Health And Disease: Latin America

Diego Armus
Swarthmore College, darmus1@swarthmore.edu

S. Palmer

Follow this and additional works at: https://works.swarthmore.edu/fac-history

Part of the History Commons
Let us know how access to these works benefits you

Recommended Citation
https://works.swarthmore.edu/fac-history/273

This work is brought to you for free by Swarthmore College Libraries' Works. It has been accepted for inclusion in History Faculty Works by an authorized administrator of Works. For more information, please contact myworks@swarthmore.edu.
Latin America

The great backdrop to the modern history of health and disease in Latin America is the European expansion of the sixteenth century as a transoceanic exchange of peoples, crops, animals, and germs, with dramatic consequences at ecological, socioeconomic, and cultural levels. The Americas were not a disease-free paradise, but having been isolated from
Eurasian and African pools of infection, the indigenous population had developed a very particular set of immunities that made it susceptible to many Old World pathogens. Under such circumstances, the first contact with overseas invaders was bound to be deadly for those aboriginal peoples lacking most forms of acquired or inherited protection against common European and African diseases.

The epidemics associated with these differential immunities—notably smallpox, influenza, typhus, measles, mumps, and scarlet fever—combined with other variables, played a decisive role in the demographic catastrophe of the sixteenth century that decimated indigenous populations. The African populations introduced to supplement the labor force enjoyed resistance to many Old World pathogens while remaining vulnerable to the ravages of other diseases related to their dual condition as slaves and newcomers in the Americas. The transatlantic circulation of malaria and yellow fever was a determining factor in the development of the plantation system, its demographic configuration, and the endemic condition of these diseases (in conjunction with a complex of natural selection, racial prejudice, and biomedical perceptions).

During the first two-thirds of the nineteenth century miasmatic and environmentalist approaches dominated medical perceptions of health and disease without producing major changes in sanitary infrastructure or overall mortality. Official reactions to epidemics—for example the cholera pandemics that swept the region in the 1830s and 1850s—were spasmodic and probably ineffective, while the epidemics and reactions were aggravated by the recurrent civil conflicts of the era. Answers to epidemic catastrophes were sometimes improvised, other times reflecting incipient state policies shaped by liberal nation-building reforms and international science (at that time mostly French).

The commodity export boom of the second half of the nineteenth century contributed to the spread of epidemic and endemic diseases, with an increase in international maritime traffic and immigration, combined with developing infrastructure, massive internal migration, and the concentration of ever larger numbers of people in cities and in plantation and mining export enclaves. An insalubrious reputation stuck to Latin America's great port cities in the late nineteenth and early twentieth centuries, and local elites saw this as a grave hindrance to modernization. Sanitarism and higienismo (hygiene reform) grew up as part of an effort to manage and control mortality and morbidity patterns dominated by diseases such as tuberculosis, yellow fever, malaria, and plague. These epidemics unveiled the poor state of collective health and the limited infrastructure of sanitation and health care, but at the same time facilitated the emergence of state initiatives in public health and accelerated the presence of the state authority, both in social policy matters and in private life.

From the end of the nineteenth century until well into the twentieth, epidemic cycles were linked to the so-called social question. Thus, with the growing acceptance of mono-causal explanations for every illness, references to the larger context were inescapable: the precariousness of garbage disposal, sewer and drinking water systems, housing hygiene,
biological or racial inheritance, daily habits, the work environment, diet and poverty, massive immigration, and the “dangerous” teeming multitudes in the cities. Often these explanations were articulated in moral terms.

At the beginning of the twentieth century, statistics became a common staple of social analysis and in some countries state agencies specifically concerned with questions of public health were created. First hygienists and later public-health physicians played a decisive role in modernizing urban facilities and the networks of public assistance, reform, and social control. At times the struggle against epidemics took on the character of quasi-military campaigns—rhetorically by defining microorganisms as enemies, and in practice by encouraging intrusive interventions in neighborhoods and houses, especially those of the poor. Perhaps for that reason, these interventions were resisted on certain occasions. At other times, the struggle also included persuasion, aiming to educate the population and disseminate so-called hygienic ways of living.

The diversity of national historical experiences is present in the epidemiological history of Latin America. Thus while tropical diseases such as malaria, yellow fever, or hookworm played a specific role in the history of certain nations such as Brazil and Costa Rica, for others like Argentina and Mexico diseases and problems somehow associated with modernization and urban and industrial growth (tuberculosis, syphilis, urban hygiene, and occupational health) came to the fore.

In any case, it is important to note that over time diseases have played different roles at the national, regional, or local levels. That which became relevant in epidemiological terms in one country might have no significance in another. In certain contexts diseases like syphilis or leprosy were classified as epidemic even though they did not massively affect the population. They were turned into national problems for social, cultural, or political reasons, legitimated by medical expertise, attracting public attention and spurring campaigns designed specifically to eradicate them. Other illnesses, which did not break out suddenly like the infectious diseases but were well established in everyday life and sometimes killed and afflicted more people than epidemic diseases, did not always manage to mobilize sufficient resources to be perceived as national problems. In different times and places, this was the case with tuberculosis and gastrointestinal diseases, or malaria and hookworm in areas where they were endemic. Because they were more widespread, more difficult to treat, more closely associated with poverty, more socially or geographically distant from centers of power, and more easily overlooked, these diseases could only be made visible to public opinion and elite consciousness with enormous effort, and therefore particular policies to combat them were often rare or nonexistent.

In the urban world, some of these diseases finally did manage to become public issues because they came to be seen as part of the “social question” or strongly associated with broader national problems. In the countryside, endemic illnesses were the ones that
expanded the area of action of public-health interventions, fostering initiatives of rural sanitation that launched social policies, state expansion agendas, the centralization of power, and, more generally, nation-building processes.

Although results were uneven, during the first half of the twentieth century the prevalent epidemiological and mortality patterns based on infectious diseases that dominated Latin America began to change. Increasing efforts were made, especially after the 1940s, to deal with problems of primary care as a crucial dimension of public health and also as part of a culture of survival embodied in emergency responses, ephemeral training of lay personnel, and the creation of health posts in the poverty rings of mega-cities or in underserved rural areas. Some contemporaries were critical of these efforts, claiming that primary health care was temporary relief for ill-served social sectors or second-class medicine for the poor. Nevertheless, primary health care can be seen as a by-product of social changes and also an instrument to promote such changes.

In the reception and transfer of expertise and practices associated with the fight against malaria, yellow fever, and hookworm, as well as in the development of primary-care networks, foreign institutions played significant roles. The Rockefeller Foundation developed a series of ambitious initiatives during the first decades of the twentieth century. Its agenda aimed at organizing single-disease services and promoting technical approaches and specific cures to the detriment of more comprehensive, educational, and preventive strategies. Rockefeller missions reveal the growing influence of the United States as a new metropolitan world player with an increasing hegemonic role in the region. However, in many countries, health- and disease-related problems had already become a public issue before these missions arrived, often as a result of initiatives launched by national scientific communities. On some occasions these communities were able to develop novel and quite specific approaches to research and intervention, sometimes even before their North American peers, and on many more occasions actively negotiated with the foundation’s representatives.

In any case, the arrival of the Rockefeller missions was crucial in the orientation of sanitary reforms, particularly for rural areas and for diseases that were believed to be eradicable with little cost and in a short time. Despite varied and uneven results in different countries and with different diseases, there is no doubt that the Rockefeller Foundation projects and later NGO-promoted initiatives mobilized public opinion. This was especially true with regard to the living conditions of the rural poor. These projects also contributed enormously to centralizing sanitary efforts, reinforced the power of the central government vis-à-vis the local and regional ones, and consolidated the position of the United States as the dominant external reference in matters of public health.

As in later relations with institutions like the Pan-American Health Organization, Latin Americans played leading roles in staffing and directing these initiatives, and the relations between national and foreign medical groups were complex. In their original design,
international health projects may have been conceived as purely technical endeavors in keeping with a neocolonial philanthropic or economic agenda. But when these interventions materialized they contributed, whether intentionally or not, to establishing precedents and laying the institutional foundations for future social and preventive medicine projects that local professional actors later led.

The statist public-health model of Latin America, by and large reinforced by the evolution of U.S. and international health agencies, entered into a period of crisis and reformulation following the era of neoliberal structural adjustment in the 1980s and 1990s. As some countries in the region complete the so-called demographic transition, while others suffer catastrophic indices of morbidity and infant mortality from nutritional deficiencies, infectious disease, and gastrointestinal illness, Latin America continues to show highly heterogeneous health and disease patterns.

Bibliography


Diego Armus and Steven Palmer

Copyright © 2019. All rights reserved.

PRINTED FROM OXFORD REFERENCE (www.oxfordreference.com). (c) Copyright Oxford University Press, 2013. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single entry from a reference work in OR for personal use (for details see Privacy Policy and Legal Notice).