health, including recognition of the universal right to health regardless of gender or ethnic group, will be an essential element of the renewed vision and strategies. Special attention will be given to balancing health promotion, protection, reparative, and curative activities, so that both individual and collective needs are satisfied.

Despite the colossal challenge posed by the task, there is reason to believe, without being overly optimistic, that the current political and social context present unprecedented opportunities to renew health for all. Recent trends point to democratization and peace, greater commitment among authorities to the achievement of equity, and positive reforms that encourage social participation with redistribution of power and resources in some countries. Moreover, the dissemination of a positive view of health and a greater social consciousness about the importance of being individually and collectively healthy, coupled with the effects of the information revolution, constitute solid allies for health for all. The policies of international financial institutions currently favor investment in health, and increasing international experience in disease control is also an encouraging trend. There exist, therefore, more possibilities for interagency, intersectoral, and interinstitutional work, along with a greater managerial and technological capacity. Physicians and medical professionals are more aware and supportive of a broader view of health and health problems, and there is greater logistical support at the local level, which improves the capability to identify problems and fight poverty.

The achievement of previously set goals and new ones, as well as the successful application of strategies, depends on a variety of factors, some internal and others external to the health sector. Success will, however, ultimately depend on society's commitment to achieve higher levels of health and well-being for all.

Regional Plan of Action on HIV/AIDS Control 1996–1999 and NGO–Government Collaboration

Since the beginning of the HIV/AIDS epidemic, PAHO has supported the countries of the Americas in their prevention and control efforts—support that has included both direct technical cooperation and resource mobilization. During the Summit of the Americas in December 1994, the Heads of State of 34 countries of the Region mandated PAHO to develop a program to prevent the spread of HIV/AIDS and to identify sources of funding.

In response to that mandate and as a continuation of PAHO's work in the Region, the Organization has developed a Regional Plan of Action for HIV/AIDS Control for the period 1995–1999. It provides the necessary framework for col-

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Source: Pan American Health Organization. Poverty alleviation, health and human development in Latin America and the Caribbean 1996–2000: report of the Pan American Health Organization to the Canadian International Development Agency, January 1996. Washington, DC: PAHO; 1996.

laboration with the new Joint and Cosponsored United Nations Program on AIDS (UNAIDS), which has now succeeded the Global Program on AIDS, and for the successful implementation of culturally specific, multinational, and multisectoral responses to the epidemic. It is vital that the momentum gained to this point in the countries' fight against HIV and AIDS not be lost. The Regional Plan, therefore, is designed to provide assistance to the national HIV/AIDS programs through the provision of basic technical and financial support to sustain activities that address the health aspects of this disease. PAHO is seeking to mobilize funds from multiple donors to cosponsor this important endeavor.

Nonetheless, PAHO is also cognizant that the experience of international AIDS prevention efforts to date confirms that nongovernmental organizations (NGOs) and community-based groups have essential roles to play in AIDS prevention, control, and care. Indeed, nongovernmental and voluntary organizations were the first to respond to the HIV epidemic in both industrialized and less industrialized countries. Where governments were slow to act or failed to recognize the extent of the disease, NGOs provided education, prevention activities, care, counseling, and advocacy for people with AIDS and HIV.

Nongovernmental organizations working in AIDS prevention and care typically offer the advantages of being cost-effective and responsive to new needs, and they have access to important target groups such as youth, women, migrants, and sex workers. Today, NGOs represent the only hope of AIDS prevention and care for many marginalized communities with little access to government services.[1]

The number of individuals with AIDS or who know that they are HIV positive is still relatively small compared to the numbers projected for the future. Few human service organizations fully understand the depth of the impact that further increases in HIV and AIDS will have on service delivery. It is vital that these organizations coordinate their efforts now so that communities will be able to respond effectively and humanely in the years to come.

Complementing the Regional Plan of Action for HIV/AIDS Control is PAHO's NGO–Government Collaboration Program for HIV/AIDS prevention, care, and control. This program had remarkable success in Barbados, Guatemala, Honduras, and Saint Lucia during 1995. During a process involving a series of strategic planning workshops, the respective national governments and NGOs engaged in discussions in order to share experiences. The ultimate objective is that the exchange of ideas, perspectives, and methodologies will serve as a catalyst for the creation of formal mechanisms designed to sustain an ongoing dialogue on policy and planning. This program will continue to build on the experience gained in strengthening the capacity of NGOs to minimize the spread of HIV/AIDS in Latin America and the Caribbean by fostering systematic dialogue, planning, and action among the NGOs, the national governments, and the private sector.

The human face of AIDS is increasingly younger and female. Women constitute the fastest growing group of persons living with HIV and AIDS. Numerous and serious obstacles must be overcome if HIV/AIDS in women is to be prevented and if women living with AIDS and HIV are to receive quality health care. Some of these obstacles are cultural and religious and, consequently, will take generations to modify. PAHO's Women, Health, and Development Program concentrates on those obstacles that can be mitigated in

[1]U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). *Addressing emerging infectious disease threats: a prevention strategy for the United States.* Atlanta, Georgia: CDC; 1994:p 1.

the shorter term while also targeting long-term changes. By working closely with women's community health groups that provide integrated health care, ways to prevent STD and HIV among women can be tested in order to identify successful approaches that then can be applied on a wider scale.

The HIV/AIDS pandemic—with all its complexities of home and community care, social attitudes, and economic and human rights issues—presents innumerable difficulties which can only be solved by people from diverse organizations working together and learning from one another.

Progress toward Elimination of Chagas' Disease Transmission in Argentina

BACKGROUND

Chagas' disease exists only in the Americas. It is caused by a flagellate protozoan parasite, *Trypanosoma cruzi*, transmitted to humans by triatomine insects known in different countries by various popular names—for example, kissing bug, vinchuca, barbeiro, and chipo, among others.

Conditions permitting transmission are present from latitude 42° N to latitude 40° S. The geographical distribution of human *T. cruzi* infection extends from the southern United States of America to southern Argentina and Chile. The disease affects 16–18 million people, and some 90 million—about 25% of the population of Latin America—are at risk of acquiring Chagas' disease.

After an asymptomatic period of several years, 27% of those infected develop cardiac symptoms that may lead to sudden death; 6% develop digestive system damage, mainly megaviscera; and 3% present peripheral nervous involvement. The remaining 64% do not develop noticeable symptoms.

The rural-to-urban migration that occurred in Latin America in the 1970s and 1980s changed the traditional epidemiologic pattern of Chagas' disease, transforming it from a rural infection to one that could be transmitted in urban areas via blood transfusion.

The areas of transmission in Argentina cover about 60% of the national territory. The main vector is *Triatoma infestans*, a domestic species.

CONTROL PROGRAM IN ARGENTINA

Chagas' disease control activities started in Argentina in the early 1950s with isolated efforts in Chaco, La Rioja, and Catamarca provinces. However, it was not until 1962 that a national program was organized through the creation of two institutions: the National Vector Control

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Source: World Health Organization. Chagas disease; progress towards elimination of transmission. *Wkly Epidemiol Rec* 1996;71(2):12–15. Based on *Boletín Epidemiológico Nacional* 1994;2:3–16; Ministerio de Salud y Acción Social, Dirección de Epidemiología, Buenos Aires.