Public Health Chronicles

Brazil is now considered a rising economic power, rich in natural resources and innovative uses of agricultural products produced in its vast rural interior. One example, the use of ethanol as a major fuel source, has been hailed as a major achievement both economically and politically. Yet, as this article makes plain, this emergence is of very recent origins and was not accomplished without a major restructuring of its rural health system. In this installment of *Public Health Chronicles*, we learn of early efforts during World War II to provide health care to Brazil's rural population and to stabilize the rural economy. The effort to create an infrastructure for health was part of a larger effort to extract rubber and other needed wartime necessities and laid the groundwork for a more permanent health system.

David Rosner, MPH, PhD

Ronald H. Lauterstein Professor of Sociomedical Science and History
Columbia University, Mailman School of Public Health, New York, NY

LESSONS FROM A BRAZILIAN-U.S. COOPERATIVE HEALTH PROGRAM: THE SERVIÇO ESPECIAL DE SAÚDE PÚBLICA

AMELIA L. MAYBERRY, MHS
TIMOTHY D. BAKER, MD, MPH

While Brazil has seen enormous economic development in the last half of the 20th century and is now considered a middle-income country, this was not always the case. In 1942, Brazil had a per capita gross domestic product (GDP) that was similar to many African countries today. In constant 1990 Geary-Khamis international dollars, more than 20 African countries, including Nigeria, Ghana, and South Africa, had a higher per capita GDP in 2003 than Brazil did in 1940 (Table 1).¹ Furthermore, great disparities existed between the urban and rural areas in Brazil, as in many African countries today, with virtually no access to medical care or public health programs in rural areas. Thus, lessons learned from the highly successful Serviço Especial de Saúde Pública (SESP) rural comprehensive health service program in Brazil 70 years ago should have pertinence for programs in rural areas of low-income countries today.

The key lessons learned from the SESP, which were critical in the successful expansion and sustainability of the program and applicable to other programs, included the timely payment of health-care workers and personnel, the development of a strong *esprit de corps*, and a strong focus on personnel training. Additionally, a key component of the SESP was the cooperative effort and support from the Institute of Inter-American Affairs (IIAA) in the United States. This

cooperation paved the way for the program's success and sustainability and allowed control to be progressively turned over to the Brazilian Ministry of Health before SESP's transformation to the Fundação Serviço Especial de Saúde Pública (FSESP) in 1960. A recent

Table 1. Comparison of GDP per capita (in 1990 International Geary-Khamis dollars) in various countries^a

Country	Year	Population	Per capita GDP
Brazil	1940	41,114,000	1,250
Latin America			
Honduras	2008	7,639,000	2,323
Nicaragua	2008	5,786,000	1,674
Peru	2008	29,181,000	5,388
East Asia			
Cambodia	2008	14,242,000	2,482
Laos	2008	6,678,000	1,669
Philippines	2008	96,062,000	2,926
Sub-Saharan Africa			
Benin	2008	8,533,000	1,394
Ghana	2008	23,383,000	1,650
Lesotho	2008	2,128,000	1,952
Mozambique	2008	21,285,000	2,160
Namibia	2008	2,089,000	4,571
Nigeria	2008	146,255,000	1,524
Senegal	2008	13,343,000	1,456
South Africa	2008	48,783,000	4,793
Swaziland	2008	1,129,000	3,150

^aSource: Maddison A. Historical statistics for the world economy, 1-2003. Groningen (Netherlands): University of Groningen, Department of Economics; February 2007. Also available from: URL: http://www.ggdcc.net/maddison/Historical_Statistics/horizontal-file_03-2007.xls [cited 2010 Apr 1].

GDP = gross domestic product