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**QUINQUENNIAL REPORT OF THE DIRECTOR OF THE  
PAN AMERICAN SANITARY BUREAU 2003-2007**

***LEADING PUBLIC HEALTH IN THE AMERICAS INTO THE XXI CENTURY***

To the Member States:

As mandated by the Constitution of the Pan American Health Organization, I have the honor of submitting the Quinquennial Report 2003-2007 on the activities of the Pan American Sanitary Bureau, Regional Office of the World Health Organization. The report analyzes the most relevant information on compliance with the technical cooperation program during this period, within the framework of the strategic and programmatic orientations defined by the Governing Bodies of the Pan American Health Organization for the quinquennium 2003-2007.



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Director

**OFFICIAL DOCUMENT 329**

**QUINQUENNIAL REPORT OF THE DIRECTOR OF THE  
PAN AMERICAN SANITARY BUREAU 2003-2007**



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## **CHAPTER 1: HEALTH, A CRITICAL FACTOR IN DEVELOPMENT**

1. During 2003-2007, the work of the Pan American Sanitary Bureau (henceforth PASB or the Bureau) has been framed by the broader context of the great humanitarian and social development ideals set forth at global and regional summits in the last decade and a half, which positioned health prominently on the global and regional political agendas. With the Millennium Declaration, ratified by the heads of 189 states in September 2000, these ideals were embodied in the eight Millennium Development Goals (MDGs).

2. These goals comprise an unprecedented global plan to combat the social ills that perpetuate underdevelopment: poverty; malnutrition; disease; illiteracy; socioeconomic, ethnic, racial, and gender discrimination; environmental degradation; political corruption; and, as an underlying factor, the failure to recognize the dignity of the human being. Even though only three of the eight goals in the Millennium Declaration bear a direct relation to health—child mortality; maternal mortality; and HIV/AIDS, malaria, tuberculosis, and other infectious diseases—there is a close interdependence and synergy among them all.

3. Since the Millennium Declaration, the MDGs have been bolstered by the Region's political leaders. At the Special Summit of the Americas (Monterrey, Mexico, 13 January 2004), the heads of state and government of the countries of the Americas endorsed the values reflected in the MDGs by centering their deliberations on equitable economic growth, social development, governance, and the need to protect safety in the hemisphere. At that Summit, the goal was set, among others, to provide antiretroviral treatment to at least 600,000 people with HIV in the Americas by 2005.

4. At the "Millennium Development Goals, Proposals for the Summit" Forum (Brasilia, 4 August 2005), the ministers and representatives of the governments of Argentina, Brazil, Bolivia, Chile, Paraguay, and Uruguay and delegates of civil society organizations discussed the factors thwarting attainment of the MDGs, particularly those related to health and sexual and reproductive rights. The Brasilia Declaration established a political consensus regarding the adoption of the MDGs in Latin America and the Caribbean, underscored the importance of alliances between countries for attaining them, and outlined the responsibilities of governments, lawmakers, civil society entities, and the international community.

## **Health and Development in Summit Declarations**

### **Summits of the Americas**

“We emphasize that one of the pillars of human development and national progress is social protection for health and, accordingly, we will continue to broaden our prevention, care, and promotion strategies as well as investment in this field in an effort to provide quality health care for all and to improve, to the extent possible, social protection for all people, with a particular focus on the most vulnerable segments of society.”

*Declaration of Nuevo León, Monterrey, Mexico, 12-13 January 2004*

“We will strengthen cooperation and exchanges of information in the struggle against chronic diseases as well as emerging diseases and re-emerging diseases such as HIV/AIDS, SARS, malaria, tuberculosis, avian flu, and other health risks.”

*Declaration of Mar del Plata, Argentina, 4-5 November 2005*

### **Ibero-American Summit of Presidents and Heads of State**

“We share the concerns raised at the VIII Ibero-American Conference of Ministers of Health, regarding the number of victims that continue to be caused in the world by a curable disease such as tuberculosis. It has a toll of 5,000 lives per day, making this the leading cause of death in people with HIV/AIDS. In the context of this concern, we second the proposal that health should be made the key topic of an upcoming Summit, and that the possibility be considered of implementing a Pan-Ibero-American Plan of Action to halt this disease, in line with the United Nations initiative for 2006–2015. We request that the Ibero-American General Secretariat submit proposals aimed at promoting actions and initiatives in different sectors, such as business and labor, or others, with the aim of helping to deal with this scourge that is affecting our society.”

*Declaration of Montevideo, Uruguay, 3-5 November 2006*

### **Summits of the Río Group**

“Heads of State and Government agreed that in order to respond to the challenges posed by poverty and hunger, and achieve the highest level of economic and social development for their peoples, efforts must be focused on the most vulnerable in the population, with special emphasis on action for providing universal education, basic health care, and potable water, safeguarding the welfare of children and women, programs for the empowerment of women and young persons of both sexes, as well as the promotion of gender equality. They therefore agreed to promote development policies in their respective countries which accord priority attention to programs aimed at the reduction of poverty and the fight against hunger, as well as the achievement of the Millennium Development Goals.”

*Declaration of Turkeyen, Guyana, 2-3 March 2007*

“Considering that millions of the Region’s inhabitants lack access to basic health services, the incidence of child and maternal mortality, communicable and non-communicable diseases and the general unavailability of health insurance, the Heads of State and Government reaffirmed their commitment to a health Agenda for the Americas as currently discussed by member states of PAHO/WHO.”

*Declaration on Social and Human Issues, Guyana, 2-3 March 2007*



5. With the MDGs, for the first time in history the world community has a common program based on clear, measurable goals, which urges governments, civil society, the private sector, and international organizations to give priority in their work plans to reducing poverty and creating more equitable access to the determinants of development. The MDGs are the culmination of a long history that began in 1977 with the call for Health for All in response to growing unjust health disparities. In Alma-Ata in 1978, the International Conference on Primary Health Care urged the governments of the world to safeguard the health of their people using a rights-based approach. Since then primary care has been a platform for health policies in the Americas to put health within the reach of everyone, regardless of their economic or social conditions or where they live. The MDGs, by placing health at the center of development policies, offer an invaluable opportunity to renew and redefine the primary care strategy and the goal of health for all, in light of current epidemiological and demographic conditions, and sociocultural and economic trends.

6. Health has also held a prominent position at the subregional level in the last quinquennium. The 45th Directing Council, meeting in September 2005, issued a mandate to support the health action plans in the various subregional integration processes in the Americas. In order to target the Pan American Sanitary Bureau's efforts to the needs of the different subregions, alliances were forged with the agencies responsible for coordinating the health actions of the integration processes. In 2006, for the first time, Biennial Program Budgets (BPs) with a subregional focus were implemented. Subregional technical cooperation programs were worked out with the Caribbean Community (CARICOM), the Central American Integration System (SICA), the Southern Common Market (MERCOSUR), and the Andean Community of Nations (CAN), for the purpose of strengthening the structures and mechanisms for health development that these agencies have created in their respective geographical regions.

7. The forums in each of the subregional bodies have been used for reviewing and negotiating work proposals. The XXV Meeting of Ministers of Health of the Andean Area (REMSAA) provides an example of this, where the Ministers of Health agreed to consolidate their efforts to promote access to drugs by preparing a work plan that includes a mass communication and public information strategy, to provide continuity in joint negotiations for AIDS drugs and other strategically important drugs. The ministers of foreign affairs in CAN approved the Integrated Plan for Social Development (IPSD) in September 2004, which includes health as a line of work and defines actions to be taken through programs and community projects on the following issues: epidemiological surveillance, improving health conditions in border populations, and guaranteeing people's access to drugs and other health inputs. The Pan American Health Organization (PAHO or the Organization) is actively supporting these initiatives, which are coordinated with the Andean Health Organization—Hipólito Unanue Agreement (ORAS CONHU). Worth noting is PAHO's active support of the preparations for the

III negotiations for Antiretrovirals and Reagents for HIV/AIDS, which the MERCOSUR member countries will be joining. This cooperation adds to the support that PAHO has been providing for meeting the objectives of the resolutions adopted by the ministers of health when they meet at REMSAA at least once a year. Among these, in addition to those already mentioned, PAHO provides technical support to the countries of the subregion for implementing the International Health Regulations, using standardized epidemiological surveillance instruments and procedures, in addition to supporting the work of the Andean subregional committees on intercultural health, malaria control (PAMAFRO), disaster preparedness and response, and human resources.

8. In MERCOSUR, work is being done both with the Meeting of Ministers of Health and with working subgroups for health, agriculture, and environment in addition to their various subcommittees. Eight issues were jointly identified that were translated programmatically into five projects for that subregion, covering the issues of information systems and communicating for health, border health, International Health Regulations, National Health Accounts, the integrated strategy for dengue prevention and control, subregional regulatory measures on health, and environmental and occupational health. PAHO is coordinating implementation of the MERCOSUR subregional work plan with the corresponding president pro tempore. In addition, the Organization is involved in the dialogue between the Andean and MERCOSUR subregional bodies to identify commonalities between the two subregions and to develop a South American health agenda.

9. Central America and the Dominican Republic are very actively involved in health integration activities. Twice a year the SICA Council of Ministers of Health meets, and every year the RESSCAD (Meeting of the Health Sector of Central America and the Dominican Republic) sectoral forum brings together ministers of health and high-level representatives from the social security institutions and water and sanitation sector. The resolutions and agreements that come out of these political decision-making and consensus-building bodies are aimed at the countries' common problems, among them the prevention and control of communicable and noncommunicable diseases, and diseases stemming from external causes, as well as health and sanitation service delivery. The recent issuance of the Subregional Drug Policy, approved at the XXIII RESSCAD, which includes a common list of drugs and joint negotiations, is another example of how integration is advantageous in terms of scale and managerial and epidemiological action in improving the public health of the subregion.

10. In the mid-1980s, the Caribbean established a strategic framework for health cooperation that focuses on joint action and resources for priority health areas in the Caribbean countries. In addition, CARICOM established the Council for Human and Social Development (COHSOD) for coordinating on social issues in the subregion, including health policies. The ministers of health meet at least once a year to address

subregional health issues and to approve the budgets and programs of regional health institutions. During the last decade, the heads of state requested a review of the role and functions of these regional institutions with a view to improving their effectiveness. At their most recent annual conference, in July 2007, the heads of state agreed to merge the five regional health institutions into a single public health agency for the Caribbean. This decision contributes to health integration and provides a platform for more effective coordination of subregional health initiatives.

### **The Regional Panorama at the Start of the New Millennium**

11. Since the 1990s, PAHO, along with other United Nations agencies, called for a transformation of patterns of social inequity in order to mitigate the difficult health problems of Latin America and the Caribbean. Conditions in the Region in 2000 revealed a complex panorama. The estimated population was 832.92 million people; fertility and mortality rates were dropping, while life expectancy for males and females was increasing at all ages, with the consequent aging of the population. Nevertheless, the pace of aging was slowed in some countries because of increased mortality from traffic accidents, violence, substance abuse, and other external causes. Although the demographic transition had different characteristics in each country, a simultaneous burden of communicable and noncommunicable diseases began to emerge in all of them. Among communicable diseases, problems with emerging diseases, malaria, cholera, dengue fever, tuberculosis, and sexually transmitted infections, particularly HIV/AIDS, were especially serious. Noncommunicable diseases included mental illness, cardiovascular diseases, cancer, and endocrine disorders such as type 2 diabetes mellitus. Countries had still not eliminated neonatal tetanus, congenital syphilis, or Chagas' disease, while the demographic and epidemiological transition was creating demands that taxed the precarious public health services infrastructure.

12. In 2000, millions of people in the Region suffered from disorders related to a poor diet, including anemia, obesity, malnutrition, and micronutrient deficiency. Some population groups—among them indigenous people, children, adolescents, the poor, the unemployed, the elderly, and the uninsured—had special needs that the health care system was not meeting. Others, such as migrant and informal workers, were exposed to various chemical, biological, and mechanical risks without having even a modicum of protection.

13. Furthermore, at the outset of the quinquennium, there were persistent economic, political, and social factors in the Region that were hardly encouraging for health equity, and it was recognized that approximately 211 million people were affected by widespread poverty, undermining their ability to exercise citizenship rights and participate in global markets. Unfortunately, the Region of the Americas was and continues to be the region of the world with the greatest income inequality.

14. Although by 2002, most of the Region's countries had reached several of the objectives related to the goal of health for all, indicators revealed marked differences between and within countries, although these were masked by national and subregional averages. There were, in addition, enormous health disparities between different population groups broken down by income, sex, ethnicity, age, and other health determinants.

15. The Region's economic growth rate was quite slow at the beginning of the quinquennium. According to the Economic Commission for Latin America and the Caribbean (ECLAC), in 2003, the Region's economies grew by only 1.5% and the GDP per capita remained stagnant, after having declined in 2001 and 2002. According to an 18-country study done by the United Nations Development Program (UNDP), ECLAC, and the Brazilian Institute of Applied Economic Research (IPEA), the trends at the time indicated that only 7 of 18 countries—Argentina, Chile, Colombia, Dominican Republic, Honduras, Panama, and Uruguay—would reach the MDG poverty reduction targets by 2015.

16. However, the panorama in the Region was not entirely bleak. Noteworthy advances had been made in many countries due to the reinstatement or establishment of pluralistic governments that were more tolerant of movements defending the rights of special groups, like workers, women, and ethnic groups, and that concerned themselves more with the environment. New institutional development processes, such as decentralization and deconcentration, had contributed to increased citizen participation at the local level, although insufficient for reducing social and economic inequities. On the other hand, democratization and decentralization had begun to generate greater citizen participation in planning and managing health systems and services in the Region.

17. Uneven efforts to modernize the state apparatus and strengthen regulatory systems, coupled with the effects of globalization and economic and political instability, led to a loss of faith in the capacity of the State to ensure equity. Furthermore, economic trade liberalization had not benefited all countries to the same extent, but national economies were increasingly connected among themselves in a global marketplace. Volatility, uncertainty, and widespread instability had been caused by severe political and economic crises, such as the terrorist attacks of 11 September 2001 in the United States, the reappearance of foot-and-mouth disease and the consequent impact on livestock exports in some countries, and several natural disasters.

18. Despite some improvements, in 2002 gaps remained in the provision of clean water and sanitation services. Some 15.4% of the population of Latin America and the Caribbean still did not have access to safe water; nearly 20.8% lacked access to sanitation, and only 13.7% of the wastewater collected by sewerage systems was treated before discharge. Although an increasing number of the poorest households had water

and sanitation services, they were spending proportionately more of family income on these services. The treatment and sanitary disposal of the thousands of tons of waste produced daily in cities posed a serious problem, as did the biological, chemical, and physical contamination of the air, water, and soil from urbanization, industrialization, transportation, and consumption patterns.

19. Several natural disasters had aggravated the problem of inequity and had disproportionately affected people living in makeshift shantytowns in extremely vulnerable sites. These disasters revealed the fragility of social structures and a fatalism that keeps prevention from receiving the emphasis it is due.

20. In Latin America, progressive reforms of the state had been achieved. Health systems and services had undergone internal transformations, especially with regard to the structure and organization of the services they provide, their financing, and the participation of the private sector and of private insurers in the design and implementation of new models of health care and service delivery. However, none of this had the expected effects, and several areas needed greater attention: health infrastructure, the essential public health functions, social protection in health, equity in access to health care, human resources, and quality of care. The capacity for managing human resources, which are the most valuable assets of health systems, was weak throughout the Region. The distribution of personnel was very uneven, partly from the effect of migration in search of better jobs. Salaries were low, working conditions poor, and there was a lack of connection between training of health personnel and the needs of the health services.

21. Notwithstanding the growing popular interest in health, general well-being, and diet, attempts to influence individual lifestyles had little effect in general, with the sole exception of the healthy communities and *municipios* initiative. This was due in part to poverty and low levels of education in the target groups. Public health itself had been undergoing a transformation, and there was a greater understanding of the determinants of health and disease. Nevertheless, some essential areas were neglected; there was a lack of measures for improving population health, prevention, general well-being, communities, public health infrastructure, and services delivery. At the same time, new and unexpected challenges had arisen, such as the real threat of biological and chemical attacks and pandemics from emerging diseases, for which the health sector in all the countries had to prepare.

### **A 2003-2007 Strategic Plan Inspired by Equity and Pan-Americanism**

22. At the start of a new period in the Office of the Director of the Pan American Sanitary Bureau, the Strategic Plan 2003-2007 (hereinafter “SP 2003-2007” or simply “the plan”) was adopted in February 2003 in accordance with Resolution CSP26.R18 of the 26th Pan American Sanitary Conference. This plan was the response to a regional

health panorama characterized by enormous social inequities and focused on seeking equity and on the principle of Pan-Americanism, understood as mutual assistance between the countries of the Region for solving their problems.

23. The plan contains eight priority areas of action defined by the Member States and, in accordance with international mandates in favor of social equity, concentrating the allocation and mobilization of resources in certain vulnerable groups and in the countries most overwhelmed by indebtedness and poverty. Bolivia, Honduras, Guyana, and Nicaragua had high levels of foreign debt that impeded investments in their health infrastructure, among the most precarious of the continent. Haiti, the most underdeveloped country in the Region, had the highest rates of maternal and infant mortality.

24. PAHO not only needed to provide direct technical support to these Member States, it also needed to direct the attention and assistance of other countries of the Region toward them. At the same time, the Bureau was facing the need for complementing its concentration on those countries with systematic interventions aimed at the most vulnerable, unprotected population groups: women, children, and the elderly, particularly in the pockets of urban and rural poverty, including areas of “new poverty” in large cities, and indigenous and Afro-descendent populations.

#### **The Eight Priority Areas of the Strategic Plan 2003-2007**

- Prevention, control, and reduction of communicable diseases.
- Prevention and control of noncommunicable diseases.
- Promotion of healthy lifestyles and social environments.
- Healthy growth and development.
- Promotion of safe physical environments.
- Disaster preparedness, management, and response.
- Ensuring universal access to integrated, equitable, and sustainable health systems.
- Promotion of effective health input into social, economic, environmental and development policies.

25. Naturally, the eight priority technical areas in the Strategic Plan are not separate, independent spheres of action; instead, the natural interrelationship between many of their components makes it necessary to seek more flexible and integrated ways of carrying out the work of the Bureau. For strengthening its operating capability, PAHO wants its institutional development to be based on six concrete goals that are also part of SP 2003-2007:

- Communicate quality information in a timely manner to enhance process and impact of technical cooperation;
- Generate and use strategic intelligence to anticipate and increase proactive responses to future challenges and to reap the benefit of opportunities;
- Become a valued member of mainstream scientific and technological networks, harnessing knowledge to address regional health development;
- Become a recognized leader in transnational and global issues that affect regional and national health;
- Foster a creative, competent, and committed work force that is rated exceptional by its clients;
- Be a high-performance organization and set benchmarks for similar international health agencies.

26. A mass joint advocacy effort with the Regional Directors of the United Nations Agencies successfully raised political leaders' awareness about the overriding importance of the Millennium Declaration. The message of fighting poverty and hunger and promoting equity began to resonate with the Region, where 80% of the poor reside in non-poor countries.

27. Although the MDGs established by the United Nations were taken into account when the SP 2003-2007 was developed, it was prepared before the regional MDGs and their targets had been completely defined, which then needed to be incorporated into institutional activities as an integral part of PAHO's work. The "Faces, Voices, and Places" initiative, launched by PAHO in August 2006, was developed to help the poorest communities of Latin America and the Caribbean promote equity and attain the health-related MDGs. Based on a health situation assessment in individual communities, interventions are planned and implemented with PAHO technical support. Each intervention is grounded in the empowerment of the people and the establishment of horizontal partnerships between the community and technical assistance providers.

### **The Strategic Managerial Framework for Technical Cooperation in 2003-2007**

28. Responding to Resolution CE130.R1, a managerial strategy was developed for attaining the expected results of the SP 2003-2007, using a three-pronged approach, which sought to: (a) move the unfinished agenda forward, that is, address pending areas that have not made sufficient progress; (b) protect the accomplishments already made with regard to health; and (c) prepare the countries for facing future problems, as well as the more persistent, intractable problems in the regional health panorama.

29. Mindful of the need for renewal in the face of the rapid changes in its operational environment, starting in 2003 the Bureau has focused its strategic management on a program of institutional transformation and development with four internal objectives:

(a) cooperation that is more country-focused and better integration among and within the various levels of the Organization, including the World Health Organization (WHO); (b) a stronger capacity to act as a regional forum for debating and developing public health policy; (c) greater availability of health statistics and public health information for policy-making, program development, and continuous learning, with a view to generating, sharing, and analyzing information, forming networks, and forging partnerships; and (d) creating an enabling environment for innovation in the provision of technical cooperation.

### **Strategic Framework for the Technical Cooperation of the Bureau in 2003-2007**

#### *Conclude the outstanding health agenda:*

- Reduce the high mortality rates for mothers, infants under 1, and children;
- Improve the health indicators of the poorest sectors of society, including indigenous and Afro-descendent populations;
- Fight persistent preventable or curable “neglected” diseases, among them filariasis, trachoma, parasites, plague, Chagas’ disease, brucellosis, and yellow fever;
- Reduce malnutrition and food insecurity in the poorest communities of the Americas; and
- Increase coverage of potable water supply and sanitation services.

#### *Protect accomplishments already made:*

- Increase vaccination coverage;
- Improve local health development and governance; and
- Improve public health in border areas and integrate subregional health concerns; improve primary health care, and develop and promote solid public policies for improving people’s quality of life.

#### *Face new, unmet challenges:*

- The spread of HIV/AIDS;
- Violence;
- Severe acute respiratory syndrome (SARS);
- Avian influenza virus;
- The smoking epidemic; and
- Natural disasters.

30. This institutional transformation is being carried out with the participation of the entire Bureau staff, the World Health Organization system, other United Nations agencies, and the Member States. These have actively participated in the process through the Working Group on PAHO in the 21st Century, established in 2003 to review the Organization’s situation at the dawn of the new century, and to ensure fulfillment of certain of the institution’s performance parameters.



31. At the 45th Directing Council, held in September 2004, and at the Annual Managers Meeting of October 2004, the Director replaced the four initial strategic objectives of the managerial strategy for the institution's transformation with five new ones that, like the previous ones, stressed leading the Bureau to better serve the needs of the countries, adopt new modalities for technical cooperation, secure itself as the regional forum on health in the Americas, become a knowledge-based/learning institution, and improve management processes.

#### **The Working Group on PAHO in the 21st Century**

In September 2003, the 44th Directing Council of PAHO adopted Resolution CD44.R14 to establish a working group to review PAHO's situation in the 21st century. The group was comprised of Argentina, Barbados, Chile, Costa Rica, and Peru, in their capacity as members of the Executive Committee for 2003-2004, and it was open to all the other PAHO Member States and other organizations wishing to participate that had experience in the area of institutional reform in the United Nations, ensuring equitable distribution among the subregions. The Working Group on PAHO in the 21st Century was charged with reexamining PAHO's vision, mission, and values and recommending strategic changes that will enable the institution to face the main health challenges of the new century in the Americas and to contribute to the goals the United Nations set out in the Millennium Declaration.

After numerous face-to-face and virtual meetings and a process of analysis and discussion among the Member States with the support of the Secretariat, its final report was submitted (document CD46/29) to the Executive Committee, with recommendations on different matters related to institutional reform: the main regional public health problems expected for the coming years; the evolving nature of the associations and partnerships characteristic of international health development that could affect PAHO's function; regional and global public health goods and their relation to the Organization's mandate; the different forms of technical cooperation in health; PAHO's governance; and the human, financial, scientific, and technological resources that the Bureau has in the current context. The creation of the Working Group on PAHO in the 21st Century represented a decisive step in the process of modernization, reforms and strengthening that has enriched the Bureau's work in the 2003-2007 period.

#### **Modernization of the United Nations and the Alignment of PAHO with WHO**

32. In 1997, the Member States of the United Nations instituted a program of far-reaching institutional reform in order to more efficiently integrate the areas under its purview—especially sustainable development, human rights, and poverty eradication—into national development plans and ensure the greatest impact and effectiveness of international cooperation. The goal of this reform was to respond more efficiently, in a way that was consistent and congruent with country needs. All the agencies, as well as many bilateral donors, international financial entities, and other key collaborators, committed to harmonizing their cooperation strategies and planning cycles. The United Nations Development Group (UNDG) grouped together all the development-oriented funds and programs of the United Nations bodies in order to facilitate global policy-

making. At the same time, the Common Country Assessment was implemented along with the United Nations Development Assistance Framework (UNDAF), as strategic platforms for promoting attainment in the Member States of the objectives set at global conferences.

33. The World Health Organization (WHO) soon joined UNDG, and in the 2003-2007 quinquennium the Pan American Sanitary Bureau, as the WHO Regional Office for the Americas, undertook a process of institutional transformation designed to harmonize its policies and strategies with those of WHO.

34. In 2003, PAHO joined the Regional Directors' Group of the agencies on the Executive Committee of the United Nations Group of Latin American and Caribbean countries: United Nations Development Program (UNDP), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), and World Food Program (WFP). This group meets quarterly to coordinate joint activities in the Region and discuss topics relevant to providing an impetus for development and United Nations reform. Thanks to this interagency work, a joint report of all the regional United Nations agencies was prepared, entitled *The Millennium Development Goals: A Latin American and Caribbean Perspective*, published in 2005 by the Economic Commission for Latin America and the Caribbean (ECLAC). PAHO prepared the chapter on health and the MDGs, with input from UNFPA.

35. Additionally, the Regional Directors' Group has been supporting Uruguay in the United Nations reform process, since it is the Region's only pilot country and the only middle-income country of the eight selected pilot countries.

36. In 2006, PAHO served as host agency for the meeting of the Regional Directors' Group for Latin America and the Caribbean and presented the most recent advances in vaccination. At that meeting, the Regional Directors' Group signed a declaration recognizing the immunization program as a public good.

37. PAHO is a founding member of the group of cosponsoring agencies of the Joint United Nations Program on HIV/AIDS (UNAIDS) and, as such, it has continued to organize and attend the group's ongoing meetings for strengthening the United Nations' response to HIV and AIDS in Latin America and the Caribbean. In June 2003, the Regional Directors issued a declaration pledging to strengthen political dialogue on HIV/AIDS with the governments; intensify collaboration in that area with regional and subregional entities, civil society, and associations of people living with HIV and AIDS; and mobilize international resources to help the countries counteract this serious public health problem.

38. Since 2003, PAHO has achieved progressively greater convergence with the WHO cooperation strategy, illustrated by results-based management and country-focused technical cooperation. At the direction of its Member States, PAHO also modified its regional budget policy and restructured its budget by work areas, and with this has grouped activities independent of structures and has facilitated the use of the budget as a strategic management tool. In this regard, PAHO has been a pioneer among international cooperation agencies.

39. Alignment with WHO is one of the outstanding features of the Strategic Plan 2008-2012 (“SP 2008-2012”). This is described in the last chapter of this report, since in the coming quinquennium the Bureau’s expected results will coincide completely with the expected results in the WHO Eleventh General Program of Work and with the WHO Medium-Term Strategic Plan 2008-2013. The Bureau was the first of the WHO Regional Offices to hold consultations with their Member States concerning the Eleventh General Program of Work 2006-2015.

### **Country-Focused Technical Cooperation**

40. A key element of the strategic management of PAHO throughout 2003-2007 has been the Country Cooperation Strategy (CCS), a medium-term cooperation framework that has been part of the process of alignment with WHO. The CCSs are aimed at improving strategic planning of the work in the countries and at better integration of the technical support given to every Member State. Each CCS process begins with a careful local situation assessment and includes broad advisory meetings with actors and key partners in the health field. This approach has been so important during the 2003-2007 quinquennium that the Country Support Unit has been restructured and placed under the Director’s Office. Another very important measure was the creation of the Institutional Development Unit in 2006, which has marked a new stage, with continuous monitoring of the internal transformation process as an essential step toward achieving results-based management.

41. Once the CCS was established as a guide to the work at the country level in the medium-term, the Bureau began using it in Bolivia, Guyana, Honduras, and Nicaragua. In Haiti, a provisional cooperation framework was prepared during the political transition, which has enabled all the United Nations agencies and donors to coordinate their actions. Each CCS takes into account the MDGs, regional and subregional agreements, poverty reduction programs, and national health plans, as well as the information gleaned from national counterparts and development partners. In 2004, an advisory meeting was held of the Priority Countries Working Group.

42. All the priority country CCSs have highlighted the Bureau’s role as an entity that facilitates alliances with other agencies and strengthens national capacity to coordinate

international cooperation and sector leadership. The countries have participated in several activities that have been instrumental to this function: UNFPA and UNICEF, with the involvement of PAHO Honduras and Nicaragua, held a workshop to determine the most effective interinstitutional collaboration strategies and formulate regional operating plans for 2005-2006. Another workshop, on harmonization and alignment, organized by the Regional Development Banks, was held in Honduras in November 2004. The CCSs of four of the priority countries have been presented to the World Health Assembly and those for the five priority countries have been presented at PAHO Headquarters. The approval of 30 Technical Cooperation among Countries (TCC) projects in 2005 and 2006 were a clear manifestation of regional solidarity. The subregional integration mechanisms have been strengthened with the approval of their respective biennial program budgets (BPB) in 2006.

43. Since 2003, the Organization has notably increased its capacity to serve the development needs of the countries and has facilitated Member States' participation in subregional, regional, and global collective agreements addressing health. The preparation of the Bureau's technical cooperation framework for 2003-2007 has been a strategic milestone. This framework, together with its corresponding program and cooperation strategy, has been aimed at achieving a closer working relationship with countries; identifying the neediest countries and population groups and priority action areas; broadening the Organization's participation in global, regional, and national political debates on health; addressing the underlying problems that determine health status; building capacity at the local, national, and subregional levels; forging strategic partnerships with different members; initiating contact with other entities; and facilitating knowledge sharing within the Organization and between it and other entities.

44. The Bureau also participated more in political dialogue and consensus-building processes, reflected in the approval of the Health Agenda for the Americas by the Region's countries. The Bureau played an important role in the activities of the Inter-American System through the Summit Implementation Review Group (SIRG) and the Joint Summit Working Group (JSWG) of the Organization of American States (OAS), as well as on the activities of the Inter-American Institute for Cooperation on Agriculture (IICA) and the Inter-American Development Bank (IDB). It has participated in various interministerial meetings with the health, environment, education, labor, and agriculture sectors and in intersectoral actions on the determinants of health; and in dialogue with international financial institutions, the Fund for the Development of the Indigenous Peoples of Latin America and the Caribbean (Indigenous Fund), the Ibero-American General Secretariat, and the Ibero-American Youth Organization (OIJ).

45. In 2005, directives were prepared for obtaining the full participation of the countries and of all the levels of the Organization in the development of regional and national health plans. Furthermore, throughout the quinquennium, PAHO Country

Offices were participating more in the Bureau's institutional processes and decisions, and there was greater synergy among the areas and technical units, partly as a result of virtual meetings. In general, an integrated, interprogrammatic approach has been adopted for regionwide strategies, reflected in the establishment of working groups focusing on various areas, including epidemic preparedness and early warning systems, and preparedness and response to an influenza pandemic; nutrition and HIV/AIDS; cooperation with priority countries; and chronic diseases.

46. A decentralization policy has been adopted to facilitate service delivery. In 2006, the Caribbean Program Coordination was assigned the task of promoting health cooperation in the Caribbean (in its third phase) together with PAHO's subregional specialized centers: the Caribbean Food and Nutrition Institute (CFNI) and the Caribbean Epidemiology Center (CAREC).

47. Regional adviser posts have been decentralized to boost the capacity to provide technical cooperation by means of specialized capacity-building networks in each country. Regional technical cooperation from the Sustainable Development and Environmental Health (SDE) area has been decentralized to the Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS); the Women and Maternal Health Unit (FCH/WR) has been decentralized to the Latin American Center for Perinatology (CLAP); and the Veterinary Public Health area has been decentralized to the Pan American Foot-and-Mouth Disease Center (PANAFTOSA). The Pan American Institute for Food Protection and Zoonoses (INPPAZ) was eliminated in 2005 and its activities were integrated into those of PANAFTOSA. Furthermore, the PAHO/WHO representatives have been delegated greater authority over the procurement of services and contracting.

48. In September 2006, PAHO established the Office for the Eastern Caribbean for the purpose of improving its technical cooperation and enhancing its presence in those countries and territories. In addition to the staff of the Country Office in Barbados, four country program coordinators were hired and strategically designated to Anguilla, Antigua and Barbuda, and Grenada.

### **The Regional Program Budget Policy**

49. The approval of the Regional Program Budget Policy (RPBP) by the 45th Directing Council in September 2004 was a very important step. The RPBP is an explicit framework for guiding the allocation of resources toward achieving the results-based management (RBM) objectives, as well as the expected results for the process of organizational change.

50. The new framework for resource allocation agreed upon by the Member States has modified some of the fundamental elements of the Organization's program budget

structure, allocating a greater proportion of resources to country programs; it has created a subregional level for the allocation of technical cooperation support in the context of the subregional integration processes; and it has laid the foundation for the allocation of resources among the countries according to their needs and according to criteria of equity and solidarity.

51. In accordance with the RPBP, resources come from the regular budget (Member State quota contributions), from the WHO contribution (regular and voluntary), and from other sources (voluntary contributions to the Bureau). The RPBP improves alignment between the programs of work of PAHO and WHO and thus makes it possible for the Bureau to align its efforts with global and regional needs and mandates.

52. The RPBP has introduced a new policy for the distribution of resources among the countries that consists of two components: one basic and another variable. The basic component covers 95% of the allocation to the countries and consists, in turn, of two parts: one fixed and one needs-based. The needs-based allocation depends on the country's health situation (determined by a composite index of health needs); the fixed part is equal for all the countries, respecting the Organization's principle of cooperation with all the Member States, regardless of their relative health status. The variable part of the allocation, which will not exceed 5% of the total resources allocated to the country, is meant to lend flexibility to the allocation process.

#### ***A new subregional budget component***

53. The principal objective of the new program-based subregional budget component has been to increase PAHO's assistance to subregional health integration processes in the Americas. These processes are primarily based in the Caribbean Community (CARICOM), the Central American Integration System (SICA), the Southern Common Market (MERCOSUR) in the Southern Cone, and the Andean Community of Nations (CAN). The subregional allocation category also encompasses regular and extrabudgetary PAHO resources intended for the three subregional centers—the Institute of Nutrition of Central America and Panama (INCAP), the Caribbean Food and Nutrition Institute (CFNI), and the Caribbean Epidemiology Center (CAREC)—and for the PAHO U.S.-Mexico Border Field Office in El Paso, Texas.

#### **Institution Building in Accordance with New Global Standards**

54. At the beginning of the new century, the Organization found itself in an environment characterized by a predominance of new expectations and global standards for international agencies. The reform undertaken in the United Nations System and the Inter-American System is a reflection of the general interest in strengthening governance,

improving planning and management processes, and increasing accountability and transparency. The fundamental purpose of these changes is to ensure that all of the institution's activities help bring about desired change in population groups.

### ***Results-based management***

55. In the 2003-2007 period, PAHO implemented results-based management (RBM). This means that all its activities have revolved around given desired or expected results, in particular, the changes it seeks in the health status of its Member States' inhabitants. In PAHO, RBM has focused on planning, execution, and management of the measures designed to attain the expected results in the SP 2003-2007. RBM has involved a gradual change in the managerial culture, which was reinforced in the 2003-2007 quinquennium through a new strategic planning process, biennial program budget (BPB), and performance monitoring by the American Region Planning, Programming, Monitoring, and Evaluation System (AMPES). Internally, RBM has required changes in all strategic planning and evaluation processes, in the delegation of authority, in the accountability system, and in staff development programs.

### ***Planning, monitoring, and reporting***

56. Planning is a fundamental aspect of RBM that is carried out in the Bureau in accordance with a logical method for the design of results-based projects (logical framework). Its principal elements are the Strategic Plan, which determines the results expected by the Secretariat for the Region; the program budget, which is PAHO's basic operational document; and the unit work plans, which are the previously described biennial program budgets (BPB). Starting with the planned results in the program budget, each unit prepares its biennial work plan, linking its own expected results with the approved regionwide expected results.

### ***Governance***

57. Strengthening governance has been an essential aspect of PAHO's institution building. As a result of the review done by the Working Group on PAHO in the 21<sup>st</sup> Century, in 2005 the Executive Committee created the Working Group on Streamlining the Governance Mechanisms of PAHO, in keeping with decision CE137(D5), to review several aspects of PAHO's government, among them the process for choosing the Director of the Pan American Sanitary Bureau and improving the Governing Bodies' rules of procedure. In particular, the group examined the activities of the Subcommittee on Planning and Programming (SPP); the Subcommittee on Women, Health, and Development; and the Standing Committee on Nongovernmental Organizations, and recommended ways to simplify and reorganize them.

58. The SPP was replaced by the Subcommittee on Program, Budget, and Administration (SPBA), invested with new functions, among them analyzing technical cooperation policies; planning, programming, and budgeting; strategic plans, program budget, and reports on performance and evaluation; and monitoring mainstreaming of gender equality in the Organization; in addition to examining official relations with NGOs. The Subcommittee on Women, Health, and Development was also dissolved and it was recommended that gender equity and sensitivity be mainstreamed in all technical aspects of the Bureau's work and in the overall public health reports to the Executive Committee.

59. The general recommendations of the Working Group on PAHO in the 21<sup>st</sup> Century include improving communication within Governing Bodies and amongst Member States; promoting involvement of NGOs and other professional associations in the Bureau's work; implementing a more formal, transparent process for selecting candidates for top senior posts; providing Member States with data on the operational, managerial, and financial practices of the Bureau; improving efficiency of the Country Offices; and enhancing the relationship between PAHO and WHO. It also highlighted the work of the United Nations' Joint Inspection Unit in the review of results-based management and the recommendations of the internal and external auditors.

### **Road Map for Institutional Transformation**

60. The transformation of PAHO stemmed from several internal initiatives launched in 2003 for the purpose of renewing the Bureau and adapting it to the requirements of SP 2003-2007. In its early stages, the process led to a new structure, to new ways of delegating authority, and to the establishment of the Executive Management Group. But this process was being undertaken at the same time the Bureau was trying to achieve the objectives of SP 2003-2007 with limited resources. In March 2005, the Director launched the Road Map for Institutional Transformation, containing 11 initiatives related to the five key strategic objectives in the management strategy. Eleven working groups were formed, each in charge of reviewing and analyzing one of the 11 initiatives and formulating recommendations to facilitate its implementation.

61. All the Road Map groups have issued recommendations that have been used in developing the expected results and setting the appropriate indicators for the Strategic Plan and the area-specific work plan for 2008-2012. Furthermore, since the launch of the Road Map, new political decisions have been made with guidance from the WHO and PAHO Governing Bodies, especially in connection with the deliberations and conclusions of the Working Group on PAHO in the 21st Century, the resolutions of the 45th Directing Council concerning the new Regional Program Budget Policy (RPBP), and the subsequent recommendations of the External Auditor.



62. The Road Map has raised awareness in the institution of the value of teamwork and has provided an example of long-distance collaboration between groups through the use of new communication technologies.

**The Strategic Objectives for Organizational Change and the 11 Initiatives  
of the Road Map for Institutional Transformation**

- *Respond better to country needs*  
Country-focused cooperation  
Organization review of the units and program areas
- *Create a knowledge-based/learning organization*  
Leadership development and learning  
Knowledge management
- *Adopt new modalities of technical cooperation*  
Regional public health plans
- *Make PAHO a regional forum for health in the Americas*  
Public Health in the Americas Form
- *Enhance management practices*  
Standards for accountability and transparency  
Internal communication  
External communication  
Human resources strategy  
Resource mobilization

***Create a knowledge-based/learning organization***

63. During the quinquennium, PAHO has implemented a strategy for knowledge management and information technology aimed at turning the institution into an authoritative source of public health information and a learning organization based on collaboration and on the formation of networks and associations. The Area of Publications (PUB) has generated many books and other technical materials of a practical nature for public health professionals, researchers, and other health workers, as well as for experts in other fields and people interested in the health problems of the American continent.

64. The Information and Knowledge Management Area (IKM) and the Information Technology Services Area (ITS) have worked together during the quinquennium on forming communication networks inside and outside the Bureau. As a result, connectivity

among the PAHO/WHO Country Offices has been improved, and virtual forums for teamwork have been created. The expanded use of *SharePoint* as a work platform has enabled more efficient collaboration on document preparation. Measures have also been adopted—virtual meetings, teleconferences, and electronic files—for reducing the costs of document preparation and distribution. In general, country support has improved thanks to the use of these and other communication technologies.

65. Various external communication networks have been formed, including one for Health in the Americas (2007); the Ibero-American Networks; the Regional Forum for Public Health in the Americas; and the Virtual Campus for Public Health, during the pilot phase of which more than 80 mentors were available for distance learning and 250 workers received training on the most pressing health public problems. The pilot phase led to reorienting the strategic model to one with an open, decentralized network approach. Institutions from six countries currently participate in the Campus with technical assistance from INFOMED. In the 2006-2007 period, the second phase was carried out, and the support served as a point of contact between the Virtual Campus for Public Health and the virtual health libraries system, promoted by the Regional Library of Medicine (BIREME) on the one hand and the PAHO policy on information and knowledge management on the other.

66. A new tool for virtual collaboration has been adopted by the Organization (*Illuminate Live!*), and personnel have been trained, with WHO support, on the Health InterNetwork Access to Research Initiative (HINARI) and Global Information Full Text (GIFT), which put a broad collection of journals and biomedical databases within the reach of WHO personnel around the world and public institutions in developing countries.

67. Improvements have been made in knowledge sharing between experts in various fields, as well as in staff members' abilities and skills, through the *Digital Literacy* training program; through *Help Desk*, a technological assistance system for staff members; and through courses and workshops on knowledge management, both at Headquarters and in the countries.

68. In 2006, a new Bureau website was created and websites were also created for the Country Offices and for the units and projects at Headquarters, in order to standardize the Organization's image.

69. A blog has been created on PAHO's website where the Director voices her opinions and engages in lively debate with health professionals in the countries. The blog is part of a communication strategy whose main purpose is to make PAHO a special and reliable source of public health information and to keep the people of the Americas informed about the activities of the Organization. Since the blog was created, it has

received more than 54,000 visits. Opinion articles by the Director have been published periodically by the main mass media in the Member Countries, leading to strengthened institutional presence throughout all subregions. Interviews have taken place, and special reports have been published in the press and in electronic and specialized information sources in the Americas and even in other regions.

70. Internationally known stars from the world of entertainment have actively participated in campaigns and other activities sponsored by PAHO for the promotion of public health in the Region: Don Francisco in the fight against obesity; Monica, the comic strip character, in the activities surrounding Immunization Week; and other artists belonging to the ALAS Foundation in the promotion of other causes, including the fight to eliminate violence against women and road safety promotion.

71. PAHO has produced public information materials and has distributed them to a very large audience. A number of staff members have given interviews on different aspects of public health in the Americas, and a number of agencies, wire services, and television programs have profiled PAHO programs and initiatives. Through the use of fresh, modern graphics highlighting significant information on key subjects, PAHO reached ever larger audiences. Special posters, folders, calendars, publications, and related items have also helped spread the word about the initiatives of the Organization, and a partnership with the NBA Washington Wizards basketball team showed PAHO health messages to new audiences.

72. PAHO's biannual magazine, *Perspectives in Health*, showed a growing audience throughout the world the human face of public health, and the Organization's newsletter, *PAHO Today*, helped audiences keep up with activities and programs.

### **Developing scientific and technical information and communication infrastructure and capacity**

In the last five years, PAHO, through BIREME, has consolidated initiatives, programs, and information networks that guarantee equitable access to information and scientific knowledge. Prominent among these are the Virtual Health Library (VHL) and the Scientific Electronic Library Online (SciELO), through which PAHO has contributed to the dissemination of scientific and technical information and to the utilization of the knowledge, technologies, and innovations generated by scientific research and field experience. The Region as a whole and the vast majority of the countries have advanced steadily in the compilation, organization, publication, indexing, conservation, use, and evaluation of scientific and technical information.

In the last three years, expansion of the VHL in the Region has led to PAHO's participation in initiatives promoted by WHO, including the Global Health Library, which exports the VHL platform to other WHO regions; the ePORTUGUÊS network, which takes the VHL to Portuguese-speaking countries; and the TropIKA Initiative (Tropical Disease Research to foster Innovation and Knowledge Application) for research on infectious diseases that affect poor populations. BIREME cooperates with the United States National Library of Medicine (NLM) through the VHL and SciELO networks, and has strengthened its ties with Spain and Portugal.

The VHL and SciELO have entered the global knowledge economy through scientific information systems, networks, and services that operate on the Web, including NLM's PubMed, ISI/Thomson's Web of Science, Elsevier publishing company's Scopus, Google Scholar, Lund University's Directory of Open Access Journals in Sweden, and others. SciELO in particular represents one of the principal international initiatives for open access to scientific knowledge. The VHL and SciELO are also connected to other regional networks, such as the Virtual Campus for Public Health (VCPH); the Iberoamerican Cochrane Network; and the ScienTI network, run by national councils on science and technology that provide directories of researchers and research groups, institutions, and projects.

The VHL offers open access, universal, and up-to-date services, with interfaces in Spanish, English, and Portuguese, to the principal reference sources for national, regional, and international scientific and technical health literature.

In 2007, there were more than 100 VHL portals, with regional, national and subject-matter coverage in all Latin American countries and many Caribbean countries. The VHL has also facilitated the creation of virtual communities, practice communities, and learning and information environments in health institutions and settings, contributing in this way to social inclusion and access to information.

### ***Adopt new modalities of technical cooperation***

73. The Regional Public Health Plans have been the key to attaining this objective. These plans, collectively developed by the countries, represent a regional commitment to addressing the most pressing public health problems comprehensively and with clearly defined goals, objectives, and strategies. They constitute a call to collective action and are a strategic and unifying tool linking the activities of a network of national entities—from the public and private sector, institutions and centers, NGOs, financial agencies, and

civil society—in order to efficiently achieve common goals and objectives with support from international organizations such as PAHO. The Regional Public Health Plans serve as instruments of governance and negotiation that promote democratic stability and contribute to countries' social development.

74. The Regional Public Health Plans also include novel cooperation modalities, such as horizontal cooperation among and within countries, and among academic, scientific, and research institutions; the establishment of revolving funds and trust funds to promote economies of scale; the manufacture of inexpensive, good-quality supplies, materials, products, drugs, and food; cooperation with a subregional focus; and interprogrammatic work in the Secretariat through the creation of working groups, joint missions to countries, focus on priority countries, joint projects among different programs, creation or expansion of virtual networks, and mobilization of resources for joint projects.

#### ***Standards for accountability and transparency***

75. A number of the recommendations of the Road Map working group in charge of this initiative have been channeled through the Integrity and Conflict Management System (ICMS), under the corresponding Coordinating Committee, made up of the Grievance Panel, the International Labor Organization's (ILO) Appeals Board, the mediator, the head of the Ethics Office, the Area of Human Resources Management (HRM), the Office of Legal Affairs (LEG), and the Staff Association; the ICMS Focal Point in each country; Internal Oversight Services; and the Information Security Officer. The purpose has been to improve mechanisms for individual and institutional accountability through clearly defined, communicated, and implemented policies and procedures governing standards of conduct for staff members, conflict of interest, financial disclosure, reporting of complaints, relationships with partners and governments, and the use of the PAHO and WHO names and logos.

76. The accountability system is part of PAHO's overall internal system for institutional governance and supervision. It defines the flow of authority and its purpose, as well as the responsibility inherent in the exercise of that authority. In PAHO, accountability occurs at different levels: (a) in the units, through AMPES and the BPB; (b) at the individual level, through the personnel performance evaluation process (PPES, which was automated in 2006); (c) through the PAHO competencies; (d) through existing financial and staff regulations and rules; and (e) through the existing model for delegation of authority. In the 2003-2007 quinquennium, the PAHO accountability system was brought into line with that of WHO.

77. During the quinquennium, the Administrative Management Operations Unit was created, based on the experience of the work done by the special adviser for field activities. Broader institutional monitoring and development functions were formulated,

and outfitting of the Office of Internal Audit was completed. Improvements were also made in the areas of Finance and Procurement (FAMIS/ADPICS), Financial Management, Personnel (PAS), Staff Health Insurance (SHI), Map Products Information System (MAPS), Correspondence Tracking System (CTACS), Leave Tracking System (LTS), Payroll, and various Web/Intranet applications.

78. In 2007, a thorough review and revision was undertaken of all delegation of authority and accountability processes, in line with the current resource mobilization strategy. The Bureau's competencies model was updated to give greater added value to technical cooperation. The review of staff member competencies and strategic alignment of personnel in the Caribbean Program Coordination (CPC) office were begun.

### ***Internal and external communication***

79. Much progress has been made with regard to strengthening internal cooperation, networking, teamwork, and information and knowledge sharing. This can be seen in the internal interprogrammatic working groups in the technical areas and at the area managers' quarterly meetings. The knowledge management strategy and the Road Map have given rise to initiatives that have facilitated internal communication.

80. In 2005, the Road Map working group did a market survey in the Member States and among personnel and other interested parties to determine what the international community expected from PAHO. The results revealed the need for making communication more transparent, speeding up organizational change, improving efficiency, and achieving more cohesive leadership. The direction that the institutional transformation is taking was validated and greater emphasis was placed on forming institutional and intersectoral alliances. The study also revealed that PAHO holds a significant and unique place in the field of public health in light of its technical capacity, knowledge, presence in the countries, close relationship with national authorities, and the dedication of its staff.

### ***The human resources strategy***

81. In line with a related activity undertaken by WHO in 2005, the Bureau initiated a Strategic Assessment and Resource Alignment (SARA) exercise. The activity is designed to ensure that management unit objectives, functions, and resources (primarily human resources, but also finance and others) are both well defined and clearly aligned with the Organization's strategic priorities.

82. A new competency model is being instituted as an essential tool for achieving greater strategic alignment. Staff members are being assigned to those functions where their respective competencies are more needed, and an individual development plan is

being prepared that will make it possible for each staff member to acquire or improve the competencies they need for performing their functions. Generic post descriptions are being prepared for all positions. The inclusion of hiring goals for each sex and geographical area in the Strategic Plan 2003-2007 represents a great step toward mainstreaming gender equity as PASB policy.

83. Steps have also been taken to improve the system for personnel evaluation and for awarding prizes and incentives. A Learning Board led by the Assistant Director was created to determine staff development priorities. A learning plan was also created to determine the needs of each office and develop annual plans for improving staff members' skills and competencies. Several national and regional level managers participated in the Global Leadership Program. In addition, a policy on HIV/AIDS in the workplace was developed.

84. PAHO received almost US\$2 million in funds from the WHO Global Learning Program, which were used to strengthen project management, leadership, knowledge management, communications, and technology skills, among others. The successful execution of these learning funds in PAHO was recognized by WHO and used as a model for other regions. PAHO staff members directly supported the creation of a similar learning framework in WHO's EURO and AFRO regions.

85. PAHO offices in priority countries were strengthened through the assignment of program officers responsible for supporting national health development through negotiations with other sectors, resource mobilization, and coordination of alliances with donors.

86. In order to strengthen a work environment based on the respectful treatment of colleagues and partners and in accordance with the principles of the Organization, PAHO has implemented three important policies: (a) Policy on the Prevention and Resolution of Harassment in the Workplace (2004), (b) Code of Ethical Principles and Conduct (2005), and (c) HIV/AIDS in the Workplace (2006). PAHO also created an Ethics Office, which investigates any alleged violation of these policies. This office and these policies, to which all PAHO staff members are considered accountable, constitute the basis for an Organization that defends the principles of ethical conduct and takes action when these principles are violated.

87. The Organization entered into a contract to develop an automated database (Expertise Locator System), which became operational in 2007. The database improves the identification of experts and the transparency of the recruitment process, while leveling chances for candidates in all countries.

## **International Cooperation and New Partners in a Globalized World**

88. Until 2001, 11% of all official development assistance (ODA) was allocated to the Region of the Americas, but that percentage has been gradually declining, down to 9% in 2005. Everything indicates that this figure will not be increasing again in coming years. This situation should be seen as a result of the increase in the mobilization of resources for Africa, for the countries affected by the tsunami in Southeast Asia, and for resolving armed conflicts in the Middle East.

89. The total monetary contribution for ODA in the world increased from approximately \$6.9 billion in 2003 to \$103.9 billion in 2006, and health cooperation has increased at an annual rate of 5.4% in the last 15 years; however, these increases have not been felt in the Region of the Americas.

90. In the 2003-2007 quinquennium, the Bureau put a lot of energy into mobilizing resources and forming strategic alliances and partnerships. It kept up constant dialogue with partners in the international community, among them bilateral agencies, which made it possible to select issues of mutual interest through a comparison of the agencies' cooperation policy priorities and the public health priorities of the Region' countries and of the Bureau.

91. PAHO optimized its dual role as the specialized health agency of both the United Nations System and the Inter-American System, by means of its privileged contact with the Organization of American States. It took the following fundamental aspects into account when evaluating opportunities for new alliances and for strengthening resource mobilization:

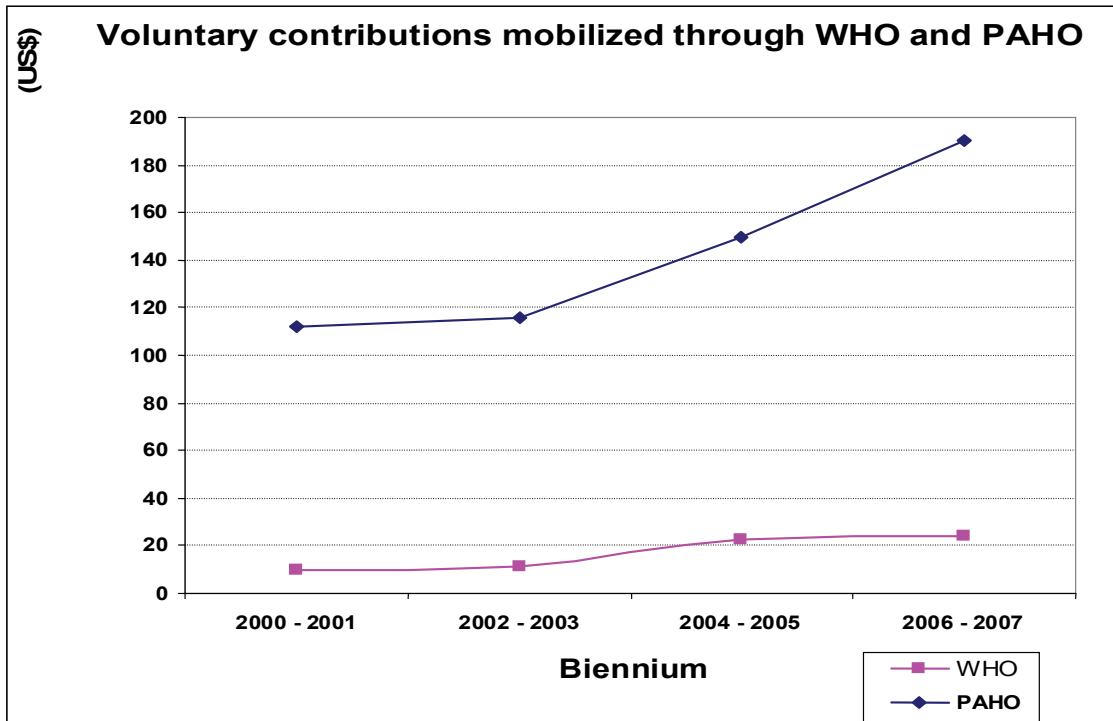
- The implementation of programs aimed at attaining the MDGs.
- The proliferation of potential partners in the health field at the global and regional levels, including the emergence of new partnerships with the private sector.
- The decision of the Organization for Economic Cooperation and Development (OECD) to give greater importance to the processes of harmonization and convergence by strengthening the steering role of governments in developing countries.
- The likelihood of epidemiological emergencies or emergencies from natural disasters and bioterrorism.
- The need for boosting the institutional capacity of the ministries of health to respond to the new challenges posed by adherence to the new International Health Regulations (IHR).



### *High-level forums on the harmonization of development assistance*

92. During 2003-2007, two high-level forums on harmonization and alignment for international aid effectiveness were held: the first in Rome in 2003 and the second in Paris in 2005. At the 2003 forum, the main multilateral development banks, international and bilateral organizations, and country representatives issued the Rome Declaration on Harmonization and pledged to adopt measures to ensure, among other things, that development assistance is provided in keeping with the priorities of the partner country and that harmonization activities are adapted to the country's situation. Two later years, the Paris Declaration on Aid Effectiveness translated the general consensus reached in Rome to increase efforts regarding harmonization, alignment, and management into mechanisms for monitoring the progress made. These new initiatives and approaches to international cooperation implied new opportunities for the health sector in priority setting and resource mobilization.

93. PAHO has internalized the provisions of the Rome and Paris declarations. The program-based approach to cooperation, initiated in the 2002-2003 biennium, rapidly bore fruit and was expanded considerably in the 2006-2007 biennium. This has made it possible for the Bureau's technical and budgetary programming for a given biennium to form the basis for negotiating the mobilization of resources and establishment of agreements. The program-based approach has been designed to encompass planning, programming, monitoring, and evaluation. This program-based approach has also been promoted through several political dialogue and negotiation meetings with traditional partners. Noteworthy among these are the meetings with Norway, the Canadian International Development Agency (CIDA), the Swedish International Development Cooperation Agency (SIDA), the United States Agency for International Development (USAID), and the Spanish International Cooperation Agency (AECI).



**PAHO Performance Evaluation by Douglas Lindores (Canada)  
and Leif Lunde (Sweden)**

To build partners' confidence, assessments were made of the Bureau's capacity to adopt a new orientation toward collaboration and the establishment of partnerships. The corresponding reports, prepared in 2004 by experienced advisers from Canada and Sweden, showed very satisfactory results. This made it possible for the Bureau to continue with negotiations on programming with these two countries.

The report by Mr. Douglas Lindores, for the Canadian International Development Agency (CIDA), concluded that PAHO as an institution is a common good that belongs to the Region of the Americas. Thus, strengthening it is a task that contributes to the implementation of specific programs and projects for improving health in general. It was also found that PAHO is respected in the Region and that its personnel and its different systems are of the same, or better, quality that those of other multilateral agencies.

The report by Mr. Leif Lunde, for the Swedish International Development Cooperation Agency (SIDA), found that PAHO, despite depending on WHO, stands out as being independent and self-confident. It has a greater presence at the country level than many specialized global agencies of the United Nations, and with over a century of experience, the Organization is one of the oldest multilateral bodies in existence. PAHO has a very clear vision and mandate and very solid links with governmental entities and the ministries of health in the countries. Its strategic approach coincides, in this regard, with that of other sections of the United Nations, and thanks to this, PAHO has forged partnerships for promoting its vision, goals, and strategies with skill and dedication.

During the quinquennium, several consultations were held with bilateral partners to reexamine the collaboration established with them, evaluate the progress made as a result of that collaboration, and make needed changes or adjustments. At first, the consultations were one-on-one, but starting in early 2005, the decision was made to hold joint consultations with some of the Nordic countries, such as Sweden and Norway, and it is hoped that beginning in 2008, advisory meetings involving several partners will be held.

An interesting example of these joint consultations is the Partnership for Health Preparedness (PHP). This consortium of donors (CIDA, Canada; DFID, U.K.; ECHO, European Union; and OFDA, USAID) contributes to PAHO's disaster preparedness and mitigation activities. The PHP functions as a mechanism for liaison and dialogue with, and collective reporting to, these central donors, who support disaster risk reduction in the health sector in Latin America and the Caribbean.

***Networks and alliances***

94. In 2005, the Ibero-American Summit in Salamanca approved the creation of four Ibero-American health cooperation networks: the Donation and Transplant Network, coordinated by Spain; the Public Health Teaching and Research Network, coordinated by Costa Rica; the Tobacco Control Network, coordinated by Brazil; and the Drug Policy Network, coordinated by Argentina.

95. Since 1999, PAHO has been a member of the Alliance for Cervical Cancer Prevention (ACCP). This group of five international organizations—EngenderHealth, the

International Agency for Research on Cancer (IARC), JHPIEGO, the Pan American Health Organization (PAHO), and PATH—with funding from the Bill & Melinda Gates Foundation, has been working toward a shared goal: to prevent cervical cancer in developing countries.

96. In order to maximize collaboration among the partners and carry out joint activities, ACCP formed a steering committee and created four working groups. The Alliance's work has made it possible to evaluate the feasibility and effectiveness of various screening and treatment methods for preventing cervical cancer.

97. The Regional Interagency Task Force for Maternal Mortality Reduction, comprised of PAHO, the World Bank, the Inter-American Development Bank, UNICEF, UNFPA, USAID, the Population Council, and Family Care International, supports and advances international initiatives, among them the MDGs and the Safe Motherhood Initiative. In February 2004, the Task Force signed a joint declaration pledging to collaborate on promoting action to fight maternal morbidity and mortality and trying to establish partnerships for mobilizing the financial resources needed at regional, subregional, and national levels.

98. To support neonatal health actions in the Region within the continuum of maternal, newborn, and child care, an interagency alliance was created, comprised of PAHO, UNICEF, USAID, CORE Group, BASICS, Plan International, the Latin American Association of Pediatrics (ALAPE), Save the Children, the Saving Newborn Lives initiative, and other entities. The alliance has published a strategic consensus on neonatal health and will support the Regional Neonatal Operational Plan that will be presented to the Bureau's Governing Bodies in 2008.

99. In October 2004, WHO launched the World Alliance for Patient Safety at PAHO Headquarters. The Alliance and various international experts and forums have pointed out the need to include the patient's voice in initiatives to improve the quality and safety of health care. To that effect, PAHO has coordinated two regional workshops (San Francisco, May 2006; Chicago, June 2007) with the participation of patients and several collaborating centers, and is currently providing guidance to the Alliance in designing a Pan American network of patient leaders who will carry out awareness-raising projects in the countries of the Americas.

100. In addition to patient safety, other factors go into the making of safe hospitals. One of them is response capacity when disasters occur, that is, the ability to hold up during a crisis and to continue functioning when most needed. PAHO's Member States have made important strides in this regard. The alliance with the United Nations' International Strategy for Disaster Reduction (ISDR) will help disseminate knowledge about these critical issues. Plans for the Campaign for Disaster Reduction 2008-2009

were triggered by concern over safe hospitals. This alliance, for which PAHO provides technical cooperation, will help garner the support of international partners for the ISDR's national platforms for disaster reduction.

101. PAHO is also a member of the Inter-American Coalition for the Prevention of Violence, established in June 2000, as are the Inter-American Development Bank, UNESCO, OAS, Centers for Disease Control and Prevention (CDC), World Bank, and USAID. In March 2007, the Coalition's members met in a high-level meeting at PAHO, where they ratified their commitment to fighting violence.

102. In the context of the Regional Strategy on Nutrition in Health and Development, approved by the 47th Directing Council in September 2006, the Organization has participated in interagency efforts to develop and implement activities to promote optimal nutrition.

103. During the quinquennium, PAHO has received financing from its main international donors, including the Canadian International Development Agency (CIDA), USAID, the Spanish International Cooperation Agency (AECI), the Swedish International Development Cooperation Agency (SIDA), and the Norwegian Agency for Development Cooperation (NORAD). It has also promoted alliances for mobilizing cash and non-cash resources from philanthropic foundations and other civil society entities, notable among which are the Bill & Melinda Gates Foundation, the Bristol-Myers-Squibb Foundation, the Ford Foundation, the WK Kellogg Foundation, the United Nations Foundation, the International Red Cross and Red Crescent Movement, Rotary International, and the Catholic Medical Mission Board (CMMB).

104. Since 1968, PAHO has received invaluable support from the Pan American Health and Education Foundation (PAHEF), a U.S. public philanthropic organization. For the period 2003-2007, the program contributed approximately \$7,877,715 to impact health and health education in PAHO/WHO member countries. Through its Expanded Textbook and Instructional Materials Program, it distributed 784,107 textbooks and training manuals, and 197,710 medical instruments at a reasonable price to hundreds of low-income students and health workers in 19 countries of the Region.

## **CHAPTER 2: THE UNFINISHED AGENDA: THE ETHICS OF HEALTH AND DEVELOPMENT**

105. The remarkable progress in improving health conditions and access to health care services in Latin America and the Caribbean has not been uniform. A large debt has been accumulated that is reflected especially in those health problems and living conditions that disproportionately affect the most disadvantaged social sectors. Diseases, death, and disability, while concentrated in high-poverty settings, decrease a society's capacity for productivity and development. Reducing this burden of social injustice is an urgent task for the Region in the 21st century.

106. Fulfilling this unfinished agenda is a complex undertaking. It requires not only redressing the poverty in which most of the population lives, but also eliminating the social, ethnic, cultural, and racial factors that perpetuate inequality and social exclusion and predispose certain groups to suffer illness more often than others, or that hamper their ability to enjoy the same opportunities as the rest of society. Because of their vulnerable situation, special attention should be given to the needs of disabled people, the elderly, children, women, and populations of Amerindian or African descent. It is necessary to fight against gender inequality and stigma and discrimination within communities and health services. Actions are needed to address the causes of diseases that have been neglected because they mainly affect the poor inhabitants of rural or marginal areas.

107. In the health sphere, primary health care (PHC) is the surest road toward achieving the goals related to this unfinished agenda and to the MDGs. Today there is full recognition that social solidarity and community participation, cornerstones of PHC, are indispensable for bringing about the profound, practical, and sustainable changes that can lead to better health by reducing the risk factors for disease and the inequities that limit access to health care and social development. For this reason, PAHO's Member States have made a collective appeal to renew the PHC strategy and to reorganize their health systems accordingly. An Interprogrammatic Working Group on Primary Health Care was established in 2007 to bring greater internal integration and coherence to this task.

### **Care of Vulnerable Groups**

#### ***The Health and Human Rights Project***

108. In its role as a WHO Regional Office and as the specialized health agency within the Inter-American System, PAHO works to protect the right of every inhabitant of its Member States to enjoy the best possible state of health.

109. For the purpose of disseminating the international norms and standards that protect the right to health and other basic rights of vulnerable population groups, PAHO has organized training workshops in collaboration with other agencies, among them the Inter-American Commission on Human Rights (IACHR). Furthermore, PAHO has held successful training workshops for its own technical and managerial staff members as well as for public health personnel in nine countries.

**Paraguay adopts precautionary measures to protect people confined to a neuropsychiatric hospital**

In 2004, in the Inter-American Commission on Human Rights of the OAS, a historic agreement was signed between the Government of Paraguay and two NGOs in response to an appeal by the latter for urgent precautionary measures to protect 450 people interned in the Neuropsychiatric Hospital of Paraguay. From the beginning of this process, PAHO provided technical assistance regarding health, disability, rehabilitation, and human rights to the national government and to the Commission. For the first time, a PAHO Member State made a formal commitment to reform its public health services in line with the provisions of regional human rights treaties and the recommendations of regional human rights agencies. The agreement was the direct result of PAHO's technical collaboration with its Member States in the dissemination of information on human rights; the technical training of public health personnel on applicable standards pertaining to human rights, disability, and health; and the review of health legislation and policies in light of international human rights norms.

***PAHO's collaboration with regional and international human rights organizations***

110. PAHO collaborates extensively with regional human rights agencies, such as the Committee on Economic, Social, and Cultural Rights, the Committee on the Elimination of Discrimination against Women, and the Special Rapporteur on the Right to Health. The collaboration between PAHO and IACHR involves visits to public health institutions; technical interpretation of the American Convention and the American Declaration on the Rights and Duties of Man in light of international standards of protection that are applied in fields such as mental health, HIV infection, and neglected diseases; and the implementation of precautionary measures. The technical collaboration between these two agencies, aimed at protecting the lives, personal integrity, and other rights of individuals who are confined to health facilities or who carry particular diseases, has resulted in major reforms.

***The health of the indigenous peoples of the Americas***

111. Throughout the 2003-2007 quinquennium, PAHO has promoted its Health of Indigenous Peoples Initiative with the ongoing participation of the Amerindian communities themselves, promoting recognition and respect for their ancestral wisdom. There have been two important milestones: (1) an evaluation of health achievements at

the end of the International Decade of the World's Indigenous People in 2004, and (2) Resolution CD47.R18, adopted by the 47th Directing Council in September 2006, which advocates for the period 2007 to 2011 the incorporation of indigenous peoples' perspectives into the attainment of the Millennium Development Goals and national health policies, a better understanding of the health of indigenous populations, the integration of an intercultural approach into the national health systems of the Region as part of the PHC strategy, and the development of strategic alliances with indigenous peoples and other stakeholders.

112. With the sponsorship of the Indigenous Fund, two graduate-level programs have been developed that combine traditional academic scholarship with indigenous knowledge: the International Degree in Intercultural Health of the Universidad de la Frontera (UFRO) in Chile, and the Masters Degree in Intercultural Health Management of the Universidad de las Regiones Autónomas de la Costa Caribe Nicaragüense (University of the Autonomous Regions of the Caribbean Coast of Nicaragua, URACCAN). This work has also benefited from the establishment of strategic partnerships with agencies such as UNICEF, ECLAC, and the Andean Regional Health Agency, and from participation in regional and global networks such as the Intercultural Health Network and the United Nations Permanent Forum on Indigenous Issues.

113. The regional project on Improvement of Environmental Conditions (Water and Sanitation) in Indigenous Communities has yielded some interesting results, including two projects of technical cooperation among countries. The first one, known as Water and Sanitation in Indigenous Communities, made it possible for Panama, El Salvador, and Guatemala to share their experiences among themselves. The second project, called Primary Environmental Care in Indigenous Communities of Costa Rica, Guatemala, and Panama, featured public education on solid and liquid waste management, personal hygiene, wastewater drainage systems, and indoor air pollution.

114. In Panama, a National Working Group (GNT) was formed with the participation of the indigenous communities and of various governmental and international entities, including UNICEF and PAHO. Also in Panama, a national project known as Monitoring Water Quality in Indigenous Communities was carried out, using an intercultural approach. That project, which was promoted by the Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS) with financial support from German Cooperation for Development (GTZ), focused on the community of Union Chocó in the region of Emberá. As a result of the project, the organizations represented in the GNT and especially the Ministry of Health became interested in establishing a national system for surveillance of drinking water quality. The indigenous communities of Ipetí-Emberá and Haytupo-Kuna also benefited from training aimed at improving their environmental conditions that was provided in the context of PHC.



### **Workshop on health and human rights of the indigenous Miskito population**

Between 1999 and 2004, 596 divers from the indigenous Miskito populations on the Atlantic Coast of Nicaragua and Honduras suffered decompression syndrome while fishing underwater for lobsters, their main source of livelihood. In that same period 13 divers died due as a result of damaged hyperbaric chambers, a lack of adequate rehabilitation services, and working conditions incompatible with international standards.

In 2004 PAHO carried out in Puerto Lempira, Honduras, a national workshop on human rights, disability, and the health of the indigenous populations. Participants included government officials, leaders of the Miskito community, the human rights ombudsman, the Inter-American Commission on Human Rights, and various organizations of civil society. As a result of PAHO's technical assistance in connection with the regional and international human rights standards that protect indigenous populations, the Honduran Ministry of Health repaired the hyperbaric chambers and improved medical and rehabilitation services. For its part, the Inter-American Commission on Human Rights is collaborating with PAHO to continue reviewing the situation of the Miskito in light of regional human rights treaties and regional and international standards pertaining to disability, rehabilitation, and health.

115. In Colombia and Ecuador PAHO works with communities in the Department of Cauca and the canton of Cotacachi, applying an intercultural approach that takes advantage not only of the resources offered by the health services but also of the traditional medical resources of the community and its indigenous health workers. The activities focus on promotion of healthy spaces, tuberculosis control, and protection of sexual and reproductive health.

116. Due to their living conditions, diet, and situation of displacement, the indigenous peoples of Colombia have an incidence of tuberculosis that exceeds the national average (25 cases per 100,000 population). In 2002, Colombia was incorporated in a project financed by PAHO and the Canadian International Development Agency (CIDA) that encouraged adoption of the DOTS strategy (Directly Observed Treatment, Short-Course) in indigenous communities.

### ***Displaced groups***

117. Political conflicts and natural disasters have led to the displacement of millions of people in Latin American and Caribbean countries. Colombia alone has some 2 million displaced persons, mostly women and children, as a result of the situation caused by illegal armed groups. These displaced people live in conditions of economic and social vulnerability. PAHO has concentrated on strengthening coordination among the different actors in government, civil society, and the international community to protect displaced people and refugees and has advocated better health care for these groups. As a result of this joint effort by PAHO and the Government of Colombia, with support from other agencies and financial allies, there has been an improvement since 2003 in the capacity

of the municipal and territorial authorities in affected areas to devote public resources to humanitarian assistance.

### ***People with disabilities***

118. People with disabilities have difficulty gaining physical and economic access to treatment, essential drugs, and goods and services for health and rehabilitation. They also face obstacles to the enjoyment of their fundamental human rights and freedoms. In the Region of the Americas, from 7% to 10% of the population—around 60 million to 80 million people—have some type of disability. The national figures for prevalence of disability in the Region vary widely as a result of the diversity of methods used to generate these figures and the absence of harmonization and standardization of technical criteria for defining disability.

119. Aware of the limitations of population censuses for depicting the situation of disability in the general population, some countries have conducted specific prevalence surveys. In Argentina and Uruguay, for example, surveys showed a prevalence of about 7.1% and 7.6%, respectively. Cuba carried out a psychosocial study of persons with disabilities and of the social, clinical, and genetic characteristics of persons with mental retardation. The study, which is known as *Por la Vida* (For Life) and ended in 2003, covered the country's 169 *municipios*. More recently, with the approval of the International Classification of Functioning, Disability and Health (ICF) in May 2001, countries have begun conducting prevalence studies that use this classification as a technical basis. Between 2003 and 2005, national studies based on the ICF were conducted in Chile, Ecuador, Nicaragua, and Panama; more recently, the ICF was used in developing the disability module for Colombia's population census.

120. PAHO provides technical cooperation in this area to the countries of the Region through its Regional Program on Disability Prevention and Rehabilitation and other interprogrammatic interventions. Furthermore, it collaborates with its Member States in generating policies, plans, interventions, and projects designed to prevent disability and enable disabled individuals to be rehabilitated and to enjoy the same opportunities as the rest of the population. Most of the countries have rehabilitation services available in their tertiary health care facilities. The strategy of community-based rehabilitation services (CBR) for the comprehensive care of disabled individuals has been promoted for more than two decades, although not all the countries have incorporated this as yet into their national health plans.

121. Chile is the first country in the Region to have developed an abbreviated version of the ICF. It conducted its first National Study on Disability through a survey of 14,000 families in order to determine the scope, distribution, and nature of disabilities in the population. Furthermore, Panama, with the active participation of PAHO, has

conducted its first survey on disability (PENDIS), has adopted measures to promote equal opportunity for persons with disabilities, and has created both a national council and a national secretariat to work for the social integration of such persons (CONADIS and SENADIS).

122. In Cuba, the care of disabled people is one of the health system's priority areas. PAHO's cooperation program includes support for the National Health System in its efforts to build capacity to address disability as a public health problem, as well as to enhance the program of comprehensive care for persons with disabilities.

### ***Gender equality and equity***

123. Global and inter-American conferences have issued important mandates calling on national governments to promote gender equality in the formulation of their public policies and programs. In the Region, gender equality was particularly emphasized in the Convention of Belém do Pará (1994), which dealt with the prevention, punishment, and eradication of violence against women, and in the 2002 Summit of the Americas, which set targets for gender equality in the Quebec Charter.

124. Gender inequalities in health exist in various ways, especially in the unequal access of men and women to care and in the lack of attention to the particular health needs of each sex. PAHO has integrated a gender perspective into all facets of its work: planning, execution, monitoring, and evaluation of policies, programs, projects, and research. The PAHO Policy on Gender Equality, introduced in 2005, calls for work with governments, civil society, and other entities in the Member States to eliminate all inequalities in health between women and men and to advance toward women's empowerment. The main objective is for both men and women to enjoy an optimal state of health and well-being throughout their life cycle.

125. These actions are consistent with WHO's gender policy, approved in 2002, and with the decision by all United Nations agencies to incorporate the gender perspective into all U.N. policies and programs. This approach is also in line with the PAHO Strategic Plan for 2003–2007, which stipulates that “reducing the impact of poverty, gender, and ethnicity as determinants of inequities in the health situation and in access to health care needs to be integrated into all programs.”

126. PAHO also promotes gender equality in its own work force in accordance with resolutions of the World Health Assembly and the United Nations General Assembly. It includes gender equality in its policies and programming, including the biennial program budget. The mainstreaming of gender, although initially overseen by the Gender, Ethnicity and Health Unit, is now the responsibility of all departments and levels of the Organization and of the ministries of health, other governmental sectors, academic and

research institutes, and NGOs. All technical and administrative areas of PAHO have gender focal points, as does every PAHO Country Office and every ministry of health. These, along with all the areas and units of the Organization, gather data by sex in order to permit data analysis from the standpoint of gender and the design of materials and interventions that use a gender-based approach.

### **Malnutrition and Food Insecurity**

127. In Latin America and the Caribbean, much of the population consumes insufficient quantities of nutrients and calories, which can lead to a broad range of clinical symptoms. Poor nutrition, when suffered early in life, undermines human capital, income, productivity, and development, as shown by the Longitudinal Study of Growth and Development carried out by the Nutrition Institute of Central America and Panama (INCAP) and other related studies.

128. Various analyses performed in the Region, based on national statistics and particular studies, have confirmed the relative importance of chronic malnutrition as opposed to acute malnutrition, which is less prevalent in all the countries. These studies have also made it possible to identify the determinants of the problem, which are basically associated with the agricultural, food, and nutrition system and which relate directly to the availability, accessibility, consumption, and biological utilization of food, and thus to food and nutritional insecurity.

129. At the national and subregional levels during the five-year period, certain joint initiatives of the health sector and other sectors, with the participation of PAHO and its specialized centers, have produced very good results, especially with respect to nutritional status in infancy. They include the Productive Municipios Movement in Cuba; Municipios for Development in Central America; transborder programs in health and nutritional and food security in several countries; national plans to reduce hunger in the population (for example, *Cero Hambre* (Zero Hunger) in Brazil); the programs and measures to reduce the population that suffers from hunger (such as *Cero Hambre* in Brazil and the naming of a commissioner against hunger in Guatemala), and different subregional initiatives in the context of the Nutrition and Food Security Initiative (SAN) launched in the 1990s.

130. In the area of nutrition, PAHO has provided technical cooperation through its subregional centers (INCAP and CFNI), mobilizing resources and transferring technologies and methodologies to the national institutions. In Costa Rica, INCAP has supported the SAN with a view to combating the gender inequity and inequality that afflict the country and contributing to the comprehensive development of poor families living in marginalized communities.

131. Activities to reduce chronic malnutrition have been particularly successful in Central America. Based on the approval of a specific proposal submitted by the World Food Program (WFP) to the XXI Special Meeting of the Health Sector of Central America and the Dominican Republic (RESSCAD), held in Belize in 2005, all the countries, with the support of PAHO/WHO, WFP, and INCAP, are strengthening their actions and implementing a new generation of food and nutrition programs based on scientific and technical evidence. In Guatemala, the Nutrition and Food Security Secretariat has coordinated intersectoral efforts involving the public sector, private enterprise, and civil society to target food and health programs to the higher-priority *municipios*, while other countries of the subregion have given priority to conditional cash transfer initiatives.

132. Since 2003, microenterprise has been promoted among rural women in Honduras, not only to combat food insecurity but also to empower women and enable them to participate in development processes. In Bolivia, the model of nutritional IMCI has been redesigned and is an essential part of the Zero Malnutrition Bolivia 2010 program, launched in July 2007 in order to radically reduce malnutrition rates in children under 5 and pregnant women. The Zero Malnutrition program is being disseminated rapidly throughout the Region, and nutritional evaluation has become the first rather than the last step in the IMCI algorithm.

133. Another important achievement is the assessment of linear growth in addition to weight-for-age; this is of special importance in the Region, where growth retardation is much more common than insufficient weight-for-age. Height is being added to the protocol for growth evaluation in Bolivia, Guyana, Honduras, Nicaragua, and other countries.

#### **The new WHO guidelines on child growth**

In April 2006, WHO launched new guidelines on childhood growth in breast-fed children. The new growth curves are already being applied in clinical settings in Bolivia, Brazil, and Chile. To promote adoption of the guidelines in 13 other countries of the Region, PAHO has held national workshops with key entities including the ministries of health, pediatric societies, United Nations agencies, bilateral agencies, and NGOs. Argentina, Guyana, and Mexico are already in the process of adopting the guidelines. PAHO has also offered three subregional courses—in South America, the Caribbean, and Central America—on the proper assessment of growth.

As a result of these actions, a group of facilitators is currently designing and presenting national courses to train health workers in the use and interpretation of the new curves. In countries such as Colombia, the new guidelines have led to the review of all nutritional programs and interventions with a view to redesigning or adapting them to achieve more favorable results. PAHO, with support from WHO, has introduced the new growth guidelines and has provided training materials.

PAHO has prepared a manual known as *Guidelines for Monitoring Child Development*, with versions in Spanish, English, and Portuguese. In the last two years almost 1,000 health professionals in 10 countries of the Region have been trained using this manual.

134. With the support of PAHO, courses and conferences on malnutrition have been offered in Mexico, educational materials and nutritional guides have been prepared, and support has been provided for the National Nutritional Sciences Congresses. Studies have been done on the nutritional impact of food supplementation on children under 5 through the Free Program of Conasupo Industrial Milk and the Secretariat of Social Development (LICONSA-SEDESOL).

135. Based on experiences in the Region to date, the 47th Directing Council (CD47.R8) in September 2006 approved the Regional Strategy and Plan of Action on Nutrition in Health and Development 2006–2015. The strategy addresses the complex relationships between nutrition and health. It covers both nutritional deficiencies (hunger, insufficiency of micronutrients, and chronic malnutrition, including growth retardation) and the excesses and imbalances that result in the epidemics of obesity and of chronic and metabolic diseases, such as diabetes, that have been observed in poorer populations.

#### **The Lima Act contributes to the fulfillment of several MDGs**

In November 2006, PAHO and other agencies of the United Nations system such as FAO, UNICEF, and the World Food Program, together with bilateral agencies such as USAID and various civil society organizations, signed the Lima Act as part of the initiative “Towards the Eradication of Child Malnutrition,” which includes health measures in the fight against poverty. Upon signing the Act, PAHO, the World Food Program, and UNICEF committed to helping Peru prepare and execute a plan to combat not only the most immediate causes of chronic malnutrition but also their social determinants, which are reflected in several MDGs.

### **Child and Maternal Mortality**

136. High rates of child and maternal mortality are a serious problem in Latin America and the Caribbean, especially among indigenous populations. There are enormous disparities between the countries and unacceptable figures in the poorest countries, such as Bolivia, Guatemala, Haiti, and Honduras, that are masked by regional averages. There is little reliable information on maternal and child mortality in the Region, and more data disaggregated by ethnic group is needed to better understand the cultural and social determinants of the problem. In Argentina, Colombia, Ecuador, Guatemala, Mexico, Panama, and the United States, meetings have been held to examine the needs of indigenous populations and the suitability of an intercultural approach.

137. PAHO and other agencies are working intensively in community programs with midwives and community leaders to improve health conditions during deliveries, expand care provided by skilled birth attendants, and identify and refer high-risk cases in a timely fashion.

### ***Integrated Management of Childhood Illness (IMCI)***

138. The potential for public health improvements in the new millennium lies in collaboration between families and communities and the health and social protection sectors. Estimates suggest that with good community interventions, almost half of childhood deaths could be prevented. The Integrated Management of Childhood Illness (IMCI) initiative was launched in the Region in 1996 to reduce morbidity and mortality caused by preventable childhood illnesses in children under 5. IMCI has three basic components—clinical, neonatal, and community—and local needs determine which of them should be promoted in particular places and circumstances.

139. In the Region, IMCI has transformed family health care and has led to a new type of community mobilization. In the countries where it has been adopted, it has been used to teach family practices that benefit children's health and that allow sick children to be cared for within the community itself. It has also improved equity by concentrating on vulnerable and indigenous populations.

140. January 2007 saw the conclusion, with good results, of the partnership forged in 2000 between PAHO, the U.S. Red Cross, and the United Nations Foundation (UNF) to help the ministries of health and the national societies of the Red Cross in 11 countries (Bolivia, Colombia, the Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Nicaragua, Peru, and Venezuela) introduce the IMCI strategy within families and communities. The efforts of this alliance laid the foundations for an interinstitutional collaboration that has allowed the community component of IMCI to be firmly incorporated into the official plans and policies of these 11 countries. PAHO provided the necessary leadership and technical support to ensure that the IMCI strategy became an element of national programming based on the fundamental principles of PHC.

141. In order to promote the community component of IMCI, a model based on social actors was created. According to this model, the entire community identifies its health needs based on epidemiological data and conceives of interventions and programs that it later implements.

### **Community IMCI yields abundant benefits in Bolivia, Peru, and Honduras**

In Bolivia, IMCI was integrated into national health policy in order to support the governmental initiative of Zero Malnutrition Bolivia 2010, and the community model based on social actors has been applied widely. In Cotahuma, a poor peri-urban area of La Paz where most residents are indigenous Aymara speakers, the work with community IMCI has transformed family practices of key importance to child health. It has catalyzed joint action by a range of important actors, among them the Ministry of Health, the Ministry of Education, Red Cross volunteers, neighborhood councils, local health councils, community health promoters, and city hall.

The district of Chao in the Department of La Libertad, Peru, also applied the social actor model to promote IMCI, with a positive impact on parents' knowledge about the health of their children. Similar results were obtained in Honduras, where mothers learned to recognize the warning signs in children under 5 suffering from respiratory and intestinal infections and to seek medical care immediately when these signs are present.

142. In Guyana, IMCI was introduced in 2001 in an effort to reduce high infant mortality. It has been very fruitful, given the serious lack of resources and the difficulty in reaching the inhabitants of remote areas who lack access to essential diagnostic services. By the end of June 2007, Guyana had trained a critical number of health workers throughout the national territory. The Ministry of Health, with the technical support of PAHO, has expanded the initiative by introducing community IMCI.

143. In Ecuador, clinical, neonatal, and community IMCI has been promoted. In view of the high mortality rates in neonates, several workshops were held in 2006 to train nearly 200 professionals, including physicians and nurses, in neonatal IMCI. With support from PAHO, 14 universities in the country have incorporated IMCI as a clinical and community integrating strategy in the curricula of programs to train health personnel. The country's first breast milk bank was established at the Isidro Ayora maternity center in Quito.

144. Since 2003, the work of PAHO in the Dominican Republic has focused on the promotion of neonatal IMCI. From 2005 to 2006, mortality in children under 1 year of age was reduced 7.3%, according to data of the Ministry of Public Health and Social Welfare (SESPAS) and of the National Epidemiological Surveillance System (SINAVE). This means that during that period it was possible to prevent the deaths of over 500 children, especially neonates, partly through the impact of neonatal IMCI.

145. PAHO has undertaken a strategy of technical cooperation with the department of Antioquia in Colombia in order to integrate the experiences and practices characteristic of PHC, IMCI, and the Program to Improve Food and Nutrition (MANNA) of the government of Antioquia.



### ***Maternal mortality***

146. High maternal mortality is one of the most serious public health problems in Latin America and the Caribbean, where every year some 233,000 women die from complications of pregnancy and childbirth. Throughout 2003–2007 a great effort was made to strengthen the maternal mortality surveillance systems in the Region, especially in the neediest countries. Unfortunately, Latin American and Caribbean countries do not always have up-to-date data that would make it possible to determine how much progress has been achieved toward this goal of the fourth MDG.

147. In September 2002, the 26th Pan American Sanitary Conference approved a new regional strategy with concrete goals for the reduction of maternal mortality based on lessons learned and on the best available scientific tests. In 2003, the Latin American Center for Perinatology and Human Development (CLAP) located in Uruguay promoted the creation of a network of centers of excellence in order to accelerate implementation of the plan to reduce maternal mortality.

148. In Bolivia, maternal mortality is 230 per 100,000 live births, and in the Guatemalan indigenous population the rate is much higher than the national rate. Guyana, whose maternal mortality ratio in 2003 was 123.6 deaths per 100,000 live births, developed a National Strategic Plan for the Reduction of Maternal Mortality 2006–2010. To strengthen the maternal mortality database in Guyana, PAHO helped the Ministry of Health establish in the country's two largest hospitals a Maternal Mortality Audit Committee that will review, investigate, and classify all maternal deaths. The Ministry of Health and PAHO have also helped set guidelines for the Maternal Mortality Epidemiological Surveillance System and have prepared a training program on the management of maternal deaths in the maternity centers.

149. CLAP collaborated in implementation of a Perinatal Information System (SIP) in local hospitals that will make it possible to monitor all maternal, perinatal, and neonatal deaths in the country. The data obtained will be used to evaluate the quality of care provided to pregnant women from the initial prenatal consultation through the conclusion of the pregnancy.

150. In December 2004, the government of Panama and PAHO made a commitment to confront the problem of maternal mortality and prepared a strategic plan for the reduction of maternal and perinatal morbidity and mortality for the period 2006–2009. The plan includes the creation of local health plans to offer special obstetric and neonatal care (CONE) and reduce the gaps observed with regard to maternal and perinatal health in the country. It gives priority to the rural areas, which have predominantly indigenous populations and high rates of maternal and child mortality. Emergency obstetric and neonatal services are being studied in these areas with a view to creating new models of care.

151. In Haiti, where the maternal mortality rate is the highest in the Region, nearly 76% of women give birth at home because of economic barriers and 25% suffer complications. In collaboration with the Ministry of Health, PAHO has promoted the introduction of free obstetric services as a linchpin of health system reform in the country, with support from partners such as CIDA (Canada) and the European Communities.

152. In Mexico, the Secretariat of Health implemented the Equal Start in Life program in the period 2001–2006 as a national strategy to reduce maternal and child morbidity and mortality, particularly in the population with higher indices of poverty and marginalization. PAHO has supported the strategic component of the program, whose activities include surveillance, evaluation, and operations research. It has also supported, in nine Mexican states, an evaluation of the underreporting of maternal mortality due to faulty classification of deaths. This has made it possible to improve maternal mortality statistics with a modified version of the RAMOS method (Reproductive Age Mortality Survey).

153. In 2007 the Congress of the Republic of Peru held a forum where staff members of the Ministry of Health, PAHO, the UNFPA, UNICEF, CARE, and representatives of other entities signed an act of commitment to support the National Alliance for Healthy and Safe Motherhood.

#### **Promotion of safe motherhood in Colombia**

In 2000, Colombia had a maternal mortality ratio of 105 per 100,000 live births, an excessive rate in light of the country's level of development and high public spending on health. The Ministry of Social Protection of Colombia endorsed in 2003 the creation of a network of four centers of excellence to improve the surveillance and quality of maternal and neonatal care.

With support from PAHO, the Colombian centers have implemented an epidemiological surveillance system on maternal mortality that covers approximately 223,000 of the 800,000 deliveries recorded annually in the country. It is estimated that in the areas affected by the centers, maternal mortality has declined by 25% to 40% between 2003 and 2006.

Since 2003, the PAHO/WHO Country Office in Colombia has been in charge of developing the annual work plan and coordinating the monitoring of deliveries. This has made it possible to design a system for evaluating processes and outcomes and has facilitated the activities shared among different centers, as well as the articulation with national and departmental health authorities and with the regional program of PAHO. CLAP has trained focal points in the centers and in local hospitals within their area of influence; it has also provided methodological instruments for their work as well as initial financial support.

## ***Teenage Pregnancy***

154. Protecting the sexual and reproductive health of adolescents (SRHA) is very important in connection with the MDGs and the reduction of poverty, understood to mean not only insufficient income, but also low schooling, physical and mental vulnerability, and low participation in the political and social spheres.

155. As part of its initiative to promote healthy sexual practices and prevent pregnancy in adolescents, PAHO has been supporting developing countries in developing policies and information systems; building capacity; integrating SRHA and HIV services, and strengthening interagency and intersectoral work based on an ecologic, gender and human rights approach and which fosters community participation and the incorporation of current scientific evidence.

156. Materials for the promotion of adolescent health have been developed, such as the *Guía para abogar por la salud integral de los/las adolescentes, con énfasis en salud sexual y reproductiva* and the *Recomendaciones para los servicios de salud integrales para los/las adolescentes, con énfasis en salud sexual y reproductiva*, and workshops have been held in 11 countries of the Region. Didactic materials have also been prepared, and long-distance education programs have been implemented in order to improve the technical competencies of health professionals who provide sexual and reproductive health services to adolescents and young adults.

## **Communicable Diseases**

### ***HIV infection and AIDS***

157. HIV infection and AIDS are public health problems that require special and urgent attention around the world. In the Region, the epidemiological distribution of this disease, which previously was concentrated in men who have sex with men and in injecting drug users, is showing a clear trend toward feminization.

158. PAHO's support for activities aimed at fighting HIV infection and AIDS is coordinated with the work of other important partners who are active in the Region, among them the Global Fund to Fight AIDS, Tuberculosis and Malaria.

159. PAHO has been supporting its Member States as they prepare proposals and strengthen coordinating mechanisms in the countries. PAHO has collaborated with the United States President's Emergency Plan for AIDS Relief (PEPFAR) in the target countries (Guyana and Haiti) and has been working jointly with USAID, CDC, and other partners that are implementing PEPFAR in the Caribbean and Central America. The areas of collaboration include stigma reduction, laboratory support, case surveillance, behavioral change, and preventive interventions.

160. In keeping with PAHO's recent decentralization policy and in order to strengthen the Organization's response to the threat of sexually-transmitted infections and HIV, in August 2007 the Caribbean HIV/STI Office was set up in Port of Spain, Trinidad and Tobago, to coordinate technical support for PAHO's Caribbean HIV/STI Plan. The Office will be the main interface with agencies that specialize in supporting HIV-related projects, such as the Pan Caribbean Partnership on HIV/AIDS (PANCAP) and the Caribbean Regional Network of Seropositives (CRN+). CAREC will support laboratory and HIV surveillance activities, while CFNI will attend to the nutritional aspects.

### ***Regional Revolving Fund for Strategic Public Health Supplies***

In the full spirit of Pan-Americanism, in 2000 PAHO created the General Revolving Fund for Strategic Public Health Supplies to help Member States purchase medicines and essential public health supplies at reasonable prices. This is achieved through the negotiation capacity acquired by purchasing large volumes directly from the manufacturers.

The Strategic Fund, which some countries in the Region are members of, is a source of technical assistance and training on needs assessment and planning for procurement of medicines and essential supplies. In 2004, the PAHO Directing Council urged Member States to increase their use of the fund. This led to workshops being held in Central America, the Caribbean, and the Andean region for ministry of health personnel and major organizations that are beneficiaries of Global Fund projects. Activities in these areas have focused on examining and formulating national procurement plans financed by the Global Fund to help countries overcome the administrative and technical obstacles they face when converting available financing into product supply. All activities have been conducted with the assistance provided by PAHO Collaborating Centers and technical institutions of reference, with the support of the Global Fund.

Through the Strategic Fund, PAHO has helped countries that participate in global antiretroviral initiatives such as "Three Million by 2005" as well as Global Fund projects to fight AIDS, tuberculosis, and malaria. Favorable prices have been obtained from the Strategic Fund for orders of large amounts of vaccines. A ministerial meeting was planned in member countries of the Strategic Fund in order to generate consensus with regard to a reasonable price for introduction of the new rotavirus vaccine. It has also promoted introduction of new vaccines on the market, and annual agreements have been established for the drugs used most frequently.

### ***The Three Ones principle***

161. The Three Ones represents a new approach to the organization of the response to HIV in the countries. It entails the creation of one agreed HIV/AIDS action framework, one national AIDS coordinating authority, and one agreed country-level monitoring and evaluation system. With a view to applying these principles, PAHO and the other co-sponsors of UNAIDS meet annually to jointly plan strategies, examine progress to date, and harmonize activities.

162. The regional directors have reaffirmed their commitment and support for the Three Ones and their will to work in coordination with national leaders, multilateral and bilateral partners, and other key collaborators to implement the Three Ones principles in the countries. Resolution CD45.R10 of the 45th Directing Council of PAHO, adopted in 2004, supported the expansion of treatment for HIV infection and AIDS as well as other sexually transmitted infections (STIs) as part of an integrated response to the epidemic.

163. Since the adoption of this resolution, PAHO has increased its direct technical support to the countries in order to strengthen the health sector's response to the HIV epidemic. PAHO continues to decentralize its resources and technical assistance in view of the fact that improvements in prevention, care, and treatment will require not only drugs and other goods but also investments in building the capacity of the health systems to provide treatment effectively and equitably.

164. A good example of these efforts is in Panama, where the government, with support from PAHO, has achieved notable advances in the last five years on the road toward universal access to comprehensive care for people with HIV infection. A law has also been adopted to protect the rights of people infected with HIV. The prevention of this viral infection has been strengthened through specific public campaigns carried out by the Ministry of Health or by civil society entities. These initiatives have included campaigns for the elimination of stigma and discrimination against people with HIV.

165. Before 2005 in Suriname, the majority of screening tests were done in a single laboratory, based on clinical indications and doctor referrals. Starting in that year, however, the Ministry of Health has expanded screening services. Key aspects of the strategy have been the preparation of a national screening protocol, the delivery of same-day results, an expansion in the number of clinics and in their hours, and the integration of voluntary testing services into primary health care centers.

166. Another noteworthy experience is that of Guyana, which has mobilized \$1.2 million from PEPFAR to finance its strategic plans against HIV and AIDS. With these funds, PAHO provides technical cooperation to enable health workers in remote areas of the country to implement comprehensive plans to bridge the gaps in patient treatment within the framework of the Integrated Management of Adolescent and Adult Illness strategy. The initiative contributes to the fulfillment of the sixth MDG in Guyana and in the entire Caribbean area.

167. In the Dominican Republic, the prevention and control of HIV infection has received intensive support, and surveillance and epidemiological information systems have been strengthened. PAHO technical cooperation has been aimed at achieving goals and objectives for increased impact, improving information systems, reducing risk in the community, and improving care for affected people. As a result, from 2004 to 2006 the

number of people diagnosed with HIV infection increased from 5,041 to 14,050; the number being treated with antiretroviral drugs rose from 956 to 5,001; the number of health centers providing comprehensive care for people with HIV increased from 14 to 46; and the number of health facilities with trained staff and inputs for the interventions established in the Program to Reduce Vertical Transmission increased from 22 to 122.

168. With its INTEGRA program, Colombia has integrated technical assistance and voluntary testing for HIV infection in the sexual and reproductive health services of some *municipios*. The principal recipients are young people, and the model is spreading to health institutions in those parts of the country characterized by high vulnerability in relation to sexual and reproductive health. Together with UNICEF, the UNFPA, and UNAIDS, PAHO is represented on the managerial committee of the project and directed the preparation of the three modules it uses. PAHO also provides technical support for the development of the project and for assessment of results in the selected sites.

169. In Cuba, the Ministry of Health, supported by PAHO, has strengthened the monitoring and evaluation of activities to combat HIV and AIDS in 47 priority *municipios* connected to the national surveillance network. It has improved the laboratory network for local diagnosis; expanded the screening program in high-risk areas; trained health workers, especially in the polyclinics of those areas; and established a program of home visits by nurses to strengthen adherence to treatment.

170. PAHO has supported the sharing of experiences and the participation of Cuba in international events, and it has facilitated the creation of a multicountry project for the prevention and control of HIV/AIDS in the Region under the coordination of Cuba. This project, in which the Bahamas, Belize, Guatemala, Guyana, Jamaica, Honduras, and Nicaragua are participating, aims to identify best practices and lessons learned in the prevention and control of HIV/AIDS in the area of mother-to-child transmission. It also promotes technical cooperation among countries, documents and disseminates best practices and positive and negative experiences, and makes recommendations based on them.

**Chile formulates a quality-of-life index for people  
with HIV infection or AIDS (2003–2007)**

In the context of Chile's project to Accelerate and Deepen the National, Intersectoral, Participatory, and Decentralized Response to the HIV/AIDS Epidemic, which was approved by the Global Fund to Fight AIDS, Tuberculosis and Malaria, in 2006 a cross-sectional survey was carried out in Santiago and Valparaiso on the quality of life and adherence to antiretroviral treatment in 409 people affected by HIV who were served in the eight public hospitals with the highest concentration of HIV-positive people in the country.

This activity has made it possible to create an index to be used in calculating the impact of the disease on the lives and well-being of infected people. In addition to shedding light on the quality of life of people affected by HIV and AIDS, the index reveals the contrast between this group and the general population of the country and points up the impact of social determinants on the life situation of the HIV-affected population. A workshop on South-South cooperation was also held, with contributions from CONASIDA, the National AIDS Program of Brazil, and PAHO.

PAHO collaborated with the Global Fund on the project design, formed part of the coordination mechanism in the country that directed and managed the project, and provided financial support. South-South cooperation in the simultaneous prevention of HIV/AIDS and sexually transmitted infections has enabled the participating teams to better understand the importance of adopting complementary measures.

**The 2007 Latin American and Caribbean Forum on HIV/AIDS and STDs**

The fourth Latin American and Caribbean Forum on HIV/AIDS was held April 15–20, 2007, in Buenos Aires, Argentina. Its slogan was "Latin America and the Caribbean: United in Diversity Towards Universal Access." Its principal objectives were to promote universal access to public education on HIV prevention, to treatment, and to health care provided with respect and sensitivity.

In tandem with the official event, the Regional Community Networks of Latin America and the Caribbean on HIV/AIDS (LACCASO, ICW Latina, REDLA, RELARD, REDLACTRANS, ASICAL, MLCM+, REDTRASEX) convened the 2007 Community Forum. The theme addressed by this gathering was "25 years of the HIV/AIDS epidemic and the response of the community movement and civil society of Latin America and the Caribbean; past, present, and future challenges and opportunities."

The Community Forum is an opportunity for dialogue and collaborative work among the communities and civil entities of the Region whose task relates in some way to HIV/AIDS. In the Community Forum, held on April 18, 2007, the Latin American and Caribbean Women's Health Network participated in the regional launch of the "Women Won't Wait" campaign, whose call is to "End HIV & Violence Against Women Now!" This is an international women's coalition that promotes the health and human rights of women within the framework of the struggle against HIV and violence against women. The campaign, which aims to respond effectively to both problems, reflects the fact that violence against women and girls aggravates the ongoing feminization of the HIV epidemic.

171. With regard to the prevention of mother-to-child transmission of HIV (PMTCT), the report of 11 PAHO Member States indicates that the coverage of PMTCT programs ranges from 2.1% in Paraguay up to 87% in Argentina, with large disparities both within and between countries. There are new experiences in this field, for example in the Bahamas, where no case of death in children due to HIV/AIDS was recorded in 2002, and in Trinidad and Tobago, where between 85% and 95% of pregnant women were screened for HIV between 2002 and 2005.

### *Dengue*

172. Dengue, a disease of great epidemiological, social, and economic impact, constitutes a growing problem for public health worldwide and especially in the Americas. In 2007, facing the threat of a regional epidemic, PAHO issued an alert to the entire Region. The countries have made an effort to prepare and implement Comprehensive Care of Dengue, but the factors that facilitate transmission of the disease still persist in the Region. This has prevented the Region from meeting its goal to reduce incidence by 40% in 2007, although the marked reduction in mortality from the disease is very encouraging.

173. Central America is one of the most affected areas, with cases of dengue hemorrhagic fever concentrated primarily in El Salvador, Honduras, and Nicaragua, as well as in the Dominican Republic. In order to cope with the problem, PAHO has prepared the Strategy for Integrated Dengue Management in Central America and the Dominican Republic (EGI-DAC), based on a new model of work that encompasses health promotion and the development of new partnerships to prevent and control dengue. The Dengue Technical Group was created in 2003 as a group of experts who participate in the work of the country technical teams to jointly prepare a national strategy of integrated management.

174. El Salvador prepared guidelines for the Central American Comprehensive Plan for Dengue Prevention and Control that were presented at the meeting of the Coordinating Committee of the Central American Network for the Prevention and Control of Emerging and Reemerging Diseases (RECACER), held in Panama August 21–22, 2003.

175. Dengue is the communicable disease that poses the greatest threat to public health in Costa Rica, where 37,798 cases were reported in 2005, equivalent to an incidence rate of 890 per 100,000 population. The country has adopted the Strategy for Integrated Dengue Management (EGI-Dengue), which is being implemented in almost the entire national territory with the holding of regional workshops for discussion and analysis in each of the seven regions of the country. Since EGI-Dengue was implemented, the cases of dengue declined in 2006 and 2007, mainly in the regions of the country most affected by dengue and in the population with more vulnerable living conditions.



176. In Ecuador, dengue continues to be an important public health problem that transcends the sphere of activity of the health sector and as a result requires comprehensive, interprogrammatic, and multisectoral interventions, with local community organizations playing a key role. Thanks to vector control interventions and proper case management in hospitals, deaths from dengue in the country have declined from 14 in 2005 to 6 in 2006 to only 4 in 2007. Two important initiatives are under way in Ecuador, one in the community of Paraíso de la Flor and the other in the Galápagos Islands, both aimed at bringing about changes in behavior. Evaluations have shown favorable changes in the habits of the population and a reduction in the number of cases.

### ***Tuberculosis***

177. Although tuberculosis is preventable and curable, it continues to be an important public health problem in the Americas. The simultaneous presence of tuberculosis in many patients suffering from other diseases and the appearance of multidrug-resistant tuberculosis pose a challenge for control of the disease in all the countries. The problem is aggravated by the weaknesses of the health sector in the poorest countries and the adverse impact of health sector reforms.

178. During the last decade, adoption of the DOTS strategy (Directly Observed Treatment, Short-Course) has made it possible to improve the detection and cure of cases. The Region is on track to attain the indicators and goals set forth in the MDGs. Nevertheless, the best results have been obtained in the countries with high or medium income and long-standing national tuberculosis programs.

179. During the 5-year period, PAHO technical cooperation with the Ministry of Health of Brazil has resulted in the expansion of the DOTS in that country, where more than 40,000 health professionals have been trained in the application of control measures. The Brazilian Partnership against Tuberculosis (Fórum da Parceria Brasileira contra a Tuberculose) has been formed to undertake tuberculosis control with the participation of over 52 civil society organizations. Joint actions against tuberculosis and HIV infection have also been implemented in high-risk groups in the country.

180. Due to the varying levels of development of the countries, PAHO technical cooperation has been provided in different epidemiological and operational contexts and has given priority to those countries that are most vulnerable because of their poverty, high incidence of tuberculosis, HIV/AIDS situation, and presence of multidrug resistance. The Regional Strategy for Tuberculosis Control for 2005–2015 was established in order to provide a response tailored to the problems in each country through initiatives based on the DOTS strategy that improve the quality of care, community participation, and social mobilization.

181. Haiti is one of the poor countries that have made progress, but the advances have not been sufficient to enable the National Tuberculosis Program to reach its objectives. The principal obstacles are the HIV epidemic, the low coverage with DOTS (less than 60% of the country), insufficient control of the delivery of drugs, the emergence of multidrug-resistant tuberculosis, and scarcity of funds.

**The Dominican Republic strengthens its national tuberculosis program and reduces the impact of the association between HIV infection and AIDS**

Due to its high burden of the disease, the Dominican Republic is one of nine countries identified by PAHO as priorities for tuberculosis control. As such, it participates in all regional events related to the Stop TB Partnership. In December 2001, USAID signed a two-year cooperation agreement with PAHO for the purpose of strengthening the National TB Control Program (NTCP) of the Ministry of Public Health and Social Welfare in the Dominican Republic and adopting the DOTS strategy in seven priority provinces and the National District.

In 2007 the project with USAID was extended, with the following objectives: strengthen the actions of the NTCP through expansion of the DOTS strategy in five provinces and support for bordering provinces; consolidate and extend the strategy to all health facilities in the seven provinces and eight areas of the District National benefiting from the project; strengthen detection and comprehensive care of patients with multidrug-resistant tuberculosis; respond to tuberculosis and HIV co-infection; articulate binational actions for tuberculosis control on the island of Hispaniola; and collaborate with the project of the Global Fund to strengthen the NTCP. PAHO has provided technical and administrative support and has mobilized technical human resources from other countries with financing from USAID and other agencies.

### *Malaria*

182. Although the general incidence of malaria has declined in the Region in recent years, the disease continues to be a public health problem of first magnitude and the results of control efforts carried out in the different countries have been very unequal. It is calculated that some 40 million people in the Region live in areas of moderate and high risk. In 1992 WHO, having been unable to eradicate the disease, launched the Global Malaria Control Strategy. In order to strengthen it, the Roll Back Malaria (RBM) initiative was implemented in 1998 with a view to reducing the disease burden 50% by 2010. In the 42nd Directing Council of PAHO, the Member States where malaria continued to be a public health problem adopted the RBM initiative.

183. In Guyana, malaria continues to be an important public health problem that is the cause of a significant proportion of outpatient consultations in ambulatory health centers and of hospital admissions. Guyana has received resources from the Global Fund and from the Amazon Network for the Surveillance of Antimalarial Drug Resistance

(RAVREDA), and the current Ministry of Health has given priority to malaria control. The disease affects more than 85% of the Amerindian population, whose poverty indices exceed those of all other population groups in the country.

184. In 2005, the Guyana Ministry of Health issued a mandate to integrate the vertical malaria program into the Regional Health Services. The National Malaria Diagnosis Network has been evaluated and restructured and national therapeutic guidelines have been written for uncomplicated malaria, which are currently being put into practice. After a study of the supply of antimalarial drugs in the country, the supply channels were improved and national policies were defined. Laboratory tests were also created for quality assurance of antimalarial drugs, and personnel were trained in their application. Chloroquine, primaquine, and mefloquine were subjected to repeated tests in two mini-laboratories in order to determine their quality.

185. In Suriname, the incidence of the disease has been reduced by 70% between 2003 and 2007. The country has a Malaria Board which, with support from RAVREDA and financing from the Global Fund, has directed measures to improve the control and prevention of malaria in the country. The disease is confined to the interior, a territory inhabited by Amerindians, Afro-descendants, and *garimpeiros* (miners originally from Brazil). Each inhabitant of the interior has received a mosquito net impregnated with long-acting insecticide and the initiative has been publicized over radio and television in the different languages spoken in Suriname. PAHO participates actively in the coordination by RAVREDA and in implementation of the project of the Global Fund.

#### **The Bahamas responds to a malaria case cluster in Exuma**

At the beginning of June 2006 the Ministry of Health of the Bahamas reported to the PAHO/WHO Country Office several cases of locally transmitted malaria on the island of Exuma. In collaboration with the Regional Malaria Program of CAREC, technical human resources were mobilized to assist the vector control unit of the Department of Environmental Health Services. This program arranged for Brazil and Nicaragua to donate drugs that could not be obtained locally.

PAHO mobilized the appropriate technical resources and provided technical assistance in the areas of epidemiological research and case search, detection, and care to complement national technical capabilities. It also acquired drugs and diagnostic products. The guidelines published by PAHO, WHO, and CAREC provided a technical foundation for the response to the outbreak. Thanks to the excellent collaboration between the Ministry of Health and various units of PAHO, as well as the assistance of Brazil, Guyana, and Nicaragua, the transmission of malaria was interrupted rapidly in Exuma.

186. Since 2003, action plans have been carried out in Nicaragua in the 36 *municipios* with the greatest transmission of malaria. These efforts are directed especially to vulnerable groups, many of them indigenous, living in remote and high-poverty areas. These *municipios* have only 26% of the country's population but account for 93% of the burden of disease from malaria. In the period 2003–2007, cases of malaria declined 54%; the annual parasite index has fallen from 1.20 to 0.55 per 1,000 population. The index of positive slides in 2006 was 0.65%, the lowest in the history of the malaria program. Beginning in 2006, and for the first time in the history of the epidemiological surveillance system for malaria, the data on positive cases were disaggregated by ethnic group. As part of the Roll Back Malaria initiative, PAHO has promoted adoption of the 7-day treatment for a radical cure. It has provided systematic support for the interventions and for continuous monitoring of the action plans.

**Regional program of malaria vector control without the use of DDT  
in Central America and Mexico**

In order to combat the adverse effects of DDT (dichloro-diphenyl-trichloroethane) and other persistent insecticides on human health and the environment, the Regional Program of Action and Demonstration of Sustainable Alternatives to DDT for Malaria Vector Control in Mexico and Central America was launched in August 2003 in Belize, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, and Panama. The program, whose objective is to demonstrate the effectiveness of alternative methods of vector control that do not entail the application of DDT, has shown very good results.

The Regional Program, financed by the Global Environment Facility (GEF) over three years, represents the second phase of a project that in its first phase (2000–2002) consisted of collecting information about the use of DDT and about malaria control measures in the subregion. It is one of the first projects in the world to implement the recommendations of the Stockholm Convention on Persistent Organic Pollutants, adopted in 2001. In the countries where it has been applied, but especially in Mexico, the Regional Program has demonstrated that the malaria vector can be controlled without DDT, using comprehensive measures based on community participation and on collaboration between governmental entities, NGOs, and civil society.

***The response to avian and pandemic influenza***

187. In accordance with the International Health Regulations of 2005 (IHR 2005) and with the mandates of the Governing Bodies and of the Fifth Summit of the Americas of November 2005, PAHO has supported the Member States in developing plans of national preparedness for a flu pandemic. When the virus mutates into a new strain that can be transmitted from person to person, disease can spread rapidly, resulting in a pandemic capable of exhausting the resources of the Member States. The possibility that a strain with such characteristics could arise has forced the countries to put in place national preparedness plans. Fortunately, the H5N1 virus, which causes avian flu and which is

very pathogenic, continues to affect mainly domestic birds, with very sporadic cases in human beings. To date, no case of an animal infected in the Americas has been reported.

188. By May 2007, all Member States were carrying out activities in preparation for an influenza pandemic, and PAHO had received proposals for national plans from 28 Member States. All countries had received training on risk communication and outbreak notification as part of the process of alertness and preparation for a possible flu pandemic. Workshops were held that stressed the need to strengthen communication before, during, and after an outbreak.

189. PAHO technical cooperation has aimed at strengthening the core competencies of the Member States to detect and respond to unusual or unexpected situations, as established by the IHR 2005. In order to strengthen early warning systems in the countries, a new generic protocol for influenza surveillance was prepared with the CDC; according to this protocol, any isolated case caused by a new viral subtype has to be reported immediately to WHO. Introduction of the protocol has begun in the Caribbean and Central America and in the Southern Cone. In the Caribbean subregion, its implementation is under way in seven countries, coordinated by CAREC and by the focal points of the ECC. Laboratories have also been strengthened in the countries and the vaccine against seasonal flu has been introduced gradually into the Region.

190. PAHO has established at its Headquarters an Emergency Operations Center with networking capacity, computers, communications, software, and other equipment needed to coordinate the Organization's response to emergencies. PAHO has also helped train national staff members in communication during outbreaks and crises and has helped the countries establish detailed communication strategies as part of their preparedness plans. In July 2006 a workshop on training of instructors was held in Washington, D.C., with the participation of 80 staff members from almost all the countries of the Americas. Currently, all the countries of the Region have at least one trained instructor.

191. In July 2006 PAHO sponsored the Inter-Agency Communication Framework for Avian and Pandemic Influenza in the Americas, and it has coordinated information sessions for the U.S. Congress, the Board of Governors of the Inter-American Development Bank, the Permanent Council of the OAS, the U.S. State Department, and the World Bank. As a result of these encounters, an interinstitutional project on avian and pandemic influenza has been carried out by PAHO and the IDB.

192. The PAHO/WHO Country Offices have served as coordinators of the national teams of the United Nations agencies for avian and pandemic influenza in 25 of 28 countries that have U.N. offices. These activities have been carried out with economic support from USAID, the CDC, the IDB, WHO, and CIDA.

193. Uruguay is an example of a country that has prepared for an eventual flu pandemic with effective coordination and community participation and that has created a work plan for coping with outbreaks, epidemics, accidents, and disasters. Uruguay's strategy has been characterized by decentralization and local development of preparation activities. A subregional workshop, a national workshop, and three departmental workshops have been held in the country.

194. The Dominican Republic has prepared a pandemic plan with the cooperation of PAHO and with regional support and support from USAID and the Inter-American Institute for Cooperation on Agriculture (IICA), among other entities. The plan includes the development of mass communication and prevention of risks in the most vulnerable groups, especially health workers, farmers, and agricultural workers. The country now has technical personnel trained in laboratory techniques, rapid response equipment for emergencies, and a contingency and preparation plan for avian flu.

#### **Cuba is prepared for avian and pandemic flu**

Cuba has developed a national preparedness plan for avian flu in which several institutions and levels of management participate. The Ministry of Public Health and the Ministry of Agriculture are in charge of monitoring and executing the plan.

The country has participated in various international meetings for the training of staff members in the different sectors that are involved in these plans (public health, agriculture, veterinary medicine, communication). This complements the preparation of national human resources in other areas, such as regulations and standards, services, surveillance, response to outbreaks, vaccination, impact measurement, and evaluation of plans.

The management of information and knowledge has been systematized and instruments have been created for self-evaluation and impact measurement. Improvements have also been made in the process of planning and organization through action plans and implementation of a generic surveillance protocol. PAHO in Cuba was responsible for the technical aspects of the contingency plan used by United Nations personnel in the country to confront the threat of avian flu.

### **Tropical and Neglected Diseases**

195. In Latin America and the Caribbean there is an enormous burden of morbidity from tropical diseases and zoonoses. These diseases are mainly found in the rural areas and their transmission is facilitated by the poor housing conditions characteristic of underdevelopment. Hence the fight against these diseases is closely linked to several of the MDGs.

196. In the context of the MDGs, PAHO has undertaken an initiative against the so-called neglected diseases, whose victims tend to belong to the poorest and most vulnerable strata of societies located in tropical and subtropical regions. Over the years the health sectors and the pharmaceutical companies, focused on other priorities, have shown very little interest in these diseases, even though they constitute a serious obstacle to development and to human well-being because of their great economic and social impact.

197. They include, among others, Chagas' disease (neglected in certain parts of the Region despite notable progress in its control in the Southern Cone), Buruli ulcer, yellow fever, cholera, foodborne trematode infections (such as fascioliasis), some treponematoses (congenital syphilis among them), the Hantaan virus infection, plague, cysticercosis, leishmaniasis, hydatidosis, leptospirosis, lymphatic filariasis, onchocerciasis, schistosomiasis, the geohelminth infections, trachoma, and hemorrhagic fevers of viral origin (except for dengue hemorrhagic fever, which is not considered neglected). The victims of these afflictions often suffer disabilities that prevent them from living normal lives and make them prone to social marginalization.

198. There are several programs in the world to eliminate or control the geohelminth infections, schistosomiasis, onchocerciasis, and lymphatic filariasis, and their lines of action have been applied in the Region. WHO and PAHO have issued resolutions to eliminate onchocerciasis and lymphatic filariasis as public health problems, and over the quinquennium PAHO has implemented its Regional Program on Parasitic and Neglected Diseases, an initiative that seeks to prevent, treat, or eliminate many of these diseases simultaneously using an integrated, interprogrammatic, and intersectoral approach. This type of approach has special usefulness in the fight against parasitic and neglected diseases since some interventions are effective against several of them.

199. PAHO has noted the need to abandon vertical programs characterized by the centralized definition of policies. Some neglected diseases are currently being targeted by small-scale interventions in Belize, Bolivia, Brazil, the Dominican Republic, Ecuador, Haiti, Honduras, Nicaragua, and Suriname. Efforts are under way to strengthen partnerships with the international development banks, the World Food Program, NGOs, and pharmaceutical companies, which donate the drugs needed to sustain the elimination programs. Everywhere, there is a need to enhance community participation and strengthen infrastructure and the cadre of trained staff.

### *Chagas' disease*

200. An estimated 40 million people in the Region are at risk of contracting Chagas' disease. Control of this disease in several countries was neglected for many years due to its image as a disease of rural areas and of very poor populations living far from the urban centers.

201. The regional Chagas' disease program, located in Uruguay, has played an active role in the international fight against the disease through four subregional initiatives covering the Southern Cone, Central America, the Amazon area, and the Andean subregion. Before 2003 a reduction of 94% had already been achieved in the incidence of Chagas' disease in seven countries of the Southern Cone, and on June 9, 2006, the Southern Cone Intergovernmental Commission to Eliminate *Triatoma infestans* and Interrupt the Transmission of Transfusional Trypanosomiasis certified the interruption of vector-borne transmission in Brazil, a stage that is technically indispensable for later elimination of the vector.

202. In the Andean subregion an active struggle continues through the Initiative of the Andean Countries to Control Vectoral and Transfusional Transmission of Chagas' Disease, which held three subregional meetings during the quinquennium 2003-2007.

203. During the quinquennium 2003–2007, PAHO's regional Chagas' disease program has continued technical cooperation activities and has taken advantage of the partnerships already forged with agencies such as the Japan International Cooperation Agency, CIDA (Canada), Doctors without Borders, the Inter-American Development Bank (IDB), the Red Cross, and the European Communities. Its mission is to provide technical cooperation to those countries where the disease is endemic with a view to interrupting the household vector-borne transmission of *Trypanosoma cruzi*, contributing to the interruption of the transfusional transmission of the parasite, and improving the diagnosis, treatment, and surveillance of the disease.

204. Based on the good results obtained in the Southern Cone, PAHO has been promoting the Initiative of the Countries of Central America for Control of Vector-Borne and Transfusional Transmission and Medical Care for Chagas' Disease (IPCA), which was launched in Tegucigalpa, Honduras, in 1997. Within the framework of this initiative, PAHO and the Japan International Cooperation Agency (JICA) have been collaborating to promote control of Chagas' disease in Guatemala since 2000 and in Honduras and El Salvador since 2003.

205. The projects of JICA and PAHO in Central America are coordinated with those of other international agencies, such as CIDA (Canada) and World Vision. PAHO provides technical cooperation and evaluates the project activities. The coordination among several donors is particularly evident in Honduras, where the Ministry of Health has produced a national strategic 5-year plan with which all the donors are harmonizing their activities. JICA has placed a regional adviser in the PAHO/WHO Country Office in Honduras in order to further strengthen its collaboration with the IPCA. The coordination achieved in Honduras stands as an example for the international community.



### **The fight against Chagas' disease yields good results in Guatemala**

The principal vector of Chagas' disease in Guatemala is *Rhodnius prolixus*, which has been found in 10 departments of the country (nearly 50% of the national territory). In 2002 an estimated 4,022,000 inhabitants (36% of the Guatemalan population) were considered at risk of contracting the disease. That year saw the start of vector control interventions in the country, mainly against *R. prolixus*; treatment of all patients under 15; and expanded coverage of blood donor screening.

JICA and Doctors without Borders have played a key role in the struggle against Chagas' disease in Guatemala. For its part, the Guatemalan government has participated in the contracting of human resources, the execution of operational actions, and the expansion of blood donor screening, and it has contributed funds equivalent to double the amount that has been contributed by international cooperation.

Guatemala has eliminated *R. prolixus* and managed to control *Triatoma dimidiata*; as a result, seroprevalence in children declined from 12% to 1% in the last five years. It is expected that transmission will have been eliminated in the country by 2010.

Previously, Guatemala accounted for about 33% of the population at risk of contracting Chagas' disease, 41% of the seroprevalence, and 45% of the annual acute cases in Central America. Therefore, the interruption of vector-borne and transfusional transmission of Chagas' disease in Guatemala as a result of the actions against it served to significantly reduce the burden of the disease in the subregion. The good results obtained in Guatemala and the excellent interagency coordination made possible the financial intervention of JICA in El Salvador and Honduras, with plans for Nicaragua and for a second phase in Guatemala, of CIDA in Honduras, and of Doctors without Borders in Nicaragua.

### ***Leprosy***

206. Leprosy is a curable disease, and thanks to good case-finding and the global application of an effective multidrug therapeutic regimen, it has stopped being a public health problem in various countries. In the majority of the Caribbean countries, where the disease was most prevalent in earlier times, the incidence has been reduced to a few isolated cases per year, although Guyana, Jamaica, St. Lucia, Suriname, and Trinidad and Tobago continue to have slightly higher incidence than the rest. CAREC has provided assistance in three of those countries, with a subsidy of \$166,000; Suriname receives direct assistance from Netherlands Leprosy Relief (NLR). The Caribbean countries where leprosy continues to exist have related dermatological services. Nevertheless, some health systems have incorporated vertical components for leprosy control. In accordance with the global strategy developed by WHO, PAHO makes an effort to integrate control activities into the PHC system.

207. Paraguay, where the prevalence of leprosy has traditionally been high, the disease was eliminated as a national public health problem in 2001, and in 2003 PAHO helped carry out the second monitoring exercise in connection with elimination activities. The

results obtained led to the development and review of plans of action for eliminating the disease subnationally. In 2005, patient care and follow-up were integrated into PHC activities in different parts of the country, and in 2006 and 2007 efforts have focused on strengthening the leprosy program's institutional capacity centrally and in the five areas of the country given the highest priority.

208. Another case worth noting is that of Brazil, which has the second-highest annual incidence of leprosy in the Region and is one of five countries that have not yet eliminated the disease. In 2006, 47,612 new cases were found within the national territory, 15% of them in persons younger than 15 years. Fortunately, leprosy is one of the diseases that the government prioritizes, and control activities have been integrated into basic health services. More than 64,000 people in the country receive multidrug therapy. Thanks to the coordinated actions of the health sector, PAHO, two PAHO/WHO collaborating centers and other entities, Brazil has achieved its national goal for the reduction of leprosy and hopes to reach its goals for the subnational level by 2010 through combined strategies.

209. With PAHO's technical cooperation and the support of the Sasakawa Foundation and of the German Leprosy Relief Association, the countries have taken steps to eliminate the disease as a public health problem.

### *Yellow fever*

210. Yellow fever is a sylvatic disease in South America and in some countries of the Caribbean where ecological conditions permit the presence of competent vectors and of susceptible vertebrates. In the Region, the countries with enzootic areas are Bolivia, Brazil, Colombia, Ecuador, French Guiana, Guyana, Panama, Peru, Suriname, Trinidad and Tobago, and Venezuela. From 2003 to 2007, five of these countries reported a total of 596 cases, mainly of sylvatic transmission affecting farmers, travelers, ecotourists, and immigrants without immunity who penetrated danger zones.

211. The most severely affected countries have made great advances toward control of yellow fever thanks to the adoption, with PAHO's support, of national plans that include vaccination of the inhabitants of enzootic areas and of the areas where immigrants tend to originate. In particular, Bolivia, Colombia, Peru, and Venezuela have included yellow fever vaccine in their national routine immunization series for children 1 year of age.

212. Since implementation of the yellow fever control plans, a reduction of cases has been observed in the Region. However, it is important to continue immunizing inhabitants of the high-risk areas and areas of emigration, as well as to maintain high vaccination coverage in the new 1-year-old cohorts in countries with enzootic areas.

### *Hydatidosis*

213. There has been major progress with respect to hydatidosis (or hydatid cyst) in Latin America and the Caribbean, where PAHO has strengthened measures to eradicate the disease in Argentina, Bolivia, Brazil, Colombia, Paraguay, Peru, and other countries. According to the World Organization for Animal Health, some areas of the Region are already free of hydatidosis.

**Project to eliminate hydatidosis from the Island of Tierra del Fuego, Chile,  
and to control it in neighboring territories**

At the end of the 1970s, the prevalence of hydatidosis in canines, cattle, and sheep exceeded 45%, 80%, and 55%, respectively, in both the Argentine part and the Chilean part of the Island of Tierra del Fuego. Interventions have been carried out since then to reduce this prevalence and mitigate the danger of infestation in the human population. As a result, in the 1990s the prevalence of hydatidosis in sheep fell to less than 7%. However, control activities have been weak for the last several years, and not only has the disease not been eliminated, but there is the risk of losing the gains made to date.

In response to expressions of interest on the part of Argentina and Chile, PAHO recently approved a project of technical cooperation among countries whose purpose is to analyze the political, technical, institutional, and financial viability of formulating a control program to eliminate hydatidosis from the Island of Tierra del Fuego. If such a control program succeeds, it would be the first time in the Americas that the disease is eliminated from a territory where it has been endemic. This in turn would create the conditions for more effective control of hydatidosis in the continental part of both countries, especially in the provinces of Punta Arenas and Última Esperanza in Chile and Santa Cruz in Argentina.

### *Lymphatic filariasis*

214. This disease affects more than half a million people in the Region, with another 6 to 8 million, at a minimum, at risk of contracting it. There are seven countries in Latin America and the Caribbean where lymphatic filariasis is endemic (Brazil, Costa Rica, the Dominican Republic, Guyana, Haiti, Suriname, and Trinidad and Tobago), but in three of them (Costa Rica, Suriname, and Trinidad and Tobago) the absence of transmission has been confirmed. In fact, everything indicates that the Region could become the first in the world to eliminate the disease, thanks to important regional advances in morbidity control and operations research as well as the many alliances and associations that have been forged among the different countries, the international community, various NGOs, and the private sector. In the context of WHO's Global Programme to Eliminate Lymphatic Filariasis, PAHO and GlaxoSmithKline (GSK) have joined the struggle to eliminate the disease from the continent.

215. Operations research activities have been extensive throughout the Region. Health professionals in Brazil, Haiti, the Dominican Republic, and Trinidad have kept up a

continuous exchange of experiences that soon will extend to the use of geographic information systems to map the transmission foci. PAHO's partners in the Region, both business and institutional, especially the Bill & Melinda Gates Foundation, have contributed substantial support during the 5-year period. The Lymphatic Filariasis Support Center at Emory University in the United States, the School of Tropical Medicine in Liverpool, England, and the PAHO/WHO collaborating center on lymphatic filariasis that is located in the U.S. Centers for Disease Control and Prevention (CDC) have continued to support control activities in the Americas.

### ***Leishmaniasis***

216. The cutaneous and visceral types of leishmaniasis constitute a growing problem in the rural and peri-urban areas of many countries of the Region, from the north of Argentina all the way to the south of Texas in the United States, with almost 35,000 reported cases in Brazil in 2003 alone. Muco-visceral leishmaniasis, a disfiguring variant that can follow the cutaneous disease, is endemic in Mexico and in some countries of Central America and South America. Peru has a high prevalence of leishmaniasis, especially the cutaneous type. Chile and Uruguay are the only countries in the Region that have not reported cases. However, underreporting or lack of information is common in the areas where these diseases are commonly found.

217. The Region has a Regional Program on Leishmaniasis that collaborates with the Regional Program on Parasitic and Neglected Diseases. Its activities include establishing sentinel sites for surveillance, finding new and less expensive drugs, increasing access to the health services, promoting research, formulating guidelines for diagnosis and case definition, setting up working groups in the countries, and evaluating the results of interventions.

218. Leishmaniasis is a priority disease for the Special Program for Research and Training in Tropical Diseases of UNICEF/UNDP/World Bank/WHO (TDR), which works with the PAHO Communicable Disease Research Program.

### ***Onchocerciasis***

219. Nearly half a million people in the Region are at risk of contracting onchocerciasis, also known as river blindness. Within the Region, this disease poses an especially serious problem in an extensive area of remote communities on the Amazon border between Brazil and Venezuela. Elimination of the disease is the goal of a multinational and multi-institutional initiative based in Guatemala and known as the Onchocerciasis Elimination Program for the Americas. The activities of this program focus on the six countries where the disease is endemic—Brazil, Colombia, Ecuador, Guatemala, Mexico, and Venezuela—and consist mainly of promoting the large-scale

administration of ivermectin every six months, with the goal of treating a minimum of 85% of the population at risk of getting sick over a 12- to 14-year period. PAHO participates actively in this program, together with the Merck pharmaceutical company, the CDC, the Carter Center, the Lions Clubs International Foundation, and various academic institutions in the Region. The activities undertaken in the Region are linked with the Global Initiative for the Elimination of Avoidable Blindness, also known as Vision 20/20: The Right to Sight, which was launched in 1999 as a partnership between WHO and the International Agency for the Prevention of Blindness.

220. In 2003, all the countries with endemic onchocerciasis reached the target coverage with drug therapy. That level of coverage has been sustained since then, making it feasible to aim at cutting transmission in half by the end of decade. As a result of this progress, there have been no new cases of blindness caused by the disease and interruption of transmission has been achieved in six of the 13 endemic areas. In the fall of 2003 it was estimated that \$15 million would be needed in order to eliminate onchocerciasis from the Region by 2010. Toward that end, the Bill & Melinda Gates Foundation made an initial contribution of \$5 million and urged other donors to contribute the same amount, promising to match each donation. With the support of over 70 donors, the necessary funds were mobilized four years before the deadline. The goal of eliminating onchocerciasis from the Americas is close to being fulfilled.

### ***Trachoma***

221. This disease, which can cause blindness by damaging the ocular conjunctivas, continues to be hyperendemic in Brazil, Guatemala, and Mexico. PAHO has been applying the “SAFE” strategy (surgery, antibiotics, facial cleanliness, and environmental improvement) developed by WHO. This strategy aims to eliminate the disease worldwide, using a community approach in the context of PHC and as part of the Alliance for the Global Elimination of Blinding Trachoma by the Year 2020 (GET 2020). Component E of the strategy depends to a great extent on education, environmental sanitation, and poverty reduction, so that any progress in this regard will be measured in light of the fulfillment of the MDGs. As in the case of onchocerciasis, many of the activities to combat the disease in the Region are linked with the Global Initiative for the Elimination of Avoidable Blindness.

### ***Congenital syphilis***

222. Congenital syphilis can be prevented with a single dose of penicillin. Nevertheless, it is estimated that in Latin America and the Caribbean more than 100,000 children are born every year with the disease. In order to help the countries to combat the problem, PAHO has spearheaded the creation of an interprogrammatic group that will work to strengthen preventive measures at the regional level. PAHO is also collecting

epidemiological data in order to have figures of reference and is conducting a study in three countries to determine the magnitude of case underreporting, which is believed to be extensive. It has also modified the perinatal clinical file in an effort to facilitate detection and early treatment of the disease and improve the incidence statistics.

### ***Schistosomiasis and geohelminth infections***

223. Schistosomiasis and soil-transmitted helminth infections continue to be the parasitic diseases of highest prevalence in the world. PAHO estimates that 20% to 30% of all Latin Americans are infected by intestinal parasites and that this figure rises to 50% in the poor strata and to 95% in some indigenous tribes.

224. Several countries have recognized the magnitude of the health problem caused by schistosomiasis and soil-transmitted helminth infections and have carried out control activities for years, with excellent results. In Brazil, morbidity and mortality due to schistosomiasis have been dramatically reduced. Other countries, such as the small Caribbean island nations, Puerto Rico, and Venezuela, are coming closer to the goal of elimination or have already reached it.

### **Drinking Water and Sanitation**

225. The poverty that exists in many sectors of Latin America and the Caribbean is associated with precarious sanitation conditions that leave the population vulnerable to many communicable diseases. It is estimated that in 2000 around 45% of the rural populations of Latin America and the Caribbean lacked access to drinking water and basic sanitation systems, a clear manifestation of the marked inequities between the poorer and the more privileged sectors of society. Fortunately, during the quinquennium the majority of the countries in the Region, supported by PAHO and many other entities, have obtained encouraging results in this area. On this basis it is possible to predict that by the end of 2007, the goal of reducing by 25% the deficit in drinking water supply and sanitation services in Latin America and the Caribbean will have been reached, although not in the rural areas of the poorest countries.

226. By May 2007, some 10 countries (28% of the Member States) had national policies, and nearly 20 (55%) had national plans for solid waste management. In countries such as Colombia and Peru, local authorities have prepared very complete general plans, as required by law, while in others, such as Argentina, Brazil, Cuba, Mexico, and Uruguay, master plans for the disposal and treatment of solid waste have been prepared for the larger cities.

227. PAHO, together with WHO, has prepared new standards for air quality and is putting them into effect in the Region. The standards are being disseminated

electronically and in print. A regional publication has been prepared on the effects of air pollution, pointing out some of the measures being taken in that field by Latin America and Caribbean countries. Information in the publication mainly concerns certain metropolitan areas of Argentina, Bolivia, Brazil, Chile, Colombia, Cuba, Ecuador, Mexico, Peru, and Puerto Rico, where the majority of program activities entail the ongoing control of air pollution and the determination of its origin. Some countries, such as Bolivia, Peru, and Puerto Rico, have created cooperative programs with the support of other international programs such as Swisscontact and the U.S. Environmental Protection Agency (EPA).

228. In June 2005, the Meeting of Health and Environmental Ministers of the Americas was held. It was attended by then WHO Director General Dr. Lee Jong-wook, who gave the opening speech. During the meeting, the Declaration of Mar del Plata was issued, calling for regional cooperation in three major areas: the integrated management of water resources and solid residues; the safe handling of chemical substances, and children's environmental health, for which PAHO is responsible.

229. In the Dominican Republic, diseases associated with the poor quality and low coverage of water and sanitation services contribute enormously to infant mortality, which was estimated in 1997 and 2002 at 31 per 100,000 live births, according to the latest demographic survey, DHS 2002. In order to fulfill one of the goals of the seventh MDG, the Dominican Republic has implemented a strategy targeted at the populations of rural areas and urban fringe neighborhoods that lack adequate drinking water and sanitation services. The strategy has consisted of the monitoring and the national evaluation of the goal, institutional arrangements, the development of new technologies, and the strengthening of programs for health surveillance and interinstitutional coordination.

### **Comprehensive Program on Sustainable Development and Environmental Health of PAHO and the Caribbean Environmental Health Institute (CEHI)**

There is a long history of collaboration between the Caribbean Environmental Health Institute (CEHI) and PAHO, which provided technical assistance and technical cooperation to establish the Institute as part of the Caribbean Community and Common Market (CARICOM). These ties have been further strengthened with the Caribbean Cooperation in Health initiative, for which the CEHI acts as the agency in charge of environmental and health issues.

PAHO intends to strengthen the ties between the two agencies in order to respond more effectively and with greater synergy to the needs of the countries, and to facilitate a more solid common program for the countries of the Eastern Caribbean.

PAHO and CEHI have agreed to collaborate to create and launch a comprehensive environmental health program for the Caribbean area. The objective of the agreement is to strengthen the technical cooperation that PAHO and CEHI provide to the Caribbean countries and to promote joint action aimed at improving the use of resources and helping to improve health and environmental conditions in the countries.

The relationship is strengthened by the experience of the PAHO technical advisers within the CEHI, especially the Environmental Health Adviser (EHA), and it aims to create a program structured in close collaboration with the environmental health officials in the Caribbean ministries of health and with other stakeholders committed to sustainable development.

### **Household Environmental Pollution**

230. Household environmental pollution is related to smoking and to the use of fossil fuels and biomass as sources of energy for cooking and home heating, which continues to be common in the rural and peri-urban areas of some countries. In 2005, PAHO organized a series of five-day training workshops to begin to create regional capability with regard to control of household contamination and use of fossil fuels in dwellings.

### **Occupational Health**

231. To the eight countries that had systematically adopted surveillance systems in this field—Argentina, Brazil, Chile, Colombia, Jamaica, Mexico, Panama, Uruguay—have been added Ecuador and Venezuela, with new information systems for occupational accidents that are of special usefulness for the health sector. Brazil and Chile have also initiated the control and reporting of silicosis cases as part of their national surveillance systems. The participation of the WHO Collaborating Centers—the National Institute for Occupational Safety and Health (NIOSH) of the United States, the National Public Health Institute (INSP) of Chile, the Chilean Safety Association (ACHS), and FUNDACENTRO of Brazil—facilitates the attainment of these objectives.



232. The adoption of a “toolbox” to improve workplace environments in Central America continues to be extended to additional industrial sectors. To date, 160 companies have established health and safety committees thanks to a partnership between PAHO and FUNDACERSSO as well as financial support from the OAS and the Ministry of Labour of Canada.

#### **Peru attends to its unfinished agenda in environmental health**

Peru is taking steps to complete its unfinished agenda with regard to environmental health as part of an effort to protect human rights in the area of health and reduce health inequities in the country. To document the status of environmental health, Peru, with the assistance of PAHO, has used several indicators that reveal unequal access to drinking water and sanitation: the Lorenz curve, the Gini coefficient, the rate of exclusion, the inequality index, and the index of investment in health. A state-of-the-art geographic information system based on Google Earth has also been created in order to better visualize the territorial distribution of these inequities.

The use of these methods of analysis and communication has made it possible to analyze health status in greater depth and has played a decisive role in the inclusion of various programs and actions in the central government’s work plan. These include the Water for All program, which seeks to extend coverage of drinking water services to 97%, and the National Water and Sanitation Plan, which has already exceeded the goal of sanitation coverage of 77% by 2015. Since the MDGs set goals for sanitation and drinking water of 76% and 87% by 2015, respectively, Peru has already reached the goal for sanitation and will reach the goal for drinking water without difficulty. The country has also carried out construction of safe dwellings through several projects, and in some departments a large project has upgraded kitchens to reduce household environmental pollution and the incidence of acute respiratory infections in the Andean highlands.

## **CHAPTER 3: HEALTH ACHIEVEMENTS AND SOCIAL PROTECTION IN HEALTH**

### **Extension of Social Protection in Health**

233. In the early years of the 21st century, the inclusion of poverty, social exclusion, and inequity on the political agendas of countries and international organizations led to increased discussion about social protection. The institutional space in which public policies must be formulated and implemented has gained greater importance in the regional context. It is characterized by four elements: (a) questioning the sectoral reforms of the 1980s and 1990s; (b) lack of a cohesive social protection network capable of serving as a foundation for social development in the new context; (c) commitment to achievement of the MDGs by 2015; and (d) concern about persistent inequity, social exclusion, and poverty in the countries of the Region.

234. Within the framework of PAHO technical cooperation, social protection in the field of health considers four conditions that are directly related to the determinants of health exclusion. These conditions are access to services; economic security of households and families; collective financing; and health care with quality, dignity, and sensitivity to cultural diversity.

235. During the past five years, an attempt has been made to replace or supplement the traditional organization of health systems in the Americas with new models. Some of these models entail significant changes in government organization as regards formulation and implementation of social policies. Some examples are the Unified Health System in Brazil; the Ministry of Social Protection in Colombia; the Social Security System in Health in the Dominican Republic; National Health Insurance in Aruba, Bahamas and Trinidad and Tobago; and the Explicit Health Guarantees system in Chile.

236. Other countries have opted for creation of limited plans for financing and provision of health goods and services. These plans focus on improving access to health care and health outcomes observed in specific population groups. Such plans include Chile Solidario; Maternal and Child Universal Insurance (SUMI) in Bolivia; Comprehensive Health Insurance (SIS) in Peru; Social Protection Health System (SPS) in Mexico; the Free Maternity and Infant Care Act in Ecuador; Maternal and Child Provincial Health Insurance in Argentina; Mission into the Neighborhood (MBA) in Venezuela; Extension of Coverage to Rural Populations in Guatemala, El Salvador, and Honduras; and the family protection policy in Nicaragua. In 2006, there were 16 countries in the Region that had or were preparing strategies or interventions to extend social protection in public health to mothers and children, particularly in poor strata and the informal labor sector.

237. In November 2006, the “Social Protection in Health for Women, Newborn, and Children in Latin America and the Caribbean: Lessons Learned To Prompt the Way Forward” Regional Forum was held in Tegucigalpa, Honduras. The project, which was organized by PAHO, and also sponsored by the United States Agency for International Development (USAID), the Spanish Agency for International Cooperation (AECI), and the Swedish International Development Agency (SIDA), examined the general situation of social protection in health in the Region and issued recommendations for extending protection to the maternal, neonatal, and child population in all countries. The information served as a basis for the “Social Protection in Health Schemes for Mother and Child Populations: Lessons Learned from the Latin American Region” document prepared by PAHO.

**The 13th Ibero-American Social Security Congress was held  
in Salvador de Bahia, Brazil**

Since the First Ibero-American Social Security Congress was held in Barcelona in 1950, several countries in the Region have adopted social protection programs, or have expanded or changed the programs they already had in order to improve the protection offered, management models, and financing methods. These changes have been discussed in the different Ibero-American congresses held since then, including the congress that took place from 23 to 26 March 2004 in Salvador de Bahia, Brazil.

At this congress, agreement was reached on measures to be taken to expand social security system coverage, particularly as regards social and health services, seeking to achieve optimum transparency, effectiveness and efficiency, and establish mechanisms to prevent improper use of special privileges and benefits. The countries also agreed to safeguard equality of opportunities and combat all types of discrimination, as well as establish mechanisms that are flexible enough so that part-time workers and workers hired for short time periods will have the same access to social protection systems as other workers.

### **National Social Security in Bahamas**

From 2002 to 2007, Bahamas created a Social Security system following the recommendations of an accreditation committee designated by the prime minister.

The initiative involved consultation with interested parties, providing technical training on the principles of national social security, and formulating proposals in order to strengthen the health system and insurance. One of the main objectives was to improve equitable access to health care by seeking to eliminate the obstacles that prevent it, particularly those faced by persons without private insurance that are unable to pay for services not provided by the public health system.

PAHO provided technical assistance to the accreditation committee during review of the different financing options, and helped prepare the proposal.

Bahamas decided that the Canadian Integrated Public Health Information System (i-PHIS) was the one that was most suitable for its needs. A provisional draft was prepared in order to test the system during a pilot phase, which was conducted in 2003 and 2004, and evaluated at the end of 2004.

The i-PHIS is an automated and integrated program for reporting and control of medical records, which can be accessed at the site where services are provided by all health care providers. The program improves the continuity of health care. Moreover, it includes the information required to evaluate the health status of the entire population as well as specific subgroups. Consequently, it facilitates the study of most vulnerable groups as well as gaps in the health status of the population.

238. The Commission on Social Determinants of Health was established by WHO in 2004 for the purpose of making recommendations based on the available scientific evidence regarding interventions and policies for modifying the social determinants of health and reducing health inequities. In the Region of the Americas, the Commission was launched in Chile in 2005, and subsequently other countries established their own national commissions on the social determinants of health.

239. With support from the OAS and the governments of Brazil and Chile, in April 2007 a consultation process with civil society took place in Brasilia in which the governments of the Region and international organizations were urged to commit themselves to supporting the process initiated by creating the Commission. After these events, PAHO conducted a series of consultations and carried out a global continuing education effort for the benefit of its staff, government officials, and members of academia.

### **The legacy of the sectoral reforms of the 1980s and 1990s**

240. In the framework of the macroeconomic reforms of the 1980s and 1990s, several countries in the Region reformed their health systems in order to increase cost-efficiency, economic sustainability, and decentralization, and provide a more prominent role for the private sector.

241. In general, health sector reforms were carried out without taking into account the characteristics of each country, nor the degree of development of their health institutions. Rather, the multilateral economic aid agencies promoted certain standardized models that focused on certain financial and administrative changes, deregulation of the labor market, and decentralization. The reforms gave little attention to the effect these changes could have on certain groups, particularly on health care workers. There was no connection between different functions of the systems, and the national health objectives were not defined. Although the reform processes were oriented towards development of a regional work plan that promoted pluralism, efficiency, and quality in provision of health services, in practice it led to a reduction in the government's steering capacity. There was a general weakening of health system operation and matters related to public health were relegated to a secondary role.

242. As part of the efforts to remedy the situation, the International Course on Development of Health Systems was held in Nicaragua from 17 April to 6 May 2005. This course was designed for health care professionals, and high and intermediate level managers. It was organized and planned on a joint basis by PAHO, the Swedish International Development Agency (SIDA), and different educational institutions in the Region.

### **Progress toward the Renewal of Primary Health Care in the Region of the Americas**

243. Following approval of the Regional Declaration on the New Orientations for Primary Health Care (Declaration of Montevideo) by the 46th Directing Council in September 2005, several countries in the Region have renewed their efforts to include the values, principles, and essential elements of primary health care (PHC) as a strategy for development of their national health systems. Furthermore, the priority currently granted to primary health care by WHO has been another powerful factor to promote the commitment by PAHO, which was reaffirmed in 2003, to restore the spirit of Alma-Ata and adapt it to the new social context.

244. PAHO promotes an initiative to determine the status of good PHC practices in each country in the Region. It collaborates in a project promoted by the GAVI Alliance to strengthen health services in Bolivia, Cuba, Haiti, Honduras, and Nicaragua. PAHO also participates in a project based on an agreement with the government of Antioquia, Colombia, in order to integrate the Food and Nutrition Improvement in Antioquia (MANA) program, Integrated Management of Childhood Illness (IMCI), and primary health care projects in the country. The organization is creating an international network of centers of excellence in the field of primary health care with the participation of academia and the health services, in order to promote generation and circulation of scientific evidence in this area. In its recent position paper regarding renewal of primary

health care, PAHO has expressed its viewpoint on reorientation of the health sector and strengthening health systems in the Region. Furthermore, in April 2007 the *Pan American Journal of Public Health* dedicated a special issue to PHC.

245. At the primary care level, other initiatives are also being implemented in order to improve the quality of PHC services. One of these is an accreditation project for primary health care networks based on a system validated by pilot tests in Brazil, Costa Rica, and Nicaragua. Another project is an evaluation instrument for clinical management, while a third project, in the preparatory phase, seeks to improve home and community care for older adults, particularly those with functional limitations, in several capitals in the Region.

#### **A comprehensive health care model in Nicaragua**

In 2007 Nicaragua designed and implemented the comprehensive health care model (MAIS). This model is characterized by a biopsychosocial approach; comprehensive, accessible, longitudinal, and continuous care; and an emphasis on promoting health and preventing disease. The model, which is based on the primary health care strategy, focuses on the family, community, environment, and the individual. It seeks to guarantee a series of public health services throughout the life cycle. In addition to the health care component, the model has components for provision, management, and financing.

Provision of services to the population is based on two basic foundations: (a) delimitation of space in sectors with up to 3,000 inhabitants in the rural area and 5,000 inhabitants in the urban area, and (b) assignment of a basic health care team (EBA) made up of a physician and two nursing staff members in each sector. The MAIS includes popular education on health as an essential element for achievement of healthy lifestyles. It organizes public health facilities so that they are oriented towards: (a) improving the health conditions of the Nicaraguan population, (b) satisfying the need for health services, (c) protection from epidemics, (d) improving the quality of services, and (e) strengthening inter-institutional and intersectoral relations. The MAIS includes activities for promotion, protection, health recovery, and rehabilitation.

246. At PAHO Headquarters, the different technical areas are including the PHC strategy in their technical cooperation projects. The Human Resources Unit (HSS/HR) is preparing an educational strategy to develop the competencies of the multidisciplinary PHC teams in accordance with the renewal approach. Different policies and instruments for integrating health services in PHC-based health systems are also being formulated, in conjunction with the Health Policies Unit (HSS/HP). A virtual course for managers and leaders of the PHC area will be launched soon.

## Essential Public Health Functions

247. In 2000, PAHO launched the Public Health in the Americas initiative, whose purpose was (a) to generate a regional consensus on the concept of public health and its essential functions, (b) to create methods for evaluation of performance of these functions in the Region, and (c) to develop strategies in order to strengthen them based on research findings. A method for self-evaluation of essential public health functions in the national area was created and application of this method was promoted. As a result, 41 countries and territories in Latin America and the Caribbean performed their evaluations in 2001. Throughout the quinquennium, PAHO has helped 12 countries to conduct new national measurements and adapt the instrument for evaluation of public health performance in their states, departments, provinces, and *municipios*. In Peru, for example, the initiative has facilitated public health planning in all departments. Essential public health functions are also being measured in each province in Argentina. In the *municipios* and departments of Colombia, the initiative has made it possible to include public health components in national development plans and local government work plans.

### Essential public health functions in Brazil

With the participation of the Ministry of Health and the National Council of State Ministers of Health (CONASS), several meetings were held in Brazil in 2003 in order to discuss the Public Health in the Americas initiative and strengthen the essential public health functions. CONASS and PAHO signed a technical cooperation agreement to adapt and apply these methods for management of the Brazilian Unified Health System (SUS). In the Brazilian states that voluntarily requested cooperation, the process was conducted by a joint PAHO and CONASS team using methods and an instrument adapted to the national reality through a technical and political consultation process. All financing was provided by the states, the Ministry of Health, CONASS, and PAHO.

248. Although the plans formulated by the aforementioned countries have been oriented toward strengthening public health and its essential functions, other countries and territories such as Puerto Rico have concentrated on institutional organization of public health. The School of Public Health of the University of Veracruz in Mexico has used these concepts to analyze training of public health experts. Honduras has used them to formulate policies and the Ministry of Health of Costa Rica has used them to conduct research in the field of public health.

249. In general, the Public Health in the Americas initiative has made it possible to better define the responsibilities of health authorities in the national and territorial area, identify functions with low performance, identify deficiencies in the areas of infrastructure and capacity, and formulate plans to improve public health.

### **Steering role of the health authority**

Several countries in the Region have shown great interest in applying the performance measurement instrument to the steering role of the National Health Authority (NHA) and the NHA mapping instrument. In the Dominican Republic, use of these instruments at the subnational level has led to generation of data used to prepare action plans that seek to strengthen the steering role of local health authorities. In March 2007, PAHO sponsored a workshop on the subject, which was attended by several high-level staff members throughout the Region.

250. In its interest for safeguarding the quality of health care and strengthening the steering role of the national health authority, PAHO supports actions that strive to improve national capacity to respond to new challenges resulting from globalization and free trade.

251. Globalization, proliferation of free trade agreements, increased mobilization, and introduction of new products pose new challenges for government regulation and control of imported raw materials used to manufacture drugs and medical supplies, as well as introduction and marketing of new technologies and equipment.

252. With the support of PAHO, Panama has introduced a process to strengthen its drug and technology regulatory systems. For this purpose, it has formed interdisciplinary working groups with professionals from the Ministry of Health (MINSa), PAHO, the Social Security Fund (CSS), the University of Panama, the Specialized Institute of Analyses, and the National Association of Pharmacists. The country has developed draft legislation that includes changes in current standards and creation of a National Drug and Technology Authority as an autonomous entity under the Ministry of Health.

253. PAHO contributed the instrument for characterization and diagnosis of regulatory processes and the role of the regulatory entity. In addition, it ensured that the regulations and processes adopted by the country were harmonized with the international standards of the Pan American Network on Drug Regulatory Harmonization (PANDRH).

### **Public Health Spending to Assure Universal Access to Health Services**

254. Public health spending is one of the main public policy tools for assuring universal access to health services. In Latin America and the Caribbean, total health spending as a proportion of gross domestic product (GDP) has been increasing since 1990, with its having risen to just over 7%, public health spending the central and local governments and public health insurance systems was just over 3.6% for 2004-2005. This proportion has remained largely unchanged since the mid-nineties. The reform processes

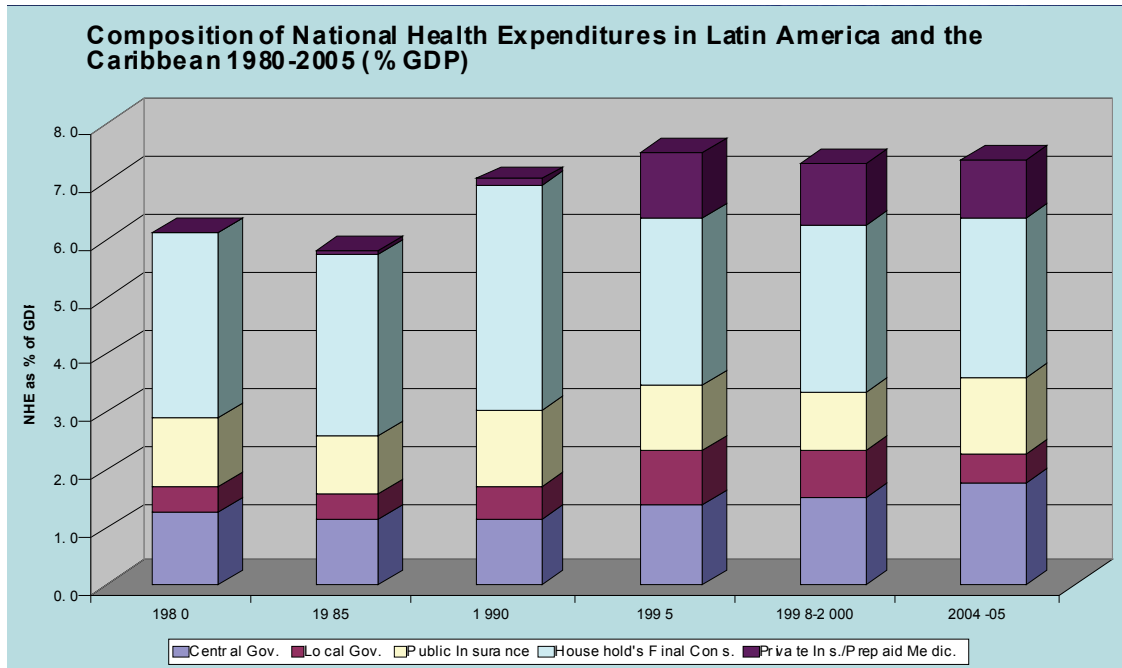


of the nineties were based on the premise that public expenditure was sufficient and that the problem lay in inefficient spending. As a result, increases in public health spending were halted for nearly a decade, undermining many countries' ability to provide universal access to health services. What is even more troubling is the change that invariably took place in the ratio of public to private spending for over three decades, during which private spending has comprised a share of over 50% for nearly 30 years. Furthermore, the out-of-pocket expenses borne by families have not only been uncommonly high, but have fluctuated widely over that period. The opposite is true for developed countries of the Organization for Economic Co-Operation and Development (OECD), which have shown absolute increases in public health spending and where the proportion of the GDP comprised by the latter has not been under 6% for the past 10 years. This shows that if universal access to health services is to be provided, it becomes necessary to attain at least a similar proportion, independently of the model and health care system adopted by each country.

255. Insufficient public health spending comes in addition to a lack of mechanisms for assuring that public financing will benefit society's most disadvantaged groups. While several countries in the Region have implemented policies and mechanisms that have had a distributive impact on public health spending in lower-income groups, there are still some countries in the Region that are far from attaining these objectives.

256. In short, a lack of sufficient public health spending and of mechanisms for assuring its distributive impact are the main factors in the way of any strategy that aims to reduce poverty, provide universal access, and attain greater equity in health.

## Latin America and the Caribbean Public Expenditure for Health



Source: Pan American Health Organization, 2006

257. Throughout the quinquennium, PAHO has worked with the Ministries of Health, the central banks, the Institutes of Statistics and Ministries of Finance in the annual production of economic and financial health indicators within the framework of the System of National Accounts (SNA-1993) and functional classification of expenditures according to the Public Finances Statistics Manual. As a result, during this period it has facilitated use of economic and financial indicators for decision-making and generating public health policies. In addition, the health economics and accounts institutes, centers, and departments in the Ministries of Health have been strengthened. Availability of regional estimates of health expenditures has improved with application of the Satellite Health Account Manual launched by PAHO in July 2005.

258. PAHO's work in Costa Rica over the biennium 2005-2007 stands out as a successful experience at the country level. With the support of an international expert, the method used to create the satellite health account was designed and implemented. This account currently includes information for 2004 and 2005. Starting in 2008, information will be included for 2006 and 2007, as well as each of the previous years.

259. As a result of this work, the Ministry of Health now has a permanent work team made up by specialists in health economics. The functions of this team are to guarantee

that each institution responsible provides the input required to generate the satellite health account each year and to create, analyze, and circulate information about the satellite account, so that the competent authorities can make decisions that contribute to the achievement of equitable, sufficient, and sustainable financing for the health sector.

### **Human Resources and their Fundamental Role in Health**

260. The workforce plays a critical role in fulfillment of the MDGs and other health-related national objectives. In 2005, 28 countries of the Americas and several different international agencies agreed on certain lines of action in order to overcome human resources difficulties. The Toronto Call to Action pointed out the need: (a) to define policies and plans to satisfy the fluctuating needs of health systems, and generate the work capacity to implement these systems and review them periodically; (b) placement of different types of personnel as required; (c) control of migration and displacement of health care workers so that the entire population has continuous access to health care; (d) create healthy occupational environments; and (e) promote cooperation between teaching institutions and health services in order to ensure that the curriculum for health care workers is adapted to the needs of the population.

261. At PAHO, strengthening policies and information related to human resources has occurred in connection with the Observatories of Human Resources for Health initiative, which is a network for research, analysis, information exchange, and advocacy designed to guide human resource policies.

262. The observatory initiative was created in order to collect information and scientific evidence that could serve as a basis for formulating policies, renewing and improving the work force, and strengthening the relationship between unions, the academic world, and health authorities in order to correct deficiencies and imbalances in the distribution of health care workers.

263. By 2006, 26 countries took part of the network, which began only with nine countries. It also had more than 40 nodes and workstations in a widely known network that has produced national studies and analyses, and generated a movement that is currently a regular component of planning activities and policy design in the countries of the Americas. At present, many of these countries, such as Brazil, Colombia, Cuba, Nicaragua, and Peru, have introduced an observatory unit in the institutional framework of their ministries of health.

### ***Planning health human resources for 2006-2015***

264. In 2006, this was reinforced by interest aroused by World Health Day and the WHO World Health Report 2006, *Working Together for Health*, as well as PAHO's

celebration of Pan American Health Week 2006. These focused the world's attention on the current human resources crisis and provided an opportunity for advocacy and generating additional technical instruments. The initiative, which at one time was promoted exclusively by PAHO, has now become a partnership between different interested parties, not only from the Americas, but also from other regions that respond to the same principles.

265. Taking advantage of the commitments by the countries and worldwide support, PAHO Human Resources Management (HRM) Unit and the Regional Network of Observatories joined with Brazil and Canada, in addition to Costa Rica, Jamaica, Peru and other countries, in order to create the Pan American Steering Committee and a human resources planning consortium that guarantees a coordinated response to the Toronto Call to Action. Two subregions (Central America and the Andean countries) began an intense process of strengthening capacities in the political and administrative areas by offering on-line courses, training at different sites, and teaching activities from country to country.

#### **2006-2015 Ten-Year Human Resources Plan**

Costa Rica participated in preparation of a position paper on challenges in the human resources area, and in the 2006-2015 Toronto Call to Action for a Decade of Human Resources in Health for the Americas meeting. It has also created an intersectoral technical committee for development of human resources that began its functions in 2005. Moreover, it supports formulation and adoption of national policy for management of health human resources. Costa Rica has a 2006-2015 Ten-Year Human Resources Plan that includes activities such as establishment of a human resources information system, professional recertification, research in the field of human resources, and work with institutions from several different sectors, including the health sector.

266. This integrated multinational approach confirms that a subject that has been overlooked in health work plans can become the central element of international action within a relatively short period of time. It also shows the value of leadership when promoting international commitment and horizontal cooperation to introduce national and regional movements of change.

267. A central component of this human resources planning strategy consists of finding ways to stop or reduce to a minimum the harmful effects of migration of health workers with essential functions from developing countries to developed countries. Although this phenomenon is observed worldwide, the entire Region of the Americas has joined forces in order to take measures in this regard. Argentina, Brazil, Canada, Chile, Colombia, Ecuador, United States, Peru, Uruguay, and Venezuela are participating in multinational studies on migration of nurses and physicians in the Americas. These studies served as basis for a political dialogue between ministers of health from Latin America and several

European countries, which led to identifying ways to counteract its effects on populations with inadequate services. CARICOM countries are establishing guidelines for travel and interchanges of health human resources between member countries so that health care workers can migrate within the subregion without worsening the scarcity of personnel in their native countries, while also seeking to favor workers and benefit the economies of destination countries. The guidelines for migration of health workers will include training and certification standards, and interchange of resources from destination countries to countries of origin.

### **Epidemiological Surveillance Systems**

268. In June 2007, 19 out of 21 countries had implemented the subregional communicable disease surveillance system; 17 had formulated national manuals on the subject; 4 had prepared national manuals; and 9 had held national training workshops on surveillance.

269. Epidemiological surveillance is one of the basic functions of the Caribbean Epidemiology Center (CAREC), which works with Member States in formulation of national and regional policies and guidelines. During the Cricket World Cup held in nine countries in the Caribbean, on-line reporting systems were introduced in order to facilitate transmission of data and information. It is hoped that this initiative will be expanded as the systems continue to be strengthened.

270. In recent years, surveillance activities have been expanded to comprise creation of surveillance systems for noncommunicable diseases and their risk factors. Four countries have conducted population surveys on these factors and six more countries are planning to do so. PAHO and CAREC also collaborate with countries in implementation of the regional plan for noncommunicable diseases in the Caribbean.

### **International Health Regulations**

Since May 2003 the national health authorities of Panama have participated in review of the International Health Regulations (IHR) and approval of the version revised in 2005. These authorities established a model of protective measures for countries in the event that a public health problem of international scope is declared, ensuring a timely response.

Furthermore, information and know-how about the new IHR are also circulated in the country. This includes early alert and timely response measures for present and future challenges posed by infectious diseases and other health problems of importance for the country and the international community. In this context, Panama has taken measures to strengthen epidemiological surveillance and detection, and prevent and contain communicable diseases. It considers that, regardless of its origin, an epidemic in the country could spread rapidly and produce economic losses that worsen the situation of poor populations.

Current population and environmental determinants, continuous international travel of persons and goods, and the threat of a flu pandemic highlight the need to strengthen epidemiological surveillance and analytical capacity in order to implement timely interventions based on clinical, epidemiological, and laboratory data. These interventions should increase the effectiveness of national health services and provide an efficient system of warning and response to epidemic emergencies.

The health authorities are developing their National Focal Point related to functions, basic structure, and capacity to receive, analyze, and transmit information that may be politically or economically sensitive in some cases. Although the epidemiological surveillance unit of the Ministry of Health has the technical responsibility for this focal point, efforts are made with regard to detection, analysis, reporting, and actual response time, in the terms established by the IHR (2005).

In order to resolve limitations related to implementation of the IHR (2005), Panama is leading the proposal for technical cooperation (CTEP) between Central America, the Dominican Republic, and Cuba. The purpose is to develop and/or strengthen capacities and networking in order to prevent, protect, and control international spread of diseases through appropriate public health responses to risks, preventing unnecessary interference in international trade and commerce in accordance with the provisions of the IHR (2005).

271. The Latin American Center for Perinatology and Human Development (CLAP) is preparing new versions of the perinatal information system and the adolescent computer system, a task that includes updating the content of perinatal medical records and adolescent medical records in accordance with optimum current scientific tests. The purpose is to generate more efficient information systems that facilitate data recording and automatic analysis, as well as development of operational investigation, and monitoring quality of care and decision-making. CLAP is finalizing evidence-based situation analyses that seek to support local processes in development of standards of care and training of resources in reproductive, maternal, and perinatal health with a primary health care focus, in accordance with the concept of continuum of care. These guides are accompanied by several different technologies, including standards and guidelines that are easy to use and interpret, which support the recommended care processes.

### **Epidemiological surveillance in the Caribbean**

The epidemiological surveillance systems in the Region have gained critical importance in recent years. As a result of the events of 11 September 2001 in the United States and the emergence since 2003 of West Nile virus, severe acute respiratory syndrome (SARS), Creutzfeldt-Jakob spongiform encephalitis (“mad cow disease”), avian flu, and other emerging and reemerging fatal diseases that spread rapidly, some countries in the Caribbean have requested the assistance of PAHO to strengthen their port health systems in order to control penetration of these diseases in their territory.

Tourism and international movement of animals and products lead to problems related to food safety, water, vector-transmitted infections, exposure to certain transmissible diseases imported from abroad, and occupational safety. By May 2004, Bahamas, Barbados, Dominica, Saint Kitts and Nevis, Santa Lucia, and Trinidad and Tobago had opted for mutual collaboration in order to improve competence in the field of port health.

Before the International Health Regulations took effect on 15 June 2007, the Caribbean Program Coordination (CPC) had already prepared a list of points in order to facilitate the capacity of national resources and structures to meet minimum requirements for implementation of the regulations. In collaboration with the PAHO/WHO representative in Suriname and the national authorities in this country, the list has been used to evaluate Suriname’s capacity to implement the requirements of the regulations. Saint Lucia has also used it to conduct its own evaluation, and other countries are preparing to use it.

### **Achievements in the fight against vaccine-preventable diseases**

272. As a result of the Expanded Program on Immunization (EPI), significant progress has been made in the Region in the past 10 years as regards protection of inhabitants from vaccine-preventable disease, as shown by eradication of polio, elimination of measles and neonatal tetanus, control of yellow fever, and introduction of the rubella and pentavalent vaccines. In fact, mortality caused by most diseases for which there are vaccines has been reduced by over 90%. These achievements have been due to the sustained commitment by governments, health care professionals, and the general population.

273. Hepatitis B and *Haemophilus influenzae* type b (Hib) vaccines have been introduced in all the countries in the Region but one, and the combination diphtheria-hepatitis B-Hib pentavalent vaccine is used in 34 countries. Since Hib vaccines were introduced in public sector vaccination regimens, the number of cases reported has decreased significantly. Several new vaccines have been introduced in the vaccination regimen..

274. Before the rotavirus vaccine is introduced, PAHO is supporting countries in establishing a rotavirus surveillance system. The purpose of surveillance is to determine the burden of disease in the countries and the viral subtypes circulating in these countries.

275. In 13 countries, including the Netherlands Antilles and Aruba, a general evaluation of the immunization program was conducted and identified areas to be strengthened. All countries have taken measures to correct most of the deficiencies detected. Evaluation has been used as a strategy to share experiences and teach skills to health care professionals in the evaluating country, as well as team members from other countries.

276. Haiti is the only country in the Region that has not yet introduced the rubella, hepatitis B, and *H. influenzae* type b vaccines. With the technical support of PAHO and the other members of the Interagency Coordinating Committee (ICC), these vaccines will be introduced in the next two years. This year, the rubella vaccine will be introduced through a national campaign and will continue to be included in the basic vaccination regimen. Furthermore, the country will be supported technically in presentation of a proposal to the GAVI Alliance (previously known as the Global Alliance for Vaccines and Immunization) on introduction of DPT-Hib-HB pentavalent vaccine in 2008. PAHO Immunization Unit will continue to help the national immunization program in Haiti to raise funds and implement sustainable financing strategies such as creation of laws that establish a specific budget for vaccination.

277. In the 2003-2007, Cuba has introduced three vaccines in its vaccination regimen: the synthetic Hib vaccine produced exclusively at the national level, the tetravalent vaccine (DPT-HB), and the pentavalent vaccine (DPT-Hib-HB) of national production. In addition, the country prepared a vaccination series to protect over 40,000 Latin American students against measles, rubella, hepatitis B, meningococcal meningitis, and tetanus. In general, the country improved the surveillance system by guaranteeing systematic data analysis and provision of reliable and timely information.

278. During the quinquennium, typhoid fever and Hib infection are no longer public health problems in Cuba, and morbidity and mortality related to mumps, meningococcal meningitis, and hepatitis B have decreased significantly. There is over 95% vaccination coverage with all vaccines in the regimen, which combat 12 diseases. In 2004, PAHO conducted the international evaluation of this program. It has also supported several research projects and negotiation of a GAVI Project to strengthen the health services.

279. Guatemala maintains optimum standards for epidemiological surveillance of vaccine-preventable diseases. It has introduced sentinel surveillance of diarrhea caused by rotavirus, seasonal flu, meningitis, and bacterial pneumonia. National coverage with all vaccines has been over 90% since 2002. This country, which does not have measles or poliomyelitis, has included the pentavalent and seasonal flu vaccines, and is preparing to introduce other new vaccines.



### **Ecuador without poliomyelitis, measles, tetanus, rubella, or rabies**

In Ecuador, poliomyelitis has not been a public health problem for 17 years. Measles has not been a problem for 10 years and rubella, congenital rubella syndrome, and neonatal tetanus have not been a problem for 3 years. At present, only sporadic cases of these diseases occur. This is due to the priority the government has granted to financing the vaccination program, as shown by the 600% increase in the vaccine budget in the quinquennium 2003-2007. New vaccines have been introduced, including pentavalent and hepatitis B vaccines for groups at risk, and flu vaccine.

For rabies, mass vaccination campaigns, increased epidemiological surveillance, adequate treatment of exposed individuals, and active community participation have led to a significant reduction in cases of human and canine rabies. In 2006, no cases of these diseases were reported.

The progressive increase in vaccination coverage has been brought about by strengthening the managerial level of the Expanded Program on Immunization (EPI) in the health areas and provinces, reinforcement of the cold chain, and adaptation of processes at all levels, including epidemiological surveillance of vaccine-preventable diseases.

280. After detection of the last case of poliomyelitis due to wild poliovirus in the Region, which took place in Peru in 1991, this virus is no longer circulating in the countries of the Americas. Cases of acute flaccid paralysis (AFP) are still being monitored, as there is over 1 case per 100,000 children under 15 years of age. The countries in the Region are completing an inventory of laboratories with poliovirus or material possibly infected with poliovirus as part of a plan to contain the virus in the laboratories. While poliovirus continues to circulate elsewhere in the world, the countries on the continent will be at risk of importing it. When polio vaccine coverage is low in countries, municipalities, and towns, there is danger of an outbreak of infection with the vaccine strain, as occurred in the Dominican Republic and Haiti in 2000-2001.

281. Cases of tetanus have been reduced as a result of widespread use of tetanus toxoid in children and women of reproductive age in order to prevent neonatal tetanus (NNT). Elimination of NNT as a public health problem (defined as less than 1 case per 1,000 live births in each district) has already been achieved throughout the world, except in Haiti. In Latin America, cases of whooping cough have decreased progressively in recent years, from 9,421 cases in 1999 to 4,921 cases in 2003. Nevertheless, 4,928 cases were reported in 2004 and 6,807 cases were reported in 2005. There continue to be outbreaks. Over 70% of all cases of whooping cough reported in the Americas during these years occurred in the United States, where incidence of disease has increased gradually since the early 1980s. For diphtheria, nearly 100 cases were reported each year throughout the Region between 1999 and 2003. However, 181 cases were reported in 2004, and 272 cases were reported in 2005 after an outbreak in Haiti and the Dominican Republic. An

abrupt decline in Hib infection has occurred in some countries with good detection systems. Finally, the results of hepatitis B vaccination will not be evident for a few years. But they are expected to be good, since there has been over 90% regional coverage with the third dose since 2004.

#### **Annual Vaccination Week in the Americas**

In April 2007, the Region celebrated the fifth Annual Immunization Week. Forty-five countries and territories participated, and more than 47 million people were vaccinated. In the Andean subregion 11,284,046 were vaccinated: in Central America and the Spanish-speaking Caribbean, 10,810,337; in the Southern Cone and Brazil, 18,347,938, and in the English- and French-speaking Caribbean, 162,220. Canada, some Caribbean countries, and the United States focused on social communication.

282. Although overall vaccination coverage is good in the countries, there is great disparity between different *municipios* in each country. In order to extend global protection with the vaccine to all children and vulnerable persons in the Region, countries are determining which *municipios* are at risk in order to be able to concentrate interventions in these areas. Furthermore, the Vaccination Week in the Americas (VWA) held in April is a regional initiative that enables countries to target the groups at greatest risk and neglected areas in their interventions. As a result, they can generate the political support required for prevention and control of vaccine-preventable diseases.

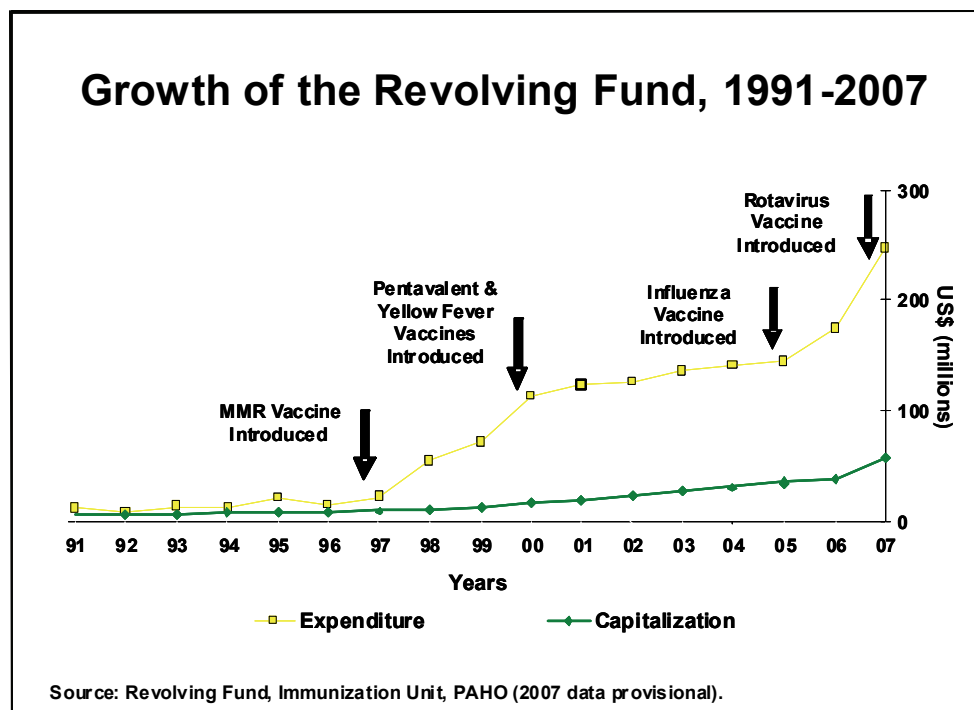
283. Several new vaccines are being prepared or have already been prepared. The decision to introduce these vaccines must be based on scientific data. These new vaccines are much more expensive than the traditional vaccines, and they pose new challenges in terms of planning. Six countries have included the rotavirus vaccine in their ordinary vaccination regimens. Three more countries will do so before the end of 2007. The conjugate pneumococcal vaccine has been partially introduced in three countries as part of public vaccination programs. The human papillomavirus (HPV) vaccine offers an opportunity to reduce the burden of infection of HPV and cervical cancer. However, its cost (more than \$100 per dose in the three-dose regimen) and the need to strengthen cancer prevention and control programs as well as vaccination services could hinder introduction of the vaccine in the short term.

284. PAHO helps countries improve their immunization and surveillance programs, diagnostic capacity, and regional laboratory networks. It helps strengthen political priorities and vaccination program sustainability by adopting laws and guaranteeing a timely supply of quality vaccines through the PAHO Revolving Fund for Vaccine Procurement. In the current quinquennium, use of the Revolving Fund by countries has been the highest recorded to date.

## Revolving Fund for Vaccine Procurement

285. The Revolving Fund is PAHO's mechanism for bulk purchasing of vaccines and immunization supplies. It has helped Member States manage their vaccine and immunization supply needs since 1979. Each year, PAHO consolidates vaccine orders from participating countries and carries out an international bidding process with the participation of all vaccine manufacturers. PAHO procures vaccines with funds drawn from the fund, and countries reimburse the fund for purchases made on their behalf.

286. As of 2006, 37 countries are making regular use of the Revolving Fund for the procurement of up to 45 different vaccine products. The fund is streamlining its integrated services to countries and further reducing the costs of procurement, holding, distribution and use of vaccines throughout the supply chain. At the close of 2005, the fund was capitalized at just over \$34 million, and total expenditures exceeded \$154 million that year. The Revolving Fund, as a highly efficient procurement agency, is positioned to continue its strategic role in strengthening the sustainability of national immunization programs throughout the Region.



287. The Pro-Vac initiative for the promotion of political decisions based on scientific data regarding introduction of new vaccines in Latin America and the Caribbean, and the regional vaccination vision and strategy will enable PAHO to continue to lend technical support in order to help countries face the challenges approaching in the upcoming years.

288. Achievements with regard to vaccination have strengthened the general public health infrastructure and regional laboratory networks in particular. They have promoted good intersectoral coordination, improved equity, and increased awareness of the importance of prevention in the population.

#### **Elimination of rubella and congenital rubella syndrome in the Americas**

In 2003, the PAHO Directing Council adopted Resolution CD44.R1, which advocated elimination of rubella and congenital rubella syndrome (CRS) in the Americas by 2010. The measure responded to the need for availability of a safe, reasonably priced, and effective vaccine. It was based on experience acquired in administration of measles and rubella vaccines to large heterogeneous population groups, and the data available as regards the relationship between cost and efficacy/effectiveness. The countries were urged to prepare action plans in order to reach the goal. The PAHO Director was asked to prepare a regional action plan to mobilize the resources required. In 2006, Resolution CD47.R10 reaffirmed the need for elimination of rubella and CRS.

By June 2007, 41 countries (93%) and territories (91% of the population in the Region) already had vaccination strategies for adolescents and adults (men and women) with at least 95% coverage. From 1998 to the first semester of 2007, Argentina, Bolivia, Brazil (only women), Chile (only women), Colombia, Costa Rica, Ecuador, El Salvador, the English-speaking Caribbean, Guatemala, Honduras, Mexico (subnational), Nicaragua, Paraguay, Peru, the Dominican Republic, and Venezuela (only cohorts of young people) conducted extensive vaccination campaigns for adolescents and adults (men and women) in order to rapidly interrupt rubella transmission and prevent CRS. By mid-2007, more than 125 million men and women (children and adolescents) had been vaccinated against measles and rubella in the context of elimination of these diseases. When the campaigns planned for 2008 are completed, an additional 108 million people will have received the measles and rubella vaccines.

As a result of the satisfactory coverage obtained with the different vaccination strategies, incidence of rubella has been significantly reduced on the American continent. Between 1998 and 2006 the number of confirmed cases of rubella decreased by nearly 98% (from 135,947 to 2,912). In 2006 only 14 confirmed cases of CRS were reported. Reduced incidence of rubella has been more pronounced in countries where both men and women were vaccinated.

PAHO has integrated rubella elimination activities with the basic principles of primary health care. This has led to improved health care services. Furthermore, elimination strategies have strengthened the health infrastructure. They have led to increased coordination, improvement of blood banks and services for newborns and infants, and generated greater awareness of safe vaccination practices. By improving maternal and child health, and enabling women to reaffirm their right to satisfactory health care, elimination of rubella is contributing to fulfillment of the MDGs and reduction of health inequities.

### **Bolivia launches a campaign to eliminate rubella and congenital rubella syndrome**

With the slogan “Once and for All,” Bolivia introduced the rubella and congenital rubella syndrome elimination campaign in May and June 2006. In this context, the bivalent measles-rubella virus vaccine was administered to men and women from 15 to 39 years of age in the 327 *municipios* of the country. The Ministry of Health, prefectures, *municipios*, and the population were mobilized by union organizations, and the goals established were achieved.

After 6 weeks of vaccination, national administrative coverage was 106.8%. The percent surplus has been attributed in part to vaccination of persons over 39 years and under 15 years of age in some areas due to demand. All departments in the country attained administrative coverage of over 95%. Surprisingly, vaccination was very well-accepted by the adult male population, which was uncertain at the beginning of the campaign.

No confirmed cases of rubella have been reported in Bolivia since week 6 of 2006. The campaign has also strengthened measles elimination in the country, since the last case of measles detected occurred in 2000. For the first time, “safe vaccination” has been a component of a vaccination campaign in the Region.

### **Eye Health in Latin America and the Caribbean**

289. The regional eye health initiative seeks to increase access to eye health services for the economically and socially marginalized population. This is conducted with a view to preventing nearly 80% of the cases of blindness and visual impairment that currently occur in the Region. In Latin America and the Caribbean, nearly five out of 1,000 persons are blind, and 20 out of every 1,000 persons have a visual impairment. The leading causes of avoidable blindness in the Region are cataracts that have not been operated on. These lead to over half of the cases of blindness, refractive error, child blindness, diabetic retinopathy, and glaucoma.

290. Reducing blindness and poor vision helps relieve poverty and underdevelopment. It improves educational and work opportunities for persons. In the last five years, access to eye health services has increased in marginalized urban and rural areas in many countries of the Region as a result of the support of PAHO, 20-20 Vision, and international NGOs, as well as bilateral cooperation by countries such as Cuba and Venezuela. During the past five years, the number of countries with national eye health plans has increased significantly. Access to services, as seen by the annual number of cataract removal operations performed per million inhabitants, has improved considerably in the Region. More than 1,500 such surgeries per million inhabitants were performed in 26% of the countries in 2002, and in 50% in 2006.

291. The role of the Regional Eye Health Program, headquartered in Colombia, has consisted of demonstrating the magnitude and causes of the problem through epidemiological studies. This has presently been completed in nine countries in the Region. The studies have measured prevalence of blindness and visual impairment, the percentage of cases of blindness caused by cataracts, coverage and quality of services, and barriers to access. The results have shown that there is higher prevalence of blindness and visual impairment in marginalized and poor populations than in other groups. This data has been an instrument for planning and advocacy.

### **Oral health in the Americas**

292. There have been important strides in the area of oral health in the Americas. The consolidation of fluoridation programs has reduced the burden of dental caries in the entire Region by 35% to 85%. The technical cooperation provided by PAHO's Oral Health Program has tried to motivate countries with high mortality and a lack of preventive policies to begin implementing effective policies and generating better indicators of the status of oral health. A successful fluoridation program was presented as a case study in the publication titled *Millions Saved: Proven Successes in Global Health*. So far, more than 25 countries and over 350 million people have had accesses to fluoridation programs in the Americas.

293. With support from the IDB, the Oral Health Program has developed a basic best-practices model that is intended to improve access to treatment for dental caries through simple techniques. In three Latin American countries, clinical trials have shown that the atraumatic restoration technique (PRAT systems) is more cost-effective than traditional treatment and prevention measures. Several countries have incorporated the PRAT system in their health agendas, and an increasing number of countries are requesting help in establishing this system.

### **Health Promotion**

294. In addition to the communicable and nutritional diseases characteristic of underdevelopment, the countries in the Region have high morbidity due to injuries and noncommunicable diseases with risk factors associated with the typical lifestyles of industrialized societies. In these societies, factors such as inequitable distribution of income, urban development, technological advances, growing influence of the media, violence, and social inequality contribute to a sedentary lifestyle, nutritional imbalances, alcohol consumption, smoking, and other practices that are detrimental to health. The consequences include obesity, cardiovascular disease, lung cancer, colon cancer, and diabetes mellitus.

295. Throughout the quinquennium, PAHO Member States have been extremely active in adopting health promotion measures that combat the social, behavioral, and biological determinants associated with risk of contracting noncommunicable diseases or experiencing injuries caused by acts of violence, occupational accidents, or travel accidents. These measures have focused on the recommendations of the Ottawa Charter.

296. In 2005, the Bangkok Charter for Health Promotion led to reorientation of work toward establishing partnerships with government agencies and civil society. The same year, the health promotion capacities of 28 Member States were mapped in order to strengthen national and local capacities. Since 2006, PAHO has included health promotion activities horizontally in all technical areas. The “healthy spaces” approach (e.g., healthy communities, cities and *municipios*; healthy schools; healthy workplaces) has been applied with very good results in many countries in order to empower the community and attempt to reduce risk factors and social determinants that are detrimental to health. In 2007, 19 of the 35 countries and 3 territories in the Region participate actively in the Healthy Communities, Cities and Municipalities Initiative. In addition to the Network of Healthy communities, Cities and Municipalities in the Americas, 10 countries have established national or regional networks and have contributed to promote initiatives in favor of healthy spaces in the working plans of countries.

297. In May 2005, PAHO and the Basque government signed a collaboration agreement in which the government agreed to support strengthening of health-promoting schools in Latin America. As a result, several products are being prepared, including the First Ibero-American Competition on Good Health Promotion Practices in the School, an on-line training course, a “tool box,” and a series of educational materials on health promotion.

### **The National Network of Healthy Communities and Municipios of Peru**

In Peru there are 750 *municipios* that are members of the Healthy Communities and Municipios (MCS) initiative. There are 15 regional MCS networks which also have local development plans that seek to have a positive effect on health determinants and respond to local priorities. In July 2007 the national network of healthy communities and *municipios* was formed, with 15 regional networks.

In order to stimulate the processes, a series of health promotion pamphlets were prepared, which has been circulated throughout the Region. Several of the 23 issues in the series deal with the subject of healthy *municipios*, primarily as regards road safety policies, solid waste, smoking, violence, childhood, adolescence, gender, older adults, human rights, social determinants of health, the MDGs, and education.

In terms of efficacy and effectiveness, the MCS initiative has strengthened the competencies of the institutions participating through continuous training processes with methods based on scientific evidence, such as Youth Participation, WHO TEACH-VIP, and Strong Families, in addition to local projects. As a result of the initiative, there is an active strategic partnership between the national government, the *municipios*, civil society, and cooperation agencies. Furthermore, strengthening competencies has led institutions to work directly with adolescents and families in their areas of intervention, using the methodologies taught.

### **The Healthy and Productive Communities Strategy in Uruguay**

The Uruguayan Initiative for Health-Agriculture Joint Activities, signed by the ministries of both sectors under the sponsorship of PAHO, promotes the productive and healthy communities strategy as part of a government plan to achieve a productive, healthy, and caring country. The strategy promotes creation of local opportunities so that communities can work together for the common objective of improving their quality of life and health status, and changing the social determinants of health.

The Ministry of Livestock, Agriculture and Fisheries and the Ministry of Public Health introduced the strategy at the national level in conjunction with municipal governments, PAHO, and some national organizations. With the active participation of organized civil society, local production projects based on promotion of comprehensive health care and social inclusion are conducted. The objective of these projects is to improve living conditions for small farmers and their families, particularly small farmers with or without land, women and schoolchildren in rural areas, artisanal cheese makers, unemployed youth, small subsistence producers, and seasonal workers. A wide range of activities and resources are used to attempt to improve the physical and sociocultural environment in extremely poor areas where social policies seldom reach.

The results of the strategy include establishment of local intersectoral teams; introduction of training processes in areas such as horticulture, animal husbandry, food preparation, hydroponics, and product packaging; as well as promoting health through healthy nutrition; encouraging physical activity and preventing smoking; fostering collective work and “empowerment” for negotiation in local management; greater participation by the educational sector in development of the strategy; and coordination of the strategy with the oral health initiative promoted by PAHO as well as several programs and projects established by the national government.

The strategy has been extended progressively to nearly all administrative political units in the country. Binational strategic partnerships have begun to be established between Uruguay and Brazil, including the Rivera-Livramento binational committees and the alliance between Aceguá (Brazil) and Aceguá (Uruguay).



298. Based on the Intersectoral Strategic Partnership between Health, Education, Work, and Environment presented at the 47th PAHO Directing Council, regional consensus-building has been promoted with education, health, and development agencies in order to grant priority to promoting health in early education. PAHO supported the Health-Promoting Schools Technical Meeting organized by WHO and the Canadian Consortium for Education and Health, which was held from 5-8 June 2007. At this meeting, the countries in the Region stated that they were in favor of strengthening the alliance between the ministries of education and the ministries of health. They decided that a meeting would be held in Fortaleza, Brazil in October 2007 to strengthen the alliance between the two sectors in the national as well as the regional area, in order to reorient health promotion in view of the social determinants of health and the MDGs.

299. PAHO has prepared a series of planning and evaluation guides for strengthening national capabilities and generating scientific evidence of the effectiveness of health promotion initiatives. During the period from 2004 to 2006, participatory evaluations were conducted in several countries in the Region.

300. On 15 September 2007, the CARICOM Summit for Non-Communicable Diseases was held under the theme “Stemming the tide of non-communicable diseases in the Caribbean.” The Summit was attended by policy-makers and representatives of CARICOM and other regional and international health agencies wanting to develop and undertake actions to combat diseases that are related to lifestyle. The objectives of the Summit were to develop a common regional approach for the prevention and control of non-communicable diseases, to assess the burden of such diseases in the Region, and to propose imminent control measures.

301. The Summit was called in response to the results obtained in 2005 by the Caribbean Health and Development Commission, which was launched in 2003 with PAHO’s assistance in order to act on the Nassau Declaration that “the wealth of the Region is the health of the Region.” The report of the Commission, which was initially headed by Sir George Alleyne, former Director of the Pan American Sanitary Bureau, showed that non-communicable diseases, HIV/AIDS, and injuries are very important health problems in the Region

### ***The fight against tobacco***

302. Tobacco is one of the leading causes of morbidity and mortality in the Region. It has been widely demonstrated that in order to reduce smoking, clear and forceful laws must be adopted. Moreover, actions must be introduced to promote health and prevent diseases caused by smoking.

303. Uruguay was the first tobacco smoke-free country in America. In June 2003, Uruguay signed the Framework Convention on Tobacco Control. Decree 268/05 on 100% smoke-free environments took effect in the country on 1 March 2006. These achievements were mainly due to the activities of the National Alliance for Tobacco Control. PAHO promoted formation and consolidation of this alliance.

304. Several activities have been conducted in the context of tobacco control, including the “A Million Thanks” campaign (2006), which expresses appreciation for the commitment by persons opposed to smoke in indoor places. Over 1,200,000 Uruguayans participated in this campaign. A toll-free telephone line (0-800-HUMO) was also established, which allowed people to consult and participate in the global campaign. Public awareness-raising campaigns have also been conducted.

305. In order to evaluate public opinion on Decree 268/05, a knowledge and attitude study was conducted in 2006. The study demonstrated that most of the Uruguayan society has come to understand that breathing other’s tobacco smoke is dangerous and it is a violation of a legitimate individual right. In 2007, another study was conducted in order to evaluate the impact of Decree 268/05 on commercial activity. According to the results, the economic impact is insignificant.

306. In 2006 the president of Uruguay received the WHO Director-General’s Award, which was awarded by the WHO Director during the celebration of the 8th Ibero-American Conference of Ministers of Health in Colonia.

### WHO Framework Convention on Tobacco Control

The Framework Convention on Tobacco Control is the first international public health treaty that has been negotiated with the mediation of WHO. It was negotiated in a four-year period, opened for signatories in June 2003, and took effect on 27 February 2005. In the Americas 32 countries have already signed it and 21 have ratified the Convention.

From 2003 to 2007, training workshops on tobacco smoke elimination policies were held in 11 countries: Argentina, Costa Rica, El

Countries that have ratified the Framework Convention		
<b>Antigua and Barbuda</b>	<b>Dominica</b>	<b>Panama</b>
<b>Barbados</b>	<b>Ecuador</b>	<b>Paraguay</b>
<b>Belize</b>	<b>Guatemala</b>	<b>Peru</b>
<b>Bolivia</b>	<b>Guyana</b>	<b>Saint Lucia</b>
<b>Brazil</b>	<b>Honduras</b>	<b>Trinidad and Tobago</b>
<b>Canada</b>	<b>Jamaica</b>	<b>Uruguay</b>
<b>Chile</b>	<b>Mexico</b>	<b>Venezuela</b>

Salvador, Guatemala, Honduras, Jamaica, Panama, Peru, Saint Lucia, Suriname, and Uruguay. As a result, many advances have been made in the Region as regards enactment of legislation.

Tobacco smoke-free environments in the Americas (new laws enacted between 2003-2007)*		
<b>100% tobacco smoke-free environments (bars, restaurants, discotheques, clubs)</b>	<b>100% tobacco smoke-free environments at the subnational level</b>	<b>2 out of 3 tobacco smoke-free: health, education, and government facilities</b>
<b>Uruguay (2006)</b>	<b>Argentina, with 3 provinces (where 20% of the total population lives): Córdoba (2003), Santa Fe (2005), Tucumán (2005)</b>	<b>Ecuador (2006): health, education, and government facilities</b>
		<b>Peru (2006): health, education, and government facilities</b>
		<b>Panama (2005): health and government facilities</b>

In Canada and United States, tobacco laws are enacted by each state. Consequently, approximately 80% of Canadian residents and 50% of United States residents live in a jurisdiction where there is no tobacco smoke in public spaces, including bars, restaurants, and workplaces.

307. In Argentina, the provinces of Córdoba (2003), Santa Fe (2005), and Tucumán (2005), which represent 20% of the population of the country, have been the first to adopt standards to eliminate tobacco smoke in indoor public places. The significance of the event is even greater since Argentina has not yet ratified the WHO Framework Convention on Tobacco Control.

308. The province of Córdoba has implemented the Permanent Provincial Program for Smoking Prevention and Control, which was created by a provincial act that was enacted in 2003 and took effect in 2004. Since then, there has been another provincial law that

prohibits smoking in public institutions dependent on the national government, and a national law that limits tobacco advertising. The Santa Fe Act has a wider scope, as it also prohibits direct and indirect advertising of tobacco products, sales to children, having automatic vending machines, and distribution of free samples. The province has other laws that establish definitions, prohibitions, limitations, and penalties, as well as clear mechanisms of control and penalization.

309. In Tucumán, a law prohibited smoking in convention halls, museums, libraries, banks, offices, bars, movie theatres, restaurants, and other indoor public places, even if they are private. Furthermore, it established that the owners or persons responsible for these places could request the aid of the police, and the appropriate penalties for failure to abide by the law. It has been supported by the media and by nonsmokers.

310. PAHO has supported health promotion programs in Brazil, Chile, Guyana, Jamaica, Mexico, Panama, Peru, Trinidad and Tobago, as well as other countries. The Actions for Multifactorial Reduction of Non-communicable Diseases (CARMEN) and the Integrated Initiative for Prevention of Non-communicable Diseases are regional initiatives that aim at increasing the physical activity by the population. Television host Mario Kreutzberger (*Don Francisco*), whom PAHO named a “champion of health” in 2002 because of his role in promoting health in the Americas, attended the opening ceremony of the 46th Meeting of the Directing Council of the PAHO in Washington, D.C. Don Francisco took the opportunity to launch the campaign “Let's eat healthy, live well and get moving Americas,” which is part of WHO's Global Strategy on Diet, Physical Activity and Health.

### **Chile's fight against obesity**

In Chile, being overweight is common in all age groups, even childhood, and it is increasing. Obesity affects 7.4% of children under 6 years, 17% of schoolchildren in their first year of school, and nearly 25% of adults and the elderly. It is estimated that the country currently has 3.4 million obese persons. If the current trend continues, by 2010 there will be over 4 million persons.

Like other countries in the Region, Chile is experiencing a cultural, social, and economic process that favors unhealthy lifestyles. Comparison of the last two national surveys on family budgets and expenditures shows that a significant portion of the increase in the income of the poorer strata has been used to purchase food with high levels of fat and refined sugar, processed food, televisions, electrical appliances, telephones, and vehicles. These are products that contribute to an unbalanced diet and a sedentary lifestyle.

In 2006, Chile adopted the Global Strategy against Obesity (EGO-Chile), which is based on the recommendations of the Global Strategy on Diet, Physical Activity, and Health. It supplements and expands the nutritional intervention strategy throughout the entire life cycle. This strategy has an important communication component that seeks to foster better eating habits and regular physical activity.

PAHO and the Ministry of Health have established a joint national effort that focuses on physical activity. The goal is to increase individual and population levels through the *Ciclo Recreo Via* program in Santiago, which offers children and adults a safe environment for recreation and physical activity. In Chile, PAHO seeks to guarantee the sustainability of the program.

### **Prevention of Accidents and Injuries caused by Acts of Violence**

311. Since 2002, PAHO and the Centers for Disease Control and Prevention (CDC) have participated in a joint project in hospitals in Colombia, El Salvador, and Nicaragua with a view to establishing surveillance systems that facilitate collection of up-to-date and timely information on the magnitude and characteristics of injuries by patients that visit the health care services for this reason. The ministries of health and some hospitals have used these analyses to make internal decisions and propose interventions that prevent injuries. The initiative is currently being extended to other countries.

312. With funds from the German agency GTZ, PAHO has been promoting the Youth Development and Prevention of Violence project in Argentina, Colombia, El Salvador, Honduras, Nicaragua, and Peru since 2004. The project seeks to strengthen government institutions and NGO networks, and publish national materials on public policies and participatory experiences related to prevention of violence in these countries. Work with other agencies has also been promoted during the quinquennium. PAHO has sponsored the Inter-American Coalition for Prevention of Violence (CIPV) since 2003. This coalition is made up of several multilateral and bilateral agencies that formulate strategies and possible solutions to reduce violence and crime in countries of the Americas.

313. In March 2007 the directors of these agencies held a meeting at PAHO Headquarters, and a five-year report was submitted. Since it was established five years ago, the coalition has introduced specific activities with measurable results. In addition, it has acted as a catalyst for inter-agency collaboration and implementation of effective strategies throughout Latin America.

314. In collaboration with the PAHO/WHO Collaborating Center for Prevention of Injuries and Violence, the Center for Health Research and Violence (CISALVA) of the Universidad del Valle in Cali, Colombia, USAID, PAHO and CIPV have applied an intersectoral model in some *municipios* of El Salvador, Nicaragua, and Panama in order to improve the poor quality of registries of deaths caused by deliberate and involuntary injuries. In Colombia, the model has produced good results in at least 30 *municipios*.

315. Since World Health Day was held in 2004, PAHO has reaffirmed its commitment to promoting the safety of the road network. Cooperation with national authorities has led to approval and publication of National Road Safety Plans in several countries, including Costa Rica, Ecuador, El Salvador, and Peru. PAHO ensured that activities were conducted in nearly all countries in the Region in April 2007 on the occasion of Road Safety Week and the Youth Assembly for Road Safety. A document with recommendations on obtaining, analyzing, and circulating information about traffic accident-related injuries has been prepared and made available.

### **Disaster Preparedness and Other Unforeseen Situations Important for Health**

316. At the request of the Ministers of Health in the Region, PAHO has established a regional response team for emergencies and disasters. A total of 111 national experts have been trained in 15 countries. This multidisciplinary team, which includes specialists in disaster management, epidemiology, water and sanitation, communications, mental health, health services, civil engineering, administration, and logistics, has been mobilized with very good results in the emergencies that have required international solidarity and PAHO technical cooperation.

317. Since 1976, when the PAHO Disaster Program was created, there has been continuous progress in activities by the health sector to reduce, prepare for, and respond to disasters in the Region. However, this progress has never been systematically measured. Therefore, PAHO designed and applied a regional evaluation survey. This survey has produced results that have been used to establish the level of institutional development and evaluate the status of planning, training, and availability of resources in order to respond to disasters and reduce their health consequences.

318. During the past five years, PAHO has consolidated the experience gained in the countries in the Region by producing guides and technical materials for comprehensive

management of emergencies and disasters in the field of health. These materials have been produced with the participation of entities such as WHO and other agencies of the United Nations, Red Cross, and the World Bank. With the support of the Regional Disaster Information Center (CRID), several countries have developed health information systems. The CRID is an initiative sponsored by six organizations, including PAHO, which have joined to compile and circulate information about disasters in Latin America and the Caribbean.

319. Although the impact of disasters has varied during the quinquennium, PAHO has always managed to assist the countries by mobilizing funds and response teams, and especially by providing technical cooperation in situations of internal conflict such as those that occurring in Haiti and Colombia. By opening decentralized offices, they have been able to concentrate cooperation in the communities that are directly affected.

320. Honduras, a country that is susceptible to hurricanes, offers an example of the progress achieved. Honduras currently has departmental emergency plans in 19 of its 20 regions. The Ministry of Health disaster unit has placed a great deal of importance on training resources in the departments. Training has been implemented for local teams so that they can predict and respond better to disasters.

321. Disaster management training has also been included in master's level courses on public health and risk management given by the National Autonomous University of Honduras. In addition, the country has the Emergency Operations Center manual for the health sector, an instrument that defines organization of the sector in order to respond in the event of an emergency or disaster.

### **Guatemala recovers from damages caused by the tropical storm Stan**

In 2005, the tropical storm Stan shook Guatemala, where it caused loss of life and significant damage to the public and social infrastructure of 15 departments in the country. As a result of the storm, 670 deaths, 844 missing persons, 495,927 direct victims due without housing, and 2.7 million affected inhabitants were reported. Many of them had to be lodged in 762 provisional shelters. Furthermore, there were damages to 38,058 dwellings in 1,372 communities located in 251 of the 331 *municipios* in the country. Eighty-seven health stations, 31 health centers, and more than 15 thousand water wells were affected. The areas affected most were important centers of Mayan population (*Mam, Kaqchiquel* and *K'iché*), where many poor and vulnerable households headed by women are located.

Under the management of the Ministry of Public Health and Social Welfare (MSPAS), with the participation of PAHO, UNFPA, UNICEF, UNDP, CDC and USAID, comprehensive interventions were conducted in several areas. PAHO mobilized more than \$3 million from the governments of Canada, United States, Netherlands, Norway, Monaco, and Sweden. The initiative reduced death and disease in the populations affected, and made it possible to maintain dynamism and solidarity for reconstruction of the social fabric, social services, governance, and the local economy. It also strengthened the local capacity to cope with future natural disasters.

Mental health care for the populations affected became a fundamental element of comprehensive care. Teams of psychiatrists, psychologists, and social workers evaluated the situation and provided care for the persons affected. Intersectoral brigades were formed, comprised of these experts as well as physicians, nurses, nursing assistants, nutritionists, epidemiologists, sanitation engineers, vector specialists, pharmacists, health promoters, and volunteers.

Integrated and coordinated food assistance was provided by the agricultural and health sectors, the food and nutrition safety program of the Ministry of Health (PROSAN), the Ministry of Food Safety and Nutrition (SESAN), and other institutions. A nutritional surveillance system was created in seven *municipios*. This system facilitated detection of deficiencies, as well as provision of food and micronutrients for children and pregnant women at risk of malnutrition.

322. In January 2005, torrential rains caused serious floods along the coast of Guyana, which is the most populated area in the country. Approximately 290,000 people were affected (39% of the total population). Within a few hours, thousands of victims had to leave their homes in the capital and coastal towns, and nearly 5,000 had to go to improvised shelters.

323. With the support of PAHO, the Ministry of Health organized and dispatched 30 to 40 mobile medical teams every day to provide medical care, and administer medication and oral rehydration. Environmental health experts also advised inhabitants on the best water treatment practices at home, and distributed bleach and cleaning products.

324. A public campaign for the prophylactic treatment of leptospirosis was conducted, and suspected cases were sent to Georgetown Public Hospital. Extensive public information campaigns were also conducted on water, sanitation, personal hygiene, diarrhea prevention, oral rehydration salts, and cleaning measures after floods.



325. PAHO provided assistance for epidemiological surveillance, health systems management, water and sanitation, hygiene measures, and food supply. It collaborated in supervision of 43 registered shelters and prepared a manual on health protection in the shelters. It also helped the health authorities on the island to improvise health care centers.

#### **The Cricket World Cup held in the Caribbean poses health challenges**

Between 11 March and 28 April 2007, several countries in the Caribbean served as hosts for the Cricket World Cup (CMC), an event of international importance sponsored by the International Cricket Council. Host countries were Antigua and Barbuda, Barbados, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Lucia, Trinidad and Tobago, and Saint Vincent and the Grenadines. During the Cup, the countries were considered to be a single domestic area for safety and immigration purposes. The arrival of over 100,000 visitors was expected, including spectators, participants, and the press. Due to its magnitude, the event required implementation of public health measures and reinforcement of epidemiological surveillance. The emergency and port health services applied international standards in order to guarantee a safe and healthy environment for competition, and protect the health of the local population as well as visitors.

Starting two years before the Cup, PAHO supported training activities in all countries that participated in the competition. A total of 1,302 people were trained, and a database was provided with experts from several disciplines trained in disaster management. Simulation activities were conducted in several host countries. PAHO also provided the countries with direct technical assistance on environmental health, waste disposal, and food hygiene. The collaboration between agencies enabled the countries to gain experience in procurement of ambulances, critical care equipment and instruments, personnel training, and use of operating systems. As a result of this collaboration, there were no disease outbreaks with epidemiological importance.

326. In 2004, the 45th PAHO Directing Council approved Resolution CD45.R8 urging Member States to adopt the “Hospitals Safe from Disaster” slogan as national policy in order to reduce hospital risks. The resolution established a regional goal that all new hospitals must be built with protective measures that guarantee they continue to function during disaster situations. It also calls on governments to ensure that reinforcement and refurbishing of existing health facilities, particularly those providing primary and emergency care, includes introduction of appropriate disaster reduction measures.

#### **National Border Health**

327. As a result of the current processes of commercial integration in the Region, national border health has become increasingly important. In order to control sexually transmitted diseases, the United States and Mexico requested that PAHO create a field office on the Mexican-American border. This office, which was established in 1942, has conducted activities that have been implemented in other border areas in Central America and South America.

### **Health at the Brazilian, Colombian, Ecuadorian, Peruvian, and Venezuelan borders**

Within the framework of different subregional agreements, the border areas between Andean countries conduct activities that integrate several sectors of development. One of the most dynamic sectors is the health sector, which emphasizes epidemiological surveillance committee (COVES) activities, disease prevention and control activities, and agreements on common use of services. In recent years, the spheres of action have been extended to also include pesticide poisoning and water quality surveillance (Colombia-Ecuador border); development and application of methods to analyze the comprehensive health situation (ASIS) (all borders) as a basis for development of the Andean Border Health Plan; local reinforcement for functions considered in the International Health Regulations (Colombia borders with Brazil and Peru); studies on prevalence, behavior, and availability of services for persons with HIV (Ecuadorian border); and development of care models for the indigenous population (Venezuelan border); training in epidemiology, situation rooms, and the geographic information system.

The progress of activities is evaluated continuously, and reviewed and adjusted by neighborhood committees, binational technical health committees, and the presidential committee on border integration (COPIAF). PAHO has provided technical support for preparation of disease control modules based on epidemiological principles (MOPECE), the geographic information system (SIGEPI), the ASIS method, and the water quality monitoring and situation room, as well as other activities. In addition, it has provided economic cooperation through three technical cooperation projects with these countries (Colombia-Ecuador, Colombia-Venezuela, and Brazil-Colombia-Peru). The instruments described above are distributed and used in all projects.

In addition, binational health actions support the integration efforts agreed on by the respective ministries of foreign affairs and subregional agencies (Meeting of Ministers of Health of the Andean Area and Andean Health Agency).

328. On the border between Belize, Guatemala, and Mexico, projects focusing on surveillance, prevention and control of communicable diseases such as human rabies, Chagas' disease, and malaria have been conducted. These have been promoted by the Tuxtla Agreements, the Puebla-Panama Plan, and other formal collaboration treaties supported by PAHO as well as other international cooperation agencies.

329. Uruguay has worked in conjunction with Brazil, particularly Rio Grande do Sul, with extensive participation by the municipal governments of Uruguay and the prefectures of Brazil, on border matters of mutual interest related to promotion of productive and healthy communities; development of zoonosis control strategies; integration of actions in health and agriculture; performance of coordinated municipal activities on food safety; and integration of joint binational bodies with local integration.

330. On the binational border between Brazil and Uruguay, PAHO has formed binational health committees; productive and healthy communities in neglected areas of Artigas, Rivera, and Cerro Largo; and coordination meetings between several different national agencies. All of this work has been demonstrated by national and subregional projects, such as the PAHO subregional projects, the Southern Cone Project for Hydatidosis Surveillance and Control, and Chagas' disease control.

## **CHAPTER 4: HEALTH CHALLENGES OF THE NEXT DECADE AND A PAHO PREPARED TO FACE THEM**

### **Health Agenda for the Americas**

331. In the 2003-2007 quinquennium, the technical cooperation of the Bureau was directed to accelerating the attainment of the MDGs most closely related to health. In their efforts to improve health, guarantee equity, and remedy the persistent disparities, the Member States of PAHO collectively defined and stated their public health priorities in the Health Agenda for the Americas, launched in Panama on 3 June 2007, in a ceremony that was attended by the President of Panama, Martín Torrijos; the Minister of Health of Panama, Dr. Camillo Alleyne; the Secretary General of the United Nations, Ban Ki-moon; and the Director of the Pan American Sanitary Bureau. Several ministers of foreign relations were also present. The Agenda, a declaration of political will at the highest level in the sphere of health in the Region, is a collective call to fight to ensure that all inhabitants in the Americas, without exception, have access to preventive and curative health services and that all families and communities receive public health benefits in equal measure.

332. The Agenda is a long-term planning guide for defining the strategic objectives of the Bureau's results-based management, according to the recommendations made in 2005 by the United Nations Joint Inspection Unit.

333. The Bureau assisted the countries throughout the process of priority setting, helping them to achieve consensus among themselves and with governmental and nongovernmental, academic, and civil society entities. The Agenda expresses the common goal of the countries to concentrate their actions throughout the decade 2008-2017 on eight strategic areas, which will serve as the foundation for the future health plans of the Hemisphere's countries and for all organizations interested in cooperating with them in health.

### ***The values and principles reflected in the Health Agenda for the Americas***

334. The Health Agenda for the Americas is based on respect for and adherence to the following values and principles:

335. *Human rights, universality, access, and inclusion.* In order to make the right of every human being to enjoy the highest attainable standard of health a reality, the countries of the Region should work toward achieving universality, access, integrity, quality, and inclusion in the health systems, which in turn should be accountable to citizens for the degree to which they achieve these ends.

336. *Pan American solidarity.* Solidarity, defined as collaboration among the countries of the Americas to advance shared interests and responsibilities to reach common targets, is an essential condition for overcoming the inequities observed in health and enhancing Pan American health security during crises, emergencies, and disasters.

337. *Equity in health.* The search for equity in health is manifested in the effort to eliminate all health inequalities that are avoidable, unjust, and remediable among populations or groups. This search should emphasize the essential need for promoting gender equity in health.

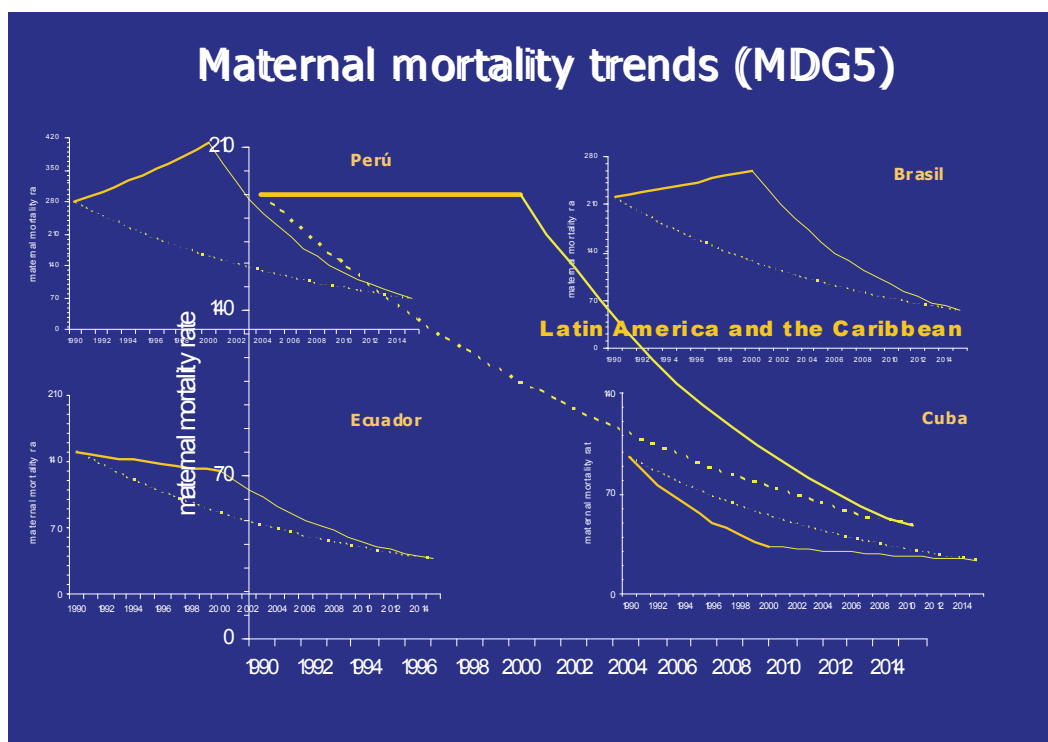
338. *Social participation.* The opportunity for all of society to participate in defining and carrying out public health policies and assessing their outcomes is an essential factor in the implementation and success of the Health Agenda.

### **Progress Toward the Attainment of the Millennium Development Goals**

339. A recent report coordinated by ECLAC, to which PAHO and other international organizations contributed, has summarized the status of the MDGs in the Member States of PAHO. According to this report, Latin America and the Caribbean have made some progress toward achieving several of the objectives, but a number of countries are very behind. The main stumbling block is the persistent inequity, which is ethically unacceptable. The values of social justice should serve as a guide for improving this situation.

340. Judging by the trends observed since 1990, the progress has chiefly been in reducing hunger, malnutrition, and child mortality, providing better access to safe drinking water, and promoting gender equity in education. All this notwithstanding, in some countries it is clear that the current rate of progress will not be sufficient to reach the goal of reducing under-five mortality by two-thirds between 1990 and 2015. Similarly, not enough progress has been made in reducing extreme poverty and maternal mortality, providing primary education for all, expanding basic sanitation coverage, and protecting the environment.

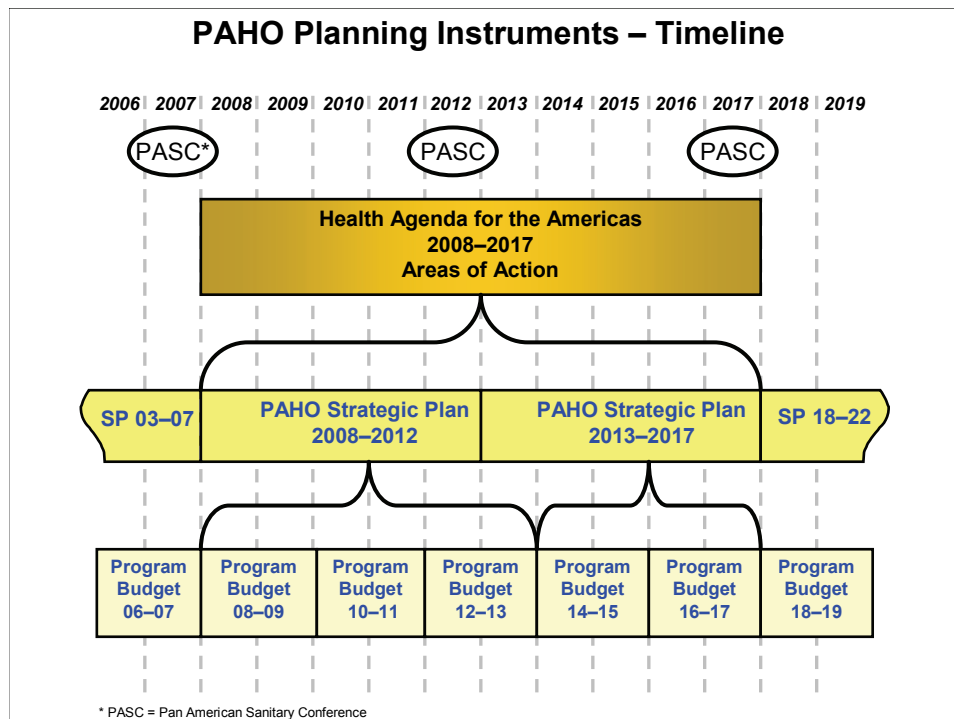
341. The figure below illustrates how far Latin America and the Caribbean still have to go toward attaining one of the MDGs.



### Strategic Plan 2008-2012

342. The Strategic Plan of the Pan American Sanitary Bureau 2008-2012 is the highest-level planning instrument of PASB and is based on both the Health Agenda for the Americas and the global health agenda adopted with WHO's Eleventh General Program of Work. The plan, whose preparation involved a broad participatory process, contains 16 strategic technical cooperation objectives and their expected results for 2008-2012 and represents all the work contemplated by the Bureau for the period.

343. In the SP 2008-2012 there is a close connection between the biennial work plans of each structural unit, the expected results, and the program budget. This eliminates the need for extensive program planning every two years and makes it possible to use the program budget evaluations produced at the end of each biennium as reports on the execution of the SP 2008-2012.



344. The strategic framework for 2008-2012 lends continuity to that of 2003-2007. The PASB will continue to focus its technical cooperation primarily on priority countries and the unfinished agenda. It will make efforts to safeguard the achievements obtained to date in all the countries of the Region and will target the most neglected and vulnerable population groups, thus promoting equity in and from the field of health.

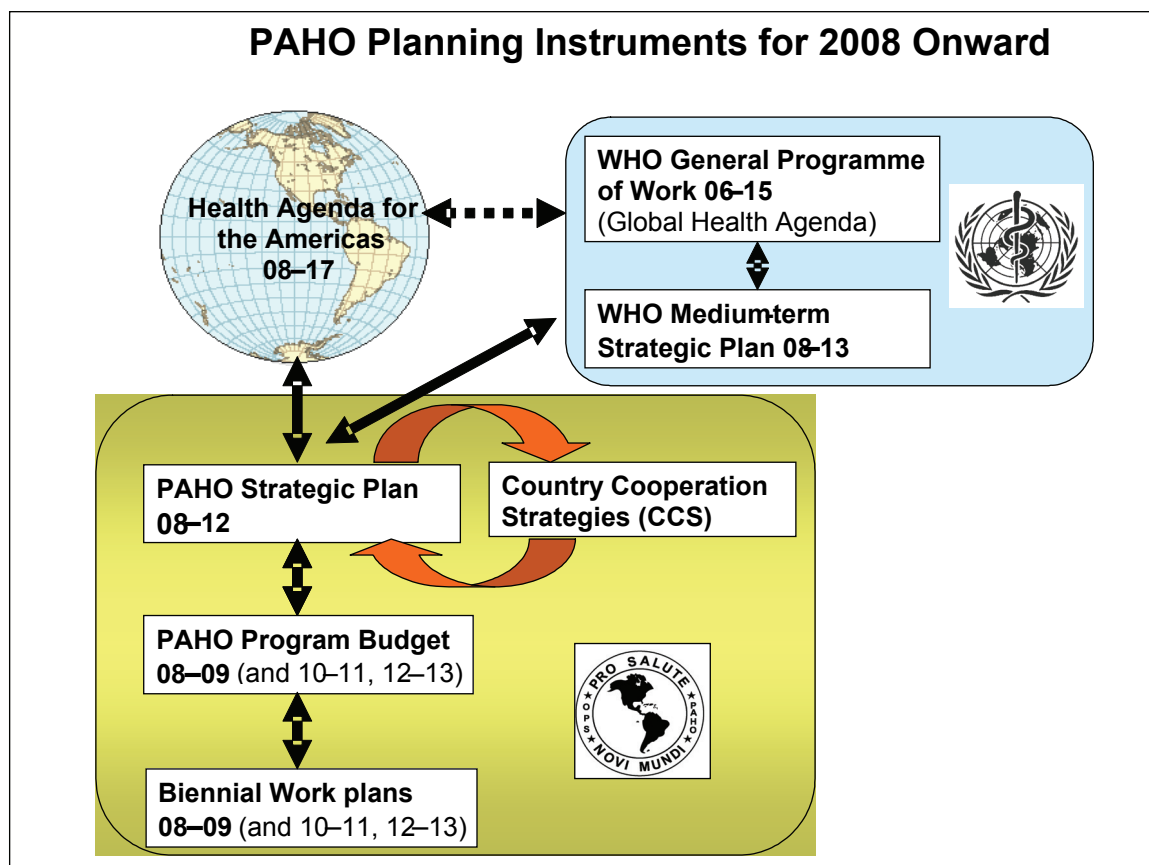
345. As part of the country-focused cooperation strategy, PASB will continue to apply the regional program budget policy (RPBP). A greater proportion of institutional resources will be channeled to country programs and to the new subregional allocation level to increase technical assistance to the Hemisphere's subregional integration processes.

### **Alignment with WHO**

346. The SP 2008-2012 is aligned with the Eleventh General Program of Work and the Medium-term Strategic Plan of WHO. Formerly these plans had never been in alignment. Moreover, the expected results of the PASB represent the Bureau's contribution to the expected results for all of WHO, and for the first time, the respective regional and global indicators have been brought into line. Program convergence with WHO has gradually been accomplished during previous planning cycles, recognizing PASB's function as the

WHO Regional Office for the Americas. The SP 2008-2012 completes the program integration process while responding to the mandates of the Governing Bodies and other important forums, mandates that include the development goals of the Millennium Declaration.

347. The plan relies heavily on the harmonization and convergence of initiatives and the horizontalization and articulation of approaches so that all lines of action in the countries and at Headquarters synergistically complement one another. The SP 2008-2012 will steer planning toward securing better results, facilitate surveillance and reporting, and increase the transparency of PASB activities and accountability to the Member States. Furthermore, the expected results are flexible enough to allow the Bureau to adapt and respond to new challenges that may arise. There is close a connection between the objectives of the SP 2008-2012 and the areas of action contained in the Health Agenda for the Americas.



## **The Challenges of a Changing Environment**

348. Added to the major public health challenges outlined in the Health Agenda are those that PAHO must address, deriving from the profound transformations of the past 30 years in the Region and worldwide.

349. The number of actors and entities working in the health sector has soared, making it necessary for the Organization to rethink its position as a regional intergovernmental technical cooperation agency in public health. Working as part of a team without losing its identity and continuing to adhere to its values while contributing to the work of others, is a significant challenge for PAHO at present. At the same time, the Organization must meet new expectations about the transparency of its procedures and convergence with other entities, in addition to finding innovative mechanisms to mobilize resources and forge partnerships. This is particularly true given the fact that the Region is comprised largely of middle-to-high-income countries that are not of the highest priority from the standpoint of official international development assistance.

350. Economic globalization facilitates the transfer of environmental risks due to the movement of people and goods across borders, the spread of unhealthy lifestyles, and the rising international trade in harmful substances for licit and illicit consumption. Globalization, however, has also led to the strengthening of democratic processes around the world. Nevertheless, serious inequities persist, along with economic instability and insecurity, engendering social discontent and undermining public faith in democracy, especially its ability to provide opportunities and social protection. Restoring that faith is another major challenge.

351. Globalization has brought about other phenomena like urbanization, air pollution, and an increase in carbon dioxide emissions. The impact of these factors on human health, and especially on the people who live in developing nations, is increasing daily. Although urban living should be beneficial to health, serious problems have emerged in major cities in terms of access to services, resulting in reduced quality of life. In view of the fact that the future is likely to bring about more urbanization and that in a few years we will reach a crossroads in the history of humankind, with half of the world's population residing in urban areas, PAHO has acknowledged the importance of this issue and launched various activities in order to define the strategic approach that should be taken in dealing with urban health and determine prevailing urban health conditions in selected cities of the Region.

352. Climate change also is one of the great challenges faced by the health sector. In its 2001 and 2007 reports, the Intergovernmental Panel on Climate Change (IPCC) noted that global warming of 1.4 to 5.8 ° C is expected to occur by 2100; this has implications for health and portends an increase in the natural disasters that such environmental changes tend to bring about.



353. PAHO studied the problem and expressed its position and vision for the future regarding climate change in two international public health events: Montreal 2006 and Vancouver 2007. A follow-up to the Barbados meeting on the effects of climate change is being prepared.

354. A conference and workshop on climate variability and climate change and their health impact in Central America were held in San Jose, Costa Rica, in August 2007 with representatives of several Central American countries (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama) and national and international institutions. The conclusions served as the framework for the design of the Organization's projects and programs in the coming years.

### **Primary Health Care**

355. On 17 August 2007, the 30-15 international conference on PHC was held in Buenos Aires. It was attended by the Director of the Pan American Sanitary Bureau and by WHO's Director General, Dr. Margaret Chan.

356. During her visit, Dr. Chan also visited Uruguay, where she confirmed WHO's commitment to the United Nations reform system, and Brazil, where she met with President Lula to explore the possibility of establishing south-south cooperation agreements.

#### **Buenos Aires 30-15: From Alma-Ata to the Millennium Declaration**

During the World Health Assembly held in May 1977, the countries of the world set the goal of achieving health for all by the year 2000 and agreed that the appropriate strategy for achieving this was primary health care (PHC). In September 1978, the International Conference on PHC, held in Alma-Ata, Republic of Kazakhstan, WHO, and UNICEF issued the Declaration of Alma-Ata, whereby the Member States of WHO adopted the primary health care strategy as the most promising way to secure access to health care for everyone.

With the 30th anniversary of the Conference approaching, Argentina's Ministry of Health issued a call for an international meeting whose purpose was to build new consensus and promote global and regional partnerships that would strengthen health policies to achieve the Millennium Development Goals by 2015.

To this end, it invited the Ministers of Health from every region, together with international experts, health authorities, and staff from international and technical agencies, to discuss these issues. The final joint Declaration, entitled "Towards a Health Strategy for Equity, based on Primary Health Care," reaffirmed the role of health in generating the development and growth of nations and expressed the countries' commitment to developing processes that incorporate the values and principles of the primary health care strategy to guide health system policies, structure, and functions at all levels and for all people.

357. The governments' commitment to fight for equity in health and for the attainment of the MDGs, stated in Resolution CD44/R6 adopted by the Ministers of Health in September 2003—exactly 25 years after Alma-Ata—provides an opportunity to renew PHC and reorient management, organizational, financing, and care models in the direction of health system development. This renewal, which is essential for achieving equity in health and improving health conditions in the countries of the Hemisphere, is one of the main challenges facing the health sector.

### **Intellectual Property and Patents**

358. Recent controversy regarding intellectual property and patents poses a challenge for the development of new, quality drugs, vaccines, and state-of-the-art technologies. Respect for intellectual property rights is important for developing new products. However, it is also essential to ensure affordable prices, which are often beyond the population's ability to pay. The 2001 Doha Declaration of the World Trade Organization states that public health should take precedence over industrial property rights. Developing countries have an opportunity to take advantage of certain flexibilities within the TRIPS (*Trade-Related Aspects of Intellectual Property Rights*) agreement to lower the price of proprietary products.

359. Unfortunately, the fact still remains that relatively few patents are obtained in Latin America and the Caribbean. For example, of the 13,566 patent applications submitted in Mexico in 2001, only 5% came from Mexicans. The situation with respect to antiretrovirals and other costly drugs is especially troubling, although Brazil has set a precedent in this area. The use of generic drugs is one of the most effective health interventions, and making them accessible to the population plays a fundamental role in achieving equity in health. Moreover, few science and technology policies are sensitive to national health policies. It is therefore necessary to promote and strengthen the actions of the ministries of health in research and development and in the production, distribution, assessment, and use of health technologies. Science and technology policies must include proposals and measures that specifically target the health industry, since the countries need vaccines, sera, blood products, diagnostic kits, equipment, and other medical supplies produced by industry.

### **Human Security and Health**

360. Health is at the heart of human safety. Diseases, injuries, disabilities, and preventable deaths are all critical threats to human well-being and security. Health is also a prerequisite for social stability and the promotions of fully functional and economically productive societies.

361. Certain infectious diseases are becoming an ever-increasing threat that is spreading far and wide at a fast pace. Despite the great strides in medicine and technology, the world's poorest people continue to shoulder a very heavy burden. Injuries, disabilities, and death from traffic accidents and interpersonal violence directly undermine development objectives and call for new and intuitive forms of cooperation between public safety and public health. A broad range of actors is needed for a deeper, more integrated approach to the problem.

362. Defining the essential public health functions as they pertain to human security will enable the health sector to better exercise its ability to invite others to share in the provision of intersectoral cooperation. In recent years, PAHO has made a commitment to integrate the concept of human safety into work areas that, as mentioned earlier, play a key role in efforts to establish a safer, more humanitarian Region.

### **Building the Future**

363. It is essential to invest not only in public health and primary care but in the sciences, technology, research, and human resources as well. One of today's challenges lies in putting the scientific and technical information needed to improve health status within the reach of developing countries. This implies providing institutions and the population with easier access to electronic and digital media. The digital revolution has bypassed virtually all the Latin American and Caribbean countries. It is essential to promote the creation of information networks and databases in these countries to facilitate epidemiological surveillance and the resulting data collection and analysis.

364. We must find out more about the institutional, organizational, and managerial determinants of ethnic and racial disparities in the quality of the health care received. To develop effective health interventions, it is important to know the relative importance of the various factors that affect health.

365. Over the next five years, the Organization will intensify its institutional transformation process. This will buttress its international leadership in health and its status as an institution that encourages the participation of its Member States in defining health policies; that has an improved financial management system; that applies clear criteria for effectiveness and equity in allocating financial resources; that has strong partnerships and linkages; that is closely aligned with WHO; that is able to coordinate international, national, and local aspects of the health agenda; and that promotes community participation and social involvement.

366. The goal is to attain transformation for action and a renewal process whose overarching purpose is to achieve regionwide equity in health and put health within the reach of all as a tangible contribution to the creation of inclusive, united societies that practice solidarity and encourage the full development of human beings. The SP 2008-2012 of the PASB provides a flexible, coherent strategic response that addresses all of these major challenges together with those of the Health Agenda for the Americas.

367. It is important to encourage structural changes that will enable citizens to become the architects of their own destinies through active community participation. To this end, we must offer citizens better tools and mechanisms to bolster their natural capacities so that they can fulfill their potential, especially the youngest among them. The creation of a better future with more equitable and inclusive societies with greater solidarity is in their hands.

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