Development as Gender Equity: Women’s Advocacy and Cancer Control at the Pan-American Health Organization, 1980–2000

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Abstract
Women’s advocates’ strategies to influence international health agencies offer a new way to think about development. This article deals with the vibrant growth of women’s health initiatives at the Pan-American Health Organization during Latin America’s financially turbulent years from the 1980s through the 1990s. The multi-faceted nature of this process was especially apparent in the case of cervical cancer, the illness that launched the organization’s cancer control programs. Archived reports and interviews with former officers show how the Pan-American Health Organization’s approach to women’s health broadened in this period to include new actors in response to demands of women’s health advocates from Latin America. These advocates advanced the position that gender inequality played a fundamental role in placing women at risk for lethal and preventable illnesses. They also challenged international health agencies such as the Pan-American Health Organization to prioritize redressing those gendered inequalities as integral to development, rather than define the latter solely in terms of the improvement of economic conditions.

Keywords
development, Latin America, Pan-American Health Organization, women’s health advocacy, cancer

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The intertwining of cervical cancer control and women’s health advocacy at the Pan-American Health Organization (PAHO), the pre-eminent international health agency of the Americas, was marked at the dawn of the twenty-first century. Indeed, the strategy of PAHO’s 2005 Cervical Cancer Prevention Initiative emphasized cancer screening in locales with high poverty rates along with messages underscoring female empowerment behaviors ‘rather than pharmacological treatments’ alone. At the time, cervical cancer remained the main cause of cancer deaths among women in Latin America and the Caribbean, leading to some 72,000 new cases and 33,000 deaths every year, with Haiti’s mortality rate the highest at 48 per 100,000 women. This contemporary mutual reinforcement between urgently needed cervical cancer control and women’s advancement activities resulted from decades-long negotiations within PAHO, energized by a series of initiatives begun in the 1970s, led by women’s health advocates who occupied official posts in PAHO’s administration as well as throughout governmental, medical, public health, academic, and community organizations in Latin America. These advocates acted not only as change agents, but as harbingers of a different way of understanding development, one rooted not on the improvement of economic conditions, but on the subversion of harmful social hierarchies that placed women at risk for lethal and preventable illnesses.

Initially called the Pan-American Sanitary Bureau, PAHO was founded in 1902 as the world’s first international health agency. In 1948, following the World Health Organization (WHO)’s establishment, PAHO became one of its affiliates. Originally dedicated to checking the spread of contagious diseases such as plague and yellow fever, which negatively affected the trade interests of the United States, PAHO soon began to include delegations of member states in its Directing Council and Pan American Sanitary Conference, its main governing bodies. These delegations inaugurated a tradition of vocal Latin American representation at PAHO, which presently includes 35 member states and works through partnerships with the governments and civil society organizations of its members. Although PAHO began to address medical emergencies as well as the strengthening of health systems in the mid-twentieth century, it only turned to the specific challenges of women’s health in the 1970s through its Women in Health and Development (WHF) program.

1. Most Pan-American Health Organization reports are digitized in the online IRIS repository, and additional ones are available at the PAHO library in Washington DC. Many thanks to PAHO librarian Eliane Pereira dos Santos for help locating these materials. PAHO, Advances on Gender, Health, and Development, February 23, 2005, document MSD21/3, Rev. 1, p. 17. The intertwining trend continues to this day. See PAHO, Plan de Acción sobre la Prevención y el Control del Cáncer Cervicouterino, 2018–2030, resolución CE162.R2.

2. PAHO, Regional Strategy and Plan of Action for Cervical Cancer Control and Prevention: Latin America and the Caribbean, 2008–2015, document CE140/14.

3. M. Cueto, El Valor de la Salud: Historia de la Organización Panamericana de la Salud (Washington 2004).

4. https://www.paho.org/en/who-we-are, accessed February 7, 2021. The argument for the prominence of Latin American actors in regional health matters can also be made about other institutions, such as the Rockefeller Foundation, whose operations and priorities were also shaped by people in Latin America and the Caribbean. See A.E. Birn, Marriage of Convenience: Rockefeller International Health and Revolutionary Mexico (Rochester 2006) and S. Palmer, Launching Global Health: The Caribbean Odyssey of the Rockefeller Foundation (Michigan 2010).
WHD’s history shows how ideas concerning women’s health have seeped into international health organizations. The demands and aspirations that women’s advocates articulated have crossed national boundaries in the Americas since the 1910s, leading to a Pan-American feminist movement that thrived by the early 1980s, and was outspoken about the health needs of pregnant and birthing women. It is less clear, however, how the movement’s vitality influenced the male-dominated international health establishment in the Americas or elsewhere. Debates between colonial legacies and emerging nationalistic projects, rather than gender-driven concerns, powered the priority setting of the WHO regional offices in Africa and India in the 1950s and 1960s, for example. And, in the 1970s and 1980s, it was career officers and medical consultants, with seemingly little input from women’s advocates, who shaped the WHO’s approaches to primary health care. In contrast, women’s health advocacy gained a foothold at PAHO through the WHD program, offering an opportunity to understand its limitations and possibilities in the international health arena.

WHD’s historical trajectory also provides an alternative way to consider the history of international health organizations through the lens of a program that did not explicitly deal with a given ailment, such as malaria, Chagas disease, or malnutrition. Instead, the program exerted its greatest influence through the critical analysis of underlying conditions shaping health. The scant available scholarship on this topic has addressed human resources training and the human rights framework as initiatives that, indirectly, have prevented disease, promoted health, and enhanced health equity.

In like fashion, led by Latin American actors, WHD tackled issues ranging from the representation of women in health leadership positions to rural girls’ mental health, yet mainly addressed the patterns of gendered inequality lying beneath these matters.

5. K.M. Marino, *Feminism for the Americas: The Making of an International Human Rights Movement* (Chapel Hill 2019); O. Otovo, *Progressive Mothers, Better Babies: Race, Public Health, and the State in Brazil, 1850–1945* (Austin 2016); M. Sinha, D. Guy, and A. Woollacott (eds.) *Feminisms and Internationalism* (Oxford 1999); D. Guy, ‘The Politics of Pan-American Cooperation: Maternalist Feminism and the Child Rights Movement, 1913–1960’, *Gender and History*, 10, 3 (1998), 449–69; A. Lavrin, ‘International Feminisms: Latin American Alternatives’, *Gender and History*, 10, 3 (1998), 519–34; N. Saporta Sternbach, M. Navarro-Aranguren, P. Chuchryk, and S. Alvarez, ‘Feminisms in Latin America: From Bogotá to San Bernardo’, *Signs*, 17, 2 (1992), 393–434.

6. M. Saavedra, ‘Politics and Health at the WHO Regional Office for South East Asia: The Case of Portuguese India, 1949–61’, *Medical History* 61, 3 (2017), 380–400; J.L. Pearson, *The Colonial Politics of Global Health: France and the United Nations in Postwar Africa* (Cambridge 2018).

7. M. Cueto, T. Brown and E. Fee, *The World Health Organization: A History* (Cambridge 2019).

8. M. Cueto, *Cold War, Deadly Fevers: Malaria Eradication in Mexico, 1955–1975* (Baltimore 2007); S.P. Kropf, *Doença de Chagas, Doença do Brasil: Ciência, Saúde e Nação, 1909–1962* (Rio de Janeiro 2009); J.C. Yañez Andrade, ‘Los Pobres Están Invitados a la Mesa: Debates y Proyectos Transnacionales de Alimentación Popular en América del Sur, 1930–1950’, *Historia Crítica*, 71 (2019), 69–91.

9. F. Pires-Alves, C.E. Paiva, and G. Hochman, ‘História, Saúde e Seus Trabalhadores: Da Agenda Internacional às Políticas Brasileiras’, *Ciência & Saúde Coletiva*, 13, 3 (2008), 819–29; B. Meier and A. Ayala, ‘The Pan American Health Organization and the Mainstreaming of Human Rights in Regional Health Governance’, *Journal of Law, Medicine, and Ethics*, 42, 3 (2014), 356–74. On the historical importance of these schemes within international health organizations, see I. Borowy, ‘Shifting Between Biomedical and Social Medicine: International Health Organizations in the 20th Century’, *History Compass*, 12, 6 (2014), 517–30; and R. Packard, *A History of Global Health: Interventions into the Lives of Other Peoples* (Baltimore 2016).
which redress, WHD maintained, were integral to development. Recognizing the historical mortality and morbidity burdens of cervical cancer, I concentrate on WHD’s work on cervical cancer control, a priority for PAHO since the 1960s and for WHD since its formal inception in 1981. WHD’s insistence on reimagining development as bound with the subversion of harmful social hierarchies that systematically hurt women’s health, particularly exposing them to cancer, departed from the understanding of development that had been hegemonic since the 1940s as a process linked to the improvement of economic conditions and the quantification and achievement of targets in education, employment, and health.10

Situating the rich concept of ‘development’ in context is one of the tasks recently taken up by historians, who no longer approach this phenomenon as solely linked to state regulation, as James Scott effectively did decades ago.11 As Stephen Macekura and Erez Manela have recently posited, for example, development appears to be less a universally standardized mechanism governments have used than a contingent and contested process of ‘explaining the past and imagining the future’, in which various actors in different social circumstances participate.12 Recent historiography has evaluated the rise of global projects to dismantle socioeconomic barriers to women’s development, but analyses of the health dimensions of women’s development are still rare.13 The participation of specific social actors in these endeavors is challenging to document in an organization such as PAHO, which often does not identify individual contributors in archived reports. Available sources and interviews, however, show the chronologically uneven emergence of a female-centered vision of development at PAHO that had implications for cervical cancer care, with a slow build-up in the 1970s, evolving momentum in the early 1980s thanks to the WHD program, and rapid institutionalization in the early 1990s. The vagaries of this process owed as much to global reform proposals, such as the 1976–1985 Decade for Women, as they did to PAHO activities, which brought together disparate Pan-American efforts, amplified the demands and aspirations of Latin Americans, and disseminated novel tools and ideas throughout the region.

10. C. Unger, ‘Histories of Development and Modernization: Findings, Reflections, Future Research’, www.hsozkult.de/literaturereview/id/forschungsberichte-1130, accessed February 7, 2021.
11. J. Scott, Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed (New Haven 1998); J. Pribilsky, ‘Development and the “Indian Problem” in the Cold War Andes: Indigenismo, Science, and Modernization in the Making of the Cornell-Peru Project at Vicos’, Diplomatic History, 33, 3 (2009), 405–26; T.M. Li, The Will to Improve: Governmentality, Development, and the Practice of Politics (Durham 2007); A. Staples, The Birth of Development: How the World Bank, Food and Agriculture Organization, and the World Health Organization Changed the World, 1945–1965 (Kent 2006); N. Gilman, Mandarins of the Future: Modernization Theory in Cold War America (Baltimore 2003); T. Mitchell, Rule of Experts: Egypt, Techno-Politics, Modernity (Berkeley 2002); A. Gupta, Postcolonial Developments: Agriculture in the Making of Modern India (Durham 1998).
12. S. Macekura and E. Manela, ‘Introduction’, in S. Macekura and E. Manela (eds.) The Development Century: A Global History (Cambridge 2018), 1–17, 10.
13. H. Schopp-Schilling and C. Flinterman, Circle of Empowerment: Twenty-Five Years of the UN Committee on the Elimination of Discrimination against Women (New York 2007); E. Boris, Making the Woman Worker: Precarious Labor and the Fight for Global Standards, 1919–2019 (Oxford 2019); and J. Meyerowitz, A War on Global Poverty: The Lost Promise of Redistribution and the Rise of Microcredit (Princeton 2021).
In the 1960s, amid Cold War tensions over rapid population growth, Latin American and Caribbean country representatives began to use PAHO as a forum to question the legitimacy of US interventions in this field, particularly the US Agency for International Development’s promotion of birth control as a lever of economic prosperity, which the US State Department took as a fundamental component of national development and a bulwark against communism. Family planning also attracted controversy because of the financial support it received from non-government agencies in advanced capitalist nations, because of its association with racist population limitation agendas, and because it encouraged women to reject the presumed-natural role of motherhood. Latin American representatives at PAHO were more welcoming of family planning when framed narrowly as a means to curb women’s health problems, particularly maternal mortality and abortions following unintended pregnancies. Cervical cancer became a pressing issue for PAHO in this context, evincing pitfalls to which WHD would call attention.

Even though several Latin American nations had been amassing cancer statistics in hospitals in the 1910s, PAHO based its first cancer control views mainly on the results of the Inter-American Investigation of Mortality (IAIM). Begun in 1957 and completed in 1967, this study was led by a team of statisticians and cardiovascular disease and cancer specialists, primarily based at the WHO, PAHO, US and UK universities, and the US Public Health Service. The IAIM sampled about 2000 recorded deaths of adults from 10 Latin American cities and aspired to provide ‘a comprehensive account, as accurate and as comparable as possible, of the causes of mortality of adults in highly diverse and widely separated populations’. The IAIM gave research on chronic illnesses a significant boost in Latin America, as it documented high rates of deaths due to cardiovascular and kidney disease. Previously, medical researchers focused on respiratory infections, pregnancy- and birth-related complications, and accidents as the main drivers of regional mortality. Most significant to this story, 8806 of a total 43,298 deaths, or 20.3%, were caused by cancer, according to the

14. Among the non-government agencies involved in financing birth control activities were the International Planned Parenthood Federation, the Population Council, and the Pathfinder Fund. See R. Necochea López, ‘Gambling on the Protestants: The Pathfinder Fund and Birth Control in Peru, 1958–1965’, Bulletin of the History of Medicine, 88, 2 (2014), 344–71; R. Hynson, Laboring for the State: Women, Family, and Work in Revolutionary Cuba, 1959–1971 (Cambridge 2019); N. Kimball, An Open Secret: The History of Unwanted Pregnancy and Abortion in Modern Bolivia (New Brunswick 2020).

15. R. Necochea López, A History of Family Planning in Twentieth Century Peru (Chapel Hill 2014); J. Pieper Mooney, The Politics of Motherhood: Maternity and Women’s Rights in Twentieth-Century Chile (Pittsburgh 2009).

16. R. Necochea López, ‘The Anti-Cancer League and Public Outreach for Cancer Control in Peru’, História, Ciências, Saúde – Manguinhos, 27, suppl. (2020), 49–69; N. Maldonado, ‘El Dr. Isidro Martínez y el Registro de Cáncer de Puerto Rico’, Galenus, 38 (2013), 72–3; J. Moroder and M. de Viado, ‘Contribución a la Patología Regional del Cáncer: Registro Nacional del Cáncer de Chile, 1959–1960’, Boletín de la Oficina Sanitaria Panamericana, 53, 4 (1962), 303–12; P. Correa and G. Llanos, ‘Morbidity and Mortality from Cancer in Cali, Colombia’, Journal of the National Cancer Institute, 36 (1966), 717–45.

17. R.R. Puffer and G.W. Griffith, Patterns of Urban Mortality: Report of the Inter-American Investigation of Mortality, PAHO Scientific Publication 151 (1967), 2. To enhance the study’s comparative potential, Bristol in England and San Francisco in the US were selected along with ten Latin American cities: Bogota, Cali, Caracas, Guatemala, La Plata, Lima, Mexico, Ribeirão Preto, São Paulo, and Santiago, all of which had readily available mortality statistics.
IAIM. ‘Cancer is being increasingly recognized in Latin America as an outstanding health problem’, its report concluded, theorizing that ‘as in other parts of the world where communicable diseases are prevalent and populations have a relatively young age structure, cancer has been overshadowed by other pressing health needs’. The IAIM took special note of the morbidity and mortality of cancers in certain organs, particularly the lungs, the stomach, and the uterine cervix, the most important single site for fatal cancers in women. However, while the study made no recommendations to deal with stomach cancer and vacillated about the measures to check lung cancer, it was confident that early diagnosis and treatment of cervical cancer could curb the illness’s mortality rate.

Buoyed by the momentum created by the study, PAHO began to concentrate on a first offensive against this disease. In 1968, it established a Cancer Control Unit with a mandate to ‘develop programs for the control of cancer of the cervix uteri, [...] for which well-defined control methods are already available’. The method in question was cytological screening through the Papanicolau exam (Pap smear). Crucially, the unit urged that cervical cancer screening be made part of existing family planning programs, arguing for it as a clinical service for women whose high parity and general poor health put them at greater risk of cancer, threatening not only the women but also their children, who would potentially be left motherless. This approach met criteria PAHO Director Abraham Horwitz had outlined for the expansion of family planning programs in the region. Under tremendous political pressure to back birth control activities, Horwitz, the first Latin American PAHO director, came to support contraception provided it did not impair the ‘normal preventive and curative activities’ of other health services. The addition of cancer screening helped legitimize the expansion of family planning programs, underscoring such programs’ clinical features while reinforcing traditional views of women as mothers and caregivers of children.

PAHO’s favoring of Pap smear screenings as components of existing family planning services encouraged a structural bias against women beyond their reproductive years and women who did not seek birth control but were sexually active. PAHO medical officers understood the etiology of infections such as syphilis and gonorrhea in both men and women but, at first, failed to inquire as to the daily exigencies shaping sexual behaviors,

18. Puffer and Griffith, Patterns of Urban Mortality, 79.
19. Puffer and Griffith, Patterns of Urban Mortality, 99, 116. The stomach was the most important single site of cancer in all cities, with 1,545 deaths assigned, 17.5% of all cancer deaths. The number of deaths assigned to uterine cervix cancer was 820, or 17.9% of all cancer deaths of women.
20. PASB, Annual Report of the Director, 1968, document 95, p. 89. On the history of cervical cancer, see I. Löwy, A Woman’s Disease: The History of Cervical Cancer (Oxford 2011). On cervical cancer screening in Latin America, see L.A. Teixeira and I. Löwy, ‘Imperfect Tools for a Difficult Job: Colposcopy, “Colpocytology” and Screening for Cervical Cancer in Brazil’, Social Studies of Science, 41, 4 (2011), 585–608; and Y. Eraso, ‘Migrating Techniques, Multiplying Diagnoses: The Contribution of Argentina and Brazil to Early Detection Policy in Cervical Cancer’, História, Ciências, Saúde – Manguinhos, 17, supl. 1 (2010), 33–51.
21. See interventions by Abraham Horwitz, Guillermo Adriasola, and Hernán Mendoza in Report of the Third PASB Conference on Population Dynamics, June 9, 1967, Washington DC, document RES6/19, p. 1, 15. Sarah Rodriguez’s paper in this volume makes similar observations about the role of women in the context of US-based international health research in the 1990s.
especially those of women. For example, while they advised more socio-behavioral research be conducted to understand men’s ‘tenderness taboos’ and their relations with sex workers, they refrained from recommending similar studies on the context of women’s sexuality.22 Likewise, despite the acknowledged strong link between cervical cancer and factors such as age at sexual initiation and number of sexual partners, PAHO Regional Advisor for Cancer Control Daniel Joly avoided addressing the social roots of such phenomena and, adducing the difficulty of changing sexual behavior, backed Pap smear programs as ‘the most effective prophylactic against cervical cancer’.23

Unfortunately, the public health impact of Pap screenings in the late 1960s and 1970s was less impressive than its proponents assured.24 Moreover, like the family planning services whose template they followed, cancer screenings reinforced health workers’ authority and convenience, and seldom encouraged active roles for women in their own care. As Dr S.M. Frazier, Bermuda’s Director of Health Services, acknowledged at a PAHO conference in 1967, clinical encounters even sowed systematic disconcert and mistrust, as when clinicians assured patients being fitted with intra-uterine devices that such contraptions did not cause cancer, while at the same time performing Pap smears on those patients during the same visit.25 Taking seriously women’s misgivings and their disadvantages in their relations with men, as well as women’s own potential to tackle these conditions, would become part of an emergent development agenda of women’s health advocates at PAHO.

As cervical screening grew more prominent in the cancer control arena, parallel events in the international governance sphere created and fortified new spaces for women’s participation. The United Nations announced a Decade for Women for 1976–85, to promote equality between men and women and, in a nod to the Cold War, ‘to recognize the importance of women’s increasing contribution to the development of friendly relations among States and the strengthening of world peace’.26 The beginning of the Decade for Women also coincided with the end of the tenure of Abraham Horwitz as director (1958–75), who was replaced by Héctor Acuña (1975–83). Leadership change at PAHO and the affirmation provided by the UN’s global initiative made room for the formal establishment of the WHD program as well as a reassessment of ongoing cancer control efforts.

22. PASB, Venereal Diseases as a National and International Health Problem, October 8, 1970, document CSP18/DT/7 EN.
23. OPS, Seminario sobre Registros de Cáncer en América Latina, Cali, Colombia, 15–20 de Setiembre de 1969, publicación científica 215, p. 13.
24. M. Piñeros, W. Ramos, S. Antoni, G. Abriata, L.E. Medina, J. Miranda, E. Payet, and F. Bray, ‘Cancer Patterns, trends, and Transitions in Peru: A Regional Perspective’, Lancet Oncology, 18 (2017), e573–e587.
25. Third PASB Conference on Population Dynamics, June 9, 1967, Washington DC, document RES6/19, p. 29.
26. PAHO, International Women’s Year, 1975, document CE74/10, p. 1. The Decade for Women included two founding events, the 1975 World Conference on Women in Mexico City and the declaration of 1975 as International Women’s Year. See also J. Olcott, International Women’s Year: The Greatest Consciousness-Raising Event in History (New York 2017); L. Baldez, Defying Convention: US Resistance to the UN Treaty on Women’s Rights (Cambridge 2014); M. Chen, ‘Engendering World Conferences: The International Women’s Movement and the United Nations’, Third World Quarterly, 16, 3 (1995), 477–93.
Planning for economic development had been one of the watchwords the US-led Alliance for Progress championed since its launch in 1961, when it brought together Latin American policymakers seeking to benefit from the financial aid offered. By the early 1970s, the Alliance for Progress waned but Latin American enthusiasm for development planning continued. Abraham Horwitz’s Ten-Year Health Plan for the Americas (1971–80), for example, detailed how health planning contributed to economic development. Most of PAHO’s attention in its 1975 International Women’s Year report, also produced during Horwitz’s tenure, was devoted to the care of women in the reproductive age groups (15–44 years), arguing that repeated cycles of pregnancy, breastfeeding, and uninterrupted work, coupled with dietary inadequacies, created deadly medical problems with downstream socioeconomic consequences that stood in the way of member states’ economic progress and women’s social status.

While focused on women’s pregnancy and perinatal health, PAHO did not neglect cancer, considered the second-gravest threat to women in the region. Still insisting on the importance of Pap smear-based early detection and treatment, PAHO under new director Acuña turned a critical eye to the broader context in which women’s lower status was (re)produced, and to the shortcomings of the cancer control programs it championed, finding that placing these within family planning services often limited screening to better-off women in urban areas. This admission was surprising at a time when PAHO’s support for such cancer control programs multiplied through Latin America.

Acuña, keener than previous directors to delegate executive responsibilities within PAHO and its field offices, appointed a Special Group on Women and Health in 1977 which, in turn, called for the establishment of a dedicated office for women within the Family Health division. This first opening, however, was short lived, as it did not suit the growing consensus at PAHO that multifaceted problem areas, such as women’s health, did not lend themselves to solutions controlled by any one division. Intersectoral solutions were also favored by the primary health care perspective WHO endorsed in the late 1970s, most visibly through the 1978 Alma-Ata Declaration.

Country representatives at the World Conference of the UN Decade for Women meeting in Copenhagen in 1980, the halfway point of the Decade for Women, concurred

27. This promotion of economic development, of course, was also partly shaped by the US-USSR adversarial relation, especially after the 1959 Cuban Revolution.
28. A. Horwitz, ‘Planning a New Decade’, PAHO Bulletin, 7, 4 (1973), 61–74; and PASB, Report on Health Activities Carried Out in Conformity with the Charter of Punta del Este and Their Future Prospects, July 5, 1962, document CSP16/7.
29. PAHO, Critical Issues and Outlook for the Health Conditions of Women in Latin America and the Caribbean, 1975, document CE74/10.
30. Especially Brazil, Guatemala, Peru, Venezuela, Mexico, Paraguay, Trinidad and Tobago, Argentina, and Chile. See PAHO, Annual Report of the Director, 1975, document 143, p. 199.
31. PAHO, Report of the Director, Quadrennial 1974–1977, Annual 1977, document 158. The Family Health division managed budgets and programs concerning maternal-child health, nutrition, and mental health, but not cervical cancer, which fell under the jurisdiction of the Disease Control division.
32. PAHO, Technical Seminar ‘Relation between the Health Needs and Conditions of the Working Women in Latin America’, September 16–19, 1975, document CIM/OEA-UNICEF-PAHO.
33. https://www.paho.org/English/DD/PIN/alma-ata_declaration.htm, accessed May 20, 2020. See also Gaëtan Thomas’s article in this issue.
that poor intersectoral coordination of pro-woman policies, especially in the so-called developing nations, had hampered the hoped-for goal of consolidating gains for women in education, employment, and health.\footnote{UN, Programme of Action: World Conference of the United Nations Decade for Women, Copenhagen, Denmark, 14–30 July 1980, document A/CONF.94/34, p. 14.}

In response, PAHO’s Directing Council formed a special sub-committee of Women in Health and Development to examine the Copenhagen conclusions and tailor them to the needs of the Americas. The result was the Five-Year Regional Plan of Action on Women in Health and Development of 1981.\footnote{PAHO, Women in Health and Development, Proposed Five-Year Regional Plan of Action, August 6, 1981, document CD28/15.} In the broadest sense, the WHD Five-Year Plan was meant to help PAHO and its member governments successfully bring women of the Americas into new and continuing activities, as recipients, providers, and promoters of health care.\footnote{PAHO, Five-Year Regional Plan of Action on Women in Health and Development Progress Report, July 19, 1982, document CSP21/15; PAHO, A Guide to the Five-Year Regional Plan of Action on Women in Health and Development in the Americas, scientific publication 448, 1983, p. v, 1.} The new policy, however, perpetuated the Horwitz-era view equating development and economic growth, adding appeals to individual responsibility, especially those of women, for the accomplishment of health targets. The Five-Year Plan blamed the ill health of individuals and families on ‘ignorant, malnourished, or over-worked’ women, while simultaneously praising them as natural caregivers and health workers, who ‘largely determine the acceptance of new facilities or services in their communities’.\footnote{PAHO, A Guide to the Five-Year Regional Plan of Action on Women in Health and Development in the Americas, scientific publication 448, 1983, p. v, 1. This view is also evident in earlier documents. See PAHO, Informe sobre el papel de la Mujer en el Desarrollo, August 15, 1980, document CD27/33, p. 8–9.} These multiple expectations of women, even couched in benevolent terms, without clear incentives or fundamental changes in the relations between health care providers and patients, or between men and women, could be onerous and even odious: a way to feminize the duty to alleviate not only poverty, as Sylvia Chant found, but also disease; or a means to portray development as the burden of individual women.\footnote{S. Chant, “The “Feminisation of Poverty” and the “Feminisation” of Anti-Poverty Programmes: Room for Revision?”, \textit{Journal of Development Studies}, 44, 2 (2008), 165–97.} Particularly damaging was that these expectations encouraged the common medical opinion that women were personally to blame for not getting Pap smear tests. Still, it was also in the early 1980s that a critical approach to the gendered inequalities shaping women’s ill health arose, through PAHO-sponsored mechanisms that drove Latin American women’s advocates’ views deep into the organization’s structure.

Shortly after its establishment, the WHD sub-committee decried the paucity of systematic information on women’s health. PAHO responded by recommending that each country appoint an officer, designated a ‘focal point’, to channel data about women’s health activities, and to foster the involvement of women and women’s organizations as providers and administrators of primary health care services.\footnote{Annex VII, ‘Resolution VII, Women in Health and Development’, in PAHO, Five-Year Regional Plan of Action on Women in Health and Development Progress Report, July 19, 1982, document CSP21/15.} Within a year, of the 32 PAHO member governments, all but two had designated such a focal point person.
An important and immediate consequence of the establishment of the focal point positions was that an influential group of Latin American advocates could now voice their discontent regarding existing health programs. Most of the focal point positions were held by women employed in government agencies responsible for health, women’s issues, or education, resulting in a group with uniform strengths navigating organizational bureaucracies, despite variations in the character of the local agencies in which the women worked. In addition to their professional credentials, several had significant experience as women’s rights activists. Among them were Dorla Bowman at the Women’s Bureau of Belize; Ana Quiroga at the Gregoria Apaza Women’s Center of Bolivia; Vilma Espín, founder of the Cuban Federation of Women; the Haitian family planning pioneer Adeline Verly; and Lea Guido, the former Sandinista fighter and health minister of Nicaragua.40

Officers serving as focal points were blunt about not only the dearth of facts and figures on women’s health but also the sexist misgivings of some health ministry personnel regarding WHD’s objectives.41 These problems, focal points noted, were compounded by the chronic lack of resources afflicting government agencies, as well as by the demands made on the attention of busy public servants by many organizations (PAHO included) that financed various health programs. Giving these national frontrunners a direct channel to influence PAHO’s structure as WHD focal points proved crucial to the evolution of PAHO’s views on women’s health in general and cervical cancer in particular.

In 1985, toward the end of the Decade for Women, WHD ramped up its critique of PAHO’s shortcomings in diplomatic terms that betrayed impatience. For starters, the WHD subcommittee, led by representatives of Canada, Cuba, and Ecuador that year, praised PAHO’s thorough reporting in the areas of maternal-child health and family planning, but it noted others that had not been addressed, including mental health. In addition, the WHD subcommittee commended the greater awareness that public health authorities evinced on the distinctiveness of women’s health needs, visible in new legislation to protect women’s rights to divorce, abortion, health care, and equal pay. However, it faulted the weak political will of governments, instead of simply blaming the economic crises Latin American nations faced in the 1980s, for the lack of follow through with their own laws.42 According to the WHD subcommittee, its work needed to persist beyond the original five years PAHO originally allowed.43 Cutting their mission short, they contended, imperiled PAHO’s self-imposed development goals.

40. A. MacPherson, *From Colony to Nation: Women Activists and the Gendering of Politics in Belize, 1912–1982* (Lincoln 2009); https://www.gregorias.org.bo/quienes-somos/ accessed May 24, 2020; L. Trujilo, *Vilma Espín: La Flor Más Universal de la Revolución Cubana* (Melbourne 2011); A. Bordes, J. Allman, and A. Verly, ‘The Impact on Breastfeeding and Pregnancy Status of Household Contraceptive Distribution in Rural Haiti’, *American Journal of Public Health*, 72, 8 (1982), 835–8; L. Guido, ‘Nos Jugamos la Vida por la Libertad’, in M. Baltodano, *Memorias de la Lucha Sandinista, Tomo III* (Managua 2011), 1–24.
41. PAHO, Women, Health, and Development, July 31, 1984, document CD30/8, p. 4, 8.
42. Anexo ‘Informe del Subcomité Especial sobre la Mujer, la Salud y el Desarrollo’, p. 2; and anexo I ‘Actividades de la OPS Relativas a la Mujer, la Salud y el Desarrollo, 1976–1985’, p. 24 in OPS, *La Mujer, la Salud y el Desarrollo*, 23 de abril de 1985, document CE95/8.
43. Annex ‘Report on the Special Subcommittee on Women in Health and Development’, in PAHO, *Women, Health, and Development*, April 6, 1984, document CE92/10.
These critiques resumed a few months later – and on a bigger stage – at the World Conference to Review and Appraise the Achievements of the UN Decade for Women, held in Nairobi in 1985. Since 1975, conference representatives concluded, women had made legal and political advances. In most countries, however, major obstacles to women’s progress remained, including continuous stereotyping of women’s roles, worsening economic conditions that strained resources for social programs, and persistently sexist attitudes among decision-makers.\textsuperscript{44} The signature critical positions WHD adopted vis-à-vis failures to deliver on women’s health must be understood in the context of 10 years of promises and preparation at PAHO, the justification of these critiques by the unfulfilled goals of the Decade for Women, as well as the momentum Latin American focal points gained in the 1980s seeking the redress of conditions that harmed women, a political goal WHD deemed integral to development.

Within two years of the Nairobi conference, PAHO Director Carlyle Guerra de Macedo (1983–95) established an Internal Advisory Group to enhance cooperation with national focal points and to maintain WHD activities within PAHO, instead of phasing them out after five years as scheduled. Going forward, Macedo envisioned the need for greater cooperation between programs dedicated to maternal health, cancer care, occupational health, and mental illness, with the intention of furthering the Alma Ata vision of ‘health for all by the year 2000’.\textsuperscript{45} Given WHD’s stronger institutional position and Macedo’s commitment to advancing primary care, the second half of the 1980s (often referred to as Latin America’s ‘lost decade’) was poised to become a period of vibrant change for WHD, including in cervical cancer control, during which the contours of a new woman-centered vision of development sharpened, contrasting with that found in the Five-Year Plan.

Besides attending to needed changes regarding women’s health in their respective countries in the mid-1980s, and despite missing data, sexism at all levels, and severe economic crises compounded by structural adjustment policies that resulted in cutbacks in social programs throughout Latin America, WHD focal points also worked toward strengthening transnational networking with each other and with nongovernmental and community groups. Cervical cancer played a prominent role in these discussions. Although few WHD Latin American focal points claimed expertise in cancer care, they nonetheless channeled and amplified the worry this illness caused in their home countries among women.

An emblematic encounter took place in 1984 in Mexico City, where PAHO held a Meeting on Cervical Cancer Control that WHD had proposed. Its intent was to harness the energy of volunteer leagues against cancer, which ‘exist[ed] in practically all Latin American countries’. Their staffs, ‘composed primarily of non-professional women’, in PAHO’s understanding, provided support to cancer patients, families, and cancer

\textsuperscript{44} Annex ‘Final Draft: Regional Forward-Looking Strategies on Women, Health, and Development’, in PAHO, Report of the Special Subcommittee on Women, Health, and Development, April 9, 1986”, document CE97/12.

\textsuperscript{45} PAHO, Report of the special Subcommittee on Women, Health, and Development, April 9, 1986, document CE97/12; C. Guerra de Macedo, ‘The Challenges Ahead’, World Health (October 1987), 26–29.
treatment facilities, and participated in public education campaigns. With support from the American Cancer Society, the meeting was meant to stimulate the exchange of information among the various leagues, and to allow invited health authorities to better understand the contributions these leagues could make to cancer control.

A group of 52 Latin American and Caribbean government delegates attended, alongside representatives from 14 national cancer leagues. Despite the acknowledged differences between governmental and volunteer cultures and operating procedures, there was unanimous agreement that formally constituted cancer societies must collaborate with national ministries of health. Cancer societies, which, to varying degrees, welcomed the involvement of all qualified people and community representatives from groups at higher risk of cancer, successfully advanced a position legitimizing a vigorous role for themselves in the areas of information dissemination, public and professional education, fundraising, and the management of screening operations.

In public health terms, the PAHO/volunteer societies confluence that WHD brokered broadened the array of actors relevant in cervical cancer control efforts. On the other hand, participants at the Mexico City meeting did not challenge the centrality of Pap smear screening, which the health specialists in attendance promoted. In fact, the meeting became an occasion to publicize the advantages of high-volume centralized cervical cytology laboratories, that is, those processing at least 50,000 Pap smear specimens annually. They were less expensive to operate than smaller ones, better able to offer work opportunities for laboratory technicians and pathologists, and ultimately more likely to deliver accurate test results through a well-trained workforce and robust infrastructure.

The Mexico City meeting, then, legitimized the contributions women and women-led organizations could make to cancer control, an important corrective to the notion of development goals as solely determined by medical experts. At the same time, it reaffirmed PAHO’s reliance on one technical tool for prevention during the long and grim reign of cervical cancer. The disease remained the most widespread and lethal of women’s cancers in the mid-1980s, much as it had been in the 1960s, striking down over 30,000 women every year in Latin America and the Caribbean, many of them still relatively young. Indeed, in 1985 the estimated number of women ages of 35–64 years in Latin America and the Caribbean who died of cervical cancer was at least four times higher than in the United States or Canada. The last two averaged 6.8 and 6.5 per 100,000 cases per annum, respectively, whereas these figures in Paraguay, the English-speaking Caribbean, Chile, and Mexico were 30.3, 29.5, 27.7, and 25.8 per 100,000 cases, respectively. Cervical cancer screening did not reach a vast proportion of women in various health centers, hindering prevention efforts. As an indication, 71.5% of patients with advanced cervical cancer at the Sótero del Río Hospital, where

46. PAHO, Five-Year Regional Plan of Action on Women in Health and Development Progress Report, July 19, 1982, document CSP21/1, p. 17.
47. Beginning in the late 1970s, PAHO and Latin American nations moved to establish new comprehensive cancer control programs, rather than continue dividing cancer care across various administrative units. See PAHO, Report of the Director, Quadrennial 1974–1977, Annual 1977, document 158, p. 36.
48. PAHO, Final Report: Meeting on Cervical Cancer Control, Mexico DF, 17–20 January 1984, document CE92/INF/1.
a large number of Santiago’s poor sought care, had never had a Pap smear. Besides differences in the availability of preventive and treatment services by country, there were also great differences within each nation, with rural and peri-urban areas lagging behind national averages.49

Importantly, calls to reform cervical cancer services grew in a direction compatible with WHD’s development vision among PAHO clinicians most directly involved in addressing these burdens. In the mid-1980s, these medical experts became more likely to discuss openly not only the factors long linked to the illness, such as age at first sexual encounter and number of sex partners, but also new ones, such as poverty, the failures of screening programs, and the nature of women’s relationships with men. Dr Helena Espinosa de Restrepo was representative of this trend. A self-identified feminist public health physician from Colombia, Espinosa joined PAHO’s Program for the Control of Noncommunicable Diseases in 1982 and rose to become Director of Health Promotion and Protection, the division most deeply involved in cervical cancer prevention.50

Pragmatically and enduringly committed to the familiar Pap smear, Espinosa and her colleagues urged the deployment of the technology at the most basic levels of care for all women who were or had been sexually active, as well as increasing the size, accuracy, and record-keeping ability of test-processing laboratories. By the mid-1980s, however, the demands of Espinosa and her like-minded colleagues addressed broader social aspects. They argued that cervical cancer control programs failed the women who most needed them because resources tended to be concentrated in specialized cancer hospitals and because programs relied on ‘dismal education materials’ that scapegoated women for their lack of trust in the health personnel who conducted screenings.51 Funds for primary-level screening and treatment services were far scarcer, yet the places that offered such services were better able to attract women and offer follow-up care by cooperating with female-led organizations.52

A key convergence occurred between WHD’s position and that of feminist public health physicians such as Espinosa, who would lead the WHD Internal Advisory Group in the early 1990s. Both sought to institutionalize the participation of women and women-led organizations in cancer control efforts against prevailing trends. Male chauvinist attitudes, Espinosa observed, were rife at PAHO headquarters in Washington, DC, and the conditions in the field were scarcely better. Physicians and nurses with whom she worked blamed women for their cervical cancers, either because they did not submit to regular Pap smears or because of their alleged sexual promiscuity. The providers’ duty to follow up with their patients or to attract new ones

49. Anexo II in OPS, La Mujer, la Salud y el Desarrollo, 23 de abril de 1985, document CE95/8, p. 8. Cuba was an exception, with a death rate of 9.7 per 100,000.
50. The Program for the Control of Noncommunicable Diseases was established in 1980 and incorporated PAHO’s old Cancer Control Unit. See PAHO, Program for the Control of Noncommunicable Diseases, July 24, 1980, document CD27/17.
51. Helena Espinosa de Restrepo, written communication, February 28, 2020.
52. H. Restrepo, J. González, E. Roberts, and J. Litvack, ‘Epidemiología y Control del Cáncer de Cuello Uterino en América Latina y el Caribe’, Boletín de la Oficina Sanitaria Panamericana, 102, 6 (1987), 578–93, p. 588.
with quality services hardly registered with Espinosa’s interlocutors. Most strongly rebuffed was the suggestion that men might play a role in transmitting cervical cancer to women. In Quito, Espinosa recalled, a male gynecologist nearly assaulted her after she told him that a nursing assistant in his team had confided such suspicions to her.\(^{53}\)

Considering men’s sexuality in the etiology of cervical cancer had been uncommon in the 1980s, but the idea resonated with Espinosa and others.\(^{54}\) To them, it helped explain anecdotal clinical observations, and it appealed to the feminist position widely shared among WHD focal points that sanctimonious accusations of promiscuity needed to be abandoned in cervical cancer care in favor of fine-grained discussions about the place of sex in the subsistence economies of Latin American cities.\(^{55}\)

Women’s survival in these settings often depended on their ability to find men to shoulder part of the burden of providing for dependents and who would protect women in hostile environments. The result was a pattern of multiple transient unions inimical to women’s health and wellbeing. While men in these relationships demanded women’s sexual fidelity, women could not do the same, given their more precarious place in the labor market and their fear of men’s jealousy-driven violence. Conditioned by widespread patriarchal prejudices, men were more likely to have several sexual partners, becoming likely vectors of sexually transmitted infections, including HPV (human papillomavirus). The latter, PAHO admitted in the late 1980s, bore a strong epidemiological relation with the risk of cervical cancer.\(^{56}\)

This position concerning cervical cancer, ascendant at WHD, constituted an indictment of a gendered political economy that put women at risk of lethal diseases, which (1) health systems and providers did not care well for; (2) were studied without due consideration to the role of men as vectors of disease and social misery; and (3) could be controlled more effectively if women’s organized voices were considered. Promiscuity was not the root problem in this framework. Unequal power was – between men and women, between (usually male) health care providers and female patients, and between expert-run and lay women-led organizations. The early 1980s strategic leap enabled by the WHD focal points evolved by the late 1980s, through cooperation with public health physicians, into an emergent vision linking development to the subversion of gender inequality, which departed from the dominant definition of development at PAHO as the meeting of quantifiable targets, including medical ones, that contributed to national economic wellness, as determined by experts, and with which individuals were urged to comply.

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53. Helena Espinosa de Restrepo, written communication, February 28, 2020.
54. D.C.G. Skegg, P.A. Corwin, C. Paul, and R. Doll, ‘Importance of the Male Factor in Cancer of the Cervix’, *Lancet*, 320, 8298 (1982), 581–83. The theory acquired momentum in the late 1980s. See R. Herrero, L.A. Brinton, W. Reeves, et al., ‘Factores de Riesgo de Carcinoma Invasor de Cuello Uterino en América Latina’, *Boletín de la Oficina Sanitaria Panamericana*, 109, 1 (1990), 6–26.
55. H. Restrepo, ‘Epidemiología y Control del Cáncer de la Mujer en América Latina y el Caribe’, in E. Gómez (ed.) *Género, Mujer y Salud en las Américas* (Washington DC 1993), 98–113.
56. PAHO, Health of Adults Program, Summary Report of the Consulting Group on Cervical Cancer Research, Washington, October 9–10, 1990. The earliest findings linking HPV to cancer date from the early 1980s. See R. Peto and H. zur Hausen (eds.) *Viral Origin of Cervical Cancer, Bambury Report no. 21* (New York 1986).
WHD moved to put this vision into practice by the early 1990s. Among their initiatives, those originating in Central America are the most richly documented in WHD’s archived history and offer important insights about the aspects of cervical cancer care that were most salient to women. In the late 1980s, health offered itself as a topic for public engagement and as a lever for social change in Central America. The region was grievously afflicted by civil wars and the forced displacement of thousands, provoked in part by US-backed insurgencies, such as the Contras in Nicaragua, who sought to restore or strengthen regimes with anti-communist inclinations. Cold War terror in Latin America, ‘executed, patronized, or excused by the United States’, as Greg Grandin has put it, militarized societies and undermined political rights.57 Rather than seeking alignment with the United States interests only, health reformers interacted with the United States, European, and Soviet players, as well as with other Latin American nations.58 Under the banner of ‘Health: A Bridge to Peace’, the Contadora Group (made up of Colombia, Venezuela, Panama, and Mexico) and PAHO urged the international community to provide assistance for projects to provide essential medications, food, and vaccines. Between 1983 and 1989, about US $425 m in aid, mainly from Spain, Sweden, Norway, and, ironically, the United States, financed over 150 projects.59 As a second round of financing got underway for 1991–94, director Macedo and PAHO’s Central American WHD focal points mobilized in earnest to propose projects to improve maternal-child health and the health of adult women, foster women’s health research, as well as for cervical cancer prevention.60

The feasibility of these projects was discussed at the First Meeting on Women, Health and Development in Central America in Managua in August 1988, organized by PAHO, Nicaragua’s Ministry of Health, and the Luisa Amanda Espinoza Association of Nicaraguan Women.61 The Central American bid successfully competed against 80 other projects, receiving about US$ 1.5 m, thanks to its focus on women as a group whose health was especially vulnerable to political violence.62 Beginning in 1990, the Integral Health of Women in Central America project became an umbrella for locally run sub-projects in Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, Belize, Panama, and the Dominican Republic.

A high degree of camaraderie and mutual learning characterized the WHD’s ‘new phase of more direct action’ in the early 1990s,63 thanks to frequent communications between

57. G. Grandin, The Last Colonial Massacre: Latin America in the Cold War (Chicago 2004).
58. A.E. Birn and R. Necochea López (eds.) Peripheral Nerve: Health and Medicine in Cold War Latin America (Durham, 2020).
59. M. Cruz-Peña, Salud e Historia en Centroamérica: Análisis de las Reuniones del Sector Salud de Centroamérica y República Dominicana 1985–2000, OPS/Ministerio de Salud de Nicaragua, Julio 2001, p. 14.
60. PAHO, Annual Report of the Director, 1988, document 228; OPS and Centro Latinoamericano de Demografía – San José, Estudio de Factibilidad para el Sistema Centroamericano de Información sobre la Mujer en la Salud y el Desarrollo, San José, Costa Rica, May 1989.
61. On the storied women’s movement in Nicaragua, see K. Isbester, Still Fighting: The Nicaraguan Women’s Movement, 1977–2000 (Pittsburgh 2001); F. Babb, Después de la Revolución: Género y Cultura Política en la Nicaragua Neoliberal (Managua 2012); N. Stoltz Chinchilla, ‘Revolutionary Popular Feminism in Nicaragua: Articulating Class, Gender, and National Sovereignty’, Gender and Society, 4, 3, (1990), 370–97.
62. OPS, Salud Integral de la Mujer en Centroamérica en su Fase II, 1992, document SMSD12/4 (Esp.).
63. PAHO, Annual Report of the Director, 1988, document 228, p. x.
Central American focal points and a newly-created WHD regional office in Costa Rica, directed by Lea Guido, who marshalled the efforts of dozens of nurses, midwives and community health workers serving women in poor urban and rural areas. Complementing this grassroots clinical mobilization, the recently appointed WHD officers at PAHO headquarters, particularly Elsa Gómez from Colombia and Rebeca de los Ríos from Venezuela, embraced the Latin American urban and cosmopolitan feminist intellectuals’ drive to analyze health as a field in which multiple forms of oppression against women intersected and were produced. In effect, influenced by the Latin American and Caribbean Women’s Health Network, founded in the early 1980s, WHD reports and publications of the early 1990s began to incorporate the concept of ‘gender’ as a term of art to provide clarity and cohesiveness to their work, using it to refer to socially constructed traits defining masculine and feminine roles in different contexts, internalized and manifested by individuals, and sanctioned by social institutions, including families, schools, and health systems.

From these complementary clinical and critical vantage points, the vulnerability that women experienced regarding cervical cancer could not be isolated from the broader context that discriminated against women, while privileging men and ostensibly masculine activities and behaviors. WHD, particularly in Central America, became deliberate about viewing old problems, such as low Pap smear rates and women not receiving appropriate follow-up care after a course of treatment, through the lens of gendered inequalities, rather than treating such phenomena as the product of individual ignorance or carelessness by women. Development work to change these conditions, they claimed, must move beyond target-setting, expert consultation, and quantification to deep engagement with men and women’s daily lives.

Between 1991 and 1994, Lea Guido and WHD focal points organized dozens of workshops with hundreds of health workers throughout Central America, using publications produced by allies in various national ministries, feminist organizations, and universities. The workshops’ objective was to foster reflection about how clinicians treated women, with the ultimate goal of cultivating ‘a critical mass of health professionals who will have an impact on the processes of renewal and change that are required by policies and models on women’s health care’. Guido’s approach occasionally irked WHD staffers in PAHO’s headquarters, who were circumspect about stepping into discussions about national political changes. However, cervical cancer care itself provided a lynchpin in the Central American workshops, yielding two important lessons.

64. Gómez, Género, Mujer y Salud en las Américas; OPS, Informe del Subcomité Especial sobre la Mujer, la Salud y el Desarrollo, 2 de Mayo de 1990, document CEI05/19 (Esp.); A.M. Portugal and M.A. Saa, Movimiento Feminista en América Latina y el Caribe: Balance y Perspectivas (Santiago 1986). Peruvian journalist Ana María Portugal and Chilean physician María Isabel Matamala founded the Red de Salud de las Mujeres Latinoamericanas y del Caribe, which exists to this day. See https://www.reddesalud.org, accessed June 29, 2020.
65. OPS, Informe de Actividades de Cooperación Técnica sobre Mujer, Salud y Desarrollo Llevadas a Cabo por el Secretariado en 1990: Perspectivas Futuras en el Marco de las Orientaciones Estratégicas y Prioridades Programáticas 1991–1994, 15 de marzo de 1991, document SMSDI1/3 (Esp.)
66. PAHO, Review of the Structure and Functions of the Focal Points for Women, Health, and Development in the Region of the Americas, March 15, 1991, document SMSD11/4, p. 19–20.
67. Interviews with Elsa Gómez, February 6, 2020, and Rebecca de los Ríos, February 16, 2020.
First, clinicians acknowledged their awareness of women feeling mortified by pelvic exams, necessary for cancer screening. Such deep reactions, according to focal points, were a gateway to empathy and solidarity for all health workers towards their patients. For some workers, however, admitting the validity of women’s disgust and reticence came more easily than for others. Nurses and public health physicians, for example, were well-disposed to appreciate the context of historical discrimination against poor and Indigenous women and routine rough treatment in medical settings. Even gynecologists, who claimed Pap smear tests as something of a jurisdictional right, acknowledged the systemic shortcomings that alienated patients in need of preventive care. Such sensitivity, however, was primarily discernable among gynecologists as individuals. In groups, by contrast, they tended to be refractory and hostile.68

A second important lesson drawn from the Central American gender and health workshops was the extent to which the notion of self-care advanced by WHD officers, focal points, and their allies resonated with rank-and-file health workers.69 Whereas ‘self-care’ typically conjured the need for individual women to seek and comply with medical advice, especially concerning cervical cancer prevention, WHD instead promoted a definition of self-care grounded in the respect of women’s autonomy, their everyday practices, and the diversity of their interests. The contours of this perspective were worked out at a 1991 WHD conference in Cali, Colombia, with representatives of 14 Latin American nations. Refuting the decades old PAHO view of women as self-denying caregivers for all, the Cali consensus emphasized the right of women to care, above all, for themselves, and the corresponding duty of medical experts and health organizations to rise to the occasion by re-organizing themselves in line with such expectations.70 Central American health workers at these gender and health workshops endorsed the recommendation that trusted others, such as women’s partners or birth attendants, ought to be welcomed in the normally private exam room during a Pap smear.71 By 1994, these WHD measures to promote self-care became formal PAHO best practices to improve the health of Indigenous women in Guatemala and were later disseminated throughout Latin America. Attending to these self-care dimensions, as participants at the Cali meeting put it, liberated all women from the subservient relations they had with their own bodies, other people, and the body politic.72

68. Interview with Panama focal point Leonor Calderón, February 24, 2020. Following her service as PAHO focal point for Panama, Calderón worked for the Office of the First Lady of Panama, and then became the inaugural Minister of Youth, Women, Children, and the Family and, later, the inaugural Minister of Social Development in 2005.
69. Y. Arango, Mujer, Salud y Autocuidado (Washington 1992); Y. Arango Panesso, ‘Autocuidado, Género y Desarrollo Humano: Hacia una Dimensión Ética de la Salud de las Mujeres’, La Manzana de la Discordia, 2, 4 (2007), 107–15.
70. OPS, Informe de Relatoría del Grupo de Trabajo sobre el Tema de Mujer, Salud y Autocuidado, enero de 1992, documento SMSD12/7 (Esp.), p. 15.
71. Interview with Guatemala focal point Lily Caravantes, February 18, 2020. Following her service as PAHO focal point, Caravantes became the inaugural Secretary General of Guatemala’s Presidential Office on Women in 2000 and has served in the city council of Guatemala City.
72. PAHO, Health Education and the Promotion of Self-Care with Indigenous Guatemalan Women, 1994, documento PAHO/PWD/94-009; and annex ‘Final report of the 16th meeting, March 29, 1996’, p. 5 and 16, in PAHO, Report of the Special Subcommittee on Women, Health, and Development, April 11, 1996, documento CE118/6.
that sense, self-care was less about assisting economic development and more about advancing ‘human development’.  

In closing, let us re-visit how cancer control offers a window into the emergence of a woman-centered vision of development in the international health establishment. WHD’s boldness in the 1990s seems like something of an inflection point in the context of two major UN conferences, the Cairo International Conference on Population and Development of 1994 and the Beijing World Conference on Women of 1995, which affirmed that gendered inequalities indeed placed women at risk for lethal and preventable illnesses, particularly cervical cancer. Throughout the decade, WHD staffers and focal points insisted that PAHO reckon with its own deficiencies regarding women’s health by addressing their exposure to cervical cancer. They also continued channeling Latin Americans’ demands for improved cancer screening activities and disseminating ideas about gender equity in the region. Adopting this perspective necessarily implied treating problems such as women not getting Pap smears as something other than individual failings. Simply increasing opportunities for individual women to get screened for cancer, for example, would make little difference in cancer death rates, unless clinicians and policymakers understood how social structures were stacked against women as a group, through the everyday power of men over women, the historical lack of employment and educational opportunities for women, and the naturalization of the care of others as a woman’s duty, even to the detriment of her self-care. This radical gender equity orientation is discernable in every document WHD published through the 1990s and beyond. Combatively, WHD Coordinator Pamela Hartigan even vowed to make ‘all technical staff—beginning with the Director—aware of the meaning of gender in health and development’. Bluster aside, the diverse women’s health advocates associated with WHD indeed held that subverting the power differential between men and women was not only fair, but also an integral aspect of development.

As I have argued, however, this position emerged at PAHO years before the 1990s. In the mid-1970s, Latin American public health officials, clinical workers, and women’s advocates began to criticize the flaws inherent to making cervical cancer screenings part of the family planning programs PAHO had supported since the late 1960s. Despite these programs’ ineffectiveness in curbing cancer rates, though, divesting them from family planning services proved challenging, not only because of the abundant external funding the global birth control juggernaut enjoyed, but also because of the prestige population policymaking to national economic development schemes at the

73. OPS, Informe de Relatoría del Grupo de Trabajo sobre el Tema de Mujer, Salud y Autocuidado, enero de 1992, document SMSD12/7 (Esp.), p.
74. See Strategic Objective C.4 in UN Report of the 4th World Conference on Women, Beijing, 4–15 September 1995, https://www.un.org/womenwatch/daw/beijing/pdf/Beijing%20full%20report%20E.pdf, accessed June 29, 2020.
75. M.I. Matamala, F. Berlagosky, G. Salazar G, and A.L. Núñez, ‘Calidad de la Atención desde un Enfoque de Género’, in OPS, Mujer, Salud y Desarrollo (Washington DC 1995); E. Gómez Gómez, La Salud y las Mujeres en América Latina y el Caribe: Viejos Problemas y Nuevos Enfoques, OPS Serie Mujer y Desarrollo (Santiago de Chile 1997).
76. OPS, Ministerio de Salud de Chile, and Servicio Nacional de la Mujer de Chile, Mujer, Salud y Desarrollo (Santiago 1995), p. 251.
time and because clinicians encouraged the public to see cervical cancer prevention, like contraception, as a woman’s duty to her family.

Although the Decade for Women ushered an important re-consideration of the link between women’s social status and their health, its dynamism was dulled by the strength of PAHO’s older commitment to economic development as the most important driver of women’s health and by the broadly held view of women as natural caregivers in families and communities.

Yet women’s health advocates never ceased adapting to PAHO’s slow-paced, consensus-building bureaucracy to draw attention to the gendered political economy that influenced diseases, and they achieved a breakthrough in the early 1980s with the establishment of WHD, which made several fundamental contributions to international health organizations’ cancer control efforts and nurtured an alternative view of what development could mean through a gendered lens.

First, WHD broadened the array and number of actors whose voices and concerns echoed through PAHO, as focal points and as Latin American members of women-led organizations who knew first-hand the ravages of cervical cancer and were eager to signal their discontent and get a seat at PAHO’s executive table. Second, WHD focal points refused to let PAHO member governments simply blame the economic crises of the 1980s for their failures to improve cancer care and urged a steady political will to improve women’s health. Third, WHD amplified and validated the counterhegemonic minority views of feminist public health physicians about the complex etiology of cervical cancer, which, in their opinion, ought to go beyond casting individual blame for non-compliance with medical advice, to address the meager resources devoted to preventive activities, the poor quality of clinical services (from screening to bedside manner to follow-up), the role of men as disease vectors, and the weak position of women’s organized voices. Fourth, WHD wove the concepts of gender equity and self-care to give cohesiveness to its agenda in a way that resonated throughout the region after its rollout in Central America.

In the early 1990s, the Integral Health of Women in Central America project became the testing ground for two distinctive WHD proposals meant to influence key aspects of cervical cancer care. The first was the imperative to unite women-led organizations to demand better treatment from clinicians; the second was the inclusion of the notion of gender equity in all PAHO activities affecting women’s health. The organization of the laborious gender and health workshops showed that WHD could establish successful and reliable partnerships with women-led organizations despite the region’s political violence and frequent employee turnover. Without challenging the Pap smear, these workshops pointed out the conditions under which cancer control programs could routinely alienate women by not acknowledging the obstacles they faced to receiving preventive care and by sacrificing their needs to practitioners’ preferences. Though it was hard to gauge the workshops’ immediate effect on cancer control programs, they provided powerful insights that justified further collaborations with women’s and clinicians’ groups that lasted into the twenty-first century in such places as El Salvador, Peru, and Suriname.

Despite these efforts and accomplishments, however, the overall mortality rate for cervical cancer in Latin America remained high, with over 30,000 deaths estimated at the
turn of the twenty-first century, most of these happening in locales with higher poverty rates where specialized medical care is least available. The obduracy of these statistics is evidence that, despite women’s health advocates’ ability to gain a foothold in international health organizations and their effective critiques of cervical cancer screening shortcomings, political will and support at the national level has yet to match advocates’ commitment. The disappointing statistics also attest to the limitations of international health organizations, such as PAHO or WHO, which can offer advice and funds, but ultimately cannot determine nations’ health priorities. The absence of political support for this major public health issue has translated into problems reaching women either before or after a Pap smear, poorly coordinated screening initiatives with insufficiently trained lab technicians, and a persistent concentration of specialized cancer care services and professionals in wealthier urban areas.

As disappointing at the turn of the twenty-first century was the sidelining of the radical diagnosis and proposals WHD pioneered concerning the causal links between gender inequality, development, and ill health. The late-1990s UN-propounded move to ‘mainstream’ gender (assessing the implications for women and men of planned legislation and programs) made gender a matter for all of PAHO to consider, but at the cost of phasing out WHD, its most dedicated champion for gender equity. Since the 1980s, WHD had been not only denouncing gender-based inequality in PAHO’s programs, but also treating women’s health advocates as harbingers of a novel way of understanding development, based on the subversion of harmful social hierarchies that placed women at risk for lethal and preventable illnesses, such as cancer. Furthermore, WHD’s reliance on focal points, woman-led volunteer cancer organizations, and clinician workshops in peri-urban and rural areas showed a commitment to imagining women’s health as the deliberative product of multiple stakeholders surging, bottom-up, to shape PAHO’s developmental agenda.

The early 1990s were a propitious time for such heterodoxy, as global events put a premium on inspiring new visions of development, especially in Latin America. Colombia’s Minister of Health Camilo González Posso, a guest at the WHD’s 1991 conference in Cali, outlined the new landscape when he noted how the collapse of the Soviet Union had emboldened triumphalism about free markets and deregulation as the solutions to economic and social problems. But the story, in González’s telling, was far from over. What was emerging in Latin America in response to the Soviet collapse were both faith in neoliberalism alongside ‘viable and necessary utopias’ struggling to translate into state policies. Clearly, for González, proposals emanating from organized women’s groups were welcome, and so were female health visionaries themselves. Support for

77. M.J. Lewis, A Situational Analysis of Cervical Cancer in Latin America and the Caribbean (Washington DC 2004), p. 1.
78. For a similar critique, see L.A. Teixeira and L. Pumar, ‘Tecnologia e Campos Disciplinares: Os Citotécnicos e a Implementação do Teste de Papanicolaou no Brasil’, Dynamis, 34, 1 (2014), 49–72.
79. PAHO, Report on PAHO Advances on Gender, health, and Development, February 23, 2005, document MSD21/3, Rev. 1, p. 3.
80. OPS, Informe de Relatoría del Grupo de Trabajo sobre el Tema de Mujer, Salud y Autocuidado, enero de 1992, document SMSD12/7 (Esp.), p. 18, 20.
this attitude was fledgling but staunch among students of Latin American reality. Note the similarity between González’s language and that of his contemporary, Colombian anthropologist Arturo Escobar, who stressed the importance of ‘alternatives to development’ issuing from ‘Third World’ social movements to re-invigorate democracies in the aftermath of World War 2.81 Following Brazilian sociologist Marianna Penna, women’s struggles to turn quotidian political work into ambitious aspirations was not unusual among Latin American social movements of the late twentieth century.82 WHD’s struggle and imagined future were subversive and risky, not only because they depended on PAHO’s overall strategic priorities, but also because the broad base WHD brought into being imbued women’s health advocacy with fault lines, some of which the Central American project bared.83

Latin America’s stubborn cervical cancer mortality rate in the early twenty-first century stands as a sobering reminder that WHD’s development alternative remains a work in progress. But whether the connections and imaginative power it unleashed shaped realms beyond incidence statistics remains to be addressed. Further, realizing the potential of contemporary technical fixes such as HPV vaccination will require situating them in the context of older aspirations. Critical among these are those of women who articulated a vision of fairer global health governance, with a more capacious definition of development, and a richer diagnosis of the sociomedical problem of cervical cancer.

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81. A. Escobar, ‘Imaginaing a Post-Development Era? Critical Thought, Development and Social Movements’, Social Text, 31/32 (1992), 20–56.
82. Mariana Affonso Penna, ‘Movimento das Comunidades Populares: A Brazilian Uchronic Utopia’, Ephemera, 20, 1 (2020), 51–89.
83. See also M.D. Gordin, H. Tilley, and G. Prakash, ‘Introduction: Utopia and Dystopia beyond Space and Time’, in M.D. Gordin, H. Tilley, and G. Prakash (eds.) Utopia/Dystopia: Conditions of Historical Possibility (Princeton 2011), 1–17.
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