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ANNUAL REPORT OF THE DIRECTOR
OF THE PAN AMERICAN SANITARY BUREAU

Promoting Health, Well-being, and Human Security in the Americas

CONTENTS

Page

From the Director

To the Member States:

In accordance with the provisions of the Constitution of the Pan American Health Organization, I have the honor to present the 2009–2010 annual report on the work of the Pan American Sanitary Bureau, Regional Office for the Americas of the World Health Organization. The report highlights the Bureau's major work in providing technical cooperation during this period within the framework of the 2008–2012 Strategic Plans of the Pan American Sanitary Bureau, defined by the Governing Bodies of the Pan American Health Organization.

Mirta Roses Periago
Director

Chapter I. Human Security: A Holistic Vision

"Human security is reflected in a child who doesn't die, a disease that doesn't spread, a job that isn't eliminated, ethnic tension that doesn't explode into violence, a dissenter who isn't silenced. Human security doesn't involve concern about guns but concern about human life and dignity."

Dr. Mirta Roses Periago
Director, Pan American Health Organization

1.   In 2009–2010, events in the Americas brought into sharp focus the importance and the interconnectedness of health, security, and human well-being. The frightening onset of the H1N1 influenza pandemic tested and largely validated several years of public health preparedness efforts that were grounded in the principles of international health security. The January 2010 earthquake in Haiti showed the tragic consequences of unplanned urban sprawl and the extreme vulnerability of populations living in poverty. Recalling these events, one understands at an intuitive level that human security cannot be taken for granted; it must be protected and promoted as a basic requirement if people, communities, and countries are to carry on in a meaningful way.

2.   The concept of human security has received growing attention in recent years, and not just because of pandemics and natural disasters. Since the end of the Cold War, the number and intensity of armed conflicts among countries has declined dramatically while global interdependence has increased significantly. In this context, the continued suffering and vulnerability of millions of the world's less advantaged people stand in disturbing contrast to the wealth and comfort of the more privileged. The inherent injustice and instability created by these trends have helped shift the focus of security concerns from the protection of national territory and sovereignty to the protection of human well-being.

3.   This shift was articulated and brought to the fore of the global development agenda by the United Nations Development Program's (UNDP) *Human Development Report 1994*. It argued that, in the post–Cold War era, people's insecurity stems much less from the threat of international conflict than from threats to their daily lives—to their jobs and income, to their health, to their environment, and from crime. This calls for a new approach to security, one that addresses the full range of threats to people's well-being.

4.   The idea that human security is as critical for peace and development as military security is not new. The importance of both was recognized by the founders of the United

Nations. After attending the U.N. Charter conference in San Francisco in 1945, the then U.S. secretary of state told his government:

> The battle of peace has to be fought on two fronts. The first is the security front where victory spells freedom from fear. The second is the economic and social front where victory means freedom from want. Only victory on both fronts can assure the world of an enduring peace….No provisions that can be written into the Charter will enable the Security Council to make the world secure from war if men and women have no security in their homes and their jobs.

5.   The idea of a "human" side to security lost ground during the Cold War decades, but re-emerged with the UNDP's 1994 report. It acknowledged the difficulty of providing a rigorous definition of human security but proposed four essential characteristics of the concept:

- **Universality** – human security concerns are common to people everywhere, in rich and poor countries alike, and include unemployment, drugs, crime, pollution, and human rights violations.
- **Interdependence** – when the security of people is endangered in one place, this has consequences for others as well. The consequences of hunger, disease, drug trafficking, terrorism, ethnic disputes, and social disintegration can no longer be confined within national borders.
- **Focus on prevention** – it is easier to address human security concerns preventively than through after-the-fact interventions. For example, investments in primary health care and family planning education could have helped contain the spread of HIV/AIDS during the 1980s.
- **People-centered** – human security is concerned with how people live in society, how freely they exercise their choices, how much access they have to economic and social opportunities, and whether they live in conflict or in peace.

6.   The report outlined two types of threats to human security: chronic ones such as hunger, disease, and repression, and threats that are sudden and cause harmful disruptions to daily life. Failure to provide protection from both these kinds of threats can impede human development and lead to social conflict and even violence. In this way, human security—security for people in their daily lives—is also clearly related to collective security and to the state.

7.   At the 2000 Millennium Summit, U.N. Secretary-General Kofi Annan spoke of the importance of "freedom from fear" as well as "freedom from want," invoking the concept of human security to motivate rich and poor countries to work together to reduce human deprivation. Although the subsequent Millennium Development Goals (MDGs) focused on the latter, the summit called for the creation of an independent Commission on Human Security to explore the former. That commission's 2003 report, *Human*

Security Now, called for a paradigm shift and a stronger and more integrated response to these issues from communities and states.

8.   The Commission on Human Security's report reaffirmed and elaborated the view that "freedom from fear" and "freedom from want" are equally important. But it also emphasized the empowering function of people-centered security, noting that it also meant "freedom to take action on one's own behalf." Human security means protecting "the vital core of all human lives in ways that enhance human freedoms and human fulfillment." It means more than the absence of conflicts; it means creating systems— political, social, environmental, economic, military, and cultural—that give people the building blocks of survival, livelihood, and dignity.

9.   The 2007 World Health Report, *A Safer Future: Global Public Health Security in the 21st Century,* showed how growing interdependence and increased mobility have increased the vulnerability of people around the world to new and emerging threats such as epidemic outbreaks, acts of terrorism, and chemical or radioactive events. The report stressed the importance of countries' working collectively to protect their populations from such threats through the International Health Regulations and similar mechanisms as well as through increased investments in public health and safety.

10.   In the Americas, the concept of human security emerged on the hemispheric agenda early this decade, as the Organization of American States addressed new threats to regional security such as organized crime, terrorism, environmental degradation, and climate change. In the 2002 Declaration of Bridgetown, OAS Member States recognized the "multidimensional" nature of hemispheric security, noting its political, economic, social, health, and environmental components. In the 2003 Declaration on Security in the Americas, the countries declared that "the basis and purpose of security is the protection of human beings."

11.   As part of these deliberations, PAHO was asked to participate in a working group of the Committee on Hemispheric Security, to advise on matters related to health. PAHO produced a report, *Health and Hemispheric Security*, which argued that "health is a national and international security interest" and an intrinsic part of human security; better health leads to greater human security, and greater human security leads to better health and quality of life. It also explored the interrelatedness of health and other components of human security, particularly poverty, democracy and peace, the environment, and disasters, both natural and manmade. It noted that people's health depends not only on health care and disease prevention systems but on social determinants such as education, income, access to essential resources, social and political participation, and the environment.

12.   This view of health and its interrelatedness with other aspects of human security echoes the holistic vision of the MDGs, which recognize the interdependence of health and political, economic, social, and cultural factors in determining human well-being. This view was elaborated from a public health perspective in the 2008 report of the WHO Commission on the Social Determinants of Health. It urged rich and poor countries alike to reduce inequities in the distribution of power, money, and resources, and to work on all fronts to improve people's daily living conditions—including the circumstances in which they are born, grow, live, work and age. Though its focus was on health and social justice, the report provided strong analyses of the many components of human security along with valuable recommendations for addressing them.

13.   In these and more recent discussions, the main components of human security fall into seven major areas: economic, food, environmental, personal, community, political, and health. From a public health perspective, however, all seven of these areas include threats to, components of, or determinants of health, and all are amenable to public health interventions. Indeed, PAHO's ongoing technical cooperation encompasses all these areas. Chapter 2 provides examples of this work in PAHO Member States during 2009–2010.

Chapter II. Promoting People-Centered Security

14.   PAHO's ongoing technical cooperation with its Member States addresses a wide range of health and health-related issues that, as discussed in Chapter I, are both directly and indirectly related to human security. This chapter presents highlights of PAHO's work in these different areas during 2009-2010. Examples are grouped thematically according to the seven major components of human security: economic, food, environmental, personal, community, political, and health.

Health Security and the Global Economic Crisis

15.   The global economic downturn has put significant pressure on social spending in PAHO Member States. This has made it difficult for countries to sustain their national health budgets or, for countries striving toward universal coverage, to increase their budgets. PAHO's technical cooperation during 2009-2010 addressed these concerns with a particular focus on the search for sustainable health financing solutions, the reorganization of health systems using the renewed primary health care approach, and increasing equity in the distribution of scarce health resources.

16.   In **Ecuador,** PAHO supported the government's efforts to comply progressively—despite the global economic crisis—with a constitutional mandate that calls for increasing financing for the National Health System by at least 0.5 percent of GDP each year until the financing reaches at least 4 percent of GDP. PAHO helped develop a set of guaranteed health services to be offered by the public health network under the Right to Health Regime, as well as a methodological framework for evaluating the impact of health investments during the past three years, which includes the formulation and publication of "national satellite accounts."

17.   PAHO promoted discussion among ministries of health of the Eastern Caribbean countries and territories—**Anguilla, Antigua and Barbuda, Barbados, British Virgin Islands, Dominica, Montserrat, Grenada, Saint Lucia, St. Kitts and Nevis,** and **St. Vincent and the Grenadines—**on sustainable collective financing options for improving health systems and social protection while safeguarding households against catastrophic health expenditures. Three countries conducted consultations on primary health care to guide this process. In addition, PAHO organized a high-level meeting with health authorities on the primary health care renewal strategy to exchange lessons learned and review the countries' progress in this area. PAHO also provided technical cooperation to **Grenada**, **Barbados**, and **Saint Lucia** to strengthen their institutional capacity to improve the financing of national health systems, particularly through the use of national health accounts.

18.   In **Venezuela**, PAHO supported a technical working group on national health accounts and contributed to the formulation of a novel matrix incorporating the social determinants of health approach. PAHO partnered with the Ministry of Health, the Central Bank of Venezuela, and the National Institute of Statistics.

19.   In **Cuba**, PAHO provided analysis and documentation of lessons learned and best practices adopted during the economic crisis of the 1990s, to guide current and future efforts to respond to economic pressures. This included strategies for social protection, reductions in public spending, efficient management of health services, and the introduction of new healthcare technologies.

20.   **Colombia**'s Ministry of Health applied PERC (Production, Efficiency, Resources, and Cost), a PAHO-developed tool for health systems assessment and management, to a new primary health care–based model of services for dispersed populations in difficult-to-reach areas. The use of PERC facilitated the reorganization of services to increase efficiencies in expenditures and demonstrated that the new model was efficient and sustainable using resources from Colombia's General System of Social Security in Health (SGSSS). Colombia is now considering extending the model from the department of Chocó to other dispersed populations in geographically isolated areas throughout the country and in areas of the department of Nariño.

21.   During 2009-2010, PAHO worked with the **Costa Rican** Social Security Fund (CCSS) to strengthen its network of services based on the primary health care renewal approach, a process that is expected to lead to better allocation of financial and human resources and better management of services. This included the design and redefinition of networks by level of complexity using the structural and functional elements of primary health care as a basis. Expected outcomes include reduced demand for hospital care, increased ambulatory and home-based care, the incorporation of health promotion into all levels of care, and earlier detection and treatment of chronic diseases.

22.   PAHO assisted **Brazil** with the development of policies to improve equity in the financing of the Unified Health System by transferring resources according to the needs of municipalities and by reducing the gaps between rich and poor regions.

Ensuring Food Security

23.   According to the World Food Summit of 1996, "food security exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life." PAHO's technical cooperation reflects this view, seeing both nutrition and food safety—not just sufficient calories—as essential aspects of food security.

24.   In 2009-2010, PAHO's technical cooperation in this area ranged from support for family and community projects aimed at advancing MDG-1 to assistance for food safety regulatory agencies. It included support for planning and policymaking, legislation and advocacy, human resources training, the adaptation and implementation of standards, and research on malnutrition and the burden of foodborne illness.

25.   In **Costa Rica**, PAHO worked with the Nutrition Institute of Central America and Panama (INCAP) in priority communities along the country's northern border, providing technical assistance to community organizations, primarily of poor rural women, to help them produce safe and nutritious foods. Also in collaboration with INCAP, PAHO provided technical and financial cooperation to improve nutrition for young children in public daycare centers in the **Dominican Republic**.

26.   PAHO supported the development and implementation of a number of food security projects financed through the MDG Achievement Fund, sponsored by the Government of **Spain**. These included projects in **Bolivia, Brazil, Colombia, El Salvador, Guatemala, Nicaragua,** and **Peru** focused on children's food and nutrition security, as well as 27 family projects in indigenous communities in **Costa Rica**. In **Cuba**, PAHO was in charge of more than US$1 million of a US$8.5 million project financed by the MDG Fund to fight anemia in pregnant women and children under 5. PAHO helped strengthen capacity in maternity homes and maternal-child health observatories and provided support for nutritional surveillance, information systems, and human resources training.

Hunger Emergency in Guatemala

In 2009, **Guatemala** suffered one of its worst droughts in history, producing substantial losses in corn and beans—the country's main food crops—in an area known as the "dry corridor." Coupled with the impact of the global economic downturn, this led to a critical situation of food insecurity, particularly for poor families who are highly dependent on remittances.

Following the declaration of a hunger emergency by the Government of Guatemala in September 2009, the United Nations Central Emergency Response Fund (CERF) provided US$ 5 million to FAO, WFP, UNFPA, UNICEF, and PAHO to implement emergency agriculture, food, nutrition, and health programs and to provide immediate assistance to 65,000 affected and at-risk families. PAHO was charged with administering US$ 700,000 of the funds, which it used to support actions to reduce severe acute malnutrition in 11 priority departments. PAHO worked closely with Guatemala's Ministry of Health to develop a plan of action to improve early detection, treatment, and follow-up of acute malnutrition through the implementation of treatment and referral protocols, training for health personnel, and improved surveillance and reporting, including obligatory daily notification of cases of severe acute malnutrition.

Following Tropical Storm Agatha in May 2010, which killed more than 150 people in Guatemala and forced 27,000 into shelters, PAHO helped identify cases of malnutrition in shelters in eight municipalities in the department of Totonicapán.

27.   **Nicaragua**, like Guatemala, also experienced a drought during 2009-2010, and in this context, PAHO successfully promoted the incorporation of specific nutritional interventions into the U.N Country Team's disaster response plans. These included support for exclusive breastfeeding, micronutrient supplementation, provision of oral rehydration salts, growth monitoring for small children, and surveillance of mothers and children under 5 to detect changes in nutritional status following disasters and after the provision of food assistance.

28.   PAHO also provided support for **Belize'**s National Food and Nutrition Security Commission and for **El Salvador**'s National Council on Food and Nutritional Security (CONASAN). The work included a review of Belize's 2001 National Food and Nutrition Security Policy and 2005-2010 action plan as well as strengthening of CONASAN's ability to develop public policies, create healthy and protective environments, strengthen social participation, and reorient the health services to focus more on food and nutritional security, especially in municipalities with high prevalence of chronic malnutrition.

29.   PAHO continued to support the work of the Pan American Alliance for Nutrition and Development, launched in 2008. As one of 14 members of an inter-agency technical team, PAHO helped develop and disseminate conceptual and operational principles for the alliance in various academic and political-technical forums at both the national and regional levels. In early 2010, action began on developing integrated intersectoral interventions to address the social determinants of nutrition in **Guatemala, El Salvador, Nicaragua,** and **Paraguay**. These interventions tackle issues ranging from clean water and sanitation to sexual and reproductive health, income and working conditions, and social participation and empowerment.

30.   In the area of food safety, PAHO worked in 2009-2010 to promote the World Health Organization (WHO) Five Keys to Safer Food as a training and social communication tool to reduce food safety risks in countries throughout the Region. In **Guatemala**, for example, PAHO helped develop manuals based on the Five Keys for teachers and school administrators that were subsequently adapted and validated in 12 rural and urban primary schools in four departments. Using Guatemala's experience as a model, PAHO worked with WFP, INCAP, and national health authorities to carry out similar projects in **Belize**, **El Salvador,** and **Honduras**. PAHO has also supported the implementation of the Five Keys in rural schools of **Bolivia**'s Altiplano and Chaco regions and in indigenous Amazonian communities in **Venezuela**. Manuals are now available in Spanish, English, and Portuguese.

31.   PAHO provided technical cooperation in the development of food safety policies and plans in **Antigua and Barbuda, Dominica, Grenada, St. Vincent and the Grenadines,** and in the **U.K. Overseas Territories**. In addition, PAHO's Caribbean

Epidemiology Center (CAREC) provided technical cooperation to strengthen foodborne disease surveillance, outbreak investigation, and laboratory capacity in 11 Caribbean countries through training and updating of protocols on integrated laboratory-based surveillance; specimen collection, transport, and diagnosis; and reporting of foodborne pathogens.

32. Similarly, PAHO supported **Cuba**'s efforts to improve national management of foodborne disease outbreaks through better detection, diagnosis, and response, and to prevent outbreaks through sanitary inspections. PAHO also supported Cuba's "productive municipalities" strategy, which seeks to increase production of foods of animal origin while strengthening prevention, surveillance, and control of zoonoses.

33. In the **Dominican Republic,** PAHO supported efforts to harmonize food safety legislation and regulation as well as inspection and control of food risks in the context of the United States–Dominican Republic–Central America Free Trade Agreement (CAFTA-DR). In **Ecuador,** PAHO helped develop guides and tools for surveillance and early warning of foodborne disease outbreaks, as part of the National Epidemiological Surveillance System (SIVE ALERTA).

34. Similarly, in **Chile,** PAHO helped the Chilean Agency for Food Safety (ACHIPIA) develop a new legal-regulatory framework, which is currently under discussion in the Chilean parliament**.** In addition, PAHO helped Chile address food safety concerns in areas affected areas by the February 2010 earthquake and tsunami. Work included training and promotion at the community level based on the WHO Five Keys**.**

35. In countries throughout the Region, PAHO is supporting research as part of the Global Burden of Foodborne Diseases initiative, a WHO effort to generate more complete information about the etiology and scope of foodborne disease outbreaks and risk factors associated with food handling, preparation, distribution, and consumption. The information is intended to help policymakers justify investments in this area, prioritize problems, and design better food safety interventions. In 2009-2010, studies were begun or completed in **Dominica, Guyana, Grenada, Jamaica, Saint Lucia,** and **Trinidad and Tobago** as well as in **Argentina** and **Chile,** in collaboration with the Pan American Foot and Mouth Disease Center (PANAFTOSA). Final results from **Cuba** were published in June 2010. As part of these efforts, CAREC organized a subregional Burden of Illness Analysis workshop in November 2009, in which 18 participants from nine Caribbean countries and territories—**Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Lucia, Trinidad,** and **Turks and Caicos**—were trained to use survey data from their own countries to calculate the burden of illness due to acute gastroenteritis.

36.   In 2009-2010, PAHO supported and promoted "healthy food markets" in **Bolivia**, the **Dominican Republic, Guyana,** and **Paraguay**. PAHO's assistance combined training in food safety with technical cooperation in basic sanitation, including disposal of solid and liquid wastes. In Bolivia, the initiative has proved so successful that it has been extended to several departments.

Building Secure Environments

37.   Environmental security is a longstanding focus of PAHO's technical cooperation, which recognizes and addresses a wide range of environmental risks to health. These include contaminated water and untreated waste, infestations of mosquitoes and other disease vectors, exposures to industrial and agricultural chemicals, and vulnerabilities to natural and manmade disasters. During 2009-2010, PAHO's efforts in this area ranged from risk reduction and disaster preparedness to primary environmental care, the promotion of "healthy spaces," and efforts to protect children and workers from exposure to environmental risks.

Children's and Workers' Health

38.   PAHO and other UN agencies supported **Argentina** in developing the *Atlas of Childhood Environmental Risks*, published in 2009, which documents the incidence, distribution, and sources of environmental contaminants that impact children's health. According to the atlas, 58 percent of children living in Argentina (more than 5 million) are at risk from environmental contaminants; the majority live in poor areas that lack access to basic water and sanitation services and are exposed to agricultural or industrial chemicals and waste products. In follow-up to the atlas, PAHO is helping develop a manual of procedures and processes to combat environmental contamination, along with tools for detecting and responding to related health problems at the local level. The methodology will be made available for other countries to develop their own atlases of environmental risks.

39.   Also in the area of children's environmental health, PAHO supported a horizontal technical cooperation project for **Argentina** and **Chile** that led to the creation of new pediatric environmental units in two hospitals in Chile and to the joint publication of manuals, guides, and other support materials for training in this area.

40.   During 2009-2010, PAHO facilitated the creation of a binational academic technical advisory group to support the United States–Mexico Environmental Program: Border 2012, coordinated by the US Environmental Protection Agency (EPA) and Mexico's Secretariat for the Environment and Natural Resources. With PAHO support, the group developed and began implementing an action plan to strengthen the technical capacity of the Border Environmental Cooperation Commission in the area of environmental health. The plan included the development of a binational

multidisciplinary and inter-institutional research project to assess the vulnerability of children in the El Paso del Norte region to health risks associated with climate change, the development of a risk communication strategy in children's environmental health, and training for graduate and undergraduate students in the US–Mexico border region in interdisciplinary team approaches to addressing children's environmental health.

41.   In **Colombia**, PAHO supported intersectoral working groups led by the National University of Colombia and the Secretary of Health of the Department of Cundinamarca in efforts to develop a departmental policy on workers' health and local policies for 11 municipalities. PAHO also collaborated with the U.S. National Institute for Occupational Safety and Health (NIOSH) and Colombia's Ministry of Social Protection to organize the Regional Meeting on Health Protection for Health Sector Workers, held in March 2010.

42.   In **Guyana,** PAHO collaborated with the Fuddie Hospital, West Demarara Regional Hospital, and Georgetown Public Hospital to establish occupational health and safety committees that will address workers' health in the context of hospital operations, including needle safety and infectious waste management. PAHO also helped develop new policies on the health and safety of health workers in the **Dominican Republic.**

43.   In late 2009, PAHO mobilized experts from NIOSH to visit a major public hospital in the **Bahamas** and conduct a detailed assessment of a mold infestation. The visit produced extensive recommendations for resolving the problem and provided an opportunity for capacity-building on health and safety issues for the hospital's management and employees, trade union members, and the staff of the Department of Environmental Health of the Bahamas' Ministry of the Environment. The consultation resulted in the Bahamas' Hospital Authority implementing a series of corrective actions to prevent or remove mold and moisture and chemical and physical hazards, as well as to promote health and safety in general for hospital workers and patients.

44.   In **Trinidad and Tobago,** PAHO mobilized human and financial resources from the Government of **Canada** to support efforts to protect the health and safety of healthcare workers and the public during two large international meetings in 2009: the Fifth Summit of the Americas and the Commonwealth Heads of Government Meeting. PAHO helped mobilize a team from Canada's University of British Columbia and Vancouver Coastal Health to carry out a rapid assessment and provide training on the surveillance and control of respiratory pathogens. PAHO also facilitated the acquisition of personal protective equipment for healthcare workers as well as biosafety cabinets for three laboratories. In addition, financial resources were provided to each of the country's regional health authorities to develop and implement projects to enhance local capacity for occupational health and infection prevention and control.

45.   During 2009-2010, PAHO's Virtual Campus of Public Health offered the second edition of its Virtual Course on Work and Health, developed in conjunction with the School of Public Health at the National University of Cordoba in **Argentina**. The course is aimed primarily at public health educators and officials from the human resources units in ministries of health. PAHO also supported workshops and seminars for methodological and technical updating on workers' health in **Cuba**, as well as training and guides for evaluating and controlling occupational risks in **Ecuador** and **El Salvador.**

Primary Environmental Care

46.   In the area of primary environmental care, PAHO's technical cooperation ranged from support for the development and implementation of water safety plans and programs to community participation in building healthy environments.

47.   PAHO, working with other UN agencies, supported several projects financed through the MDG Achievement Fund aimed at strengthening policies on and management of water and sanitation services and environmental risks, with an emphasis on citizen participation. In **Paraguay,** PAHO helped mobilize the participation of eight indigenous communities in the Chaco region to carry out community diagnostics on environmental and housing risks. In **Ecuador**, PAHO supported the design and implementation of a plan for surveillance of water quality and also provided capacity-building for the country's Administrative Water Boards. In **Nicaragua**, PAHO helped advocate new legislation to promote safe drinking water, in conjunction with youth-based environmental groups.

48.   Similarly, in **El Salvador**, PAHO provided technical cooperation in the planning and management of water supply, sanitation, solid waste disposal, and protection of water sources.

Environmental Preparedness in Costa Rica

Costa Rica is exposed to a number of environmental hazards, including extreme weather events, earthquakes, volcanic eruptions, and chemicals from industrial installations. These varied risks require the country—and PAHO's technical cooperation—to prioritize preparedness and response efforts. Because 80 percent of emergencies are related to problems with rainwater management, PAHO has focused its work in the country on strengthening capacities in this area. This has included support and training for staff of the Ministry of Health, the Costa Rican Social Security Fund (CCSS), the Costa Rican Institute of Water Supply and Sewerage Systems (AyA), and the Red Cross, in coordination with the National Commission of Risk Prevention and Emergency Care (CNE).

In 2009-2010, some 60 staff members participated in training on the formation of national response teams, techniques for damage assessment and analysis of health needs, integrated management of supplies, and information collection and decision-making in special centers for health coordination during disasters (CCSD). PAHO also supported improved rainwater management through Costa Rica's National Management Plan for Water Resources and produced a situation analysis of risks associated with basic environmental services. PAHO also helped the AyA develop a domestic sanitation agenda in accordance with Costa Rica's commitments within the framework of the Forum for Central America and the Dominican Republic on Drinking Water and Sanitation (FOCARD-PHC).

Healthy Settings

49.   PAHO continued to support healthy settings initiatives throughout the Region, including healthy communities, healthy workplaces, healthy schools, and the youth-based Ecoclubs movement.

50.   In **Colombia**, PAHO worked with UNDP, UNICEF, and FAO on a project financed by the MDG Achievement Fund aimed at reducing vulnerabilities due to environmental degradation and climate change in the country's poorest and most affected areas and populations. PAHO helped introduce "healthy environment" interventions as measures to adapt to climate change in the Colombian Massif ecosystem and also contributed to the recommendations of Colombia's National Council on Economic and Social Policy (CONPES) on climate change.

51.   PAHO helped strengthen the national healthy schools networks in countries including **Chile**, **Cuba**, and **Ecuador**. In **Chile**, PAHO's country office organized a contest to identify the best examples of health promotion in schools. In **Cuba** and **Ecuador**, PAHO helped strengthen and expand membership in the national healthy schools networks. By the end of 2009, Ecuador's network counted 2,700 members, representing 20 percent of the country's public schools.

52. In **Suriname**, PAHO supported a school-based hygiene project launched on the Second Global Handwashing Day, October 15, 2009. The goal was to raise awareness of the importance of hand hygiene among school children, teachers, and their communities to reduce acute respiratory infections and diarrheal diseases. PAHO helped mobilize the private sector—including soap distributors, water supply companies, and private laboratories—to provide financial and in-kind support, helped develop educational materials, facilitated training for 31 school teams, and helped document the project.

53. In **Panama**, PAHO helped mobilize some 3,000 youths from more than 20 Ecoclubs throughout Panama to undertake studies on the social determinants of health and to carry out community-based projects and activities to protect and improve the environment.

54. PAHO's efforts to promote healthy environments included support for preparations and activities leading up to World Health Day 2010, whose theme was urbanism and healthy living. Among the most notable of these activities was the First World Fair on Municipalities and Health, organized by PAHO and **Argentina's** Ministry of Health in Buenos Aires in August 2009. The four-day conference attracted some 5,000 participants and provided a high-visibility forum for promoting sustainable, participatory local development and the importance of "health in all policies."

55. Also during 2009-2010, PAHO headquarters in **Washington, D.C.,** adopted a PAHO Green and Healthy Initiative to reduce the Organization's environmental impact. The effort is being overseen by PAHO's Health, Safety and Well-being Committee and contributes to the Sustainable United Nations (SUN) initiative.

Tobacco Control

56. During 2009-2010, PAHO provided technical cooperation to help its Member States implement tobacco control measures recommended in the WHO Framework Convention on Tobacco Control (FCTC). In **Venezuela**, for example, PAHO supported the consolidation of the country's National Plans and Programs for Prevention and Control of Tobacco as a legal framework in accordance with the terms of the FCTC. PAHO provided support for Venezuela's implementation of Article 11 of the FCTC, on packaging and labeling of tobacco, through the publication of 10 new graphic health warnings in 2010. PAHO also provided evidence to support increased taxes on tobacco and supported the development of proposed legislation that would require all enclosed public and work places to be smoke free, as called for in Article 8 of the FCTC.

57. During 2009 and 2010, three countries—**Trinidad and Tobago, Paraguay,** and **Peru**—became 100 percent smoke-free, joining the Region's five other smoke-free countries: **Canada, Colombia, Guatemala, Panama,** and **Uruguay.**

58.   In the **Bahamas**, PAHO organized a train-the-trainer workshop to pilot a newly developed WHO training package on treatment for tobacco dependence. Forty-three participants were trained in the "5A" (Ask, Advise, Assess, Assist, and Arrange) and "5R" (Relevance, Risks, Rewards, Roadblocks, and Repeat) models and in identification of evidence-based tobacco dependence treatments, assessment of nicotine dependence, pharmacological treatment, and prescribing of nicotine-replacement products. At the end of the workshops, the participants recommended that the Bahamas implement population-level tobacco control measures such as smoke-free work and public places and incorporate treatment for tobacco dependence into the curricula of health professionals' on-the-job-training.

Disaster Response

59.   PAHO's ongoing technical cooperation in disaster preparedness and risk reduction have paid off in recent years as more and more Member States in Latin America and the Caribbean are able to respond to emergencies and disasters with their own resources, without seeking aid from the international community. In 2009, this was the case in the aftermath of several natural disasters. However, the earthquakes in **Haiti** and **Chile** in early 2010 proved an exception. In events of such magnitude, no amount of preparedness would have allowed the countries to respond effectively without international support.

The 2010 Haiti Earthquake

60.   **Haiti**'s massive earthquake on 12 January 2010 caused tremendous loss of life and countless injuries that required surgery and trauma management. Officials reported more than 220,000 deaths and more than 300,000 injured. Nearly 2 million people lost their homes, and more than 500,000 sought shelter outside the most severely affected departments. Many victims were left with disabilities that will require specialized care. Six months after the quake, many homeless remained in shelters or camps, creating overcrowding and poor sanitary conditions that increase the risk of water-, air-, and vector-borne diseases and the potential for epidemic outbreaks.

61.   In the three most affected departments—Ouest, Sud-Est and Nippes—60 percent of hospitals were severely damaged or destroyed, including Haiti's only national teaching and reference hospital. Haiti's Ministry of Health building collapsed, killing 200 staff.

62.   Following the quake, PAHO supplemented its core in-country staff of 52 with more than 60 international experts in disaster management, logistics, epidemiology, surveillance, communicable disease control, water and sanitation, neonatal health, mental health, rehabilitation, and other areas. PAHO established a field office in Jimaní,

the Dominican Republic, as a logistics hub and to support local health facilities, which received over 3,000 patients in the first few days. PAHO's Logistics Support System (LSS/SUMA) team provided crucial support in receiving, sorting, and distributing a massive inflow of humanitarian supplies from operations bases in Jimaní, at the PAHO-run PROMESS warehouse at the Port-au-Prince airport, and later at the Port-au-Prince port terminal.

63.   As the lead agency for the UN-organized Health Cluster, PAHO played a key role in coordinating and prioritizing relief efforts in the health sector. Among its most important contributions were coordination of foreign medical teams and mobile clinics. PAHO helped Haitian health authorities define a basic health package that mobile clinics would provide free of charge, organized a referral system to facilitate access to services at different levels of care, established an information system to record the clinics' activities, and coordinated the integration of different players working in mobile clinics.

64.   In the reconstruction phase, PAHO has also helped health authorities design a training program for waste management in shelters as well as a registration system to ensure that patients returning to Haiti from the Dominican Republic receive proper follow-up care. PAHO has also helped Haiti's Ministry of Health train staff in rehabilitation services and, in coordination with the nongovernmental organization Love a Child, has supported needs assessments for patients with amputations or other quake-related injuries.

65.   Throughout the response phase, PAHO also supported the Dominican Republic, which provided some $28 million in healthcare services through its public service network for more than 18,000 affected Haitians. PAHO's support included administrative, logistic, and technical assistance in areas such as health services organization, epidemiology, water and sanitation, and information and communication.

66.   PAHO's activities in Haiti were supported by **Canada** (through CIDA), the European Commission (through ECHO), Italy, Japan, **Spain** (through AECID), the United Kingdom (through DFID), the **United States** (through the State Department and USAID), the World Bank, CERF, the Principality of **Monaco**, the Pan American Health and Education Foundation (PAHEF), the Japanese Private Kindergarten Association, EISAI Co. Ltd., and others.

Responding to Chile's Disaster

67.   The 8.8-magnitude earthquake that struck **Chile** on 27 February 2010 affected six regions that are home to 80 percent of the country's population. The quake and the ensuing tsunami claimed more than 500 lives, affected some 2 million people, and caused an estimated US$30 billion in damages (17 percent of Chile's GDP). In the

health sector, 79 hospitals were affected (60 percent of the total), of which 54 required repairs and 17 were left unable to function. Chile's government estimated the costs of reconstructing the health sector at US$180 million.

68.   PAHO collaborated closely and actively with Chilean authorities and other UN agencies as part of the UN Country Team starting immediately after the disaster. PAHO mobilized international experts in disasters, hospital infrastructure, environmental health, mental health, and mass communication to bolster Chile's response. It also coordinated donations of 175,000 doses of hepatitis A vaccine and 5,000 doses of pneumococcal vaccine, the purchase of a mobile vaccination center and US$1.5 million worth of biomedical equipment and electric generators, and the delivery of 30,000 guides on disease prevention in post-disaster settings.

69.   A key PAHO contribution was its support for developing and implementing a comprehensive environmental health plan after the earthquake, which included measures for safe drinking water, waste management, vector control, food safety, and hygiene. PAHO also helped implement a mental health action plan and helped Chile's National Disabilities Service develop a strategy and manual on post-disaster care for people with disabilities.

70.   In addition, PAHO mobilized more than US$2.8 million from the European Commission (through ECHO), **Canada** (through CIDA), CERF, and the Government of Japan to support projects to reconstruct and strengthen the health network and reduce the risk of public health problems.

Safe and Secure Hospitals

71.   The dedication of World Health Day 2009 to the theme "Save Lives: Make Hospitals Safe in Emergencies" gave PAHO's ongoing Safe Hospitals initiative new visibility and impetus. In September 2009, PAHO's 49th Directing Council held a roundtable discussion on the same subject. Its final report noted that more than 67 percent of the nearly 18,000 Latin American and Caribbean hospitals are located in areas at high risk for disasters, and that many of these facilities have been left unable to function after major earthquakes, hurricanes, and floods. As a result, more than 45 million people have failed to receive needed hospital care over the years, and the direct economic losses from the destruction of infrastructure and equipment have probably exceeded US$4 billion in the last quarter-century.

72.   The 2009 roundtable report formally endorsed a PAHO action plan to support and monitor efforts by Member States to promote safe hospitals. The plan calls on all Member States to establish national safe hospitals programs, create information systems to register repairs and construction, set up mechanisms to supervise all new health

facilities, incorporate mitigation measures into new health infrastructure, and ensure that existing health facilities are retrofitted to be safer in disasters.

73.   During 2009-2010, PAHO supported efforts undertaken within the framework of this plan in countries including **Argentina, Bolivia, Costa Rica, Cuba, the Dominican Republic, Ecuador, Guatemala, Mexico, Nicaragua, Panama, Peru,** and the Caribbean Islands of **Anguilla** and **St. Vincent and the Grenadines.** PAHO's work on safe hospitals was supported by **Canada** (through CIDA), the European Commission (through DIPECHO), **Spain** (through AECID), **the United States** (through USAID), the World Bank, and UNISDR.

Using the Hospital Safety Index

The Hospital Safety Index, developed by PAHO in consultation with experts on risk reduction, had been applied to 327 hospitals in 27 PAHO Member States and territories by mid-2010, and an adapted version of the index was being applied in lower-level health facilities. The index allows trained teams of evaluators to assess the probability that a hospital or a health facility will continue to function in a disaster or emergency and helps officials prioritize investments needed to improve its safety.

So far, the use of the Hospital Safety Index has revealed that only 39 percent of evaluated hospitals in Latin America and the Caribbean show a high probability of continuing to function in cases of disaster. Fifteen percent require immediate attention because they may not be capable of protecting the lives of patients and staff in a disaster. The index also shows that most hospitals and health facilities are more vulnerable to functional problems than to structural failures.

During 2009-2010, countries including **Argentina, Belize, Bolivia, Costa Rica, Cuba, the Dominican Republic, Guatemala, Panama, Paraguay, Peru, Suriname,** and **Trinidad and Tobago** applied the Hospital Safety Index, received training in its use, and/or took measures to address vulnerabilities detected through its application. An adapted version of the index is being used in a new Safe Schools initiative sponsored by the Office of the Vice-President in **Guatemala**. PAHO continues to promote the index as a tool for assessing and improving the nearly 17,000 hospitals in the Region.

People-Centered Security

74.   PAHO's technical cooperation has been growing in a number of areas that impact on health but that fall outside the core areas of disease control and prevention. These include efforts to address the social determinants of health, as described in some of the examples above, but also programs and interventions addressing issues such as intra-family and gender-based violence, stigma and homophobia, and mental health. All these issues directly affect people's sense of and status with regard to human security, and

PAHO and its Member States have developed and applied effective public health interventions to address them.

Gender-Based Violence

75.   Gender-based violence is a major public health problem in the Americas and a significant obstacle to personal security. While data are not comprehensive, existing studies suggest that nearly half of all women in Latin America have been victimized by or threatened with violence. During 2009-2010, PAHO created a new position of Regional Advisor on Intra-Family Violence and continued supporting Member States' efforts to reduce gender-based and intra-family violence. Activities included national and subregional workshops in **Guatemala**, **Mexico**, and **Jamaica** on prevention of intimate partner and sexual violence and on monitoring and evaluation of programs that address violence against women.

76.   In addition, PAHO published several reports on intimate partner and sexual violence in the Region. These included the Spanish translation of *Unhappy Hours: Alcohol and Partner Aggression in the Americas*; the second edition of *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing* Countries (June 2010), published in partnership with International Planned Parenthood Federation; and Sexual Violence in Latin America and the Caribbean (June 2010), a desk review published in partnership with the Sexual Violence Research Initiative, UNFPA, and Ipas.

77.   In **Barbados**, PAHO supported the efforts of gender bureaus in **Eastern Caribbean** countries and territories—**Anguilla, Antigua and Barbuda, Barbados, British Virgin Islands, Dominica, Montserrat, Grenada, Saint Lucia, St. Kitts and Nevis,** and **St. Vincent and the Grenadines**—to mainstream gender issues and to involve men as part of the solution to gender inequalities, and particularly violence.

78.   In **El Salvador**, PAHO supported the implementation of a national Plan for Prevention and Care of Intra-family Violence, which includes a comprehensive approach involving the health, education, and judicial sectors as well as civil society. Key achievements during 2009-2010 included the strengthening of four special treatment centers in different parts of the country, a research project on intra-family violence and HIV, the incorporation of norms for addressing violence against women and sexual violence into the Ministry of Health's Family Health Program, and strengthening of an action network against gender-based violence.

79.   Similarly, in **Ecuador,** PAHO worked with UNIFEM on the development and dissemination of new norms and protocols for integrated treatment and care for victims

of gender-based, family, and sexual violence as part of the National Plan to Eradicate Violence against Women and Children in Ecuador.

80.   PAHO also supported the joint UN program "Consolidating Peace in **Guatemala** through Violence Prevention and Conflict Management," a three-year project financed through the MDG Achievement Fund and also supported by UNDP, UNICEF, UN-HABITAT, UNESCO, UNFPA and national authorities. During 2009-2010, PAHO began updating protocols for care and handling of victims of violence and worked with law enforcement, judicial, and health personnel on the appropriate application of legal frameworks, particularly regarding gender-based violence. This work was also supported by Sweden (through SIDA).

81.   In **Haiti**, PAHO carried out a needs assessment of the health sector response to survivors of violence, outlining key areas for intervention to guide technical cooperation in this area.

82.   With support from Norway (through NORAD), PAHO assisted women's organizations in **Nicaragua** with efforts to prevent and respond to intra-family violence, which claimed the lives of 79 Nicaraguan women during 2009. PAHO also worked with Nicaragua's Ministry of Health to strengthen its capacity to respond to violence through the adoption and application of norms and through joint efforts with women's and community organizations. PAHO is also supporting efforts to improve access to justice for Nicaraguan women who are victims of violence.

83.   In **Paraguay**, PAHO is a member of an interagency team charged with developing plans of action to incorporate violence prevention and treatment into emergency health care in six referral hospitals specializing in maternal-child care. The team has developed and helped implement protocols to improve the treatment of victims of sexual and intra-family violence in the country's health services.

84.   Similarly, in **Cuba**, PAHO collaborated with the Ministry of Health's mental health team to provide training to health professionals on the diagnosis, referral, and treatment of violence and to promote changes in attitudes, practices, and knowledge in providing care for families that suffer from such violence.

Workplace Violence in the Health Sector

PAHO supported efforts in **Jamaica** to understand and address the problem of workplace violence in the health sector, including violence, bullying, and other forms of psychological pressure. One study found that 71 percent of nurses and doctors at two Kingston hospitals reported encountering violent or threatening patients or family members at least once in the previous year. Other research suggests that such problems are a significant factor in nurse migration throughout the Caribbean. In Jamaica, healthcare workers were exposed to lethal violence from gunfire and large, intimidating crowds around hospitals during recent civil unrest. In 2010, PAHO organized a workshop on workplace and gender-based violence in the health services and issued a call for proposals to study the problems. Currently, seven PAHO-funded studies are under way in hospitals, healthcare centers, and in the field. PAHO is also supporting the development of a draft national policy on health workplace violence and a work plan for its implementation.

In a similar effort, PAHO helped **Uruguay** develop a methodology for collecting primary data on gender-based violence in its health services.

Homophobia and Stigma

85.   The problem of homophobia and stigma against sexually diverse individuals is a significant threat to personal security as well as a contributor to the spread of HIV and other sexually transmitted infections. Discrimination against these individuals has declined in the Region but remains a problem. During 2009-2010, PAHO provided technical assistance and advocacy to promote the human rights of lesbian, gay, bisexual, and transgender (LGBT) people and people living with HIV in both in the health sector and in society at large.

86.   PAHO supported efforts by Eastern Caribbean countries and territories— **Anguilla, Antigua and Barbuda, Barbados, British Virgin Islands, Dominica, Montserrat, Grenada, Saint Lucia, St. Kitts and Nevis,** and **St. Vincent and the Grenadines**—to address HIV-related stigma in the health services, to reduce barriers to access to services, and to scale up access to HIV testing.

87.   PAHO helped **Argentina's** Ministry of Health develop a new guide to providing health care for transgender people, *Health, HIV/AIDS and Transsexuality*. PAHO also worked with the Argentine Association of Transvestites, Transsexuals, and Transgender People (ATTA) on HIV prevention and helped them disseminate the video *Translatina*, which depicts the lives of transgender people in Latin America.

88.   In **Guatemala**, PAHO supported efforts to reduce homophobia and helped promote sexual diversity issues on the country's health and human rights agendas. PAHO provided technical and financial assistance to nongovernmental organizations working in this area, including training in administration and project management, and supported a campaign carried out by Guatemala's National Sexual Diversity and HIV Network, which included public service messages aimed at raising awareness of these issues. PAHO also helped improve clinical treatment of people with HIV and sexually diverse groups through upgrades of clinic infrastructure and equipment and through the validation of models of care that address their special needs.

89.   In **Belize**, PAHO provided support and guidance to a newly developed support group for people with HIV and helped the United Belize Advocacy Movement (UNIBAM), which promotes LGBT issues, to develop its institutional capacity and a draft strategic plan.

90.   In **Costa Rica,** PAHO worked with UNAIDS to provide training and other support for civil society organizations that promote issues of concern to sexually diverse populations. PAHO also organized events to raise awareness among public officials of these issues and to promote respect for gender diversity. Similarly, in **Cuba,** PAHO collaborated with other UN and national agencies to develop strategies to fight homophobia as well as gender-based and intra-family violence through courses and workshops, cultural activities, social communication campaigns, and dissemination of best practices.

91.   With support from Norway (through NORAD), PAHO promoted the harmonization of policies, plans, and legislation related to adolescent and sexual health with international human rights treaties ratified by PAHO Member States. Activities included training workshops on sexual health and human rights in Bolivia, El Salvador, the Dominican Republic, Guatemala, Honduras, Nicaragua, and Panama as well as support for reforming Guatemala's national HIV law to be consistent with UN and OAS human rights treaties and standards. In addition, PAHO collaborated with ministries of health, national parliaments, and courts in Argentina, Honduras, and Peru, providing technical information on emergency contraception in a manner consistent with the observations of the UN Committee on the Elimination of all Forms of Discrimination against Women and the UN Committee on the Rights of the Child.

92.   In **Paraguay**, PAHO supported the incorporation of human rights, gender, and nondiscrimination perspectives into the country's schools of public health through the project "Public Policies for Education in Sexuality in the Paraguayan Educational System."

Mental Health

93.　Just as mental health is an integral part of human health—as enshrined in the WHO Constitution—it is a critical component of personal security. This is reflected in PAHO's inclusion of mental health concerns in its emergency and disaster response efforts and in its programs addressing intra-family and gender-based violence.

94.　Mental health problems are a major public health concern in Latin America and the Caribbean. Over 125 million people suffer from some form of mental disorder but fewer than half have access to treatment. The challenge in this area is to improve access to adequate services in all of the Region's countries. Progress toward this end came in 2009, when PAHO's Directing Council approved the Strategy and Plan of Action on Mental Health. In endorsing the plan, countries pledged to integrate mental health into their health policies and programs and to promote reforms and other changes reflecting a new approach to psychosocial problems.

95.　In support of these efforts, PAHO worked closely with its Member States throughout 2009-2010 to develop policies on mental health within national health plans and to strengthen the community-based model of care to replace the traditional curative model. An example of this work is a PAHO Technical Cooperation among Countries (TCC) project involving **Cuba, El Salvador,** and **Guatemala** aimed at decentralizing mental health services from hospital settings to community-level primary care.

96.　PAHO also provided support for legislative changes to advance mental health reform. In **Argentina**, PAHO supported legislators in drafting a new National Mental Health Law and provided support for its presentation to congressional health committees and during subsequent debates and discussions. Similarly, in **Belize** PAHO helped develop a national mental health policy and supporting legislation as well as a National Plan for Mental Health and Psychosocial Support in Emergencies. PAHO also worked with **Trinidad and Tobago**'s Ministry of Health to update and improve mental health legislation, encouraging the adoption of a human rights approach. PAHO also helped the ministry implement a new integrated approach to mental health service delivery and advocated with both the Ministry of Education and the private-sector Employers Consultative Confederation for the adoption of strategies to promote mental health in the workplace.

97.　PAHO collaborated with the health secretariats of **Mexico** and Chihuahua state to organize a workshop in Ciudad Juárez on mental health care for people affected by violence. With an average of 139 homicides per 100,000 population per year, Ciudad Juárez has one of the highest murder rates in the world. The workshop, supported with funds from the **United States** (through USAID), focused on comprehensive mental

health care based on community and primary care models incorporating gender-sensitive and human rights approaches.

98.   Also during 2009-2010, PAHO mobilized mental health experts in support of **Mexico**'s response to the H1N1 outbreak and as part of its disaster response team following the earthquakes in **Chile** and **Haiti**.

99.   In addition, PAHO worked with the School of Public Health at the University of **Chile** to develop a new diploma program in management of mental health services, offered via PAHO's Virtual Campus of Public Health, and continued to provide technical support for comprehensive audits of mental health systems, which have been completed in 20 Member States (reports are available on www.paho.org).

Community Security

100.   Violence and injuries are major contributors to human insecurity in Latin America and the Caribbean. The increase in violence in many countries during recent years has had a negative impact on human development as well as on democratic governance. At the same time, the Region of the Americas has proved to be fertile ground for policies, strategies, and interventions that seek to prevent violence and injuries by addressing their risk factors. PAHO provided support for a number of initiatives in these areas during 2009-2010.

101.   In **Jamaica**, PAHO joined forces with the Violence Prevention Alliance to celebrate the International Day for Peace 2009 with activities focused on young males, the group most seriously affected by violence in Jamaica, both as perpetrators and victims. The celebration encouraged young men to break down barriers and focus on their commonalities rather than what they see as differences. PAHO sponsored a sports event for young men as well as the production of educational materials distributed at the event. Also in Jamaica, PAHO partnered with the Council of Voluntary Social Services to provide training in conflict resolution among youths for nongovernmental organizations involved in violence prevention services at the community level.

102.   In the **Bahamas**, a participant in PAHO's Leaders in International Health Program began a study on the epidemiology of violence among the country's youth. The study is a response to the increasing incidence of violence-related injuries, which disproportionately affect youths ages 15 to 24. The results will shed light on the determinants of violence, their impact, and how they interact at the national, regional, and international levels, with the goal of providing evidence for policymaking and programs.

UN Trust Fund for Human Security

During 2009-2010, PAHO worked with other UN agencies on a number of community security projects that were financed through the UN Trust Fund for Human Security, sponsored by the Government of Japan.

In **Bolivia**, PAHO collaborated with UNFPA and UNICEF to promote human security among adolescents in 20 municipalities of Cochabamba and Beni. The project brought together members of the education, health, and justice sectors to implement interventions aimed at empowering youths, promoting sexual and reproductive rights, preventing violence, and preventing early pregnancies. PAHO also helped strengthen the capacity of health workers to provide quality health care for adolescents.

In **Brazil**, PAHO continued its work with UNICEF, UNESCO, and UNFPA on a project that seeks to reduce violence and promote a culture of peace in the city of São Paulo by providing "humanizing" experiences in the areas of health, education, and community action. The three-year project brings UN experts together with municipal officials working in health, education, and social services as well as representatives of the community and adolescents to exchange ideas and promote capacity-building for individuals, families, and communities to influence public policy and cope with threats to human security.

In **El Salvador,** PAHO worked with UNDP, UNICEF, and ILO on a project to strengthen human security by fostering peaceful coexistence and improving citizen security in three municipalities in the department of Sonsonate. PAHO promoted an integrated approach to intra-family and sexual violence by working with health workers, law enforcement officials, and members of the community to improve the treatment of victims, raise awareness of prevention measures, promote community reporting of intra-family and sexual violence, develop information systems on violence, and form support groups for victims. As part of the same project, PAHO also provided technical cooperation in the area of traffic safety (see below).

In **Honduras**, PAHO worked with UNDP, UNICEF, FAO, UNHCR, and UNFPA on the Joint Program for the Support of Human Security in Honduras. The project included institutional strengthening for the involved municipalities, the creation of youth networks and microenterprises for youths, and violence prevention through Peace Expos (Ferias Expo Paz) and peace marches designed to mobilize youths along with other local actors and institutions.

103. Also in **El Salvador**, PAHO worked in coordination with UNDP, UNICEF, UNFPA, and ILO on the Joint Program on Violence Reduction and Construction of Social Capital, financed through the MDG Achievement Fund. PAHO helped carry out a diagnostic study on the collection, analysis, and distribution of information related to violence and crime with a view to strengthening these processes to inform policymaking and planning in violence prevention. PAHO also supported research on violence at the

national level and helped create spaces and mechanisms for youth participation and expression, including special youth meeting places in local health centers.

104.   With support from Sweden (through SIDA), PAHO designed a self-guided CD to develop competencies among primary healthcare providers to work with youth on sexual and reproductive health issues. The module has been implemented in Nicaragua and Honduras to build capacity in a critical mass of service providers. PAHO also designed a CD for youth promoters, "Adventures to the Unknown," which trains peer educators to be facilitators in interventions that let youths explore and learn to optimize their options for the future while avoiding HIV, STIs, and unintended pregnancies.

105.   In 2010, PAHO signed an agreement with UNDP's Regional Office for Latin America and the Caribbean to work together to promote human security in **Central America** through efforts in the areas of violence prevention, road safety, disaster preparedness, and climate change. PAHO and UNDP agreed to develop a plan of action for identifying and reducing threats to human security in each country, to improve information and knowledge on human security through the exchange of experiences and best practices, and to strengthen institutional capacity for work in this area through coordination, training, and the promotion of joint initiatives.

106.   PAHO also provided support for **Brazil**'s "Rede VIVA" injury surveillance system that collects information on violence through sentinel sites in the health services and through annual surveys.

Road Safety

107.   PAHO's work promoting road safety during 2009-2010 included two publications, *Advocating for Safe and Healthy Public Transportation* and the *Regional Status Report on Road Safety*, as well as the dissemination of the *Global Status Report on Road Safety* in major road safety meetings held in **Argentina, Brazil, Colombia,** and **Panama.** These reports show that traffic injuries are a leading cause of death in the Region, especially among 5- to 44-year-olds, claiming some 142,252 lives each year and injuring over 5 million people**.** Highlights of PAHO's technical cooperation in this area during 2009-2010 include:

108.   In **Costa Rica**—the country with the highest per-capita spending on road safety in the Region—PAHO supported efforts by the Road Safety Council (COSEVI) to prevent traffic accidents, particularly among youth. PAHO also worked with COSEVI and the Institute on Alcoholism and Drug Dependency (IAFA) to promote passage of a law to reduce blood alcohol limits for drivers, to develop a new national policy on alcoholic beverages, and to prevent consumption of alcohol by minors.

109.   In **El Salvador**, PAHO supported the implementation of a new National Road Safety Plan in collaboration with members of the National Commission on Road Safety (CONASEVI), including the National Civil Police, the Ministry of Government, the Ministry of Health, and municipal governments. Efforts included the establishment of a surveillance system for traffic accidents, strengthening of enforcement of speed limits and other traffic norms, the development of a technical guide on emergency care for victims of both road crashes and violence, and traffic safety education for children and youths at 11 critical safety points. The activities were supported in part by the UN Trust Fund for Human Security (see also above).

110.   In **Cuba**, PAHO worked with the Ministry of Transport and the National Institute of Sports, Physical Education and Recreation to promote road safety through community activities targeting children and adolescents.

111.   PAHO also supported a project of **Brazil**'s Ministry of Health aimed at reducing deaths and injuries due to traffic accidents by providing financing to municipalities to plan activities in these areas. In addition, PAHO is supporting Brazil's participation in the global Road Safety in 10 Countries (RS10) project, funded by the Bloomberg Family Foundation. Brazil's activities will focus on drunk-driving reduction and speed management and will be implemented in the cities of Palmas, Teresina, Belo Horizonte, Curitiba, and Campo Grande.

112.   In **Trinidad and Tobago**, PAHO supported the launch in 2010 of the national EVIPNet (Evidence-informed Policy Network) and hosted a training workshop on the development of policy briefs for the prevention of violence and injuries.

113.   PAHO also supported a study on the economic impact of traffic injuries in **Belize** and helped analyze data on deaths and injuries due to road incidents in major cities of **Ecuador**.

Participation and Social Protection

114.   Social protection schemes are the most established broad-reaching mechanism for ensuring human security in the Americas, and health protection is an integral part of these schemes. During 2009-2010, PAHO supported countries' efforts to strengthen social protection schemes by developing and implementing policies, laws, and programs that seek to eliminate exclusion; guarantee equitable access to goods, services, and technologies in health; and establish health as a universal human right. Much of PAHO's work in the area of social protection in health was supported by Sweden (through SIDA).

115.   In **Guatemala**, PAHO helped health authorities develop a proposed law on universal coverage and financing for comprehensive health care. The law would

establish a coordinated national health system, legal framework, and budget to finance universal coverage and provide explicit guarantees to ensure access for all Guatemalans, without discrimination, to free and comprehensive health care. The proposed legislation was presented to the Health Commission of the Guatemalan Congress in May 2010.

116.   In a similar vein, **Bolivia**, with PAHO support, developed legislation to create a Unified Health System that would ensure that all public health facilities—including those in the social security system—offer the same quality and services and provide access to free health care for all Bolivians. The law was expected to be approved by the Bolivian Congress in 2010 and to begin functioning in January 2011.

117.   PAHO also supported **Uruguay**'s efforts to incorporate additional population groups into the National Health Fund (FONASA). As a result of this work, spouses, retirees, and professionals who do not contribute to Uruguay's Social Security Bank are scheduled to be incorporated into FONASA during 2010.

118.   In **Colombia**, PAHO supported a project funded through the UN Trust Fund for Human Security to develop an integrated and sustainable social protection system. PAHO is helping design a primary health care model that is consistent with Colombia's National Health Policy and is using a "healthy housing" strategy to empower 500 families to improve their housing conditions. Other UN agencies working on the project are FAO, OCHA, UNHCR, UNICEF, UNIFEM, UNODC, and WFP.

119.   Also during 2009-2010, PAHO collaborated with other U.N. agencies to promote and document existing integrated social protection systems in the Region. An example was a study begun in September 2009 on the Nutritional Dimension of Social Protection Networks in Central America and the Dominican Republic, led by WFP with the participation of PAHO, INCAP, ECLAC, UNAIDS, UNICEF, and the OAS. The final report on the study was released in April 2010.

120.   In the **Dominican Republic**, PAHO is supporting a conditional cash transfer initiative known as the "Solidarity" program, in which low-income families receive money in exchange for complying with a series of health and education requirements. These include getting vaccines and micronutrient supplementation for children under 3, Pap smears and pre- and postnatal care for women, and annual check-ups for family members over 65, as well as participation by adolescents in activities aimed at reducing risk factors. The program currently covers more than 750,000 households.

Access to Services

121.   PAHO continued in 2009-2010 to support its Member States' efforts to expand access to health services for their populations. Technical cooperation in this area ranged

from support for legislation guaranteeing access to health care to initiatives aimed at improving the coordination and delivery of health services.

122.   In **Guatemala,** PAHO worked with the Health Commission of the Guatemalan Congress, the Ministry of Health, the University of San Carlos, and the Guatemalan Social Security Institute (IGSS) to design and advocate a proposed new law based on the human right to health, with provisions on financing of universal care. PAHO also helped develop new legislation creating a public service career in the health sector, which seeks to guarantee the availability of human resources in health in poor and remote rural areas. It includes personnel incentives designed to promote patient-centered care and respect for patients' rights and to improve the productivity and quality of care in the country's health system.

Free Health Care in Haiti

One of most successful recent efforts to expand access to basic health services is **Haiti**'s Free Obstetric Care (SOG) program, developed with financing from **Canada** (through CIDA) and with PAHO technical support. The program provides free health care to low-income pregnant women and operates by purchasing the services from public, mixed, and private nonprofit health facilities throughout the country. The program was launched in 2008, initially working through 45 health facilities, and within a short time had significantly increased the proportion of institutional births, improved emergency obstetric care, and reduced maternal deaths. Following the January 2010 earthquake, PAHO worked with UNFPA, UNICEF, OCHA and other partners to ensure the program's continuation, and as of mid-2010, it was providing health services to 50,000 beneficiaries. Plans are to increase the number of participating institutions, expand services to include comprehensive pre- and postnatal care, and increase the number of beneficiaries with the goal of ensuring that all Haitian women have access to obstetric care. In addition, the expanded SOG program will replace payment for services rendered with payment for performance.

Based in part on the SOG model, Haiti's Ministry of Health has developed, with PAHO support, an ambitious plan to provide free basic health services to the entire population. The first phase of the plan began in June 2010 and involves the purchase of health services from 33 public, private, and mixed health facilities. The second phase will expand the number of facilities and services to be able to cover the major health needs of the Haitian population.

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123.   In **Venezuela**, PAHO provided support for the development of "community health houses" as part of the National Plan for Reducing Maternal and Infant Mortality. The community health houses operate out of private homes and are headed by a volunteer member of the household, typically mothers, who provide care for pregnant women and children under 5, based on the Integrated Management of Childhood Illnesses (IMCI) strategy. Begun as a way to expand access to health services, the community health houses have become an integral part of local health networks and have had a positive impact on reducing child and maternal deaths.

124. PAHO supported efforts by the Eastern Caribbean countries and territories—**Anguilla, Antigua and Barbuda, Barbados, British Virgin Islands, Dominica, Montserrat, Grenada, Saint Lucia, St. Kitts and Nevis,** and **St. Vincent and the Grenadines**—to reorganize their health delivery networks based on the primary health care strategy and to upgrade their health infrastructure. PAHO's technical cooperation included support for the development of comprehensive models of care and for the design and assessment of integrated healthcare networks. As part of this process, PAHO engaged UNOPS, whose staff worked with health ministry officials for the first time in the English Caribbean to present reliable and cost-effective options for hospital infrastructural development in **Barbados, Saint Lucia** and **Grenada.**

125. In **El Salvador**, PAHO is helping to implement integrated health service delivery networks (IHSDN) in seven municipalities in the country's western region. The process includes community participation and intersectoral cooperation, coordination between hospitals and health units, improvements in infrastructure and quality of care at different levels, referral systems, improvements in the management of clinical laboratories, and implementation of a system for effective pre-hospital emergency care.

126. With support from Sweden (through SIDA), PAHO organized a multicenter study on the impact of exclusion from health services on access to essential medicines. Country studies for Guatemala and Nicaragua were finalized during 2009-2010, and PAHO organized workshops to discuss and disseminate the results and lessons learned. In addition, a comparative analysis of those results and results from Honduras was completed in 2009.

127. Other PAHO-supported efforts in this area during 2009-2010 included a seminar on the right to health and improved access to basic services, co-hosted with **Belize**'s Ministry of Health in December 2009, and the Third Congress of Social Security Regulators, held in Santiago, **Chile**, in November 2009. PAHO also supported a report based on that meeting comparing social security systems in nine PAHO Member States and detailing the major obstacles facing these systems in the Region today.

Community Health Security in Colombia

The internal displacement of large numbers of people because of conflict is a major contributor to insecurity for communities and population groups. In **Colombia**, armed groups continue to perpetrate violence among vulnerable populations, particularly in the departments along the Pacific coast. This has provoked major internal movements of individuals and families to areas that are more secure but which leave them vulnerable to other threats including disease, malnutrition, and human rights violations. During 2009-2010, PAHO helped step up health interventions in these areas, specifically in 24 priority municipalities in the departments of Nariño, Chocó, Cauca, Valle del Cauca, Arauca, Norte de Santander, Huila, Putumayo, and Caqueta.

According to government data, the number of displaced persons has grown at an increasing rate, reaching nearly 3 million people, a large majority of whom are women and children with no access to health and social services. Official sources point to health indicators among these displaced groups that are characteristic of underdeveloped and socially excluded populations, including high mortality rates among infants and children under 5, acute diarrheal diseases and respiratory infections, high rates of death and illness among young and pregnant women, and low vaccination coverage.

During 2009-2010, PAHO continued to work with national and departmental authorities to increase access to primary health care and improve the quality of life and nutritional status for displaced populations, through strategies tailored to individual locations. Efforts included the formation of local rapid response teams, generation of baseline data and information, and the establishment of political and technical agreements to integrate health into municipal agendas. Members of displaced communities themselves received training in the care and management of healthy settings, appropriate management of drinking water, primary care of water sources, and disease prevention. Mobile health teams specialized in emergency response have also been a key part of these strategies.

Through these interventions, PAHO continues to strengthen the capacity of local health services to manage health crises, improve the availability of health information on displaced populations, and ensure that displaced persons can fully exercise their civil and social rights. Support for this work was provided by **Canada** (through CIDA), the **United States** (through USAID and the State Department), the European Commission (through ECHO), **Spain** (through AECID), and CERF.

Health Security and Disease Control

128.   Among PAHO's most direct contributions to human security in the Region of the Americas during 2009-2010 was its work in the area of control and prevention of diseases. PAHO's ongoing efforts in this area address all the major contributors to the burden of disease in the Americas, with emphasis on diseases that disproportionately affect the poorest and most marginalized population groups and those that are most effectively addressed through regional efforts.

IHR and Regional Health Security

129.   The International Health Regulations 2005 (IHR) require countries to have the ability, by 2012, to detect, evaluate, confirm, report, and implement control measures for any health event that has the potential to cause an international public health emergency.

130.   PAHO supported its Member States in their efforts to fully comply with the IHR's requirements by helping to evaluate their capacities for surveillance and response and with training to improve capacities in these areas. To date, 28 of 33 countries in Latin

American and the Caribbean have prepared national plans for strengthening their IHR capacities, and 26 have established National IHR Focal Points (NFP), which operate 24 hours per day, seven days per week. For 11 priority countries, PAHO mobilized $1.1 million to strengthen NFPs through training, guidelines, and tools for health surveillance and NFP operations. PAHO also organized the First Regional Meeting on the Implementation of the International Health Regulations in Quito, **Ecuador**, in May 2010, for officials responsible for IHR implementation in their countries. In addition, PAHO prepared and disseminated a "Framework for the Normative Implementation of the IHR (2005)," which includes recommendations on regulations and best practices for implementing the IHR from a legal standpoint.

131. To strengthen response capacities, PAHO supported training for rapid response teams in **Bolivia**, **Costa Rica**, **Chile**, and **Ecuador**; participated in the preparation of a proposal for a new Field Epidemiology Program in **Paraguay**; and is supporting similar efforts in **Peru** and **Argentina**. This work has included the provision of tools for field investigations (including personal protective equipment) as well as training in infection control strategies, safe handling of clinical samples, management of mass casualties, and risk and outbreak communication.

132. In addition, PAHO has helped 18 Member States evaluate their capacities for detection and reporting of health events at ports of entry; 10 countries have now prepared corresponding action plans. PAHO's advisor on this subject has carried out technical cooperation missions to **Argentina, the Dominican Republic, Ecuador, El Salvador, Nicaragua,** and **Uruguay,** and the Organization hosted a meeting in El Paso, Texas, where countries shared knowledge and experiences on border crossings. Participants included representatives from **Brazil, Guatemala, Mexico, Peru, the United States,** and **Uruguay.**

133. During 2009, as the IHR Regional Focal Point, PAHO registered 166 events of importance to international public health, 39 of them related to the 2009 (H1N1) pandemic. Thirty-four percent were notified by NFPs in the countries, 14 percent were reported by other governmental institutions, and 52 percent were captured through routine surveillance. PAHO's regional event management site (EMS) provided 539 updates on 49 public health events that were analyzed at daily event evaluation meetings.

134. Other capacity-building efforts in the area of surveillance and response have included the PAHO-CDC Generic Protocol for Influenza Surveillance, aimed at creating a surveillance system that will allow assessment of influenza activity throughout the Region and facilitate comparisons across regions and subregions of circulating influenza strains and cases of infectious respiratory disease.

135.   In related efforts, PAHO has worked with Member States to improve laboratory capacity through training in laboratory techniques and the procurement of equipment, reagents, and other materials. As a result of this work, five new National Influenza Centers in the Region were designated by WHO in the past five years (three—in **Bolivia, Guatemala,** and **Nicaragua**—during 2009-2010) for their abilities to safely and effectively diagnose influenza viruses.

The 2009 (H1N1) Pandemic

136.   The 2009 (H1N1) influenza pandemic provided an important test case for the new International Health Regulations (IHR) and for several years' worth of preparedness efforts carried out in the Region with PAHO support. Six months into the pandemic, at a September 2009 meeting in Miami, representatives of PAHO Member States agreed that recent efforts to improve countries' abilities to comply with the IHR as well as specific pandemic preparedness efforts had been instrumental in strengthening the Region's response to the 2009 pandemic.

137.   The emergence and spread of the novel (H1N1) virus beginning in April 2009 produced an overwhelming demand for technical cooperation from PAHO. The Organization responded quickly by mobilizing interdisciplinary teams of experts through WHO's Global Outbreak Alert and Response Network (GOARN). They provided assistance to affected countries in surveillance of respiratory diseases, infection control, laboratory diagnosis of influenza, and outbreak and risk communication.

138.   One of the most important areas of PAHO support was for training in the use of polymerase chain reaction (PCR), one of the few reliable methods to detect the pandemic (H1N1) 2009 virus. PAHO also coordinated the purchase of equipment, materials, and reagents for laboratories. As a result of these efforts, every country of the Region now is in a position to diagnose the pandemic (H1N1) 2009 virus.

139.   PAHO also helped its Member States intensify their surveillance of acute respiratory infections, providing guidelines and training. In addition, PAHO coordinated purchases and donations of materials and equipment, including more than 589,000 doses of oseltamivir and 50,000 kits of personal protective equipment. In collaboration with the Pan American Association of Infectious Diseases, PAHO convened a group of experts to develop clinical guidelines for management of cases of suspected or confirmed pandemic (H1N1) 2009. Other forms of information support included the translation of multiple guides into Spanish and the publication of a weekly bulletin summarizing the latest epidemiological and virological information on the pandemic.

140.   To assure access to the new pandemic (H1N1) 2009 vaccine for its Member States, and following a request from heads of state of the Union of South American

Nations (UNASUR), PAHO's Revolving Fund for Vaccine Procurement opened a bid solicitation on behalf of the countries and territories of the Region. By mid-2010, 23 countries had acquired more than 20 million doses through the fund. In addition, **Bolivia, Chile** (after its earthquake), **Cuba, El Salvador, Guatemala, Guyana, Honduras, Nicaragua, Paraguay,** and **Suriname**—received donated vaccines through WHO.

141.   Support for these activities was provided by **Canada** (through CIDA), **Spain** (through AECID), **the United States** (through USAID and CDC), the Inter-American Development Bank (IDB), and WHO.

Preparing for pandemics

In the **Bahamas** and **Turks and Caicos** PAHO provided updated technical information and guidance to health officials on issues related to the 2009 (H1N1) pandemic, including the management of outbreaks on cruise ships that call at their islands. PAHO facilitated discussions between health officials and the chief physician of a major cruise liner to gauge the ship's level of preparedness for handling sick passengers and crew members and to assess the capacity of on-board medical and emergency facilities. PAHO's technical cooperation in this area also included a series of simulation drills in the Turks and Caicos islands and the development of a new influenza pandemic preparedness plan.

Immunization

142.   As one the most effective interventions in the public health arsenal, immunization is a critical contributor to health and human security and has long been one of PAHO's most important areas of technical cooperation. During 2009-2010, PAHO's immunization program played a critical role in two major areas: the 8th annual Vaccination Week in the Americas and the regional rollout of the pandemic (H1N1) vaccine.

143.   Vaccination Week in the Americas 2010 was celebrated on 24 April to 1 May in countries throughout the Americas. The slogan for the event, "Reaching Everyone," reflected the initiative's objective of reaching out to adults and children, males and females, the very young and the elderly, with the overall goal of reaching some 42 million people regionwide. Countries and territories throughout the Region carried out a wide variety of activities to promote vaccination and other preventive interventions, including Vitamin A supplementation.

144.   The launching events for the 2010 Vaccination Week took place in **Nicaragua**, on the **United States**–**Mexico** border (in conjunction with the US National Infant Immunization Week), on the border between **Haiti** and **the Dominican Republic**, and on the border between **French Guiana** and **Suriname**. The latter marked the first bi-

regional launch of Vaccination Week in the Americas, since French Guiana is a French department. Health workers from both sides of the border participated in a series of workshops to share immunization practices and address issues related to border populations, such as the challenges of tracking immunization of children who have been vaccinated in more than one country. As a result of these efforts, the two countries have pledged to strengthen their reporting and sharing of epidemiological information and data on vaccination coverage.

145.   This year also saw further geographical expansion of the Vaccination Week initiative. Observers from WHO's Africa Region (AFRO) participated in VWA activities in **Haiti** and the **Dominican Republic**, while the European Region (EURO) celebrated its 5th European Immunization Week on 24 April to 1 May. In addition, the first Vaccination Week in the Eastern Mediterranean Region (EMRO) was held on 24–30 April, with launching events in Lebanon, Afghanistan, Iraq, Pakistan, and Sudan, among others. If progress continues as planned, the goal of a global immunization week will be closer than ever.

146.   PAHO also worked in 2009-2010 to strengthen health regulation and regulatory systems in its Member States to improve access to medicines, vaccines, and other biologicals, including biotechnology products and antivenoms. At the regional level, these efforts were carried out through the Pan American Network for Drug Regulatory Harmonization (PANDRH). PAHO also began developing and implementing a process for evaluating the capacities of national regulatory authorities to carry out basic functions established by WHO for this area.

Neglected Diseases

147.   In 2009, PAHO's Directing Council, through Resolution CD49.R19, agreed to work together to eliminate or reduce neglected and poverty-related diseases such that they are no longer public health problems by the year 2015. To advance this goal, PAHO joined forces in 2009 with the IDB and the Global Network for Neglected Tropical Diseases/Sabin Institute to create a trust fund to support the elimination of these diseases in PAHO Member States. The fund's first initiatives included two pilot projects: in Recife, Brazil, to eliminate lymphatic filariasis, and in Chiapas, **Mexico**, to eliminate onchocerciasis and trachoma.

148.   PAHO continued its longstanding efforts to eliminate Chagas' disease, which affects an estimated 8–9 million people in the Region, with signs of transmission in 21 countries. During 2008–09, four countries—**Chile, Guyana, Panama,** and **Peru**—joined 14 other countries with universal screening for Chagas in their blood banks and there was an increase in preventive prenatal diagnosis of maternal infections with Chagas to facilitate early diagnosis and treatment of newborns. In addition, PAHO

produced new guides and training resources to address foodborne outbreaks of the disease.

149. More than 9 million people continue to be at risk of lymphatic filariasis in the Region, the largest proportion of them in **Haiti**. The January 2010 earthquake complicated the timely delivery of drugs to treat the disease, but a meeting convened by PAHO in February 2010 mobilized international partners to continue working toward the disease's elimination.

150. PAHO also supported efforts to expand antiparasitic treatment to cover an increasing proportion of the estimated 46 million children in Latin America and the Caribbean who are at risk of geohelminths, or soil-transmitted intestinal parasites. PAHO data show that in 2009, 4,805,522 preschool-age children and 37,430,165 school-age children received deworming medication at least once a year.

151. Schistosomiasis—a chronic parasitic disease that can damage internal organs and impair growth and development in children—continued to be transmitted in four countries of the Region: **Brazil, Saint Lucia, Suriname,** and **Venezuela**, with 25 million people at risk, most of them in Brazil. In 2009, PAHO helped design a study of the prevalence and intensity of schistosomiasis as well as geohelminth infections in Suriname. The study is expected to be completed in 2010.

152. PAHO continued to promote surveillance of leprosy, also known as Hansen's disease. In 2009, 48,432, cases were reported in 27 countries of the Americas. In all countries except Brazil, cases have been reduced to less than 1 per 10,000 population.

153. During 2009-2010, PAHO supported the mapping of cases of trachoma at the municipal and community levels in **Brazil, Guatemala,** and **Mexico**, and helped develop comprehensive plans for implementing the SAFE (Surgery, Antibiotics, Facial cleanliness, and Environmental improvement) strategy for its elimination. PAHO also worked to forge strategic partnerships with institutions, universities, NGOs, and donors to support comprehensive trachoma elimination plans in Guatemala and Brazil.

154. PAHO continued in 2009-2010 to support and promote the prevention and control of malaria. Since 2000, 18 of the Region's 21 endemic countries have reported a steady decline in the number of cases, and the elimination of malaria transmission is considered feasible in **Mexico** and **Central America, Haiti** and **the Dominican Republic,** and **Argentina** and **Paraguay.** PAHO has supported the expansion of the Amazon Malaria Initiative, which now includes Brazil and eight neighboring countries. PAHO is also supporting the extension of efforts of the Amazon Network for the Surveillance of Anti-malarial Drug Resistance (RAVREDA) to other subregions, including Mesoamerica, with funding from the **United States** (through USAID).

155.   Neonatal tetanus has been eliminated as a public health program in all countries of the Region except **Haiti**, which reported more than half all cases during the last five years. PAHO supported vaccination of Haitian women of childbearing age carried out in 2009 and following the earthquake in 2010.

156.   With PAHO's support, countries continued efforts in 2009-2010 to eliminate human rabies transmitted by dogs. **Haiti** succeeded in vaccinating 400,000 dogs and cats in a campaign that began before the earthquake and was completed afterward, using vaccine donated by Brazil. In its first mass rabies campaign in recent decades, the **Dominican Republic** vaccinated more than 1 million animals, also using vaccines donated by **Brazil**. PAHO also provided support to **Bolivia**'s national rabies program, which has cut human rabies cases in half. In the Region as a whole, cases of human rabies have been reduced from 268 in 1983 to 17 in 2009, 10 of these transmitted by dogs.

Mother-to-Child Transmission of Syphilis and HIV

During 2009-2010, PAHO and other partners developed a new Regional Initiative for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis. The initiative's goal is to increase coverage to more than 95 percent, by the year 2015, in the following areas: prenatal care and skilled attendance at birth, screening for syphilis and HIV in pregnant women, prophylactic treatment of syphilis in pregnant women, and prophylactic management of HIV in children. Other goals include increasing to 95 percent the proportion of first-level health centers that integrate prevention and diagnosis of HIV and other STIs into their services, and increasing to 95 percent the proportion of countries that have information systems to measure progress toward the elimination of mother-to-child transmission of HIV and congenital syphilis and to support decision making. In 2009-2010, the conceptual framework, clinical guide, and monitoring and evaluation document were completed.

In June 2010, PAHO and UNICEF hosted a two-day meeting in the **Bahamas** for the chief medical officers of CARICOM and the Technical Working Group on the Initiative for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis. Participants reviewed the current status of the problem, discussed targets and timelines for the initiative, and emphasized the need for standardized case definitions and quality laboratory support.

Sexual and Reproductive Health

157.   Sexual and reproductive health impacts heavily on human security and human development, with life-and-death consequences as well as lasting effects on individuals' psychological, physical, and socio-economic well-being. During 2009-2010, PAHO continued to provide technical cooperation addressing key sexual and reproductive health issues, including safe motherhood and newborn survival, sexually transmitted infections, and the prevention, detection, and treatment of cervical cancer.

Safe Mothers and Children

PAHO's specialized Latin American Center for Perinatalology/Women's and Reproductive Health (CLAP/SMR) in **Uruguay** coordinated much of the Organization's work in this area. A major focus during 2009-2010 was on improving training for healthcare providers using updated guidelines, especially the *Guide for the Continuum of Care for Women and Newborns, with a Primary Health Care Approach*. CLAP organized training workshops at the local, subregional (Central America), and regional levels for doctors, midwives, and obstetric nurses from countries with high rates of maternal mortality.

CLAP also developed a new Perinatal Clinical Record and Perinatal Computing System to facilitate data collection and analysis for monitoring and evaluation of interventions and programs for maternal and newborn health. The clinical record captures essential information on mothers, unborn babies, and newborns and was developed through consultations with experts in PAHO Member States. In 2010, CLAP published a guide to using the new clinical record and computing system.

PAHO also continued efforts to increase access to maternal-child care, particularly for rural and indigenous women. Examples include the promotion of the "Maternal Homes" strategy, which has a multicultural focus, and support for **Haiti**'s Free Obstetric Care (SOG) program (described in detail above).

Also during 2009-2010, PAHO promoted a new conceptual framework and clinical norms for the elimination of vertical transmission of syphilis and HIV/AIDS, and instituted automatic reporting of syphilis as part of the Perinatal Information System (SIP).

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158.   In **Bolivia** and **El Salvador**, PAHO supported the implementation of new national strategic plans for sexual and reproductive health and provided technical cooperation on care of women in pregnancy, childbirth, and postpartum; newborn care; family planning; prevention and treatment for sexually transmitted infections; prevention of cervical cancer; and prevention and care for adolescents.

159.   Also in **Bolivia**, PAHO helped develop new protocols for cervical cancer detection and control and helped implement control and monitoring of cervical cancer in health units where such services were formerly unavailable. PAHO's support included providing laboratory equipment for cytopathology and colposcopy and providing training for doctors and nurses in screening using both the Pap smear and visual inspection with acetic acid.

160.   In **Ecuador**, PAHO supported efforts to implement a paradigm change in the health services from "maternal-infant care" to a broader focus on sexual and reproductive health. In addition PAHO worked with CLAP, WHO, and the Partnership for Maternal, Neonatal and Child Health (PMNCH) to support a horizontal technical

cooperation project to promote maternal, newborn, and child health in **Bolivia**, **Chile**, **Ecuador**, and **Paraguay** through the development of joint proposals, training, and the exchange of information and experiences.

161.   In **Costa Rica**, PAHO collaborated with the Ministry of Health, UNFPA, the Costa Rican Social Security Fund (CCSS), and civil society institutions to organize the 2010 National Survey on Sexual and Reproductive Health. The survey will focus on women and men ages 15 to 80 and will collect data on such issues as sources of information on sexual and reproductive health, knowledge about contraception and family planning, and sexual behavior, including age at initiation, types of partners, types of relations and levels of satisfaction, maternal health, fertility, and attitudes toward pregnancy. The last such survey in Costa Rica was carried in 1996.

Faces, Voices and Places of the MDGs

The PAHO initiative "Faces, Voices and Places of the MDGs" (FVP) uses a participatory and integrated approach to municipal health development and poverty reduction with the goal of advancing the Millennium Development Goals in vulnerable communities in the Americas. The initiative now includes over 30 communities in 17 countries. During 2009-2010, FVP began work in four Eastern Caribbean islands—**Anguilla, Montserrat, Grenada** and **Dominica**—and extended its work in three municipalities of the South American Chaco region, with special emphasis on water and micro productive projects. In addition, FVP developed a program to strengthen cooperative action between the health, education, and development sectors at the local level in **Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua,** and **Panama** and in **Argentina**'s Chaco region.

Also during 2009-2010, PAHO launched the Faces, Voices and Places Program of Young Professionals for the MDGs, with support from **Canada** (through CIDA). The program selects young people with interest and experience in international development and provides them with a week of specialized training followed by three months' living and working in an FVP community. A first group travelled in mid-2009 to communities in **Bolivia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Panama,** and **Peru,** while a second travelled to **Anguilla, Dominica, Grenada,** and **Montserrat** in mid-2010. Participants worked with youths and other community members to identify best practices for MDG achievement at the local level and to document these practices using multimedia formats, including video.

Chapter III. Lessons Learned and Future Challenges

162.   The components of human security, as illustrated in Chapters I and II, are not new concerns for PAHO. The threat of international epidemics was among the chief reasons PAHO was originally founded in 1902 as the International Sanitary Bureau. The impact of conflict on health was addressed by PAHO's efforts to use "health as a bridge for peace" in Central America during the 1980s, while disaster response and risk reduction, like safe water and sanitation, are longstanding areas of work for the Organization. Even PAHO's work in areas such as community and intra-family violence, healthy environments, and traffic safety began in the 1990s, before human security became a central theme on the international agenda.

163.   As a "new" concept, however, human security can be seen to add value to PAHO's technical cooperation in public health in several ways. It highlights the fundamental importance of health to human well-being and, by viewing health as inherent to human security, it gives governments major responsibility for ensuring and protecting it. It also elucidates the connections between health and other aspects of human security, thereby confirming the need for intersectoral action and providing guidance for its design. In these ways, the human security approach complements and strengthens PAHO's growing focus on the social determinants of health.

164.   It is also true that public health has made significant contributions to the field of human security, particularly by providing ethical and methodological guidance for addressing its complex social dimensions. The use of an epidemiological approach to the issue of violence, for example, has led to evidence-based public health interventions to address it. The successful use of such interventions—for example, in Bogotá and Medellín, Colombia—has helped changed the perception that violence is an inevitable social ill. By contrast, the persistence and increase of violence in other countries is at least partly the result of a failure to apply a public health approach, particularly by identifying and addressing the underlying social determinants of violence.

165.   Chapter II of this report presented highlights of efforts by PAHO Member States to apply public health approaches to the various components of human security in 2009-2010. These efforts produced important advances and yielded valuable lessons, yet many challenges remain to be met. Some of the most noteworthy of these are presented and discussed below.

Economic Security

166.   The economies of Latin America and the Caribbean have been affected to different degrees and in different ways by the global economic downturn. Health spending has been constrained in most countries, and unemployment has reduced

contributions to social security regimes while also reducing the capacity of poor households to absorb out-of-pocket healthcare costs. At the same time, deteriorating economic conditions have negatively impacted the social determinants of health. In all these ways, the crisis is likely to further widen the already existing gaps between countries' economic progress and their levels of human development. PAHO studies suggest that the most important factors perpetuating these gaps are inequitable income distribution, the lack of harmonization of social policies, and weaknesses and inefficiencies in the organization of national health systems.

167.   PAHO Member States face the challenge, both short- and medium-term, of developing new financing solutions for the health sector and new mechanisms of access to social protection that are not exclusively employment-based. Equally important are continued efforts to increase the efficiency, effectiveness, and equity of health systems through reforms grounded in the principles of primary health care.

Food Security

168.   Latin America and the Caribbean as a region remain on track to meet the hunger-reduction targets of MDG-1. But rising food prices, the global economic downturn, and ecological crises have slowed progress and have increased important disparities within and across countries. Moreover, chronic malnutrition—which is not included in the MDG targets—remains high in a number of countries and among the most vulnerable population groups. Regionwide, an estimated 9 million children under 5 suffer from chronic malnutrition, while some 22.3 million preschool children, 3.6 million pregnant women, and 33 million women of childbearing age suffer from anemia—all this in a region that produces 130 percent of its basic food needs.

169.   PAHO's experience suggests that nutrition is not a simple function of economic status but that it plays a complex and, as a critical factor in human development, partly causal role in the interaction between economics and health. Chronic malnutrition in particular is the result of multiple factors, including direct ones such as maternal malnutrition, poor diet, and repeated infections as well as indirect ones, including lack of access to safe water and sanitation, inadequate quantity and quality of foods, frequent exposure to unsafe foods, low educational levels of mothers, teen pregnancy, poor health care, and poor child-raising practices. Indeed, chronic malnutrition, measured as low height for age, is a meaningful indicator of the overall life conditions in a given population.

170.   The complex interactions between nutrition and other social and economic determinants call for integrated multisectoral approaches that seek to improve people's physical and social environments; ensure access to safe water, sanitation, and hygiene; improve education and information (including information about safe food handling);

increase food security; ensure decent work, working conditions, and income; and increase access to quality health services that employ proven nutrition interventions throughout the life course and that promote reproductive health, particularly during pregnancy and pre-pregnancy.

Secure Environments

171.   Environmental influences are among the most important determinants of human health and security and have wide-ranging and interrelated impacts. Major forces that shape the environment in Latin America and the Caribbean include population growth and distribution, climate change, patterns of economic development, and income inequality. The Region is also highly susceptible to natural disasters such as earthquakes, storms, drought, and floods.

172.   As the most urbanized region in the world, the Americas face major challenges stemming from rapid and unplanned urban growth. Informal settlements, substandard housing, and inadequate water and sanitation services increase the vulnerability of marginal urban populations—particularly the poor, Afro-descendants, and indigenous people—to diseases and environmental hazards. Inadequate transportation systems and growing traffic congestion increase air pollution and put pedestrians, cyclists, and motorists at risk of injuries or death. Urban centers characterized by high population density and neglected zones become areas of exclusion and poverty that breed violence, crime, and substance abuse. Moreover, a shortage of public parks and green spaces combines with other patterns of urbanization and development to encourage lifestyles that increase people's risk factors for chronic noncommunicable diseases.

173.   Rural populations too are affected by some of these same problems, particularly substandard housing and lack of access to safe water and sanitation. Regionwide, an estimated 40 million people, both rural and urban, lack access to improved drinking water, and 115 million lack access to improved sanitation facilities, increasing their exposure to water- and foodborne diseases and disease-carrying rodents and insects. The vast majority of the estimated 190 million people living in poverty in the Region reside in inadequate housing and/or precarious geological zones, increasing their vulnerability to natural disasters.

174.   Addressing these environmental influences on human security requires integrated multisectoral and multidisciplinary approaches that mobilize political commitment as well as social participation and action. These include primary environmental care projects and programs as well as "healthy governance" approaches that advocate for equitable allocation of resources by demanding accountability, transparency, and proper public policy management from local governments. In these approaches, it is important to identify community assets—including human, financial, and physical resources as

well as social networks, civic organizations, and local leaders—and build upon these to develop infrastructure, programs, and processes that maximize those resources and that are fully aligned with communities' characteristics and needs.

175.   Also needed are urban and development planning and policies that emphasize managed growth, safe and smoke-free public spaces, risk reduction for natural and manmade hazards, and transportation systems that include mass transit as well as bikeways, walkways, and other incentives for physical activity.

176.   All these approaches require, for any given environmental context, assessing the health and equity challenges and opportunities, identifying stakeholders—both individuals and institutions—and developing their capacity to take action, ensuring intersectoral collaboration, mobilizing or redistributing resources, implementing programs, and advocating for policy change.

Disasters and Response

177.   Haiti's catastrophic January 12 earthquake was a tragic reminder that chronic poverty, haphazard urbanization, and weak governance enhance vulnerabilities to natural disasters. At the same time, the international response to the disaster underscored the pivotal role of coordination in emergency relief operations.

178.   With an estimated 220,000 dead and 300,000 injured, UN and other international agencies, nongovernmental organizations, and bilateral teams mobilized a massive influx of human and material resources to help victims of the disaster. The destruction of transportation and health infrastructure—including the loss of Haiti's Ministry of Health building along with many of its key personnel—created unprecedented challenges in managing these resources. PAHO's PROMESS warehouse, which was fully stocked when the earthquake struck, played an important role in distributing medicines and medical supplies to where they were most needed.

179.   PAHO also provided critical leadership as head of the Health Cluster, coordinating the efforts of health partners as they established field hospitals, mobile health clinics, water and sanitation facilities, and a referral network linked to functioning hospitals. Among the major challenges in this regard were keeping track of changes in partners' locations, operations, and scope of services and maintaining consistency between the work of these partners and the objectives and priorities of Haiti's Ministry of Health.

180.   The six-month report of the Inter-Agency Standing Committee (IASC) on the Haiti response points out that, in general, the international humanitarian community failed to engage sufficiently with local organizations and authorities, and therefore

missed the opportunity to benefit from their expertise and local knowledge. An exception to this rule was organizations with permanent in-country operations. PAHO, which had a permanent staff of 52 in Port-au-Prince, was able to respond better and provide better leadership as a result of its longstanding relations with government officials, local partners, and the Haitian people.

181. Chile's February 27 earthquake was some 500 times stronger than Haiti's, yet the impact of the quake and ensuring tsunami was far less devastating. In Chile, the affected areas were less densely populated, housing and infrastructure were more structurally sound, and the government, headquartered far from the epicenter, was left intact and was fully able to respond.

182. Despite the loss of 4,000 hospital beds, Chile's health system was able to provide needed services throughout the emergency. This was made possible by the rapid deployment of field hospitals and the fact that the majority of permanent hospitals in the affected areas remained functioning.

183. Most hospitals that did suffer damage were older structures that had not been upgraded to reduce their vulnerabilities to disasters. Many of these damaged facilities were near, and in some cases just meters away from, new hospitals or health facilities that suffered little or no damage. These newer facilities, built to "safe hospital" standards, continued providing health services, absorbing the demand left by the damaged structures. Chile now has the opportunity to build or retrofit all its hospitals to be disaster-safe.

184. Other lessons from Chile's quake include the need to improve early warning systems, update preparedness and response plans, and provide simulation exercises and training to improve collaboration and coordination among the institutions involved in disaster response.

Personal Security

185. Violence and personal insecurity remain serious problems in many countries of the Region and, in many cases, are on the increase. PAHO's support has been aimed at promoting public health interventions where these can make a difference, particularly in the areas of gender-based and intra-family violence, adolescent health and development, and homophobia and stigma.

186. While progress has been made in the areas of gender-based and intra-family violence, much more work remains to be done. Primary prevention, that is, preventing violence before it takes place, is a relatively new field that is still building a knowledge base about risk and protective factors and effective interventions. Current evidence

suggests that exposure to violence in childhood is a consistent risk factor for both perpetrators and victims of violence later in adult life. However, strategies to address child maltreatment and gender-based violence are often implemented separately. Greater efforts are needed to address these and other issues, such as poverty and alcohol use, in an integrated manner and to intervene at a young age. Moreover, primary prevention efforts are necessarily multisectoral and need to bring together various actors, including from the health, education, social, and judicial sectors. PAHO is working to strengthen the capacity of Member States to carry out primary prevention strategies in various ways, including through capacity-building workshops and rigorous evaluation of innovative efforts, such as home visitation programs for adolescent mothers.

187.   Although primary prevention of violence is a priority, it is also important to ensure that survivors of violence have access to appropriate health services and to justice. Additional efforts are needed to strengthen the quality of existing services, increase monitoring and evaluation of these efforts, and determine the best strategies to address new challenges, such as gender-based violence as it relates to migration, HIV/AIDS, the drug trade, and natural disasters. PAHO is working to improve the health sector response to survivors of gender-based violence through efforts to build capacity on monitoring and evaluation of gender-based violence programs and the publication of resource manuals.

188.   Finally, while considerable progress has been made toward improving the quality of prevalence data on gender-based violence in the Region, limited comparability and a lack of follow-up studies make it difficult to contrast data across countries and to monitor trends over time. PAHO is working with other organizations, such as the CDC, to improve the quality, availability, and use of population-based data on gender-based violence to help strengthen programming in this area.

189.   As for stigma and discrimination, there have been many positive developments at the global and regional levels. Nevertheless, discrimination against people with different sexual orientations or sexual identities persists in society in general and in the health sector in particular. It directly contributes to the spread of HIV, as the fear of stigma tends to dissuade people from seeking HIV testing and counseling as well as treatment. Studies have documented the effects on victims of homophobic bullying, which can include lack of sleep, loss of appetite, isolation, nervousness, elevated rates of actual and attempted suicide, absenteeism and truancy, and limited achievement at school.

190.   Other manifestations of homophobia and transphobia range from job and social discrimination to verbal and physical violence, including murder, prompting several PAHO Member States to begin registering hate crimes against sexual minorities.

191. Changing the values and attitudes that underlie homophobia and transphobia requires the participation of health providers, families, communities, policymakers, and other key stakeholders. Civil society and national authorities must come together to define and standardize clear values regarding diversity, safety, inclusion, and human rights and the unacceptability of stigma and discrimination. Support should be given to individuals who suffer discrimination or aggression, and institutions and individuals need to be held accountable for their actions in this regard. Nevertheless, preventive, rather than reactive, action should be the priority. In addition, countries should step up their monitoring of homophobic and transphobic discrimination and violence.

192. A related challenge is discrimination associated with social exclusion, an important social determinant of health and human security. This type of discrimination can increase during times of economic stress, when competitive strategies for personal and family survival can eclipse concerns such as social solidarity and the common welfare. Examples include growing anti-immigrant sentiment and questioning of the affordability of social protection schemes (see also below). In these contexts, public health proponents must continue to stress the interdependence of individuals, communities, and countries and the fact that individual security depends heavily on collective security.

Systems for Social Protection

193. The notion that people have a human right to social security is gaining currency at the global and regional levels, producing considerable political will for expanding social protection systems. This is reflected in the new Social Protection Floor Initiative, led by the ILO and WHO and supported by 19 UN agencies as well as development banks, bilateral organizations and NGOs. In the Region of the Americas, this growing political will can be seen in the September 2009 launch of the new Inter-American Social Protection Network, in response to a request by heads of state at the Fifth Summit of the Americas four months earlier. The network is intended to facilitate the exchange of experiences to support the development of social protection systems that are efficient and effective in reducing poverty and inequality and improving quality of life for the Region's poor.

194. The experiences of Bolivia and Haiti show that schemes for social protection in health are not luxuries that only higher-income countries can afford. On the contrary, in poorer countries they can contribute to notable improvements in population health, particularly by reducing maternal and infant mortality. Moreover, history shows that societies with wide social protection are the most resilient in times of economic stress. Marshaling such evidence can strengthen advocacy for establishing and expanding social protection in health even in the current economic climate.

195.   For existing social protection systems, the most important short-term challenge is sustainability. This is especially true in countries such as Haiti that lack a tax structure to generate the necessary funds for these systems to continue functioning. But even better-established social protection systems face this challenge during times of economic strain. Finding new ways of financing these systems sustainably and without relying solely on employment contributions is essential. In poorer countries like Haiti, it will be necessary to align all available resources—including both domestic and international cooperation funds—with national health plans under the direction of the country's health authorities.

The H1N1 Pandemic

196.   As noted in Chapter II, the 2009-2010 H1N1 influenza pandemic tested several years' worth of pandemic preparedness efforts undertaken by the hemisphere's countries with PAHO support. In a meeting in mid-September 2009, representatives from PAHO Member States discussed those efforts in the context of the H1N1 pandemic. Among their conclusions were the following:

- The existence of national pandemic preparedness plans in nearly all the countries provided needed guidance, but most plans were insufficiently operational, particularly about action required at the local level.
- Preparedness efforts should involve the private as well as public sectors and should include measures for intersectoral coordination. This would facilitate more rapid incorporation of private healthcare providers into a coordinated pandemic response.

- Pandemic preparedness plans should be flexible and adaptable to different scenarios, given the wide range of characteristics and evolutionary patterns that future pandemics could present.

197.   Despite the moderate-to-mild virulence of the H1N1 virus, the 2009-2010 pandemic exposed weaknesses in countries' health systems. In several countries, the large numbers of cases put such a strain on health services that regular surgeries and other services had to be postponed. Certain risk groups, particularly pregnant women, were more heavily impacted than is recognized by the general public, and partly as a consequence, pregnant women were among the groups with the lowest uptake of the pandemic H1N1 vaccine.

198.   The pandemic also highlighted once again the importance of public trust in health authorities and evidence-based decision-making, as well as the power of fear based on poor information. The adoption of unnecessary restrictions on people's movements or

gatherings and the public's limited uptake of the new H1N1 vaccine in many parts of the world are just two examples.

199.   One of the most important lessons of the 2009-2010 pandemic speaks in a larger sense to the issue of human security: in a globalized world, no individual, family, community, or country can be completely secure when the security of others is at serious risk. This means that investments in public health, strengthening of health systems, international partnerships, and solidarity are the best weapons to defend against the next, quite possibly more virulent, global public health enemy, whether a new influenza virus or a different threat. Combined with intersectoral efforts that address the other components of human security, such investments and partnerships will yield short- and longer-term dividends for both human and societal development, strengthening the resilience of countries while substantially improving their populations' quality of life.

200.   This report covers a very challenging year for public health in the Region of the Americas. Most of the preparedness efforts paid off. Nevertheless, the huge differences in countries' capacities to ensure the human security of their citizens remain a priority to be addressed. Solidarity and horizontal cooperation among countries on health matters have again been shown to be strong assets in the quest to protect peoples' lives and well-being. At the same time, PAHO's mission of leading strategic collaborative efforts has again proved vital to improving the well-being, health, and security of the peoples of the Americas.

ACRONYMS AND ABBREVIATIONS	
ACHIPIA	Chilean Agency for Food Safety
AECID	Spanish Agency for International Development Cooperation
AFRO	WHO Regional Office for Africa
AIDS	Acquired immune deficiency syndrome
AMRO	WHO Regional Office for the Americas
AyA	Institute of Water Supply and Sewerage Systems (Costa Rica)
CAFTA-DR	United States–Dominican Republic–Central America Free Trade Agreement
CAREC	Caribbean Epidemiology Center
CCSD	Centers for health coordination during disasters (Costa Rica)
CCSS	Costa Rican Social Security Fund
CDC	U.S. Centers for Disease Control and Prevention
CERF	United Nations Central Emergency Response Fund
CIDA	Canadian International Development Agency
CLAP/SMR	Latin American Center for Perinatalology/Women's and Reproductive Health
CNE	National Commission of Risk Prevention and Emergency Care (Costa Rica)
CONASAN	National Council on Food and Nutritional Security (El Salvador)
CONASEVI	National Commission on Road Safety (El Salvador)
CONPES	National Council on Economic and Social Policy (Colombia)
COSEVI	Road Safety Council (Costa Rica)
DIPECHO	Disaster Preparedness ECHO (European Commission)
ECHO	Humanitarian Aid department (European Commission)
ECLAC	Economic Commission for Latin America and the Caribbean
EMRO	WHO Regional Office for the Eastern Mediterranean
EPA	Environmental Protection Agency (EPA)
EURO	WHO Regional Office for Europe
EMS	Event management site (IHR)
EVIPNET	Evidence-Informed Policy Network
DFID	UK Department for International Development
FAO	Food and Agriculture Organization
FCTC	WHO Framework Convention on Tobacco Control
FOCARD-PHC	Forum for Central America and the Dominican Republic on Drinking Water and Sanitation
FONASA	National Health Fund (Uruguay)
FVP	Faces, Voices, Places of the MDGs
GOARN	Global Outbreak Alert and Response Network
GDP	Gross domestic product
HIV	Human immunodeficiency virus
IAFA	Institute on Alcoholism and Drug Dependency (Costa Rica)
IDB	Inter-American Development Bank
IGSS	Guatemalan Social Security Institute
IHR	International Health Regulations
IHSDN	Integrated health service delivery networks
ILO	International Labor Organization
IMCI	Integrated Management of Childhood Illness
INCAP	Nutrition Institute of Central America and Panama

ACRONYMS AND ABBREVIATIONS *(cont.)*	
LGBT	Lesbian, gay, bisexual, and transgender
LSS/SUMA	Logistics Support System/Supply Management System
MDG	Millennium Development Goals
NFP	National focal points (IHR)
NGO	Nongovernmental organization
NIOSH	National Institute for Occupational Safety and Health (United States)
NORAD	Norwegian Agency for Development Cooperation
OAS	Organization of American States
OCHA	Office for the Coordination of Humanitarian Affairs
PAHEF	Pan American Health and Education Foundation
PAHO	Pan American Health Organization
Panaftosa	Pan American Foot and Mouth Disease Center
PANDRH	Pan American Network for Drug Regulatory Harmonization
PCR	Polymerase chain reaction
PERC	Production, Efficiency, Resources, and Cost
PMNCH	Partnership for Maternal, Neonatal and Child Health
RAVREDA	Amazon Network for the Surveillance of Anti-malarial Drug Resistance
RS10	Road Safety in 10 Countries
SAFE	Surgery, Antibiotics, Facial cleanliness, and Environmental improvement
SGSSS	General System of Social Security in Health (Colombia)
SIDA	Swedish International Development Cooperation Agency
SIP	Perinatal Information System
SIVE	National Epidemiological Surveillance System (Ecuador)
SOG	Free Obstetric Care (Haiti)
STI	Sexually transmitted infection
SUN	Sustainable United Nations
TCC	Technical Cooperation among Countries
UN	United Nations
UNAIDS	United Nations Joint Program on HIV/AIDS
UNASUR	Union of South American Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UN-HABITAT	United Nations Human Settlements Program
UNHCR	United Nations High Commissioner for Refugees
UNIBAM	United Belize Advocacy Movement
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNISDR	International Strategy for Disaster Reduction
UNODC	United Nations Office on Drugs and Crime
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
WFP	World Food Program
WHO	World Health Organization

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