

DAVID ROCKEFELLER CENTER FOR LATIN AMERICAN STUDIES

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MARK MOSELY

"Health: The Hope of Haiti" Photoessay by Mark Mosely on p. 24. Also see related lead essay "Whither Equity in Health? The State of the Poor in Latin America" by Paul Farmer on p. 3.

Health in the Americas

A Search for Equity

BY GEORGE A.O. ALLEYNE

THE STATE OF HEALTH OF THE WESTERN HEMISPHERE, I AM PLEASED TO SAY, IS IMPROVING, DISTINGUISHED READERS. Every country in the Americas is experiencing a decline in child mortality, a decrease in fertility rates and increased life expectancy. The population is just over 800 million, and the percentage of those over the age of 60 is rising steadily.

In the Western Hemisphere we are particularly proud of the achievements in the field of immunization, where first we conquered smallpox and then boldly went on to end polio, both tasks that stand as remarkable testimony to the will and commitment of the governments of the countries, as well as to the effectiveness of partnerships in which various public and private agencies worked together. We are on track to eliminate measles, once thought to be a pesky childhood disease but in reality a killer. Childhood



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tetanus is receding. New vaccines exist for meningitis and hepatitis and one for HIV/AIDS is on the horizon.

Coverage of water and sanitation services is expanding. Governments are spending more on health, the number of physicians and nurses is increasing, and almost every country is trying to reform health services.

We are improving. Yes. But we can't be satisfied while there is so much more to do. Tuberculosis continues to plague us with a quarter of a million new cases each year. Dengue outbreaks appear with each rainy season. Obesity due to a lack of exercise and proper nutrition is widespread. Maternal mortality in our Region is a scandal. Some 24 million people in the Americas suffer from depression. And latest reports indicate that more than 2,000 people die every day from tobacco-related diseases.

I am even more concerned, however, with an insidious scourge that is undermining any and all advances. The cause is poverty, grinding poverty. We must be exquisitely aware that not only is poverty the cause of much ill health, but also that attention of health can be a mechanism for alleviating poverty. The poor are doubly damned — they are more likely to be ill, and the economic cost of illness weighs more heavily on them than on the rich.

There is acceptance of the fact that dealing with poverty on such a massive scale needs collective action, and we see rich industrialized countries laying plans and devising schemes for action to reduce income poverty, most of which are based on enhancing economic growth. We also need collective advocacy from private groups to argue much more vigorously for a multidimensional approach to poverty reduction, an approach that seeks to strengthen institutions and give voice to the voiceless poor.

In the region of the Americas, the problem is not only poverty, it is inequality — the disparities that are socially unjustified and lead to ill health. The better the efforts of the countries to collect good data and disaggregate them, the more easily we identify the gross disparities in health status among and within countries. It is important to recognize these health disparities that we deem to be inequities, but if we are going to address them we have to do so by first identifying the disparities in the determinants of health.

There are disparities particularly in the economic and social conditions that lead to differences in health status that we consider unfair and so socially unjust that we brand them as inequities. Health indicators are worse in poor countries, but within all countries the distribution of indicators of mortality and morbidity shows gross disparities. Within countries, we see vast differences when ethnicity and geography are used as determinants. The poor health of indigenous peoples is a classic example of health inequity, and this is not a problem only of the indigenous people of poor countries.

The search for equity in health must be guided in large measure by reliable data. The search for equity in health

must be guided in large measure by reliable data that are transformed into information about the nature and distribution of health problems. This information should be widely shared so that countries—particularly those with scarce resources—can effectively apply them.

The distribution of income is a major determinant of health outcomes. Where traditional approaches to the relation of wealth to health dealt with absolute differences between groups divided according to income, there is significant interest now in the distribution of income in a society and its effect on various outcomes. It has been known for centuries that the poor are less healthy and die younger and there

are numerous eloquent statements on the role of poverty in disease. This is of particular relevance to the countries of Latin America and the Caribbean, which have the unfortunate reputation of having the worst distribution of income in the world.

I am a loud advocate for more equity in our region, not just because of the morality of the issue but also because I know it is good for the societies in which we live. Differences between and among people that are avoidable are a cause for the kind of jealousies that lead to social instability. Let me say that investment in health must be seen as producing a public good and contributing to the economic well being of our citizens. Let me say that we seek health—for all.

Dr. George A.O. Alleyne, MD, is the Director of the Pan American Health Organization, the oldest international public health agency and the Regional Office for the Americas for the World Health Organization. A native of Barbados, Alleyne was knighted by Queen Elizabeth in 1981 for his work in medicine.

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Whither Equity in Health?

The State of the Poor in Latin America

BY PAUL FARMER

A WAITING ROOM IN A CHARITY clinic in rural Haiti. It is a humid afternoon, and huge drops of warm rain are starting to fall. A young woman is watching as her ten-year-old son, Dominique, clutches miserably at his abdomen; he is staring at the roof, not saying anything. A Haitian colleague says to me, "His temp is 104, it's been up for over a week, his belly pain began three days ago. I'm getting the films and labs now." He pauses, looks darkly at the mother: "It's late." I say nothing, but look at the woman as I reach for the boy's abdomen, praying that it's not yet rigid (it is not). Though she is no doubt younger than I, she appears weathered, for Haiti has been no kinder to her than to her son. She

looks at me, sighs, and wordlessly makes a weary gesture. I know it well: *What can I do?*, she asks with her hands. *It's beyond my control.*

And so it is. Well beyond her control. Her boy probably has typhoid fever, and the severe abdominal pain is ominous: one of the worst complications of typhoid is intestinal perforation, which usually leads to peritonitis and death in rural Haiti. Typhoid, a classic public-health problem, is caused when drinking water is polluted by human feces. Not her fault. Ours perhaps, I think immediately. We could have worked harder on water-protection efforts, even though another, more conventional voice in my head reminds me that Dominique and his mother live well

outside of our "catchment area," the region in which we — Partners In Health, a Harvard-affiliated public charity — work closely with community-health workers. And only by redefining the whole of public health as a private concern, one to be handled by do-gooder organizations like our own, could this be seen as our responsibility.

Increasingly, such a redefinition — the "privatization" of health — has come to hold sway in the hemisphere. Assessing public health in Latin America is a treacherous exercise. This is not because it is impossible to evaluate the state of the region's health, nor is it because the admittedly enormous variation, both across and within nations, leads to analytic impasse.

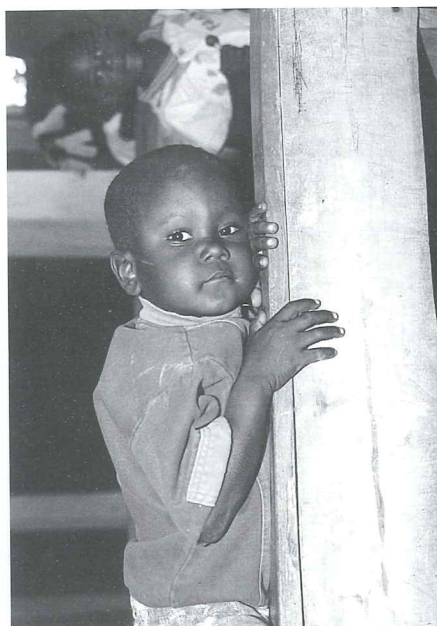
Schoolchildren in Tumbaco, Ecuador, enjoy a nutritious breakfast provided by UNICEF.

The health of the poor – like this young boy in Haiti – is now deemed less important than cost-effectiveness.

It is treacherous to comment on public health in Latin America because of the ideological minefields one has to traverse in order to do so.

In the past, such assessments may have been easier, and not because public health was then a more robust undertaking. Rather, there was formerly a consensus that the health of the poor — meaning people like Dominique and his family — was a cardinal indicator of how well the stewards of the public's well-being were doing their job. Rudolph Virchow has been called the father of social medicine, and it was he who termed doctors “the natural attorneys of the poor.” Doctors were supposed to defend the poor because the impact of their social condition — poverty — was embodied as preventable or treatable sickness.

As public health has become a larger enterprise, it has defined a turf of its own; as nation states have come into being in Latin America, they have defined national public-health agendas, increasingly with the assistance of international experts. The “welfare



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state” that we think of as having been progressively built up, from the 1930s to the beginning of its decay in the 1980s, barely got a start in Latin America before debt, the cupidity of local strongmen, and the agenda-setting of First World economic advisers attempted to terminate it as a public responsibility. The health of the poor is now deemed less important than what is often termed “cost-effective,” which too often calls for minimizing the drain on national budgets increasingly dedicated to the supposedly higher goals of debt service and privatization.

Those struggling to promote the health of the hemisphere's poor are now in the defensive position of having to show that proposed interventions are both effective *and* inexpensive, regardless of gravity of the health problem in question. Some would be surprised to learn that the largest financiers of public health in Latin America include the international financial institutions, such as the World Bank and, less directly, the International Monetary Fund. In some regards, this makes sense, given the undeniable

association between economics and health. But there is a dark side to the new accounting, as even a physician can see: such sources of funding for public health place us within a framework developed by economists working within a paradigm in which market forces alone are expected to solve social problems. As efforts are made to determine whether or not an intervention is “cost-effective,” the destitute sick are often left out altogether.

As time has gone by, certain trends have become palpable within much of Latin America. Some have been favorable: vaccination and other interventions have lowered infant mortality; polio has been eradicated from Latin America. Some countries, such as Chile and Cuba, have health indices similar to those registered in North America. But in most of Latin America, we see that a shrinking commitment to public subvention of health care and a push for its privatization have led to a widening gap in access to quality health care. These trends are registered even as the fruits of science become ever more readily translated into effective therapies. And that, in my view, is the central irony of public health in Latin America: national statistics continue to suggest improvement, even here in Haiti. But the poor, as Dominique's experience suggests, are doing poorly. They are doing a bit better than in previous

From the Editor

This issue of DRCLAS NEWS on health and equity was created—literally—by efforts from Argentina to Zanzibar. Dozens of e-mails scurried across the continents with suggestions, contacts, and article proposals. Dr. Adolfo Rubinstein from Buenos Aires, Argentina, filled me in on the Clinical Effectiveness Program there, a joint effort of the Hospital Italiano, Faculty of Medicine of the University of Buenos Aires and Harvard School of Public Health (p. 22). Dr. Jim Yong Kim, co-director of Partners in Health, was just about to win my congratulations for the most distant e-mail (from Moscow, where he was on a World Bank mission on drug-resistant tuberculosis), when Dr. Arachu Castro of the Harvard School of Public Health checked in from Zanzibar.

As Dr. Mary Wilson, Associate Professor of Medicine at Harvard Medical School, stresses in her thought-provoking article on infectious diseases (p. 29), health is truly an international affair, stretching beyond borders and influenced by environment and demography. It's not only the diseases that go beyond borders, but also creative solutions to the region's daunting health challenges, as evidenced in the pages of this issue.

We've chosen to give special attention to Brazil (pp. 31-40) and Haiti (pp. 24-28), although countries and topics range from Mexico to Colombia to U.S. Latin@s (my favorite way of saying Latino/as).

Special thanks go to Dr. Paul Farmer for his guidance, Bryna Brennan of the Pan American Health Organization for her support and collaboration, and to Susie Seefelt Lesieutre for her excellent editing skills.

June C. Elick

decades, but much less better than might be expected, if the fruits of science and technology were used wisely and equitably.

IT HAS BEEN MY GREAT PRIVILEGE to spend most of my adult life working as a doctor in Latin America, including many working visits to Peru and Mexico. But the country I know best, although it is sandwiched between two indisputably Latin countries, is one often forgotten in Latin American studies. When I first went to Haiti, in 1983, I remember writing "West Indies" at the end of my Port-au-Prince return address. I stopped doing this after reading a multi-volume history of the U.S. military occupation of Haiti (1915-1934). The author, Roger Gaillard, had affixed his address to the inside of each volume. After Port-au-Prince, Haiti, he added "Amérique Latine."

It was a polemic note, perhaps, but Gaillard had a point. Haiti is, in many ways, the most "Latin American" of all countries — not because it is "Latin" in having a Romance-based Creole for its national language, and not because of its historical Catholicism, but because of its having endured a history the outlines of which are familiar throughout South and Central America. When we look back at mid-century writings about the region, we find political scientists describing Latin America as poor, rural and agrarian; as having high indices of social inequality; as marked by colonialism (once European, now a condition described as being in the "sphere of influence" of the United States). On each of these counts, the most extreme example is Haiti. One of the reasons Haiti has become so Latin American is that it has had more time to do so. Haiti is the oldest republic in Latin America, independent (at least in name) since 1804. When Simón Bolívar was looking for allies and supplies, he went to Haiti, which welcomed and supplied him.

Although Latin America has changed enormously since mid-century, there is a part of every Latin American country that has much in

common with Haiti. A trip to a poor village in Chiapas or highland Guatemala reminds one of Haiti far more than might a trip to the French overseas départements of Guadeloupe and Martinique. Political violence, among other afflictions of poverty, is endemic here. Haiti is the sickest of New World republics. (I am writing this essay in our clinic, between emergencies.) The history of Haiti's poverty — how it was generated and sustained — is important, though often forgotten. If you are interested in public health, which you necessarily are if you are sitting in a clinic in rural Haiti, you cannot forget poverty's impact on the Haitian people. This year, we are likely to see 45,000 patients in the ambulatory clinic — as many as will be seen in the emergency room of Boston's Brigham and Women's Hospital, where I also have the good fortune to work. The difference, of course, is that the Brigham has a huge medical and nursing staff, excellent laboratories and radiographic services, operating rooms and blood banks, is located in the middle of a region dedicated to advanced medical research, and so forth. And apart from the fact that we don't have such amenities here in Haiti, the patients are sicker. They come to us with illnesses such as tuberculosis, hypertension, malaria, dysentery, complications of HIV infection, all typically in a more advanced state than we'd see at the Brigham. The children are malnourished, and many of them will have severe protein-calorie malnutrition as well as an infection. Some will have typhoid, measles, tetanus, or diphtheria (although these patients will be, like Dominique, from outside of our catchment area). Some will have surgical emergencies: abscesses, infections in the chest cavity, fractures, gunshot and machete wounds.

Or they will be pregnant and sick. Few things are more tragic than third-trimester catastrophes: eclampsia, arrested labor, hemorrhage. As I write these lines, the local "midwives" are meeting outside. They're not really midwives, they're traditional birth

attendants — a mix of women and men, most of them over 50 and unable to read. None know how to gauge blood pressure. Many feel overwhelmed. And justifiably so. Maternal mortality is higher in Haiti than anywhere else in Latin America. In one study, conducted a decade ago around the town of Jacmel in southern Haiti, maternal mortality was 1,400 per 100,000 live births. It's under 20 in Cuba, Jamaica, St. Lucia, and the United States. Our clinic's obstetrician-gynecologist long ago left for Florida, where he joined a community of more Haitian physicians than are now present in all of rural Haiti.

Seeing the rest of Latin America through Haitian eyes — and, currently, coming to see Haiti as a

Keiichi Hayashi made this photo of a boy in Havana, Cuba, during a Harvard School of Public Health study tour.



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Latin American country — is an instructive exercise. When I first went to Mexico it was on a visit to the national school of public health, in beautiful Cuernavaca. This looks nothing like Haiti, I thought. Then I started visiting Chiapas, and had something with which to compare both Haiti and Cuernavaca. I was at first surprised to see that parts of Puerto Rico looked so much like Florida, where I had grown up, and this reversal of expectations — I'd thought that the Caribbean islands would look more alike — led me to read more about the history of colonialism in the region, and to seek to understand more about the flow of people into

A mother and child in Cuba. For a complete account of the Harvard School of Public Health study tour, see <http://www.fas.harvard.edu/~drclas>



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and out of the Caribbean. Peru was another eye-opener: although significantly less poor than Haiti, the slums of northern Lima recalled the dusty towns of northwest Haiti. And here was a place where my Haitian clinical experience proved helpful: in the Peruvian shantytown of Carabaylo, rates of tuberculosis were as high as in Haiti — as high as anywhere in Latin America. What's more, disruptions in the economies of these countries were felt immediately among the people who were my hosts in each of these settings. As in Haiti, the poor felt the impact of adverse trends before any others; their health suffered, often grievously.

HAITI IS OFTEN COMPARED, AND unfavorably, to the Dominican Republic. Neither country has much to boast about in terms of public health. The country sited on the other two-thirds of the island has poor health indices, if nowhere near as bad as those here in Haiti. But what about Haiti's second-closest neighbor? Although popular conceptions in the United States sometimes underscore similarities between Haiti and Cuba — one generates boat people, the other *balseros* — one could not find a starker contrast within this hemisphere. There are some similarities in initial conditions: less than 100 miles apart, the two islands have identical climates and topography. And like Haiti, Cuba has known major economic disruption in the past decade.

The impact on Cuba of the breakup of the Soviet Union, which contained its major trading partners, has been much commented upon. From 1989 onward, the Miami papers have been full of predictions of the imminent fall of Castro and the end of communism in Cuba. But in fact Cuba, unlike Haiti or Chiapas or Peru, has not known significant unrest or political violence.

The Cuban economy, however, did sustain major blows. I'm no economist — and some might argue that

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it's even more difficult, in economics, to wade through the ideology than it is in public health — but reports suggest a net loss, between 1989 and 1994, of more than 80% of all of Cuba's foreign trade. This was as severe a contraction as that faced by any Latin American economy. So what about the impact of such seismic rumblings on the health of the

Cuban poor? Was the story the same as in Haiti (or Peru or Chiapas), where economic turmoil led inevitably to immediate and adverse impacts on the health of the most exposed part of the population? The short answer: no. In fact, although much is made of the harm done by the U.S. embargo to Cuban medicine, the Cuban people remain healthy. Even epidemic optic neuropathy, locally and internationally attributed to vitamin deficiency, was more likely caused by an as yet unidentified viral pathogen.

Some years ago I turned, with fascination and a bit of dread, to comparing these two neighbors. Haiti has the highest maternal mortality in the hemisphere; Cuba's is among the lowest. Haiti has the highest infant mortality rate in the hemisphere; Cuba, the lowest (in fact, infant mortality in Mission Hill, mere yards from the front door of the Brigham and Women's Hospital, is said to compare unfavorably to Cuba). The leading killers of young adults in Haiti are tuberculosis and HIV; Cuba has the lowest prevalence of HIV in the hemisphere, and remarkably little tuberculosis. Typhoid, measles, diphtheria, dysentery, dengue, parasitic infestations — all are common in Haiti and almost unknown in Cuba. I could rattle off any number of indices leading to the same contrasts. There's a saying in Cuba: "We live like the poor, but we die like the rich."

In Haiti, as in Chiapas and the slums of Lima, poor people live and die like poor people. They die of preventable or treatable infections; they die of violence. Why, then, do Cubans leave Cuba? One of the reasons is probably that poor people are not satisfied to die like rich people, they want to live like them, too. This is for me a philosophical question rather than a medical one; I have not interviewed poor people who die of the same diseases that end affluent lives in their eighth decade. The people who crowd our waiting rooms here in Haiti do not have such expectations; they do not have such life expectancies.

I recently went to visit the new Escuela de Medicina de las Americas, with which Cuba proposes to serve the hemisphere by training a new generation of doctors. Say what you will about propagandistic intent, transforming — in less than a year — a naval base into an international medical school is the ultimate in swords-into-plowshares. The facility was attractive and clean. There were few supplies, of course, and not much in the way of textbooks. But the student body came from all over Latin America. And they looked quite different from the students I had met in the capital cities of the region. Several of the students from Bolivia, Mexico, and even Colombia had the look of indigenous people, the ones you could imagine seeing scorned for their appearance or their accent in the

streets of La Paz or San Cristóbal de las Casas.

I was there to beg for medical school spots for rural Haitians, of course, and the Cubans were more than interested. My tour guide was none other than Dr. José Miyar, a Secretary of State and one of the leading figures in the development of Cuba's health sector after the revolution. We spoke about Haiti and other countries with similar health indices. "Maternal mortality?" commented the white-haired doctor, looking pained. "Not merely a tragedy in itself, but the cause of a long chain of tragedies for the other children who survive. For then comes malnutrition, diarrhea, and, often enough, death for these children."

Maternal mortality brings me back from pleasant memories; I am not vis-

iting Cuba this morning, but opening office hours in Haiti, the place I call home. There is a long line in front of the women's health clinic. We're hoping to recruit a new obstetrician-gynecologist. We're also in need of a pediatrician. We've had offers from U.S. physicians, but need fluent Creole speakers. The operating room is closed for a while, as we await the arrival of a full-time surgeon. She is Cuban.

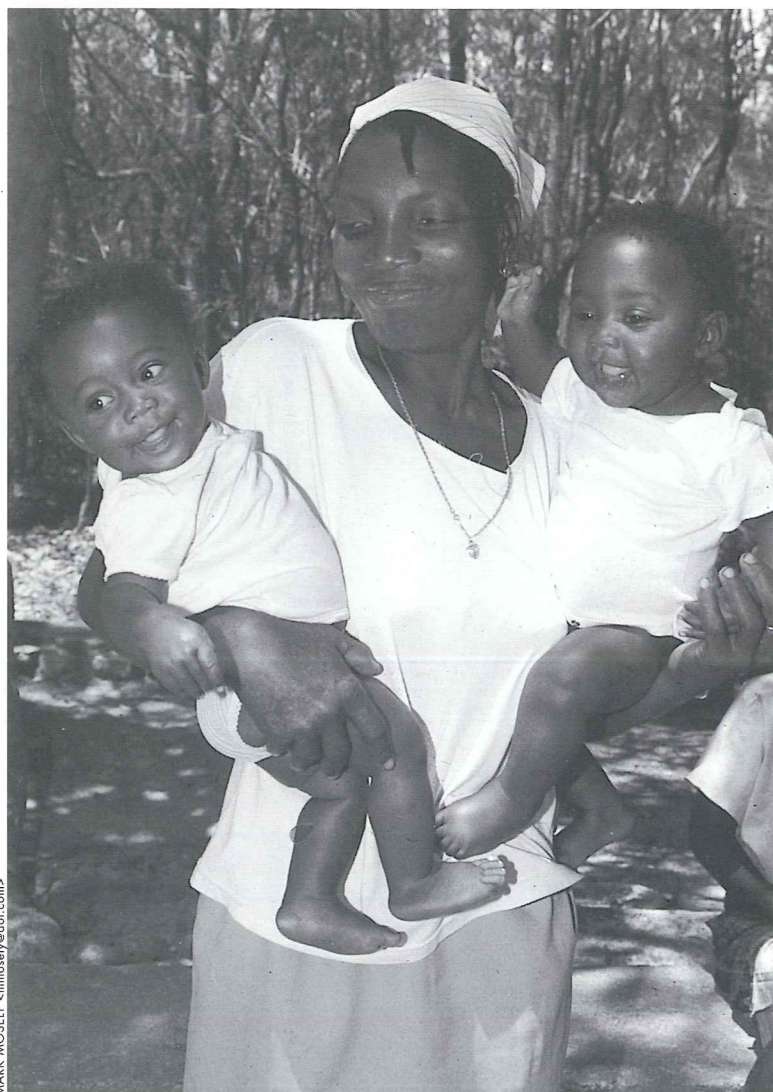
Outside, I hear the midwives chattering. When they talk to me, they speak of their own ailments. "How can I walk to deliver babies when my leg hurts so much?" queries one. Another adds, "We are hungry and do not have gloves or aprons."

Definitely back in Haiti.

AT THE CLOSE OF JUNE, 2000, THE World Health Organization released an assessment of the health systems of all member states. The evaluation took into account several indicators, including quality of health services, overall level of health; health disparities, and the nature of health-system financing. Of 191 countries surveyed, the United States spent the highest portion of its gross domestic product on health, but ranked only 37th in terms of overall performance. Tiny Cuba, spending a smaller portion of its small GNP, was ranked at roughly the same level as the United States, and was one of the four highest-ranked countries in Latin America. As for "fairest mechanism of health system financing," Cuba was the number one nation in Latin America; in this category, the United States did not even figure in the top 50.

What conclusions can be drawn from these comparisons? Audiences in the United States, I have found, are not pleased to hear such analyses. But if they are revealing and startling, surely there is some point in discussing them? I know that I'm not so much interested in the ideological underpinnings of the various approaches to public health as I am in the results, as manifest in morbidity and mortality rates. Let the edi-

The Haitian studies series at DRCLAS in Spring and Fall 2001 will bring together Haitian scholars and policymakers and Harvard students and faculty to examine Haitian health, education, and development challenges.



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Haitian mother waits with children for immunizations.

torialists rant about socialism or its opposites; doctors and public-health practitioners have to be "outcome-oriented." Of course, the major debate in social policy is about what outcomes should be perceived as "of interest." For economists, such matters as GNP and external debt are the preferred indices (although these are, in my view, ideologically freighted subjects in and of themselves). For education experts, it's literacy rates. The human rights community, interestingly, almost always narrows its focus to favor rights of expression and representation and to exclude social and economic rights — an omission that should trouble physicians, who need supplies of tangible goods, the very tools of their trade, before they can go to work. Unless the Latin American poor are accorded some right to health care, water, food, and education, their rights will be violated in precisely the ways manifest in my waiting room here in Haiti: their lives will be short, desperate and unfree.

Just ask the Cuban doctors now working here. There are probably more Cuban physicians in rural Haiti than there are Haitian doctors (remember: the Haitian M.D.s are in Port-au-Prince, Miami, New York, Montreal, etc.). What do the Cubans do when they encounter patients so poor that they cannot fill prescriptions, buy intravenous solutions, or feed their children? The Cubans are well-trained, clearly, and skilled at making the most of scanty resources. But all the training in the world cannot substitute for a healthcare system. They, too, will have to start from scratch—and learn to beg for supplies, as we all do down here — if they wish to serve the Haitian poor.

And so I return, as always, to the health of the poor as the most telling social-policy outcome. Even as national economies and stock markets boom, the health of the Latin American poor remains abysmal by both absolute and relative criteria. This is true in Chile, Brazil, Mexico, Peru—and of course Haiti. It's a quick enough trip from the glittering

towers of Mexico's *zona rosa* to the squalid villages of Chiapas. In Lima, excellent highways lead past glass bank and insurance skyscrapers to the miserable *invasiones* of the city's northern reaches, where, as noted, rates of tuberculosis run as high as anywhere in Latin America. The shiny towers and dismal health statistics are

The health of the Latin American poor remains abysmal by both absolute and relative criteria.

of course related, since the privatization of health care occurs at the same time, and as part of the same policy environment, as do massive transfers of public wealth to private coffers. This year, Peru will pay about 20% of its GNP to finance its foreign debt. Most of it will go to even taller towers in wealthy cities like New York. Even well-off Chile, with three times the per capita income of Cuba, has been forced to acknowledge a growing equity gap in health outcomes.

Watching the health of the poor is the best way to assess public health in Latin America, but these days there is more enthusiasm for "environmental report cards" than for this once-respected marker. Indeed, the rain forests and their non-human fauna seem to occasion more comment than the premature deaths of the hemisphere's poor. The poor in most poor countries are living in the worst of the industrial world's off-scourings, surrounded by bad air, bad water, bad soil, and working, when they can find jobs, under dangerous conditions; but it is a rare First World environmentalist who recognizes them as deserving to be "saved" no less than the forests, the whales and the tree frogs.

Back to our waiting room. What is to be done if we want to take stock

of the health of Latin America's poor, and act purposefully? Of course, we need resources, and to be quite honest, resources should not be the problem. In this time of record profits for many industries and dazzling individual fortunes, is it unthinkable that we should spread the wealth? I just came across an interview with the chairman of Intel, a certain Andy Grove. He grew up in Hungary, he notes, during the Stalinist era. "Profits are the lifeblood of enterprise," he remarks. "Don't let anyone tell you different."

Unlikely that anyone would try, these days. Certainly not a physician sitting in a clinic in rural Haiti. But surely there is some way to redirect some part of the profit stream to take care of the destitute sick, right now? Otherwise, doctors will stand by, as helpless as Dominique's dispirited mother, watching resources flow — along the gradient established for them by our policies, our choices, and our blind spots — to become ever more narrowly concentrated in the hands of a few. If the health of the poor is the yardstick by which our public-health efforts in Latin America are judged, we or our descendants will have a lot of explaining to do when history sits to consider our case.

Paul Farmer, MD, PhD, is a medical anthropologist whose work draws primarily on active clinical practice: he divides his clinical time between the Brigham and Women's Hospital (Division of Infectious Disease) and a small hospital in rural Haiti. Through Partners In Health, the public charity he helped to found, his work has focused on the prevention and treatment of diseases disproportionately afflicting the poor. The Program in Infectious Disease and Social Change, which Farmer runs along with his colleagues in the Department of Social Medicine, has pioneered novel, community-based treatment strategies for sexually transmitted infections (including HIV), drug-resistant typhoid, and tuberculosis in resource-poor settings.

Safe Blood for Transfusion

The Challenge of Scarcity

BY JOSÉ RAMIRO CRUZ

JOSÉ OSCAR COTTO LÓPEZ HAS DONATED 140 PINTS OF blood since 1966. The 53-year old resident of San Salvador, El Salvador, does so because he believes it is an expression of love. "We must be aware that donating blood is the best way to express solidarity and love to our fellow human beings," he says. "It is the most beautiful gift we can give, the gift of life."

Unfortunately for the people of the Americas, Cotto López is a rare individual. Blood for transfusion is scarce in all countries of Latin America and the Caribbean. Only Cuba collects blood from the equivalent of five percent of its population, the amount that the World Health Organization and the International Federation of Red Cross and Red Crescent Societies estimate is necessary for a community to achieve sufficiency. Most of the remaining countries hardly collect one-fifth of what they need.

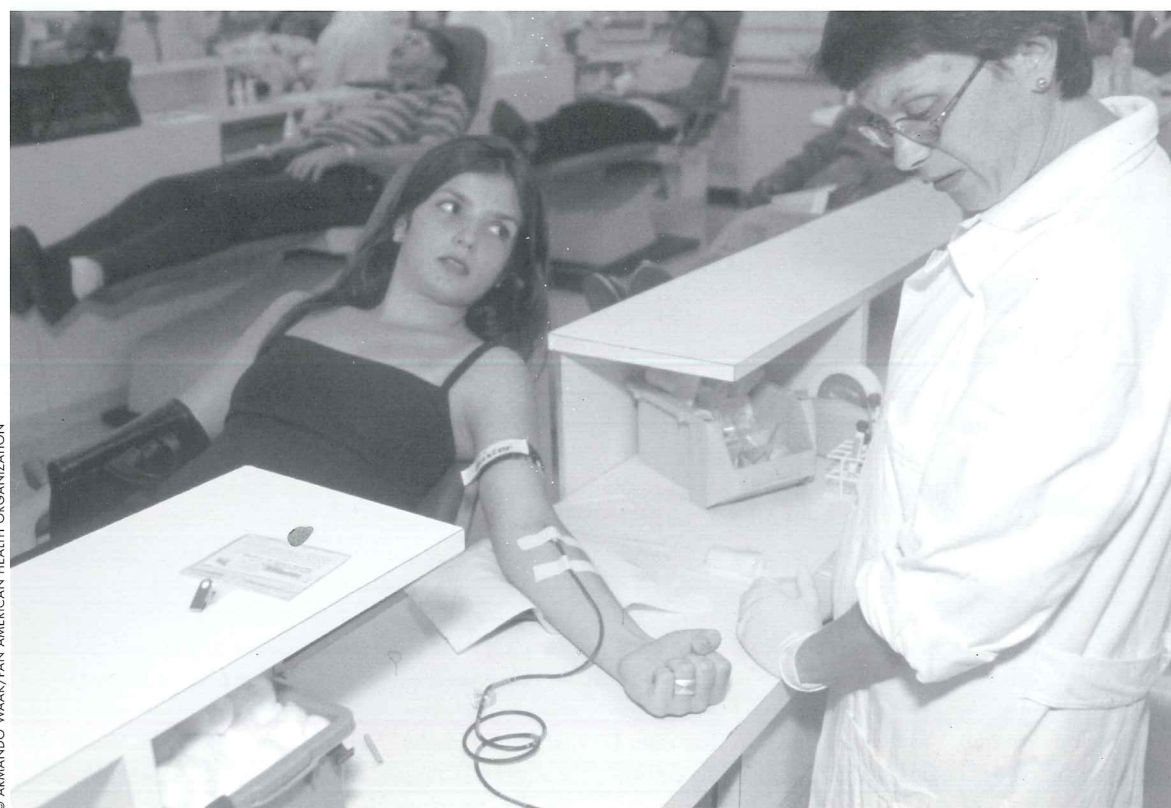
Due to the scarcity of donors, hospital-based blood banks in Latin America usually ask patients' relatives to bring in two or three blood donors—known as replacement donors—to cover the patient's needs. Sometimes, relatives have difficulty finding people who will donate blood and must resort to buying it. In other instances, the blood bank itself pays the "donor."

Working with the Pan American Health Organization

in laboratory and blood services all over the region, I have found that replacement and remunerated donors usually do not respond to pre-donation questionnaires with honesty. They need the monetary incentive or feel they are being forced into giving blood, so they hide risk behaviors from the blood bank personnel. "I don't even bother asking the donors all those questions; they all lie," a nurse in Santiago, Dominican Republic, told me. "We take a blood sample from the potential donor early in the morning, test it for infectious markers and, if the results are negative, we draw his blood later that day," said another nurse in Mazatenango, Guatemala.

Practices like these increase the cost of the blood collection process and represent a serious hurdle for ensuring the safety of blood in the Americas. For example, Dr. Marco Herdoiza, Secretary of Ecuador's Blood Program, found that, in 1998, the probability of finding a donor with a positive marker for hepatitis B, hepatitis C or HIV/AIDS is 12,000 times higher in blood banks that collect all their blood from replacement donors, than those that have at least 60 percent voluntary, altruistic, non-remunerated blood donors.

Programs to promote voluntary, altruistic, non-remunerated donations are practically nonexistent in Latin



A young woman gives blood in a clinic. Blood for transfusion is scarce in all countries in Latin America and the Caribbean.

America and the Caribbean. In a few countries, the Red Cross blood bank may have a mobile team — with both personnel and a vehicle — that collects blood from donors in their workplace, or in social and religious centers. But these are, for the most part, unusual. “The only place I see posters asking people to donate blood is the blood bank,” said a young woman in Managua, Nicaragua. “Why don’t you place them in supermarkets, movie theaters or shopping malls?”

A common belief in all Latin American countries is that donating blood makes a person either gain or lose weight. Others believe that giving blood is literally an act of giving away the essence of life. An individual in Quito, Ecuador, put it this way: “I am not going to give part of my life away... they tell me that by giving blood I also give life.”

We must develop and implement structured social marketing and educational programs aimed at recruiting donors from the population groups that are at low risk of acquiring and transmitting infectious diseases.

The safest blood donors are the voluntary donors who give blood repeatedly. And first-time donors will come back voluntarily only if they receive adequate information and proper treatment from the blood bank personnel. Therefore, blood banks must be accessible and donor-friendly. “It is hard to get to the hospital and, once in the hospital, it is difficult to find the blood bank,” a potential donor in Guatemala City commented. In addition, the infrastructure of the blood banks must be improved. “I not only give my blood and my time, but also must buy the bag to collect my blood,” complained a donor in Asunción, Paraguay.

Attitudes of blood bank staff sometimes aggravate these problems. If blood donors express mistaken beliefs and common myths, blood bank personnel often will treat donors as ignorant. Very seldom will they try to educate them. In fact, more often than not, personnel who interview the potential donors seem to be looking for ways to catch them telling untruths about potentially risky behaviors.

Furthermore — and associated with the lack of harmonized, structured questionnaires and the lack of continued in-service training — staff may miss the point of the interview. On various occasions when I pretended to be a donor, I was turned down because I had just traveled, even though the country I had just traveled from was the United States. Or my age became a question. I was told that in the absence of clear guidelines the blood bank would defer anybody who was “too old.” When I asked the nurse to explain what “too old” meant, she responded, “Anybody over 50.” So I responded, “In that case, I could not give blood” because I was 51. Obviously embarrassed, the nurse told me, “You don’t look 50, you can

donate.” It is clear to us, then, that programs to promote voluntary, repeated, altruistic, non-remunerated blood donation must include an educational component directed at blood bank staff.

With the support of a group of anthropologists, the Pan American Health Organization has developed the “Methodological Guidelines for Socio-Cultural Studies on Issues Related to Blood Donation.” These guidelines have been adapted for local application in El Salvador, Nicaragua, Dominican Republic, Colombia, Ecuador, Argentina and Paraguay.

The research has been used to develop the content of public service announcements taped by Don Francisco — the host of the popular weekly show “Sabado Gigante,” broadcast from Miami to 30 countries. Don Francisco

—Mario Kruesberger in real life — has accepted the task of being the messenger for PAHO’s appeal to the Latin American countries on voluntary blood donation issues. PAHO is also helping national blood authorities develop their own programs, with social marketing as a very strong component.

We are supporting the in-service training of blood bank personnel, using the distance learning approach.

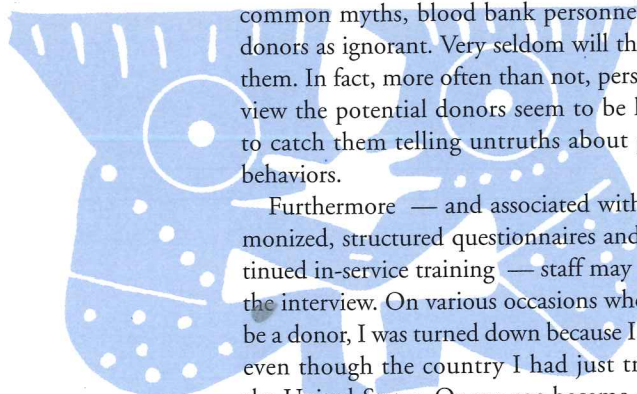
Modules on “Safe Blood and Safe Blood Products” have been developed by the World Health Organization and translated into Spanish by the Asociación Argentina de Hemoterapia e Inmunohematología. Specific programs in academic centers or by health authorities in Mexico, El Salvador, Honduras, Nicaragua, Colombia, Ecuador, Peru, Paraguay, Uruguay, Argentina, Dominican Republic are now using these modules.

To date, more than 5,000 professionals and technicians have initiated the distance learning program on safe blood and safe blood products in Latin America. We expect that with the active participation of the University of West Indies the modules will be applied shortly in the English-speaking Caribbean.

The availability of mobile teams that can collect blood in workplaces, social clubs, churches or other public places is also very important. In addition, they must have adequate resources, including personnel and budget. We believe that the collection of blood for transfusions should be taken out of the hospital environment. If blood banks are accessible to the public, friendly to the donor and properly staffed, they will contribute greatly to voluntary, repeated altruistic donation.

José Ramiro Cruz received his degree of Master of Science (1976) and his degree of Doctor of Science in Virology and Immunology (1980) from the Department of Tropical Public Health, Harvard School of Public Health. He is a regional advisor, laboratory and blood services, for the Pan American Health Organization.

We must develop and implement structured social marketing and educational programs to recruit low-risk donors.



Decentralization

Is It Good For Health Systems in Latin America?

BY THOMAS BOSSERT

WE WERE IN THE MAYOR'S OFFICE in a small village outside Cochabamba, Bolivia to interview officials about the impact of the new Popular Participation Law that had granted municipalities new resources for social and economic programs like health, education, sports and municipal roads and civil works. The mayor was proud of his new proposal to build a hospital to replace the clinic that had only one doctor. I asked him why he thought he could afford a hospital in such a small

village. With good transportation to the large hospitals in Cochabamba, it seemed to me no real need existed for a hospital in his village. He smiled and told me that he did not have to pay the salaries of the doctors – they would be paid by the Ministry of Health, and his new resources would be enough to cover the costs of medicines and other supplies.

"But the Ministry has frozen hiring for the last four years, they surely will not want to staff a hospital where it is not needed," I protested.

He smiled even more broadly and pointed to the main road to Cochabamba and the cement factory on the other side. "I am a popular mayor, and if I lead my village will follow. We just have to occupy the road between the cement factory and the city where they need cement for all their new construction and soon the government will supply the doctors." I could see that the process of decentralization was going to be hard to study with this kind of political interplay between the center and the

Comparative Decision Space: Current Ranges of Choice

| FUNCTIONS | RANGE OF CHOICE | | |
|---|--------------------------|-----------------|-------|
| | NARROW | MODERATE | WIDE |
| FINANCING | | | |
| Sources of Revenue | Colombia, Chile, Bolivia | | |
| Expenditures | Colombia, Chile, Bolivia | | |
| Income from Fees | Chile, Bolivia | Colombia | |
| SERVICE ORGANIZATION | | | |
| Hospital Autonomy | Colombia, Chile, Bolivia | | |
| Insurance Plans | Colombia, Chile, Bolivia | | |
| Payment Mechanisms | Colombia, Chile, Bolivia | | |
| Required Programs & Norms | Colombia, Chile, Bolivia | | |
| Vertical Programs, Supplies and Logistics | Colombia, Chile, Bolivia | | |
| HUMAN RESOURCES | | | |
| Salaries | Colombia, Chile, Bolivia | | |
| Contracts | Colombia, Bolivia | | Chile |
| Civil Service | Colombia, Chile, Bolivia | | |
| Access Rules | Colombia, Chile, Bolivia | | |
| GOVERNANCE | | | |
| Local Accountability | Colombia, Chile, Bolivia | | |
| Facility Boards | Colombia, Bolivia | Chile | |
| Health Offices | Colombia, Bolivia | Chile | |
| Community Participation | Bolivia | Colombia, Chile | |
| TOTAL DECISION SPACE | | | |
| Colombia | 8 | 5 | 2 |
| Chile | 7 | 5 | 3 |
| Bolivia | 9 | 5 | 1 |

A note on terms used in this chart: "Facility boards" are hospital or health center governing boards usually made up of representatives of the community, government and facility staff. "Vertical programs" are programs like immunization, family planning, Tuberculosis and HIV/AIDS projects which are run by the central Ministry as separate activities and not "integrated" into the local level health programs.

local governments. The myths about the advantages of decentralization were going to be challenged.

And the myths were great. Decentralization has been touted as a means of improving the equity, efficiency, quality, and financial soundness of health systems. It is argued, especially by economists, that local people with local information can make much better decisions than distant bureaucrats.

On the other side, there have been fewer voices, mainly Health Ministry officials, who have feared decentralization as an invitation to chaos, disruption of effective priority programs, local patronage, and waste. While decentralization is being implemented in a growing number of countries, there are few studies that show whether the advocates or the detractors are right.

Perhaps too eager to try to fill this gap, I was able to design and implement a series of studies on decentralization in Chile, Bolivia and Colombia, as part of the Data for Decision Making Project of the Harvard School of Public Health. These studies, funded by the LAC Health Sector Reform Initiative of the United States Agency for International Development, selected countries with a significant period of actual implementation of decentralization policies. We sought to use evidence from their experiences to see if decentralization was as good as advocates said—or as bad as my experience with the Bolivian mayor suggested.

"DECISION-SPACE" METHOD

THE RESEARCH WAS CARRIED OUT WITH an innovative "decision-space" methodology, developed at Harvard School of Public Health, to determine the range of choice (from narrow to wide) allowed to local officials for functions such as financing, service provision, human resources, and governance. We found that the "decision-space" varied among countries as well as over time within countries. Countries tended to give wider choice initially, but to reduce the decision space over time. In Chile, for example, municipalities were initially allowed to deter-

mine salaries and to hire and fire staff, but later restored many national civil service protections.

In general, greater choice was allowed over contracting of private services and governance decisions, while the "decision space" for financial allocations tended to be moderate. Human resources, service provision, and targeting of priority programs usually remained centralized. This tended to limit local control over those functions most likely to affect the efficiency of health services. The table shows the ranges of choice for the different countries.

PERFORMANCE

IN EACH COUNTRY WE SELECTED A well-qualified research team and developed a national data base with a minimum of three years of data for municipalities to examine the impact of decentralization. The most important and reliable findings were related to changes in equity indicators at the municipal level.

In all three countries, we found that per capita health spending was increasing during the period of decentralization. In Chile and Colombia, although wealthier municipalities were spending more per capita than poorer municipalities, the gap between them was narrowing over time, resulting in more equitable allocations. In addition, per capita utilization of health services was increasing and the gap between wealthier and poorer municipalities was also declining.

Three important mechanisms seemed to be responsible for greater equity of allocations. In Chile, a horizontal equity fund called the Municipal Common Fund, reassigned up to 60% of the "own-source" revenues from the wealthier municipalities to the poorer municipalities using a formula based on population and municipal own-source income.

In Bolivia, the mechanism earmarks central government transfers to municipalities, requiring that 3.2% of these transfers be assigned to fund a priority benefits package for mothers and children. And in Colombia, a mechanism mandates that a mini-

mum percentage of central government transfers be assigned to health in general by municipalities.

Since these formulas were largely population-based, they appear to have resulted in more equitable spending patterns and perhaps in protecting priority programs. In Chile, municipalities were only responsible for primary health care, so increases in municipal health funding did not go to hospital-based care. In Colombia, a proportion of one type of inter-governmental transfer was assigned to prevention and promotion, which resulted in a doubling of per capita expenditures on these programs and a narrowing of the gap between wealthy and poor municipalities.

CONCLUSION

THESE RESEARCH FINDINGS SUGGEST that neither the advocates nor the detractors of decentralization policies are one hundred percent right. In most cases, decentralization is neither likely to lead to radical improvement in a health system, nor to produce a disaster. However, forms of decentralization that include mechanisms to improve equity, like the Municipal Common Fund in Chile and the earmarking of central funds in Bolivia and Colombia, can definitely improve resource allocations and utilization.

The range of choice allowed to municipalities is quite limited for certain functions that might be needed to improve performance—such as hiring and firing, payments to providers, and decisions about health service norms. It seems likely that experimenting with wider decision space, and appropriate incentives for guiding those choices might be worth evaluating for their impact on efficiency and quality. For instance, had the mayor at the beginning of this story been responsible for the salaries of the doctors, he might not have thought it wise to build an unnecessary and wasteful hospital.

Thomas Bossert is a Senior Political Scientist and Lecturer in the International Health Systems Group at the Harvard School of Public Health.

For complete
report, see

Thomas J. Bossert.

Decentralization of
Health Systems in

Latin America: A

Comparative Study

of Chile, Colombia,

and Bolivia.

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See <[http://www.](http://www.hsph.harvard.edu/organizations/ddm/homepage2.html)

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Carola Eisenberg
with a patient on a
1987 medical mission
to El Salvador.

Physicians for Human Rights

Becoming a Human Rights Activist

BY CAROLA EISENBERG

AS A MEMBER OF A 1983 AMERICAN PUBLIC HEALTH Association delegation to evaluate medical neutrality in El Salvador, I saw mothers and children begging for food and for help in getting back home from detention camps. I saw political prisoners confined under brutal conditions after torture. Although I left my homeland of Argentina as a medical student before the terrible misfortunes of dictatorship, I had been afraid to speak out from a distance lest family and friends be targeted. The El Salvador trip crystallized my commitment to the battle for human rights, and I became a founding member of the Nobel Prize winning Physicians for Human Rights.

My interest in human rights began, you will not be surprised to learn, with my parents. My father was an Argentine proud of the independence of his country, my mother, a Russian immigrant who knew despotism from first-hand experience. Most nights after dinner, my father would read news stories to us and invite us to comment on reports dealing with injustice, and intolerance. Both parents emphasized the importance of education. Although few of the girls in my elementary school went on to high school, there was never any question in our family that I should and I would.

When I enrolled in the medical faculty at the University of Buenos Aires, I was one of a handful of women in a class numbering nearly a thousand. Bizarre as this decision was to some relatives ("Who would ever marry a woman who had seen a naked man!") my parents never wavered in supporting my right to choose. And that was in a country where women had not yet won the right to vote!

After completing my adult psychiatry training, I won a competitive fellowship to study child psychiatry abroad because there were no child programs in Argentina. Despite all her worries about how safe I would be, my mother helped me pack for North America (adding warm undies for the snow we had never seen in Buenos Aires).

I came to the States to stay a year, but the year became a lifetime. I met and married a wonderful man with whom I had, in short order, two children, then and now the light of my life. Although I had left Argentina before Peron, the letters I have from home and the terrible misfortunes that befell relatives and friends (two of whom had their children killed by the secret police) made clear the meaning of dictatorship. Happily, my sisters and their children succeeded in emigrating to North America. (My parents had already died.)

PHR membership is open to all, not just physicians.

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Physicians for

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MA 02116, phone:

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email:

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Although I had been nervous about the American Public Health Association trip to El Salvador because of my concern about personal safety, the experience of Argentina—albeit from a distance—compelled me to join the delegation. There, in El Salvador, I saw political prisoners confined under brutal conditions after torture. I met courageous physicians who cared for the wounded and the sick despite the risk in caring for patients who were on the “wrong” side.

The need to be an activist became critical when spokesmen for the State Department denied, flat out, what we had seen with our own eyes. The dreadful and dismaying history of the U.S. Army training Latin American military officers in counter-insurgency operations was not officially acknowledged until 15 years later.

When Jonathan Fine, a long time medical activist, invited Jane Schaller, Bob Lawrence, Jack Geiger, John Constable and me to join him in founding Physicians for Human Rights in 1986, I did not hesitate. PHR soon received an urgent request for a delegation to visit Chile because the officers of the Chilean Medical Association had been jailed after the CMA demonstrated to defend the right of Chilean workers to protest inhumane conditions. Bob Lawrence of Cambridge Hospital and I flew to Santiago where we visited the imprisoned doctors (after some difficulty). We went to see a young Chilean student hospitalized with severe burns after military police doused her and her partner with gasoline and set them on fire. He died; she survived, but barely so. John Constable, a Massachusetts General Hospital plastic surgeon, evaluated her status to determine whether appropriate burn treatment was available in Santiago. Her parents arranged for her evacuation to a hospital in Canada, where, I am happy to report, her rehabilitation was successful.

Our visit led to a crowded press conference in Santiago, where we demanded that the imprisoned Chilean physicians be freed and that the right to free speech be respected. Did we have any effect? The prisoners took comfort from our visit and the political opposition to Pinochet responded enthusiastically to support from abroad. The imprisoned physicians were freed some weeks after our visit, whether coincidentally or because of what we did, there is no way to know.

In 1988, I went to Paraguay on behalf of PHR to assess the psychiatric condition of an army officer who had taken refuge in the Venezuelan Embassy. He was a recently released prisoner who had been tortured during the dictatorship of General Stroessner, then still in power. The documentation I provided gave grounds for the Papal Legate to intervene with the Paraguayan Government to obtain a permit for the Captain to fly to Spain for asylum.

Since then, Physicians for Human Rights has expanded its horizons enormously. The United Nations has called on our forensic pathologists to exhume and identify bodies using DNA testing. PHR delegations have visited Palestinians held in Israeli detention camps, victims of apartheid in South Africa, Kurds mistreated in Turkey and Iraq, women repressed by the Taliban in Afghanistan, refugees from the civil wars in Somalia and Rwanda, Albanian victims of Serbian war crimes in Kosovo. In this country, many of us have volunteered to examine some 300 refugees claiming political asylum because of torture and mistreatment. Our court testimony has been crucial in instances when the U.S. Immigration and Naturalization Service had refused legitimate claims. PHR was awarded a share in the Nobel Peace Prize for its contribution to securing an international ban on land mines (signed by 139 nations and ratified by 105; every NATO nation except Turkey and the United States is among that number).

I am proud to be an officer and a member of an organization that takes its mission from the Universal Declaration of Human Rights; to defend “the inherent dignity and inalienable right of all members of the human family to freedom, justice, and peace in the world ... to life, liberty, and security of person.”

Dr. Carola Eisenberg, MD, a Lecturer in Social Medicine at Harvard Medical School, was formerly Dean of Student Affairs, first at the Massachusetts Institute of Technology, then at the Harvard Medical School. She is a founding member of Physicians for Human Rights.

Harvard Interfaculty Initiative in Health Policy

The Interfaculty Initiative in Health Policy addresses the complex problems of health care policy, delivery, economics, and management through a program of research and education. The Initiative's approach is interdisciplinary: the Medical School, the School of Public Health, the Business School, the Faculty of Arts and Sciences, and the Kennedy School of Government all contribute their unique perspectives to this enterprise. The academic focus of the Initiative includes a Ph.D. Program, an undergraduate certificate program in health policy including new undergraduate courses in health policy, and an Executive Program.

■ The Initiative's goals are not only scholarly. The Health Policy Initiative aims beyond the academy to advance the national discussion about health care and to contribute to efforts at change. Joseph P. Newhouse, John D. MacArthur Professor of Health Policy and Management, is the faculty chair of the Initiative. For further information, please visit the Initiative's website at <<http://www.fas.harvard.edu/~healthpl>> or contact Joan Curhan, Administrative Director <Joan_Curhan@harvard.edu>.

Reproductive Health

Building Women's Citizenship

BY BONNIE SHEPARD

ON A HOT, DUSTY DAY IN THE middle of a long drought, I attended a day-long assembly convened by the Ministry of Health's Reproductive Health and Family Planning Program in Chulucanas, the provincial seat of Piura, Perú. The bare auditorium with wooden seats had no ventilation, and held about 200 people — mostly women — wiping sweat from their brows and fanning their faces with whatever pieces of paper were at hand. Present were more than 100 representatives of the Rural Women's Networks from throughout the rural region of Alto Piura, all of the midwives and some health authorities of the zone, municipal authorities, and non-governmental organizations (NGOs). The 1995 meeting was called to present the findings of a participatory evaluation on the quality of the women's health services in the public sector, part of a national experiment in women's participation in the health sector. The evaluation, conducted by a local NGO, included surveys of health providers and clients, as well as observations in health centers. It is a testimony to these women's commitment to dialogue that in spite of the oppressive heat, most of the participants were still in the auditorium, talking with each other, at the end of the day.

Notable among the women's findings were the presence of some new issues related to reproductive health, not traditionally addressed by the health services — problems within the couple, and domestic violence. After both providers and women's organizations had noted the need to provide a more holistic service, the midwives presented their work plan for the year: two Pap smear/cervical cancer prevention campaigns and two sterilization campaigns, at appropriate 3-month intervals. (In Peru, a

"campaign" is usually modeled on the traditional vaccination campaigns, aiming for maximum coverage over a limited space of time, and waiving the usual fees for the services.) An NGO representative got up after this presentation and said, "Wait a minute. What does this have to do with everything we just heard?" After all, what

returned home without their reading. While this meeting did not discuss the ethical problems in the sterilization campaigns, chilling accounts of coercion emerged shortly thereafter. While the outcome of the meeting was inconclusive and frustrating, it was just the beginning of a longer process of change.



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was the point of having this evaluation, if the work plans were already set in stone before the meeting? In the ensuing discussion, it soon became clear that little could be done; the mandates for the campaigns came from the central authorities in Lima.

Further dialogue revealed serious ethical problems with the cervical cancer campaigns, in particular because of user fees. The drought meant many *campesino* families were desperately short of cash. The women in the assembly complained that while the Pap smear itself was provided free during the campaigns, they had to pay for the return visit to learn the results, and some testified that they had

The meeting in Chulucanas took place at the end of the first phase of a five-year program in Perú organized by Consorcio Mujer. Similar evaluations and dialogue meetings took place in 1994-1995 in Cusco, Tarpoto, and in three low-income neighborhoods in Lima. From 1996-1999, the program trained both women's organizations and providers in concepts of users' rights and helped them to design joint work plans to improve the quality of a key health center, usually one that was to serve as a "hub" under the ever-evolving decentralization plans of the Ministry of Health. At the time, I was closely connected with the Consorcio Mujer program

Latin American women are demanding quality care.

as its funder. I was the Program Officer for the Ford Foundation in Santiago, Chile, where I was in charge of the sexual and reproductive health program for the Andean and Southern Cone Region.

I had many conversations with the Peruvian women's organizations about the theoretical and political framework for the Consorcio Mujer program. We saw this effort as an experiment in ways to encourage a transition to democracy in the health sector, just as similar transitions were occurring in the political realm in many countries in Latin America. We recognized that many efforts in the public health and population fields have been devoted to working with health providers and family planning services to improve quality of care and respect for individual rights. On the other hand, only feminist and some community health NGOs have worked consistently on transforming the "demand side" of the system — the users. In the traditionally vertical context of a biomedical setting, both providers and users are prisoners of unspoken assumptions and corresponding roles in a paternalistic system.

The shift to a more democratic system entails greater consciousness of and respect for users' rights on the part of providers, and both consciousness of rights and the ability to demand respect for these rights on the part of users. To achieve this shift, a profound process of questioning of assumptions and attitudes on both sides is necessary. Programs may implement more conventional measures such as changes in indicators of quality, mechanisms for user feedback and community involvement, and greater quality-related incentives, but changes in attitude are fundamental. Furthermore, few examine how health sector reforms and the financing of services create incentives and disincentives that affect quality and respect for users' rights. How can programs help users construct their identities as citizens with rights, so that they demand their rights and recognize violations of rights? How can

programs help health providers respect these rights within the framework of improving quality, and help them be more receptive to horizontal relationships with users? The Consorcio Mujer program was designed to respond to these questions.

When adequate health care is framed as a basic human right, the whole dynamic surrounding attempts to improve quality of care changes. Under the paternalistic model, health services benefit users, and health providers are doing low-income people a favor by serving them. It is viewed as extremely bad manners to complain about the quality of favors received. In a citizenship model, the service is a right, not a favor, and users have the right to decent quality as well. In the paternalistic relationship of provider and patient, the provider knows what is best. In a democratic relationship of equals, the user has a right to information, and participates actively in health promotion with the providers. Several quotes from the training courses throughout Perú illustrate this shift.

'Before the providers were the authority, and the patients asked us to help them as a favor. Now we say, 'We are employed thanks to the patients.'
—Clinic Director, Lima

'Now we can complain and denounce mistreatment. We communicate with the superiors.'
—Leader, women's group, Tarapoto

Pilar Puente, the former project coordinator in Piura, described the process in the users' training workshops: "What is new about the module is the concept of citizenship and rights. While the women [community health promoters] already had some idea of these concepts, now they were able to internalize them. The women reflected deeply. At the beginning of the training, they said that the quality of the services was just fine. Then, as we probed more into the different aspects of users' rights, the incidents of violations emerged — having to do with lack of privacy, inadequate information, mis-

treatment At the beginning, I didn't think that the women were going to open up, but I was wrong. Little by little, they began to talk about everything they had left unsaid, and to express it with all their emotions. One woman wept as she described how she had been humiliated."

This process Puente describes is a vivid reminder of the limitations of user surveys in health care; when women have low expectations, little consciousness of their rights, and low self-esteem, they are not apt to express dissatisfaction with services. She also illustrates the psychological/social aspect of the processes of change leading to more democratic cultures; feminists and human rights activists in Latin America describe this aspect as "constructing oneself as a bearer of rights (sujeto de derechos)." Some more prosaically refer to constructing "self-esteem," but the psychological community-based goal is more than that, since the change process is not just individual, but involves recognizing oneself as part of a group (citizens, women, low-income neighborhoods, youth, etc.) with rights. Constructing democratic cultures involves transforming both governments and the populations they govern, both health systems, and those they serve, on many levels. The social and cultural levels leading to recognition and defense of citizen rights are a necessary part of the change process.

Bonnie Shepard was a Visiting Fellow at DRCLAS from 1998-2000 and conducted research with support from the Ford Foundation for a more comprehensive case study based on the Consorcio Mujer programs and other programs in the Andean and Southern Cone Region. She is now a consultant, a member of the Board of Directors of the Boston Women's Health Book Collective, and a Visiting Fellow at the François-Xavier Bagnoud Center for Health and Human Rights in the International Health and Human Rights Program at Harvard School of Public Health. She can be contacted by e-mail at <Bonnie_Shepard@alumni.ksg.harvard.edu>.

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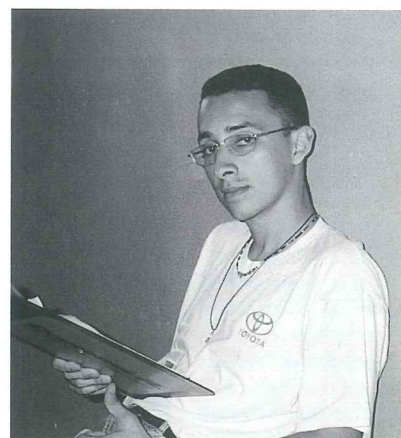
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JUNE CAROLYN ERLICK



Doctors in the Field

Mission to Honduras

BY JUNE CAROLYN ERLICK

ZAMORANO, HONDURAS — THE FAMILY OF EIGHT RURAL villagers crowded on a narrow wooden school bench in the improvised clinic. They had traipsed from their tiny village, almost two hours more into the mountains, to the schoolhouse-clinic in the Honduran hills a half-hour ride and a world apart from the prestigious Zamorano College.

Medical brigade volunteer Dr. Wei-jen Chang asked them patiently through an interpreter what the problems were. And they were multifold. The bad colds in two of the children turned out to be pneumonia. And then there were the problems with asthma, headaches, machete wounds, malnutrition, and parasitic infections. Chang gave them as much sage medical and practical advice as he could muster, and then sent them to the “meds” table staffed by Linda Jo Stern, the director of the Brigham and Women’s Hospital Medical Mission to Honduras, and Reyner Maradiaga, who works in rural development for Zamorano in the surrounding Yeguaré region.

At the improvised pharmacy, the family could pick up medicine, collected by the mission for this purpose, and resume its hike home.

For five days, Chang and his colleagues — doctors, nurses, midwives and dentists, accompanied by Honduran

dentists and medical students—listened to the concerns of the poorest of Hondurans and tried to do something to at least alleviate some of the problems.

“It’s a level of involvement that’s difficult to replicate,” said Dr. Edwin Rock, a medical resident at Brigham and Women’s Hospital, a Harvard teaching hospital.

The Medical Mission is in its third year. All the brigade members take vacation time from their jobs and pay their own way, volunteering to serve this poor region that was even further devastated by Hurricane Mitch two years ago. Mitch destroyed roads, bridges, water supplies, and agricultural crops. The needs are immense. When a medical student told a mother she should boil her water, he received a frustrated answer: there isn’t enough wood left to make fires to boil water. A doctor cautioning a patient to eat more vegetables received a stare: “It isn’t the season for vegetables.”

It’s a two-way street. Villagers receive health care and medicine and even such simple needs as dandruff shampoo and aspirin. Doctors and medical students come back with a more thorough understanding of the complex needs and interwoven social issues of health, sanitation, and education, as well as some practical training in tropical diseases and ailments they might not see in Boston. One

Clockwise: A mother waits for medicine; Honduran medical student Jairo Caballero examines his chart; U.S. volunteers set up the schoolhouse clinic.

(above) Volunteers distribute fluoride to children; (below) Linda Jo Stern and Reyner Maradiaga give out medicine.



JUNE CAROLYN ERLICK

For more information about the BWH Medical

Mission to Honduras, contact Linda Jo Stern at (617) 983-4242 or <ljstern@partners.org>. You can also visit <www.pih.org/honduras> on the Internet.

might even call the brigades a three-way street at this point, since the brigade collaborates with the Honduran Ministry of Health and works together with Honduran dentists and medical students.

"This has been an amazing experience for me," said Jairo Caballero Valle, a fifth-year medical student at the Honduran National University in Tegucigalpa, who was on his second brigade. "It's been a chance to work alongside U.S. doctors and to learn something about another side of my own culture too."

Six brigades a year go from Boston to rural Honduras to provide basic medical and dental care to the villagers, whose average income is \$3 a day per family, according to Peter Doyle, who runs Zamorano's rural development department.

"Families are getting poorer because of the lag effect from Mitch," he observed. "That's why you get 2000 people attended by these brigades. Health and tourism are very critical for rural development, and these are areas where Zamorano hopes to have more impact."

Zamorano hopes to strengthen its formal relationship with the brigades and to work on issues of health education and structural reforms, as well as medical delivery, Doyle said. The college, primarily an agricultural school, received three years of funds from the Kellogg Foundation in 1997 to strengthen its social and community projects. The project was called UNIR—the Spanish word for "to unite."

"We're trying to build on top of what we started with UNIR," said Doyle. "And health is an important cornerstone."

Stern, the energetic director of the brigades, who also is the executive director of the Southern Jamaica Plain



Health Center, made her first trip to Honduras in 1994. The missions were an outgrowth of a Falmouth-based organization called Cape CARES. Stern partnered with Dr. Helen Burstin of Brigham and Women's Hospital, Zamorano, and Partners In Health to extend the project.

"The goal now is to provide resources, support, and training for the Honduran health care providers so they can serve the people of their country," she commented.

She now wants to extend the project even further, hoping to raise funds for a full-time commitment to the project to work more intensively on its health education and community development aspects.

"The medical brigades are a challenge, an opportunity for learning and service, and they make a small but real difference in the world," commented Stern on the July brigade to Honduras. "It's much different to see the reality down here than telling people about the limited resources in a conference room in Boston."

June Carolyn Erlick is publications director at the David Rockefeller Center for Latin American Studies.

Medicinal Herbs in Times of Low Intensity War

The Case of Chiapas, Mexico

BY RAUL RUÍZ

JULIO WAS WET FROM THE POURING rain and frightened. He ran through the streets of Polho, a community in Chiapas sympathetic to the Zapatista rebels, to find Carlos, the health promoter. He explained to Carlos, in Tzotzil that his young wife Ana had delivered their first child an hour ago and was still heavily bleeding at home. I ran with the student nurse to the clinic's poorly stocked pharmacy to get the postpartum hemorrhage kit.

We put on our plastic ponchos and heavy boots and followed Julio and Carlos in a straight line an arm's length from each other in order not to get lost in the thick nocturnal clouds. I tried to balance myself walking in a mudslide down the hill from the clinic but fell twice. Everyone but the nurse laughed at my mud soaked pants and inexperience with extreme conditions of poverty.

We arrived 40 minutes later. Julio's tiny one room home was constructed from horizontal wood planks supported by four corner posts and draped with thick plastic sheets. A small fire in the center of the dirt floor used for light and heat produced a thick smoke that irritated my eyes and throat. Ana, covered with old colorful Mexican blankets was lying on her wooden plank bed holding her newborn girl, Esperanza. Ana's mother, standing near a corner worried, directed two adolescent girls to mend the fire, get water, and keep the children out of the way.

I stayed by the door to protect Ana's modesty as the nurse checked her vital signs and performed the exam. The blood pressure was stable and the bleeding stopped.

The entire family smiled at the good news and thanked us in Tzotzil.



Herbal medicine is also popular in Cuba. Here, photographer Héctor Delgado from Cuba depicts a traditional cure prepared with earth from 21 places, among other ingredients. The doll represents death.

They said that a *partera* (traditional midwife) delivered the baby but left the complications for a doctor to handle. My stomach cringed as I asked myself what if the nurse and I were not there? If she continued to bleed would Ana have died? On my way out I gave one last good look at the house to imprint it on my memory forever. On the ground near Ana's bed were three neatly tied bunches of herbs.

As a Harvard medical student with a Paul Dudley White and Andrew Sellar Traveling Fellowship, I spent eight months investigating the use of

herbs by health promoters in Chiapas, a state in southern Mexico that has experienced a state of low intensity warfare for the past six years. I interviewed several directors from non-government health organizations, doctors, curanderos, and countless health promoters from the highlands and jungle. I worked at two clinics and helped the organization, Equipo de Atención y Promoción de Salud y Educación Comunitario (EAPSEC) — a sister organization of Harvard Medical School based Partners in Health — train health promoters in preventive medicine and primary care.



HECTOR DELGADO-chidalgado@eubarte.cult.cu>

Photographer Héctor Delgado made this photo in Cuba. Herbs are prepared with powdered eggshell, perfume, liquor, tobacco smoke, and holy water.

I wanted to better understand the factors that influenced health promoters' use of herbal medicine.

My initial understanding of herbal medicine as a viable substitute for Chiapas's scarce health care services changed to a deeper understanding of the socioeconomic and political interplay between using the herb or the pill. Poverty, war, *indigenismo*, the culture of medicalization, and their lack of knowledge of herbal remedies influence the health promoters' motivations and limitations in using medicinal plants.

Julio and Ana's story illustrates the multifaceted dimensions of health promoters' use of herbal medicine. It demonstrates the lack of health resources that leaves women like Ana needing to rely on traditional medicine such as *parteras* and medicinal plants. A study by El Colegio de la Frontera Sur in San Cristóbal de las Casas revealed that only 14% of births are attended by doctors or delivered in a hospital or clinic. Chiapas has the fewest doctors and nurses with only one doctor for 18,900 inhabitants in the conflict zones. It also has the least number of hospital beds and operating rooms, with only one available for 3,000 and 83,300 people respectively.

In Polho, one doctor from the Mexican Red Cross and one temporary doctor from Doctors of the World, two Mexican medical students and a nurse on their mandatory rural year of service, and indigenous health promoters serve 8,000 people. Most villages I visited, however, were completely dependent on minimally trained health promoters. Most communities had no doctors, clinics, or pharmacies, and in some, the nearest clinic or pharmacy was a six hour walk away.

Low intensity warfare compels health promoters to use herbal medicine.

Health promoters desperately seek resources. Herbal medicine, in Mexico's most bio-diverse state, seems to be the only plausible available form of therapy. Health promoters say they use herbal medicine because they "cannot afford medicines." One health promoter in broken Spanish said, "the government never attended our suffering. We struggle to find

someone in our community who can cure with plants." Another said, "we want medicines and clinics in the communities but there is no place to buy [medicine] and the doctors can't send them. We are abandoned like the government's trash. The problem is that we don't have medicines because we don't know how to organize. The rich make medicines from plants. We need to do the same."

Furthermore, the low intensity warfare compels health promoters to use herbal medicine. Since the cease fire agreements in January 1994 between the Mexican Army and the Zapatista Army for National Liberation, the Mexican government militarized Chiapas with a third of its forces and promoted the formation of paramilitary groups to terrorize Zapatista sympathizers. Julio and Ana are two of 5,000 refugees in Polho displaced from their communities.

Physicians for Human Rights (see related article, p. 13) documented multiple violations of the neutrality of health care. Health promoters concurred that the Mexican government causes divisions among community members by providing aid only to non-Zapatista sympathizers, uses state police and soldiers to assist the Mexican Red Cross deliver medicine, and interrogates clinic patients suspected of being Zapatista sympathizers. Moreover, military and immigration checkpoints are located in strategic entry sites creating fear and limits on community members' ability to travel and organize. They also harass international human rights observers and providers of humanitarian aid, according to Physicians for Human Rights and local non-governmental organizations.

To avoid the risk of interrogation and harassment, health promoters see herbal medicine as a means to be independent from government services. One promoter said, "we need to be prepared with medicinal plants [and] train more people in other collective work in order not to depend on the government." Another questioned, "if there is war and we don't

know how to use medicinal plants, how will we treat the indigenous?"

Indigenismo, a movement to increase awareness and pride in the accomplishments and cultures of indigenous peoples, also motivates health promoters to use medicinal plants. To many health promoters, herbal medicine is a form of identity and connection to their history. This is evident when a health promoter said, "our culture like our ancestors who cured with medicinal plants are really important and need to be respected." A health promoter in Polho added, "... that's what our ancestors used. [Allopathic] medicine have side effects and can not cure everything." Others said that the herbal medicine was better because their ancestors were healthier and lived longer. They mentioned certain culturally specific ailments such as *empacho*, *alteracion*, and *susto* that western doctors could not treat. Health promoters seemed to justify their use of herbal medicine and intended to claim value in their traditional practices.

Historically, Christian missionary doctors and government personnel from the Indigenous National Institute in the '50s and '60s tried to undermine traditional beliefs to assimilate indigenous Chiapanecans to western philosophies and the mestizo culture. As a result, a competitive and unfriendly interaction between allopathic doctors and traditional healers was reported in the interviews with health promoters. Graciela Freyermurth, a medical anthropologist in Chiapas, confirms these observations.

Some health promoters however, prefer pills to herbal medicine; they associate allopathic medicine and the pill with modernization and prestige. That is the manifestation of the assimilated culture of medicalization. A health promoter said that "the people do not believe [in traditional medicine] because private doctors give pills and devalue traditional medicine. Most people request the pill." A health promoter in Polho said that it was "difficult using herbs

because the people want medicine." His idea of a bad doctor was one "that disrespects us and does not give medicines." Some health promoters simply believe that pills work better than herbal medicine.

Moreover, many health promoters, like Carlos in Polho, do not know how to use medicinal herbs. Ana's *partera* used the three bunches of herbs I saw on the floor; Carlos observed he knew little about herb usage. Some health promoters are refugees or migrants unfamiliar with local plants. Their minimal knowledge was learned from family members and non-governmental health organizations such as EAPSEC or the Catholic Church, but rarely from *curanderos*. Some claim that *curanderos* are not willing to teach their trade since it is their source of income and hierarchy. "In these days," a health promoter said, "curanderos charge 200 to 300 pesos in the community and even ask for a chicken."

Rafael Alarcón, the director of the

syrops, tinctures, and salves.

Nevertheless, the creation of herbal gardens and remedies requires resources that health promoters do not have. Time attending herbal gardens or making remedies is time away from their work in the harvests. Money is needed to buy gardening tools, containers, syrup, and vaseline to make medicinal syrups and salves and to build adequate storage rooms.

Relying on herbal medicine to curve Chiapas's adjusted infant and maternal mortality rates, which are amongst the worse in Mexico, is an overly ambitious goal and as Ana's *partera*, neglectful. Chiapas will still lead the nation in deaths due to diarrhea and have the second lowest access to immunization coverage and the fourth lowest life expectancy. Therefore, given Chiapas's poor health indices, and its immediate need, priority and resources should wisely be directed towards adequate and effective allopathic systems of care and treatments. Only then will



Raul Ruiz made this photo of a health promoter in the Moises Ghandi community in Chiapas, Mexico. The markers— in Tzeltal— name the plants and their uses. A *curandero* helped the community to plant the medicinal herb garden and trained health promoters in their use.

Organización de Medicos Indígenas in Chiapas (OMIECH) said that herbal medicine is a dying knowledge that needs to be rescued. One health promoter observed, "we need to rescue and practice our traditional medicine and customs to better our health because if we don't we will lose our tradition." In response, *curanderos* from OMIECH hold workshops to train health promoters how to use herbal medicine and make medicinal

herbal medicine be a true "alternative" and infants like Esperanza can hope for available health resources. Otherwise, herbal medicine will remain to be the only dying option.

Raul Ruiz, a member of the Partners in Health Chiapas Health Project, is an MD and MPP candidate class of '01, Harvard Medical School and Harvard University's John F. Kennedy School of Government. He

Program in Clinical Effectiveness

An initiative of the Hospital Italiano, Faculty of Medicine of the University of Buenos Aires and Harvard School of Public Health

BY ADOLFO RUBINSTEIN

AS A FAMILY PHYSICIAN, I'VE ALWAYS BEEN INTERESTED in primary care and also in the broader perspective of health care systems focusing both on the individual patients and on populations. That's why I became involved with the Argentine Program on Clinical Effectiveness, co-directed by myself and Fran Cook of the Harvard School of Public Health (HSPH).

I am often startled that Argentina spends approximately \$650 per person per year in health care. This figure represents more than 7% of the GDP (Gross Domestic Product) and more than 40% of it corresponds to out of pocket expenses paid by the families or individuals who can afford some kind of private insurance. Despite the fact that per person expenditures are the highest in Latin America, more than 40% of the people, probably those who need it most, lack health care coverage and therefore rely on an increasingly impoverished public health care system.

The children and maternal mortality rate is extremely high, and in more than 60% of the cases deaths could be avoided with a correct and timely diagnosis and treatment. Cuba, Chile, Uruguay and Costa Rica spend much less than Argentina but they show lower neonatal and infant mortality rates. These results are much more surprising if we consider that, except for Uruguay, the number of beds and physicians per person in Argentina is higher than in the rest of Latin America.

Since I was also interested in the field of epidemiology, I wanted to learn about ways to improve the effectiveness of interventions in the day-to-day clinical practice setting. Unfortunately, there was not such a program in Argentina.

In 1994 I decided to apply to the HSPH Clinical Effectiveness Program. Soon, I realized that all that I had been seeking was already there. I found an atmosphere of academic excellence, superb and warm faculty and students, and very high standards in all the courses I had the opportunity to take. Undoubtedly, that was the program that met all my expectations.

At that time, my brother Fernando, also a primary care physician, had recently returned to Argentina with a Master's in Public Health from San Diego State University.

We had talked many times about working together in the field of primary care, epidemiology, clinical research, health policy and health services research. In April 1996, we were in New York for a meeting of the Society of General Internal Medicine. We were walking downtown along Fifth Avenue and right where it meets Broadway, facing the Flatiron building, we dared to imagine for the first time what would be like to set up a program in Clinical Effectiveness in Argentina with the HSPH support.

Of course we had the perfect model with the Harvard program, but we did not know if there was any chance of getting Harvard interested in it. Although it surely was a long shot, I thought about talking this idea over with my Harvard mentor: Dr. Fran Cook.

I timidly started asking his opinion about the project and, to my great surprise, his response was incredibly supportive and encouraging. He became a crucial source of ideas, advice and key contacts to turn this ambitious idea into a real training program.

THE PROGRAM

WE WERE ABLE TO RECRUIT A GREAT GROUP OF INCREDIBLY enthusiastic faculty members, who were committed to the idea. We met once or twice a week to discuss every single detail, from academic programs, course syllabi and evaluation strategies to the quality and quantity of the pastries to be served during the coffee breaks and of course, the chronically constrained budget.

In May 1998, we signed the awaited Memo of Understanding (MOU) with Fran and Dean David Shore at HSPH and celebrated the realization of a dream.

Today, the Program of Clinical Effectiveness is a two-year Master's Program of the University of Buenos Aires jointly organized by the Hospital Italiano de Buenos Aires (our home Institution and a large teaching hospital), the School of Medicine of the University of Buenos Aires and HSPH.

The program, which started in 1999, today has more

The second year class of the Argentine Program in Clinical Effectiveness.



than 80 students between first and second year. Most of them are medical doctors with leadership positions in public and private health organizations. The curriculum was developed by the local faculty with strong collaboration from the faculty in the Program in Clinical Effectiveness at HSPH.

We thought it would not be feasible to set up a summer program for the first several years, so we designed it as a two year program with classes meeting every fifteen days (14 hours) and home assignments in between. Approximately every two months a week-long series of lectures are given by local faculty and visiting faculty, mostly from Harvard University. At the end of the two years, students receive a Certificate issued by the Program in Clinical Effectiveness of the Hospital Italiano and Harvard School of Public Health. Then, those who complete their Master's Thesis obtain the degree of Master in Clinical Effectiveness of the University of Buenos Aires.

WHY CLINICAL EFFECTIVENESS?

PLANNING HEALTH SERVICES AND MANAGEMENT OF health care organizations, as well as most medical practices, are often based on uses, customs and experiences, many of them not scientifically grounded. Moreover, the current situation of the country together with the dynamic changes that we are facing makes it necessary for doctors and other health professionals to acquire new skills in order to implement different and broader approaches. This is where the field of Clinical Effectiveness, a new basic science of clinical practice, comes into action. In this context, Clinical Effectiveness provides better information through basic tools and methods for the analysis of population problems in order to:

- Reduce the nature and extent of health care errors in health decision making.
- Improve medical practice based on existing evidence.
- Use programs for improving the quality of care when planning Health Policies and Services.
- Acquire skills to design studies to generate new evidence

This field has grown around the world in the last decade due to the dynamic changes of health systems that also occur in our country. These changes include not only a financing crisis but also a policy, and quality crisis affecting the current health care system. This process requires the incorporation of new training techniques for those in charge of the decision making process in order to adapt and evolve in today's scenario.

What are the contents?

The Program includes a group of disciplines that trains doctors and other health professionals in the practical application of the necessary tools for clinical and epidemiological research, technology assessment, health policies and health services research. The courses focus on the development of quantitative skills to allow students, at the end of the program, to perform analyses of critical information for the decision making process, especially regarding the impact of clinical practices and health policies.

WHO SHOULD ATTEND?

THE MAIN PURPOSE OF THIS PROGRAM IS TO GIVE TOOLS to close the existing gap between the physician in his medical activity and the physician or health professional in his management position. Its ultimate aim is that of offering a health 'evaluating attitude.' The Program of Clinical Effectiveness is directed to selected health professionals, leaders in the health care industry (physicians, non-physicians leaders of health care organizations) who wish to contribute with the application of their knowledge in other health care settings.

FACULTY

CORE FACULTY IS DRAWN FROM PROFESSORS FROM THE Argentine Program in Clinical Effectiveness and Harvard School of Public Health who travel to Argentina during the school term. Local faculty is chosen for their academic expertise and all have solid training in their fields, both from Harvard and other important Universities from the US or Canada.

PURPOSE OF THE PROGRAM

THE PROGRAM OF CLINICAL EFFECTIVENESS IS CURRENTLY recognized as the most dynamic program of the country in regards to health policy and management, and clinical and outcome research. In June 2000, our program became an associate member of the Cochrane Collaboration in Argentina, a non-profit international organization led by Oxford University and McMaster University which aims to promote the evaluation of the effectiveness of health intervention. In the near future, we aim to create an Institute for the Evaluation (Assessment) of Health Technology and Policies in order to fill an empty gap that still exists in our country.

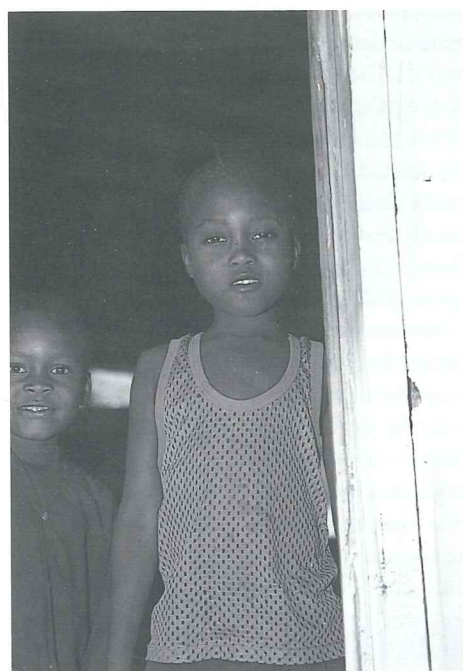
Health providers and financing agents from different sub sections within the health care system have to improve the effectiveness and efficacy of services due to the health care cost-containment crisis. In this framework, the training of experts that may lead health organizations towards that objective will be a high priority in the near future.

Being at this crisis point of poor results and great inefficiency of the health system, such initiatives as those of the Program of Clinical Effectiveness, are fundamental. For any country that takes human resources seriously, a different training, designed for those playing an active role in the evolution of the health care system in order to improve effectiveness, quality of care and rational use of resources, is extremely important.

Adolfo Rubinstein MD, MSC, Hospital Italiano. Facultad de Medicina. Universidad de Buenos Aires, and Fran Cook ScD, Program in Clinical Effectiveness. Harvard School of Public Health, are co-directors of the Program in Clinical Effectiveness, an initiative of the Hospital Italiano, Faculty of Medicine of the University of Buenos Aires and Harvard School of Public Health. Dr. Rubinstein can be reached at <dolrub@hitalba.edu.ar>.

**The Program
of Clinical
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two-year Master's
Program of the
University of
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jointly organized
by the Hospital
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the School of
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University of
Buenos Aires and
Harvard School of
Public Health.**

The Hope of Haiti:
Its Children



Health: the Hope of Haiti

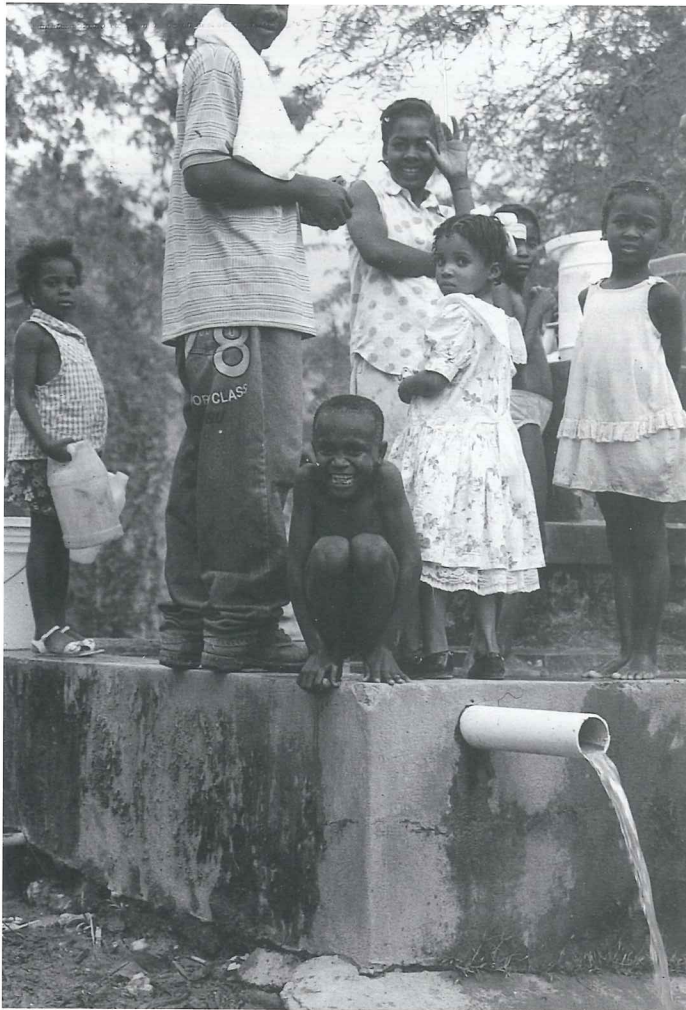
PHOTOESSAY BY MARK MOSELY

MY WORK IN HUMANITARIAN ASSISTANCE HAS TAKEN ME TO 30 countries on five continents over the last decade. At no time have I felt more vital than in serving at Partners In Health (PIH), and seldom more needed than in places like Haiti.

In the Haitian people, as well as in every other country that PIH serves, we find an incredible courage and capacity to survive. It is with the world's poor, and other community-based organizations such as

Sócios En Salud (Peru) and Apoyo A Mujeres and Guatemalan Refugee Project (Mexico), that Partners In Health struggles against the forces of poverty and, in doing so, we strengthen ourselves.

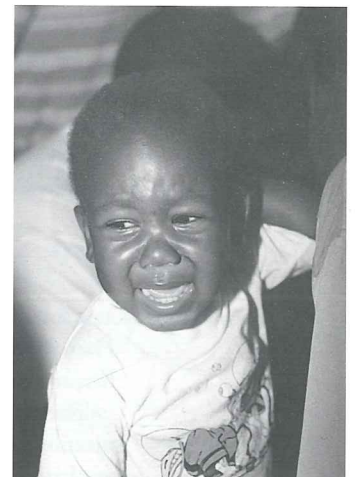
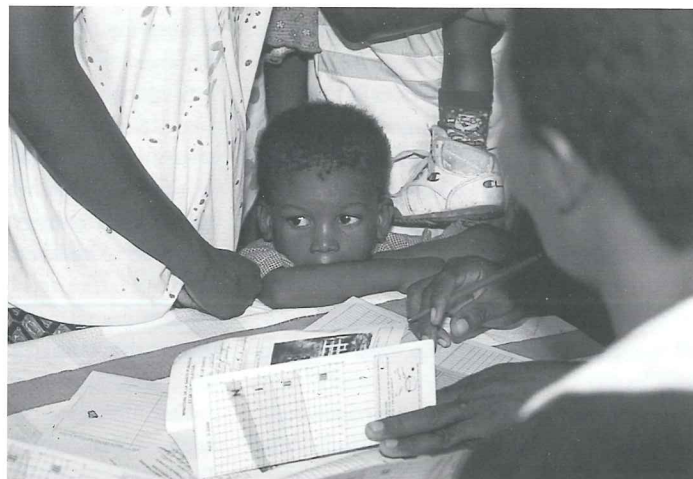
Serving beside these incredible human beings also teaches to blend good medicine and social justice to fight economic and political structures which create their poverty—the true cause of most healthcare challenges in the developing world. We need to make health a right,



Water for the Soul: Community wells reaching deeper than despair



Immunization Day: An ounce of prevention is worth a pound of cure



whether we achieve this through health surveillance, clinics, laboratories, water wells, sanitation projects, education, or a tuberculosis prevention project, it's about people, not statistics. Haiti does not allow you to insulate yourself from the truth that we all bleed and die the same.

Many ask us if the struggle is a losing battle, if it's worth it. Just ask the mother whose child survived cholera for the cost of your

cappuccino or the father who just learned that using clean water from the new community well means his family will avoid many sicknesses which kill millions every year.

Or look into the faces of the children staring out at you from these pages who now have a future—and judge for yourself.

Mark Mosely is Director of Program Services for Partners In Health.

Infectious Diseases

Looking at Medicine and Social Justice

BY DAVID WALTON

HARVARD MEDICAL SCHOOL'S PRE-CLINICAL CURRICULUM has some telling blind spots. During the first two years, we mostly discussed diseases prevalent in the United States and other developed nations. Many lectures and tutorials were devoted to atherosclerosis and its common variants: coronary artery disease, cerebrovascular disease, and peripheral vascular disease. Other, more common diseases among the world's population were discussed less frequently. Tuberculosis, say, was only given four hours of attention.

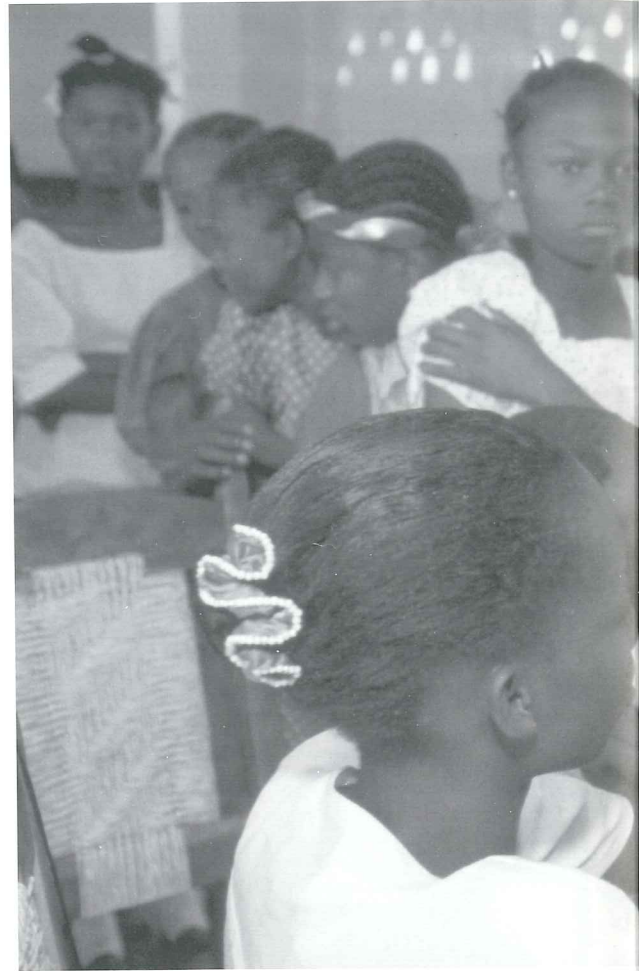
When infectious diseases were finally discussed, our instructors peppered their lectures with comments such as, "Don't worry about this because it is exceedingly rare in the United States," or, "This is not seen in the U.S." They failed to mention that many rare diseases in the United States are significant causes of morbidity and mortality around the globe. Infectious diseases remain the world's single most common cause of death. Recent surveys suggest that some two billion people—nearly one-third of the world's population—are infected with the tubercle bacillus. Coronary artery disease kills some 500,000 Americans each year, most of them elderly; although tuberculosis kills few in the United States, each year it claims almost two million lives, making it the leading cause of young adult mortality worldwide. Complications of HIV infection have joined tuberculosis to become the leading cause of young adult death in many parts of the world. Even in the United States, treatable infections continue to kill the poor. In one cohort of New York City welfare recipients, TB and HIV were leading causes of death. It was as if the first two years of medical school were taught with blinders on, keeping diseases that affect the poor and marginalized out of view.

HAITI

DURING MY PRE-CLINICAL YEARS, I SPENT SEVERAL MONTHS at a small hospital in Cange, on Haiti's Central Plateau. Haiti humbled me, brought tears to my eyes, and lit a fire in my heart.

The clinic, run by Partners In Health and its sister organization, Zanmi Lasante, is located in the destitute Péligre basin of Haiti's Central Plateau. A 1956 hydroelectric dam flooded out thousands of peasant farmers, most of whom received no compensation for their lost land. Over the past 15 years the Haitian staff of Zanmi Lasante has served these landless peasants and their children.

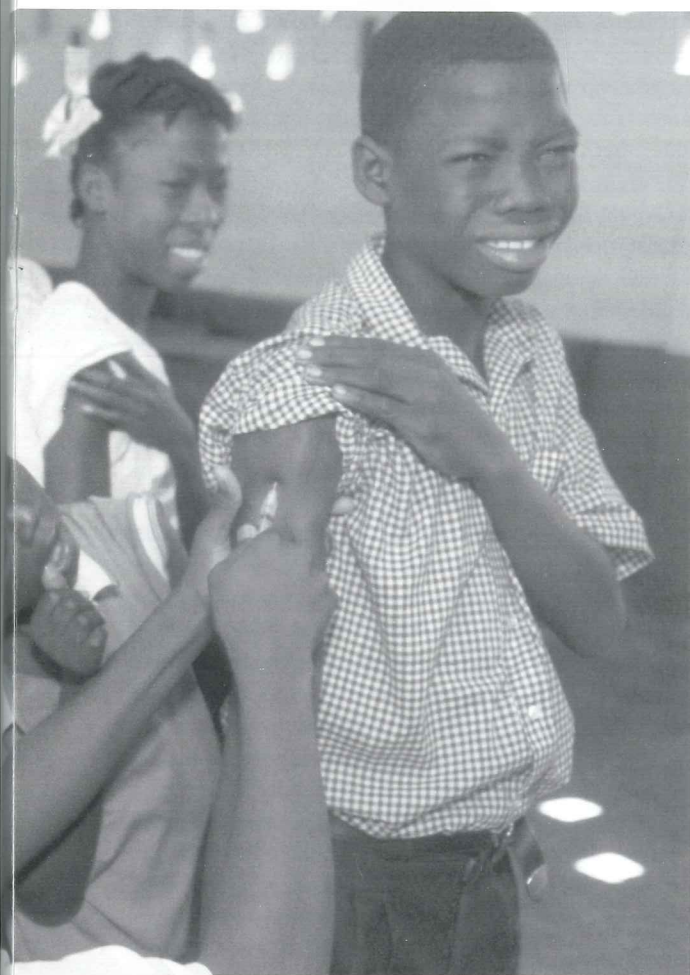
More than 50,000 patients visit the Clinique Bon Sauveur each year. The main clinic has a staff of 50—including six physicians and a nursing staff—and houses 30 hospital beds, four isolation beds, and a



couple of post-operative beds. A new referral center for multidrug-resistant tuberculosis contains 20 more beds. Over the years, Zanmi Lasante has become the largest employer in the Central Plateau, creating jobs for the families that had lost their land.

Most peasants lived in poorly constructed shacks, surrounded by even poorer land. I couldn't believe my eyes when I saw a woman planting seeds in what appeared to be a field of large white rocks. I realized later that there was, in fact, corn growing in the small spaces between the rocks. The hot, arid environment of the deforested Central Plateau acts like a kiln, scorching the earth, making farming virtually impossible. And yet that is precisely what this woman and her neighbors have to do in order to survive, plant corn among rocks.

One afternoon, Dr. Paul Farmer and I stopped to see Adeline, a young woman suffering from advanced HIV disease. Most people in the United States would long since have been receiving treatment with state-of-the-art antiretroviral medications, coupled with antibiotic prophylaxis. But the annual cost of these medications can exceed \$14,000, and initially Partners In Health could treat Adeline only for opportunistic infections. These came in rapid succession. In 1999, she was hit hard by a chronic enteropathy (an intestinal disease that causes a wasting diarrhea). Her weight dropped significantly, and by June, when we



© ARMANDO WAAK/PAN AMERICAN HEALTH ORGANIZATION

saw her, she weighed 79 pounds and was too weak to walk.

That November, Adeline began therapy with three potent antiviral drugs to treat her HIV disease. Adeline does not pay for her medicine; it is donated by supporters of Partners In Health. In addition to medication, she receives financial assistance and nutritional supplementation. Although many public-health experts would argue that it is not “cost-effective” to treat Haitian peasants with expensive medications, it seems that “unorthodox” solutions are necessary for a virus that seems to have settled amongst the poor, much like other infectious pathogens.

A HOUSE THAT'S NOT A HOME

WE ALSO STOPPED TO VISIT ABSOLY, A PEASANT FARMER in the same village. Absoly was physically slight; his thin, sinewy build and work-worn hands revealed a lifetime of hunger and hard labor. Fifteen years ago, before the hospital in Cange was constructed, he fell victim to a serious infection in his right leg. The unchecked infection progressed until it damaged the blood supply to his leg. The residual, necrotic tissue created an ideal environment for parasites, and his leg soon became infested with maggots. With the help of his family he was eventually able to reach the nearest hospital, some six hours by foot—and even farther on a makeshift stretcher. His right leg was amputated at the hip. After a long recovery he was forced

to use his hands to ambulate; his remaining leg became misshapen and atrophied.

When we visited Absoly, he was living in a “house” with his wife and child. I use quotation marks because the dwelling was no larger than seven by five by eight feet—there was scarcely enough room for his sleeping mat. The walls and roof provided little protection from the elements. As storm clouds were gathering, I stared at the dirt floor and at the thatched roof, imagining what it would be like to sleep there for even a single night.

Just before our arrival, a Zanmi Lasante community-health worker had met Absoly in the course of regular walks through the catchment area to identify people with acute social, economic, and health problems. The health worker knew that the best health intervention we could make would be to build a house—another “unorthodox” medical intervention in the eyes of some. As we spoke to Absoly and his family, less than 40 feet from his shack, construction workers were clearing the ground for a new home, which would be covered by a tin roof and have a cement floor.

Five weeks later I paid my final visit to Kay Epin village. Absoly's new house was almost complete—the tin roof was up, the wooden walls were standing tall, and plans were underway to fill in the dirt floor with cement. As we were leaving the construction site, a community-health worker, reflecting on the role of Partners In Health in rural Haiti, commented, “God catches the crabs and places them in the blind man's sack.”

THE STORY OF DOMINIQUE

A YEAR LATER, PAUL FARMER AND I WERE SITTING IN HIS office at the clinic when he called for the next patient, who was thought to have infectious pulmonary tuberculosis. Since I hadn't yet been exposed to tuberculosis, I was asked to leave the room. I passed Dominique in the hallway: a six-foot-tall man who, supported by his mother and sister, lacked the strength to stand. He was covered in a cold sweat, and undoubtedly feverish. His emaciated body gave me an entirely new understanding of the age-old term for tuberculosis: consumption. TB had consumed every aspect of Dominique, and it now threatened to take his life.

It took them nearly four minutes to walk the 20 feet that separated the waiting area from the office. The diagnosis was obvious, even to a second-year medical student. The only question that remained was his survival. The order was given for him to be admitted and to be immediately started on antituberculous drugs.

Farmer told me that Dominique had been sick for several months, and there was talk that he had been to see an herbalist, or *doktè fey*, before he arrived at the clinic. Dominique's radiograph bore almost no similarity to normal human anatomy. His right lung had been completely consumed by TB. His heart, and what remained of his left lung, had been pulled to the right side of his chest. After viewing the radiographs, Farmer commented that this was one of the sickest TB patients he had ever encountered.

Vaccination and other interventions have lowered infant mortality in Latin America and the Caribbean, but treatable infections continue to kill the poor.



tered, and he was unsure of his prognosis.

Later that evening we went to check on Dominique. I stood at the doorway as Dr. Farmer examined him. I watched him listen to the *right* side of the chest for heart and lung sounds. He touched Dominique on the arm and tried to reassure him. I, too, believed that although Dominique was very sick, he would eventually live to tell his friends and family about his brush with death.

Unfortunately, I was mistaken. The next evening, as I finished dinner, one of the doctors caring for Dominique delivered the news: Dominique had died suddenly, in the middle of a conversation with his mother. The news hit me very hard, and I initially refused to believe it. Dominique had looked much better earlier that day, and had even gotten out of bed to take a few steps. Another doctor had examined him 30 minutes earlier, and Dominique looked like he was beginning to respond to treatment. Why, then, did Dominique die? The explanation, in fact, was quite clear. A lifetime of poverty, hunger, and finally, tuberculosis, had consumed him.

PRAGMATIC SOLIDARITY

At last year's Haitian National Tuberculosis Program conference, Farmer and I found out that the Département du Centre, which includes the Zanmi Lasante catchment area, had the highest cure rate—well over 90%—of Haiti's nine "departments."

The Central Plateau cure rates exceed some in the United States, and far surpass most other TB programs in Latin America. Another department, by contrast, had a 26% cure rate. Everyone in the meeting was astounded. "How do you get such high cure rates?" asked the Surgeon General. Farmer explained that, contrary to the belief of some in the room, patients are not inherently non-compliant (non-compliance is often cited as the reason for low cure rates, obscuring other factors that affect efficacy of treatment). Farmer continued, "We have such high cure rates because we remove barriers that prevent patients from complying." Cure rates in the Central Plateau did not significantly improve until Zanmi Lasante started giving financial and nutritional assistance to their patients. Free care alone was insufficient.

The role of the community-health workers is also crucial to the success of the TB program. The 70 community-health workers are proud of their role in good TB outcomes, and they aim to have zero patients abandon treatment this year. To date, no abandons have been documented.

While in Haiti, I was able to witness the final stages of construction of the new Thomas J. White Center. Imagine, a top-notch infectious disease center in rural Haiti! Surrounded by naysayers, Partners In Health and Zanmi Lasante have built a facility to help people like Adeline and Absoly recover from treatable infections. The Center has been named the national referral center for

multidrug-resistant tuberculosis. In-patient capacity has doubled, and the new lab is efficient and reliable. Another radiology suite is under construction, and the new pharmacy is already stocked with medicines to treat TB, HIV, and other infectious diseases.

ASKING HARD QUESTIONS

During the course of my time in Haiti, I began to lose sight of my own needs and desires. I came to realize that the destitute sick deserve preferential treatment. I started to understand that diseases settle in the poor because they have been forced to endure hunger, famine, political violence, and inequality—"structural violence."

When I first arrived in Cange, I was so struck by the abject poverty and suffering that I wrote a lifelong friend an emotional, heartfelt e-mail. His response, which consisted of one line, shocked me: "Sounds pretty depressing. What else is going on down there?" I am not disappointed because I know he and I are drifting apart. Rather, I am disappointed because he embodies the sentiments of the majority of people who have not known hunger, violence, and a near-total lack of health care. Few stop to think about social and economic inequalities that surround them. The Uruguayan theologian Juan Segundo put it something like this: "The world that is so comfortable for us is the same one that is so unbearable for billions of others."

While U.S. pet owners spend nearly three billion dollars annually on veterinary care, the International Federation of Red Cross and Red Crescent Societies report that most of last year's 13 million deaths from infectious disease could have been prevented at a

cost of \$5 dollars per person. I struggle to understand the apparent indifference of those, like me, who live in comfort. Sometimes I wonder if we see the poor as another species.

The most important and meaningful moments in my life have been in Haiti. I melted when I saw a mother and father smile with joy when their child was cured. I got goose bumps when I saw a patient with typhoid, who was bedridden a few days earlier, up and walking. I feel blessed to be able to work for Partners In Health and to have become involved in such important work. As Dr. Jim Kim, the director of Partners In Health, often says, there is not a long line of people waiting to fight for the social and economic rights of the poor. I have already signed up for this battle, and I am working my way towards the front of the line.

David Walton is a third year medical student at Harvard Medical School and a volunteer at Partners In Health. In conjunction with Harvard's Program in Infectious Disease and Social Change and Dr. Paul Farmer, he has published several papers on tuberculosis, HIV, and social and economic rights. He plans a career in infectious disease.

Jeffrey Sachs and

John Gallup of

Harvard's Center

for International

Development have

written a

provocative essay

on "The Economic

Burden of

Malaria." See:

<[http://www2.cid.](http://www2.cid.harvard.edu/cidpapers/mal-wb.pdf)

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Emerging Infections

Dengue and Beyond

BY MARY WILSON

WE ALL KNOW INFECTIOUS DISEASES from personal experience. Starting in childhood we typically experience influenza, chickenpox, strep infections of the throat, viruses that cause upper respiratory infections, and miscellaneous skin infections. We expect that most serious infections can be prevented with vaccines, treated with antibiotics, or will retreat, given time. In the middle part of this century, the success with vaccines and drugs led some to speculate about the end of infectious diseases as a major problem for humans. Those speculations were shortsighted and wrong. Recent events have made it clear that infectious diseases are alive and well, even thriving, and are changing in ways that had not been expected.

Beginning in the early 1990s, a group of faculty at the Harvard School of Public Health (HSPH) began regular discussions to try to understand why we were seeing accelerated changes in infectious diseases and seemingly unexpected events. We organized a 1993 workshop at Woods Hole that led to the publication of a book (*Disease in Evolution: Global Changes and Emergence of Infectious Diseases*, New York Academy of Sciences, 1994). A second, larger meeting (Emerging Infections: Origins, Ecology and Prevention) at HSPH in 1997 supported in part by DRCLAS, drew international participation, including several participants from Latin America. In both meetings, disease examples from Latin America had a prominent role.

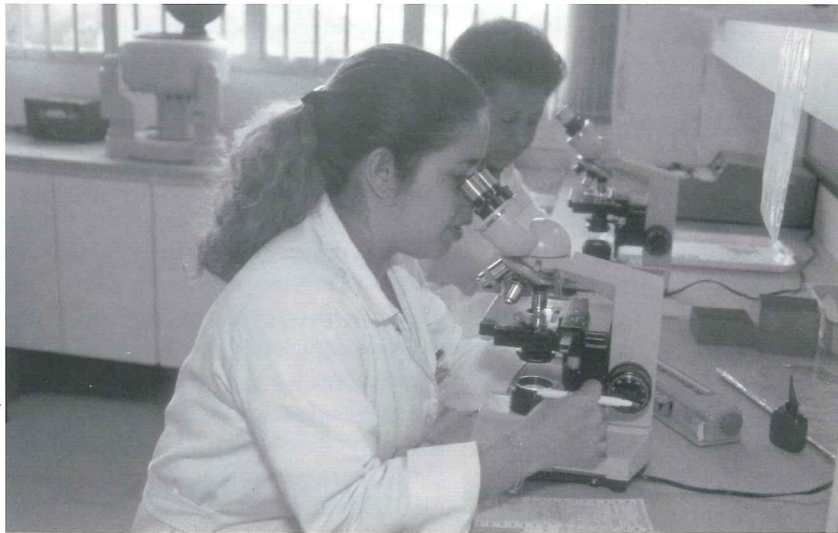
Several infectious diseases have had dramatic impact in Latin America in the last decade – outbreaks of cholera, spreading of AIDS, movement of leishmaniasis into new areas, includ-

ing urban areas, massive epidemics of dengue fever, outbreaks of leptospirosis, increases in multidrug resistant tuberculosis, appearance of newly recognized hantaviruses and hemorrhagic fever viruses, among others. Many have had major economic repercussions.

Changes in several of these infectious diseases reflect population size,

dengue virus exist, numbered 1-4. A second infection is about 100-fold more likely to lead to one of the serious complications, dengue shock syndrome (DSS) or dengue hemorrhagic fever (DHF), which can be fatal.

Dengue fever outbreaks probably first occurred in the Americas centuries ago. There has been a major increase in the burden of dengue dis-



Despite vaccines, some infectious diseases are alive and well, even thriving, and are changing in ways that had not been anticipated.

mobility, density, vulnerability and changes in the environment and land use. Through specific disease examples, I will explore the interactions between social, economic, demographic, environmental circumstances and infections. Infectious diseases are dynamic and can be expected to continue to change in the future.

Dengue fever, also known as break-bone fever, is caused by a virus carried from one human to another by a mosquito, usually *Aedes aegypti*. A first infection with a dengue virus typically causes fever and a flu-like illness. In contrast to many infections that are followed by lifelong immunity to that disease, infection with one type of dengue virus primes a person for more severe illness if infected in the future with a different strain of dengue virus. Four different types (serotypes) of

dengue virus exist, numbered 1-4. A second infection is about 100-fold more likely to lead to one of the serious complications, dengue shock syndrome (DSS) or dengue hemorrhagic fever (DHF), which can be fatal.

Humans are the only important host for the dengue virus; infected humans, who carry the virus in their blood, transport the virus from one geographic region to another. If a mosquito competent to transmit dengue virus takes a blood meal from a human infected with dengue virus, it can spread the infection to other humans. *Aedes aegypti*, the most important mosquito vector for dengue, now infests large parts of urban and rural Latin America and the Caribbean. The habits and habitats of *Aedes aegypti* make it well suited to sustain dengue fever outbreaks. It is highly domesti-



cated, breeding in and around houses. It lays eggs in flowerpots, discarded plastic containers, used automobile tires, buckets, and any trash items that collect water. The adult mosquito prefers to rest indoors and to feed during daylight hours on humans, its preferred host. After a mosquito ingests virus by biting an infected human, the virus replicates within the salivary glands and the mosquito becomes infectious (capable of transmitting the virus) after 8-10 days and remains infectious for life. If the female mosquito is interrupted while feeding, she may bite (and infect) multiple other humans.

Aedes aegypti also transmits the viral infection, yellow fever, which, although often fatal, can be prevented with a highly effective vaccine. In the 1940s, 1950s, and 1960s the Pan American Health Organization (PAHO) carried out *Aedes aegypti* mosquito eradication campaigns to prevent urban epidemics of yellow fever. The mosquito was eradicated from large parts of Latin America. Since the program's discontinuation in the early 1970s, the mosquito has reinfested most of the region. This has coincided with increasing numbers of epidemics of dengue fever, infecting millions of people. Countries free of dengue for decades had severe epidemics in the 1980s. DHF/DSS emerged as a major public health problem in Latin America in the late 1980s and continues unabated today.

For example, in Brazil, more than 500,000 dengue cases were reported in 1998, and *Aedes aegypti* infested all important urban centers in Brazil. As of 1999 *Aedes aegypti* was present in all states, and dengue transmission had been reported in 22 of 27 states. Dengue serotype 1 has been present since 1986 and serotype 2 since 1990, setting the stage for widespread DHF/DSS if new serotypes of dengue are introduced. As of early 1999, all four serotypes had been documented in Mexico, Puerto Rico, Barbados, and Guatemala.

Two other factors – travel and urbanization – have contributed to the appearance and spread of dengue

virus. More people live in urban areas than ever before. In South America, 78% of the population lived in urban areas in 1995; this is projected to increase to 88% by 2025. Much of the growth of cities is unregulated and huge slums surround some cities, areas with poor housing, inadequate waste disposal, and lack of clean water—an ideal environment for breeding of mosquito vectors (and presence of rodents, relevant for other diseases). Poor housing and absence of screens increases the potential contact between mosquitos and humans. It is estimated that a population size between 150,000 and 1 million is needed to sustain the circulation of a dengue virus and to increase the risk of severe forms of dengue fever. Recent studies also point to another reason to be concerned about population size. Over the past two centuries the number of dengue lineages has been increasing roughly in parallel with the size of the human population. Scientists have suggested that a larger human population in which the virus replicates allows increased opportunities for viral evolution and enhances the potential for the appearance of more virulent strains.

Global travel continues to increase. Air traffic volume has increased about 7% per year for the past 20 years and as of the mid 1995s about 5000 airports had scheduled worldwide service. This massive movement of the human population links all major urban areas of the world. Speed of travel means that a person bitten by a mosquito carrying dengue in Bangkok can reach home in Brazil before symptoms of infection begin. Travelers carrying the dengue virus have transported it around the globe and introduced different serotypes into new areas where competent vectors exist. It is the co-circulation of more than one dengue serotype that sets the stage for severe disease.

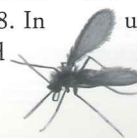
When dengue epidemics occur in Latin America, the virus also infects travelers to the region. A sharp increase in dengue cases in the United States was reported in 1997 and 1998. In 1998 almost 40% of reported

dengue cases in the US followed travel to the Caribbean. In 1997 and 1998, of the 122 imported cases for which the travel history was known, 88 reported recent travel to the Caribbean islands, Central or South America.

Poor housing and lack of vector control can increase the risk of exposure to dengue virus. Lack of access to good health care can lead to increased mortality from the severe forms of dengue fever (DHF/DSS). Mortality for cases of DHF exceeded 20% in some Latin American countries in 1998 but was less than 1% in others. Major epidemics sometimes overwhelm local health facilities.

Good laboratory support is essential to identify dengue infections – and other diseases. This is important not only because knowledge of circulating viruses can inform public health interventions but also because many other diseases can resemble dengue fever. The following examples underscore the relevance of identifying the exact cause of disease and point to the critical role of laboratories.

In September 1989 an outbreak of severe hemorrhagic fever in Guanarito, Portuguesa State, Venezuela, was initially thought to be dengue hemorrhagic fever. When tests for dengue were negative, additional studies were performed. A new virus, an arenavirus designated Guanarito virus, was identified as causing the disease, now described as Venezuelan hemorrhagic fever. Between September 1989 and May 1995, 105 cases were reported, more than 30% fatal. Once identified, the virus' origins and means of transmission could be investigated. Since other arenaviruses have rodent reservoirs, investigators searched for the virus among local rodents and found the same virus in the cotton rat and cane mouse. These rodents are chronically infected without symptoms but shed Guanarito virus in their urine and saliva for up to five months. Investigation revealed that the virus was an old one, long present in rodents in the area, and perhaps causing occasional, unidentified infections in humans in the past. What had changed



was that during the 10 years before the outbreak the human population in the area had more than doubled, mostly through migration. New agricultural lands had been developed. In addition to the local residents, large numbers of temporary agricultural workers entered the area during planting and harvesting seasons. Changes in land use provided more favorable habitats and food for the rodents, allowing rodent populations to increase significantly. Expansion of human and rodent populations increased the likelihood of human-rodent contact. Knowledge of the means of transmission of this infection has allowed more informed decisions about working the land in this area.

In late 1995 after heavy rains and flooding in a rural area north of Lake Managua, Nicaragua hundreds of people became ill with acute onset of fevers, chills, headaches, and muscle aches. By early November at least 150 people had been hospitalized and at least 13 had died from respiratory distress and lung hemorrhage. Initial tests focused on dengue and dengue hemorrhagic fever, but tests were negative for dengue. Further investigation revealed that the cause of the outbreak was leptospirosis, a bacterial infection that is treatable, if recognized. Wild and domestic animals can be chronically infected without symptoms and pass the leptospires in their urine, which can contaminate fresh bodies of water. Humans become infected

after contact with animal tissues or water or other material contaminated with infected animal urine. Water contact increased with flooding.

A large urban outbreak of leptospirosis occurred in Salvador, Brazil, in 1996. The largest peak of the epidemic came two weeks after severe local flooding. Because the leptospirosis epidemic overlapped with a dengue fever epidemic, 43% of patients with confirmed or probable leptospirosis were initially misdiagnosed as having dengue fever, delaying effective antibiotic treatment. Antibiotics can be lifesaving in leptospirosis, whereas they have no effect on dengue fever, a viral infection. [Intravenous fluids and other supportive measures can markedly reduce mortality in patients with dengue hemorrhagic fever or dengue shock syndrome.] People living in favelas (slums where 47% of housing units have open sewage systems) had a relative risk of 4.0 for acquiring severe leptospirosis, compared with residents of other districts. Rodents often carry leptospirosis and those infected were more likely to report rodent contact.

Leptospirosis increased substantially in Puerto Rico after flooding from the 1996 hurricane. In the US, nine of 26 rafters became ill after a white water rafting trip in Costa Rica. Leptospirosis was confirmed. They had rafted on flooded rivers—sometimes ingesting river water or falling into the

river. Sometimes travelers can be a sentinel population that gives insight to diseases being transmitted locally. Travelers returning to the US often have access to diagnostic testing that may be unavailable to local populations in many parts of Latin America.

Knowledge of demographic, climatic, and environmental changes that can place areas or specific populations at increased risk for infections and good surveillance, communication, and laboratory support can all help to reduce the impact of infectious diseases. Infectious diseases will continue to move and to evolve. Understanding the reasons for change requires knowledge from a range of disciplines, including ecology, entomology, epidemiology, infectious diseases, population biology, international health, climate and environmental sciences.

Mary E. Wilson, MD is Chief of Infectious Diseases at Mount Auburn Hospital, Cambridge, and is Associate Professor of Medicine at Harvard Medical School and Associate Professor of Population and International Health, Harvard School of Public Health. She has worked at the Albert Schweitzer Hospital in Haiti and served on the Academic Advisory Committee for the National Institute of Public Health in Mexico. Her main academic interests include emerging infections, travel medicine, vaccines, and tuberculosis.



Collaring Leishmaniasis

Seeking Solutions in Brazil

BY JOHN R. DAVID

DOG COLLARS, LONG A METHOD FOR IDENTIFYING AND controlling domestic dogs, have been used to control ticks and fleas. Now they may be used to control sand flies, insects that carry visceral leishmaniasis (VL), a serious parasitic infectious disease. In northeastern Brazil, where this is becoming a critical health concern in several regions of the country, researchers are hoping to move away from conventional methods of eradicating dogs, known carriers of the disease, and spraying

insecticides, to a more novel and promising approach which instead uses dog collars impregnated with an insecticide.

In 1997, R. Killick-Kendrick and his colleagues at Imperial College, UK reported that polyvinylchloride (PVC) dog collars treated with the insecticide, deltamethrin, protected dogs from 96% of bites from the *Phlebotomus perniciosus* sand fly for up to eight months. In January 1999, we began to collaborate with Dr. José Wellington Oliveira



Lima, the director of the Fundação Nacional de Saúde in Ceará, Brazil, who had received his doctorate in our department at the Harvard School of Public Health a few years back. Luisa Stamm, who had carried out her honors thesis on *Leishmania* in our laboratory and recently graduated from Harvard College, went to Fortaleza to help initiate and organize the study.

We hoped to determine if the same results could be obtained with two different species of sand fly in this area of Brazil, the *Lutzomyia longipalpis* and *Lutzomyia migonei*.

Four dogs wearing PVC collars impregnated with deltamethrin and three dogs wearing placebo collars were kept in separate kennels outdoors for eight months. Periodically a dog from each group was sedated and placed in a net cage for two hours. Within these cages 150 female sand flies had been released 10-15 minutes before. After the collars were attached, the two species of sand fly were alternatively added to the net cages every two weeks for 36 weeks.

The deltamethrin collars had a dramatic anti-feeding effect on both species of sand fly. Over a 35-week period, only 4.1% of the *Lutzomyia longipalpis* taken from the nets containing dogs wearing treated collars were engorged with blood from a meal, an average of 96%. The inhibition of feeding was 99.3% when tested four weeks after the application of the collars, 100% after eight and 12 weeks, 96% at 16 and 20 weeks, and was still 94% at 35 weeks. During this time the average sand fly mortality was 68%, with half dying in the first two hours.

In contrast, 83% of the *Lutzomyia longipalpis* recovered from the nets of placebo collared dogs were engorged, and the average mortality was 8.6 %, with only 1.1% dying in the first two hours.

The results were similar for the *Lutzomyia migonei* species of sand fly.

These studies showed that the dog collars treated with

the insecticide deltamethrin could protect dogs against sand fly bites for up to eight months, the time in which sand flies typically transmit diseases they are carrying. We are now planning two large field trials, one in Fortaleza, Ceará, and one in Jacobina, Bahia, to determine if markedly decreasing the sand fly biting of dogs results in protection of humans. If this were the case, a disastrous trend in human infection, and costs incurred in trying to prevent infection, could be reversed.

This is particularly important in Brazil. In the past two decades, VL has spread from the rural to urban areas in northeastern Brazil, possibly as a consequence of the migration of persons leaving areas ravaged by droughts. This urbanization of VL further increases the possibility of future epidemics involving many more people than previously. Furthermore,

there is a resurgence of VL in persons who have recovered from the disease in the past and have subsequently become infected by HIV.

Worldwide there are 400,000 new cases of VL and 50,000 deaths each year. The World Health Organization (WHO) estimates the severity of various diseases by determining the Disability Adjusted Life Years (DALYs) of a disease. In 1990, more than two million DALYs were estimated for VL in the world, second only to malaria for parasitic infections.

Symptoms accompanying the disease are loss of appetite, gastrointestinal problems, weight loss, and a tremendous enlargement of the liver and spleen. Full-blown VL is invariably fatal unless treated. Epidemiologic studies suggest, however, that probably only one of ten people who is infected gets the full-blown disease, with others experiencing a subclinical disease that goes away without treatment.

According to a 1997 article in *Revista de Patologia Trópica*, from 1984-1996, the cost of programs aiming to control the disease in Brazil exceeded \$96 million. In 1995 alone, the staff involved in the control program totaled 1,839 people. In seven years, nearly one million houses were sprayed and blood samples were taken from 6.5 million dogs to test for seropositivity, a sign that they are carrying the disease. In all, 153,819 seropositive dogs were destroyed. Despite this effort, morbidity and mortality in the human population remains unacceptably high.

If successful, these treated dog collars could be useful in a program to control the incidence of VL and would be much more acceptable to the population than the present methods of sacrificing seropositive dogs. We hope to intensify our efforts in experimenting with the treated dog collars in the next several years to find a practical and low-cost solution to this dire health problem.

Practical solutions may work to control infectious disease.



JOHN R. DAVID

John R. David, MD is the Richard Pearson Strong Professor, Department of Immunology and Infectious Diseases at the Harvard School of Public Health and Professor of Medicine at Harvard Medical School.

Brazilian Public Health Systems

At Home and Abroad

BY JENNIFER BURTNER

THE DAVID ROCKEFELLER CENTER for Latin American Studies, together with the Harvard School of Public Health, the Harvard Medical School and the Harvard Brazilian Organization, have organized the Fall 2000 lecture series, Brazilian Public Health Systems. The five part series features regional specialists who explore the problems and improvements in the systems that provide health care to Brazilians, both within and outside of Brazil. Brazilian and North American policymakers, researchers, practitioners and community organizers, will have the opportunity to discuss the impact new legislation, institutions and information tools and networks are having on the social conditions Brazilians face, at home and abroad.

Lecture series topics range from "Epidemiological profiles of malaria in the Western Amazon region" to methods-oriented panels such as a discussion by Harvard faculty members John David, Karen Peterson, Albert Ascherio, Ana Cristina Terra de Souza, Dieter Koch-Weser and Felton Earls on how to "Link Research to Practice."

Reducing sickness, controlling endemic disease and parasites, improving health monitoring and the quality of life of Brazilians, are goals that have guided the actions of the Brazilian Ministry of Health for the last 45 years of its existence. However, over the last 12 years, changes have taken place in the political, economic and demographic life of the country that have forced the government to significantly alter its strategies for achieving these goals. In 1988, the Constitution universalized access to public health services, and in 1990, through the Lei Orgânica de Saúde and the implementation of the Sistema Único de Saúde (SUS), the state

sought to decentralize and democratize the management of public health care.

Although politically supportive of these federal mandates, many state and municipal level governments found themselves unprepared for the financial and administrative responsibilities that these expansive and very expensive initiatives required. Changes in the Brazilian public health system demanded, for its effective implementation and maintenance, improvements in its systems of information about and implementation of health care. These improvements include, among others, wider dissemination of information about legislative and policy changes, replication of successful state initiatives (public and private) and increased support for applied health research. Within applied health work, researchers and practitioners joined representatives of state level Secretariats, adopting progressive multidisciplinary team research models that teach researchers, institutions, policymakers and practitioners how to more effectively link research with action.

While the Brazilian State sought to re-orient its goals and practices on the national, state and municipal level, growing numbers of Brazilians living in the U.S. were actively organizing themselves at the local and regional level. These new organizations and networks are reshaping the identity and raising the expectations of the growing North American Portuguese-speaking immigrant community. Throughout the Boston area, numerous private non-profit social service organizations have developed, offering programs that break down the language and cultural barriers to health and social services, education and economic opportunities. Gradually, established institutions such as

the Massachusetts Department of Public Health, Boston-area hospitals and clinics, and the Harvard School of Public Health and the Harvard Medical School, have begun to partner with these organizations, helping them to develop the information tools and networks necessary to provide services to this community.

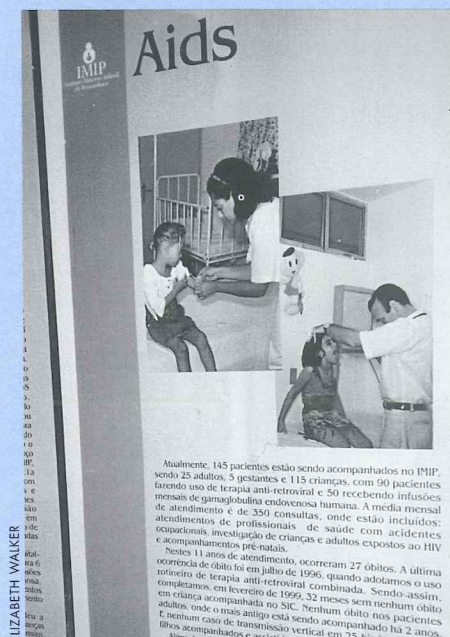
Brazilian Public Health Systems brings leading policy-makers such as Ceará Secretary of Public Health, Dr. Anástacio de Queiroz Sousa, and international researchers such as Dr. Luiz Hildebrando Pereira da Silva, together with Harvard University researchers and representatives of the Boston-area Brazilian community. Over the past several years, DRCLAS has been expanding its support for the many Brazil programs at Harvard, which were formerly isolated in different faculties and departments. For the first time, Harvard students, visiting scholars, faculty, and community members have a forum to discover their mutual interests in Brazil.

The voices range from that of Dr. John David, who has long worked on Brazilian-based health problems in the School of Public Health to that of Harvard student Siripanth Nipita, who just discovered Brazil through a DRCLAS grant there, choosing a career in medicine as a result.

Jennifer Burtner is the DRCLAS Brazil Program Coordinator. She plans and helps to administer the Center's activities to strengthen research, public events, and outreach opportunities related to Brazil. As a social anthropologist, her research focuses on relationships among local project-affected-populations, non-governmental organizations and the state, particularly in conflict areas.

BRAZIL PUBLIC HEALTH PROGRAM

Presentations are on Thursday and begin with a light lunch at 12:30 p.m. followed by the presentation at 1:00 p.m. For more information contact Jennifer Burtner, 495-5773, <jburtner@fas.harvard.edu>. For a complete schedule, check our webpage <<http://www.fas.harvard.edu/~drclas>>.



Enhancing the Care of People

Living with HIV and AIDS in Brazil

BY ANN BARGER HANNUM

KOWN FOR ITS RICH, MULTI-LAYERED CULTURE AND the warmth of its people, Brazil is a favorite destination of Sofia Gruskin, assistant professor of Health and Human Rights at the Harvard School of Public Health. But Gruskin also knows another side to this vibrant and high-spirited country, reflecting the nature of her work there for the past two years. Brazil is one of many countries worldwide caught in the grip of an escalating AIDS epidemic that threatens the lives and livelihoods of millions of its residents—and, indeed, the future of generations to come. Gruskin is one of four Harvard investigators for the Enhancing Care Initiative, located at the Harvard AIDS Institute, and operated in partnership with the François-Xavier Bagnoud (FXB) Center for Health and Human Rights at the School of Public Health. Along with principal investigator for the Enhancing Care Initiative and executive director of the Harvard AIDS Institute, Richard Marlink, M.D., Gruskin and her colleagues serve as advisors to multidisciplinary AIDS Care Teams of experts in Brazil, as well as Senegal, South Africa, and Thailand, who work to improve the care of men, women, and children living with HIV or AIDS in resource-scarce areas. These teams bring together local experts — clinicians, people living with HIV, epidemiologists, health care delivery experts, human rights specialists, behavioral scientists, economists, and political scientists — to initiate meaningful changes in HIV and AIDS policy and health care delivery in their regions.

A human rights lawyer, Gruskin emphasizes the policy and practice implications of linking health to human rights, with particular attention to women, children, and vulnerable populations in the context of HIV/AIDS. At the Enhancing Care Initiative, she is responsible for ensuring that human rights and gender concerns are incorporated into planning and providing care for people living with HIV/AIDS.

Since the Enhancing Care Initiative was established two years ago, Gruskin has worked closely with José Ricardo Ayres, M.D., and his colleagues on the Brazilian AIDS Care Team. Based in São Paulo, Santos, and São José do Rio Preto, the team discovered that in these areas, HIV infections are growing faster among women than among men, the mother-to-child transmission rate is still as high as 20 percent, and women with HIV have a 30 percent greater mortality rate than men. To try to understand these occurrences, the team designed two large studies to explore the factors that influence women's access to HIV and AIDS care in public health services in the three cities. In February 2000, the team completed data collection for these studies, the first of which investigates the barriers to care experienced by women living with HIV. The second study explores the specific barriers to HIV and AIDS care experienced by HIV-positive pregnant women in this region. Based on its Phase I findings, the team has decided to expand its focus to young people living with HIV and AIDS.

An AIDS care poster; DRCLAS student travel grant recipient Elizabeth Walker with Brazilian community health team.

According to Ayres, São Paulo, a sprawling industrial city of approximately 10 million people, was one of the first cities in Brazil to report AIDS cases, and infection rates quickly became the highest in the country. The gay community originally had the highest number of reported infections. Santos, a thriving port city of approximately 410,000 people, reported its first AIDS cases soon after São Paulo did in the mid-80s. The growth within the homosexual community was explosive, says Ayres, but the number of heterosexual cases quickly rose as well. Because it is an extremely busy port city, Santos has a large transient population and a high number of people involved in drug trafficking. HIV and AIDS quickly spread through sex workers and among drug users. São José do Rio Preto, a rural town of approximately 350,000 people, in São Paulo State, has experienced a similar pattern of HIV infection as Santos. According to Ayres, the epidemic was first identified in this predominantly agricultural and commercial area during the mid-90s, when the United States declared its war against drugs in South America. São José do Rio Preto emerged as the most expedient alternate route through which drugs were transported from Bolivia and Colombia to port cities, and the high presence of drugs fueled the proliferation of HIV. Fear of being identified as a drug user prevented many people from seeking help, and the epidemic spread.

Working closely with Ayres and his team to help support their research efforts, Gruskin has become familiar with the issues facing women in these regions living with HIV who seek medical care. "We're confident that the results of their research will be significant," says Gruskin. "The results will be particularly important because appropriate interventions can then be implemented on the basis of the findings. The hope is eventually to make access to care in these regions a high priority in order to reduce morbidity and mortality, not only within this specific group but within the general population as well. If this team of experts can determine what needs to be done to control morbidity and mortality within this group, then perhaps the same interventions might be applied to larger groups of women and perhaps to the population at large."

The Brazilian studies may shed light on care for women worldwide living with HIV. "Women are at greatest risk in most societies," says Gruskin, who has worked on gender issues for many years, including those involving women's health. According to Gruskin, discrimination against women has fueled the AIDS epidemic. Women worldwide who are HIV-positive have confronted fear, prejudice, and ignorance—significant factors in contributing to this discrimination, which in turn has aggravated the many problems associated with the epidemic.

Many women fear being tested for HIV, knowing that if they test positive, they may well be rejected by their partners and family members. In many instances, family members also face discrimination, which may lead to expulsion from the greater community. "The importance of considering the human rights component to care of people living with HIV and AIDS cannot be emphasized enough," says Gruskin. Where the rights of an individual living with HIV are violated, the human and other costs are inestimable, invariably extending far beyond the individual to the community itself. Because women are traditionally the caregivers of the family, when they become ill, the lives of all other family members are affected significantly. When women who are HIV-positive are rejected by their partners or families, out of ignorance and fear, they often have no recourse but to find whatever means possible to make a living. In some cases they become sex workers, passing on the virus to partners. In most instances, however these women find themselves without any means of support for themselves or their children and are unable to pay for medical care. Women who do not get medical attention fare far worse than those who do, and many of them also risk transmitting the virus to their children through childbirth or breastfeeding. Brazil, like many other countries trying to stanch the AIDS epidemic, is facing the additional concern of a growing number of AIDS orphans.

"Increasing people's awareness of and eliminating discriminatory practices are not easy tasks," says Gruskin.

The Brazilian studies may shed light on care for women living with HIV/AIDS in Latin America and worldwide.

Even in a culture as tolerant and embracing as Brazil's, fear—not only of HIV itself but also of discrimination, rejection, and social isolation—remains a powerful force. "The work of the Enhancing Care Initiative in Brazil not only reflects our concern for protecting the human rights of all people living with HIV and AIDS, but it also underscores the need to protect all human rights of all people within the country. This vibrant country and its people are remarkable, and they are making great strides in

fighting against the spread of HIV. In order to ensure that Brazil can continue to thrive in the future, however, efforts to slow the progress of HIV and AIDS need to be aggressive and concerted and need to include an ongoing focus on the human rights and dignity of all people, within the context of treatment and care," says Gruskin.

Ann Barger Hannum is project administrative coordinator for the Enhancing Care Initiative at the Harvard AIDS Institute. The author wishes to thank Prof. José Ricardo Ayres, MD, Department of Preventative Medicine, University of São Paulo, Brazil, and Asst. Prof. Sofia Gruskin, Department of Population and International Health, Harvard School of Public Health.

Baluchistan to Brazil

Lessons in Listening to the Community

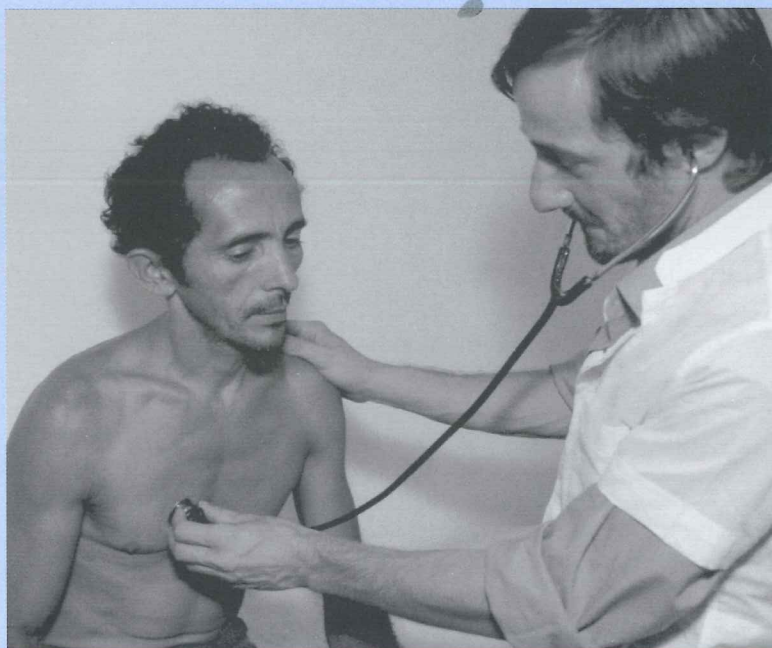
BY KAREN E. PETERSON WITH ANA CRISTINA TERRA DE SOUZA

THE TWO-YEAR-OLD PAKISTANI tot was close to death because of malnutrition and diarrhea. His parents, nomads from the westernmost part of the country, had made the arduous 180-mile trip to seek medical care in Quetta, the provincial capital. Almost certainly, his life would have been saved if his diarrhea had been treated at home with oral rehydration. After a well-intentioned trip he was now almost certain to die within a very few hours. I couldn't stop weeping as I stood among a team of colleagues visiting the pediatric ward of a local hospital.

It was 1992. I had graduated from a doctoral program at the Harvard School of Public Health (HSPH), where I focused on determinants of child malnutrition in Bogotá, Colombia. I'd been lucky enough to obtain this consultancy in Pakistan. My total inability to help the nomad child was my first experience in seeing the truly critical need to consciously link epidemiological and clinical research to action. It made me realize the need for programs and policies developed by listening to voices at different levels in the social context of children.

At that moment, my approach to the consultancy — to suggest strategies to train community health workers in nutrition education—shifted dramatically. Rather than crafting my recommendations to fit the framework of U.S. - based agencies paying for my trip, I knew I must respond to the voices from the community: the caregivers, community health workers, Pakistani pediatricians and seasoned government health officials.

Halfway around the world, Ana Cristina de Souza had begun working in the early 1990's in community clinics and with grassroots women's groups in Brazil, an experience that



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would ultimately lead to her pursuit of a MPH and PhD degree at HSPH. In 1994, she began working with Alberto Ascherio and myself to develop and conduct her doctoral research, in collaboration with colleagues at Federal University of Fortaleza in Brazil and UNICEF.

"I believe that it is only when communities and programs are truly engaged in the inquiry that researchers can make a substantial contribution to the improvement of health and social programs designed to better the lives of individuals and their communities," explains de Souza. "With the funding of DRCLAS, the two research projects we conducted in Ceará, northeast Brazil, are an example of the application of a partnership research model as a strategy to facilitate the development of individuals and communities consistent with research goals."

De Souza's doctoral research evaluated the PACS program, a state government based program of paid community health workers implemented on a municipal basis was

launched by the State Secretariat of Health with the technical support of UNICEF in 1987 (see DRCLAS NEWS, Spring 1998).

Peterson and de Souza received DRCLAS funding in 1999 to return to Ceará to conduct qualitative research assessing factors that may have hindered or facilitated the utilization of evaluation results for improving programs and designing policies to address the nutritional status of children in Ceará. "A growing body of research has demonstrated that communication strategies used during and after the conduct of community-based research increase likelihood the research will result in actions." In the past two years through her work as a post-doctoral research fellow in program evaluation with the Harvard Children's Initiative, de Souza worked with Carol Weiss of the Graduate School of Education to develop a framework that examines the main factors associated with utilization of evaluation results to improve programs and design policies ("What Happens to

Listening with a stethoscope can be easier than listening to a community.

Evaluation Results?" Harvard Children's Initiative, 1999).

For the evaluation of the PACS program we used a partnership model, bringing together key influential people to negotiate the design and implementation of the evaluation. This group included the UNICEF Representative in Ceará, health officials and program staff at the State Secretariat of Health and Municipal Secretariats of Health, and researchers from the School of Public Health in Ceará. Dr. Anastácio de Queiroz Sousa, Ceará State Secretary of Health, who recently visited Cambridge and Boston, as part of the DRCLAS Brazil Public Health initiative, noted, "the collaboration between academic institutions like Harvard and us (i.e. health officials and program staff at State Secretariat of Health) strengthens the work of our group."

The preliminary results of our research confirmed the importance of creating and sustaining a dialogue between research institutions and programs. The results of the in-depth interviews with program officials at different levels of the decision-making process revealed how the information from the evaluation has been used by program officials to improve nutrition programs and design policies that address modifiable factors affecting the nutrition status of children and their communities.

The new field research examined the link between data and action to see whether growth-monitoring data used for program evaluation influence decisions and improves data quality and usefulness at the individual, program and ecological level.

Specifically, this qualitative field research looked at how Ceará State and municipal decision-makers, municipal program managers and (CHW) supervisors had used the PACS GMP evaluation. Information will be used to recommend ways to maximize the usefulness of evaluation results at different administrative levels. We also assessed growth monitoring activities undertaken by CHWs that may influence quality of individual or aggregate data, including

weighing and measuring techniques, plotting, and recording of growth data. Study questions addressed:

- Adequacy of communication and dissemination of research results.
 - Uses and interpretation of "new information" from the evaluation related to nutrition program and policy decisions in Ceará State.
 - Relevance of findings to the daily program operation and functioning at the municipality-level.
- Factors influencing application of research and obstacles to understanding and implementing the changes at municipality and state levels.
- How community health workers, decision-makers and agency officials understand 1) the concept of child growth, 2) information from measurement on child growth (individual and population levels), and 3) information from growth references.
 - Potential ways health officials and decision-makers could address the quality of data collection presented.

As a context for public health research, Pakistan is a completely different context from Brazil viewed from almost any perspective. But my qualitative research - based on listening to voices of people with different responsibilities in the care of children in Pak-

Research methods included:

- **Interviews with key informants at State and Municipality decision-making levels.** Actions taken and interpretations of PACS evaluation data, relevance of the results for nutrition programs and policies in Ceará, and organizational and political obstacles to implementing recommendations.
- **In-depth interviews with PACS Supervisors (i.e. municipal level).** Uses and interpretation of evaluation data. Each supervisor is responsible for overseeing 10-15 CHWs.
- **In-depth interviews with CHWs.** Closed- and open-ended questions will be developed and used to assess CHWs' knowledge, skills and practices regarding GMP, based on methods previously tested (Peterson et al., 1994).
- **Direct observations of CHWs daily activities.** Documentation of actual work routine, including recording, weighing, plotting, counseling, as well as on equipment used. A simple, standard data form will be developed and used to collect information across all locations based on our previous work.

The next project is entitled "Strategies for Implementing a New Growth Reference", a collaborative effort of the Department of Maternal and Child Health and Department of Nutrition of Harvard School of Public Health, the Division of Nutritional Sciences of Cornell University, the State Secretariat of Health of Ceará, and the Department of Community Health of the Federal University of Ceará. This research proposes the use of qualitative methods to understand the factors that influencing effective and successful implementation and adoption of a new growth reference. The first set of factors relates to characteristics of the health systems, while the second relates to decision-makers', health workers' and mothers' understanding of growth and its measurement and interpretation for appropriate actions (WHO, 1995) appropriate to the user.

Field research to identify, define, and address issues related to initiation, implementation, and incorpo-

Our initial research results confirmed that treating and sustaining a dialogue between research institutions and health programs is essential.

istan, and de Souza's previous experience in working with rural communities in Brazil, was invaluable in deciding how to best listen to CHWs, supervisors, and decision-makers speak about whether and how our evaluation of GMP was useful.

ration of the new international growth reference into various settings will be needed to inform governments and international agencies of methods for successful and improved implementation and use of this new technology worldwide. Research methods also will provide a prototype for ethnographic research on issues related to the implementation and adoption of the new WHO growth reference to be conducted in other countries.

This work in Ceará, informed by "listening" in Pakistan, will be amplified and further re-invented in the

upcoming year in the WHO project. The children of Ceará can never be an abstraction for either de Souza or myself. She has spent hours listening to the stories of mothers who have lost their children to malnutrition and disease. And I have never been able to erase from my mind the eyes of the two-year-old nomad boy who changed my vision of community health.

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tor of Public Health Nutrition Practice, Harvard School of Public Health.

Ana Cristina Terra de Souza, DDS, MPH, DrPH is a Research Fellow (Berkowitz Family Legal Sea Foods Fellowship) - Public Health Nutrition Practice Department of Nutrition and Maternal and Child Health, Harvard School of Public Health, and a Research Fellow in program evaluation with the Harvard Children's Initiative. She is from Brazil.

Brazilian Women's Voices

What the Tape Recorder Didn't Capture

BY SIRIPANTH NIPPITA

THE FAINT SMILE ON MARIANA'S LIPS INTENSIFIED as she reminisced about the lazy Brazilian days she had spent on a farm during her last vacation. She described the vast fields and the warm, fresh milk on the breakfast table every morning, and we almost forgot about the nurses and doctors bustling around. We were quickly reminded that their presence was needed as Mariana's words slowly trailed off, her smile disappearing. She pressed her lips into a straight line, shutting her eyes tightly as she endured the effects of the pills she'd taken just hours earlier.

Mariana was faced with an unplanned, unwanted pregnancy that threatened her ability to keep her job and would make her a mother at the age of eighteen. She had confided in a friend, who had procured the ulcer medication Cytotec for her on the black market. The drug causes uterine contractions and is contraindicated for pregnant women. However, Brazilian women often use it for the express purpose of inducing abortion. In Brazil, a largely Catholic country where the procedure is illegal, those with financial means may obtain safe medical abortions in private clinics. Women who cannot afford abortions silently use Cytotec or other methods, subjecting themselves to the numerous health risks associated with unsafe or incomplete abortions. Some, like Mariana, make it to the hospital. Others never do. All women who have abortions, however, must contend with the severe and inevitable societal disapproval inherent in doing such an act.

In research for my senior thesis, I wanted to find out how Brazilian women dealt with social pressures and the myriad emotions they might feel following an abortion.

How would women hospitalized for complications from incomplete abortion reconcile their experience and beliefs with an act considered morally wrong by many and illegal by their government? As a researcher and as a woman, I also wanted to know if and how other women hid or expressed feelings of sadness, regret, shame, the wish to keep one's life just the way it was, and perhaps the tiniest sense of relief, albeit probably enveloped in guilt. More than once, I stopped myself mid-trudge heading up the faded blue steps to the maternity ward. Was I overstepping personal boundaries and asking too much? The women I interviewed would tell me if that was the case, but I would never expect some interviewer to ask me the same questions.

On one of my first few days in the hospital, I stopped at the preemie nursery, awed at the sight of the smallest babies that managed to cling tenaciously to life. My thoughts began to drift to Sudruk, the lone survivor of my younger twin sisters born twelve weeks prematurely. The stream of memories from home was interrupted by a voice that said, "These little babies...they're like little dolls...". This from a teary-eyed Brazilian woman who looked as though she were six months pregnant. Márcia had miscarried 15 days before, and she had begun a futile search for Cytotec to expel the fetus. "The girls who want to take theirs out can take medicine and it comes out...they find it, and I couldn't. They come in...and go home the next day...It's not fair..." I felt totally unable to help another person, and it certainly was not the last time I'd encounter that feeling during the course of the summer.

It came as a surprise to me that it was usually when the tape recorder was taking a break from capturing interview data that I learned the most from the different women I saw and spoke to in the hospital each day. It became a habit to sit and pass the long evening hours with them after senior thesis research was done for the day. Morning hospital rounds and afternoon visitors were distant memories by the time dinner plates were collected. Exhausted new mothers could nap with their little ones in bassinets at their sides or satisfy the babies' cries to be held and fed. Women like Mariana, Neide, and Ana Paula, who were there for reasons other than obstetrics, offered me anecdotes on love, life, inequality, and hardship during those calm evenings.

"I don't fight. I don't curse. When the time comes, I just leave...." Neide explained in her quiet but defiantly resistant voice as she told all of us how she left a man less than two weeks before she was to marry him. "He was so taken aback when he saw the moving truck outside the house...he spoke badly to me and cursed others...when I told him to please stop, he turned to me and said 'get used to it, because this is the way I am — you have to either accept it, or leave.' It's a lack of respect...these things don't get better with time, it keeps getting worse and worse, and if you stay, he just stays

the same way...."

Ana Paula nodded, her eyes brimming with the wisdom that comes from one ex-husband and four children. The 24-year-old woman hadn't seen her daughter from a previous marriage in years; her little girl was already eight years old by that time. Ana Paula lived with her three other younger daughters, but it seemed as though not seeing the eldest created some emptiness in her life along with another situation: "I don't have sons. I think that all the sons I've ever been pregnant with, I've lost."

One of Neide's unfulfilled wishes was to go to college. After cautioning me "not to mess with this marriage stuff," she explained why it was impossible for poor people to ever make it past high school—so much stood in the way of their even taking the *vestibular*, the national college entrance exam. "The minimum salary (was about \$80 per month at the

time)...A book to study for the *vestibular* is (\$ 40). How can people survive? It's already half your salary, you have to take the bus, get a snack, pay a fee to take the exam. For poor people, there is simply no way."

The stories they told me might seem unremarkable — they happen to different people in some way, shape or form all over the world. They are told and re-told to friends, sisters, and daughters. They were shared with me,

**I wanted to find out
how Brazilian women
dealt with social
pressures and the
myriad emotions they
might feel following
an abortion.**



Siripanth Nippita learned to listen to the concerns of Brazilian women.

however, on the rare occasion that I left my own friends and family to go to a place unlike any other I'd ever been. They made me laugh, contemplate, and cry, sometimes in the span of only thirty minutes. I arrived as a researcher from a relatively privileged background and in every sense a foreigner whose Portuguese wasn't anywhere close to being perfect. The women became more than subjects and patients who needed to come to the hospital, and I turned into something more than the researcher that came in earlier those evenings. I was someone who wanted to know about them as people, who wanted to learn about how things work in their country and what their lives were like.

I returned from Brazil to the security of my Currier House single with answers to my questionnaires, field notes, and tapes to transcribe. With the untiring support of my thesis adviser, I re-thought and re-framed the questions I wanted to ask about abortion in Brazil, and the differences between how the topic was discussed in public and in private. For almost two semesters, I tried to answer those questions. As my deadline of March 23, 2000 approached, I knew that I'd learned a lot about Brazilian discourse on abortion in the public and private spheres. Arguments of necessity, morality, importance of health, and the value of human life confronted each other, but the degree to which they appeared varied according to the circumstances surrounding a speech, narrative, or discussion. Be it on the floor of a congressional debate or in an intimate conversation between best friends, these

issues surface in various combinations, demonstrating that the boundary between public and private is permeable.

I realized that there was a serious rift between public and private discourse, in that the terms of necessity so prevalent in the latter was much less prominent in the former, which tended to use terms of morality, public health, and the value on human life. It was problematic, I wrote, for two reasons. At the public level, it signifies a break in the consensus on societal norms and points to an incongruity between moral standards and practice. More serious still were the ramifications for individuals in the private sphere. As I had seen myself and had read about further in the work that others had done, many women experienced difficulty coming to terms with abortion, attributable in part to the severe societal sanctions against it.

Those were the very valuable lessons I learned from writing my senior thesis. I spent endless days and nights sitting at my desk, on the floor, in the library—worlds away from Brazil, thinking about how the words of the women I'd met made sense (or didn't) within the context of the sociopolitical climate surrounding abortion. Throughout those months, I could not help but recall expressions on faces. On a good day, there were contemplative and sometimes enigmatic smiles; tired, fearful, and yet hopeful eyes. At other times, faces gave away that young eyes had already seen so much suffering, or they were altogether hidden from the world because of physical pain. I remembered just a small effort could brighten up someone's day with a willing ear to listen and nothing more, to break up the endless hours in an evening at the hospital and make it turn quickly into night. I remembered feeling that it was so unfair—that my contribution to them was so little compared to what they were able to give back me. I wanted so much to be able to offer real physical remedies to their pain and suffering, to have just the right combination of soothing words and medical expertise. Through my last weeks in Brazil, through my roundabout trek back to Cambridge, and through those nights I spent thinking, writing, and editing, their words inspired yet haunted me. I remembered a promise I'd made to Neide, and I thought of the many ways I could keep that promise. *Não esquece de nós*—Don't forget us, Siripanth, she had said. I knew I would not.

Siripanth Nippita was awarded a DRCLAS travel grant in the spring of 1999 to complete senior thesis research in Goiás, Brazil. She is currently working at the Institute for Health and Social Justice, of Partners in Health, and hopes to complete pre-med requirements by the end of the 2001.

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Nursing newborns
to health.



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A Latina Looks at Disparities

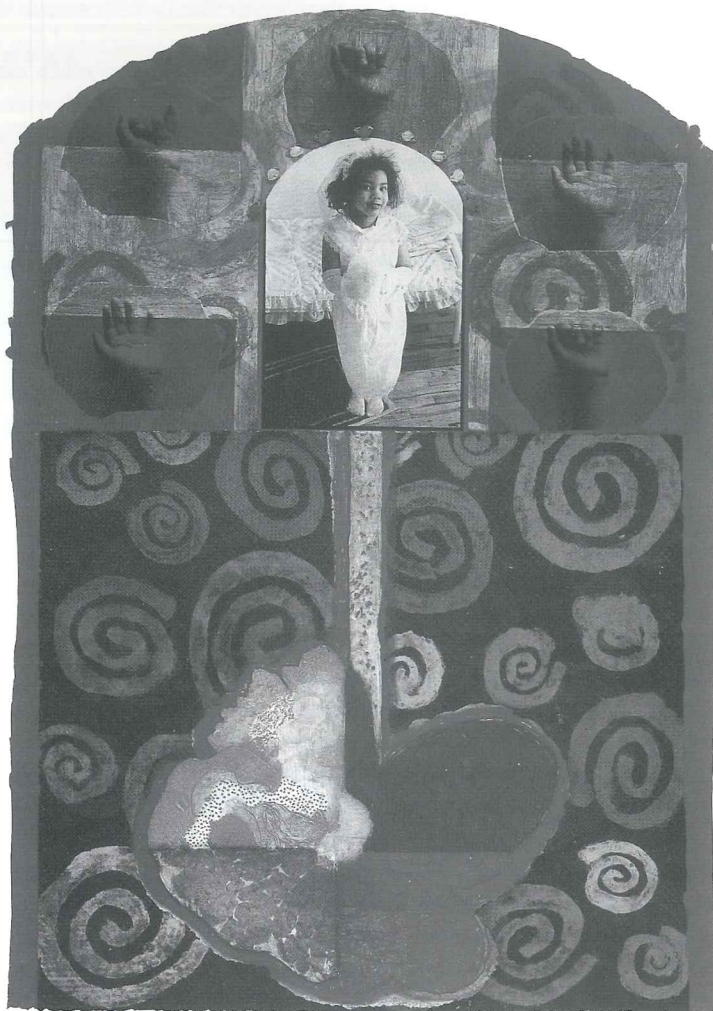
HMS and Beyond...

BY GRACE LÓPEZ

IT WAS MY FIRST YEAR OF MEDICAL school in a new city far from home. I came to Harvard Medical School in the fall of 1999 with many preconceived notions of what I would encounter. Coming from a public school University system in California, I had mixed feelings of what my experiences would be like at a private Ivy League school. Considering the lack of minorities at institutions of higher learning throughout the nation, I feared the majority of my classmates, staff, faculty, professors and doctors would be white men. I was very pleased and surprised to see that indeed there were Latin@s and many other minorities among my classmates. However, I was disappointed to see that there were too few Latinas. Throughout my first semester, I felt something was missing in my experiences and the people that surrounded me. As one of the few Latinas in my class, I felt the need to be in touch with the Latin@ community: to encounter Latin@ physicians and professors as role models; to discuss issues related to health disparities affecting the Latin@ communities; to see that clinical and scientific research was being conducted within the Latin@ communities; and to feel that an overall awareness of the disparities affecting Latin@s in medicine today would somehow be addressed. Unfortunately, I found myself searching for these experiences outside of the medical school.

In my quest to find some type of balance in my medical school experience, I first volunteered at a hospital as a translator for Spanish-speaking patients. I immediately felt welcomed by the small, understaffed interpreter service team that desperately needed the help. Because there are not enough physicians and staff at the hospitals that speak Spanish, the interpreters rotate from floor to floor looking for the

JUAN SÁNCHEZ



Artist Juan Sánchez creates the illustration "Sols y flor para Liora" ("Suns and a flower for Liora") (1997).

Spanish-speaking patients to help them communicate with their physicians to better understand their medical condition and treatments. The patients I interacted with were initially surprised to see a Latina in a white coat, yet, they were very excited and grateful to see someone that could understand and communicate with them better than their own physicians could. Although I knew that these patients were excited to see a Latina training to become a physician, I was disturbed by the fact that it is still a rarity and surprise to see Latin@s in the medical profession, especially as doctors and scientists. I believe that it is extremely important to have many more Latin@s as physicians that can better understand and be sensitive to a completely different culture with varied traditions and value

systems that affect patient care on many levels.

One day, when I wandered into an elderly Puerto Rican patient's room, I immediately saw joy upon his face as I greeted him in Spanish. He did not speak any English and often spent his days essentially isolated. His family would provide some support, but their need to work long hours kept them from lengthy visits. I befriended this patient and learned more about his Puerto Rican customs, his many struggles in life confronting poverty, language barriers and now his medical condition. We formed an exchange of cultures as he learned more about El Salvador and my experiences. This and many other patient encounters brought me a tremendous amount of fulfillment knowing that I had helped

patients feel comfortable by listening to their fears and concerns.

As I continued to volunteer at the hospital, the Latin@ patients I encountered encouraged me with their sincere words to continue with my studies, become the best doctor I could be, and to never forget about the Latin@ community, especially the poor. Most importantly, they encouraged me to become a leader and role model for others. I took these words to heart and immediately looked for another Latin@ organization and became a mentor to a young Latina. When I was young, I was fortunate to have an older sister to guide me through her mistakes to become the person I am today. I know how important it is to have someone inspire you with new challenges and experiences, especially for young people living in disenfranchised communities where role models seem nonexistent.

At Sociedad Latina, a non-profit youth organization in Roxbury, I became a mentor and role model to a young Latina in high school. Soon after assuming this role, I accepted a position as a Mentoring Program Coordinator for the agency. During this year I spent with the organization, we developed a new mentoring program for boys ages 14-18, called Viva La Cultura! Club to address a need for these young Latin@s from Roxbury to encounter positive and enriching experiences with Latin@s in college and at the professional level. These youth had similar backgrounds to my own, but without the opportunities I have today: their environments had failed them. Crime, drugs, negative stereotypes, racism, and lack of opportunities are an every day reality for these youth. They had no one to look to as role models, let alone dream of one day becoming a physician, lawyer, writer, musician or anything other than another statistic, as one particular youth feared would happen. With this knowledge, I strongly felt the need to help guide them towards a more promising future. I recruited Latin@ mentors for these young boys, organized speaker presentations, spoken word sessions, a self-defense session that focused on dealing with violence, and more impor-

tantly, I encouraged them to set goals and have dreams of their own. It was important for me to demonstrate to these youth that Latin@s are successful, that we are in colleges, and that we are capable of becoming much more than mere statistics in research journals who relegate large proportions of the Latin@ population to prisons, the judicial system, as drop outs, and spawning the burden of diseases.

Although I had turned to these communities for answers to the questions I posed and to fulfill the need to have a sense of a Latin@ community at HMS, I was still not satisfied. I was not satisfied because I felt that I had to remove myself from HMS to encounter these rewarding experiences. Other important issues related to health disparities in minority communities, were still not being addressed at the medical school. As such, I became involved in a student sub-committee to enhance our medical school curriculum by addressing issues of race, gender, sexual orientation and social class. The committee looks at issues of cultural competence in the curriculum to identify gaps and teaching opportunities that will address the needs of all patients, especially those traditionally not represented. As a culturally diverse group of students, we have proposed ways to integrate clinical and scientific information with actual social and political issues we will be confronted with as physicians. We hope that within our curriculum, such issues as race, socioeconomic status, environment, and demographics affecting differential results of clinical care will be adequately addressed.

Finally, to bring a stronger sense of a Latin@ community to HMS, I became the Co-Director for another student organization, Medical Students of Las Americas. MeSLA is a student council group that is dedicated to the empowerment of the Latin@ Community within the Boston and New England area. As a student group MeSLA hopes to achieve this goal via a multifaceted approach that includes academic support, education about social and health-related issues concerning the Latin@ population, com-

munity projects for the undeserved, and the recruitment of Latin@s to the Harvard Medical/Dental School. MeSLA also organizes social and cultural events to celebrate and promote awareness of the great diversity that exists in the Latin@ communities of the United States, Mexico, Central America, South America, Puerto Rico, Cuba and the Dominican Republic. My main reason for taking on this role was to bring about an overall awareness of the many issues Latinas/os encounter and expose the richness and diversity of our culture and people.

Throughout last year, and now that I am in my second year of medical school, I hope to continue the process of contributing to the overall enhancement of my medical school experience as well as my classmates by bringing relevant issues of disparities across many levels, among diverse populations, and in particular within the Latin@ communities to the forefront. I finally realized that I was at the right place to bring about this overall awareness of underserved communities. I have been able to find people that are willing to listen and guide me through this process. I have found non-Latin@ classmates with a similar interest and passions to address these same issues of inequalities. I have even found a Latina physician who has become a mentor to me. Most importantly, I realized that in order to confront issues of race and ethnic disparities, one must persevere when faced with obstacles, find a means to eliminate preconceived notions of certain groups, and take on the challenge of advocating for all those from underserved communities encountering inequalities that still pervade the medical establishment today.

Grace López, a second year student at Harvard Medical School, interested in addressing issues of health disparities, especially among Latin@ communities. She is co-director of Medical Students of Las Americas (MeSLA), which recently raised \$562.50 for the Pedro Kouri Institute in Cuba to improve the lives of HIV/AIDS patients in Cuba.

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Dr. Manuel Guillermo Herrera-Acena

Changing the Face of Health Care for Latinos/as

BY SUSIE SEEFELT LESIEUTRE

EVERY SEAT IN THE WAITING room is filled and even some of the floor is occupied as children sprawl with crayons and coloring books. The patients at the Spanish clinic are waiting for Dr. Manuel Guillermo Herrera-Acena, and when they see him walk in, the room lights up with a collective smile. He smiles back as he hurries to check in with Lucia Cardenas, the receptionist, and don his white coat.

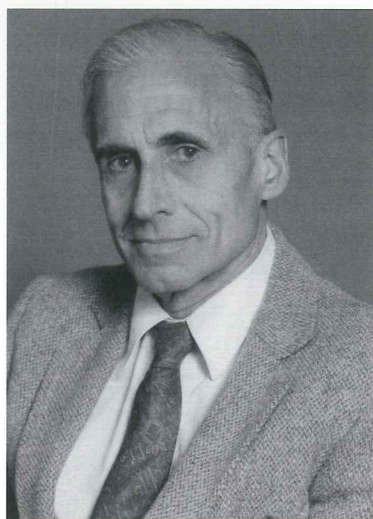
Herrera-Acena, a long time professor in the Harvard Medical School (HMS) and the Harvard School of Public Health (HSPH), runs The Spanish Clinic of Brigham and Women's out of the ambulatory building of the Harvard teaching hospital. In the late 1960s, Herrera-Acena observed that Latinos/as in the Boston area had trouble accessing adequate health care. "The barrier was not just linguistic," he notes. "It was attitudinal, it was social, it was cultural, and the lack of congruence between the culture of the patient and the culture of the care giving institution really prevented good health care and humane and effective medicine."

In 1971, with the approval of the director of Ambulatory Medicine, at what was then the Peter Bent Brigham Hospital, Herrera-Acena began to hold one session a week of the outpatient practice in Spanish. "I wanted to give patients a kinder and more receptive ambience when they approached this enormous building," he says. The Spanish clinic offered services in primary care, social services and mental health care. "The demand was there," Herrera-Acena says. "The clinic just took off."

Today the clinic is open three evenings a week with a staff comprising five primary care doctors, a nurse practitioner, a nutritionist, a psychiatrist, a social worker, a receptionist, and medical students. Spanish is the official language, and staff are required to have an affiliation with Latin America as well. They see patients from Central and Latin America, mostly immigrants, mostly middle-aged, who have come to this country to improve their standard of living.

Social worker Julia E. Rodríguez says that Herrera-Acena "is like a godfather to these people. That's the first word that comes into my mind," she adds laughing.

"When it's the patient's turn," says Rosemary Byrne, the nurse practitioner, "it's the patient's turn. It's their health issues, how's the family, what's going on at home.



RICHARD CHASE

He's not high tech and the patients really appreciate that. Dr. Herrera-Acena is the last one to leave the clinic. Always. Time with patients is first and foremost."

Byrne and the physicians on staff consistently see the same health problems among the patients — high blood pressure, high cholesterol, depression, and diabetes. Many of these problems can be traced to the host of issues they deal with as immigrants, which can either provoke poor health or worsen an existing condition. Herrera-Acena cites the emotional stress patients experience due to loss of extended family, separation

from familiar circumstances, and inadequate housing.

Rodríguez, a Dominican who lived in Puerto Rico, says she has a special affinity with the patients. She connects them to resources outside the clinic that may help them cope with their problems, especially housing issues, which she says are prevalent.

Herrera-Acena, originally from Guatemala, received his medical degree from HMS in 1957. Early in his career he identified a lack of emphasis on nutrition in medical school curricula. His investigations led him to an assistant professorship at HSPH in the mid 1960s. Today Herrera-Acena can take credit for work in several related areas: nutritional research in developing countries, a student exchange program at HMS, and the Spanish Clinic.

Herrera-Acena's work with nutrition has taken him around the world and led to collaboration with government agencies such as the National Institutes of Health (NIH) and UNICEF. In Sudan, he studied the effects of vitamin A supplementation on child mortality and morbidity, a project that involved 28,000 children. He was also the principal investigator in a joint study promoted by the Colombian government and the NIH, which studied the effects of malnutrition in pregnancy and early childhood.

"The hope is that some of our work gets translated into policy and action to solve the problems," Herrera-Acena states. "But those wheels turn very slowly, as you know. It's difficult for agencies; many times for them doing research means diverting resources from their mission. So, I think it's very important for organizations such as the World Bank and AID to fund medical research."

Herrera-Acena says he is especially pleased with the success of a student exchange program at the HMS he helped

Dr. Manuel Guillermo
Herrera-Acena

create in the 1970s. Fourth year medical students can sign up for Medicine 518, 'Nutrition and Rural Medicine in Latin America.' First they receive intensive instruction in Spanish; this portion of the course was developed by Professor Chad Wright, then at Harvard, now a professor of Romance Languages at Catholic University in Washington, D.C.

After this, the students spend two months abroad in a clerkship designed to give them medical experience in a Latin American setting. "Here they can perfect the language, they learn culture, and they learn the roots of many Latino/as who live in the US who they may later work with. The students come back transformed." Herrera-Acena beams. "They come back really conversant in the culture, able to practice medicine in Spanish."

Five hundred students have participated in the program so far; it continues to be a popular elective at HMS. In 1999, the PBS program La Plaza produced 'Doctors for Two Worlds,' a documentary which profiled a student as she progressed through the intensive Spanish course and her subsequent clerkship in Guatemala.

Students can travel to Ecuador, Bolivia, Venezuela, Costa Rica, Guatemala or Puerto Rico for their clerkship. Some of these sites send their medical students to HMS, as well, where they work with their American counterparts in Boston hospitals and help each other with cultural and language issues.

In Guatemala, the Universidad Francisco de Marroquín operates a health clinic where students from HMS work alongside their Guatemalan colleagues, who are newly graduated doctors. Supervision from senior physicians is limited, and some of the population speak only the native indigenous Cakchiquel.

Students who go to Bolivia work for the Fundación San Gabriel, started by Dr. Lisselote Barragán, the first woman in Bolivia to attend medical school. The foundation supports an 80-bed hospital in La Paz and satellite clinics in the surrounding barrios. Students divide their time between the hospital and clinics.

"The students stay in touch," says Herrera-Acena. "What is even more rewarding is that most of them are now resources for Latinos in the community." He is pleased that he can refer his patients at the clinic to former students practicing in the area.

One of his biggest challenges at the clinic is space, physical and temporal. Because they see more and more patients, he and his associates would like to expand, but don't have the space or the resources to do so.

Byrne and Rodriguez echo his frustration. Both would

like to see the clinic hours expanded. Rodriguez says that she must do her follow-up work during the day while she is at another job. Byrne says that she has seen patients reluctant to come for an evening session when the seasons change. As it gets darker earlier, and when the weather is bad, patients do not want to wait on a dark street corner for a bus. She would like to see some daytime hours.

Herrera-Acena continues to study the patient/health care relationship and finds that his efforts are improving patient health. He cites a diabetes program in which 20 patients meet on a regular basis, with clinic staff, over lunch. The goals are not only to disseminate information on treatment but more importantly to allow the patients a chance to talk about their lives in a relaxed atmosphere.

Herrera-Acena recounts the diabetes lunch session earlier that day. At the beginning of the session, as they do each time, everybody's blood sugar was measured. He invited the two with the highest readings to accompany him on a brisk walk. When they returned and their blood sugar was measured again, the levels had dropped by 1/3. This made quite an impression, he says, on all the members in the group.

This program was begun with the aid of Mercedes Barnett, then with the Office of Minority Health in the Department of Health. Another such

effort is ongoing with asthma patients, a joint effort between Spanish clinic staff and Brigham's asthma clinic.

Herrera-Acena attributes the successes of his career to the people around him. But the awards that grace his office at HSPH indicate that he has played a vital role. The honor which touched him the most was one the HMS graduating class of 1996 created, along with the William Bosworth Castle Society, an academic society composed of students and faculty. They presented him with a *huipil*, a hand embroidered blouse from Guatemala, and a plaque which reads: "To Manuel Guillermo Herrera-Acena; For your tireless efforts teaching Spanish to generations of medical students, and single handedly arranging clerkships at rural health centers in Latin America; For your creation of the Brigham and Women's Hospital Spanish Clinic, which for the past twenty-five years has provided invaluable service to the Latino community; And for your warmth, generosity and advice; We are indebted to you."

Susie Seefelt Lesieutre is a publications intern at DRCLAS for the fall semester. She is enrolled in the Certificate for Publishing and Communications program at Harvard Extension. In 1990 she received a Master's degree in TESL; she has taught ESL in the US and abroad.

Clerkships in Latin America enable medical students to better understand the U.S. Latino/a community. Students learn the roots of Latino/as with whom they may later work.



Children who immigrate to the United States, whether from Bolivia (left) or Belize, often find themselves without insurance.

No Apple a Day

Uninsured Latin@s

BY E. RICHARD BROWN

ONE IN THREE LATIN@ IMMIGRANT children up to age 11 hasn't visited a doctor during the past year. That's about twice the proportion for Asian and white children in this age group. Among adolescents ages 12-17, half of Latin@ immigrant children (51%) hadn't seen a doctor in the previous year, nor had 36% of Asian immigrant children and 26% of white immigrant children. As a result, these children are less likely to receive timely care for acute conditions such as ear infections, injuries, or communicable diseases. They are also less likely to have their chronic conditions, such as asthma or diabetes, diagnosed and appropriately managed, and less likely to receive preventive care.

Health insurance coverage is important because it promotes financial access to health care and protects families and individuals against potentially crushing medical costs. In exam-

ining how health insurance affects children's access to health services, two measures are particularly telling: whether they have a connection to the health care system (indicated by whether the child has a regular source of care) and whether they visit a physician at least often enough to receive recommended preventive care.

Noncitizen Latin@ children have an uninsured rate (56%) that is more than twice that of noncitizen non-Latin@ white ("white") children (25%) and more than five times the rate for white children with citizen parents (10%). Uninsured rates for Asian/Pacific Islander ("Asian") and non-Latin@ white children are lower than for Latin@ immigrant children. But, as with Latin@s, within each ethnic group noncitizen children have the highest uninsured rates, about double or more the rates of citizen children with naturalized parents and

children with U.S.-born parents.

Uninsured rates of children in noncitizen families rose since the enactment of welfare reform in 1996. Declining Medicaid coverage is driving these increases, adversely affecting the health care access for many children. These trends have a broad impact in the United States. One in five children in the United States is either an immigrant or has at least one immigrant parent, and many of these immigrant parents have not become citizens. Immigration and citizenship status have a profound effect on health insurance coverage and children's access to health services. The 43% of noncitizen children who lack health insurance coverage of any kind is more than triple the rate for children of U.S.-born or naturalized parents. And for children who are U.S. citizens but whose parents are, uninsured rates are approximately dou-

ble those of children whose parents are citizens.

The citizenship status of a child and of the child's parents strongly affects whether that child is uninsured in nearly every family income group, across ethnic groups, and at all family work-status and parental-education levels. Nine out of 10 uninsured children are in families with at least one working adult, regardless of the immigration/citizenship status of a child or his or her parents. More than half of uninsured children, both citizen and noncitizen, are in full-time, full-year employee families. However, since many workers are employed in minimum wage jobs without benefits, being employed is no guarantee of health care.

Education is a major determinant of employment opportunity. Nearly half of noncitizen children and citizen children with noncitizen parents live in families in which the primary breadwinner has less than a high school degree, and only one-third have parents who have had at least some college. Poverty and lack of opportunity in their country of origin drove many from school at earlier ages than is typical in the United States, restricting employment opportunities in their new country. In contrast, among children whose parents are naturalized or U.S.-born citizens, more than four out of five parents have at least finished high school.

Despite the booming economy dur-

ing the late 1990s, these conditions did not improve much for children in immigrant families. Employment-based health insurance coverage remained statistically unchanged between 1995 and 1997 for children in most family immigration and citizenship groups. During the same time period, however, Medicaid coverage fell by more than six percentage points for citizen children of noncitizen parents, and by more than five percentage points for noncitizen children. As a result, uninsured rates rose for these noncitizen families. The declines in Medicaid coverage occurred, in large part, in response to changes in public policy, mainly those related to welfare reform. Many low-income families lost welfare benefits, including Medicaid, when they took low-wage entry-level jobs that did not provide health insurance. In addition, many noncitizen children and citizen children in noncitizen families feared that enrolling or remaining in Medicaid would threaten their immigration status.

For low-income citizen children with U.S.-citizen parents, Medicaid or the new Children's Health Insurance Program (CHIP) can offset poor access to job-based insurance. Noncitizen children and U.S.-citizen children with noncitizen parents, however, have not received this protection to nearly the same extent. Only about one-third of noncitizen children living in poverty receive Medicaid coverage, compared to more than half of citizen children, regardless of their

parents' citizenship status.

Immigration laws and, more recently, welfare reform legislation have created distinctions among children based on their or their parents' immigration status. For example, because Southeast Asian immigrants qualify as refugees, their children are better protected by Medicaid. Just one in four Southeast Asian noncitizen children is uninsured because half are covered by Medicaid. In contrast, only 17% of noncitizen children from Mexico receive Medicaid coverage, leaving 60% uninsured. Although nearly all states have extended coverage to pre-welfare reform legal immigrants (those who resided in the United States when the legislation was enacted on August 22, 1996) and Congress has reinstated Medicaid eligibility for some groups it had excluded, many noncitizen families have avoided the Medicaid program due to concerns of being labeled a "public charge." They fear that enrolling even their citizen children in means-tested programs, such as Medicaid or their state CHIP plan, would be used against them when they try to renew their visas, return to the United States after traveling abroad, or apply for citizenship.

Along with other aspects of welfare reform, these provisions are most likely responsible for much of the net increase in the uninsured rates among noncitizen families from 1995 to 1998. The fears of some immigrants may be allayed by recent policy

Health Insurance Coverage of Non-Latino White and Latino Employees

Ages 18-64, United States, 1997

| | NON-LATINO WHITE | ALL LATINOS | MEXICAN-ORIGIN | CENTRAL AND SOUTH AMERICAN | PUERTO RICAN | CUBAN-ORIGIN |
|--|-------------------|-------------------|------------------|----------------------------|------------------|----------------|
| Total Employees | 92,920,000 | 12,240,000 | 8,262,000 | 2,240,000 | 1,179,000 | 564,000 |
| Uninsured | 13.3% | 39.3% | 41.5% | 43.2% | 25.4% | 21.4% |
| Employment-Based Health Insurance | 80.2% | 53.7% | 52.3% | 51.0% | 63.9% | 64.0% |
| Privately Purchased Insurance | 3.7% | 2.1% | 1.4% | 2.7% | 2.0% | 10.4% |
| Medicaid | 1.8% | 4.0% | 4.1% | 2.6% | 6.3% | 3.9% |
| Other Government Coverage | 1.1% | 0.8% | 0.7% | 0.5% | 2.4% | 0.4% |

Source: March 1998 Current Population Survey

changes concerning Medicaid enrollment and immigration status. The INS and the State Department ruled in May 1999 that noncitizens will not be classified as "public charges" if they or their children enroll in Medicaid or CHIP (except those who receive long-term care under Medicaid). This policy change, if effectively communicated to parents, should help assure families that they do not have to fear these programs. Nevertheless, children who immigrate legally to the United States after August 22, 1996 will still not be eligible for Medicaid (except nonemergency services) unless their families are refugees or asylees—and then, only for five years. President Clinton has proposed extending eligibility to these recent arrivals. For immigrant parents who are undocumented, however, fear of the INS may deter them from applying for either program—even when their children are U.S. citizens and thus fully eligible for all benefits available to other citizens.

Despite the overriding importance of health insurance, many immigrant

families experience additional barriers in seeking access to physicians. Even among insured children, those who are immigrants are one-and-a-half times as likely as nonimmigrants to have gone more than a year without visiting a physician. Language and cultural barriers undoubtedly play an important role in reducing their access. Community clinics and other safety-net providers often help to promote access, for the insured as well as for the uninsured.

Policies that strengthen the health care safety net would enhance access for many immigrants as well as for other underserved groups. The growth and healthy development of these children are an important concern to all Americans. One in five children is an immigrant or has immigrant parents. They are a significant part of communities in which they live, and they will become a major segment of the nation's workforce in the 21st century.

Because many immigrant parents are noncitizens, they have been discouraged from enrolling their children

in Medicaid or other public health insurance programs. At the same time, their access to job-based insurance is restricted by a variety of factors. The effect of these patterns has been to curtail their children's access to essential health services. Congress can improve the access of noncitizen children and citizen children in immigrant families in two ways: by extending Medicaid and CHIP coverage to all legal immigrants on the same basis as for citizens, and by strengthening funding for the health care safety net.

E. Richard Brown is the director of the University of California, Los Angeles Center for Health Policy Research and a professor at the University of California, Los Angeles School of Public Health. Roberta Wyn and Victoria D. Ojeda contributed to this article, which was adapted from a Policy Brief by the UCLA Center for Health Policy Research, supported by a grant from The Robert Wood Johnson Foundation. For more information, see <<http://www.healthpolicy.ucla.edu>>.

Latino Mental Health

Enhancing Services and Training

BY REBECA CHAMORRO

WHAT BRINGS YOU IN TO SEE ME TODAY?" THIS IS THE typical question asked of new patients during a psychiatric evaluation in a Boston clinic. When asked of a Latino patient, however, the answer does not follow a "typical" response pattern. An Anglo who is asked the same question may provide a linear chain of events that includes symptom type and formation, duration, and current circumstance that may be exacerbating their condition. Two parts of the doctor's question may be less relevant to the Latino patient. Usually the patient has not come to his or her visit alone, but rather in the company of one or more family members. "You" presupposes individual identity. Latino patients see themselves in a group context of interdependence. The word "today" presupposes that distress comes from current or recent events rather than a historical context. One Latino patient put it well when she answered: "If I told you how I got here today I would need to start by telling you why my grandmother left Hon-

duras 45 years ago." Thus, in this immediate exchange much is communicated about Latino identity. It is largely borne out of a family framework and historical lineage.

There is a growing need for mental health services for Latinos. In response to this need, an educational initiative has been implemented at Beth Israel Deaconess Medical Center's Department of Psychiatry to offer trainees both didactic and direct clinical contact with Latino patients. It has been a pleasure to co-teach "Latino Mental Health" with Antonio Bullon, MD, to a group of psychology interns, psychiatry residents and Harvard medical students.

The students learn about the difficulties Latinos face, especially those that emigrate from rural and agricultural settings. These rural immigrants struggle to acclimate to large, urban, technological societies such as those found in our major U.S. cities. Usually the migrant farmer's skills do not transfer well to a metropolitan job market. Often times these men, heads of households, remain unemployed.



Puerto Rican artist Juan Sánchez depicts "Borinquen's Beginnings" (1985).

Their wives become wage earners, perhaps for the first time, because their skills transfer more rapidly to jobs as nannies, cooks, and seamstresses. Family dynamics suffer, usually creating marital tension as the husband begrudgingly accepts financial dependence on his wife. The Latino man must reconcile his perceived impotence with the original intention of coming to this country to provide a "better way of life" for his family. He will often quell his despondency in alcohol or other mind-altering substances.

The next generation's options are also tenuous. Only 52% of Latinos complete high school and less than 10% complete college. Thus, these young adults are already less competitive for well paying jobs. This implies facing a life with jaded dreams and the 'pathogenic reality of poverty.' Some 25% of Latinos have incomes that fall below the poverty level. When basic needs are compromised, the ensuing stress can lead to significant emotional and mental unrest.

For those more fortunate Latinos coming from higher socioeconomic conditions, their transition to U.S. culture presents its own challenges. Despite their job security and greater life comforts, they feel an emotional disconnect when they experience U.S. society which they often see as frigid and mechanistic. This leaves them nostalgic for the temperate interpersonal latitudes of home. Testimonials from Latino patients convey the sentiment well. A Mexican journalist voices: "En este país no hay humanidad, uno se endurece aquí" ("In this country there is no humanity, one becomes hardened here"). The Argentine doctor attests: "Aquí hay violencia, no como en mi país, aquí hay violencia interpersonal" (Here there is violence, not like in my country, here there is interpersonal violence").

Latinos are often at risk for depression, anxiety, substance abuse, and post-traumatic stress disorder. Howev-

er, the Latino patient is often reluctant to seek out a therapist or psychiatrist fearing the stigma that comes from being labeled "loco" or crazy. Thus many Latinos suffer unnecessarily in isolation. Often times they will wait until the symptoms become more critical and debilitating, requiring a visit to the emergency room and necessitating a psychiatric hospitalization. While cultural precursors, such as stigma, make accessing help challenging, structural impediments in the mental health service sector also create road blocks on the road to receiving care. Many ambulatory settings do not have the trained staff to meet the growing demand for Latino mental health services. Deficits in psychiatric training related to working with culturally diverse patients raises serious questions about the quality of care and the need to enhance training opportunities for future providers.

In our program, the initial goal in teaching about Latino mental health has been to first familiarize trainees with important demographics related to Latinos in the United States. Trainees learn that the U.S. is the 5th largest Spanish speaking country in the world and that Latinos are the fastest growing ethnic minority group. Thereafter trainees are informed about the relevant cultural values of this community and how to make diagnoses within a cultural framework. Moving from the general to the more specific, particular emphasis is then placed on the pluralism among Latinos.

The majority culture appears to have a general bias that all Latinos are alike. Latinos often represent themselves as one homogenous group, usually with the hope of creating a critical mass and a louder political voice. The range of diversity across race, dialect, ritual, belief system, country of origin and social condition—just to name a few—gets overlooked.

The majority culture appears to have a general bias that all Latinos are alike.

Thus, throughout the course, trainees are provided with real clinical vignettes and live interviews with patients to highlight the texture of the Latino experience. They learn firsthand about the Dominican woman working three jobs to raise money to bring her children to the U.S., whose plans are indefinitely postponed when she becomes medically disabled and

severely depressed; the Venezuelan graduate student whose attempts at academic success and acculturation leave her overwhelmed and prone to bulimia; the Puerto Rican father of five, who is laid off after 25 years in a factory job, but cannot find work given his illiteracy and suffers a psychotic break; the gay, HIV-positive undocumented Costa Rican man with a severe anxiety disorder and hypervigilant that the INS will deport him; the upper-class banker from Chile with a crippling social phobia; the young man from rural El Salvador who is sure that his friend hexed him with "Mal De Ojo"/Evil Eye leaving him listless and feeling possessed.

The course also focuses on the potential clash between

Latino culture and the culture of the medical center or department practice. The fact that the hospital has a culture and identity of its own, worthy of scrutiny, often appears to be a novel idea to course attendees. For instance, strict boundaries and confidential information in U.S. medical practice and psychiatry in particular arises from Western philosophy and legal concerns for the individual's right to privacy. This concern for privacy can appear very foreign to the Latino patient. The focus on the *individual* during a psychiatric evaluation and the seeming impenetrable boundaries between the patient's disclosures and the patient's loved ones feels awkward to the Latino patient where the expectation for family involvement and validation about any health procedure is seen as a standard of care. Trainees are instructed on how to wed both worlds: that of the profession's cultural dictates and the patient's cultural framework.

In a related topic trainees are also alerted to the process of "personalismo" in which Latinos put a premium on interpersonal contacts. The Latino patient makes a strong bond with his or her provider whereby trust and loyalty to the clinician evolve over time; the provider is considered a valuable member of the patient's family. Allegiance to the affiliated institution is only secondary.

Training hospitals in the United States have a culture of rotating interns and residents through different specialties in order to maximize clinical exposure. Such

a custom, however, disrupts the expectation that the same clinician will continuously provide care to the same patient. If the Latino patient is not made aware of this hospital practice, a change in provider may be viewed as evidence that the hospital does not take their care seriously—a default reasoning borne out of past vulnerabilities from prejudicial exchanges. Thus trainees are instructed to explain hospital policies from the onset to minimize potential misunderstandings with their Latino patients.

Towards the end of the course participants are well versed in the knowledge that individuals, groups, and institutions all have cultural identities with rules of protocol and expectation. Hopefully with this knowledge comes a new appreciation for the demands of living and practicing in a culturally pluralistic society. That is, we must constantly introduce ourselves to each other defining our goal and purpose, be humbled by our naiveté of the other, and eager to find common ground.

Rebeca Chamorro is a clinical psychologist and Director of the Latino Mental Health Service at Beth Israel Deaconess Medical Center, a Harvard teaching hospital. She is instructor of psychology at Harvard Medical School and the recipient of several grants that promote diversity training in mental health and direct service to the Latino community.

Creating Nuestros Cuerpos, Nuestras Vidas

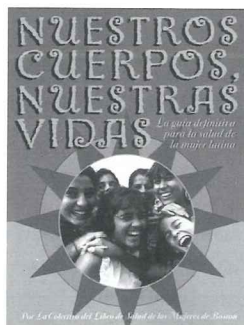
A Healer's Personal Journey in Women's Health

BY ESTER REBECA SHAPIRO ROK

AS A CUBAN JEWISH AMERICAN woman of Polish and Russian descent, I continue to discover how profoundly politics weaves itself into our intimate psychic life, its compelling poetics entangled with whom we know ourselves to be. The ways that politics became interwoven with our family's fate and my own future, my life belonging to two worlds and therefore at the same time to both and to neither, have become my life's work. I became a clinical psychologist and college professor, a healer and a teacher and I began writing about how what appears in this soci-

ety at this time as bounded individual selves are actually evolving conversations. These dialogues help us shoulder—with our ancestors, intimate families, communities and cultures—the hard work of living, growing, surviving, thriving, in eternal cycles of life and death.

My life as a woman between cultures has not been easy as I have sought, and failed, to find personally acceptable choices among my fam-



ily's and society's prescriptions for a good daughter, wife, mother, teacher, psychologist, healer. I never stopped believing in my Cuban childhood's dream of a more just world in which health, education and economic justice are fundamental human

rights. I have shifted my clinical practice to community-based health promotion that connects our personal struggles to the unjust distribution of resources necessary for health, and

recognizes the value of joining others to transform our lives and communities. I have found that sharing the lessons gleaned from my own profoundly human struggle is itself one of my most powerful resources as a teacher and healer.

Most recently, I have had the privilege of working on the Spanish language translation and cultural adaptation of *Our Bodies, Ourselves*. The ground breaking women's health information resource book, first published in 1970 and currently in its 7th edition, has sold millions of copies in the United States and has been translated or adapted into 19 languages. A source of health information, *Our Bodies, Ourselves* (OBOS) also presents women's personal experiences of struggle and success as the foundation for a feminist critique of health system practices. Women have found the book both a valuable tool for personal transformation, and a catalyst mobilizing political action in critical areas such as reproductive health and rights, social and domestic violence, gender role and economic justice.

Typically, OBOS has been translated by groups of women's health activists working in their own countries. The approaches to translation have ranged from direct textual versions to those "inspired by" or "based on" OBOS with text rewritten to better address women's experiences in diverse cultural and sociopolitical contexts. The Boston Women's Health Book Collective had translated the 1972 OBOS edition into Spanish, selling more than 50,000 copies at home and abroad. Yet many of us who appreciated the great value of the first Spanish translation saw a compelling need for a cultural adaptation addressing enormous differences at the interface of culture and gender where most of us live and love. I had been deeply influenced by the North American feminist movement during my desperate adolescent struggle to create a life outside the constraining values of my Cuban Jewish Miami upbringing. I also shared with many professional Latinas a tension between demands of our careers and enduring



JUDY HORSIGIAN

loyalty to our primary caretaking responsibilities within extended families. What might it take to go beyond words to the images and ideas capable of inspiring and sustaining personal transformation and social change? The work of cultural adaptation had been made even more of a challenge by the enormous growth in health information as the book expanded to 800 pages in the 1990s.

Although Latin American feminist groups collaborating with BWHBC believed in the dire necessity for an updated Spanish edition, none of the groups had the resources to do the work alone. They agreed to work with a Boston based editorial group of Latinas to adapt translated chapters. In 1993, they asked me to offer ideas for cultural adaptation; I suggested Paolo Freire's participatory education as an approach that could shift the book's emphasis toward participatory methodologies and collaborative learning. Both as teacher and therapist, I was increasingly turning to Freire's work as a model of mutual learning linking personal reflection, consciousness of social injustice, and action for social change. I had been delighted to learn that Paolo's work, so necessary for a social democracy, had been banned by both the right and the left. Thanks to Donaldo Macedo, Paolo's translator/collaborator and my colleague at Umass Boston, I had the opportunity to learn from Paolo personally and cook him a dinner of his favorite Cuban roast

pork and black beans before his death in May 1997.

I was aware of the enormous sacrifices in personal prestige and sources of self-regard required by true collaborative learning—you give up the expert's power to silence the more vulnerable partner, expose the vulnerability of your own learning. As often happens to me, the clarity of ideas came first and the profound, destabilizing personal learning necessary to make the work possible inevitably followed. Let me give you one example: I speak fluent home-cooked Cuban-inflected Spanish, but read little in Spanish and write even less. When I first started to read our translated chapters and the resource materials in the BWHBC library, I felt confused and deeply ashamed. Arriving in Miami in 1960, I was placed in a classroom for the mentally retarded so I could learn English efficiently. At the same time, I was diagnosed with hypothyroid disease: for at least a year I had become depressed, slow and sluggish. My family failed to recognize my illness until my physically vain Abuela Adela noticed my goiter and insisted I see a doctor upon arriving in Miami. I was placed on thyroid medication, but my parents were told to closely observe me for signs of retardation. Over the years I found, beneath my quick mind and capacious intellect, a deep terror of not knowing. With my commitment to *Nuestros Cuerpos*, I was forced to endure my panic and shame as I

Ester Shapiro (left) and Maria Aguiar co-authored the Spanish version of *Our Bodies, Ourselves*, working with Latin American and Latina feminist groups.

struggled to understand Latin American and Caribbean women's health movement texts, to express myself in written Spanish, to face that I could not write a single grammatically correct sentence in Spanish. My Spanish literacy has vastly improved, and paved the way for a far deeper knowledge of counterpoint and convergence between my public, adult, professional life in English and my private, intimate family life in Spanish. But these were excruciating if ultimately exhilarating lessons, and I can sympathize with my desire to avoid them at all costs.

Beginning in 1994, translated chapters were sent to 20 women's health organizations in the region for revisions. Veronica Nielsen Vilars, an experienced medical translator, edited each chapter word by word so as to give the book an inviting, accessible voice (to see more about the book, our editorial team and Latin American collaborators, and ordering information, please visit <<http://www.ourbodiesourselves.org>>). We worked closely with Taller Salud in Puerto Rico, and consulted with Isis International in Chile, who runs the Latin American Women's Health Information Center and makes their data base and documents available; CIDHAL in Cuernavaca, Mexico; Red de Salud in Chile, who publishes a quarterly women's health magazine and maintains a data base of regional organizations; and CIDEM in Bolivia, the coordinators of the Latin American abortion legalization campaign.

Nuestros Cuerpos Nuestras Vidas (New York: Seven Stories Press and Madrid: Debate 2000) re-organized the book at multiple levels, changing about half the text. The changes begin with the very different implications of the title, as *Nuestros Cuerpos*, *Nuestras Vidas/Our Bodies*, *Our Lives* communicates the importance of our relationships of mutuality and interdependence in promoting good health. Throughout the book, the word self-help has been translated as "mutual help"; no one takes care of themselves by themselves. We carefully crafted new introductions to cre-

ate an inviting space and supportive voice introducing the reader to the major themes in each section. We wanted women to hear the message in as inspiring and evocative a way as possible that our good health begins with us, with our wisdom, our relationships and our communities. Social support and adequate resources are essential to taking individual initiative in our lives. Under conditions of social injustice, action for social change is necessary for our health. Consistent with the strong ethics of mutual care in our communities, we emphasized that we cannot take good care of others without also caring for ourselves.

The final product
is a dynamic,
three way trialogue/
trialogo between
U.S. English speaking
women, U.S. Latinas
and Latin American
women.

We also changed the order and conceptual organization of key chapters. The book now begins with the chapters in *Saber es Poder/Knowledge is Power* (located in the English version at the end of the book). We begin with an international, women's health and human rights approach using the WHO definition of health as well-being connected to our human rights. We described the problems that the world's women face as we become increasingly responsible for paid employment outside the home while being a primary caretaker. Education, sanitation, work conditions, social support, adequate food and shelter, exercise, and other quality of life experiences determine a far larger part of our health and well-being than any

contact with the health system. The section on organizing for change includes a statement by Catholics for Free Choice, and we use the language of women's sacred responsibility for life to affirm our need for sovereignty in reproductive choice. The Traditional Medicine chapter now introduces the second section of the book, "Cuidandonos/Taking care of ourselves", recognizing the importance of religion and spirituality as sources of healing, community bonding, and political change.

Latin American feminism has its own culturally informed political strategies, and we learned a great deal from their characteristic emphasis on women's health and citizenship rights, their organized resource networks and collaborative campaigns, and the participatory practice methodologies. The final product is a dynamic, three way trialogue/trialogo between U.S. English speaking women, U.S. Latinas and Latin American women which encourages the readers to participate in completing a personally meaningful and culturally appropriate text. Initial responses from our Latin American and Caribbean collaborators, a growing network of readers, and media reviewers, suggest that we indeed succeeded in producing a text which truly speaks to some profound cultural differences in the lives of Latin American women, wherever in the world we find ourselves living, while preserving the health information, political inspiration, and stories of women's struggles and strengths which inspired a revolution. As I've traveled with *Nuestros Cuerpos Nuestras Vidas* and have spoken to groups all over the U.S. and the Caribbean, I've joked that my internalized *gringa* will never be the same.

Ester Rebeca Shapiro Rok, (aka Ester R. Shapiro PhD), Associate Professor in Psychology and Research Associate at the Mauricio Gastón Institute at University of Massachusetts at Boston, is Coordinating Editor and co-author of *Nuestros Cuerpos*, *Nuestras Vidas*. She is a DRCLAS affiliate.

Reaching Out

BY JILL NETCHINSKY TOUSSAINT

A THUNDER OF YOUTHFUL feet clambers up the once sedate stairway, and for a moment my mind races, too... what have I done? But there is no need for panic as the first middle school visit to 61 Kirkland Street, made possible in part by the Center's newly awarded Title VI National Resource Center Grant, is a resounding success.

A key component of DRCLAS outreach efforts, school visits pair students in grades six through twelve with Harvard scholars and artists involved in the Latin American and Latino Art Forum.

The thirty-five bilingual students from Martin Luther King Middle School in Dorchester, ages 11-14, talked with guest artist Dominique Pepin, whose photos "Of Reflections and Ceremonies: Meeting with a Mazatec Shaman" were on exhibit and then set off for a guided tour of the Peabody Museum's Mayan collection. The students hailed from several different Latin American countries, a few arriving just weeks before in the U.S. Their enthusiasm that day was infectious: students found respect afforded their diverse cultural backgrounds, teachers found lively resources to weave with state curriculum frameworks, and the visiting artist found herself profoundly inspired, as she later wrote in a message to the students:

My time at DRCLAS was rewarding and inspirational.... I would have loved to continue the discussions we started. I was surprised by all of your clever questions and beautiful understanding of my work. It confirmed the potential of youth and the respect that we must have towards you.



Guatemalan immigrant Everilda Chile and fellow Brighton High students visit the exhibition "A Mayan Procession."

That rewarding autumn day, and many more to come, took root last spring when the David Rockefeller Center won the designation of Title VI National Resource Center (NRC) from the U.S. Department of Education. Title VI funding supports and enhances the Center's ongoing outreach projects and enables DRCLAS to create and develop new programs that make Latin American resources at Harvard more accessible to the public—whether school children or teachers, journalists, business leaders, artists or activists. For example, now we can "put our money where our mouth is" in efforts to reach traditionally under-represented groups by means of funds that help cover transportation costs to Center events for lower-income school districts. The application that schools make for the funding provides us with valuable assessment information on

school cultures and classroom follow through.

Thanks to Title VI funding, outreach staff is busy developing an addition to the DRCLAS web site (www.fas.harvard.edu/~drclas) dedicated to educators and the community at large. We are planning an informative and interactive space to foster dialogue and increase public awareness of our resources. The Center sees itself as a partner in a community of learners and activists, and NRC funding will ensure that we can build on our successful outreach activities and partnerships.

CONTINUING PROGRAMS SUPPORTED BY TITLE VI

In conjunction with the Global Education Office of the World Affairs Council in Boston, DRCLAS sponsors professional development workshops for public school teachers on Latin American themes, a Latin American studies curriculum

resource center and a Latin American speakers bureau which places Harvard graduate students and other scholars in elementary, secondary and community college classrooms.

With the Harvard Graduate School of Education, the Center supports the Teachers as Scholars program, offering in-depth, high level seminars for high school teachers; language immersion institutes for teachers of Spanish and Portuguese are also offered to educators, administered by Harvard's Dept. of Romance Languages. We work with Title VI outreach coordinators and other educational organizations throughout Massachusetts on the annual World History Symposium at Northeastern University, and we are pleased to have produced, together with other NRC's at Harvard, the "Teaching Global Studies" web site, geared toward middle and secondary school educators, available now at

<www.fas.harvard.edu/~gstudies/>.

NEW PROJECTS SUPPORTED BY TITLE VI

It is an exciting time to have just joined the DRCLAS staff. A quick tour of the latest outreach projects and goals indicates the breadth of the Center's initiatives, which serve the academic, pedagogical, organizational and grassroots communities.

Along with the Latin American outreach web site, work has begun on companion guides to go along with *DRCLAS NEWS*, shaped to help teachers utilize our quarterly publication as part of their curriculum in social studies, world languages, history, Latin American Studies and other courses from middle school to postsecondary levels.

Our fruitful collaboration with other Title VI Outreach Centers (Russian, Middle Eastern, and East Asian Studies at Harvard and the African Studies Center at B.U.) has recently produced "Literatures of the World," a professional development course designed for secondary school teachers. The pilot version is being offered at neighboring Cambridge Rindge and Latin School. Harvard-sponsored scholars will present regional literatures, DRCLAS represented by the traditionally less-taught literature of Brazil, as a means of understanding culture and current events. Outreach coordinators will work closely with the teachers to develop practical curricular materials. An unusually large number of participants have already signed up.

DRCLAS is also compiling a comprehensive directory of Latin Americanists at postsecondary institutions around Boston, complementing the Boston Area Consortium on Latin America and facilitating the exchange of ideas. Further, Title VI will help DRCLAS expand Brazilian studies at Harvard and support programmatic initiatives in Mayan studies.

Future projects include developing Haitian and Creole outreach through scholarly, service and cultural organizations. While I came to DRCLAS with this goal in mind, it has gained new impetus from the welcome news that Harvard will fund a Haitian studies seminar series. In general, the Center looks to expand our mutually beneficial relationship with a growing

network of community, non-profit and student groups, media organizations and businesses.

To fulfill our role and our responsibility as a Latin American National Resource Center, DRCLAS staff regularly seek ideas and suggestions from our ever expanding constituencies. Title VI funding will not so much "change the face" of DRCLAS, as it will inspire us and deepen our essential mission, which is, after all, one of outreach in its broadest sense.

Jill Netchinsky Toussaint is Coordinator of Outreach Programs at the David Rockefeller Center for Latin American Studies. She can be reached at 617-495-9797 or <netchins@fas.harvard.edu>.

Harvard Business School

New Research Center in Latin America

BY SUSIE SEEFELT LESIEUTRE

THE HARVARD BUSINESS School launches its first research center in Latin America with the recent opening of the Latin America Research Center (LARC) in Buenos Aires, Argentina. The region offers substantial prospects for studying management, and based on a faculty and alumni poll, was the preferred site for the center. Two other HBS research centers, which opened in the late 1990s, are located in California and Hong Kong. A European center is being considered for 2001.

"The mission," said LARC executive director Gustavo Herrero, a 1976 graduate of the

Harvard Business School (HBS), "is to assist HBS faculty in developing research in the region. We are adhering to a collaborative approach, the sharing of intellectual capital." LARC falls under HBS' Global Initiative — one of three programs created to address the new global economy.

LARC opened in August with a two-day conference — 'Preparing for Knowledge Creation.' More than 100 academic and business leaders attended, including HBS Dean, Kim Clark, and 18 faculty members. Argentine President Fernando de la Rúa, who presided at the inaugural dinner, spoke of the honor Argentina had received in

being selected for the LARC site. He noted that Buenos Aires was truly a "ciudad universitaria"

because of all the schools in the city, and now even more so with the advent of LARC.



Dean Kim Clark cuts the ribbon; behind him are Howard Stevenson, Gustavo Herrero, André Jakurski, Carlos Cáceres and Felipe Monteiro.



Inaugural dinner, August conference

Attending from the David Rockefeller Center for Latin American Studies (DRCLAS), executive director Steve Reifenberg stated that "under the leadership of Kim Clark, the business school is greatly increasing its capacity to train leaders in an international context." Associate director Ellen Sullivan, also present, agreed, adding, "The David Rockefeller Center for Latin American Studies is delighted to participate in this exciting new venture, which will significantly strengthen Harvard's ties to the region."

One of LARC's goals is to aid HBS faculty in creating academic materials, which take the form of case studies, the predominant and highly successful teaching methodology employed by HBS. According to Herrero, LARC acts "as a hinge between the HBS faculty and the world in Latin America. We are both responsive to HBS faculty interests and proactive in that we bring ideas for case studies to HBS."

Herrero noted the large number of HBS foreign students and faculty, including Latin Americans: 34% of the HBS class 2001, 50% of the executive program candidates, and 30% of the faculty. Herrero said it was imperative that teaching materials reflect the international make-

up of HBS.

The very first case study LARC produced, in collaboration with HBS professor Pankaj Ghamawat, highlighted the Brazilian jet manufacturer Embraer, considered the global producer in the region. This study, showcased at the Buenos Aires conference, focused on the need for companies to compete globally by building sound business plans and understanding the interplay between government policies and commerce. Another company LARC hopes to study is a non governmental organization (NGO) in Bolivia — a credit business competing with institutional banks. A further possibility is the Chilean wine business — Herrero expressed interest in this industry because, for its small size, it has been very successful throughout the world.

In addition to this type of research, LARC will develop a network of Latin American universities to teach NGO management to area businesses. The center also intends to study how people go about starting a new business in the new economy.

Herrero has hired one Senior Research Fellow, Luiz Felipe Monteiro, who is based in Rio de Janeiro, Brazil. Monteiro plans to study a large Brazilian steel com-

pany and the evolution of investment banking in the country. Currently he is working with an engineering consulting firm in Colombia dealing with the departure of a founding partner.

Promotion of the research center extends beyond the conference in Buenos Aires. Prior to this meeting, a colloquium held at Harvard brought 66 academics together from Latin American universities. The goal of this gathering was to teach these professors the case study method. A similar colloquium is now planned for 2001.

The 65,000 HBS alumni around the world also contribute to the visibility of the site. Herrero stated that the alumni clubs they have formed are critical sources of information exchange.

Two advisory boards serve to guide LARC. One based at Harvard, the Latin America Advisory Group, is composed of 10 HBS faculty and chaired by Professor Howard Stevenson. The other group, the Latin

America Advisory Committee, is based in Argentina and is made up of 14 prominent business people from the area.

LARC will collaborate extensively with DRCLAS. Reifenberg sees the center "as a real step forward for Harvard in its commitment to Latin America as this is the first bricks-and-mortar initiative the university has had with the region since the founding of INCAE (a Harvard Business School affiliate) in Central America in the 1960s."

Herrero is also very pleased with the development of LARC and his new role as executive director. Having spent many years as CEO of major Argentine firms, he was looking for a change. He welcomes the part he will play in aiding HBS in their mission and in ultimately enriching business in the region. "I have been very fortunate in my life and I want to give something back," Herrero commented. "I see LARC as a win-win proposition for everyone."

Book Series

The DRCLAS Series on Latin American Studies will publish two new books in the Harvard University Press spring catalog: *Unequal Schools, Unequal Chances: The Challenges to Equal Opportunity*, edited by Fernando Reimers and *Globalization and the Rural Environment*, edited by Otto T. Solbrig, Robert Paarlberg and Francesco di Castri.

PREVIOUS BOOKS IN THE SERIES ARE:

- *Crossings: Mexican Immigration in Interdisciplinary Perspectives*, edited by Marcelo Suarez-Orozco
- *Latin America and the World Economy Since 1800*, edited by John Coatsworth and Alan Taylor
- *Bitter Fruit: The Story of the American Coup in Guatemala* by Stephen Schlesinger and Stephen Kinzer
- *The United States and Latin America: The New Agenda*, edited by Victor Bulmer-Thomas and James Dunkerley

All books may be ordered directly from Harvard University Press, tel. 1-800-448-2242; fax, 1-800-962-4983. You may also order directly from the HUP website <www.hup.harvard.edu>.

Crossroads and Unholy Water

Crossroads and Unholy Water, Poems by Marilene Phipps, Southern Illinois University Press, 2000.

A REVIEW BY EMILIO JUAN TRAVIESO

MARILENE PHIPPS' FIRST full-length collection of poems, *Crossroads and Unholy Water*, is sure to draw the same attention that won her the Grolier Poetry Prize in 1993. Also a painter, Phipps uses words like brushstrokes to create a sensory feast. Phipps masterfully gives her characters and scenes life with creative and colorful imagery, creating such a vivid impression that it becomes ingrained as part of the reader's own memory, not just as an impenetrable telling from hers. This is because her poems do not describe superficial scenery; rather, they delve into the raw emotion underlying it.

The world of *Crossroads and Unholy Water* is a very real world. It is a sphere of beauty, to be sure, but it does not fall into becoming a picturesque cliché. When Phipps mixes in Creole phrases (not to worry - she either translates or implies their meaning in the next few lines), she lends authenticity rather than exoticism to her poems. Phipps' authority is largely derived from her experience. Though not all the poems are autobiographical, they are about a world she truly knows, having grown up in Haiti.

It is a distant world from her world here at Harvard, where she has been a Harvard University Bunting Institute fellow, a W.E.B. Du Bois Institute fellow, and a fellow at the Center for the Study of World Religions. Phipps has also been a Guggenheim fellow, and *Transition* magazine will publish a new short story by her in its December 2000 issue.

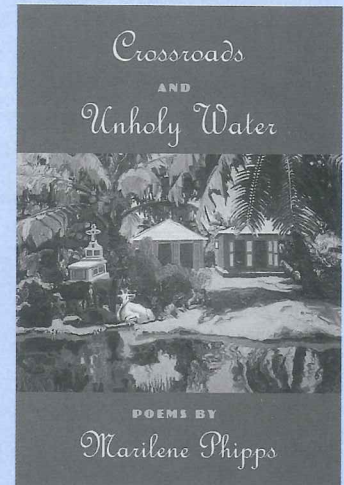
In her poems, Phipps usually focuses on the female characters, often in an original way. She has a way of exploring, and perhaps developing, the female character in the background, while leaving the dominant male in the foreground unattended. At the same time, the female's character is illustrated and defined in relation to her male counterpart. In "Elzir's Advice," a man's death serves as the occasion for Elzir, a woman, to pass on a ritual to his widow. "Caribbean Corpses" is another example. Emmanuel's funeral is used as a setting for his three granddaughters, his son's second ex-wife, his own widow, and finally his daughter, to act. In "Ti Kikit" and "Sunday Knife," the prostitutes (the former on her first night and the latter semi-retired), and not their cus-

tomers, play the central role.

Crossroads and Unholy Water is crafted in three parts, the first of which is *Caribbean Beginnings*. This set of poems draws from Phipps' childhood experiences in Haiti and is particularly rich in stimulating imagery. Phipps has a knack for describing a person or scene as if serving a banquet, one delicious image followed gracefully by another. The first poem, "Man Nini," is replete with beautiful similes. The section reveals a privileged life, with extravagant parties, and at the same time a fascination with the family's more humble servants.

Then *Life in Nerèt*, the second part of the book, moves into a less innocent phase. It starts with "Pigs and Wings," a poem in which the miracles and hopes of childhood are left in the past, and only the questions remain. With this loss of innocence, the poems in *Life in Nerèt* are about violence, full of the vulgarities and sufferings of life. This set of poems is less autobiographical than *Caribbean Beginnings*; it describes the other Haitian world: the world of the slums and poor immigrants; the world of prostitution, hunger, and disease.

Death pervades the entire



book, but it is nowhere as prevalent as in *Vigils*, the third section. Death, whether impending or having arrived, is present in every single poem of this section. The deaths of humans are couched between the first poem and the two last ones of the set, which narrate the violent deaths of animals - frogs, a bull, a snake - at the hands of humans. Perhaps this serves to remind the reader that while the human condition is to face death, it exists in a context in which we also kill.

The passage between the three parts of the book, along with the constant presence of the passage into death, suggest a meaning for the "crossroads" in the book's title. Perhaps, the "unholy water" alludes to Phipps' refusal to dress things up. Conflicts, emotions, senses, are not clouded with effervescence; she presents them as they are. Phipps insists not on profaning the sacred, but on demystifying it to show how it is already profane.

Emilio Juan Travieso is a junior concentrating in Social Studies.

Book Reviews

The Spring issue of DRCLAS NEWS will contain an extended book review section. If you have recently published a book relating to Latin America or Latin@s, please send a copy - or have your publisher send a review copy - to: June Carolyn Erlick, Publications Director, DRCLAS, 61 Kirkland St., Cambridge, MA 02138. Books may be in English, Spanish, or Portuguese.

Preference will be given to authors with a Harvard affiliation, including faculty, students, alumni, and past and present visiting scholars.

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