For a Continent Free of Disease

He had been born in Hutchinson, a small U.S. town in southern Kansas crossed by grasslands and buffeted by tornadoes. His very personality was a force of nature. According to his close friends, he only complained about two things: that there were just 24 hours in a day and that he could not be in two places at once. It was not arrogance, but rather the frustration of knowing that there was always more to be done. His solid build seemed to explain, in part, why he was tenacious, indefatigable. There was also a magnetism in his eyes that got his orders carried out ahead of schedule. He was Dr. Fred L. Soper, the fourth Director of the Pan American Sanitary Bureau, who served from 1947 to 1959.325

Fred L. Soper and the Cold War

Soper studied medicine at Rush Medical College of the University of Chicago, where he graduated in 1918. Years later he earned a doctorate at the School of Public Health of Johns Hopkins University. Both schools received strong support from the Rockefeller Foundation. After graduation, he was immediately hired by the Foundation’s International Health Division. He then began a long journey of living and working tirelessly in Brazil (where he was nicknamed “Commander”) and Paraguay, spending more than 20 years in these two countries between 1920 and 1942. One of his best-known achievements was the elimination of the African mosquito Anopheles gambiae, the transmitter of malaria, which had invaded the state of Ceará, Brazil. Also, during the Second World War, Soper spent time in Egypt and Italy helping the Allied military health services conduct delousing operations as a consultant to the U.S. Secretary of War and member of the U.S. Typhus Commission. In the Mediterranean, the group applied an efficient, effective, and low-cost typhus control protocol that introduced the recently developed insecticide DDT. A little-known story is that of the Egyptian leaders delaying implementation of the program proposed by Soper to combat an epidemic of malaria from Sudan, the same program that had already been used successfully in Brazil. The Egyptian Congress refused to tolerate the situation and shouted in unison: “We want Soper! We want Soper!”326
During his years outside the United States, Soper learned to develop, on his own, the qualities that were natural in military men like Wyman, Gorgas, Blue, and Cumming. Health was also a battlefield of sorts; public health campaigns involved an uphill struggle in which discipline, a sense of duty, and an esprit de corps were required to vanquish the enemy. In other words, just as in military conflict, they built character.

Interestingly, Soper was the first Director who had not been an employee of the United States Public Health Service. Yet like his predecessors, he had an abiding faith in the Bureau’s mission and approached every task as if it were was the single-most important one of his life. And he expected the same from his subordinates. Moreover, he engendered in them, regardless of the nature of their work, the conviction that they belonged to an organization whose purpose was noble and that each of their contributions was essential to the Bureau’s overall success.

When he accepted the directorship, Soper was already well known and respected in the world of international health. He took the position with a full awareness that the Bureau had great challenges to overcome, perhaps greater than the ability of its resources to respond to them, but he nonetheless was optimistic that he could transform the current situation. Perhaps his decision was also influenced by the fact that his wife’s mother had died that year and his wife, somewhat weary of their itinerant lifestyle, was becoming anxious to put down roots somewhere in the United States.

When Soper assumed office, he had to immediately address several delicate, though not necessarily related, issues: the expansion and reorganization of Headquarters staff in Washington, D.C.; the need to secure additional sources of funding for the Bureau’s activities; and negotiating the relationship between the Pan American Sanitary Bureau and the newly formed World Health Organization. Almost simultaneously he had to redefine the relationship with the reorganized Pan American Union which, as of the Ninth International Conference of American States held in Bogotá in 1948, was called the Organization of American States (OAS).327

Soper’s term as Director coincided with an international political period that historians have called the Cold War (approximately 1947 to 1990).328 It was an era marked by the political, economic, and cultural dominance of the United States in a world that periodically stood on the brink of a declared war involving the other global superpower: the former Soviet Union. These two spheres of influence were markedly different, not just in their economic and political systems, but also in terms of the societal model they proposed for the developing countries, which included most of Latin America and the Caribbean. At that time, the organization that came to embody the political version of Pan Americanism was the OAS, built on the foundation of the Pan American Union.

For the countries of Latin America and the Caribbean, geopolitically located within the sphere of influence of the United States, the Cold War years signified the promotion of a model of development aimed at repeating the evolution of the capitalist countries by means of such measures as limited agrarian reform, import substitution industrialization, and paternalistic—but not necessarily democratic—political regimes. There was no lack of military interventions, such as the one in Guatemala. Its President, Jacobo Arbenz, had appropriated the property of the United Fruit Company and was forced to step down in 1954 by an invasion led by Carlos Castillo Armas and supported by the United States Central Intelligence Agency. This intervention, as well as U.S. support for military dictatorships, was justified by the argument that these measures were stopping the advance of Communism.329 The United States’ period of most widespread influence during the Cold War was the two successive terms of General Dwight D. Eisenhower (1953–1957 and 1957–1961), and one of its principal champions was Secretary of State John Foster Dulles, as well known for his expertise in international relations as for his anti-communist stance.330 Despite persistent criticisms of the inter-American system as a new disguise for U.S. imperialism, most Latin
American regimes followed suit. One example was part of the speech with which Mexican President Miguel Alemán—certainly more conservative than his predecessors—welcomed President Truman: “Together we will live, together we will progress.”

The post-war era produced noteworthy demographic changes. In the late 1950s, seven countries of the Americas—no longer four, as in the 1930s—had populations of more than 10 million (the United States, 181 million; Brazil, 70 million; Mexico, 35 million; Argentina, 21 million; Canada, 18 million; Colombia, 14 million; and Peru, 11 million). Three more countries had populations of more than 5 million (Chile, Cuba, and Venezuela), and 12 had populations of between 2 and 5 million. Puerto Rico and Jamaica had more than a million inhabitants each. In some countries, the decline in the mortality rate was spectacular. In Mexico, for example, the rate dropped from 21.8 deaths per 1,000 inhabitants in the 1940–1944 period to 8.9 deaths per 1,000 in the 1965–1970 period; in Venezuela, during this same time period, the rate dropped from 18.8 to 7.8, and in Guatemala—less economically developed than the others—from 28.5 to 15.

The increased life expectancy at birth in Latin America was impressive between 1965 and 1970, reaching averages as high as that of Uruguay (69 years), Argentina (68 years), and Costa Rica (64 years), with an average of 61.2 years for Latin America as a whole. The growth rate of the population was noteworthy between 1950 and 1960, from 1.2% in Haiti to 3% in Costa Rica. At that time, most of the countries were undergoing a contradictory and rapid demographic change, with high fertility rates and a decline in the mortality rates from infectious disease. Also, as far back as 1951, most of the population of the Region of the Americas (almost 60%) did not live in the cities and was subject to a group of diseases typical of rural areas, such as malaria (this would change rapidly in the ensuing decades). The demographic and political clout the Region was acquiring, along with the growth of the Sanitary Bureau and the personality of its Director, made it possible to formalize agreements with other international organizations.

During Soper’s term in office, an agreement was signed with WHO. At that juncture, many Latin Americans were convinced that it was crucial for the organization of the Americas to be autonomous. At the proceeding for establishing WHO in Geneva, the delegate from the Dominican Republic stated emphatically that: “we want the integration of the two organizations. We do not want the absorption of one by the other.” The following year, a representative from Uruguay opening a Directing Council meeting in Washington chose similar words, saying that the best way to support the World Health Organization was: to continue strengthening and invigorating our Pan American Sanitary Organization. Not out of a local or regional spirit . . . but [out of] the absolute conviction that an individual himself is best able to understand and resolve his own problems.

This position in favor of maintaining an organization of the Americas was bolstered because little or nothing had been done to implement regionalization, even though it had been accepted in concept at the early meetings leading to the establishment of WHO. For the purposes of WHO, the world was divided into several regions besides the Region of the Americas: South-East Asia, with headquarters in New Delhi; the Eastern Mediterranean, with headquarters in Alexandria; and Europe, with headquarters in Geneva (later Copenhagen). Also created were the Regions of the Western Pacific, with headquarters in Manila (initially Hong Kong), and Africa, with headquarters in Brazzaville. But in practice, at the outset, just one regional body of WHO was in operation—that of the Americas. Even Soper thought that, in many parts of the world, those in which the idea of a multinational entity was something new, the health organization of the Americas could serve as an example.

Another fundamental reason why WHO was unable to impose absolute and immediate absorption was its small budget. That resulted in its first meetings deciding to limit the Organization’s activities to the most urgent health problems: malaria, venereal diseases, tuberculosis, nutrition, environmental sanitation, and maternal and child
health. Moreover, one of the main financial contributors was the United States (almost US$ 2 million of its total budget of US$ 5 million), whose foreign policy favored supporting not only the United Nations but also the inter-American organizations. Ratification of WHO’s Constitution by the Member States was a slow process: as of 1949, just 14 countries had done so.\(^{339}\)

 Shortly after WHO was established, the former Soviet Union and other countries that were then Communist, such as Albania, Bulgaria, the former Czechoslovakia, China, Hungary, and Poland, withdrew, undermining its legitimacy.\(^{340}\) In fact, between 1949 and 1956, WHO functioned without the participation of the Soviet Union and several eastern European countries. Also, the People’s Republic of China was excluded from the entire United Nations system up until the early 1970s. It did not join WHO until 1973. Moreover, in accordance with a request that dated back to the XII Pan American Sanitary Conference held in Caracas in 1947, it was stipulated at the initial negotiations that at least 14 Latin American countries had to ratify WHO’s Constitution in order for the agreement between WHO and the Pan American Sanitary Bureau to be effective. This was also a slow process, but the Director and other Bureau officials took steps to accelerate the agreements and activities with WHO.\(^{341}\)

 Attempts to reach an agreement between the Sanitary Bureau and WHO began at the Caracas Conference, as discussed in the preceding chapter. A special negotiating subcommittee moved forward with discussions between the delegates of both organizations, trying to smooth out differences and submitting a draft treaty at the fourth meeting of the WHO Interim Commission.\(^{342}\) That draft was approved at the First Meeting of the Pan American Sanitary Organization’s Directing Council, held in Buenos Aires in 1947, and it was sent to and accepted by the WHO World Health Assembly.\(^{343}\) The agreement was finally approved at the Second Meeting of the Directing Council, held in Mexico City in 1948. This was reflected in the aforementioned Article 54 of the WHO Constitution, which proposed a future integration based on mutual consent of the competent authorities. In the agreement between the two organizations the Pan American Sanitary Bureau was defined as the Regional Office of WHO for the Western Hemisphere. In deference to tradition, the Bureau and Sanitary Conferences would keep their own names, with the addition that the Bureau is a “regional” representative office of WHO. On 24 May 1949, in Washington, D.C., Brock Chisholm (1896–1971), the first Director-General of WHO, and Fred L. Soper, representing the Pan American Sanitary Bureau, signed this agreement, thus formalizing cooperation between the two institutions.\(^{344}\) The Second World Health Assembly, held in Rome in 1949, ratified it, and the agreement entered into force on 1 July 1949.\(^{345}\)

 The Buenos Aires meeting approved another fundamental document: the Constitution of the Pan American Sanitary Organization. Its first article set forth the Organization’s fundamental goals:

 > to promote and coordinate efforts of the countries of the Western Hemisphere to combat disease, lengthen life, and promote the physical and mental health of the people.\(^{346}\)

 In contrast, the first Constitution of WHO set forth a dramatic definition of health which, in the opinion of some, holds permanent relevance, and, in the opinion of others, represents a controversial, idealistic effort. The definition says: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” One undeniable virtue was that the second sentence of this Constitution described health as a right of every human being, regardless of creed, race, ideology, or socioeconomic level. But this definition was, and still is, debated. One of the first and less well-known criticisms of this definition associated the supposed authority to determine the level of health with the monopolization of international health activities. A pamphlet written in Nicaragua talked about the fear of absorption by asking: “Why should a newly formed administrative modality assume the privilege of determining how to ‘achieve the maximum level of health’ for a certain region?”\(^{347}\)
Under Soper’s leadership, the Pan American Sanitary Bureau adopted an approach that enabled it to survive in the midst of this new scenario of health organizations: launching ambitious programs and not duplicating the activities of other national or international organizations, but complementing them and doing something that no one else was doing. Also, Soper maintained cordial and official relations with WHO’s leadership. The first Director-General of WHO, formally elected in 1948 (although he had been Executive Secretary of the organizing Interim Commission since 1946) was the Canadian psychiatrist Brock Chisholm. His career path and his style differed from those of Soper. He studied at Yale University and in England, served on the battlefront in the First World War, and then practiced psychiatry in Toronto. Intellectually, he was tied to the European tradition of social medicine and the work of René Sand of Belgium, close to the staff of the League of Nations’ Hygiene Section, and removed from the tradition of U.S. military health and sanitation campaigns that influenced Soper so deeply.

Although Chisholm was called to public health rather late in life, he distinguished himself in the field, rising to the position of Canada’s Deputy Minister of Health. After the Second World War, he was considered an exemplary citizen because he had denounced Hitler since the 1930s, when few were taking such a stand. During the Second World War, he became Director General of the Medical Services, the highest medical rank within the Canadian Army. He concluded that the source of all wars was inferiority, blame, and fear, “recognized neurotic symptoms.”348 Chisholm was convinced that emotional maturity and an adequate standard of living would ward off any future conflict. Some said he placed too much emphasis on mental health during the early years of WHO, emphasis that seemed to give short shrift to the perennially urgent demands created by communicable diseases. His voice was soft and controlled, as was his style of managing the Organization. At some point Chisholm “resented”—he could not express it more strongly—the tendency toward excessive decentralization, which he saw as a loss of power for WHO.349 Clearly, he was a leader unlike Soper; this may be an additional explanation for the initial differences of opinion between the two organizations—which were, nevertheless, always managed with a high degree of professionalism by both directors.350

Soper’s position with respect to WHO was reinforced when, in 1950, he was reelected as Director of the Pan American Sanitary Bureau at the XIII Sanitary Conference held in Ciudad Trujillo (the temporary name of Santo Domingo between 1936 and 1961), Dominican Republic. Relations between the two institutions became less strained in 1953, when Marcolino Gomes Candau, of Brazil, who had worked in Brazil and Washington, D.C., under Soper, became WHO’s new Director-General.351

Joint activities by both organizations in different parts of the Region became common in the 1950s. Plans were drawn up for a rural health demonstration area that would organize general health services in the San Andrés Valley, a 1,200 km² expanse in El Salvador. Héctor Acuña, a young Mexican epidemiologist and future Director of the Pan American Sanitary Bureau, participated in the project. Also, a tuberculosis teaching center was built in Ecuador, with participation by the Red Cross and the young Danish health official Halfdan Mahler, whose early years were mostly spent traveling around the Andes on horseback. Mahler directed WHO in the 1970s and spearheaded the primary health care movement.352

During the Cold War, the direction and meaning of Pan Americanism remained a topic of discussion among the health officials of the Americas. In addressing the abysmal social and economic differences that coexisted in the Region, a speaker at the Pan American Sanitary Conference held in the Dominican Republic wisely observed:

. . . the presence of pain and hunger on the one hand, and comfort and even luxury on the other, may conceal an even greater truth: that the rich communities also have immense responsibilities on their shoulders and that, in addressing them, they collaborate, without any doubt, in their own happiness and in partially obtaining the happiness of . . .
The resurgence of Pan Americanism after the Second World War resulted in the redefining of relationships between the Bureau and the Organization of American States, directed at that time by Secretary-General Alberto Lleras Camargo of Colombia. Inter-American cooperation, strongly influenced by U.S. foreign policy, encompassed the economic, political, and military arenas. “Pan American” meetings, including those of specialists in tuberculosis, pharmacology, and brucellosis, just to mention a few areas, were organized. The U.S. Department of State explicitly promoted the participation of the countries of the Region in the various inter-American organizations that were being established at that time. The Inter-American Conference for the Maintenance of Continental Peace and Security, held in Rio de Janeiro in 1947, produced the historic Inter-American Treaty of Reciprocal Assistance (also known as the Rio Treaty). Its central principle is that an attack against any of the American republics is to be considered an attack against them all, thereby providing security and protection in the form of a hemispheric defense doctrine.

He was, moreover, convinced that:

> [it was] right and just that those countries in a satisfactory economic position should contribute, proportionately, throughout the Pan American Sanitary Bureau, first to the solution of regional health problems, and, eventually, to the development of adequate health and medical care programs. In doing so, those countries will be promoting their own future welfare.

The growth of the Organization

Almost immediately after his election in Caracas, Soper devoted himself to seeking out funding for the Bureau. In 1947, the Bureau’s expenses exceeded its income by 50%, despite the fact that, at that juncture, it did not have to pay rent and had only a small professional staff. A decisive measure was increasing the per capita contribution paid by each country from US$ 0.40 to US$ 1 for every 1,000 inhabitants. This resulted in a significant, fixed increase in annual income from US$ 115,000 to US$ 280,000. Also, Soper paid visits to the leaders of various countries in the Region and obtained voluntary contributions from Argentina, Brazil, Chile, the Dominican Republic, El Salvador, Mexico, and Venezuela. In 1950,
thanks to Soper’s work, the Bureau’s budget came to US$ 1,378,971. The balance in debts or arrears was just US$ 117,499, and income exceeded expenses.357

At the same time, Soper began recruiting employees for the Washington, D.C., Headquarters office. In December 1946, the Bureau had just 32 employees, many of whom were paid by their own countries. By April 1950 it had 171 employees, the vast majority paid by the Sanitary Bureau or by WHO. Four years later, there was a staff of 412, including 72 medical officers, 1 dental officer, 28 nurses, 18 scientists, 7 veterinarians, 8 sanitary engineers, and 44 technicians and non-professional field personnel. Of these, 219 (more than 50%) worked outside Washington.358

Order, professionalism, administrative efficiency, transparent accounting, and loyalty were the values Soper sought in the team that would support him. He appointed Dr. John R. Murdock, formerly in charge of planning and coordinating the Bureau’s program activities, as Assistant Director. Murdock had extensive field experience in Brazil and Ecuador. He had also actively participated in setting up the Bureau’s first regional organizations. In 1951, after 15 years with the Bureau, Murdock retired and was replaced by Paulo C. A. Antunes of Brazil. When Antunes returned to his country to accept the position of Dean of the São Paulo School of Public Health, Marcelino Gomes Candau of Brazil (1911–1983), Assistant Director-General of WHO in Geneva, accepted the position. He did not stay long in that position, however, because, as we have mentioned, he was chosen to be Director-General of WHO in 1953.

Another close collaborator of Soper’s was the Mexican epidemiologist trained at Johns Hopkins University, Miguel E. Bustamante, who was responsible for the Boletín de la Oficina Sanitaria Panamericana and the Spanish version of the WHO Chronicle. We can learn something about Bustamante from what he said at one of the first meetings of the Region’s medical educators: that health officials had two salient characteristics—having dreams and trying to make them come true.359 By 1951 the Boletín was being published monthly, distributed free of charge to the authorities of the Region, was printing more original articles, and had grown markedly: 1,446 pages and 7,400 copies, of which 7,115 went to subscribers and, of those, 6,895 were distributed in the Americas. The Boletín also became more scientific in nature, as indicated by the “writers’ guidelines” that were developed during this period:

(1) Articles submitted for publication shall be unpublished.

(2) Originals, written in English, French, Portuguese, or Spanish, shall be sent to the Editorial Section, which shall submit them for the decision of the Publications Committee.

(3) The text shall not exceed 20 pages . . . typewritten on one side of the page, double spaced, with a wide margin. The original shall be on plain paper, with one copy.

(4) The title shall be as brief as possible. The name of the author(s) shall be shown immediately after the title and at the end, along with, in the former case, the official position or academic degree and name of the institution, if the author is associated with one, and, in the latter case, the address.

(5) Each work shall include a summary and conclusions, if any. The bibliography shall adhere to the established guidelines: author’s surname; initial; title of the work in its original language; name of the publication, in abbreviated form (journals), or publisher and city (books); volume number; numbers of the first and last pages, separated by a hyphen; month; and year.

(6) The illustrations, with their captions, shall accompany the work.

(7) The originals shall not be returned under any circumstances.

(8) The authors of articles solicited by the Director of the Bureau shall receive 20 copies of the Boletín free of charge. Other authors shall receive 10 copies. Offprints shall be made at the request of the author and at his/her expense. Total or partial reproduction of the material published in this Boletín is authorized on condition that the source is cited.360
Bustamante was also responsible for preparing summary records of the Bureau’s meetings and for editing the *Weekly Epidemiological Report* on diseases subject to quarantine, which was distributed by airmail, and another Monthly Epidemiological Report, which dealt with the incidence and mortality of the major communicable diseases. Another valuable publication was the Spanish translation of the first volume of the *International Pharmacopeia*, originally published in English by WHO.361

A letter from Bustamante to the representatives at one of the first Directing Council meetings in which he participated highlights the challenges of trying to overcome the problems inherent in a slow, incomplete epidemiological information system.

**REQUEST TO THE DELEGATES**

I ask that you kindly supply, on the attached page, the current list of the major sections, divisions, or departments of your country’s sanitary organization. This request is made because the reports that the undersigned has in his possession are from prior years and, in some cases, are five years old.362

Bustamante also played a decisive role in organizing the First Inter-American Congress of Public Health, held in Havana in October 1952. The meeting was called by resolution of the XIII Pan American Sanitary Conference to commemorate the 50th anniversary of the Sanitary Bureau and as a tribute to Carlos Finlay. The meeting, held in Cuba’s ornate Capitol building, was attended by leaders in the field of health in the Americas, such as Mario Pinotti, Director of Brazil’s Malaria Service, and Brock Chisholm, Director-General of WHO. On that occasion, the Cuban scientist was recognized for being the first to discover the mechanism of transmission of yellow fever, and the status of medical and health education in the Region was studied.363

Soper also hired a legal advisor to study the contracts, agreements, and documents that had to be interpreted and signed, and, also essential to his work, he hired a secretary who could read his Pitman shorthand—a communication form that, in and of itself, indicated that he lived in a perpetual hurry. He also established a cable address—OFSANPAN—which appeared on all letterhead.364 These actions implemented an organizational structure in which the activities of the three major Divisions—Public Health, Administration, and Education and Training—were clearly specified.

The Division of Public Health was responsible for health promotion services. It included sections for administration, nursing, nutrition, and maternal and child health, among others, as well as environmental sanitation services (including sanitary engineering and insect control programs), and communicable disease services. The Administration Division had a legal office, an administrative management and personnel service, and a finance and budget service. The Education and Training Division was responsible for scholarships and educational programs. Some of the scholarships were from PAHO, and others were from institutions such as UNICEF, which had entrusted the scholarships’ selection, oversight, and administration to PAHO.365

After the Second World War, UNICEF, an arm of the United Nations established in December 1946 to save European children from famine and disease, extended its assistance to poor countries. Although it was not involved in health matters alone, it devoted a good part of its budget and efforts to them.366

Also, Soper was attracting other talented, hardworking young people to the field of Pan American health. Noteworthy among them was the U.S. pediatrician Myron Wegman who had, as Chief of the Bureau’s Education and Training Division since 1952, increased the number of scholarships and travel grants. Wegman later became Secretary General of PAHO (a high-level position that no longer exists) and, thanks to help from the W.K. Kellogg Foundation, organized two important meetings at which Latin American medical education was analyzed and more importance was placed on prevention. One was held in Viña del Mar, Chile, in 1955, and the other in Tehuacán, Mexico, in 1956.367 It was during that period that the Bureau was joined by Benjamin Blood of the United States as head of a new
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veterinary health section; Clarence H. Moore, also of the United States, in charge of administration; Chilean bacteriologist Abraham Horwitz as country representative in the Lima office; and Mexican epidemiologist Héctor Acuña as the Bureau’s first representative in the Dominican Republic. The latter three also held degrees in public health. Another official who began his career with the Bureau in 1957 was Pedro N. Acha of Peru (1931–1988), an expert in veterinary medicine, especially agricultural veterinary medicine, and in international health. He was also a noted academic and coauthor of a widely-cited book on zoonosis and communicable diseases common to human beings and animals.368

Soper himself interviewed several young people who hoped to work at the Bureau. It seems that the interviews were something to be feared. According to one report, when Soper entered a room it was immediately apparent “who was the boss.”369 He valued creativity, persistence, astuteness, and courage. And it was precisely courage that was needed in a job interview with Soper. At one, he received a young man who was applying for the position of sanitary engineer with a mixture of warning and reproach. Soper told him he thought that the members of his profession had aggravated several sanitary problems because of a lack of knowledge about public health. The applicant was undaunted. He answered, defiantly, that the real problem in public health was the doctors, who used engineering but knew nothing about it. Soper hired him on the spot.370

The Director of the Bureau concerned himself with having a centralized library; a unit of professional translators of English, French, Portuguese, and Spanish; and with finding more space. In this respect he had to show his character, sometimes facing down his own government. An envoy from President Truman tried to convince him to accept a building that had belonged to a truckers’ association. Although there was more space than the Bureau had at the Pan American Union building, the proposal meant being far from downtown Washington, the site of many meetings. The contract was for just 20 months, the rent was high and had to be paid by the Union, and the move had to be completed in one month. After seeing the building, Soper said he preferred to stay “where they were” because in that way “everyone” could see the Bureau’s “poverty,” but that if they took refuge in the proposed location, they would be forgotten. With some irony, he wrote in his diary that the employee who showed them the building “... seems to think that beggars have no right to be choosers! Too bad his experience with beggars is not more extensive!”371

Finally, that same year, Soper obtained for the Bureau’s use a beautiful mansion that had been used for the training of U.S. diplomatic personnel.372 Not long after that, thanks to a very favorable loan from the W.K. Kellogg and Rockefeller Foundations, the Pan American Sanitary Bureau moved to the Hitt House in Dupont Circle, an area surrounded by embassies and other public buildings. It also occupied a neighboring building known as Blodgett House.373 A short time later, the Executive Committee (a smaller subdivision of the Directing Council, created at the Sanitary Conference in Caracas in 1947) thought about moving the Bureau’s headquarters to some city in Latin America, such as Mexico City or Lima, and a committee was set up to seriously study the matter. But that never happened, and the headquarters remained in the capital of the United States. Nevertheless, the move discussed here would not be the last. In the mid-1960s, under the leadership of Dr. Abraham Horwitz, PAHO moved to a building especially built for its purposes near the Foggy Bottom section of Washington, D.C., which it continues to occupy until this day.

Another important step taken by the new Director was making the Bureau’s bank account independent. A large part of the institution’s funds came from the United States Department of the Treasury but, since they came through the Pan American Union’s account, there were delays and other complications.374 Soper’s solution was to open a business account and to establish a revolving fund at Riggs National Bank. That action enabled the Bureau to fulfill its financial responsibilities without undue delay and ensured better control
over the disbursement of salaries and pensions to staff members.

Although the documents merely hint at it, the style of officials such as Moll did not fit in with Soper’s plans. It would seem that Moll was not interested in working with Soper either. Beyond their differences of opinion, each represented a different era of the Bureau. Moreover, the generation of Latin American health officials that shone with Cumming—such as Paz Soldán and Alberto Zwanck (a professor of hygiene, Director of the Institute of Hygiene of the University of Buenos Aires, and representative of and advisor on international health policy to the Department of Public Health of Argentina) was moving on to retirement or was no longer being considered for service as official representatives at the inter-American meetings. John D. Long, for example, had died in Guayaquil in 1949. Nevertheless, Carlos Enrique Paz Soldán and other distinguished, experienced public health officials, such as João de Barros Barreto of Brazil, Edmundo Fernández of Venezuela, and Manuel Martínez Báez of Mexico, were recognized as “honorary members” of the Organization and, from there on out, their names appeared on back cover of official publications.

Once decisions had been made about the location of the Pan American Sanitary Bureau in Washington and its place in the realm of international organizations, Soper devoted himself to setting up a series of programs in the Region. These included organizing a nursing section under Agnes Chagas, who was appointed Regional Advisor in Nursing in 1947. Her duties included surveying the Region’s nearly 60 heterogeneous nursing schools, about which little was known—such as the fact that they had an annual enrollment of 4,000 students—and providing support to the governments and health services in the area of nursing. The first two regional nursing meetings were held in 1949 (San José, Costa Rica, and Lima, Peru, respectively).

At that time, the field of nursing was growing along with the construction of urban hospitals and the setting up of new services. It was estimated that there were 5,000 nursing professionals by the early 1950s—a significant number, but still insufficient to meet the growing demand for personnel of this type.

Skillfully, Chagas melded the desire for social advancement felt by many young women with the professionalization of advanced education in nursing and the needs for improved management in the practice of nursing. It was a professionalization process similar to the one many health workers had followed in the early twentieth century, and it transformed the nurse into an intermediary between doctor and patient, a family health advisor, and a more specialized caregiver. This evolution coincided with other important changes affecting women’s status in Latin America, since many countries were starting to legally recognize women’s right to vote and even be elected to hold high public office.

Chagas summed up the change in a profession that was largely feminine and whose prestige grew: Formerly, when the word “nurse” was mentioned, people pictured a slovenly, untrained woman working in hospitals who often could not read or write. Nowadays, however, it is very likely that the word will evoke a neat young woman, well educated in her field, dressed in a crisp, white uniform.

By late 1951 there were 17 nurses working for the Bureau, just two of whom were stationed in Washington, D.C. In El Salvador, the nursing section offered nursing graduates a refresher course. In Ecuador, nurses assigned to the tuberculosis program received special training. In Colombia, an obstetrics course was organized for nurses, and in Paraguay, a course was developed to qualify them for general public health services.

Another important change promoted by the Bureau was the significant increase in scholarships for young doctors, sanitary engineers, nurses, dentists, veterinarians, and other health professionals of the Region. Up until the Second World War, the organizations that supported study abroad and the number of scholarships were limited. But after the War, an explosion in the number of scholarships, especially to U.S. institutions, resulted in

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the “Americanization” of medical education and public health in the Region. The inter-American health organization set criteria that continue to be valid today, such as selecting candidates and fields of study in accordance with the given country’s most urgent needs and emphasizing the scholarship winner’s commitment to return to his or her country and the country’s promise to hire the scholarship winner after his or her studies were completed. In 1953 alone the Sanitary Bureau awarded a total of 415 scholarships, of which 60 were for the study of health administration and 32 were for the study of nursing. In 1958 the number of scholarship winners climbed to 560, a growth rate of more than 30% with respect to the previous year; many of these scholarships were directed at sanitation and medical education.

In the early 1950s, the Organization’s work was divided among three governing bodies. The first, the Pan American Sanitary Conference, was held every four years with delegates from the Member and Observer States. The second, the Directing Council, comprised of a representative from each of these countries, met every year. The third, the Executive Committee, consisting of representatives from seven countries, held biannual meetings. The First Meeting of the Directing Council was held in 1947 in Buenos Aires. As we have mentioned, it was here that the relationship between the Organization and WHO was defined. The major areas of work and the budget were Headquarters activities, field work, and the organization of work by zones.

Zone I, with headquarters in Washington, consisted of Alaska (with U.S. territorial status until gaining statehood in 1959), Canada, the United States, and the non-self-governing territories of the Region, except British Honduras (now Belize). Zone II was headquartered in Mexico City and included Belize, Cuba, the Dominican Republic, Haiti, and Mexico. Zone III operated out of Guatemala City and included Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama. Zone IV had its headquarters in Lima and included the Andean countries: Bolivia, Colombia, Ecuador, Peru, and Venezuela. Zone V included only Brazil and had its headquarters in Rio de Janeiro. Finally, Zone VI included Argentina, Chile, Paraguay, and Uruguay, and was headquartered in Buenos Aires. The field offices in El Paso, Texas, and in Jamaica remained in operation; the latter concentrated its efforts on the control of Aedes aegypti in the Dutch-, English-, and French-speaking Caribbean.

Clarence H. Moore of the United States (1909–1988) was a prominent official who joined the Bureau in 1952 to coordinate the expansion of the zone and country offices. His training as an administrator, his experience as a WHO official in Geneva, and his altruism prepared him to assume these difficult tasks. In 1957 he took on another very important duty: head of the budget and finance section. In this capacity he helped develop the program budgets, shape institutional policy, and provide funds for the growing number and variety of regional activities.

From a historical perspective, that incipient regionalization came after the work of the traveling representatives and ensured that direct responsibility for planning and implementing the field programs fell to the local Bureau officials. The presence of international consultants, with contacts abroad, who addressed the countries’ everyday health problems, frequently enabled them to act as catalysts vis-à-vis the national health organizations and obtain professors for training courses or technical experts for new programs. Organization by zone meant that it was no longer necessary to seek consultations and wait for decisions and funds to emanate centrally from Headquarters, thus making for more efficient decision-making and dispersal of funds as they were needed. Moreover, the zones became a source for the recruitment of new international health personnel as well as new scholarship opportunities that enabled young Latin American doctors to take postgraduate courses in public health in the United States.

Another significant process that began in the 1950s and continued through the next two decades was the progressive inclusion of the countries of the Caribbean, Central America, and northern South America in the meetings as full members, no longer
just as observers. One way to do this was to invite representatives from France (with a presence in the Caribbean and French Guiana), the Netherlands (representing the Netherlands Antilles and Dutch Guiana), and the United Kingdom (whose possessions included British Honduras, Jamaica, and British Guiana) as full delegates. At the 1951 meeting of the Directing Council, the report of the delegate from the Netherlands made it clear that “the Americas” was still not perceived as a region that included the Caribbean:

The OAS . . . [is a] purely American organization in which no foreigner has the right to participate. So I cannot but be surprised by the generosity shown in accepting foreigners at your meetings.\(^{384}\)

Over time, the foreigners stopped being foreigners and, as this statement suggests, concern over health in the Region would supersede political interests.

A basic Bureau objective during this period was that of establishing national health services with well-trained staffs. This required candidates to possess an advanced university degree in medicine or one of the health sciences and experience in public health and administrative duties. Those who met these qualifications reaped the benefit of being able to work full-time, with a secure position, adequate salary, and opportunities for career advancement—in other words, they were able to remove themselves from the vicissitudes of partisan politics. The goal was to establish services with administrative responsibilities that were decentralized (i.e., not concentrated in the office of a ministry); produced timely, clear, quantitative indicators; conducted research; adapted themselves to local conditions; and, above all, sought to extend health activities as the appropriate personnel became available, because: “rapid expansion without well-trained personnel is one of the most serious errors that can be made in public health work.”\(^{385}\)

While it is true that these objectives, approved at the XIII Pan American Sanitary Conference in 1950, were not embodied in all the national services, they had a marked influence on the employees of the zones, various research institutes to be described shortly, and Headquarters. The cadre of consultants was becoming homogeneous, and a career path and identity that were more international than national were gelling. The employees’ loyalty was to the Bureau, since they were not detailed members of the U.S. Public Health Service or of their countries’ ministries of health. They began receiving stable salaries and attractive pensions, reimbursement for settling-in expenses, and other types of assistance.\(^{386}\)

Another important feature was the increasing national and cultural diversity of the Bureau’s personnel. In 1952, of the 191 Headquarters employees, 72 were not U.S. citizens, a significant difference with respect to previous eras in which almost all the personnel were from the United States. Of the 42 employees assigned to the different zones, 24 were “international” (i.e., not nationals of the countries in which the zone offices were located). And of the 143 employees assigned to special projects, 84 were international. The constant participation in activities carried out in different parts of the world, fluency in two or more languages and their respective colloquialisms, and the ability to adapt to working with people of different nationalities and to a peripatetic existence, helped forge a new identity and career profile for the Bureau’s staff.\(^{387}\)

Many of those employees were considered regional public servants, experts in the design and application of scientific methods that led to social progress and a better quality of life. Among the problems that had to be addressed are those resulting from the fact that some of them were young professionals whose advice experienced or apprehensive national directors of health found difficult to accept. Moreover, when the Bureau hired a large number of employees who were experienced in the local arena, there were protests because the national services had been left without employees.\(^{388}\)

The staff increases of the various international organizations after the Second World War were tied to new values on the international scene, such
as technical competency in contrast to politici-
ization, the possibility of development in the poorer
countries, the universality of human experience,
and professionalism as opposed to improvisation.
That produced relative autonomy for these insti-
tutions vis-à-vis the foreign policy of the most
powerful countries during the Cold War years—
the United States and the former Soviet Union. It
was a process which, according to the historian
Irye, can be clearly traced to and identified with
the early twentieth century. But a group of health
officials whose identity was not branded by their
countries’ foreign policies or by nationalist mo-
tives was established only in the second half of
the century. This process confirmed the value
of health as a supranational objective.

In the 12 years during which Soper was Director
of the Pan American Sanitary Bureau (1947–
1959), the number of employees rose dramati-
cally: from 88 to 750. That was accompanied by
the establishment of a Staff Association and a se-
ries of newsletters. One of the earliest was Óbice,
Voz, Voix, which first appeared in December
1951 in all the official languages of the Organiz-
ation. By the late 1950s, the Bureau’s budget—
then in the neighborhood of US$ 2.5 million—
became more regularized and clear (two note-
worthy characteristics) and continued to grow steadily.
The first evaluation of the state of health
of the population of the Americas was prepared
in 1954. Since that time, a comprehensive over-
view has appeared regularly, every four years,
under the title of Health Conditions in the Ameri-
cas (it has been called Health in the Americas
since 1994).

The increase in the number of the Organization’s
employees was not limited to the Washington, D.C.,
Headquarters office. During Soper’s admistra-
tion, research institutes located in Latin America
and associated with the Organization were
founded: the Institute of Nutrition of Central
America and Panama (INCAP), with headquar-
ters in Guatemala City, and the Pan American Foot-
and-Mouth Disease Center (PANAFOTA), estab-
lished in 1950 in Rio de Janeiro. Also established
was the Pan American Zoonoses Center (known
as CEPANZO) in the city of Azul, Argentina, de-
 voted to the study of important communicable
diseases common to human beings and animals
(such as brucellosis, bovine tuberculosis, anthrax,
and rabies, just to name a few). This Center is now
known as the Pan American Institute for Food
Protection and Zoonoses (or INPPAZ), and has
been operating out of Buenos Aires, Argentina,
since 1991.

The decision to establish INCAP in Guatemala City
dates back to the XI Sanitary Conference in Rio
de Janeiro in 1942, but it was not fully opera-
tional until 1949. From its earliest days it enjoyed
the valuable support of the W.K. Kellogg Founda-
tion, which provided scholarships, donations, and
laboratory equipment. Also, the Rockefeller Foun-
dation facilitated the training of agronomists in
Mexico under the supervision of J. G. Harrar, then
the leader of the “green revolution.” Experts
and authorities from Costa Rica, El Salvador, Gua-
temala, Honduras, Nicaragua, and Panama par-
ticipated in INCAP’s work. The institution’s im-
portance to Guatemalan professionals is attested
to by the fact that, in 1951, that country had the
second-highest number of employees in the Or-
ganization, after the United States.

INCAP’s guiding principles were pertinent and
relevant: to investigate the foods of greatest nu-
tritional value and lowest cost (such as vegetable
proteins), to understand the eating habits and nu-
tritional deficiencies of the Region’s poorest so-
cial segments, and to promote food production in
accordance with the population’s basic needs, with
special attention to the problems of the single-crop
farming areas. Likewise, the programs involving
cooperation with agricultural entities acquired
growing importance in connection with the iden-
tification of more nutritious varieties of corn and
beans capable of surviving in difficult and diverse
conditions of soil, rain, and altitude. Another
project entailed producing iodizing sea salt to pre-
vent goiter, a disease associated with deafness,
muteness, and mental retardation. The Institute
produced the film Los ángeles con hambre, which
discussed the widespread practice among poor
families of diluting milk with water based on the
erroneous assumption that this would increase its
yield without nutritional loss. One of the most
interesting achievements of those years was the development of Incaparina, a flour with high nutritive and protein value.

PANAFTOSA was designed as a technical cooperation project of the OAS (with the collaboration of PAHO) and the Inter-American Institute for Agricultural Sciences, with the support of the Brazilian Government and the Food and Agriculture Organization of the United Nations. The Center’s work was to train laboratory personnel to identify and study the virus that causes the disease, run national-level programs or fieldwork, and train veterinarians to examine the tongues and hooves of cattle in order to control foot-and-mouth disease in the Americas. The objective was to encourage each country to establish a regular service with its own laboratories to diagnose a disease that was ravaging the Region’s cattle and causing, in some countries, a drop of up to 25% per annum in livestock productivity. In addition to conducting studies, analysis of samples to diagnose the disease, disinfection programs, and seminars with participants of various nationalities, films and pamphlets with interesting titles such as El magnifico toro were produced.

Although they did not attract as much funding as the diseases targeted for eradication, other actions promoted by the Bureau speak to the diversity of its activities and suggest that, while the “vertical” perspective concentrating on the application of technology could be dominant, other, more holistic approaches did not go away. For example, the Boletin disseminated information about a seminar on the teaching of preventive medicine held in Puebla, Mexico, in April 1956, and revealed an interest in two related, but often overlooked, areas: oral public health and the teaching of dentistry.

One lasting decision that was made during Soper’s tenure was that of renaming the institution. At the XV Pan American Sanitary Conference, held in San Juan, Puerto Rico, in 1958, public health leaders proposed that the Pan American Sanitary Organization instead be called the Pan American Health Organization. It was felt that the former did not fully describe the entity’s functions and suggested isolated interventions that were no longer representative. The word “health,” however, was a broader term that better captured the Organization’s character and the nature of its ongoing activities, and it would facilitate efforts to garner more support from the general public. Special care was taken to ensure that the name worked in the Organization’s four languages: Pan American Health Organization, Organisation Panaméricaine de la Santé, Organização Pan-Americana da Saúde, and Organización Panamericana de la Salud. One important continuity was that the name of the Pan American Sanitary Bureau, which basically referred to the employees in the Washington, D.C., Headquarters office, remained the same.

Another change in the Organization’s life was that, prior to the Second World War, the majority of the Conferences’ resolutions were basically recommendations for the Member Governments. But, since the late 1940s, the meetings decided on the actions that the Bureau itself should undertake, with the countries’ consent. Some of these, perhaps the most important, were imbued with an ideal that began to gain acceptance in the imaginations of Soper and the Organization: the possibility of eradicating or eliminating certain infectious diseases. A noteworthy project in those days was the fight against yaws in Haiti. The fight against this disease triggered the deployment of well-thought-out eradication strategies as an all-encompassing public health intervention.

**Eradication as Doctrine**

During the Cold War years, Soper was one of the architects of the concept of eradication of certain infectious diseases. He believed that this concept could be applied to a series of diseases, such as malaria, yellow fever, and even tuberculosis. One of his first experiences in applying this concept occurred in Haiti in the early 1950s. That country was plagued by a disease caused by the same treponema that is responsible for syphilis: yaws. It was found in all the rural areas, where it affected 40% to 60% of the population. It was feared because of its contagiousness and its effects: it ate
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away at the skin, leaving the bones almost exposed, spread across the palms of the hands, and, in severe cases, mutilated the face. Some patients walked slowly, like crabs, to avoid pain from the lesions on the soles of their feet. The traditional response was often the terrible segregation in leprosaria or yaws houses, which also entailed the loss of jobs, family, and social support.

With the excessive hope spawned by many new medical technologies, intramuscular injections of penicillin appeared as a solution more effective than the traditional drugs made with arsenic and bismuth. The Pan American Sanitary Bureau, UNICEF, and the Government of Haiti joined forces in 1950 in a titanic effort to “eradicate” the disease. Using a model that would be reproduced in other campaigns (such as those against malaria), a division of labor was established. The Sanitary Bureau’s cooperation focused on technical consultants: their travel and lodging expenses, inside and outside of Haiti. UNICEF provided the penicillin, the equipment and materials for the campaign, and the vehicles needed to carry out the program. Haiti paid for the employees in charge of performing the administrative work, administering the treatments, conducting the surveys, and tabulating the statistical data. Also, the government supplied space, furnishings, and supplies for the program offices. The Bureau’s contribution for the 1950–1954 period was estimated to be US$ 200,055; UNICEF’s contribution was approximately US$ 580,000, and Haiti’s was US$ 605,650. The Government of Haiti established a specialized service known as Campagne pour l’Eradication du Pian (Campaign for the Eradication of Yaws) which, while subordinate to the Ministry of Public Health, enjoyed a high degree of administrative and financial autonomy.

Early on, treatment centers, to which it was assumed that the patients would come, were set up. Later it was discovered that it was much more effective to set up outpatient clinics in the field and make house-to-house visits. A detailed administrative pyramid and epidemiological map of the country were developed. The country was divided into five zones, 10 subzones, and 78 districts. Each district had an inspector trained to diagnose yaws and perform epidemiological work. The program doctors and the chief and assistant chief zone inspectors carefully supervised the district inspectors. Such impressive care was taken in attempting to cover every base that it was apparent even in the campaign reports. For example, special attention was given to preventing the disease from spreading by treating the people who had come in contact with the patients with penicillin. These were not just the members of the immediate family and/or household where the patient had been identified, but included the residents of the neighboring houses and, in the case of schoolchildren, all the students at that particular school. According to Soper, this care was the essence of the “Haitian” method, and precedents included the campaigns against Aedes aegypti and Anopheles gambiae in Ceará, Brazil.

Another important lesson learned in this public health intervention was the need to understand popular sentiment. At the outset, the houses checked by the health officials would be marked with red wax pencil, but when a local resident alerted them that red was a sign of “bad luck,” they changed the system for identifying homes. The experience also brought to light the tension among the international health organizations. Soper, who had turned down the position of health director of the Institute (Office) of Inter-American Affairs because he felt it was too political, had to confront entities and institutions of his own government: he rejected using international health as a tool of U.S. or any other country’s foreign policy, an attitude which was uncommon at the time. His position was inspired by a practical conviction: in order to be effective, public health had to be concerned only with itself. A few years earlier, he had emphatically said as much to a U.S. official: “When politics and science are mixed, science generally loses out.”

As Director of the Bureau, Soper believed it was necessary and possible to maintain an organization that was eminently technical, impartial, and objective, whose purpose was to ensure the well-being of the inhabitants of the Americas. In other words, it had to be apolitical, or at least not have any partisan political commitments. This perspective—
the practicality of which is still subject to debate—legitimized the concept of inter-American public health and enabled him to use it as a shield against political pressures to accept projects that would serve chiefly as propaganda for a given regime or that were being promoted only because of their low cost. According to Soper, the “determining factor” for choosing a health program should be its appropriateness, regardless of whether it was large or small, expensive or cheap.406

Some of these ideas were applied to the fight against yaws.407

The campaign was huge: between July 1950 and March 1952, some 895,354 people were treated, and it was expected that the country’s entire affected population would be treated in short order.408 By August 1956, some 68,332 patients and 297,408 contacts had been treated with penicillin. In other words, the program cared for a total of 365,740 people affected by yaws. That was a significant number, considering the fact that Haiti had slightly more than 3.5 million inhabitants. Another impressive figure is that, by late 1954, 97% of the country’s rural population had received injections of penicillin to cure or prevent yaws.409 Complementary programs were established to fight the disease in neighboring or nearby countries, such as the Dominican Republic and Venezuela. The samples collected between 1958 and 1959 indicated that the prevalence rate for yaws in Haiti had been reduced to 0.32%, which is significant considering that the estimated percentage at the beginning of the decade was between 30% and 60%. This meant that just 40 infectious cases remained in the entire country.410

The remembrances of one of the Bureau’s health officials who worked in Haiti reveals the human and compassionate face of the medical treatment, as well as the health officials’ learning process. There is testimony about health professionals picking up a patient named Aceife from a health center and taking her to visit her family, in keeping with the practice of treating the infected person’s entire family in order to reduce the likelihood of reinflection by contact with another patient.411

Despite its grammatical flaws, what follows reads more like the script for a documentary film than a report:

Aceife is a pregnant woman who was treated for secondary syphilis. During her stay in the hospital . . . her husband . . . was also treated to avoid “ping-pong” infections. It was then decided to take the patient Aceife to her home and examine the rest of the family. . . .

At 8:30 a.m. we were in Thomazeau. The road to Thomazeau is passable except for a few miles which in rainy season would be quite a job. From Thomazeau to the patient’s home, we will have to go on foot. We asked Aceife if it is far, but she immediately affirmed that it is “very near.” . . . This . . . meant 15 kilometers and took us 2 hours and 40 minutes. . . . As we approached her house the patient complained she is sorry that she has nothing to offer us. We explained to her that our only purpose in coming [was] to clean up her household of sickness and not to be entertained. . . . We arrived at 11:30 a.m. The consultation starts. The husband who was treated by us made the propaganda for us. We wished to start with Aceife’s family, but it is out of the question, as she insisted upon cleaning her house first, washing the children, and only then . . . will she show them to us . . . . We are installed in a house, and the people are starting to come from all sides. We see many cases of mycotic infections, herpes . . . yaws, and one case of otitis. Finally we have the pleasure of confronting Aceife’s family. Two girls do not show any clinical evidence of the disease but as a prophylactic measure we inject them with penicillin. The smallest, however, shows evidence of the disease and also is treated. For this little patient it was worthwhile the entire trip.

Two final comments remain on this fascinating testimony. The health officials returned to the hotel “tired but satisfied.” The author drew some conclusions from this experience. One, which he underlined, was: “You cannot hurry these people.” Another thought reinforces the first: “To obtain cooperation . . . their native traditions need to be respected.” Finally, in pencil, he wrote a community maxim that still resonates today: “The best propaganda is done by patients.”412

The work against yaws resulted in some encounters between Soper and one of the most feared personalities in the history of Latin American politics, the dictator François “Papa Doc” Duvalier.
On one occasion, Soper and a group of officials were brought before Duvalier, a former physician who had headed Haiti’s national public health service in the 1940s and later became his country’s health minister:

when ushered into the sanctum sanctorum we found the President’s desk at the far corner of a long narrow room . . . . In moving an extra chair from along the hall . . . . I came to see, on a low table [at the] back of his desk at his right hand, a pistol which was not apparent to the others.413

Very probably, Duvalier did not have the pistol there for use against the visitors, but the incident suggests that the dictator was aware that he could be killed at any moment.

Besides yaws, there were other “vertical” programs that absorbed massive amounts of resources from the health organization of the Americas. One related to the decision to eliminate smallpox, made in 1950. This objective was achieved slowly because of the difficulties involved in preserving the vaccines, since keeping them at low temperatures, for example, was not always possible in rural areas. Also, the Bureau tried to eliminate the *Aedes aegypti* mosquito, the principal transmitter of urban yellow fever. In the budget of US$ 6,149,690 for 1958, which included all the funds administered by the Bureau, the eradication programs (malaria, yellow fever, yaws, and smallpox) and programs for the control of other communicable diseases accounted for 59.3% and 7.8% of the total, respectively. In contrast, the items “Strengthening of general services” and “Education and training” accounted for just 25.7% and 7.2%, respectively. 414

The notion of eradication colored many of the Bureau’s activities during Soper’s tenure. In the mid-1950s, in a pamphlet published in Brazil, the Director explained that: “the complete eradication of communicable diseases or their vectors is replacing, insofar as possible, simple control measures.”416 In a pivotal article published in the *Boletín* in 1957, Soper masterfully used historical examples to justify the new public health perspective. The article starts off with an example and a definition of what he understood by eradication:

Since the moment Pasteur did away with the concept of spontaneous generation of infectious disease, the concept of eradication of the causative agents of communicable disease necessarily arose. Etymologically, the word “eradicate” comes from the Latin and means “to pull out by the root” or “exterminate.” Prior to Pasteur, the verb “eradicate” and the noun “eradication” were used in medicine in a more restrictive sense, and so we spoke of eradicating a disease from a specific patient. Nowadays we understand the eradication of a disease to mean the total suppression of all sources of infection or infestation so that, even if no preventive measures of any kind are taken, the disease does not reappear.417

The most famous and widespread eradication operation was the battle against malaria, an overwhelmingly rural disease. In 1954, the Pan American Sanitary Bureau launched an ambitious effort to eradicate the disease from the Americas. This illness, characterized by intermittent fever that generally did not kill but affected peoples’ ability to work and their lucidity, was certainly one of the major diseases of rural Latin America. Arnoldo Gabaldón of Venezuela, an internationally renowned pioneer in malaria control, described in dramatic terms the humanitarian reasons for fighting the disease and recalled his own experiences:

a great tragedy was the finding [by a health official] of a boy tied to a table leg as the only safety measure his mother had when she lost consciousness due to the fever . . . . the scene a doctor found, a baby trying to suckle from his dead mother’s breast, was dreadful. The ranch where a putrid corpse lay on the ground for 48 hours following death because no one in the village had the strength to bury him was a den of terror. everyone was groaning under the devastating fever.418
The desire to eradicate the disease was marked by confidence that science and technology could win out over nature. The decision was made at the XIV Sanitary Conference held in 1954 in Santiago, Chile, where Soper was also reelected to serve another term as Director of the Bureau. Among the leaders of this campaign were Soper himself, Carlos Alvarado of Argentina, who headed the campaign in Washington, D.C., and Arnoldo Gabaldón who, while in charge of a malaria division, was successful in eliminating the disease from a good part of his country. Gabaldón, who eventually became Venezuela’s Minister of Health, shared preeminence in the valuable work of controlling the disease with Dr. George Giglioli (1897–1975) in British Guiana and Amador Neghme (1912–1987) in northern Chile. The three were firmly convinced that there were no technical or economic barriers to success in the Region.

This effort was joined by other cooperative organizations, such as UNICEF and the principal U.S. bilateral cooperation entity, the International Cooperation Administration (ICA), predecessor to the U.S. Agency for International Development (USAID), established in 1961. The ICA called the campaign the “most important program backed by U.S. foreign aid policy.” In 1956, the United States made a special contribution of US$ 1.5 million for the Special Malaria Eradication Fund administered by the Bureau. To this were added the contributions of the Governments of the Dominican Republic (which donated US$ 100,000 and promised a total of US$ 500,000) and Venezuela, which donated US$ 300,000. Subsequently, the Governments of Haiti and Colombia, among others, also made donations to the Fund.

It is clear that, in the case of some Latin American dictatorships, the work of ridding malaria was a means of legitimizing their governments’ position in a national and international political context that questioned the absence of democracy. For example, this was the case of François Duvalier, who governed Haiti from 1957 to 1971 and who, shortly before his death, transferred power to his son; of Rafael Trujillo, who governed the Dominican Republic with force and brutality for decades; and of the military regime led by Marcos Pérez Jiménez who, after manipulating the 1952 elections in Venezuela, remained in power until 1958.

UNICEF contributed significant amounts to the work of eradicating malaria in the Americas: more than US$ 14 million. Moreover, it was expected that an additional US$ 5.5 million would be added to that contribution in a short time. While substantial, these contributions did not cover all the expenses as estimated by the Bureau. In 1956, it was thought that the international assistance needed to achieve the objective would be more than US$ 40 million. But that turned out to be just 27% of the estimated total of US$ 144,406,370 that was to be contributed by the governments for malaria eradication.

According to its supporters, total eradication was far better than the traditional control measures, which, due to chronic shortages of money, resources, and personnel, were basically limited to draining swamps, promulgating laws to prohibit the planting of rice fields in close proximity to cities, and administering quinine salts. The campaign’s principal weapons were the application of new malaria drugs and the spraying of the interiors of dwellings with insecticides with residual activity, mainly DDT. There was great confidence in these technologies, despite reports that also pointed to their imperfections. The preliminary studies mentioned the resistance of some species of the Anopheles mosquito to insecticides. But those who championed eradication used this information to demonstrate the danger of a light, incomplete application of DDT. According to those who favored eradication, the mosquitoes’ resistance could be overcome only with a drastic and total application of the insecticide. In this respect, eradication was the only possible way to prevent an eventual explosion of malaria in the world. With these weapons, a model for national campaigns was developed involving four major phases of work spread over an estimated period of five to eight years.

In general, the national campaigns began with a tripartite agreement between the Pan American Sanitary Bureau, UNICEF, and the country.
agreements specified that UNICEF’s responsibility was to provide vehicles, materials, and fumigation equipment. The Pan American Sanitary Bureau, in turn, provided technical cooperation and experts. Finally, the governments saw to the appropriate legislation and the provision of local workers, including the campaign leaders. These agreements, moreover, provided for the establishment of a specialized and practically autonomous national entity devoted to malaria eradication. While most of the funding came from UNICEF and most of the bilateral cooperation came from the United States, the Sanitary Bureau provided strong leadership in the campaigns and awarded a significant number of scholarships for the study of the different aspects of malariology to prestigious academic centers in Brazil, Mexico, the United States, and Venezuela.

By the early 1960s, the majority of the governments and public health authorities of the Region had accepted the challenge of malaria eradication. The specialized services linked to the ministries of health, generally called National Malaria Eradication Services, had significant power, resources, and prestige. During the first 10 years, the majority of the Latin American countries achieved noteworthy results, especially in the control of transmission in the areas that were most economically productive, most densely populated, and most accessible by road. In addition, they were able to significantly decrease the mortality associated with malaria. By 1974, it was said that the areas where 90 million people of the Americas had been freed of the disease through eradication efforts.

Despite these achievements, the malaria eradication campaign had reductionist connotations, as suggested by a hopeful press release about its effect on a town in Venezuela:

The village of Manuaré in the highlands of Venezuela’s Carabobo province is a prosperous place. Its inhabitants are healthy and well housed. There is about them an air of confidence in their town and its future.

A few years ago things were not so pleasant in Manuaré. Most of its residents lived in miserable shanties. Not a few of them were sick, unemployed, or both. Many of the naturally rich fields that bound the village lay abandoned. Commerce and new construction were at a trickle. Manuaré had all the look of a town up against more than it could handle.

Why was Manuaré in such a state? Because malaria was over the land and there was very little, if anything, the villagers—by themselves—could do to get rid of it.

Why is Manuaré thriving today? Because the land is now clean of malaria and the government has provided the villagers the means of helping themselves to a better life.

Although the same text mentions that, in addition to the work against malaria, a housing program that raised “the hope and self-confidence of the people” was in progress, there were great expectations for the almost-immediate effect eradication would have on socioeconomic development in general. From a historical perspective, the malaria eradication campaigns had the effect of stimulating a greater awareness by public health authorities in the Americas of the special problems faced by rural populations. If the Organization’s first actions had concentrated on the ports and cities, this was an opportunity for intense work to be brought to the countryside, where the majority of the population of many Latin American countries still lived. It is true that national and local organizations had already performed valuable work in remote rural areas, but it was only with the malaria eradication program that massive economic and human resources became available and initial contact was established between public health services and many disadvantaged populations—contact which generally continued.

An unexpected consequence of the campaigns was that individuals and organizations in the community adopted them as their own. Thus, in some Latin American countries, the DDT sprayers became well-known and respected figures in the popular culture, and new volunteers stepped forth to assume increasingly important duties. They were known as “notifiers” because their formal function was to report to the public health authorities the existence of any cases of fever and to take
blood samples. They were generally school-teachers recruited in the rural communities themselves. Their responsibilities grew, eventually coming to include health education and the distribution of medicines.

In a series of rudimentary mimeographed magazines produced by Mexican health workers during the early 1960s and currently maintained in the Historical Archives of Mexico’s Ministry of Health, one can see a certain popular tone and a noteworthy esprit de corps among those involved in local anti-malaria efforts. Two of these publications, prepared in Tamaulipas and Nuevo León, include poems in homage to the “comrades and doctors” who died and reflect the feelings of comradeship and special, lasting solidarity that united those who worked on eradication:

Tedious death came
to carry Ramoncito away,
obliging him promptly
to dig his own grave.

Poor professor,
death carried him off,
the man was so good
that even his mother-in-law wept.

......

Davalitos died
with his beer in his hand,
and entered heaven
as a good citizen of Monterrey.

I am a malaria doctor
from the Monterrey sector,
if you have to pay to get in
I won’t pay; that’s my law.

Saint Peter pulled his hair
unceremoniously,
and said to himself
it’s no good, I can’t bear this.428

But the popular tone achieved by the fight against malaria sometimes was not enough to resolve the serious technical, social, cultural, and economic problems that eradication began to face in the mid-1960s, resulting in a decline of international support for the regional eradication program.429 Some of the principal technical problems were the resistance of *Plasmodium falciparum*—the agent that causes the most serious form of malaria—to chloroquine, and a greater level of insecticide resistance than expected in some species of *Anopheles* mosquitoes. Some of the species did not live inside homes, as assumed in the original design, so residential spraying turned out to be ineffective. Moreover, the campaign lost some of its authority when cases of malaria were discovered to have resulted from transmission in urban hospitals through transfusions of contaminated blood.430

The most important social problems were the poor condition of rural homes (there were few walls or surfaces that could retain the insecticides), the rural custom of sleeping outdoors during the summer, and the constant movement of itinerant populations that slept anywhere, especially those who were unaccounted for in official records. Of special importance was the appearance of new mosquito breeding grounds precipitated by road construction, deforestation, hydroelectric projects, and mining operations in rural areas. These activities, carried out in the 1960s and 1970s, with few public health considerations in some South American countries (such as Brazil and Peru), attracted numerous migrants in search of work opportunities who instead became victims of malaria.

There were also significant technological and cultural problems. The insecticides were toxic and killed not just mosquitoes, but also chickens, honey-producing bees, and other small animals bred to feed families. In some places, medical science was unable to overcome deeply rooted folk and religious beliefs related to the body, fever, and disease. Many rural dwellers believed that fevers were due to sharp changes in temperature or to the ingestion of unripe fruit. And they were opposed to providing blood samples due to fear of a loss of vigor or virility or that they could be used to cast spells or cause bad luck.

One economic limitation of the campaign was the unforeseen effect of environmental contamination, an issue which became increasingly important in the United States, especially following publication
in 1962 of Rachel Carson’s book, *Silent Spring*. The book, which sustained that DDT was endangering human life as well as poisoning wildlife and the environment in general, quickly became the bible of emerging ecology movements that urged respect for the natural environment and an end to insecticides use.

Also, at the same time that the unpopularity of insecticides was growing the costs to produce them was rising. Over the years, the geographical areas vulnerable to malaria began to expand once more, the amount and quality of blood samples studied declined, and the percentage of people living in malarial areas increased considerably. As a result, malaria has reemerged as a serious public health threat in many corners of the Region where it had once been brought under control.

**The Warrior’s Rest**

On 31 January 1959, Soper stepped down as Director of the most important health organization of the Americas. But he remained devoted to international health, first as a consultant for the ICA, and later as director of a cholera laboratory in Dacca, in the former East Pakistan, now Bangladesh. The year he retired, he sent a card to a colleague regarding the annual meeting of the American Public Health Association, stressing the importance of ethics:

> A scientist must have the following characteristics: intelligence, industry, integrity. Of these, intelligence may be mediocre; industry should be great, and integrity must be absolute.

The statement seems to suggest that, to get something in life, the important things are determination, honesty, and persistence. Soper’s career at PAHO is a testimony to, and even a reflection of, a certain obsession with these maxims.

When Soper celebrated his 80th birthday, the Organization honored him, with many people fondly remembering a person who at times had difficulties in directly expressing his own emotions and feelings. Some carefully penned their memories in a handsome blue book, and others sent heartfelt letters which were subsequently inserted into the book. Minnie Coe, the secretary who for many years had deciphered his abbreviated penmanship, wrote: “You bring out the best in us.” Myron Wegman, who had known him since the start of his tenure and was appointed Secretary General of the Bureau in 1957 by Soper himself, wrote him a poem:

> Saluting you at eight times ten
> Demands much more than prose;
> A giant in the lives of men,
> Your stature grows and grows.
> To try to do you justice then
> An epic style I chose.

> Now hear ye, and the world as well,
> Our statement shouted loud and clear,
> With echoes like a ringing bell,
> That we our champion Fred revere.

> Scientific papers tell
> That friend and foe shed ne’er a tear,
> As Ankylostoma heard the knell
> When Soper’s entourage drew near.

> On Aedes he cast a spell;
> Anopheles soon quaked with fear.
> “Eradicate!” we learned to yell
> As Soper’s couriers sped like deer,
> O’er land and sea his creed to sell.

> Rickettsia turned a frightened ear,
> The lice were quiet as they fell.
> Polioviruses proved no peer
> As Fred L. Soper gave them hell
> Until they had to disappear.

> Triumphant he in public health,
> We rightly call him sage and seer.
> For none can measure all the wealth,
> The joy he has made appear.

> So, proudly, it’s abandon stealth,
> For Fred, our hero, Cheer, cheer, cheer!!!

Shortly before Soper’s death, a former colleague sent him a letter summing up his true feelings of devotion: “For a quarter of a century I have been preaching your approach, repeating your precious
words, and telling life to meet your path . . . and to feel all the time that you are around."435 In the year of his death—1977—an emotional ceremony was held at PAHO Headquarters. Near the conclusion, a member of his family told an anecdote that captured the true treasure of a health official, national or international: Soper had joined a study group whose members knew of his good reputation, but were not well aware of the reason for it. At one of the first meetings, his new colleagues asked what his biggest achievement had been. Soper did not mention his battles against malaria, Aedes aegypti, or yaws, or his passion for nearly perfect order and punctuality. Instead, he answered: “my many friends around the world.”436

His reply suggests that public health—to play with WHO’s famous definition—is more than the unachievable “complete physical, mental, and social well-being.” It is, or can be, a brotherhood of those who practice it and those who are close to it; a necessary form of solidarity.