Local health policies under the microscope: consultants, experts, international missions and poliomyelitis in Spain, 1950-1975

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Received for publication in January 2014.
Approved for publication in June 2014.

http://dx.doi.org/10.1590/S0104-59702015000300016

BALLESTER, Rosa; PORRAS, María Isabel; BÁGUENA, María José. Local health policies under the microscope: consultants, experts, international missions and poliomyelitis in Spain, 1950-1975. *História, Ciências, Saúde – Manguinhos*, Rio de Janeiro, v.22, n.3, jul.-set. 2015. Available at: http://www.scielo.br/hcsm.

Abstract

One of the main focuses of analysis of this paper concerns the missions of international health agency experts to Spain to report on the situation, the activities in the fight against physical disabilities in children and on the actions taken to cope with the problem. The Spain-23 Plan was the instrument used by WHO and other agencies to start the process of change in a country undergoing a period of transformation under the enduring Franco dictatorship. As key sources, the paper uses unpublished reports of WHO experts on the subject, which resulted from visits to the country between 1950 and 1975. The methodological approach consists of an analysis of discourses from primary sources within the historiographical framework.

Keywords: rehabilitation; poliomyelitis; WHO expert; Spain; twentieth century.

The focus of historical research on the activities of international health organization consultants and experts is a line of research of great interest, which helps us to improve our understanding of so-called "health globalization"[1] and the historical process which created movements and transnational forces that to a great extent define the world of today (Iriye, 2002). In the historiography of science this perspective is particularly useful in the contemporary period and an essential reference in such approaches to the history of international health, such as the recent works of Brown and Cueto (2011), Cueto, Brown and Fee (2011) and Cueto (2008, 2013).

The scope of this paper is to analyze the technical reports on the situation of rehabilitation in Spain in relation to physical disabilities among children, drawn up by consultants of the World Health Organization (WHO) in the 1950s and 1960s within the framework of the measures undertaken by these experts. Our work is a preliminary approach to the possibilities presented by a specific type of source, namely the technical reports drafted in different countries by experts of international organizations on the role they played or sought to play in coping with health problems and on the reality of the practices and measures which were eventually implemented. The recommendations of international agencies offered an attractive alternative to domestic disputes and an excellent area for the development of reforms. However, the diversity of local contexts added complexity to a process which was not exempt from tension as recent historiography shows.[2] As the model of analysis, we have chosen an international organization, the WHO, and an example of health measures in which the commissioners took part.[3] Specifically, we have selected the reports of experts on the state of the rehabilitation services for children and young people in Spain, and in particular those under treatment for the sequelae of poliomyelitis.

The core of the paper is therefore based on a type of previously unused source material: the reports of the expert and advisory missions, which have proved of great importance and are kept in the Historical Archives of the WHO. The archives are located in the headquarters of the Organization in Geneva and feature an inventory ("Inventoires" of the 1st, 2nd and 3rd Generation Centralized Files). They contain material on various subjects including poliomyelitis.[4] The range of documents is broad, although they refer basically to questions of organization. The archives also include the letter of the Spanish Minister of Foreign Affairs expressing his gratitude at the inclusion of Spain in the WHO (1951). This has appeared for the first time and we consider it to be of special interest, not only in relation to the question of rehabilitation but also in the context of political history. The reports of the advisory and individual expert missions, are to be found in a particularly broad section of the Archives, belonging specifically to different European countries. The EUR-Spain-23 section includes sundry internal documents of the Organization (correspondence between the Spanish government and the WHO, reports of different missions and a variety of other sources). The documents are all mimeographed, unedited and unpublished. In total there are six related to disability and rehabilitation in Spain, varying in length (between four and 63 pages) and they are written in French.

The role of the Expert Committees and Missions in international health

The efforts made to establish a firm base for international health measures must be understood in the broader context of the growing role of science and scientists in social systems. As is well known, the universality of science had a particular bond with internationalist ideals during the interwar period. Ernst and Peter Haas (Haas, 1992, p.1-35) developed the concept of "transnational epistemic communities" discussing the role of scientific experts in specific fields and their influence on social systems. This concept has been applied to the historical analysis of the League of Nations as the developer of international networks such as those concerning the approach to health problems through the organization's specialist agencies (Weindling, 1995). Essentially this method seeks a response to the question whether public health knowledge can actually be transnational and if the answer is "yes," what form it should take in order to be universally useful. On the other hand, there is also the question of what form the community of experts should take: whether transnationality is defined by the geographical diversity of its members or rather by the type of recommendations they offer, who decides what being an expert involves and whether multinationality guarantees the internationalism of committees (Solomon, Murard, Zylberman, 2008, p.1-22).

The appearance of the committees of experts, defined explicitly as such, probably dates back to the beginnings of the Hygiene Committee of the League of Nations in 1920 and of such other agencies of the League as the Epidemic Commission, considered at the time of its creation to be the "first attempt at international cooperation" (Balinska, 1995, p.81-108). The International Health Office – later renamed Panamerican Health Office – also took part in the activities of the pioneers (Cueto, 2004). Indeed one of the main undertakings of its action on international health was to promote the work of the expert commissions in charge of establishing criteria and regulations which might be applied later in national health policies. On the whole, the collective nature of these commissions excluded the prominence of individual members, which meant a substantial increase in the legitimizing role of their recommendations for those responsible for national health policies (Barona, Bernabeu-Mestre, 2008). The findings of a collective unit of experts, in the form of committees or similar organizational structures, inspire greater confidence than those of individual experts as they arise from scientific discussion and the search for consensus in the resolution of practical problems.

The expert commissions were in charge of such diverse tasks as documentary and bibliographical studies and the co-ordination of laboratory research undertaken by different institutes, but above all else, their scope was to carry out epidemiological or socio-medical surveys through visits or missions. The approach to health problems, both scientific and socio-medical, entailed the drafting of a plan of action by the commissions of experts with the interventions of members of qualified scientific institutions. The commissions also undertook to respond to governmental demands for technical support, assistance or advice. The scientific value of the reports of the Committee of Hygiene is not easy to assess (Rodríguez Ocaña, 1993; Borowy, 2009) given the number and the variety of the issues and the people who intervened over the years. Its main task was undoubtedly to coordinate and integrate the technical work (experiments, for example) which was already being performed in different parts of the world. Moreover, it is important to highlight the atmosphere that predominated

in the meetings of the experts; isolated from the interests of domestic lobbies and national pressures, the experts were able to consider a range of solutions and reach a consensus.

The Expert Committees also played a key role in the work of the WHO. The implementation of policies and operational procedures, which were regularly reviewed, were regulated by articles 18 and 38 of the Constitution and by the preparatory reports of the First General Assembly.

The formal creation of the committees of experts must be considered in the wider framework of the General Programs set in motion by the WHO from 1951 onwards. Between 1951 and 1978, as many as five programs were implemented, with varying orientation, depending on external and internal circumstances. As the second Director-General, Marcolino G. Candau, declared on the occasion of the XXV anniversary of the creation of the WHO, one of its greatest strengths was the capacity to draw up new objectives, seek new approaches and adapt to changing conditions (WHO, 1958c) in each country. The programs could only be effectively implemented with solid scientific bases that the experts were required to provide, evaluate and adapt (WHO, 1968).

Individual members were chosen on their own merits, not as representatives of governments, institutions or associations, although attempts were made to ensure a fair geographical distribution. The reports arising from the meetings of the committees of experts did not necessarily express the point of view of the Organization itself, but did provide a fundamental tool for the preparation of policies and programs in different fields. In the general organization chart, the members of the committees of experts were chosen from a list presented by the Director General.

The experts' papers which were later published or that appear as mimeographed documents or microfilm in the archives, acquired different forms over the first 30 years of the institution. The series of technical reports, of which the total number reached one hundred in the first 10 years alone, was one of the most relevant publications of the Organization.

One especially interesting and scarcely researched type of report was that of the missions by individual consultants to one country or another under the mandate of the WHO. These advisors combined their condition as experts in one subject or another with a high degree of availability since on occasions, as was the case of some to Spain, the duration of the mission exceeded three years. However, this was not the norm. Unlike the work of the Commissions of Experts, in this case fieldwork was fundamental and was not restricted to simply describing the situation and drafting a report and recommendations. Instead the expert became involved in the activities themselves and had an impact on their development. The features that characterized these missions were superior knowledge of the terrain and the critical nature of their reports to the WHO. The criticisms included in the documents demonstrate the independence of the consultants which was not always easy in certain countries with undemocratic political systems. Most reports were not published and, as we said above, they are kept in the Historical Archive of the WHO, in the headquarters of the Organization in Geneva. It is precisely this type of source material that has been the main nucleus of our work. However, before we set out our results, we should describe the international context in which these missions took place.

The early approach to the problems of disability and medical rehabilitation in the WHO

Between 1958 and 1981, the WHO held three meetings of committees of experts to consider the question under the heading of "medical rehabilitation,"[5] which appeared in the first two technical reports that followed these meetings and were published in 1958 (WHO, 1958b) and 1969 (WHO, 1969), respectively. The third report covered the meeting of the Commission in Geneva between February 17 and 23, 1981. The Commission adopted the name of: "Prevention of disability and rehabilitation," an indication of the important changes in the concept of the problem of disability in international health circles and the terminology related to the concepts of the process of disability and rehabilitation (WHO, 1981). However, we found documents on these issues, even before the first report, in the historical archive of the Organization, reflecting the growing international interest in these questions (WHO, 1950-1955, 1955-1983), which also took the form of such initiatives as the creation of the World Confederation of Physiotherapy in Denmark in 1951 (Barros, 2008, p.943).

The consensus on terminology, the need to use statistics to understand the problem of disability in all its dimensions, the opportunity to integrate rehabilitation within the scheme of national health services and the training of medical rehabilitators, physiotherapists and other types of health professionals such as occupational therapists were the central themes of the above-mentioned meetings. Representation in the commissions of people linked to such organizations as the United Nations itself, the International Labor Office, the International Federation of Physical Medicine or the International Association for Social Security, reflected the complexity of the problems under analysis, from the legislative and economic aspects to the medical and social dimension.

The inception of the medical specialty after the Second World War (Climent Barbera, 2009) and the appearance of the profession of physiotherapy must be understood within the framework of the rise in cases of disability as a result of the war, industrial accidents and the epidemic outbreaks of poliomyelitis (Cooter, 2000), especially virulent in the mid-twentieth century.[6] Consequently, the reports of the experts insisted on the need to consolidate this medical specialty and to establish its own independent field of action, although directly linked to orthopedics, traumatology, pediatrics or neurology. Similarly, in addition to the structure and operational systems of the rehabilitation services, it was also necessary to establish a comprehensive training program both for these new specialists and also for physiotherapists. Research was considered a vital issue and emphasis was placed both on purely medical-health aspects and also those of a psycho-social and economic nature. On the other hand, among the WHO-funded study grants for training in different specialized centers (WHO, 1957), priority was given to the area of the rehabilitation of physically disabled children especially at eminent Italian centers with a long tradition in this field (Fantini, 2012, p.329-359).

The third report, which coincided with the celebration of the year of the disabled (1981), was essentially a dissertation on the subject of the prevention of disability and stressed the importance of mass vaccination against poliomyelitis in all countries. In fact, the reports of the Committees of Experts on Poliomyelitis did also include some suggestions on rehabilitation for the paralytic sequelae of the disease, although the central topic of the reports

was, above all, the discussion on the type of vaccines and how to prepare and administer them (WHO, 1954, 1958a, 1958b, 1958c, 1960). This was also top of the agenda at the Symposia of the European Association against Poliomyelitis and at the international conferences on the same question (Porras, Báguena, Ballester, 2010, p.91-118; Porras et al., 2012).

Finally, the WHO was not alone in making reports on the situation of rehabilitation in different countries. Most significant among other powerful organizations which produced their own reports was the US Department of Health, Education and Welfare (Fitzpatrick, 1963).

The visits of WHO consultants and experts to Spain

The poliomyelitis epidemics led to a sharp increase in the social demand for rehabilitation in all the affected countries, including Spain (Águila Maturana, 2000, p.245-350; Climent Barbera, 2009; Toledo Marhuenda, 2013). Although there were isolated outbreaks in Spain prior to the Civil War, the most important epidemics occurred during the Francoist period (Porras et al., 2013).[7] Indeed, between 1890 and the end of the 1930s, polio appeared in Spain only in sporadic epidemic outbreaks. There are hardly any figures for the outbreaks in Valls (Tarragona) in 1896, or in Manzanares (Ciudad Real), Fraga (Huesca) and Barcelona in 1917. The epidemic of 1929 in Madrid, with 318 cases, was the first to become the subject of a report, produced by the Central Epidemiological Service of the General Board of Health, which followed the guidelines of the new Epidemiology discipline with an assessment of all those factors which might have contributed to the spread of the disease (Martínez Navarro, Larrosa, Páez, 2004, p.963-987). The compulsory reporting of poliomyelitis cases after 1930 and the consolidation of the Health Statistics Service that same year meant that such outbreaks as those in Santander (1930) or Mallorca (1932) were studied more thoroughly. After the Civil War, during the 1940s and 1950s, polio attained epidemic proportions, the worst years being 1942 with 741 cases and 1950 with 1,597 cases. As Table 1 shows, morbidity and mortality rates for poliomyelitis remained high throughout the 1950s and early 1960s until the first mass vaccination campaign in the autumn of 1963 and spring of 1964 with Sabin's oral vaccine when both rates fell sharply.[8]

The international isolation of Spain due to political conditions led to the country's exclusion from the United Nations and its agencies, including the World Health Organization itself. Circumstances began to change after 1950. The escalation of the Cold War meant that the USA turned to Spain as an ally and a suitable location for the construction of military bases. The inclusion of Spain in the WHO is a process that has still not been researched in depth, although the archives of the Organization do provide us with some interesting data. On June 14, 1951, the Spanish Minister of Foreign Affairs, Alberto Martín Artajo expressed his gratitude to the Director General of the WHO, Brock Chisholm, when Spain was finally accepted as a member of the Organization (WHO, 1951).

On July 24, 1952, José Sebastián de Erice y O'Shea was appointed Spain's ambassador and permanent delegate to the WHO and the Vice-consul of Spain in Geneva, Luis de Villegas y Azaiz, was made secretary of the permanent delegation (WHO, 1951) thereby officially establishing Spain's membership.

Table 1: Poliomyelitis annual morbidity and mortality rates

Year	Morbidity (per 100,000 inhabitants)	Mortality (per 100,000 inhabitants)
1950	5.73	0.45
1951	1.92	0.41
1952	5.56	0.58
1953	3.37	0.42
1954	3.01	0.40
1955	3.74	0.39
1956	4.31	0.52
1957	3.12	0.50
1958	7.01	1.07
1959	7.13	1.06
1960	5.41	0.67
1963	6.25	0.65
1964	0.62	0.13

Source: Statistics Section of the General Health Board.[9]

However, this "rehabilitation" of the Franco regime was not unrestricted and the general mistrust of the western countries towards Spain remained unchanged. In spite of the internal disputes among the different "families" of the regime on how best to cope with such an important health problem as the polio epidemics and how to provide the population with essential information (Rodríguez Sánchez, Seco Calvo, 2009, p.81-116), the authorities were primarily interested in portraying the best possible image of Spain abroad as a means of legitimizing the dictatorship. Therefore, the regime was keen that representatives should attend congresses and scientific meetings on a range of different questions. In the case of polio, as we have described elsewhere, the data presented on the actual situation in Spain were not necessarily the most accurate (Bosch Marín, Bravo, 1958; Ballester, Porras, 2009, p.55-80).

In this context, the arrival of WHO consultants in Spain was to some extent an examination that the country was obliged to undergo. In the spring of 1956, at the request of the Spanish state, a series of visits by experts began with the aim of implementing a national rehabilitation program (Águila Maturana, 2000, p.135). Between 1956 and 1973 six reports were drafted specifically directed at the rehabilitation of individuals, especially children, with disabilities. With the information available, we cannot be sure that the visits were always in response to requests, indeed it seems the opposite is more likely. Most visits took place in the context of the SPAIN-23 Plan, as will be described below. As some of the visitors confirmed (Safford, Janson, 1959, p.14-19) shortly before their arrival, and above all between 1957 and 1959, new rehabilitation services were set up *ex novo*, and sometimes improvised in haste while others were in fact almost ready for opening. It is not unreasonable to suppose that this alacrity was related to the need of the Francoist regime to offer the foreign experts a favorable image of the country, a motive which was also behind the decision to hold the V Symposium of the

European Association against Poliomyelitis in Madrid, in 1958 (Ballester, Porras, Báguena, 2013, p.91-92).

The Spain-23 Operational Plan

The first of the visitors were Frank J. Safford and Kurt Janson, experts of the WHO on questions of the rehabilitation of handicapped children (according to the terminology of the day), whose mission was to describe the situation of these services in Spain and to assess whether trained personnel were available for the physical rehabilitation of children. Their report was published in Spain by the General Board of Health (Safford, Jansson, 1959). The experts described the immediate need to set up a physiotherapy school in the Clínica de la Concepción in Madrid in order to train future professionals. At the time, such professionals did not exist and it was therefore necessary for the WHO to send at least one teacher of physiotherapy. Under the influence of these experts an attempt was made to improve the situation through a two-year specialization of so-called technical health assistants (ayudantes técnicos sanitarios – ATS, a name that replaced other job titles for a few years and was then replaced by the title of "nurse"), at the end of their course. This meant that a physiotherapist's training would last five years: the three years of the ATS and two of the specialty and was considered as a way to cover the complete lack of professionals in the field. The law of July 26, 1957 regulated the exercise of physiotherapy and made provisions for the establishment of Physiotherapy Schools affiliated to faculties of medicine (Toledo Marhuenda, 2013), but the experts' report suggested that given the situation throughout the country, only three physiotherapy schools, in Madrid, Barcelona and Valencia, satisfied the conditions for the requisite level of education. Each one of the schools required a "consultant" director (who should be a teacher in the faculty of medicine), an "executive" director (specialist in rehabilitation) and a qualified physiotherapist. It was also suggested that between five and ten places should be reserved in the training centers for children and young people with disabilities. Moreover a proposal was put forward to provide boarding facilities for those with the greatest mobility difficulties who lived at some distance from the center. These arrangements were to be supervised by professional monitors whose training would be provided by grants from the International Labor Organization. An expert of this organization would be in charge of supervising compliance with the program.

The final result of the visit was the creation, between the end of 1960 and the beginning of 1961, of the Spain-23 Operational Plan: Rehabilitation of Physically Handicapped Children, under which an agreement was signed by the Spanish government, the WHO and the United Nations Children's Fund to be regulated by the recently established National Board of Rehabilitation, presided by minister Camilo Alonso Vega.[10] The Spanish Plan called for the creation of training services in rehabilitation, beyond those already established at the Clínica de la Concepción, the Hospital Provincial, the Hospital del Niño Jesús (all in Madrid) and the Sanatorio Marítimo de la Malvarrosa in Valencia.[11] These institutions were to provide suitable facilities for physiotherapy and ergotherapy, rooms for medical consultations and a conference hall, with sufficient assistant staff under the management of a doctor. Finally

the two WHO experts, a physiotherapist and an occupational therapist respectively, were to be put in charge of setting up the services and starting operations.

In October 1960, the next mission was entrusted to the Danish physiotherapist Birgit Brodsgaard (1964), who remained in Spain until December 1963. In the words of another consultant, "This person quickly became familiar with the Spanish language and way of life and devoted herself to her mission until December 1963 with competence and dedication" (Pierquin, 1965, p.4).[12] One of the tasks of this expert was to perform follow-up studies to assess the advances made under the Spain-23 Plan and within that framework, to visit a certain number of selected centers of those stipulated in the agreement and to interview people responsible for the development of the Plan with whom "she was able to establish and maintain firm and friendly relations with the best Spanish specialists: who fully acknowledge her contribution" (p.4). Because of her professional profile, her work focused fundamentally on the degree of training of the physiotherapists which she considered both weak and difficult to improve given the lack of qualified teaching personnel. Consequently one of her first recommendations was that physiotherapists from other countries be sent to Spain as expert monitors for a period of several years with the aim of successfully training a generation of Spanish physiotherapists.

A further two reports produced in 1962 (Malan, 1962) and 1963 (Abella, 1964), respectively, came to similar conclusions as those submitted by Brodsgaard. However, in terms of length and content, the most important report was undoubtedly the one drafted by the teacher of the Faculty of Medicine of Nancy, Louis Pierquin (1965), a WHO consultant for the rehabilitation of people with physical disabilities and one of the key figures in European and international rehabilitation medicine. Pierquin had the highest academic and research standing among all the consultants that the WHO had sent to Spain to date. The objectives of his mission were to assess the work carried out between 1960 and 1963 in Spain in the area of rehabilitation, physiotherapy and occupational therapy by the professionals sent by the WHO and, moreover, to discuss with the relevant Spanish authorities the future development of the program and to draw up a plan of action for the following years. To this end, Pierquin met with representatives of the health authorities, visited the hospital rehabilitation services in Madrid, Barcelona and Valencia and interviewed their directors or managers. His thorough report consisted of five main sections (Introduction, the international aid project: the training of physiotherapists and the setting up of hospital physiotherapy departments; ergotherapy; medical specialization in rehabilitation; observations and general conclusion on the hospital rehabilitation services and a final chapter on the Board of Rehabilitation and Recuperation of Invalids). Just as Safford and Jansson before him, Louis Pierquin (1965, p.1) expressed his gratitude for the positive welcome he received in Spain: "In all circumstances I received the most courteous welcome and offers of cooperation. Everywhere, detailed information was given to me spontaneously, with kindness and candor. I am also pleased to thank all those who have generously given me their help and express my sincere thanks and profound gratitude."

Nevertheless, the results of the mission were far from encouraging. On the question of physiotherapy, the report concluded that in spite of the efforts made by Brodsgaard and some hospital managers, the training of these professionals was clearly inadequate as a result of a series of reasons such as the excessive number of schools in Madrid and Barcelona,

many of which were described as "mediocre." Theory was outdated; the official syllabus was incompatible with new research and technology; the prerequisite that trainee physiotherapists should first complete the ATS course was considered useless by Pierquin; there was a lack of a sufficient number of good teachers who had themselves been trained abroad in the more advanced techniques and few foreign physiotherapists had been persuaded to participate in the Spanish schools.

In the case of ergotherapy, the situation was no better. From the moment the decision was taken to carry out a program of assistance in Spain on questions of rehabilitation (Spain-23 Plan), there was a series of recommendations for the creation of pilot centers in hospitals to introduce occupational therapy. The proposal was initially made in the reports of Safford and Janson in 1956 and must have been ignored because the same recommendation, in virtually the same terms, were put forward again in 1959 by the same experts. Yet again, they had little success. Pierquin (1965, p.13) noted that these ergotherapy services were particularly appropriate "because the spirit of the Spaniard, similar to that of the Mediterraneans, is far more suited to an individual and natural rehabilitation system."

After the institutionalization of the Plan, Mercedes Abella, a professional in occupational therapy was sent from Geneva for two and a half years (between 1961 and 1963) to make arrangements for its implementation. Cuban by birth, Abella had no linguistic difficulties and, furthermore, she received the support of the General Board of Health (which in fact subsidized the first course) and in particular of Manuel Oñorbe Garbayo, secretary-general of the Board of Rehabilitation of Invalids and author of an interesting dissertation (Oñorbe Garbyo, 1963). Abella's report (Abella, 1964) is brief and not without a certain degree of pessimism as a result of the difficulties she detected in ensuring the required continuity of the measures undertaken. The first course that Abella gave (an "intensive course" as she described it) had 13 students, most of whom were immediately required to operate occupational therapy services without having completed their training. The classes were given in the Central Rehabilitation Center in calle Maudes in Madrid and gradually – according to Pierquin's report – some health centers such as the Clínica Puerta de Hierro, the Clínica Nacional del Trabajo, the "Salus Infirmorum" Hospital in Madrid or the Sanatorio Marítimo de la Malvarrosa in Valencia, opened ergotherapy departments. In 1964, as a result of pressure from the WHO, the first official educational program was created through the Occupational Therapy School in Madrid, affiliated to both the National School of Health and the School of Medicine (Pierquin, 1965, p.23).

The experts gave a more favorable assessment of the advances made in the rehabilitation specialty in Spain. From their watch-tower, the WHO commissioners were positive in their evaluation of the effects of the grants awarded to Spanish doctors to enable them to train abroad. On their return some of these doctors were among the most important pillars of the successful development of the specialty. On the other hand, it was judged essential to harmonize the syllabi in the different Spanish centers. There was also some controversy over the introduction of rehabilitation as part of medical studies to be taught by specialists in this field, as these specialists would then be in direct competition with physical therapy teachers, orthopedic surgeons, neurologists or pediatricians. Furthermore demands were made for the

internationalization of the new specialists through participation in courses, congresses and other types of scientific meetings held outside Spain.

The results of the assessments of Spanish hospital services were not good. Availability was scarce and, especially in the old institutions, the space provided was inadequate. The facilities were described as deplorable; they were too small, they were located in hospital basements, there was a lack of light and air and exercises were performed in darkness on obsolete apparatus according to outdated principles of physiotherapy, which should be abandoned forthwith (Pierquin, 1965, p.30-31).

In the words of the commissioners, Spain-23 Plan was to a great extent a failure. The reasons for this were to be found in the lack of an organizational tradition, the shortage of economic resources and shortcomings at the political level. Of the deficiencies in the services, Pierquin (1965, p.34) wrote: "In reviewing the state of those only too rare services for which the relative success results from a combination of outstanding physicians and more resources than elsewhere, one is amazed at the lack of equipment and especially staff."

Pierquin (1965, p.34) also outlined the political causes: "In their thinking and in their actions, the public authorities have not been able to give to rehabilitation the place it deserves." In short, these failings led to shortage and mediocrity – except for some notable exceptions – in rehabilitation services for the affected population and represented an essentially lost opportunity to provide regular and up-to-date training for health professionals in this field; a setback from which it would take many years to recover. The final piece of the outlook is the analysis of other more general reports on the mother-child health services (Hagen, 1955) and on the situation of health systems in Spain (Brockington, 1967), which throw light on this historical period and are of extraordinary interest for historians.

Final considerations

The arrival in Spain of expert consultants of the WHO to carry out a series of missions in the general field of rehabilitation and, in particular, the rehabilitation of children with physical disabilities during the 1950s and 1960s (a period that coincided with the poliomyelitis outbreaks and the Francoist dictatorship) had important repercussions in the launch and early development of Spanish rehabilitation services on at least three fronts. In the first place, through independent experts, it enabled observers abroad to understand the reality of the human and material resources available to cope with the growing demand for this type of service. Secondly, the arrival of foreign teaching personnel and the establishment of study programs which funded visits to prestigious, foreign centers made it possible to introduce professional training, based on modern theories, for medical specialists in rehabilitation, physiotherapists and occupational therapists. Thirdly, these measures were also able to contribute in some way to a first tangible, albeit timid, opening of the dictatorial political regime. However, the main instrument designed to improve conditions and set Spain at the same level as the other European countries which were more developed in the field of rehabilitation – Spain-23 Plan ended in partial failure and its core elements were not implemented until well into the 1970s in a country which had by then taken the path of what became known as the political transition.

ACKNOWLEDGEMENTS

The authors wish to express their gratitude to the Director and staff of the WHO historical Archive for their invaluable help in the development of this research.

Research carried out within the framework of projects HAR2012-39655-C04-01-04 and HAR2012-39655-C04-02 funded by the Ministerio de Economía and Competitividad.

NOTES

[1] On the differences between "international health" and "global health," the essential reference is to be found in the historical reflections of Brown, Cueto, Fee (2007).

[2] Bhattacharya (2013), who has also used documents of the WHO, has shown these tensions and political interference in the process of eradication of smallpox in Bhutan.

[3] An initial approach to this subject can be found in: Ballester (2011, p.195-224). For the application of these schemes in the case of Spain, see Ballester (2012).

[4] These resources, which are not digitalized, can be consulted directly in the archives; either mimeographed or on microfilm.

[5] A suitable historical contextualization of the concept and contents of rehabilitation can be found in Climent Barbera (2009) and Águila Maturana (2000).

[6] Águila Maturana (2000) includes a wide-ranging analysis of the connection between poliomyelitis and the introduction and development of rehabilitation and physiotherapy.

[7] Among other publications on Spain and the polio epidemics, the most notable is Báguena, Porras, Ballester (2010, p.115-134). More information on poliomyelitis in Spain can be found in Martínez Pérez (2009, p.7-192). This edition of the *Asclepio* journal includes the following articles specifically related to Spain: Báguena (2009, p.39-54); Ballester, Porras (2009, p.55-80); Rodríguez Sánchez, Seco Calvo (2009, p.81-116). The coordinated project that studies poliomyelitis in Spain and Portugal has already been produced by Martínez Pérez et al. (2012, p.131-143).

[8] More detailed information on polio morbidity and mortality in Spain (with special reference to Madrid, Valencia and Castilla-La Mancha) and on the impact of the mass immunization program, can be found in De las Heras, Porras, Báguena (2013) and Porras, Báguena (2013a).

[9] From Pérez Gallardo et al. (1963) and Martínez Navarro (1979).

[10] News of its foundation appeared in the *ABC* newspaper on January 23, 1959, p.32.

[11] The role of these institutions in the fight against poliomyelitis has been analyzed by Porras, Báguena (2013b).

[12] In this and other citations of texts from non-English languages, a free translation has been provided.

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