health system. The idea is that this should take place not at the hospital and not when a patient is already ill, but before and in order to prevent illness. Effective primary health care assumes an integrated health system that reaches out to individuals, families and communities and accompanies them in their development.

A partial understanding of this has led some to think of primary health care as the opposite of hospital care. This in turn has led to a perception that primary care is of lower quality than hospital care, which is seen as more sophisticated and better. Since medical specialists are concentrated in hospitals, many thought that primary health care could be left in the hands of health promoters and volunteers rather than more qualified personnel. Furthermore, because hospitals are generally found in urban areas, some have come to think of primary health care as synonymous with rural care. In fact, effective primary health care should apply to inhabitants of rural and urban areas alike.

What primary health care was for its proponents at Alma-Ata—and what it must continue to be—is a strategy for transforming the health care system and bringing it closer to the people, precisely so that they do not need to go to the hospital except in cases of accidents or unavoidable illnesses. It means that when people must go to the hospital, they arrive not as strangers but with medical histories already known to the system. After they receive treatment, they return to their communities, where the system continues to follow up.

This is not to ignore important work that was carried out in many countries and by international agencies that understood the essence and value of primary health care. Important investments, particularly in human resources, enabled health services to reach people in their homes and communities, offsetting the tendency to concentrate resources in hospitals. Some also rightly emphasized that intersectoral action was needed to address the determinants of health in order to progressively improve health and quality of life.

What has been almost entirely lost, however, is the transformational function of primary health care. In these 25 years, we have seen major increases in health spending, but some 50–80 percent of our countries’ health budgets remain devoted to hospitals. When earlier, targeted investments in primary health care began to diminish, particularly under the pressures of health sector reform, people were left once again without services. Had primary health care successfully transformed our health systems, we would never have lost so much ground in the 1980s.

Health systems today are in as much need of transformation as they were in 1978. But we are now much better equipped to carry this out. We understand better what primary health care is all about. Moreover, technological developments make it possible to take health care to the people in ways we could not have imagined in 1978.

At its annual Directing Council meeting this September, the Pan American Health Organization (PAHO) will use the occasion of the 25th anniversary of Alma-Ata to reflect on its success and failures and to reopen the debate on primary care and the need to transform our countries’ health systems. In far too many cases, we have the opposite of “Health for All,” with large sectors of our populations almost totally excluded. Until Alma-Ata’s dream of universal, multisectoral and participatory health for all is fulfilled, we in international public health still have a pending debt.
Perspectives in Health

•

Volume 8 No. 2 • 2003

Contents

Features

Alma-Ata Revisited
by David A. Tejada de Rivero

The first International Conference on Primary Health Care, held in 1978 in Alma-Ata, Kazakhstan, in the former USSR, pledged to achieve “Health for All by the Year 2000.” Now, a quarter-century later, a key participant looks back at the accomplishments of the historic conference...and at what went wrong.

Love, Tears, Betrayal...and Health Messages
by Paula Andaló

Latin American soap operas, known as telenovelas, are a wildly popular genre that has in recent decades crossed over into international markets. While captivating viewers with stories of impossible loves and personal tragedy, they also have proven to be effective agents of social change, transmitting important social and health messages without sacrificing ratings.

An Act of Love:
Vaccination Week in the Americas
Text by Manuel Calvit, photos by Armando Waak

Health professionals and volunteers in 19 countries of Latin America and the Caribbean joined forces in early June for the first regionwide Vaccination Week in the Americas. The goal: to immunize children no matter where they live, no matter how hard to reach, leaving no child behind.

Cuba’s Jewel of Tropical Medicine
by Annmarie Christensen

The Pedro Kourí Institute of Tropical Medicine, Cuba’s preeminent medical-scientific research center, has carved for itself an indispensable niche in the global fight against tropical and infectious diseases. Its 66-year history is partly a family affair.

Hasta la Vista, Paradise!
by Tony Deyal

The worldwide shortage of trained nurses has taken a particular toll on the Caribbean, where foreign recruiters have succeeded in creating a full-blown nursing brain drain. Now the region is scrambling to find ways to keep nurses from deserting their tropical island homes for more rewarding careers abroad.

Columns

First Word
From the Director

30 Last Word
Lessons from SARS

32 Mailbox

Front cover:
The goal of “Health for All by the Year 2000” seemed attainable back in 1978, when the first International Conference on Primary Health Care met in Alma-Ata, Kazakhstan, in the former USSR. Yet 25 years later, the goal remains in significant part unfulfilled. Perspectives in Health’s cover story examines the reasons why.

Photo by Cecilia Durand.Courtesy of the Noncommunicable Diseases Unit of the Pan American Health Organization.
“Health for All by the Year 2000” was an ambitious and worthy goal. But even those who formulated it back in 1978 did not fully grasp its meaning. No wonder that 25 years later we have yet to realize all the dreams of the first International Conference on Primary Health Care.
This year marks the 25th anniversary of the first International Conference on Primary Health Care in Alma-Ata, Kazakhstan, an event of major historical significance. Convened by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF), Alma-Ata drew representatives from 134 countries, 67 international organizations and many nongovernmental organizations. China, unfortunately, was notably absent.

By the end of the three-day event, nearly all of the world’s countries had signed on to an ambitious commitment. The meeting itself, the final Declaration of Alma-Ata and its Recommendations mobilized countries worldwide to embark on a process of slow but steady progress toward the social and political goal of “Health for All.” Since then, Alma-Ata and primary health care have become inseparable terms.

A quarter century later, it is useful to look back on the event and its historical context—particularly on the theme of “Health for All” in its original sense. For one who was a direct witness to these events, it is clear that the concept has been repeatedly misinterpreted and distorted. It has fallen victim to oversimplification and voguishly facile interpretations, as well as to our mental and behavioral conditioning to an obsolete world model that continues to confuse the concepts of health and integral care with curative medical treatment focused almost entirely on disease.

**Looking back**

The 1970s saw the cresting of the scientific and technological revolution that began with the end of World War II, a revolution that produced, among other major changes, what is today known as globalization. But there was also a recognition of growing inequality among vast sectors of the world’s population. This recognition provided the impetus during the 28th and 29th World Health Assemblies in 1975–76 for the commitment to “Health for All in the Year 2000.”

Politically, the world was in a state of ideological and economic polarization, as well as a historically new form of confrontation. The Cold War was based on extraordinary technological development on the part of the competing parties, as part of an implacable economic war whose goal was the elimination of one of the two superpowers (this would eventually happen with the fall of the Berlin Wall). But within the socialist bloc, there was also a major rivalry between the Soviet Union and China. This competition would prove decisive for the conference at Alma-Ata.

At the same time, a number of developing countries had been trying, for a number of years and in various ways, to tackle health problems with limited financial, technological and human resources. Their experiences became the subject of scholarly studies in the 1960s and 1970s, with China, India and some countries of Africa and Latin America emerging as the most often cited examples. Following the publication of some of these studies, WHO—under the leadership of Director-General Halfdan Mahler (1973–88)—responded enthusiastically. Mahler saw clearly the worth of these experiences and began to promote them around the world as the responsibility of all countries, rich and poor.

**A call for action**

For Mahler and others, “Health for All” was a social and political goal, but above all a battle cry to incite people to action. Its meaning, however, has been misunderstood, confused with a simple concept of programming that is technical rather than social and more bureaucratic than political.

When Mahler proposed “Health for All” in 1975, he made it clear that he was referring to the need to provide a level of health that would enable all people without exception to live socially and economically productive lives (today we would say “a minimally dignified standard of living” in a context of “truly human development”). The reference to the year 2000 meant that, as of that date, all the world’s countries would have developed the appropriate political strategies and be carrying out concrete measures toward achieving this social goal, albeit within different time frames.

▲ U.S. Senator Edward Kennedy (left) made a surprise appearance at the 1978 Alma-Ata conference. At right is then WHO Director-General Halfdan Mahler.
The conceptualization of “primary health care” was based on erroneous and biased perceptions of the experiences of Third World countries in providing health care with limited resources. In particular, the Chinese experience with “barefoot doctors” was interpreted simplistically and superficially.

As for the concept of “care,” the original term in English was translated into Spanish as atención rather than cuidado. In Spanish, cuidado has a much broader connotation than atención, implying something integral that involves horizontal, symmetrical and participatory relationships. Atención, in contrast, is vertical, asymmetrical and never participatory in a social sense. El cuidado is intersectorial, while la atención is the work of a single sector, an institution, isolated programs or specific services.

The term “primary” has linguistically diverse and even contradictory meanings. In Spanish, in particular, some of these are nearly opposites. Primario can mean “primitive and uncivilized” or “principal or first in order or degree.” As a result of the simplistic and biased perceptions of the experiences on which the concept was based, it was easier, more comfortable and safer to accept the former meaning, while the spirit of Alma-Ata clearly embraced the latter. The Declaration states that primary health care “forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community.” It was never seen as an isolated part of the health care system, nor was it limited to marginal, low-cost treatment for the poor.

There is a fundamental difference between integral health care for everyone and by everyone—care that is multisectoral and multidisciplinary, health-promoting and preventive, participatory and decentralized—and low-cost (and lower quality) curative treatment that is aimed at the poorest and most marginalized segments of the population and, what is worse, provided through programs that are parallel to the rest of the health-care system without the direct, active and effective participation of the population.

In my academic activities I have repeatedly stressed this issue, attempting to point out what primary health care is not (regardless of its name, which can lead to mistaken assumptions), and what it indeed is.

Repeatedly, while I was deputy director-general of WHO, I was forced to keep a prudent silence when high-level officials from a given government would tell me with pride that they had a specific “office” or a “national program” for primary care, or that they had primary care activities only in the most peripheral health centers.

A Soviet proposal

It was at the 28th World Health Assembly, held in 1975, that the urgent need for new approaches to health care for everyone and by everyone was finally recognized. This is how the notion of primary health care emerged, and it was a victory for the developing world. Western powers accepted this notion, but the Soviet Union opposed it, considering it a step backward in scientific and technological progress. This showed that the “Flexnerian” model had crossed the ideological frontiers of the Cold War.

No one thought about an international conference on the subject, however, during the 28th assembly; the prevailing wisdom was that new experiences were needed in this area.

Then in January 1976, a day before the meeting of WHO’s Executive Board (prior to the 29th World Health Assembly in May of that year), Dimitri Venediktov, the powerful Soviet vice-minister for international affairs in the Ministry of Health, came to see me at my home in Geneva. He proposed holding a major international conference on primary health care and offered $2 million as an extraordinary contribution by the Soviet Union. He explained to me that the leading socialist power could not allow China a victory within the Third World. His proposal came as a great surprise, and my argument that such a conference would be premature—and that it should not take place in Moscow—did not seem to convince him.

Venediktov presented his proposal at the start of the WHO Executive Board meeting and, under considerable pressure, conceded that such a conference should take place in a developing country rather than in the Soviet capital. The idea was formally accepted four months later at the World Health Assembly, and the conference was scheduled for 1978. I was designated by the director-general as general coordinator.
Key conclusions

The final Declaration of Alma-Ata contained 10 principal points, which are summarized below. The full text of the document can be viewed at http://www.who.int/hpr/archive/docs/almaata.html.

I. Health is a state of complete physical, mental and social well-being and is a fundamental human right. Attaining the highest possible level of health is a worldwide social goal that requires the action of many sectors.

II. The existing gross inequality in people’s health status is unacceptable and is of common concern to all countries and people.

III. Economic and social development is essential to attaining health for all, and health is essential to sustained development and world peace.

IV. People have the right and duty to participate in planning and implementing health care.

V. A main goal of governments and the international community should be the attainment by all peoples by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this goal.

VI. Primary health care is based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through people’s full participation and at a cost that the community and country can afford. It is the central function of the health system and its first level of contact, bringing health care as close as possible to where people live and work.

VII. Primary health care evolves from a country’s own conditions and addresses the main health problems in the community. It should lead to progressive improvement of health care for all while giving priority to those most in need.

VIII. Governments should formulate policies and plans of action to make primary health care part of a comprehensive national health system, in coordination with other sectors. This requires political will to mobilize domestic and external resources.

IX. The attainment of health in any one country directly concerns and benefits every other country. All countries should cooperate in the development and operation of primary health care throughout the world.

X. An acceptable level of health for all people by 2000 can be attained through better use of the world’s resources, much of which is spent on military conflict.

“The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community...to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.”

is no doubt that my friend Venediktov was a consummate politician. The distortions of the concepts surrounding this subject were not a result of the conference; they must be attributed to a lack of promotion and follow-up on the part of the governments and international organizations that convened it.

Once Moscow was ruled out, the search was on for another location in the Third World to host the conference. It was a difficult task, given the economic and logistical implications of such an undertaking. There was an additional cost of slightly more than $1 million over the original...
Working documents were prepared one year ahead of the conference. Following consultations with governments and other organizations, these became official documents for the conference’s review and approval. The Declaration and Recommendations went through 18 drafts revised in meetings in the six WHO regions, in the Special Meeting of Ministers of Health of the Americas in 1977 and in meetings of special country groupings and certain individual countries as well. The conference was prepared as an open, decentralized, democratic and participatory process, though this was never formally declared.

The draft that was officially presented contained a few changes that, in hindsight, contributed to the later distortion of the original concepts. Many delegations and individual delegates fought to include details that had more to do with medical specialties than with health.

It was important that the conference was cohosted and jointly organized with UNICEF. This was difficult at the beginning, but the work done by two key UNICEF representatives, Richard Hayward and Newton Bowles, was instrumental in winning over Henry R. Labouisse, then executive director, and securing the active participation of the agency. I still consider it a privilege to have worked so closely with UNICEF and to have continued that close collaboration until my departure from WHO.

It is regrettable that afterward the impatience of some international agencies, both U.N. and private, and their emphasis on achieving tangible results instead of promoting change—something that is always difficult—led to major distortions of the original concept of primary health care. So-called “selective primary health care” and packages of “low-cost interventions,” such as GOBI and GOBI-FFF (growth monitoring, oral rehydration, breastfeeding, immunization; female education, family spacing, food supplements), as well as other variations contradicted and distorted the spirit and concepts of Alma-Ata.

There are still gaping inequities and social injustice that leave many without integral health care. Perhaps it is time for an Alma-Ata II, to reexamine the original concepts behind the call for “Health for All.”

A new era

The conditions that led to the social and political goal of “Health for All” and to the strategy of primary health care still exist and are, indeed, even more pronounced. There remain gaping inequities and social injustice that leave large segments of the population without integral health care. Poverty is on the rise, and the few resources that societies have for education and health are invested and spent in misguided and unfair ways. The confusion between health and curative medical treatment that is focused on a few diseases inexplicably still prevails. Health systems have not been decentralized effectively, and both “citizen participation” and “social control” in health remain distorted concepts.

In today’s globalized, unipolar world, where national sovereignty is increasingly threatened, one of the few ways in which countries can still control their own destiny is through the development of genuine, decentralized and participatory democracies. Nowadays it is essential to transfer, or rather, to return political power for social decision-making to its point of origin, that is, the citizenry. Integral health care for all and by all—perhaps the best way to phrase Alma-Ata’s call for genuine primary health care—is a necessity not only for health but also for the future of countries that aspire to remain sovereign nation states in an increasingly unjust world.

There have been major global changes and many important new experiences in the world during the 25 years since the first International Conference on Primary Health Care. Perhaps it is time now to convene an Alma-Ata II, to set forth again, without distortions, the original concepts that led to that conference in 1978.

David A. Tejada de Rivera was deputy director-general of the World Health Organization from 1974 to 1985 and twice served as minister of health of Peru.
Tony Dominguez tells his fiancée, Kristen Forrester, that he has tested positive for the AIDS virus, on the CBS daytime drama "The Bold and the Beautiful." The two later marry and travel to Africa to adopt an AIDS orphan. Like U.S. soap operas, Latin America’s telenovelas are increasingly tackling health and social themes along with more traditional fare.
Latin America’s telenovelas have long captivated TV audiences with their overwrought stories of love and betrayal, sin and punishment, and triumph over adversity. But for public health advocates, they also are an ideal medium for transmitting positive messages about healthier living.

José Alfredo, a handsome young Mexican, has been confined to a wheelchair since an accident two years ago. But he hasn’t let it get him down. He still plays basketball, he runs his own shoe store, and he recently married a beautiful woman. His motto is: “You’re only defeated when you feel defeated.” Julia, an Argentine housewife, is fed up with her husband’s physical abuse. After 15 years, she summons the courage to report him to the police and demand a divorce, completely changing her life. Capitú, a young Brazilian woman, holds a condom in front of her partner and with a single gesture makes it clear that they’ll make love using protection—or not at all.

They are all fictional characters, appearing in scenes from the Latin American soap operas Entre el amor y el odio (Between Love and Hate), Sin marido (Husbandless) and Lazos de Sangre (Blood Ties). Their stories, however, mirror the lives of real men and women and thus provide a powerful medium for transmitting positive messages on important issues of public health.

Soap operas, and their Latin American counterparts, known as telenovelas, are among television’s most widely watched genres worldwide. “There are data from a number of countries on their impact, not just in commercial terms but also in terms of their cultural and social importance,” says Nora Mazziotti, professor of communication sciences at the University of Buenos Aires and author of The Telenovela Industry.

The first telenovelas—which differ from U.S. soap operas in that each begins and ends within about a year’s time—appeared in the 1960s, when a group of Cuban screenwriters led by Delia Fiallo began adapting radio theater stories for use on television. From the outset these stories, with themes taken from classical tragedy—betrayal, forbidden love, punishment—captivated television audiences throughout Latin America.
In the late 1980s, these Latin soap operas began to cross over beyond Spanish-speaking audiences in North and South America to viewers overseas. In China, for example, some 450 million viewers followed the Brazilian telenovela *La esclava Isaura* (*Isaura, the Slave*). Seven out of 10 Russians tuned in regularly to Mexico’s *Los ricos también lloran* (*The Rich Also Cry*), and the Venezuelan series, *Cristal*—about a young small-town woman in the big city—ran seven seasons, with the final episode drawing some 11 million fans.

Telenovelas’ larger-than-life story lines may be exaggerated renditions of real-life dramas, but many viewers see their own lives reflected in those of their favorite stars. They identify themselves and others they know with various characters and are drawn in by the compelling twists and turns of overwrought plots. Thus, modeling a behavior they see on screen is almost natural.

No wonder then that beginning in the 1970s professional health communicators in Latin America decided to insert positive health and life-skills messages among the tears, betrayals and star-crossed love affairs. At first, the messages were basic, almost intuitive, such as “smoking is bad” or “you need an education to make something of yourself.” Over time they have evolved toward deeper social themes, providing a subtle but effective guide for public opinion on sometimes controversial matters of public health while promoting a healthier and more ethical society.

The power of fiction

An early indication of telenovelas’ enormous potential came in 1986, when a character on Venezuela’s *Cristal* was diagnosed with breast cancer. The episode led to an avalanche of female patients getting check-ups in Venezuela and in Spain, where the series also aired. But there were even earlier experiences. In *Entertainment Education: A Communication Strategy for Social Change*, Everett Rogers and Arvind Singhal analyze the success of *Simplemente María* (*Simply Maria*), the story of a Peruvian country woman who moves to the city, becomes pregnant, is betrayed and must carry and give birth to her baby alone. After the show aired in Peru in 1969 (it was re-adapted later in several other countries), there was a marked increase in enrollment in classes for literacy and sewing—the two things that helped Maria overcome her obstacles and move on in life. Unintentionally, *Simply Maria* had produced social change.

Brazilians give for life

Brazil’s TV Globo network has been incorporating social themes into its telenovelas since 1990. According to the most recent edition of its annual report *Social Marketing: Entertainment Serving Social Good*, in 2002 more than a thousand episodes of telenovelas included social themes, ranging from condom use and organ donation to caring for the environment.

To demonstrate telenovelas’ potential for promoting social change, TV Globo producers carried out a study in which they tracked changes in health services during the airing of *Lazos de Sangre* (*Blood Ties*), whose protagonist, Camila, was diagnosed with leukemia. The study, titled “The Camila Effect,” found that in November 2000, during the show’s early episodes, Brazil’s National Registry of Bone Marrow Donors reported an average of 20 new registrations per month. In January 2001, when the leukemia plot had become more established, there were 900 new registrations. Similarly, “Disque Salud,” a Ministry of Health call-in service that provides information and referrals for organ and blood donation, received 67 calls in November 2000 but 458 by January 2001. The Hematology Institute of Rio de Janeiro registered 10 blood donors in November 2000 but 154 the following January.

During the airing of *El Clon* (*The Clon*), which dealt with drug addiction, calls to the National Anti-Drug Society of Brazil increased from 900 in January 2002 to 6,000 in May of the same year. Other organizations working on drug dependency observed increases of up to 120 percent in calls requesting information and help.

Responding to such success, producers, writers and public health advocates have been working together to reinforce health themes through week-long public awareness campaigns aired in conjunction with the telenovelas. *El Beso del Vampiro* (*Kiss of the Vampire*), for example, was aired the same week as International Blood Donation Day.
Observing these successes, Miguel Sabido, former vice-president of the Mexican network Televisa and a pioneer in “edutainment,” produced a series of seven programs between 1975 and 1978, so-called “telenovelas for development,” that combined education and entertainment. One, titled Caminemos (Let’s Go), promoted sexual responsibility among adolescents. Nosotras las mujeres (We Women) promoted the notion of gender equality in Mexican society and Ven Conmigo (Come with Me) encouraged adult education.

“My intention was to have commercial television produce social benefits through telenovelas, which are viewed by the very people who most need to become better informed,” says Sabido. “I wanted to provide those viewers with the tools they need to improve their own lives. I set up study groups to analyze behaviors and ways of incorporating positive messages without betraying the rules of the genre. I capitalized on the shows’ capacity for moral reflection about good and evil and showed how all this could be done without hurting their ratings.”

In 1994, Colombia’s Ministry of Health coproduced Santa María del Olvido (Saint Mary the Forgotten), a telenovela about social and health issues aimed at a female audience. Last year, officials from Brazil’s Ministry of Health acknowledged that the theme of drug addiction in TV Globo’s El clon (The Clone) in 2001 had done more for the prevention and treatment of drug dependency than many government campaigns. As the troubled young Mel watched his life fall apart because of drug abuse, the show’s screenwriters inserted snippets of testimony from real-life drug addicts between the dramatized scenes.

“It occurred to me that testimony from people who were really suffering from drug problems would be more effective and less moralistic than psychologists babbling about how bad drugs are,” says screenwriter Gloria Perez. More than 45 million viewers watched the telenovela’s final episode.

In Brazil’s Blood Ties (2000), Camila, the star, needed blood and bone marrow donations to help her fight leukemia. In the days following the leukemia episode, interest in real-life donations increased dramatically. (See sidebar opposite page.) A similar result followed a 1992 episode of De cuerpo y alma (Of Body and Spirit) about the need for a heart donation.

Perez notes that while telenovelas cannot singlehandedly solve social problems, they can make a significant contribution. “When telenovelas spark national interest, organizations working on the same issues should take advantage of the heightened interest and carry out public-awareness campaigns,” she says.

Currently, the Hollywood, Health and Society program at the University of Southern California (USC) is working with the Centers for Disease Control and Prevention (CDC) to train screenwriters and producers on health issues. Recently, the Pan American Health Organization (PAHO) helped Suriname import the South African soap Soul City, whose plots cover such issues as AIDS, teenage pregnancy and drug addiction. (See sidebar page 12.)

### Breaking the pattern

As health themes have gained ground on the soap scene, two types of programs have emerged: telenovelas produced specifically to promote a particular message and those that include health themes in the context of a larger plot. Both types have been growing in number as well as shifting their focus as awareness of social and public health issues has increased. Many early telenovelas followed a “good vs. bad” model: the bad guys were the ones infected with HIV (for example, in the Argentine program Celeste, starring Andrea del Boca), and unwanted pregnancy was punishment for a night of sex out of wedlock—an error the heroine paid for over the course of the next 300 episodes.

A new generation of screenwriters is now producing what they call “breaking-the-pattern telenovelas.” Pushing the message-placement envelope, they have tackled such high-impact issues as urban violence, political corruption, AIDS and even trafficking in human organs in series such as Colombia’s La mujer del presidente (The President’s Wife) in 1998 and Amores perros (Love’s a Bitch) in 1999, Brazil’s Nada personal (Nothing Personal) in 1997 and Argentina’s Resistiré (I Will Resist) in 2003.

Telenovelas still have their retrograde moments, with lines such as: “Look how you treat your husband; no wonder he beats you,” spoken by a female character in Venezuela’s Telefutura production Ángelica pecado (Angelica Sin). But positive treatments of these issues are now much more the rule. For example, Brazil’s Mujeres apasionadas (Passionate Women) deals with the issue of domestic violence in a very different way: It is no longer stigmatized, and its treatment mirrors real life. This, coupled with evening airing hours,
From Mexico to India, using telenovelas for social education

Just as ratings confirm the success of telenovela story lines, the impact of social messages in telenovelas can be demonstrated quantitatively. Following nine months of episodes developing the theme of family planning in the 1977 Mexican telenovela Acompáñame (Accompany Me), the country’s National Council on Population (CONAPO) reported the following results:

- The average number of telephone callers requesting information on family planning rose from a handful to 500 per month. Many of the callers referred directly to Accompany Me.
- More than 2,000 women volunteered to work in a national family planning program, apparently in response to the show’s promotion of social work.
- Sales of birth control pills rose 23 percent in one year, compared with a 7 percent increase the previous year.
- More than 560,000 women signed up to participate in family planning programs in clinics, a 33 percent increase over sign-ups before the show.

The “Sabido model” has been successfully applied outside Latin America as well. The Mexican experience was adapted for use first by Population Communications International (PCI) and later by the Population Media Center (PMC), organizations that work at the global level to promote education in family planning, prevention of sexually transmitted diseases, reproductive health and gender equity.

PMC has used “telenovelas for development” in India, Ethiopia, Kenya, Côte d’Ivoire, Malawi, Burkina Faso, Rwanda, Sudan and Swaziland. During preproduction, experts analyze the cultural norms of each country and then adapt the stories to local cultures, increasing the messages’ chances for success.

PMC president William Ryerson believes telenovelas are an excellent way to promote positive health messages, “much better than single-episode shows, since their extension through time allows the audience to forge bonds with the characters and get involved with their thoughts and actions, creating strong emotional ties.”

Studies in Mexico, India and several African nations also confirm the genre’s potential. One study, headed by PMC president Ryerson and funded by the Rockefeller Foundation, looked at Humraachi (Come Along With Me), an Indian telenovela that aired in 1992. The study found that people who watched the show regularly changed their attitudes about the ideal marrying age and the acceptability of women in the work force, two central themes of the story.

In Kenya in 1987, the telenovela Tushauriane (Let’s Talk About It) and the radio program Ushikwapo Shikamana (If Assisted, Assist Yourself) were aired with the aim of getting men to be more open-minded about their wives’ practicing family planning. They became two of the most popular shows on Voice of Kenya. By their conclusions, contraceptive use had increased some 58 percent in the country, and the average family size considered as ideal among Kenyans had declined from six children to four. In addition, a study of rural health centers by the University of Nairobi’s School of Journalism found that women were more likely to seek birth control after hearing and seeing the programs. In Côte d’Ivoire, the show Sida dans la cité (AIDS in the City) was watched by 75 percent of the population in 1998—perhaps not surprising in a country where 640,000 people are HIV-positive.

The Soul City Institute for Health and Development Communication was launched in South Africa in 1992 to effect social change through mass media “edutainment” projects. Its flagship production is the soap opera Soul City, which features public health themes such as prevention of sexually transmitted diseases and HIV. The show’s preproduction team analyzes societal attitudes and interests and designs plots of 8 and 12. Studies done after the show aired found a significant impact on children’s knowledge and attitudes about such topics as empowerment of girls and discrimination against children with disabilities.

Today Soul City is airing in Suriname as part of a joint edutainment project involving Suriname and South Africa. PAHO has sponsored meetings in Paramaribo and Johannesburg to gather lessons from the South African experience and to provide guidance for the show’s African producers on gender issues. As part of the same initiative, PAHO is sponsoring surveys among Surinamese youth for use in developing a local pilot show titled Sabana Pasi (Savannah Road), which will incorporate health promotion and disease prevention topics of particular interest in Suriname.
has helped the show capture a growing male audience along with the usual females.

The key to success for health messages in telenovelas is to preserve the centrality of the fictional narrative, according to Argentine expert Nora Mazziotti.

“When the story gets lost and the message is not interwoven with the narrative, people don’t like it,” she says. “The message has to be attractive and easy to understand.” She favors an unobtrusive approach akin to for-profit product placement.

“Episodes involving health issues always attract audiences,” Mazziotti continues. “Telenovelas definitely educate without trying to, and it’s important to take advantage of this potential.”

For Vicki Beck, director of USC’s Hollywood, Health and Society program, the value of telenovelas as a vehicle for public health messages has been demonstrated at the global level. She notes that in Kenya, a 1987 television series that promoted family planning “became the most popular TV show in the country’s history.”

The program Beck heads, which is supported by the CDC, provides information and consultants to television screenwriters and producers and suggests important health issues that can be included in future episodes. To encourage the practice, the CDC awards an annual Sentinel for Health Award to daily soap operas that “inform, educate and motivate viewers to make choices for healthier and safer lives.”

In April in Miami, the First World Summit of the Telenovela Industry, sponsored by TV Más magazine, included health message placement in its agenda. (Since 1995, annual Soap Summits have been held to encourage social and health messages in the U.S. daytime shows.)

“Episodes involving health issues always attract audiences,” Mazziotti continues. “Telenovelas definitely educate without trying to, and it’s important to take advantage of this potential.”

For Vicki Beck, director of USC’s Hollywood, Health and Society program, the value of telenovelas as a vehicle for public health messages has been demonstrated at the global level. She notes that in Kenya, a 1987 television series that promoted family planning “became the most popular TV show in the country’s history.”

The program Beck heads, which is supported by the CDC, provides information and consultants to television screenwriters and producers and suggests important health issues that can be included in future episodes. To encourage the practice, the CDC awards an annual Sentinel for Health Award to daily soap operas that “inform, educate and motivate viewers to make choices for healthier and safer lives.”

In April in Miami, the First World Summit of the Telenovela Industry, sponsored by TV Más magazine, included health message placement in its agenda. (Since 1995, annual Soap Summits have been held to encourage social and health messages in the U.S. daytime shows.)

“Episodes involving health issues always attract audiences,” Mazziotti continues. “Telenovelas definitely educate without trying to, and it’s important to take advantage of this potential.”

For Vicki Beck, director of USC’s Hollywood, Health and Society program, the value of telenovelas as a vehicle for public health messages has been demonstrated at the global level. She notes that in Kenya, a 1987 television series that promoted family planning “became the most popular TV show in the country’s history.”

The program Beck heads, which is supported by the CDC, provides information and consultants to television screenwriters and producers and suggests important health issues that can be included in future episodes. To encourage the practice, the CDC awards an annual Sentinel for Health Award to daily soap operas that “inform, educate and motivate viewers to make choices for healthier and safer lives.”

In April in Miami, the First World Summit of the Telenovela Industry, sponsored by TV Más magazine, included health message placement in its agenda. (Since 1995, annual Soap Summits have been held to encourage social and health messages in the U.S. daytime shows.)

“Episodes involving health issues always attract audiences,” Mazziotti continues. “Telenovelas definitely educate without trying to, and it’s important to take advantage of this potential.”

For Vicki Beck, director of USC’s Hollywood, Health and Society program, the value of telenovelas as a vehicle for public health messages has been demonstrated at the global level. She notes that in Kenya, a 1987 television series that promoted family planning “became the most popular TV show in the country’s history.”

The program Beck heads, which is supported by the CDC, provides information and consultants to television screenwriters and producers and suggests important health issues that can be included in future episodes. To encourage the practice, the CDC awards an annual Sentinel for Health Award to daily soap operas that “inform, educate and motivate viewers to make choices for healthier and safer lives.”

In April in Miami, the First World Summit of the Telenovela Industry, sponsored by TV Más magazine, included health message placement in its agenda. (Since 1995, annual Soap Summits have been held to encourage social and health messages in the U.S. daytime shows.)
The whistle of a teakettle pierces the morning silence, and the clock strikes six. It is June 1, 2003. Today and throughout this week, children in 19 Latin American and Caribbean countries will be the focus of attention for doctors, community leaders, politicians, volunteers, mothers and fathers. Together they will vaccinate millions of children wherever they are, no matter how remote their villages, no matter how difficult to reach.

It is a historic effort, a gesture of love for all the region’s children, an investment of hope in their present and future.

Measles is one of humanity’s most contagious diseases and continues to be the main cause of vaccine-preventable death in the world, claiming the lives of some 770,000 children under the age of 5 each year.

Before a vaccine became available in 1963, nearly all children got measles. Then in 1994, two historic achievements were announced at the Pan American Sanitary Conference in Washington, D.C. Latin America was declared free of polio (Luis Fermín Tenorio, a young boy from Pichanaqui, Peru, was the last known case). Second, all the region’s countries united in an effort to interrupt indigenous transmission of measles.

Since then, the region’s countries have focused impressive efforts and resources on this goal. The Pan American Health Organization (PAHO) developed a measles eradication strategy based on better surveillance, targeted immunization and improved laboratory capacity.

The sheer magnitude of the problem has meant delays; new outbreaks occurred in the 1960s in Argentina, Bolivia and Brazil, and in 2000–01 in Haiti and the Dominican Republic. But vaccination efforts continued, and between November 2002 and July 2003 there was no indigenous transmission of measles anywhere in the Americas. Keeping the region measles-free, however, requires maintaining high levels of childhood vaccination.

Andean ministers of health meeting last April proposed an Andean vaccination week. The idea was soon expanded to include South America and later Mexico, Central America and the Caribbean. Eventually 19 countries joined together for the first Vaccination Week in the Americas. The focus was on children who had never been vaccinated: those in hard-to-reach rural areas or marginal urban zones whom earlier campaigns had left behind.

The campaign also helped reinforce key concepts of international public health: that joint efforts can lead to great achievements; that health is a bridge to solidarity, understanding and hope; and that vaccination is an individual right as well as an important tool of public health. In this spirit, countries mobilized their own resources and won support from agencies such as the U.S. Centers for Disease Control and Prevention, the United Nations Children’s Fund and PAHO.

Finally, Argentina, Bahamas, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, Peru, Suriname, Uruguay and Venezuela signed on to the historic initiative. Officials and health workers at all levels—ministerial, local and community—met daily through May 30, 2003, to make sure that the required personnel, equipment, vehicles and vaccines would all be in place for the week-long campaign.
Mothers and fathers line up with their children in tow, many dressed as if for a party. Enthusiasm fills the air, disturbed only momentarily by the shriek of a child who has just realized he’s going to be vaccinated.
After a quick breakfast of fresh-baked bread with butter and guava jam, black coffee and slices of fresh papaya, we leave our hotel in Guayaquil’s Simón Bolivar waterfront along the Guayas River. We head for our first destination, a small health center on the outskirts of town.

We go slowly. The street lights gradually turn off, and street vendors start to take up their positions. Some of them are children.

Before long the sun breaks out. By 7 o’clock the heat is already unbearable, as is the traffic. Our driver, Don Rafael, weaves expertly through a sea of cars, buses and pedestrians who cross the street wherever they feel like it. This is a city of both old and new, changing from block to block. We pass the cathedral and Las Iguanas Park and begin to see small repair shops, kiosks and sidewalk stands selling fruit and vegetables.

After a sharp turn to the right, we leave pavement behind and enter a narrow dirt road full of potholes. From our jeep we peer out at rickety shacks, haphazard electrical wires and residents looking hesitantly out their windows into the scorching sun.

We arrive at the Fertisa Health Center. A sign announcing Vaccination Week in the Americas hangs prominently over the entrance. Mothers and fathers are already lining up with their children in tow, many dressed as if for a party. Enthusiasm fills the air, disturbed only momentarily by the shriek of a child who’s just realized he’s about to be vaccinated. The health workers are eager to show and explain everything to us. We ask about their colleagues who are going house to house to vaccinate, interviewing residents and reviewing vaccination records. We’re told they have already left but also where we might find them. We say a quick goodbye and promise to return.
A voice from a distant megaphone at first sounds like someone hawking oranges or pineapples. We see a red truck turn the corner and head in our direction. The megaphone is on its roof. The voice becomes louder and clearer: “Vaccination Week in the Americas....Protect your children....It’s free....Health workers will come to your house or you can take your children to the health center.” The message is repeated over and over. We signal to the truck, and it stops next to our jeep. The campaign poster is affixed to each of its doors. A young nurse tells us, without our asking, “Marita, Lourdes and Joaquin are vaccinating on the next street. Go straight ahead and turn left at the green house on the corner.”

We find them there, unmistakable in their white coats, each with an ice chest in one hand and a notebook in the other. We get out of the jeep and walk toward them. We meet as they are knocking on the door of a small wood-frame house. A young woman opens the door timidly. Without hesitation, the nurses get right to the point: “Good morning. We are carrying out a vaccination campaign. Are there children in this home? Are you a mother? May we come in?”

Seconds later we’re all in the tiny living room of the modest home. Everything is tidy and clean. While Lourdes reviews the child’s vaccination card, Marita vaccinates the mother. She explains that they are also giving tetanus vaccines to mothers and women of childbearing age. From outside the house, we hear the sounds of a gathering crowd. “Where is that kid? Has anyone seen Chinto?”

He finally appears, sweating and surprised to see so many people in his house. Chinto is 4 years old, with alert eyes, cinnamon-colored skin and jet-black hair. It doesn’t take long for him to figure out what’s happening. He glances at the door, planning his escape, but it’s too late. His mother holds him gently but firmly in her arms.

Now Lourdes explains to the young woman what the pentavalent vaccine is. Chinto fixes his eyes on his mother’s face as she gently strokes him. He stops resisting and takes his shot with dignity. Joaquin, a community volunteer, rewards the brave boy with a sticker on his T-shirt, confirming that he has been vaccinated. As we say goodbye, we leave a mark on the frame of the outside door, with the owner’s permission. Now the next campaign workers will know the children in this house have already been vaccinated.

The three health workers continue their door-to-door mission beneath the hot sun. We follow them for several hours, until Don Rafael reminds us that we had promised to return to the health center.

At Huaquillas, a bridge over an invisible borderline links Ecuador and Peru. As at any border crossing, vendors sell their wares from stands on both sides. The two nationalities mix noisily, buying and selling, sharing news and gossip, coming and going with boxes and bags full of fruit and vegetables, CDs and tape recorders, shirts and sandals.

On both sides of the border children are being vaccinated. Señora Aminta, a vendor, asks me if I will watch her vegetable stand while she takes her daughter to be vaccinated. She asks me shyly, calling me “doctor,” which I am not. Her 3-year-old clings to her skirt. “Of course,” I say. “With pleasure. What do I do?” But my question gets lost in the bustle. I sit on some old coffee sacks and contemplate for a moment the symbolism of this campaign: two sister countries, joining forces, have become for this occasion a single community.
As of this week, children will no longer be mere statistics in reports or fodder for public speeches. They will be honored by people who truly care for them through actions that will help them grow up strong and healthy.
For an entire day, we visit some of the capital city’s most marginal areas: La Magdalena, Cotocollao, San Goliquí and San Rafael. In each of the health centers we visit the pace of activity and efficiency are impressive. Mothers, fathers, boys and girls are everywhere, and health workers tirelessly perform each critical task, vaccinating, reviewing records, taking notes. Others screen visitors to speed up the work: “If you’re not here for a vaccination, please come this way.” After the vaccinations comes the parent survey: “How was the experience? How long did you have to wait? How did you learn about the vaccine campaign? How can we improve our services?” Some answer quickly as they head back to their offices, shops and construction sites after taking time off to dedicate to their children’s health. A father kisses his wife and daughter goodbye and jumps on a passing microbus, which heads down the narrow streets leading to the city center.

We visit health centers of all sizes. Enthusiastic health workers show us the iceboxes where the vaccines are kept, the examination rooms, vehicles with megaphones, detailed maps. But they also show us something else: their dedication and love for their work, their joy at being able to provide a little hope for their fellow citizens.
Cusubamba, June 4

The official launching ceremony for the campaign begins at midday. We get an early start and are buoyed by cloudless blue skies and a light breeze. A detour in the road delays us, but coming out of it we soon begin a serpentine upward climb toward Cusubamba. We notice apparent deforestation, which allows for clearer views of the mountainous, arid landscape. We drive on in silence.

When we arrive, a band is playing live music, and people are everywhere, many of them in indigenous dress. The plaza, with its church and small shops, is decorated as if for a festival. Bands of children run noisily after ice cream and candy vendors while adults gather solemnly and attentively for the official ceremony. Between songs, people give speeches thanking all those whose efforts have gone into the vaccination campaign. It’s like a festival—a celebration of health. And just a few meters away from the music and speeches, children are being vaccinated. It is a spectacle of color, goodwill and dedication.

Río Daule, June 6

Slowly the late afternoon sun begins to fade. We drive along a road that parallels the Daule River, whose green waters blend in with the vegetation along its shore. We leave the car behind and continue on foot along a narrow dirt path until we reach a clearing. We hear children laughing and playing, crickets chirping and the sound of a radio. In the midst of it all, I suddenly feel myself surrounded by silence. Someone whose face I never see says, “Do you see over there on the river, in the distance? Those are health workers going by boat up the river. During the rest of the week, they’ll visit all the villages along the river to vaccinate children who can’t come all the way down here.” Three boats move gently through the murky waters, each in a different direction: upriver, downriver, onto a tributary—but each with the same goal.

During an entire week, every day from sunrise to sunset, an army of 200,000 health workers will give their best so that 15 million children can receive their vaccines. For the children, this week marks a turning point in their lives. Instead of becoming victims of preventable diseases, they will have the opportunity to grow up healthy and strong. Instead of becoming mere statistics or fodder for public speeches, they will be honored by the actions of people who truly care for them. Instead of being simple survivors, they will be able to wake up each day to the morning sun and do what all children do: go to school, play and be happy.
A turnoff at kilometer 6 of Havana’s Novia del Mediodía (“Noontime Bride”) highway leads through the gates of the Pedro Kourí Institute of Tropical Medicine (IPK), one of Cuba’s institutional crown jewels. Inside the modern 10-building complex, the island’s top medical scientists carry out research in more than a dozen fields, from biotechnology to treatment of HIV/AIDS.

In his office, the institute’s director, Gustavo P. Kourí, receives a visitor with a smile that brightens his chiseled face. On the wall behind him are myriad international and national commendations received by him and his institute over the years, including his most recent prized possession, a medal from the Vatican.

Kourí wears his white lab jacket like a family coat of arms. Continuing the work of his father, the late Pedro Kourí, he has transformed the 66-year-old institute into not only Cuba’s leading research and treatment center in tropical medicine and infectious diseases, but also a leading player in these fields worldwide.

In the process, Kourí has acquired his own impressive international credentials. He is director of the Pan American Health Organization (PAHO)/World Health Organization (WHO) Collaborating Center for Research and Training in Medical Malacology and
would follow in his father’s footsteps, en-
tering medical school and graduating in 1962. He was trained in surgery and pathology and did his medical internship in parasitology. He also spent a year at Minas del Frío in the Sierra Maestra for his clinical rural practice in general medicine.

It was in the mountains that he met Castro, two years after the revolution. Kouri was stationed at a school for primary and secondary teachers. During the conflict, the site had served as a military base under the command of the legendary Che Guevara, and it had a 20-bed hospital used by the revolutionaries. Castro, now president as well as comandante, showed up one evening and spent four hours talking with Kouri and the other medical staff-in-training. They discussed the merits of Cuba’s rural hospital program, and Castro left the young doctors and nurses with the feeling that he had complete confidence in their work.

After his stint in the mountains, Kouri decided to relicense in microbiology, but in 1965 Castro announced the formation of the National Center for Scientific Research. “It was the first big scientific institute [in Cuba],” Kouri says. Eager to hone his research skills, he joined a team of a dozen colleagues who got the center up and going.

“We called ourselves the 12 crazy doctors,” he recalls. They spent two years studying basic sciences, including physics and math, to prepare themselves for research. Kouri was named vice-director of the center in 1968. Twelve years and three posts later he landed at Cuba’s Ministry of Higher Education as national director for research and postgraduate studies.

### An institute reborn

Meanwhile, the small but impressive institute Pedro Kouri had founded went into decline after his death in 1964. For more than a decade, it carried on with just 14 staff working in a 1,000-square-meter facility. Gustavo recalls that it suffered from a “lack of leadership” and the fact that Cuba’s public health system was deteriorating and “resources were being directed to more serious problems.”

In 1979, however, the Cuban government decided to support the institute’s activities, incorporating it into the Ministry of Health and recruiting the younger Kouri as director.

“We started a second phase with full support from our government and decided to bring the institute to the highest scientific level in the shortest possible time,” says Kouri, adding proudly: “This task was given to me directly by our President.”

The new Kouri Institute cultivated scientific relationships with countries and international organizations around the world, including in the United States. Support from the Special Program for Research and Training in Tropical Diseases (TDR), of the United Nations Development Program (UNDP), the World Bank and WHO, was critical to the institute’s retooling. TDR provided training, research and project grants and helped the institute establish exchange relationships with other scientific centers around the world.

Today the Pedro Kouri Institute for Tropical Medicine comprises 52,000 square meters and 700 employees and is Cuba’s leading research and training center in infectious diseases, as well as a major player in international efforts to

---

**A family affair**

The Kouris’ battle against tropical diseases began in 1937 when Pedro Kouri created the Institute of Tropical Medicine at the University of Havana. For 20 years, the institute’s work focused on Cuba’s most worrisome parasitic diseases: malaria, Bancroftian filariasis, hepatic fascioliasis, amoebiasis and other intestinal parasites. Students from the United States, Latin America and other regions came for training in tropical medicine and research. Pedro Kouri represented Cuba at various national and international congresses, including the Third World Congress on Microbiology, held in New York in 1939, where he announced his discovery of a new parasite, *Inermicapsifer cubensis*. He developed new methods for diagnosing and treating parasitic diseases, presenting these in his four-volume publication, *Lessons on Parasitology and Tropical Medicine*.

Gustavo was an admiring witness to such accomplishments. “I was very close to my father,” he says. “Even as a boy, I worked with my father. As a teenager, I continued and worked with him at the institute.”

When Fidel Castro’s revolution triumphed, the elder Kouri took the sweeping changes in stride, according to his son. “There was no contradiction with the revolution,” recalls Gustavo. “My father and most of his colleagues reacted very favorably. He was of very poor origin and was always focused on the diseases of the poor, so he had a very advanced feeling in relation to socialism.”

It seemed natural that Gustavo Kouri would follow in his father’s footsteps, en-
control tropical diseases. Many of the national laboratories of Cuba are housed at the institute, along with the island’s only tertiary AIDS clinic and research center. It continues to receive support from TDR as well as Canada, France, Spain, Belgium, the European Union and the Wellcome Trust, among others.

While the institute originally limited its work to parasitology and tropical medicine, it now addresses infectious diseases in general, with projects in more than a dozen research fields. These range from sexually transmitted diseases and infections in immunodepressed patients to strategies for the control of the disease-bearing mosquito *Aedes aegypti*.

IPK is in charge of evaluation and clinical trials for all Cuban vaccines, “which is very relevant work for our biotechnology industry because we determine the effectiveness of our products,” Kourí says. Among the vaccines the institute is developing or preparing to test are a recombinant dengue vaccine and a vaccine for HIV/AIDS. IPK is also in charge of the control and evaluation of antiretroviral treatment for HIV/AIDS, which the government provides free of charge to those who are infected. (As part of Cuba’s public health system, the Kourí Institute provides its services free of charge to Cuban nationals.)

In addition, the institute has a medical residency program and master’s and Ph.D. programs in virology, bacteriology, parasitology, vector control, epidemiology and infectious diseases.

Kourí takes equal pride in—if not explicit credit for—Cuba’s overall health achievements, many of which could not have occurred without his institute’s contributions. They roll off his tongue like the names of his children: “Cuba was the first country in the Americas to eliminate polio. Vaccines against 13 infectious diseases have been developed, and so the incidence is very low. Typhoid is 0.1 percent, TB is 7.8 percent, tetanus is zero, and bacterial meningitis is 0.3 percent. Malaria is completely eradicated, and dengue outbreaks have all stopped. And AIDS is under control.”

Having largely conquered its own most threatening infectious diseases—thanks in significant part to the work of IPK—Cuba has more recently taken on the role of providing assistance in this area to other developing countries. As with other national health pursuits, Kourí’s institute is deeply involved in this.

Continuing in the tradition of his father, Kourí says he is especially proud of the institute’s teaching function. Since 1980, it has trained more than 20,000 students, some 1,800 of them foreigners from 72 countries.

“IPK is respected throughout Latin America and beyond,” says Paul Farmer, professor of medical anthropology at Harvard Medical School. “With a comparatively tiny budget—less than the budget, say, of a single larger research hospital at Harvard—IPK has conducted important basic science research, helped develop novel vaccines, trained thousands of researchers from Cuba and from around the world, and developed ties with researchers in the United States, too. Gustavo Kourí has provided the leadership for all of this.”

**International ties**

The Kourí Institute has developed research and educational exchange ties with a number of academic institutions in the United States, including Cornell, Harvard, North Carolina, Princeton and Yale universities. The most significant of these is with the David Rockefeller Center for Latin
American Studies at Harvard. Since the center’s inception in 1994, one of its priorities has been to reestablish and expand ties with Cuban scholars and institutions. Through its Cuba Program, the center has fostered collaboration between Cuban counterpart institutions and the Harvard Medical School, the Harvard School of Public Health, the John F. Kennedy School of Government and even the Graduate School of Design.

Harvard Medical School had strong ties to the Kourí Institute even before the revolution. That relationship dissipated following Castro’s rise to power and the institute’s decline. But in 1998, John David, professor emeritus of tropical medicine in the Department of Immunology and Infectious Diseases at the Harvard School of Public Health, wrote to Gustavo Kourí suggesting ways of strengthening research ties between the two institutions. Kourí replied with an invitation.

“I went there to see if we could have exchanges between faculty and students, and within a year we started having scientists from there come to the Harvard School of Public Health,” David says. Harvard students and faculty have also traveled to Cuba, and the two institutions have jointly sponsored conferences and workshops on dengue, immunology and health reform, among other topics.

David adds: “Our relationships have been quite separate from dissidents. The autocracy has not affected our relationships.”

The Kourí Institute has even developed relationships within U.S. government circles. Gary Clark, chief of the Dengue Branch of the U.S. Centers for Disease Control and Prevention, has known Kourí for more than a decade and participates in IPK courses on dengue fever. He notes that such collaborative ventures are important to researchers in Cuba and the United States, as well as other countries.

“It’s an opportunity to meet people with the same interests,” says Clark. “Through Dr. Kourí’s leadership and the course—currently coming up on the eighth one—we have 14 to 16 years of efforts to bring researchers together. About 50, 75 people come [to] do special laboratories…. It’s an opportunity to meet people with the same interests.”

Harvard’s Farmer observes that much more than “pure research” is at stake in these collaborations: “The IPK has singled out a number of ranking infectious threats, including TB, dengue, malaria and HIV. Comparatively speaking, these are not ranking threats within Cuba. But these diseases constitute huge problems for the poor world.” There is no effective vaccine for any of them, and they are the leading infectious diseases in the world today, he says.

Kourí also views his mission in these larger terms. “Considering the risk of introduction of exotic diseases in Cuba, our government decided to strengthen the institute and increase our surveillance. But at the same time, our president declared that this center was not only for Cuba, but also for humanity.”

For Farmer, IPK represents an opportunity not to be missed.

“Harvard Medical School and the Harvard School of Public Health may well constitute the world’s largest university-based medical research complex,” he explains. “If we were to join forces with one of the developing world’s premier research institutions to develop new tools to control or treat these plagues, it would be, as Shakespeare put it, ‘a consummation devoutly to be wish’d.’”

Annmarie Christensen is director of publications at the Global Health Council in Vermont, USA. She reported this story while visiting Cuba for the council in April.
Back in the 1980s, Glenda Caesar worked as a staff nurse in a hospital on the island of Trinidad. She earned the equivalent of about $250 per month. Given the cost of living, it left her with virtually no disposable income. To make matters worse, she says her working conditions were “deplorable,” with extreme patient overcrowding and serious shortages of medicines and equipment.

So in 1990, along with three other nurses from Trinidad, Caesar accepted a job offer in Saudi Arabia that paid her more than four times her Trinidad salary. Leaving behind her tropical island home, she traveled to the harsh desert climate of Riyadh, where she enjoyed perks such as a “rest and recreation” allowance, had much better working conditions and earned enough to live comfortably and still send money back to her family in Trinidad.

Eventually homesickness compelled Caesar to give it all up and return home. But her fellow Trinidadians and other nurses from the Caribbean are still there.

Moreover, others are following in their footsteps, emigrating to the Middle East, Europe, Canada and the United States. As fast as you can sing “Working for the Yankee Dollar,” nurses from throughout the Caribbean have been packing their bags and saying, “Farewell, paradise!”

As early as the 1970s, the World Future Society was predicting that the global demand for nurses would be virtually infinite. Today, the shortage of trained nurses has become one of the most serious crises facing the health care industry worldwide. The World Health Organization (WHO) reports a shortage of nursing personnel in each of the six regions of the world it represents. If the trend is not reversed, “the ability of many health systems to function will be seriously jeopardized,” says a 2000 WHO report.

Gloria Noel, a health systems management consultant and former nurse advisor to the Pan American Health Organization (PAHO), says three labor trends are feeding the problem: “Nurses are not entering the profession, those who are there are not staying, and those remaining are not happy. This crisis preoccupies health services policymakers, planners, educators, employers, managers and employees. Experts are studying the impact of the global nursing shortage on world health status and the quality of health care.”

The fact that these trends are not confined to the Caribbean provides little consolation to the region. In certain ways, its problem is worse. Because English is the native language of most Caribbean countries, their nurses are highly desirable to North American and British recruiters. This exacerbates the region’s homegrown shortage.

Noel says recruitment agencies from these and other countries send representatives who in some cases try to lure nurses right off hospital floors. She finds it “interesting” that “a country with the highest ratio of nurses, the United States, which has 97.2 nurses per 10,000 people, is recruiting nurses from Jamaica, where the ratio is just 11.3 nurses per 10,000, and from Guyana, with 8.6 nurses per 10,000.” She cites U.S. Bureau of Labor Statistics projections that estimate U.S. demand at an additional 800,000 registered nurses by the year 2005.
PARADISE!
The growing demand is due to several complementary factors. People are living longer than before, increasing the numbers of infirm and chronically ill. Improved lifestyles and greater health promotion reduce premature death and illness but add to the health care burden of an aging population. So, too, do seemingly endless medical-scientific discoveries and technological advances in health care.

And that’s the good news.

On the downside, Noel points to increases in antibiotic-resistant infections and “cost-cutting pressures of managed care.” There is also HIV/AIDS. While antiretroviral therapy increases the numbers of people living with HIV/AIDS, it also increases their need for trained caregivers.

The Caribbean is second only to sub-Saharan Africa in terms of HIV rates, with an estimated 2.2 percent of Caribbean nationals living with the virus, according to the Joint United Nations Program for HIV/AIDS (UNAIDS).

Studies have identified other factors underlying the nursing crisis. In the Caribbean, these include inadequate workplace environments, with facilities that are in disrepair and lacking essential equipment. The problem is compounded by inadequate compensation and benefits. Most Caribbean countries have suffered severe economic downturns and have implemented structural adjustment programs that have brought major reductions in health-care budgets.

Nurses also complain of a lack of recognition and professional power, which leads to unsatisfactory social relations at work. “There is no respect for nurses who stay and who make the sacrifices,” says Caesar. Under such conditions, even family commitment, patriotism and the opportunity to contribute to national development are insufficient motivators for trained nurses to remain in the national health service.

Caesar has been a nurse for 26 years and is now an assistant secretary with the Public Services Association of Trinidad and Tobago, the industrial relations representative of most local nurses. She says she understands well why many nurses want to leave.

“It is not only for the money. For the most part, it is a matter of improving themselves and their families. Many of us have children at university. We have mortgage payments. We have the car, food, phones and a salary that can barely feed us and pay off the bank. Our colleagues abroad have enough money to pay their mortgages and still have something left for the rainy day. This is why so many of my colleagues think, ‘maybe I should get out too.’

“When you look at the hospital where I was trained and worked, there is severe overcrowding. There used to be a staff ratio of five nurses to 109 patients in the medical wards, and that is low by international standards. Now you get three nurses to one ward, if you’re lucky.”

Contrast that with conditions in recruiting countries such as Saudi Arabia. “All the support facilities are available—the equipment, the staff, are all there,” she says. “The linens and packs are changed regularly. This is the big difference.” Asked about language and cultural differences, she says, “Patients are patients everywhere. Whatever the language, their needs are the same.”

Nursing brain drain

The impact of the nursing crisis is being felt throughout the Caribbean region. Many of the most experienced, skilled and specialized nurses have left for greener and more professionally rewarding pastures. Many of those remaining are nurses near retirement (mandatory at age 55 in most Caribbean countries), and the number of new nursing graduates is declining. About 35 percent of nursing posts in the region’s health sector are currently vacant. Many patient care units have had to be merged and elective surgery often cancelled in many hospitals. “Sick outs” by nurses demanding better pay and working conditions have cost governments almost $3 million.

As a result of the nursing brain drain, the loss in public investment in training nurses at the basic level is estimated at nearly $17 million. One senior nurse in Trinidad, who prefers that her name not be used, says that many young nurse trainees make no effort to disguise their intention of using the pro-
fession as a means of getting a “green card” to work in the United States.

“It makes me upset,” she says, noting that this further reduces the standard and quality of nursing care.

In the larger sense, the nursing crisis feeds widespread fears among the taxpaying public about the availability, safety and quality of health care. “It has, and will continue to have, a profound impact on nursing services both quantitatively and qualitatively,” says Noel. “This shortage is unlike those of the past and requires bold action and innovative and creative solutions.”

Carl Browne, former permanent secretary in the Ministry of Health of St. Vincent and the Grenadines and now project manager for a European Community HIV/AIDS project in the region, supports the initiative but is adamant that at the base of the problem is the need for more training institutions for nursing.

He says, “We need to produce more nurses. Nursing should be on the curriculum of our community colleges and other tertiary institutions. We should also establish some kind of compensation arrangement with organizations that recruit our nurses and use the funds from this to train more nurses.

“We have to recognize that the demand for trained nurses in the developed countries will continue indefinitely. Instead of viewing the situation as a crisis, we must analyze it for the opportunities that it undoubtedly contains. There are benefits that we can exploit for our countries and for our nurses. Most of those who leave remit money to relations here and buy property, intending to return home when they retire.”

Gloria Noel believes the solution must be as multifaceted as the problem. She says the Caribbean and other regions with this problem, such as Africa, need to implement sound long-range human resources planning; improve the image of nursing; increase enrollment of male and female students and marginal groups in nursing schools; redesign curricula to make nursing education programs more exciting and challenging, including adding mentoring programs; enhance opportunities for professional development and career progression; improve working conditions; match clinical practice opportunities and responsibilities with nurses’ knowledge and skills; recognize nurses as equal partners with physicians in the health team; and compensate nurses commensurately with their education, experience, responsibilities and contributions to health care.

“These reforms require commitment, cooperation, mutual trust, respect and sustained action on the part of all stakeholders,” says Noel. “These include policymakers, health systems planners, and the nursing profession, with input from consumers of health care.”

Whether sheer necessity will prompt these needed interventions remains to be seen, but whatever happens, the role of nurses in the development of health care will continue to be pivotal. They are the wheel and hub of health services.

As Noel told nurses at a recent conference on the future of nursing in Guyana: “It takes a special person to be a nurse. You are the unsung heroes, the unseen angels. Be the best that you can be. Celebrate each other, be strong, view the many frustrations as challenges, take care of yourselves, as you are the fabric and future of health care in this country and the world.”

Tony Deyal is a former advisor to the Pan American Health Organization and currently an underpaid newspaper columnist in Trinidad. He was last seen trying to find the help-wanted ads in Arab News.
In mid-June, when outgoing Director-General Gro Harlem Brundtland of the World Health Organization (WHO) announced that severe acute respiratory syndrome (SARS) had been “stopped dead in its tracks,” people around the world sighed with relief. Yet many in the international public health community believe it is unlikely that SARS has really gone away. Should it begin spreading again—or should some other threatening new disease emerge—what are some of the lessons we have learned from the first outbreak?

I would start, not last November, when word of a strange new illness began to emerge, but in the 1850s, when the legendary John Snow showed that a single water pump was responsible for infecting a large number of London residents with cholera. Snow was the quintessential “shoe-leather” epidemiologist, who painstakingly plotted an epidemic’s path and traced it to its origins, providing scientific documentation of his conclusions and producing dramatic results with his remedy.

Fast-forward to the past 20 years, which are replete with stories of talented, committed physicians and medical experts who risked their own health and well-being to visit the scene of a particularly nasty outbreak and observe, record and rapidly report their findings. Hanta, Ebola, Lassa, Marburg and West Nile viruses, along with anthrax, plague, Rift Valley fever, dengue, dracunculiasis—all are recent examples of how local, regional and global expertise and resources have been mobilized at the scene and coordinated at distant points to determine the cause and possible solutions to disease outbreaks.

At the core of all such investigations are certain principles that serve as the basis for effective and honest public health action:

- All data should be gathered, collected and shared in a quick, intelligent and scientific manner.
- Governments should cooperate fully in the investigation because the health of those they represent is at stake.
- Under no circumstances should the science be compromised, since the findings will underpin a final determination on how to control and prevent further disease spread.

In the case of SARS, we can only speculate how many lives might have been saved and economic damage avoided had officials in China (at the provincial perhaps even more than at the national level) been forthcoming earlier with information and requests for assistance. They had no farther to look than Hong Kong to see the merits of openness and international cooperation. In mid-1997, right around the time Hong Kong reverted to Chinese rule, an epidemic of avian flu broke out. But Hong Kong’s health officials reached out, and the World Health Organization (WHO), with help from the U.S. Centers for Disease Control and Prevention (CDC), responded swiftly and effectively with measures to stop the disease’s spread.

WHO’s expanded authority to respond to international epidemics will come in handy in the event of a new SARS outbreak or similar epidemic.

But equally important will be each affected country’s immediate voluntary response.

False first steps

In mid-June, when outgoing Director-General Gro Harlem Brundtland of the World Health Organization (WHO) announced that severe acute respiratory syndrome (SARS) had been “stopped dead in its tracks,” people around the world sighed with relief. Yet many in the international public health community believe it is unlikely that SARS has really gone away. Should it begin spreading again—or should some other threatening new disease emerge—what are some of the lessons we have learned from the first outbreak?

I would start, not last November, when word of a strange new illness began to emerge, but in the 1850s, when the legendary John Snow showed that a single water pump was responsible for infecting a large number of London residents with cholera. Snow was the quintessential “shoe-leather” epidemiologist, who painstakingly plotted an epidemic’s path and traced it to its origins, providing scientific documentation of his conclusions and producing dramatic results with his remedy.

Fast-forward to the past 20 years, which are replete with stories of talented, committed physicians and medical experts who risked their own health and well-being to visit the scene of a particularly nasty outbreak and observe, record and rapidly report their findings. Hanta, Ebola, Lassa, Marburg and West Nile viruses, along with anthrax, plague, Rift Valley fever, dengue, dracunculiasis—all are recent examples of how local, regional and global expertise and resources have been mobilized at the scene and coordinated at distant points to determine the cause and possible solutions to disease outbreaks.

At the core of all such investigations are certain principles that serve as the basis for effective and honest public health action:

- All data should be gathered, collected and shared in a quick, intelligent and scientific manner.
- Governments should cooperate fully in the investigation because the health of those they represent is at stake.
- Under no circumstances should the science be compromised, since the findings will underpin a final determination on how to control and prevent further disease spread.

In the case of SARS, we can only speculate how many lives might have been saved and economic damage avoided had officials in China (at the provincial perhaps even more than at the national level) been forthcoming earlier with information and requests for assistance. They had no farther to look than Hong Kong to see the merits of openness and international cooperation. In mid-1997, right around the time Hong Kong reverted to Chinese rule, an epidemic of avian flu broke out. But Hong Kong’s health officials reached out, and the World Health Organization (WHO), with help from the U.S. Centers for Disease Control and Prevention (CDC), responded swiftly and effectively with measures to stop the disease’s spread.

By contrast, official information on China’s SARS epidemic was sparse and suspect until early April, when the Communist Party fired China’s minister of health as well as the mayor of Beijing and ordered greater transparency in reporting on the epidemic. Acknowledging the error of the country’s initial response, the English version of the official China Daily News observed in an editorial: “Harsh reality demands clear information from the
authorities, so the public can be fully informed of the situation and take appropriate measures.” A subsequent article in *The Asian Wall Street Journal* also criticized government officials, saying they “thought first not of the public’s health, but of the economic and social harm that might be caused by a panic.”

It is important to note that China’s response did not violate any international agreements. Like all WHO member countries, China is a signatory to its International Health Regulations (IHR), but these require compulsory reporting on only a small number of diseases. At the most recent World Health Assembly—in Geneva in May, as SARS was dominating world headlines—WHO’s member countries expanded the organization’s authority to respond to such international epidemics. It is now authorized to consult unofficial sources of outbreak information, and it no longer needs permission from member governments to conduct on-site investigations (though it must inform governments and let them know of its teams’ whereabouts).

These changes, part of an ongoing process of revamping the IHR, will come in handy should a new SARS or other dangerous international outbreak occur. But equally important is each affected country’s immediate voluntary response. Openness is not always easy, even more so when the stakes are as high as they are in the case of SARS. Affected countries know that if their epidemic appears to international observers to be out of control, they risk serious economic loss. At the domestic level, health officials must alert health workers and the public to be vigilant, but without causing undue panic. Openness and effective use of information are critical to gaining the public trust needed for effective contagion control.

**The next time**

There is still much to learn about SARS, whether its cause is indeed a single virus and what kinds of treatments and vaccines might be effective against it. There is no better way to tackle these challenges than through a multitude of talented scientific minds evaluating both the epidemiology and the laboratory aspects of this illness as we move toward definitive findings. Just such work is now taking place in labs and public health offices around the world, and continuing openness and information sharing are essential to its success.

Our planet grows smaller every day as a result of global travel, commerce and exploding populations. SARS is unlikely to be the last public health threat of its kind. It has never been more important for governments to cooperate fully with the international scientific and health community in combined efforts to battle diseases of this kind.

Robert J. Howard heads a health communications consulting firm in Duluth, Georgia, USA, and teaches at Harvard University, the University of South Florida and six National Public Health Leadership institutes.
Kids and the environment

Your excellent article “For the Kids’ Sake” (Vol. 8, No. 1) draws attention to the many hazards children face from environmental exposures, particularly in developing countries. But there are other important environmental hazards found just as frequently in developed countries as in the developing world.

These include air quality problems, pesticide exposure, mercury exposure, exposure to lead paint and exposure to indoor mold. In the United States alone, coal-fired power plants contribute more than 100 tons of mercury each year, which is transformed into methyl mercury by bacteria in lakes and streams. These and other pollutants, such as PCBs, often accumulate in fish, resulting in particular risks to pregnant women and the unborn.

Recent U.S. Environmental Protection Agency (EPA) data show that more than 8 percent of women of child-bearing age in the United States have blood-mercury concentrations greater than the reference dose of 5.8 parts per million. In 2001, 44 states had mercury advisories in effect for noncommercial fish. Rates of asthma in the United States doubled between 1980 and 1995, and many regions have seen increasing rates of code-red days, when air quality is so poor that children and the elderly are recommended not to go outside. Certain subpopulations of children frequently face greater hazards, including pesticide exposure among farm worker children and lead poisoning among African-American youth.

What do all these problems have in common? First, none can be addressed until we recognize that “the environment” is not just forests, beaches, rivers and oceans but everywhere children learn, live, work, play and grow. Second, the proper response is to prevent exposures in the first place rather than to try to deal with their enormous health consequences after the fact.

Addressing these problems is less a question of technological know-how than of societal will. We know how to reduce mercury emissions, improve particulate levels, eliminate lead poisoning and the like. We just have to believe in the worth of children enough to ensure that adequate resources are directed toward applying solutions that are already within our grasp.

Rabbi Daniel Swartz
Executive Director
Children’s Environmental Health Network
Washington, D.C.
USA

Tobacco’s dirty tricks

It was with a profound sense of déjà vu that I read your excellent article on the tobacco industry in Latin America, now exposed from the industry’s own documents.

Change the names from Costa Rica, Guatemala and Paraguay to China, Guam and the Philippines, and you have a virtual identikit of what also happened in Asia. Nothing could demonstrate more clearly than the tobacco industry’s own words that the product is the same, the tobacco companies behave the same, and the similarities are uncanny in the way they recruited scientists, introduced youth programs, handed out freebie tours to journalists, and discussed smuggling and duty-not-paid cigarettes.

The obvious conclusion is that the action that governments must implement to curtail the epidemic is also the same. Enter the Framework Convention on Tobacco Control, which was approved by the World Health Assembly in May, the first time in its history that the World Health Organization has used an internationally binding treaty to further public health. Key issues in the convention include tackling smuggling, implementing bans on promo-

tion, creation of smoke-free areas and increasing taxes to prevent young people from buying cigarettes. The tobacco industry’s own documents show us that the need for such action is clearly global.

Judith Mackay
Director
Asian Consultancy on Tobacco Control
Hong Kong

Essential drugs

Your article “Don’t Let TRIPS Trip up Essential Drugs,” by Martin Foreman, deals with a vital issue, that of drug patents and licenses in the hands of oligopolistic international pharmaceutical laboratories. This is a problem that must be tackled by civil society on a global scale and by all the world’s governments and specialized agencies, because without health there cannot be development, much less progress.

Nelson Simatovich
General Coordinator of Programs
Instituto de Cooperación para el Desarrollo Latinoamericano (ICDLA)
Montevideo
Uruguay

We encourage readers’ comments on articles in Perspectives in Health and on the issues they raise. We will run a sampling of letters received in each issue. Some may be edited for space. Please include your name and address. Send to the Editor, Perspectives in Health, Area of Public Information, Pan American Health Organization, 525 Twenty-third Street, N.W., Washington, D.C. 20037, or via fax at 202-974-3143 or by e-mail to eberwind@paho.org. Perspectives in Health cannot be responsible for unsolicited manuscripts and/or photographs. Please query first. Guidelines are available upon request.
December 1, 2003

World AIDS Day

Eliminating Stigma and Discrimination

Live & Let Live

http://www.paho.org/
A child pauses between chores near his family’s farm in Ibarra, Ecuador, near the Colombian border. Pan American Health Organization (PAHO) staff photographer Armando Waak captured the image as part of a PAHO audiovisual team that chronicled the first regional Vaccination Week in the Americas, held June 1–8.

The 19-country initiative made a special effort to reach children in remote areas and marginal urban zones who had never been vaccinated before. By the end of the week, more than 15 million children in Latin America and the Caribbean had received vaccines. (See article page 14.)