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Marcos Cueto and Steven Palmer

Excerpt

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INTRODUCTION

All students of Latin American and Caribbean history learn early that disease and suffering, health and medicine, are woven into the main plot lines. This is true from the demographic collapse that decimated indigenous populations during and after the encounter known as the Conquest to the shocking health indicators and rural immiseration motivating modernizationists, revolutionists, and neoliberals in the post–World War II era. The social and political consequences of disease and health have been at the center of hemispheric history. Until recently, however, questions of medicine and healing were relegated to the margins of serious discussion among historians. When health and disease were the focus, they were framed by other specialties – the mortality disaster that befell the Aztec and Inca populations, for example, was an issue identified and debated by geographers and demographers. The specialized historical discussion of medicine, meanwhile, was the preserve of a small and isolated group – mostly retired physicians interested in curiosities of pre-Columbian healing, hagiographic portraits of the great men in their profession, or the charting of the arrival in Latin America of technological breakthroughs made in the metropolitan centers of Europe and the United States.

That has changed dramatically over the past thirty years. It is now possible to read a history of U.S. intervention in Cuba told as the history of yellow fever on the island, to explore an alternative African-oriented intellectual history of Latin America and the Caribbean via the story of skilled surgeons who were slaves or former slaves and continued to incorporate African-derived practices into their healing arsenal, or to learn how Latin American medical scientists carved a niche for themselves in international networks of knowledge and power. Such studies

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are possible because the history of medicine and health in Latin America and the Caribbean has become an important field of study practiced by professionally trained historians who are part of a great global flowering in the social and cultural history of medicine, and in science and technology studies. Valuable research on new problems, using new sources, has been carried out, and a new historiography has matured, perhaps most notably in the pages of the Brazilian journal *História, Ciências, Saúde – Manguinhos*, which first appeared in 1994.

With so much new historical research generated over the past few decades, there is a pressing need to take stock of the field in order to promote a fluid dialogue among, on the one hand, historians and health researchers, administrators, and activists, and, on the other hand, between historians of medicine and those who focus on Latin American social and political history, fields that, despite widening their scope to include cultural studies and everyday life, still consider the history of health a fragmented subfield lacking its own research problems. This book brings these new findings together in a way designed to promote such a dialogue. Without pretending to provide a synthesis of the new history of health, medicine, and disease in Latin America, our book proposes a historical perspective on public health that was intertwined with medicine, just as it was with medical research and sociomedical themes. In this we have been guided by provocative new research questions and by some of the most notable recent findings, and we have chosen to concentrate on the innovative health practices that have often been generated, in Latin America, at the intersection of medical research and public health initiatives. We have also tried to move beyond the framework of studies that see medicine as an instrument of social control to oppress subordinate groups, and to incorporate the contemporary focus on the role of medicine in processes of negotiation among different social actors. While the focus of the book is Latin America, we have not hesitated to include case studies from the non-Spanish Caribbean where relevant, particularly in the twentieth century.

Our first chapter begins with the practice of precontact indigenous African American and European medicine, together and apart, in the first decades of what was the colonial era for most countries, namely the early-sixteenth to the early-nineteenth centuries. Their interaction left marks, such as a mixed system of healing, that have carried over into subsequent centuries and that remain important for understanding principles of contemporary public health involving intercultural indigenous approaches. This discussion is complemented by an exploration of the

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Excerpt

[More information](#)

INTRODUCTION

3

so-called Enlightenment medicine practiced over the latter half of the eighteenth century, when petty sanitary policing and urban sanitation measures were promoted. In this context, we discuss the way that during the independence processes – in the majority of Latin American countries at the beginning of the nineteenth century – there was a certain regress in the institutional order, including in the realm of medicine. That began to change toward the middle of the century with the creation of national agencies devoted to health, and then in the final quarter of the nineteenth century as these agencies began to engage one another at international meetings on maritime sanitary questions. This was a time when key notions of control like “disinfection,” “fumigation,” and “isolation” were developed, largely in relation to the protection of the emerging export economies, and subsequently extended to the regulation of city life as well. The interaction between the international and the national sanitary domains would henceforth acquire greater intensity.

This initial “groundwork” chapter is followed by a consideration of the consolidation during the second half of the nineteenth century, and in the principal capital cities, of formal medical communities alongside councils or directorates of hygiene that were inspired by the French model. One of the most important tendencies in recent studies on medicine and health in Latin America is the excavation of research and innovation that belie the long-held notion that doctoring, medical research, and public health organization in the region were mere echoes of processes at work in Europe and the United States. Our second chapter pays close attention to the unique characteristics of the communities of medical researchers and health innovators, who were an important part of the circuitry of emerging networks of global medical science and sanitary organization. They cultivated a distinct identity and function within these networks. Though working in undeveloped political economies that displayed many traits of neocolonial dependency on the Western powers, the members of these medical communities were relatively privileged social actors associated with increasingly coherent nation-states. In this they differed markedly from the medical systems emerging in the colonial world. That is, Latin America’s native-born medical elites were not colonized subalterns working on the margins of colonial medical systems designed to protect soldiers, settlers, and administrators. They organized themselves into protean national associations to promote professional and scientific interests, and they framed certain diseases as “national” – for example, human *bartonellosis* (*Verruga peruana*) in Peru, or American *trypanosomiasis* (Chagas’

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Excerpt

[More information](#)

disease) in Brazil – in ways that sometimes allowed them to become world research leaders in fields such as medical bacteriology and parasitology.

As our third chapter shows, this scientific stature also meant that these medical elites were poised to take advantage of the development of health agencies with national scope where they could play important political and professional roles. Though some of these agencies were in fact only municipal or provincial in jurisdiction, others at least aspired to achieve a national reach, to centralize the health-related actions of the state through affiliation with the ministries of public education or of the interior, or sometimes of agriculture or commerce. The way they were appended suggests the new function, or more precisely ambition, of state health: a coercive and pedagogical capacity and the protection of economic areas considered priorities. New institutions were the platform for new professionals who sought political recognition. Generally they were involved in providing segmented services, socially differentiated in large domains such as state medicine, private medicine, medical services for the armed forces, or medical social security that took care of distinct social groups. Of course, these processes experienced advances and retreats because public health in the region was part of an aspiration to create a welfare state – a goal that would never be fully implemented. Indeed, the segmentation in the realm of medicine and public health was part and parcel of the great problematic tangle of Latin American societies – dysfunctional attempts at integration, the existence of undemocratic privileges, and the hypermarginalization of the poor.

While the countries of Latin America in the late-nineteenth and twentieth centuries might be seen, to varying degrees, as neocolonial provinces of the United States, their health politics and institutions were far from analogous to the ones being developed by the European powers in their Asian and African colonial possessions. This was true whether the agencies in question were backed by different levels of government within the national state (and increasingly achieving ministerial status) or by the new philanthropic or bilateral health initiatives (especially those sponsored by the Rockefeller Foundation) appearing with ever-greater regularity courtesy of the new hegemonic player to the north, the United States. Again, because the subordinate Latin American “partners” were nation-states, the health field created within this U.S. imperial sphere was, by definition, international far earlier than the international order that characterized the twentieth century from the League of Nations onward. The story was different in the non-Spanish Caribbean, where,

with the notable exception of Haiti's early revolutionary independence, the islands were still under European or U.S. colonial rule. Latin American health institutions were at once national, maintaining their own character (often more oriented toward social medicine and social security), and part of an international system of sanitary regulation and public health activism characteristic of the Americas under U.S. hegemony. One result of this was that Latin America served as the most active and innovative domain of early initiatives in international health and delineated one of the main blueprints for the truly worldwide international health system that would emerge after World War II. It also meant that Latin American international health actors were senior policy figures in their national political classes with significant international health experience. This allowed them to be among the architects of the World Health Organization (WHO) and its regional "counterpart," known since the early 1960s as the Pan-American Health Organization, which retained autonomy within WHO following the tradition of a distinct institutional history of public health collaboration and organization in the Americas.

Latin American medical innovation in the first half of the twentieth century was influenced by the focus of international agencies on rural health, and medical education was gradually restructured according to U.S. models promoted by a vast array of fellowships and training initiatives. Still, as our fourth chapter argues, in areas such as physiology, cancer research, eugenics, and population control, Latin America generated unique medical programs that, while in many cases highly original, often took their cue from, or forged alliances with, European social medicine or styles of laboratory research.

Matters shifted dramatically in the post-World War II scene, where, in the context of the Cold War, programs were implemented with the expectation of controlling and eventually eliminating disease. These tended to be "vertical" in nature – that is, planned and implemented from the top down according to technocratic templates, and concentrating on specific diseases rather than seeing public health holistically – and they soon showed their shortcomings and limitations.

Our final chapter deals with the development in the post-World War II era, almost in direct opposition to these vertical and single-disease-focused approaches, of the first official programs that emphasized community participation in health, the most important being the promotion of comprehensive primary health care. By this time, medical communities were consolidated, their relationship with the state solid, the political heights attained by certain medical professionals notable, and the

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system of urban hospitals widely extended (accompanied in some cases by systems of social security). Toward the end of the Cold War, during the 1980s, neoliberal proposals began to define a highly restrictive and technocratic idea of selective primary care health at both the national and international levels. They conceived of health principally in terms of cost-effectiveness. Increasingly, they battled, obstructed, and outspent the proposals for a comprehensive primary health care system that might bring “health to all by the year 2000” (the motto of the WHO at the time). Finally, we discuss the tremendous health challenges faced by Latin American communities during the twenty-first century, some of them still wrestling with pre-Columbian legacies: novel epidemic outbreaks, intercultural health, medical tourism, and the promise of new drugs acquired from a biodiversity associated with indigenous ethnicity and use by the rural poor.

One of the main propositions of this book, threaded through these chapters, is that the medical pluralism characteristic of Latin American healing throughout its history was gradually molded during the twentieth century into the basis of a modern biomedical hegemony. Not simply a rustic holdover from the rural past, medical pluralism began to operate on some levels in cities as well during a period when the region was becoming mainly urban. Medical pluralism is often presented as symptom and expression of the failure of modern forms of Western medicine to lay down roots in Latin America. Instead, we propose that a defining feature of modern Latin American healing is the way that vital forms of popular and ethnomedicine engage dominant biomedical institutions and practices even in urban centers despite the exclusionary discourses and claims of the leaders of university-trained, professional health practitioners. There was a pattern among the diverse healing practitioners to be aware of or adopt the newest ideas, treatments, and practices. The relationship between “official” and “unofficial” medicines was uneasy. It evolved over time, combining moments of tolerance with frustrated quests for hegemony and mutual rejection, but eventually resulted in an interconnected complex that was both conflictual and complementary, and articulated quite differently according to country and region.

A second proposition is that public health in the region, institutionalized in different moments during the twentieth century, developed as an engagement between partial official interventions, on the one hand, and efforts on the part of middle and popular sectors to confront adversity on the other. The ideas of the “culture of survival” and “health in adversity” will sustain the principal hypotheses of this dimension of the

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Excerpt

[More information](#)

INTRODUCTION

7

book. By “culture of survival,” we mean that most health interventions directed by states have not sought to resolve recurrent and fundamental problems that, in the final analysis, have to do with the conditions of life. The authorities have generally promoted a limited-assistance, palliative, and temporary form of public health, looking for “magic bullets” to health problems, and assuming that the population is made up of passive receivers. As a result, the design of short-term interventions has been the norm; ephemeral and isolated, they have had the negative effect of reinforcing the stigma and the blaming of victims of epidemics and major endemic diseases. At the same time, the development of public health, with a few largely recent exceptions, has sought to repress the rich indigenous and African-based traditions of informal health practices. This pattern has been expressed in health systems that have been limited by insufficient resources, fragmentation into subsystems, and discontinuity in their interventions, a hegemonic pattern that constitutes the “culture of survival” with respect to health. It was not a conscious policy to assimilate the poor into mainstream society or to promote a limited form of health for the poor under difficult living conditions. Nor was it a form to supplement with self-help the health needs of the poor. It was just a means to contain the poor in the recurrent health crisis that became visible in epidemics. The outbreaks of infectious diseases became events waiting to happen as well as the mending patches used by official authorities. It became the usual official response that avoided changing precarious social conditions and existed because of fragile state bureaucracies and because the poor were not considered citizens with social rights such as health care.

The second concept, “health in adversity,” seeks to register the sanitary gains that have been achieved, despite the discourses and practices of hegemonic power, in terms of the attainment of unanticipated adaptations born of questioning, resisting, and proposing alternatives. In addition, it signals the quest to negotiate, reject, or adapt sanitary projects designed and imposed from above; establish alliances and agendas with international networks of knowledge; downplay the role of technology; and give greater weight to community participation while committing to preventive health measures. This focus emphasizes the participation of groups and individuals generally located outside the medical elites. In some cases, health was the articulating axis of broader projects under the banner of modernization, nationalism, and rural development. This notion seeks to find patterns in the work of many health professionals, activists, and popular leaders who have developed

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Excerpt

[More information](#)

holistic projects and tried to modify the vicious cycle of poverty-authoritarianism-disease in favor of a more inclusive society and public health. It also identifies a key characteristic of the resilient ability of medical and life science investigators to maintain and search for institutional continuity of first-class research that improves medical education and practice. These investigators achieved success and were recognized abroad, at least during the twentieth century, in international scientific networks where financial, technical, and human resources were concentrated in industrial countries.

Though also marked by discontinuity, there have always existed critical, minority, or veiled ideas about health that are more holistic, ones that argue that health is an individual's right, that it goes beyond incidental interventions born of necessity. There have always been professorships, journals, and efforts to construct "health in adversity." They have usually been without the necessary resources from the state required to create an alternative and popular sanitary system involving the promotion of health by the community itself. Sometimes this kind of dissent went by the name of "social medicine," other times by that of "primary health care," and it is currently expressed under the rubric of "the social determinants of health." Though far from isolated from international influences, many of these currents emerged with the contribution of Latin Americans.

Beyond these central propositions, we consider throughout these pages whether there is some character unique to Latin American medicine and public health, first as an extension of or a variant within the history of Western medicine, but ultimately as a particular cultural formation within a global history of health and medicine. One route into this problem is the question of agency. That is, did the forces behind the creation of this variant of "Western medicine" come principally from outside – from the metropolitan centers of the West (mainly from Spain and Portugal from contact in the eighteenth century; from Paris, Berlin, and London in the nineteenth century; and from New York, Washington, D.C., and Geneva in the twentieth)? Or were Latin American actors – despite being situated in a colonized and, later, underdeveloped periphery in relation to the European Atlantic world – engines of innovation and shaping forces? Associated with this is the role of Latin America in the making of what has become known as "Western medicine." Was the region simply for the most part passive and derivative, or did it play a dynamic role in the making of this somewhat strange and unique modern amalgam of increasingly specialized science and ever more medicalized popular culture? We

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Excerpt

[More information](#)

INTRODUCTION

9

know that certain material practices at the heart of the Western medical tradition – such as the use of quinine to alleviate malarial fevers, for example – come from Latin America. But who are the defining players in the development of this practice: indigenous groups who had incorporated the properties of cinchona bark into their ritual healing practices and first explained it to colonial outsiders, the religious groups who grafted the use of the bark onto Western healing practices, or the merchants and scientist-naturalist-savants who shaped its introduction into the European pharmacopoeia? The questions are complex, but increasingly the answers proposed by historians of medicine and health in Latin America emphasize that the past was not made only through stimulus coming from outside. Instead, public health and medicine are understood as an arena contested by a wide variety of actors (including the sick) through complex local processes of reception, adaptation, eclectic redeployment, and hybridization. In addition, Latin American medicine is an excellent case to demonstrate that the history of medicine is not a linear narrative of progress but one that can be portrayed in terms of circular, dissonant, coexisting processes interpreted diachronically. In our approach, a twenty-first-century phenomenon may echo with pre-Columbian developments, and vice versa.

From this perspective, Western science and medicine are understood as the product of polycentric networks and a creative interplay between metropolitan and peripheral actors. Latin America has had its significant centers as well as significant peripheries in these ever-shifting networks, and we make an effort to identify the most important moments in this ultimately global process. Among the main contributions of the new history of health and medicine in Latin America to the larger, global field of the history of medicine is an emphasis on the way health programs were articulated with the economic and political interests of the dominant classes but also resisted by the social groups they were designed to subordinate; another is an insistence on unpacking the processes of reception of the ideas, policies, and programs imported from Europe or from the continent's capital cities. The following pages reflect these valuable contributions, showing whenever possible that local historical actors had a more autonomous role than previously imagined, that dissonance with foreign scientific orthodoxies was often generated, and that alternative sanitary discourses and practices emerged.

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CHAPTER ONE

INDIGENOUS MEDICINE, OFFICIAL HEALTH,
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The foundations of Latin American and Caribbean medicine and health were laid over three-and-a-half centuries of complex interplay among what were initially three broadly distinct civilizations. One was the grand variety of indigenous American healing systems, many of which were dismembered by contact and conquest. A second was made up of elements brought from Africa by slaves, some of them specialized healers, and reinvented by a variety of Afro-descended practitioners in contact with both indigenous and European medicine. The third was medicine from the countries of the colonizers, both popular and official, transferred to the Americas and in its official guise refashioned as an important pillar of colonial rule and legitimation.

The history of this interplay provides cues and clues to understanding the way that medical pluralism exists and interacts with official health and healing in contemporary Latin America and the Caribbean. The new history of medicine, covering the period from just before indigenous contact with the Spanish and Portuguese at the end of the fifteenth century until most of Latin America's revolutionary republics and Brazil's autonomous empire had established a tenuous independence in the mid-nineteenth century, has also expanded our knowledge of local social history. Perhaps most surprisingly, it has increased our knowledge of political history in which official and popular healers often played transformative parts. The new history of medicine and health during these three-and-a-half centuries also provides a much better sense of the agency of local actors, including indigenous and Afro-descended ones, in the global circulation of medical materials, ideas, and practices. This is parallel to a new history of science that finds insufficient the unidirectionality and dichotomy implied in previous models that emphasized the